LEABHARLANN CHOLÁISTE NA TRÍONÓIDE, BAILE ÁTHA CLIATH | TRINITY COLLEGE LIBRARY DUBLIN
Ollscoil Átha Cliath | The University of Dublin

Terms and Conditions of Use of Digitised Theses from Trinity College Library Dublin

Copyright statement

All material supplied by Trinity College Library is protected by copyright (under the Copyright and Related Rights Act, 2000 as amended) and other relevant Intellectual Property Rights. By accessing and using a Digitised Thesis from Trinity College Library you acknowledge that all Intellectual Property Rights in any Works supplied are the sole and exclusive property of the copyright and/or other IPR holder. Specific copyright holders may not be explicitly identified. Use of materials from other sources within a thesis should not be construed as a claim over them.

A non-exclusive, non-transferable licence is hereby granted to those using or reproducing, in whole or in part, the material for valid purposes, providing the copyright owners are acknowledged using the normal conventions. Where specific permission to use material is required, this is identified and such permission must be sought from the copyright holder or agency cited.

Liability statement

By using a Digitised Thesis, I accept that Trinity College Dublin bears no legal responsibility for the accuracy, legality or comprehensiveness of materials contained within the thesis, and that Trinity College Dublin accepts no liability for indirect, consequential, or incidental, damages or losses arising from use of the thesis for whatever reason. Information located in a thesis may be subject to specific use constraints, details of which may not be explicitly described. It is the responsibility of potential and actual users to be aware of such constraints and to abide by them. By making use of material from a digitised thesis, you accept these copyright and disclaimer provisions. Where it is brought to the attention of Trinity College Library that there may be a breach of copyright or other restraint, it is the policy to withdraw or take down access to a thesis while the issue is being resolved.

Access Agreement

By using a Digitised Thesis from Trinity College Library you are bound by the following Terms & Conditions. Please read them carefully.

I have read and I understand the following statement: All material supplied via a Digitised Thesis from Trinity College Library is protected by copyright and other intellectual property rights, and duplication or sale of all or part of any of a thesis is not permitted, except that material may be duplicated by you for your research use or for educational purposes in electronic or print form providing the copyright owners are acknowledged using the normal conventions. You must obtain permission for any other use. Electronic or print copies may not be offered, whether for sale or otherwise to anyone. This copy has been supplied on the understanding that it is copyright material and that no quotation from the thesis may be published without proper acknowledgement.

Realising the right to health in private and public law

Des Hogan

Candidate, Ph.D. (Doctor in Philosophy)

Declaration

This thesis has not been submitted as an exercise for a degree at this or any other University.

It is entirely my own work, drawing on the references set out in the footnotes and bibliography.

I agree that Trinity College Library may lend of copy of the thesis upon request, on the understanding that this permission covers single copies made for study purposes only and subject to the normal conditions of acknowledgement and citation.

Des Hogan

27 February 2013

TRINITY COLLEGE
- 4 MAR 2014
LIBRARY DUBLIN

Thesis 10245

Summary

The methods used in this thesis were primarily literature-based involving a review of relevant international and national jurisprudence relating to international human rights law, constitutional law, administrative law and the law of tort. Also reviewed was the literature covering these disparate areas, core texts, interpretative comments, commentaries, opinions, theories and responses of commentators. Areas covered include philosophy, jurisprudence, law, medicine, social science and international relations.

Most of the research was conducted in Trinity College Dublin and through its extensive on-line electronic catalogues. Some of the research was conducted at the Bodelian Law Library, Oxford University, England. Having worked in the area of human rights for a number of years, the purpose of undertaking the research was to deepen my academic expertise in the field.

The research question in this thesis is whether the right to health, as set out under international human rights law, is adequately reflected in domestic Irish law and, in particular, whether domestic law adequately vindicates the right to health through legal accountability where violations of the right occur.

The major findings of the thesis are first that there is an identifiable right to health under international human rights law of which there are two core non-derogable aspects which concern Ireland and other developed States, namely non-discrimination in access to health (available, accessible, acceptable and quality health services) and the requirement of an effective health system, strategy and plan which delivers the right to health; second, there is an obligation to ensure the right in the State through justiciable means in the absence of alternative forms of redress; third, Ireland's dualist system of law and the traditional private form of health delivery renders it difficult to transpose the right under existing structures of law and regulation; fourth that constitutional law recognises aspects of a right to health including its horizontal justiciability; fifth, that with the decline of identifiable sources of law following the relegation of natural law doctrine, this recognition is subject to strict separation of powers, judicial deference and judicial mechanisms which review interferences rather than omissions of the State; sixth, that constitutional or legislative control doctrines could, if introduced, rectify these

structural concerns if a justiciable right to health were introduced, seventh, that equality law could also provide a justiciable right to health - whether vertical or horizontal and whether at constitutional or legislative level; eighth, that constitutional law defers to the law of tort and medical negligence in addressing medical malpractice claims under which right to health litigation occurs; ninth, that interpersonal relations and the requirement to meet strict duty of care and causation tests predicate the response of tort law; tenth, that under traditional deference to medical paternalism, the courts assessment is based primarily on medical peer review with modified causation tests possible in pockets only; eleventh, that with the advent of enterprise liability, the direction of law is turning in favour of medical claimants; twelfth, that no fault doctrines of tort may increase compensatory relief but may remove incentivisation, regulation of malpractice and civil redress of moral wrongs; thirteenth, that while accountability through regulatory approaches also allows for aspects of the right to health to be vindicated, key aspects of justiciability (legal or reparations accountability) render it questionable whether the State can meet its right to health obligations including compensation, deterrence, accountability and non-repetition through tort law alone.

The main thrust of the thesis is that aspects of the right to health are increasingly been recognised in domestic systems and by the European Court of Human Rights, the European Union and UN treaty bodies under the doctrine of positive obligations which suggests that a transformative culture of the right to health is emerging and being introduced directly (EU law) and indirectly (European Court, UN conventions) into Irish law.

The thesis considers whether the right to health is evident under Irish domestic law with its two-tier system of parallel public and private health provision. Examining the core non-derogable right to health of access to available, accessible, acceptable and quality health care on a non-discriminatory basis and an effective health system to deliver health care under the tripartite "respect", "protect" and "fulfil" typology requirements, the thesis considers the extent to which Irish law meets the international right to health.

Acknowledgements

There are a number of people to whom my gratitude is owed.

I wish to thank Professor William Binchy, for suggesting the topic to me and for encouraging me to re-enter the terrain of research and critical thinking in pursuit of this thesis. I thank you for your time, your patience and your deep humanity during our many discussions over the course of this thesis.

I wish to thank my employer, the Irish Human Rights Commission, for supporting me in the pursuit of and throughout this thesis.

I thank Sue Bird, Bodleian Law Librarian for the hospitality afforded me during my time in Oxford researching the thesis.

Most of all, I thank Jenny for her enduring patience, support and humour.

DH

TABLE OF CONTENTS

Declaration 2

Summary 3

Acnowledgements 5

Table of Contents 6

PART 1

Introduction 10

1 Introduction to international human rights law 13

- Healthcare as an international concern 16
- World Health Organization 17
- Public and private health 22

2 Right to health under international law 26

- Council of Europe 28
- European Convention on the Protection of Human Rights and Fundamental Freedoms 29
- Revised European Social Charter 39
- European Union 49

3 The right to health on the universal level 71

- International Covenant on Economic, Social and Cultural Rights 72
- Dimensions of the right 73
- AAAQs 76
- The progressive nature of the right 79
- Presumption against retrogression 85

4 "Core" Obligations of immediate effect 88

- Non-discrimination as a non-derogable core obligation 92
- The importance of non-discrimination in improving health outcomes 101

5 The framework within which the right must be capable of being accessed 109

- Obligation to "Respect": non-interference 109
- Obligation to "Protect": measures to be taken..... 111
- Obligation to "fulfil": legislation and national health policy and plan 112

6 National framework 115

- Benchmarks and indicators 116
- Complementary approaches: WHO..... 117

7 Accountability 125

- The obligation to regulate private actors who deliver health services 128
- The obligation to ensure reparation for violations of the right to health 131
- State review by the CESCR 136
- Justiciability before national courts 141
- Other remedies 145
- Privatisation and the UN Guiding Principles 146
- The World Trade Organization 153
- Obligations concerning the acts/ omissions of private entities 160

PART 2

8 The right to health under domestic law..... 166

- Dualism: The penetration of international conventions into domestic law 169
- European Union law 172
- The European Convention on Human Rights Act 2003 173
- The Equal Status Acts 2000-2012..... 178
- The Health Acts 1947-2007 183
- The Health Insurance Acts 1957-2012 186

9 Fundamental rights under the Constitution 196

- The right to life 199
- The unenumerated right to bodily integrity and its source ... 214

- Sources of unenumerated rights: the role of Natural Law..... 221
- Article 45 as a source of interpretation..... 234
- Article 6 as a source of interpretation 238
- Dignity and paternalism 241
- The right to privacy and bodily integrity 243
- The right to the person 250

10 The Separation of Powers Doctrine 258

- Constitutional litigation and judicial deference 266
- Criticism of judicial restraint..... 279
- Judicial review of public and private actors 285

11 Constitutional and Legislative control doctrines 301
12 Equality and non-discrimination 317
13 Is there a horizontal constitutional right to health? 336

- Presumption that constitutional rights can be vindicated through the law of tort..... 340
- Is there a doctrine of horizontality under Article 40.3? 346

- The effectiveness of tort law 350

PART 3

14 The Law of Tort 352

- The relevance of tort law to the right to health 352

- How contract law differs from tort 353
- The purpose and function of the law of torts 357
- The duty to my neighbour 370
- Statutory duties 382

- **Linkages with the right to health 383**

15 Medical negligence: individual liability 387

- ***Res ipsa loquitur* 404**
- **Duty of care owed by hospitals and institutions 412**
- **Organisational or institutional liability..... 414**
- **Vicarious liability 414**
- **Organisational negligence 418**
- **Non-delegable duty of care 425**

16 Modified tests: material causation of the harm occasioned.... 436

- **Loss of Chance 440**
- **Disclosure/ informed consent 446**
- **Compensation 453**

17 Can Tort vindicate the constitutional right to health? 454

- **No fault compensation 456**
- **Individual versus community response: the "justice" argument..... 457**
- **No fault and accessibility 462**
- **Other rationales for no-fault 465**

PART 4

18 Accountability: Regulation 472

- **Administrative complaints 482**

PART 5

19 Conclusions..... 485

Appendix 496

Introduction

In this thesis we will examine whether there is an internationally recognised norm of universal health care for all and whether domestic Irish law adequately vindicates the right. International standards, recognising as they do the status quo and seeking the consensus of States in their adoption, envisage either public or private provision, or indeed a mix of both, provided the State ensures the right to health. The international right to health was established in the context of healthcare being traditionally a private interpersonal matter, provided by a doctor to a patient and arising from his "status and "common calling". The traditional private "medical model" focused on illness and cure in its interpersonal doctor-patient relationship where the State had no role, rather than public population-based approaches to health stressing the social determinants of health and the need to reach disadvantaged persons or groups.

Despite the fact that a right to health is recognised in the constitutions of a number of States, including (implicitly) Bunreacht na hÉireann,[1] the need for constitutional or legislative control doctrines to ensure accountability and transparency of delegation to private bodies delivering health services has received less scrutiny, partly on the basis that medicine and the law's account of malpractice through medical negligence has traditionally been the preserve of physicians and the judgments of their peers. Insofar as it originated in private law interactions, it was not a State function "privatised" to private actors. The nation state and later the international community introduced legal frameworks against the backdrop of this private law preserve. More recent emphases on public health and their social determinants, with the concomitant national health strategies and plans of action and organisational and enterprise liability doctrines, are modern developments.

In this thesis we will examine the significance of the right to health under international law insofar as it may apply across these dimensions, in public and in private law, whether governed by statute, tort or no-fault systems. In addition to specifying the scope and content of the right to health, we will

---

[1] Bunreacht na hÉireann is the 1937 Constitution of Ireland: see Appendix for right to health prov isions in other national constitutions.

observe how a key aspect of the right is its justiciability: simply put States have a requirement to ensure that the right is capable of being claimed and vindicated in domestic law, regardless of whether health care decisions are acts or omissions or whether they are taken by public or private actors.

Internationally, the right to health is often discussed in terms of the imposition of private health care markets on developing States under liberalisation policies, the impacts and sometime injustices of these policies which bring with them competition and intellectual property rules. In parallel, recent refocusing on the social determinants of health involve increased international efforts to develop "pro poor" policies which target vulnerable groups with poor health outcomes. These international trends form a further backdrop to the evolving framework of the right to health and how it is discussed, protected and guaranteed.

The aim of this thesis is to examine whether domestic Irish law adequately vindicates the right to health as that right is understood in international law, under the tripartite "respect", "protect" and "fulfil" typology, with particular focus on those core non-derogable aspects of the right namely the right of access to available, accessible, acceptable and quality health care on a non-discriminatory basis and the right to (or rather the obligation of the State to provide) an effective health system to deliver health care. In Part 1 we consider the scope and nature of the right to health under the international instruments located in Council of Europe, European Union and United Nations conventions with a focus on legal accountability. In the second part of the thesis, we consider the situation in Ireland. In Part 2, we examine the constitutional right to health under the unenumerated rights doctrine, the limitations on the right following the demise of the normative Natural Law doctrine and whether recent enumerated rights jurisprudence, when coupled with judicial restraint, can vindicate the right. We also consider the scope of judicial review for private actors performing public functions and the promise of constitutional and legislative control doctrines on privatisation before considering the constitutional right to equality and the nature of horizontal constitutional rights. In Part 3, we consider the law of tort in Ireland. As a matter of interpersonal justice, the law of medical negligence has evolved from individual to enterprise liability, customary practice, the all-or-nothing causation rules, modified

causation and no-fault alternatives allowing consideration of whether the law of tort can ensure vindication of the right to health. In Part 4, we briefly consider regulatory accountability mechanisms in Ireland including both the regulation of healthcare professions and organisational regulation of both the public and private health systems. In Part 5, we profer some tentative conclusions as to how framework right to health legislation might vindicate the right to health in Irish law.

PART 1

1 Introduction to international human rights law

> ...the difference between international law and the law of a state ... is one of degree and not kind, and it tends to be reduced as the practice of resorting to international courts, which are able to work out the practical implication of general principles, becomes more common...
>
> J L, Brierly, *The Law of Nations* (6th Edition) (1963) at 76.

In Part 1, we will trace the development of international human rights law and consider how healthcare moved from being a mere private to public and later international concern, how it was framed under the developing standards of the Council of Europe and United Nations codified in conventions. The future impact of European Union law is also considered. We will observe how the early promise that the World Health Organization could shape and mould the contours of the developing right to health to include focus on the social determinants of health and marginalised communities was not realised. We consider the nature of the right to health and in particular two core non-derogable aspects of the right, namely non-discrimination and the requirement for a national public health strategy and plan of action which *inter alia* protects vulnerable groups. Having established the scope of the right to health, we consider whether international law binds private bodies where they deliver public health functions.

The State is the primary subject of international law. According to Article 38 of the Statute of the International Court of Justice, custom, treaties and general principles of law are the primary sources of international law. Once a State signs and then ratifies or accedes to an international treaty, convention or agreement, that State assumes legal obligations under international law in relation to the rights or freedoms guaranteed to legal persons in the agreement in question.[2] Traditionally under the law of nations, international obligations

---

[2] H J Steiner, P Alston, R Goodman *International Human Rights in Context, Law Politics Morals* (3rd Ed.) Oxford University Press (2008) at 152.

were owed to other States, with individuals viewed solely as objects, rather than subjects under international law.[3]

The establishment of the United Nations signalled a retreat from this absolutist position. The 1945 United Nations Charter specifically referred to human rights in its Preamble in addition to six of its articles.[4] Article 68 of the Charter established the Economic and Social Council which established the Commission on Human Rights. It was this Commission which was charged with establishing a Bill of Rights from 1946.[5] In 1948 the Commission presented a draft Declaration to the General Assembly which adopted the Universal Declaration of Human Rights ("UDHR").[6] The UDHR for the first time established the fundamental principle that individual humans, regardless of their identity or citizenship, had individual rights. However, the hope of a swift and unified Bill of Rights faded with the advent of the Cold War. In 1952 it was decided to divide the principles in the UDHR into two treaties, the International Covenant on Civil and Political Rights ("ICCPR") and the International Covenant on Economic, Social and Cultural Rights ("ICESCR"), which were approved by the General Assembly in 1966. These covenants only came into force in 1976 after the requisite number of State ratifications. Together they are known as the International Bill of Rights, argued by some to constitute customary international law.[7]

In parallel, regional systems for the protection of human rights were established, most notably the Council of Europe. Established in 1949, the Council of Europe has adopted regional multilateral human rights conventions of which the 1950 European Convention on Human Rights and Fundamental

---

[3] See D McGoldrick, *The Human Rights Committee, Its Role in the Development of the International Covenant on Civil and Political Rights*, Clarendon Press Oxford (1994) at 4.

[4] Namely Articles 1(3), 13(1)(b), 55(c), 62, 68 and 76 (see also Article 56).

[5] In 2006 the Commission was replaced by the Human Rights Council.

[6] The vote was 48 states in favour with 8 states abstaining: see H J Steiner, P Alston, R Goodman *International Human Rights in Context, Law Politics Morals* (3rd Ed.) Oxford University Press (2008) 108 at 135.

[7] A Clapham, *Non State Actors under International Law*, Oxford University Press (2008) at 148-149.

Freedoms ("ECHR")[8] and the 1961 European Social Charter (since 1996 the Revised European Social Charter ("RESC")) for the most part replicate the civil and political and economic, social and cultural rights respectively identified in the two international covenants. Inevitably, they also replicate the "priority" afforded to civil and political rights at the time.

The terms 'treaties', 'conventions', 'covenants' and 'agreements' are interchangeably employed to refer to human rights treaties but their meaning remains the same. Under international law, once a State ratifies a convention, it freely assumes obligations under international law according to the maxim 'pacta sunt servanda'.[9]

It can seek to limit these obligations through entering a reservation upon ratification[10], but this caveat aside, a ratifying State owes to individuals on its territory (regardless of nationality), the guarantee of the rights and freedoms set out in the respective United Nations or Council of Europe convention. The provisions in these conventions are interpreted according to the 1969 Vienna Convention on the Law of Treaties which codifies international law rules on such interpretation. A convention is to be interpreted 'in good faith in accordance with the ordinary meaning to be given to the terms of the treaty in their context and in the light of its object and purpose'.[11]

Thus far so good: individuals possess human rights as contained in international conventions and by upholding those rights, States are doing no more than honouring the legal commitments freely they entered into. Unfortunately this optimistic theme runs into the roadblock of States' routine disregard for human rights: not only do States fail to secure (respect, protect, fulfil) the rights they have committed themselves to guarantee, they often violate those rights through their agents. If we take the example of children and

---

[8] See D J Harris, M O'Boyle & C Warbrick, *Law of the European Convention on Human Rights* (2nd Ed.) Oxford University Press (2009) at 1-2.

[9] This is reinforced by Article 26 of the Vienna Convention on the Law of Treaties which provides that every treaty in force is binding upon the parties to it and must be performed by them in good faith; UN Doc, A/CONF, 39/27, 63 A.J.I.L. 875 (1969); 1155 UNTS 331.

[10] See H J Steiner, P Alston, R Goodman *International Human Rights in Context, Law Politics Morals* (3rd Ed.) Oxford University Press (2008) at 110 and 1124-1155.

[11] Article 31 of the Vienna Convention on the Law of Treaties.

the widely ratified 1989 UN Convention on the Rights of the Child ("CRC"), any review of the Concluding Observations of the Committee on the Rights of the Child makes clear that the rights of children are routinely trammelled on a daily basis by ratifying States.[12] The question is posed as to the purpose of international human rights conventions if the rights they guarantee are ignored.

There are two responses to this question: the motivating response - that international human rights conventions do work and do make a significant difference to State Parties - and the de-motivating response - that matters would be infinitely worse without their presence which acts as a constraint on the excesses of States. Regardless of either response, an ensuing question raises a number of conceptual difficulties. What if the agency which breaches individual human rights is not the State but rather a private actor? Can the very incidence of scrutiny and accountability of a State's acts or omissions against a universally agreed standard, with the ancillary peer and institutional review at the United Nations (coupled with the State's Universal Periodic Review on its human rights record), cover such situations? This thesis will seek to address that question in the specific context of the right to health. First we turn to the provision of health under international law.

1.1 Healthcare as an international concern

Prior to the nineteenth century, healthcare (public and private health) responsibility fell to families, religious organisations and private charities.[13]

---

[12] See for example the Committee on the Rights of the Child Concluding Observations on Panama on the conditions in juvenile detention centres in the State; Committee on the Rights of the Child, Fifty-eighth session, 19 September-7 October 2011, CRC/C/PAN/CO/3-4; on Italy regarding detention of child asylum seekers; Committee on the Rights of the Child Fifty-eighth session, 19 September–7 October 2011 CRC/C/ITA/CO/3-4; at para 63; on Egypt regarding the high level of sexual harassment and abuse of young girls: Committee on the Rights of the Child, Fifty-seventh session, 30 May-17 June 2011 CRC/C/EGY/CO/3-4; at paras 82-83. See also *UNICEF Guide to the Optional Protocol on the Involvement of Children in Armed Conflict* (2003) at 11.

[13] The emphasis in medical ethics - such as the Hippocratic Oath – on the physician's duty to the patient never extended to any duty to the entirety of the population of a nation until the formation of the Nation State: historically, the legal obligations of a doctor were derived from his "status and 'common calling', that is, to exercise the skill and diligence expecting of his calling". R Mulheron, *Principles of Medical Law* (3rd Ed.) Oxford University Press, (eds.) A Grubb, J Laing, J McHale (2010) at 135. The authors cite the first reported case against a doctor as being *The Surgeon's Case (or Morton's Case)* (1374) 48 Edw 11; at fn 22.

Only with the public health movement of the nineteenth century, with its emphases on sanitation, occupational hazards and environmental health, did the trend of widening the concept of responsibility from the feudal towards the nation state begin.[14]

1.2 World Health Organization

The World Health Organization ("WHO"), established as a specialised agency of the United Nations in 1946 on foot of the Charter and on the basis that "health is essential to international peace and security",[15] has three constituent organs. Its first organ, the World Health Assembly consists of Member States delegates and is the decision-making body. It may legislate in the form of treaties or regulations and it who may also issue recommendations, principles and guidelines.[16] Its second organ is its Executive Board comprising 32 technical individuals in the field of health with three year terms whose primary function is to give effect to decisions and policies of the Assembly and to provide it with advice. The third organ is the Secretariat, headed by the Director General and comprising 3,800 experts working in Geneva or in 6 regional offices.[17] The WHO Constitution, which is binding on State Parties, provides that the right to health 'is a fundamental human right'. Its Preamble states that "[T]he enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social conditions." The Preamble also defines health as 'a state of complete physical, mental and social well-being

---

[14] The concern of European powers of the time was not to tackle universal health problems, but rather to prevent the spread to Europe of the contagious diseases of cholera and yellow fever. This is also evident in the 1945 United Nations Charter health provisions which reflect primarily programmatic approaches to public health with its calls for inter-governmental cooperation to address risk of epidemics and pandemics; see Articles 1, 55-56. See generally Y Arai-Takahashi, *The Right to Health in International Law - A Critical Appraisal*, in R Martyn, & L Johnson (Eds), *Law and the Public Dimension of Health* London Cavendish Publishing Limited (Chapter 5) (2001) at 116 and M Ssenyonjo, *Economic, Social and Cultural Rights in International Law*, Oxford and Portland Oregon: Hart Publishing (2009) at 316.

[15] M Ssenyonjo, *Economic, Social and Cultural Rights in International Law*, Oxford and Portland Oregon: Hart Publishing (2009) at 317.

[16] See Articles 19-23.

[17] See World Health Organization Annual Report 2010.

and not merely the absence of disease or infirmity'.[18] Article 1 of the WHO Constitution provides the sole objective of the WHO is the "attainment by all peoples of the highest possible level of health".[19] Although this concept of "health for all" is the main focus of the WHO, despite its establishment as the directing and co-ordinating authority on international health work with an explicit mandate "to propose conventions ... with respect to international health matters", it has not promoted law-making in the field of health, with the notable exception of the 2003 WHO Framework Convention on Tobacco Control, pursuing rather a medical ethics technical and latterly biomedical approach to its mandate.

Some authors suggest that the WHO pursued neither its original mandate nor the principles of the UDHR before the WHO's convening of the Alma-Ata International Conference on Primary Health Care in 1978, in overwhelmingly addressing clinical/ biomedical aspects of health to the detriment of ignoring social and economic determinants. Such criticism suggests that WHO policy, since the socioeconomic approach to health rights embodied in the 1978 Alma Atta Declaration, has been undermined by not only other "adopted" UN organs such as the International Monetary Fund ("IMF"), the World Bank ("WB") and the World Trade Organization ("WTO"), but also by its own loss of credibility on the intersection of human rights and health[20], which has led to WHO adopting a paradigm of public-private partnership arguably inimical to its "health for all" mandate.[21] Here it is contended that WHO was "hobbled" in its efforts by its unwillingness and inability to engage with the "language of law

---

[18] This "Magna Carta of health" represented "the broadest and most liberal concept of international responsibility for health ever officially promulgated"; B M Meier, *Global Health Governance and the Contentious Politics of Human Rights: Mainstreaming the Right to Health for Public Health Advancement*, 46 Stanford Journal of International Law (2010) at 24.

[19] Signed by 61 States in 1946. Today the WHO has 194 Member States and an annual budget of $800m: see *www.who.int/gho/publications/world_health_statistics/en/index.html*

[20] Meier asserts that when WHO sought to "reclaim the mantle of human rights" in the pursuit of its Health for All strategy, its past neglect of rights-based strategies "left it without the human rights legitimacy necessary to implement primary health care pursuant to the Declaration of Alma-Ata"; B M Meier, *Global Health Governance and the Contentious Politics of Human Rights: Mainstreaming the Right to Health for Public Health Advancement*, 46 Stanford Journal of International Law (2010) 1 at 8.

[21] See T MacDonald, *Health, Human Rights and the United Nations, inconsistent aims and inherent contraditictions?* Radcliffe Publishing Oxford, New York (2008) at 136-145.

or set standards under international agreements" with the effect that while WHO's 1981 *Health for All* strategy was conceptualised in human rights terms[22], it depicted human rights "as a general humanitarian imperative rather than a specific legal obligation".[23] Although the Declaration of Alma-Ata framed its programmatic obligations on the basis of a human right to health[24], this was done without any specific reference to treaty law, an omission given the fact that human rights law had promulgated a human right to health.[25] WHO saw "no direct link" between Article 12 of the International Covenant on Economic, Social and Cultural Rights ("ICESCR") and WHO standards.[26] This led to the CESCR and the Special Rapporteur on the Right to Health increasingly taking the lead on the formulation of the right to health.

The reasons for WHO's early reticence to be the key UN agency in shaping the contours of the right to health appear to lie with the changing political directions in the organisation. After initially embracing the intersection of health and human rights and showing leadership on the formalisation of what became Article 12 of ICESCR in the period 1951-53[27], a change of leadership

---

[22] "A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice"; Declaration of Alma-Atta, para 5; see *www.who.int/publications/almaata_declaration_en.pdf* accessed on 11 January 2013,. This became WHO's *Global Strategy of Health for All by 2000*, World Health Organization 198, Geneva, available at *whqlibdoc.who.int/publications/9241800038.pdf* accessed on 11 January 2013.

[23] B M Meier, *Global Health Governance and the Contentious Politics of Human Rights: Mainstreaming the Right to Health for Public Health Advancement*, 46 Stanford Journal of International Law (2010) 1 at 44.

[24] "The people have the right and duty to participate individually and collectively in the planning and implementation of their health care", Declaration of Alma-Atta, para 3; see *www.who.int/publications/almaata_declaration_en.pdf* accessed on 11 January 2013.

[25] Article 25 of the Universal Declaration on Human Rights and Article 12 of the International Covenant on Economic, Social and Cultural Rights.

[26] B M Meier, *Global Health Governance and the Contentious Politics of Human Rights: Mainstreaming the Right to Health for Public Health Advancement*, 46 Stanford Journal of International Law (2010) 1 at 44. Consequently without an established human rights framework to guide primary health care, "WHO leaders could not bring states to accept their obligations to realize underlying determinants of health." The author asserts that insofar as the WHO focused on health as a set of functional problems rather than as a human right, "it failed to achieve both, undercutting its own practical health goals by denying them a grounding in the legal frameworks of the right to health"; ibid, at 45.

[27] By introducing important concepts such as the social determinants of health.

in 1953 led to the WHO "repositioning" itself in global health governance as a technical organisation which focused on "medical intervention and disease eradication to the detriment of rights advancement".[28] This in turn led to the draft text of Article 12 being stripped of its important provisions on the social determinants of health when finalised at the General Assembly in 1957.[29]

This leads to the interesting observation that several "UN" agencies are uncooperative in promoting the aims of the UDHR, with the work of the IMF, the WB and the WTO arguably in conflict with the WHO, the United Nations Children's Fund (UNICEF), the United Nations Educational, Scientific and Cultural Organization (UNESCO) and CESCR on the basis of ideology and politics. The latter agencies were created in order to further and strengthen key clauses in the UDHR whereas the former agencies were latterly established to protect the "rights" of banks and corporations in "developing" countries to keep with financial policies advantageous to the stockholders in those banks and corporations.[30] As will be observed, this leads to normative misunderstandings and conflict where liberalisation of trade can serve to undermine such human rights as primary healthcare (the pivotal policy

---

[28] B M Meier, *Global Health Governance and the Contentious Politics of Human Rights: Mainstreaming the Right to Health for Public Health Advancement*, 46 Stanford Journal of International Law (2010) 1 at 8. WHO Director-General MG Candau succeeded B Chisholm in 1953 and was in turn succeeded by Halfdan Mahler in 1973 who attempted to re-orientate WHO to re-focus on human rights and social justice, culminating in the Alma-Atta Declaration and the *Health for All* strategy; see below.

[29] Meier records how, when the finalisation of the right to health moved to the Third Committee of the General Assembly in 1957, "WHO had lost credibility to effect change within the U.N. Secretariat and among state delegations." As delegates "summarily eliminated the definition of health from the human right" under contradictory rationales that a) the definition was either unnecessarily verbose or b) irreconcilably incomplete, WHO personnel "made little attempt to prevent this deletion". Despite WHO's previous argument that the definition "accounted for the relationship between underlying determinants of health and disease, a causal link that states had implicitly adopted through the WHO Constitution, state amendments prevailed in eliminating from the right to health both a definition of health and any reference to "social wellbeing"; B M Meier, *Global Health Governance and the Contentious Politics of Human Rights: Mainstreaming the Right to Health for Public Health Advancement*, 46 Stanford Journal of International Law (2010) 1 at 48.

[30] The Articles of Agreement of the IMF and of the World Bank ("International Bank for Reconstruction and Development") were concluded at the Bretton Woods Conference in July 1944, with the World Bank (now primarily a development institution) originally designed to aid postwar reconstruction, whereas the IMF (primarily now a medium to long term financial institution with a mandate that includes development issues) was originally designed to correct disequilibria in the balance of payments and maintain an orderly system of receipts and payments between nations.

paradigm between promoting and sustaining development through global "free" or "fair" trade).

Does this argument ignore the successes of the WHO – from its immunisation programmes of a range of infectious diseases – smallpox, polio, thyphoid, cholera, measles to its public health information campaigns and provision for global epidemiological research?[31] Further consideration of the structure, mandate, work and institutional positioning of the WHO may suggest that both truths co-exist. Certainly its emphasis on addressing communicable diseases and responding to the needs/ requests of States through empowering its regional offices in technical assistance programmes brought with it many gains. The abandonment of its earlier emphasis on identifying global health priorities for the disadvantaged which by definition included non-communicable diseases and underlying determinants of health, meant, however, that it lost its leadership role on the right to health and meant that when it sought to implement its 1981 *Health for All* strategy, it had neither the legal framework to present to States nor the inter-sectoral collaboration of other UN specialised agencies to rely on.[32] WHO's re-focusing on the social determinants of health arguably came too late and foundered when not based on an application of human rights standards.[33]

WHO's earlier distancing of itself from inter-sectoral collaboration at the UN placed it an institutional disadvantage in its relations with the IMF, WB and

---

[31] See T MacDonald, *Health, Human Rights and the United Nations, inconsistent aims and inherent contraditictions?* Radcliffe Publishing Oxford, New York (2008) at 154.

[32] B M Meier, *Global Health Governance and the Contentious Politics of Human Rights: Mainstreaming the Right to Health for Public Health Advancement*, 46 Stanford Journal of International Law (2010) 1 at 25.

[33] Arguably WHO had little choice but to re-focus on the social determinants of health insofar as by the 1970s, the "promise of the golden age of medicine" which followed the Second World War, based as it was on a "biomedical vision of health, emphasizing antibiotics, medical technologies, and private urban hospitals as a means to achieve economic growth based on vertical medicine" had given way to new theories for "preventive medicine" in health discourse which "showed far greater promise in ameliorating communicable, acute, and chronic disease" This emphasis was to focus on the correlations among increasing poverty, inequality, and ill-health and sought to address perceived emergence of new threats (heart disease, cancer, labor migration and exploitation, drug addiction, overpopulation, and environmental harms) shifting public health toward an emphasis on the prevention of social, "lifestyle" determinants of disease; B M Meier, *Global Health Governance and the Contentious Politics of Human Rights: Mainstreaming the Right to Health for Public Health Advancement*, 46 Stanford Journal of International Law (2010) 1 at 25-28.

WTO as they developed and has contributed to the economic liberalisation policies of these institutions gaining precedence over the right to health where the two are in conflict.[34] This has arguably undone the broad definition of primary health care in the Alma-Atta Declaration and replaced it with a definition that "focuses on vertical, narrow, curative interventions in the context of national health system retrenchment, reduced health expenditure, and widening health inequities".[35] Where public health is treated as a humanitarian imperative rather than a legal right, it will invariably become subjected to legal frameworks as they become established.

Later in this thesis we will explore the potential for the WHO human rights mandate to be deepened, drawing on such WHO approaches as its 2000 *Health Systems, Improving Performance* and its 2007 report *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes*[36] in its call for a return to the Alma Atta priorities and focus on the social determinants of health and whether this may yet reconnect WHO programmatic with the legal right to health.

1.3 Public and private health

At the national level, traditional public health focused on "removal of sources of disease from the social environment, treating the person as the innocent victim of the dangers of nature, [whereas m]odern public health is

---

[34] Meier asserts that the "neoliberal economic paradigm" which he describes as policy prescriptions for privatisation, deregulation, and decentralisation, has led to the "dismantling of national health systems and the reorienting of economic development to the detriment of developing states" which has exacerbated health inequalities "within and between countries"; B M Meier, *Global Health Governance and the Contentious Politics of Human Rights: Mainstreaming the Right to Health for Public Health Advancement*, 46 Stanford Journal of International Law (2010) 1 at 47. MacDonald notes how the WHO was "gradually made to play second fiddle to the fiscal development interests of the WTO", T MacDonald, *Health, Human Rights and the United Nations, inconsistent aims and inherent contraditictions?* Radcliffe Publishing Oxford, New York (2008) at 137.

[35] B M Meier, *Global Health Governance and the Contentious Politics of Human Rights: Mainstreaming the Right to Health for Public Health Advancement*, 46 Stanford Journal of International Law (2010) 1 at 47. Rather, WHO has ben "forced into public-private partnerships for individual health care instead of primary health care for the public's health"; ibid.

[36] World Health Organization, *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes*, World Health Organization, Geneva (2007) at 2.

characterised by an understanding of the dynamic of relationships between people, States and nature, and of the health dangers arising from the modern industrialised technological world".[37]

Private health with its doctor/ patient relationship has been identified and recognised in law, whereas the law has been slow to recognise the contours of public health.[38] In contrast to private health law, public health law has proceeded on the assumption of authority of the State acting exceptionally for the benefit of the population such as in public health crises.[39] This approach is, however, now being challenged "from above and below" at both the international and individual level.[40]

In contrast to developing public health and practice, private health has focused primarily on the physician-patient relationship, even where this relationship occurs through the public health system. Discussions about patient autonomy tend to have an "exclusive focus" on individual patients, a pattern mirroring

---

[37] R Martyn, & L Johnson (eds.), *Law and the Public Dimension of Health* London: Cavendish Publishing Limited (2001) at xxxvi. The authors argue that this shift from prevention and cure to risk containment of activities has not been fully recognised in public health law according to some commentators, who suggest that public health law at all levels, most commonly national, remains grounded in the "identification of statutory nuisances as sources of public health harm; ibid.

[38] Johnson suggests that public health has "since at least the 19th century, been treated as the other, with private medicine dominating as 'real medicine"; L Johnson, *Defining Public Health*, R Martyn, & L Johnson (Eds), *Law and the Public Dimension of Health*, London: Cavendish Publishing Limited (2001) at 6. It will be observed that private health law is regulated by the law of tort (concerning physician or hospital-patient relationships), the law of contract (concerning health care arrangements between the State and private providers or contracts between those providers and private health "consumers") and more rarely the law of nuisance: see Part 2 of this thesis.

[39] Here, is observed the traditional obligation of citizens to subjugate themselves to State authority: L Johnson, *Defining Public Health*, R Martyn, & L Johnson (Eds), *Law and the Public Dimension of Health*, London: Cavendish Publishing Limited (2001) at 25.

[40] Namely on the one hand by regional and international authorities (e.g. WHO) who cause governments to reconsider health law and practice in light of major public health concerns which extend beyond borders and can no longer be properly addressed from a national standpoint, such as pandemics, global warming, poverty, pollution, immigration and on the other by the attitudes of individuals to State authority which has changed so that now interventions in (or indeed omissions from) one's private life by States must be increasingly justified according to criteria subject to law. The individual is presented less as the grateful recipient of largesse in the form of charitable health funded by the State but rather "an agent of health"; variously as citizen, consumer, service user" meaning that the responsibility for the attainment of health must be negotiated between State and individual. The clear parallel here is the movement of the individual from object to subject of international law; see L Johnson, *Defining Public Health*, R Martyn, & L Johnson (Eds), *Law and the Public Dimension of Health*, London: Cavendish Publishing Limited (2001) at 6.

medicine's tendency to approach illness "as primarily a problem of particular patients" with suffering located and addressed in the individuals who experience it "rather than in the social arrangements that may be responsible for causing the problem".[41] Western medicine has traditionally stressed a paternalistic value system in which doctors, rather than patients or their families "are presumed capable of making decisions about what is best for a patient".[42] Yet the emphasis on "private medicine" and on paternalism appears in contradistinction to the suggestion that most factors influencing health (individual and population health) are outside the control of the health services with the "main influences" being genetic factors (the individual's predisposition to disease); environmental factors (air, water pollution and housing) and lifestyle (smoking, alcohol use, exercise and diet and socio-economic) factors.[43] This is changing: it is now increasingly recognised that a patient autonomy model which "adopts a model of shared decision-making" promotes good health.[44] The right to health under international law frames this developing model where the focus commences on the individual yet takes account of societal concerns (including decisions on resource allocation).

A secondary, more recent, aspect of private health is privatisation. Here rather than commencing with private health, we may observe public health institutions being privatised. Whereas the law governing physician-patient relationships has primarily been regulated by the law of tort and the duty of care owed by a doctor to a patient in his or her care, privatisation of aspects of

---

[41] E Jackson, *Introduction to Bioethics* (Chapter 1), *Medical Law, Text, Cases and Materials* (2nd Ed.) Oxford University Press (2010), quoting S Sherwin *A Relational Approach to Autonomy in Healthcare* in Sherwin (ed.) *The Politics of Women's Health: Exploring Agency and Autonomy* (Temple UP: Philadelphia, 1998) at 2, 19-47.

[42] J Katz, *The Silent World of Doctor and Patient* New York, The John Hopkins University Press (1922) Foreword A M Capron (2002) cited by R Weitz, *The Sociology of Health, Illness and Health Care, a Critical Approach* (3rd Ed.) Wadsworth (2004) at 351.

[43] P Doorley, *Health Status* in *A Healthier Future, Managing Health Care in Ireland* (eds.) E McAuliffe and L Joyce, Institute of Public Affairs (1998), discussed further below. This is not to argue that the physician-patient relationship is not key to one's health and well-being: clearly if one is ill, one needs clinical diagnosis, care and treatment. But nowhere in the traditional physician-patient discussion was there emphasis on how the individual gains access to that relationship; where the relationship commences or ends, the extent of timely continuity from primary to secondary or tertiary care, whether access is on an equal basis as others and what accountability mechanisms are in place where private and public health meet.

[44] S Halliday, *Legislating To Give Effect To Precedent Autonomy: Comparative Reflections on Legislative Incompetence*, 11 Medical Law International (2011) at 127.

public health is governed by the law of contract. Here a private health provider contracts to deliver a service and the delivery of that service comprises performance of the contract. Internationally, since the 1980s, in response to increasing costs of health care there has been a tendency among States to favour moves towards privatisation of health by increasing the number of markets in which health care is delivered, and for a mixture of public and private healthcare systems.[45] This trend has also seen conditionality imposed in the structural engagement programmes for developing countries in receipt of international community finance which have included a focus on opening up health markets and in accession to the WTO (discussed below).[46] Weaknesses in law as a tool for the protection of health clearly emerge from these developments given the range of differing political and sociological approaches to health protection, which philosophical underpinnings are subject to rapid change and alteration. A clear need for the law to respond to these challenges is identified.[47]

---

[45] Watson and Ovseiko describe a two-fold process: the first a under the general rubric of health care reform and ever-increasing demands for efficiencies in the face of increasing costs of health care, which sees an increase in the number of markets in which health care is delivered under the guise of public, private or mixed organisation and management of consumption care organisations. The advantage from market solutions is perceived speed: reform has been rapidly achieved in developing States under structural adjustment programme conditions which form part of debt-funding agreements with the WB and IMF. However, it is suggested that they have employed partial models of health care reforms from developed State markets to justify their policies with little review of their efficacy; J Watson and P Ovseiko, *Health Care Systems, Major Themes in Health and Social Welfare* UK: Routledge, Introduction to Volume 1 (2005).

[46] The assumption behind the global trend to restructure health care systems is ostensibly to allow the citizen and the market take over some of the state's powers and responsibilities leading to perceived improvements in the effectiveness, efficiency and quality of health care, and patient choice and a belief that greater reliance "on market mechanisms, and the promotion of pluralism and patient sovereignty, should ensure such improvements"; J Watson and P Ovseiko, *Health Care Systems, Major Themes in Health and Social Welfare* UK: Routledge, Introduction to Volume 1 (2005).

[47] This need is "prompted by domestic law, the influence of European and international law, changing public attitudes to health risks and health provision, and awareness of the importance of a concerted global approach to many health concerns"; R Martyn, & L Johnson (eds.), *Law and the Public Dimension of Health* London: Cavendish Publishing Limited (2001) at xxxvi.

2 Right to health under international law

What then are those "recognised rights"? While Article 45 of the UN Charter states that the promotion of 'higher standards of living' and 'solutions of international ... health, and related problems' is one of the primary objectives of the UN, the definition of a right to health was only formulated in 1948 in Article 25(1) of the Universal Declaration on Human Rights ("UDHR"). This provides:

> Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control...

Here the right to health is seen as an indirect right, being dependent on the enjoyment/ realisation of other rights such as the right to food, clothing etc.; the right being "wider than medical care"[48]. The right to health was subsequently codified in Article 12 of the UN International Covenant on Economic, Social and Cultural Rights ("ICESCR"). Article 12 of the ICESCR defines the 'right to health' as the 'right to the highest attainable standard of physical and mental health' and its elaboration through General Comment 14 of its supervisory body the Committee on Economic, Social and Cultural Rights arguably provides the most comprehensive definition of the right to date. Before considering this provision and Articles 11 and 13 of the (Council of Europe) Revised European Social Charter, it is useful to outline the right as set out in other international declarations and conventions. Article 25 of the 1948 UDHR (note above), Article 5(e) of the 1965 International Convention of All Forms of Racial Discrimination ("CERD"), Articles 11, 12 and 16 of the 1979 Convention on the Elimination of All forms of Discrimination Against Women ("CEDAW"), Article 24 of the 1989 Convention on the Rights of the Child ("CRC"), Articles 28, 43(e) and 45(c) of the 1990 Convention on the Protection of the Rights of All Migrant Workers and Members of their Families

---

[48] M Ssenyonjo, *Economic, Social and Cultural Rights in International Law*, Oxford and Portland Oregon: Hart Publishing (2009) at 319.

and Article 25 of the 2006 Convention on the Rights of Persons with Disabilities, all set out the right.

At the regional (Council of Europe) level, Articles 11 and 13 of the 1996 (revised) European Social Charter (RESC) and (indirectly) Articles 3 and 8 of the 1950 European Convention on Human Rights and Fundamental Freedoms address the right (ECHR). Other regional conventions include Article 16 of the 1981 African Charter on Human and Peoples' Rights and Article 10 of the 1999 Additional Protocol To The American Convention On Human Rights In The Area Of Economic, Social And Cultural Rights "Protocol Of San Salvador"

While the right to health is generally classified as an economic and social right[49], it intersects with social, political and even cultural rights (see below) and is also "a fundamental building block of sustainable development, poverty reduction and economic prosperity"[50]. However, being placed with other economic, social and cultural rights, the right to health has until recently lacked "conceptual clarity" as to its definition and scope, compounded by the lack of significant jurisprudence (domestic or international) on enforcement of the right.[51]

Before one can consider the nature of the obligations of non-state actors under the right to health, one must first examine the nature and scope of the right itself. This thesis will consider the scope and content of the right to health. It will ask what obligations States have assumed to 'respect, protect and fulfil' the right to health under General Comment 14[52]. Of these obligations, the thesis will identify which aspects of the right to health are 'minimum core obligations' which the State must immediately ensure. And of these core aspects, it will consider the situation where private provision for aspects of the right occurs – whether State obligations continue or whether non state actors

---

[49] Y Arai-Takahashi, *The Right to Health in International Law - A Critical Appraisal*, in R Martyn, & L Johnson (Eds), *Law and the Public Dimension of Health* London Cavendish Publishing Limited (Chapter 5) (2001) at 144.

[50] M Ssenyonjo, *Economic, Social and Cultural Rights in International Law*, Oxford and Portland Oregon: Hart Publishing (2009) at 314.

[51] M Ssenyonjo, *Economic, Social and Cultural Rights in International Law*, Oxford and Portland Oregon: Hart Publishing (2009) at 315.

[52] See also General Comments Nos. 12 and 13.

assume legal responsibility or co-responsibility for the right. It will then consider the constitutional aspects of horizontal justiciability and whether tort law can effectively vindicate the right to health.

2.1 Council of Europe

The Council of Europe is an intergovernmental treaty-based system founded in 1949 by 10 States, whose membership has now increased to some 47 States and which seeks to develop throughout Europe common and democratic principles based on the European Convention on Human Rights and other reference texts, the rights of individuals.[53] While other Council of Europe conventions - for example the 1997 Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (the Biomedicine Convention)[54] and Recommendations – Recommendation of the Committee of Ministers to member states on good governance in health systems[55] - address aspects of the right to health, the two main conventions are the (Revised) European Social Charter and the European Convention on the Protection of Human Rights and Fundamental Freedoms ("ECHR").[56]

---

[53] The Council of Europe was formed in London, 5.V.1949 See *www.coe.int/* According to its Statute, the Council of Europe defines its aim in Article 1a as achieving a greater unity between its members for the purpose of safeguarding and realising the ideals and principles which are their common heritage and facilitating their economic and social progress.

[54] See also the Additional Protocol to the Convention on Human Rights and Biomedicine, Concerning Genetic Testing for Health Purposes.

[55] Recommendation CM/Rec (2010)6 Committee of Ministers, adopted on 31 March 2010 at the 1081st meeting of the Minister's Deputies.

[56] Ireland ratified the ECHR on 25 February 1953, the European Social Charter on 7 October 1964 and the Revised European Social Charter on 4 November 2000.

2.2 European Convention on the Protection of Human Rights and Fundamental Freedoms

There is no right to health as such under the ECHR. However, the jurisprudence of the European Court of Human Rights ("European Court")[57] has steadily expanded to "read in" aspects of such a right to health under the ECHR under its "positive obligations" doctrine.[58]

Under Article 2 of the ECHR (right to life), the Court has placed positive obligations on the State. Initially holding that while acts and omissions of authorities in the field of health care policy may engage Article 2, where a State has made adequate provision for securing high professional standards among health professionals and the protection of the lives of patients, a mere error of judgment on the part of a health professional or negligent co-ordination among health professionals in the treatment of a particular patient will not violate the provision[59], it later held that what was required was "effective investigation or scrutiny". *Siemenska v Poland*[60] saw increased focus on

---

[57] The ECHR originally created two organs - the European Commission of Human Rights ("the European Commission") and the European Court of Human Rights ("the European Court"). Since the entry into force of Protocol No. 11 to the ECHR in November 1998, the European Commission has been abolished with the European Court now comprising Single Judges (for some admissibility decisions), Committees of Three (see Protocol No. 14), Chambers and a Grand Chamber. Ultimate supervision of the ECHR is exercised by the Council of Europe's Committee of Ministers. The European Court can consider and deliver judgment on individual complaints to it deemed admissible, it can seek to secure friendly settlements or unilateral declarations in cases and it can deliver advisory opinions at the request of the Committee of Ministers. Under the Interlaken (2010), Izmir (2011) and Brighton (2012) Declarations, States Parties have committed themselves to wide-ranging reforms of the ECHR including through further admissibility criteria, effective domestic remedies/ subsidiarity, enhanced execution and advisory judgments: see draft Protocols 15 and 16.

[58] The European Court's "positive obligations" doctrine holds that ECHR rights create obligations on States to take pro-active measures to secure those rights: see C Donnelly, *Positive Obligations and Privatisation*, 61 Northern Ireland Legal Quarterly (2010) 210 who describes positive obligations as importing a transformative oversight mechanism which avoids "reductionist understandings of the individual" insofar as they acknowledge "the many dimensions of the individual's personality - the vulnerable witness in need of police protection, the abused child in need of a safe home, the homeowner suffering pollution from the nearby factory, the transsexual concealing his or her birth certificate - and they also require the state to acknowledge and respond to these facets of the individual personality"; at 211.

[59] *Powell v United Kingdom*, Application No. 45/305/99; Admissibility Decision. "[W]hat is required is accountability and proper investigation into what occurred ("the adequacy of the mechanisms in place for shedding light on the course of those events, allowing the facts of the case to be exposed to public scrutiny – not least for the benefit of the applicants)"; ibid.

[60] Application No. 37602/97, Admissibility Decision.

accountability mechanisms encompassing the need for hospital regulations, an effective judicidal system "for establishing the cause of a death which occurs in hospital and any liability on the part of the medical practitioners concerned."[61]

The procedural element contained in Article 2 imposes the obligation to ensure an effective investigation or scrutiny to establish the facts of death in cases of suspicious death,[62] while under its Article 13 jurisprudence, read with Article 2, deeper obligations are implied (see below).

The prohibition on ill-treatment under Article 3 of the ECHR usually requires that the ill-treatment in question attain a minimum level of severity. This "usually involves actual bodily injury or intense physical or mental suffering"; however even without these, where treatment "humiliates or debases an individual, showing a lack of respect for, or diminishing, his or her human dignity, or arouses feelings of fear, anguish or inferiority capable of breaking an individual's moral and physical resistance, it may be characterised as degrading and also fall within the prohibition of Article 3".[63] The right to health has also been considered in relation to medical authorities' refusal to provide "requisite medical assistance" to prisoners under Article 3 of the ECHR.[64] If a prisoner is "not provided with the level of medical assistance

---

[61] Application No. 37602/97, Admissibility Decision. See also *Calvelli and Ciglio v Italy*, Application No 32967/96, Judgment 17 January 2002 ECHR 2002-I. See also *Senturk v Turkey,* Application No.13423/09, Judgment 9 April 2013 (Hudoc 2013) in which the Court held that the denial of access to appropriate emergency treatment for a a 34 week pregnant woman at risk of death (who subsequently died) on the basis of inability to pay led to State responsibility for a violation of the substantive obligation under Article 2, compounded by a procedural violation of Article 2 in not conducting an effective independent judicial system so that the cause of death of patients in the care of the medical profession, whether in the public or the private sector, could be determined and those responsible made accountable (available in French version only).

[62] See the Court's jurisprudence concerning effective investigation of suspicious death. In *McKerr* v *United Kingdom* (2002) Application No. 28883/94, Judgment 4 May 2001 (2002) 34 EHRR 553, the Court held that there must be a sufficient element of public scrutiny of the investigation or its results to secure accountability in practice as well as in theory which will invariably involve the next-of-kin of the victim "to safeguard his or her legitimate interests"; at para 115. See also the related cases of *Shanaghan, Jordan* and *Kelly and Others v United Kingdom* delivered on the same day.

[63] *Pretty v United Kingdom*, Application No. 2346/02, 29 April 2002, 35 EHRR 1 at para 52. See also *Price v United Kingdom*, Application No. 33394/96, 10 July 2001, 34 EHRR 1285.

[64] In *Kudla v Poland*, Application No. 30210/96, Judgment 26 October 2000, 2000-ECHR XI, the European Court held that under Article 3 the State must ensure that a person is detained in conditions which are compatible with respect for his human dignity" and that the manner and method of the execution of the measure do not go beyond the "unavoidable level of suffering

required by his condition" there will be a violation of Article 3 on account of the duty the State owes to respect the dignity of the individual.[65] Absence of treatment for tuberculosis will violate Article 3 where the absence of medical treatment causes "considerable mental suffering diminishing his human dignity, which amounted to degrading treatment within the meaning of Article 3 of the Convention".[66] This is particularly where the illness was contracted in prison.[67] A delay in medical treatment in the situation of refusal of an x-ray for six days may constitute a breach of Article 3.[68] Sterilisation of women without their consent will also constitute a violation of Article 3.[69]

Mental health issues may also come within the scope of Article 3. In *Keenan v United Kingdom*[70] a case concerning suicide in prison, the European Court found that the lack of both effective monitoring and informed psychiatric input into the prisioner's assessment and treatment disclosed "significant defects in the medical care provided to a mentally ill person known to be a suicide risk" and, with his isolated segregation, constituted a violation of Article 3.[71] Compulsory medical interventions in prison may violate Article 3. The European Court had earlier found in the early case of *Herczegfalvy v Austria*[72] that where "medical necessity has been convincingly shown to exist" food and drugs may be forcibly administered where the "sole aim" was therapeutic, and

---

inherent in detention" with health and well-being to be adequately secured by "providing him with the requisite medical assistance"; at para 94.

[65] See Grand Chamber Judgment in *Paladi v Moldova* (Application No. 39806/05), Judgment 10 March 2009; at para 72.

[66] See *Hummatov v Azerbaijan,* Application Nos. 9852/03 13413/04, Judgment 29 November 2007 at paras 107-122.

[67] *Hummatov v Azerbaijan,* Application Nos. 9852/03 13413/04, Judgment 29 November 2007 at paras 107-122.

[68] Friendly settlement in the case of *Hurtado v Switzerland*, Application No. 17549/90, Judgment 26 January 1994 (Hudoc 1994), following Commission finding of violation of Article 3 due to lack of immediate medical attention.

[69] *IG v Slovakia*, Application No. 15966/04, Judgment 13 November 2012 at paras 124-126. There was also a violation of in a violation of Article 8 of the ECHR; at 145-146. See also *VC v Slovakia*, Application No. 18968/07, Judgment 8 November 2011 and *NB v Slovakia*, Application No. 29518/10, Judgment 12 June 2012.

[70] Application 27229/95, Judgment of 3 April 2001 33 EHRR 903.

[71] Application 27229/95, Judgment of 3 April 2001 33 EHRR 903, at para 116.

[72] Application No. 10533/83, 24 September 1992, 15 EHRR 437, at para 82.

it had been terminated "as soon as the state of the patient permitted this."[73] However more recent caselaw suggests that the European Court will question "that the medical necessity has been convincingly shown to exist". In the case of *Nevmerzhitsky v Ukraine*[74] the European Court found that force feeding while on hunger strike violated Article 3 insofar as it was arbitrary and lacked "procedural safeguards."[75] Similarly in *Jalloh v Germany*[76] the European Court found that any forcible medical intervention to obtain evidence of a crime "must be convincingly justified on the facts of a particular case".[77] A number of factors would be considered by the European Court including:

> the manner in which a person is subjected to a forcible medical procedure in order to retrieve evidence from his body must not exceed the minimum level of severity prescribed by the Court's case-law on Article 3 of the Convention.[78]

In that case the use of emetics "in order to retrieve evidence they could equally have obtained by less intrusive methods" violated Article 3.[79]

Under Article 8 of the ECHR (right to respect for private and family life), the European Court has interpreted "interferences" and even "omissions" by the State as engaging Article 8(1). The European Court will then typically consider whether the interference/ omission was in accordance with law, for a specified legitimate aim and proportionate to that aim under Article 8(2). In *Van Kück v Germany*[80] the refusal to reimburse the Applicant by a private health insurance company for the transgender surgery he underwent, on the basis that it was not considered to be a medical necessity and on the basis of the proofs required of him resulted in a violation of Article 8 in addition to a violation of Article 6 (right to fair hearing). The European Court held that "the burden placed on a

---

[73] Application No. 10533/83, 24 September 1992, 15 EHRR 437, at para 81.

[74] Application No. 54825/00, Judgment 5 April 2005, ECHR 2005-II.

[75] Application No. 54825/00, Judgment 5 April 2005, ECHR 2005-II, at para 96.

[76] Application No. 54810/00, Judgment 11 July 2006, 44 EHRR 667.

[77] Application No. 54810/00, Judgment 11 July 2006, 44 EHRR 667, at para 71.

[78] Application No. 54810/00, Judgment 11 July 2006, 44 EHRR 667, at para 72.

[79] Application No. 54810/00, Judgment 11 July 2006, 44 EHRR 667, see paras 71 and 82.

[80] Application No. 35968/97, Judgment 12 June 2003, 37 EHRR 51.

person to prove the medical necessity of treatment, including irreversible surgery, in one of the most intimate areas of private life, appears disproportionate", there being no fair balance struck between the interests of the private health insurance company and the applicant.[81]

In *MS v Sweden*[82] although finding no violation of Article 8, the Court pointed out how respecting the confidentiality of health data is crucial "not only to respect the sense of privacy of a patient but also to preserve his or her confidence in the medical profession and in the health services in general."[83]

Other ECHR provisions involving right to health issues have included the procedural obligation on States under Article 2 (the right to life) as noted, to require national authorities to effectively investigate suspicious deaths[84], not to put one's life at risk by denying health care available to others[85] and not to deport individuals living with HIV/AIDS in certain circumstances.[86]

The approach of the European Court may also be predicated upon whether domestic law provides an entitlement. In *Van Kück* there was no right under Articles 8 or 6 to reimbursement for transgender surgery; however, where domestic law provided for such an entitlement, the State's positive obligations were triggered including the regulatory obligation to monitor the manner in which decisions were taken.

At the same time, the right to prohibition of discrimination in relation to Convention rights as set out in Article 14 has increasingly been employed by

---

[81] Application No. 35968/97, Judgment 12 June 2003, 37 EHRR 51, paras 82-84. In *Schlumpf v Switzerland*, Judgment of 8 January 2009 (available in French version), the European Court found that rigid rules on reimbursement of medical costs breached Articles 6 and 8.

[82] Application No. 20837/92, Judgment 27 August 1997, 28 EHRR 313.

[83] Application No. 74/1996/693/885, Judgment 27 August 1997 at para 41.

[84] *McKerr v United Kingdom* , Application No. 28883/94, Judgment 4 May 2001 (2002) 34 EHRR 553.

[85] *Cyprus v Turkey,* Application No. 225781/94, Judgment 19 May 2001, 35 EHRR 30, at para 219.

[86] *D v United Kingdom*, Application No. 30240/96, Judgment 2 May 1997, 24 EHRR 423 at para 5; see also *Bensaid v United Kingdom* Application No. 44599/98, Judgment 6 February 2001 33 EHRR 10 and *N v United Kingdom*, Application No. 26565/ 05, Judgment of 27 May 2008, 47 EHRR 885.

Applicants to contend they have received unjustified less favourite treatment than others on the basis of their identity (status).[87] Discrimination can only arise under the ECHR where the matter comes within the scope of a substantive ECHR right (such as right to private life). In Article 14 cases, a violation can only occur where first a substantive provision of the Convention is triggered and second where the impugned measure or omission has directly or indirectly discriminated against the individual on the basis that the State could not demonstrate that the means employed had been proportionate to the legitimate aim sought to be achieved by the State.[88]

Difference of treatment on certain grounds will attract strict scrutiny, requiring "very weighty reasons". Such grounds are sex[89], race[90], "illegitimacy"[91], nationality[92], religion[93], sexual orientation[94] and disability.[95] In *Kiyutin v Russia*[96] the European Court recognised "health" as a prohibited ground for discrimination in a case involving a HIV foreign national refused residence

---

[87] Application No. 35968/97, Judgment 12 June 2003, 37 EHRR 51; see above.

[88] The Court adopts a four fold test to discrimination: a) whether the matter falls within the ambit of a substantive Convention right; b) whether a difference of treatment on the basis of status can be demonstrated; c) whether any difference of treatment pursues a legitimate aim; and if so, d) whether the measure in question is proportionate to the aim. The latter test includes an examination of whether the difference of treatment extends beyond the State's margin of appreciation. See *Report on an Enquiry into the Impact of Certain Provisions of Social Welfare Legislation on the Self-Employed*, Irish Human Rights Commission at 44-45 (2007), available at *www.ihrc.ie/download/pdf/pensionenquiry.pdf* accessed on 21 October 2012. See also O Arnardottir, *Equality and Non-Discrimination under the European Convention on Human Rights*, Martinus Nijhoff Publishers (2004) at 1-17.

[89] *Rasmussen v Denmark*, Application No. 8777/79, Judgment 28 November 1984, 7 EHRR 372.

[90] *Abdulaziz, Cabales and Balkandali v The United Kingdom Abdulaziz, Cabales and Balkandali v The United Kingdom*, Application Nos. 9214/80, 9473/81 and 9474/81, Judgment 28 May 1985 7 EHRR 471.

[91] *Hoffman v Germany*, Judgment 11 October 2001 (Hudoc 2001).

[92] *Gaygusuz v Austria*, Application No. 17371/ 90, Judgment 16 September 1996, 23 EHRR 364.

[93] *Thlimmenos v Greece*, Application No. 34369/97, Judgment 6 April 2000, 31 EHRR 411.

[94] *Salgueiro da Silva Mouta v Portugal*, Application No. 33290/96, Judgment 21 December, 1999, 31 EHRR 1055.

[95] *Glor v Switzerland*, Application No. 13444/04, Judgment 30 April 2009 (available in French only) (Hudoc 2009).

[96] Application No. 2700/10 Judgment 10 March 2011 (Hudoc 2011).

status. The European Court found that a Convention right had been triggered insofar as the Applicant had a recognised family life in the Russian Federation. The European Court then considered that although the protection of public health was indeed a legitimate State aim, the Government had been unable to adduce compelling and objective arguments to show that this aim could be attained by the applicant's exclusion from residence on account of his health status, noting *inter alia* that "... travel and residence restrictions on persons living with HIV may not only be ineffective in preventing the spread of the disease, but may also be actually harmful to the public health of the country".[97]

Accordingly the fact that the applicant "belonged to a particularly vulnerable group", the European Court found that his exclusion "has not been shown to have a reasonable and objective justification, and that the contested legislative provisions did not make room for an individualised evaluation". On that basis, the Government had overstepped the "narrow margin of appreciation afforded to them in the instant case". The applicant was a victim of discrimination on account of his health status, in violation of Article 14 of the ECHR taken together with Article 8.[98] As will be observed, the non-discrimination test under the ECHR is similar to that under other international conventions.

Another important right under the ECHR is Article 13 which provides that everyone whose Convention rights are violated "shall have an effective remedy before a national authority".

Article 13 may be triggered where there is an arguable claim that there has been a breach of an ECHR right.[99] It requires a domestic remedy to deal with the substance of an "arguable complaint" and to grant appropriate relief.[100] An effective remedy need not be judicial, while the aggregate of remedies provided for under domestic law may suffice. The remedy before the national

---

[97] Application No. 2700/10 Judgment 10 March 2011 (Hudoc 2011), at para 71.

[98] Application No. 2700/10 Judgment 10 March 2011 (Hudoc 2011) at para 74.

[99] *Klass and others v Germany*, Series A No. 269, Judgment 6 September 1978) 2 EHRR 214, at para 64. *See* also *McFarlane v. Ireland,* Application No. 31333/06, Judgment, 10 September 2010 (Hudoc 2010), at paras 120-124.

[100] *Doran v Ireland*, Judgment 31 July 2003 (Hudoc 2003), at para. 55.

authority should concern both the determination of the claim and any redress.[101] Article 13 has also been considered in conjunction with Article 3 where the failure by a State to carry out a thorough and effective investigation into an allegation of ill-treatment or to allow effective access to the investigatory procedure will violates Article 13.[102] Similarly, in circumstances where a punishment which breached Article 3 could not be challenged during a period of detention, the European Court has found a violation of Article 13.[103] Article 13, when considered in conjunction with Article 8, requires judicial review by domestic courts to be effective and that any thresholds involved in taking a case would not effectively exclude consideration of Article 8 (i.e. whether an interference with an applicant's rights addressed a pressing social need or was proportionate to the aims pursued).[104]

In the recent judgment of *Reynolds v United Kingdom*[105], a case concerning a person's suicide by jumping from the sixth floor of a psychiatric unit, the European Court considered Article 13 in conjunction with the right to life under Article 2, finding first that there was an arguable claim under Article 2 that the position of the applicant's son "was such that an operational duty arose to take reasonable steps to protect him from a real and immediate risk of suicide and that that duty was not fulfilled".[106] Turning to Article 13, the Court considered that the Inquest into the death could not examine individual civil

---

[101] *Silver and Others v The United Kingdom*, Application No. 5947/72, Judgment 25 March 1983, 5 EHRR 347, at para 113.

[102] *Assenov and Others v Bulgaria*, Judgment Application No. 24760/94, Judgment 28 October 1998, 28 EHRR 652, at paras 101-106 and 117-118. See also *Atalay v Turkey*, Application No. 1249/03 Judgment 18 September 2008 (Hudoc 2008), at paras 46-47.

[103] *Keenan v The United Kingdom*, Application 27229/95, Judgment 3 April 2001, 33 EHRR 38, at paras 12-127.

[104] *Smith and Grady v The United Kingdom*, Application No. 33985/96 and 33986/96, Judgment of 27 September 1999, 29 EHRR 493, at para. 135; *Peck v. The United Kingdom*, Application No. 44647/98, Judgment 28 January 2003, 36 EHRR 719, at para. 106; *CG and Others v Bulgaria*, Application No. 1365/07, Judgment 24 April 2008, 47 EHRR 1117, at para. 62.

[105] Application No. 2694/08, Judgment 13 March 2012 (Hudoc 2012).

[106] Application No. 2694/08, Judgment 13 March 2012 (Hudoc 2012) at para 67. The applicant complained there were no effective domestic mechanism whereby issues of civil liability could be determined in respect of the alleged negligent care of her deceased son and through which she could have obtained compensation for the non-pecuniary loss sustained by her including grief, loss and distress.

liability; that there was no question of criminal or disciplinary responsibility, while the internal inquiry held was not independent of the health service. It found further that a civil claim under the UK's Human Rights Act failed, while a claim in negligence for "psychiatric injury" was not recognised by domestic law. The Court found that there had been a violation of Article 13 in conjunction with Article 2.[107]

Another aspect of developing ECHR jurisprudence is the manner in which the European Court draws on the provisions of other conventions to interpret ECHR rights which may suggest that the right to health as identied in other conventions may be increasingly recognised in ECHR jurisprudence.[108]

Two recent Court Judgments against Ireland highlight a number of issues as to the justiciability of the right to health under Irish law where the State has difficulty in demonstrating that its system of domestic remedies are indeed effective for the vindication of ECHR rights. The first of these Judgments, *McFarlane v Ireland*[109] had nothing to do with the right to health. Rather it concerned the right to an effective domestic remedy by which the Applicant could have challenged the long delay in a criminal prosecution against him. In its defence, Ireland advanced a number of arguments concerning the Applicant's ability to seek prohibition of his trial under the Constitution and how to seek civil damages for an arguable breach of the right to a speedy trial

---

Application No. 2694/08, Judgment 13 March 2012 (Hudoc 2012) at para 68: "The present applicant did not have available to her, prior to the introduction of her application to this Court, civil proceedings to establish any liability and compensation due as regards the non-pecuniary damage suffered by her on her son's death"; at para 67. See also the Judgment of the UK Supreme Court in *Rabone and another (Appellants) v Pennine Care NHS Foundation Trust (Respondent)*, 8 February 2012 (unreported) where Baronness Hale stated that the first question was whether the risk was sufficiently real and immediate to require consideration of what might be done to prevent it, finding that if the patient had remained in hospital rather than being discharged, "she would not have succeeded in killing herself" Having regard to "the nature and degree of the risk to her life, and the comparative ease of protecting her from it, I agree that her right to life was violated"; at para 107.

[108] See for example *Glor v Switzerland*, Application No. 13444/04, Judgment 30 April 2009 (available in French only) (Hudoc 2009) where the Court interpreted disability discrimination in light of the provisions of the 2006 UN Convention on the Rights of Persons with Disabilities.

[109] Application No. 31333/06, Judgment, 10 September 2010 (Hudoc 2010).

under Article 6 of the ECHR. The European Court found for the Applicant, finding that theoretical constitutional remedies were insufficient.

The second case was that of *A, B and C v Ireland*[110] and concerned a claim of breach of Article 8 of the EHCR on the basis of lack of effective access to abortion in Ireland. Here the State argued that in addition to the Applications being premature, not having exhausted domestic remedies, that the State was entitled to a wide "margin of appreciation" insofar as the issue of abortion was one of particular moral concern, with the right of the "unborn" being protected under Article 40.3.3 of the Constitution. As in *McFarlane*, the Court did not entirely agree. It did afford the State a wide "margin of appreciation" in relation to Applicants *A* and *B*, but not in relation to Applicant *C* where it found that domestic law was insufficient to meet Article 8 requirements.[111] The manner in which the Court approached these cases – controversially in relation to *A, B and C* – was by considering whether domestic remedies were practical and effective. These findings have significance for the protection of the right to health in Ireland, as we will discuss in Part 2 of this thesis. For the present, it may be observed that where domestic law provides for a "right" or "entitlement", the positive obligations doctrine of the ECHR will impose a transformative requirement on the State to ensure that the application of the entitlement in question secures and does not breach ECHR requirements. This will assume particular importance where the State decides to legislate for aspects of the right to health or for statutory bodies to deliver or regulate healthcare provision.

---

[110] Application No. 25579/05, Judgment of 16 December 2010. See too *RR v Poland*, Application No. 27617/04, Judgment 26 May 2011 (Hudoc 2011), in which the Court found a violation of Articles 3 and 8 on the basis that the applicant was a person in a situation of "great vulnerability" who had sought early medical advice on an abortion, had suffered "acute anguish" at the hands of the doctors involved who had procrastinated and delayed in providing her with the relevant tests; her treatment had been humiliating and had violated Article 3; at paras 157-162.

[111] The Court accepted the applicant's arguments that her life was at risk and then found she could not apply to a national authority to have determined whether she could obtain a "lawful" abortion under Article 40.3.3. This, the Court considered, did not vindicate her Article 8 rights.

2.3 Revised European Social Charter ("RESC")

The RESC is the Council of Europe convention addressing economic, social and cultural rights, whereas the ECHR has been traditionally identified as a civil and political rights convention. The right to health protection is clearly set out in Article 11 of the RESC which provides that:

> With a view to ensuring the effective exercise of the right to protection of health, the Parties undertake, either directly or in co-operation with public or private organisations, to take appropriate measures designed inter alia:
>
> 1. to remove as far as possible the causes of ill-health;
>
> 2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;
>
> 3. to prevent as far as possible epidemic, endemic and other diseases, as well as accidents. [112]

As will be noted, this formulation differs from that under the ICESCR insofar as it focuses not on the right to health per se but on the right to "protection of health" through three non-exhaustive means: removing the causes of ill-health, health education/ promotion and the prevention of diseases and accidents. Article 11 focuses on a healthy environment (including air pollution risks, nuclear hazards, asbestos-risks, food safety, tobacco, alcohol and drugs, immunisation programmes, prevention of accidents, education and awareness-raising, pregnancy services, occupational health and safety, children's, women's and older persons rights to health.[113]

---

[112] The European Committee of Social Rights ("ECSR") is the 15 member committee which has responsibility for monitoring State's compliance with the RESC. Elected by the Committee of Ministers and previously entitled the Committee of Independent Experts, the ESCR adopts conclusions on national reports and decisions on collective complaints made to it. Under a 1995 optional protocol, complaints of violations of the ESC/RESC may be lodged with the ECSR. However, only certain organisations are entitled to lodge complaints. Overall supervision of the RESC rests with the Committee of Ministers of the Council of Europe.

[113] Secretariat of the European Social Charter, *The Right to Health and the European Social Charter, Information document prepared by the secretariat of the ESC*, Council of Europe (2009) at 2-10.

Article 13(1) of the RESC provides that:

> With a view to ensuring the effective exercise of the right to social and medical assistance, the 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.[114]

Article 13 provides for the right to right to social and medical assistance for persons without resources. In the case of sickness, this will mean the health care required by the condition free of charge.[115] Unlike Article 11, under Article 13(4) lawful or unlawful foreign nationals in the State territory with an immediate "state of need (accommodation, food, emergency care and clothing)" have a right to emergency assistance which will include emergency medical care.[116]

The European Committee of Social Rights ("ECSR") supervises the Charter through conclusions, statements of interpretation, examination of State reports and individual complaints.[117] The ESCR has defined health in accordance with the definition in the Constitution of the WHO.[118]

---

[114] Subparagraphs 2-4 provide: "[With a view to ensuring the effective exercise of the right to social and medical assistance, the Parties undertake:] 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 Parties lawfully within their territories, in accordance with their obligations under the European Convention on Social and Medical Assistance, signed at Paris on 11 December 1953."

[115] Digest of the Case Law of the European Committee of Social Rights, 1 September 2008, at 99.

[116] Digest of the Case Law of the European Committee of Social Rights, 1 September 2008, at 104. Paragraph 1.1 of the Appendix provides an exception to the general principle that only foreign nationals lawfully resident or working in a State Party come within the scope of the RESC.

[117] See generally, T Hervey, *We Don't See a Connection: The 'Right to Health' in the EU Charter and European Social Charter*, in *Social Rights in Europe*, G de Búrca, B de Witte (eds.), Oxford University Press 315 (2005) at 305-335.

[118] Conclusions XVII-2 and Conclusions 2005, Statement of Interpretation on Article 11§5.

In 2006, the Committee of Ministers, which has overall supervision for the RESC, adopted a new system of thematic reporting by States.[119] The theme for the second round of reporting was "Health, social security and social protection" and included consideration of Articles 11 and 13 of the RESC.[120]

This represented a new approach to State reporting. In addition to seeking information on health care indicators[121] and prevention of diseases under Articles 11(1) and (3), the Committee also adopted the following two "general questions" addressed to all States which have accepted the provisions concerned:

> "The Committee asks that the next report on Article 11 contain information on the availability of rehabilitation facilities for drug addicts, the range of facilities and treatments as well as whether supply matches demand under Article 11."

This illustrates how the ECSR may adapt its monitoring to investigate particular aspects of the right to health such as availability of facilities. Since

---

[119] The decision by the Committee of Ministers was to divide the provisions of both the 1961 Charter and the Revised Charter into four thematic groups, with States to present a report on the provisions relating to one of the four thematic groups on an annual basis, with each provision of the Charter reported on once every four years. The four themes are: Employment, training and equal opportunities; Health, social security and social protection; Labour rights and Children, families and migrants: see *www.coe.int/t/dghl/monitoring/socialcharter/Complaints/Complaints_en.asp*

[120] See RESC Activity Report 2009 (25 June 2010), available at *www.coe.int/T/DGHL/Monitoring/SocialCharter/* accessed on 28 October 2012. Commenting in 2005, Hervey noted how recent Conclusions of the ECSR structured the sections on Article 11 into the following categories: removal of the causes of ill-health; state of health of the population – general indicators; health care system; advisory and educational facilities; developing a sense of individual responsibility; counselling and screening; prevention of diseases; policies on the prevention of avoidable risks and prophylactic measures, leading her to conclude that these elements constitute the content of the right to health under Article 11; T Hervey, *We Don't See a Connection: The 'Right to Health' in the EU Charter and European Social Charter*, in *Social Rights in Europe*, G de Búrca, B de Witte (eds.), Oxford University Press 315 (2005) at 321. The subsequent practice of the RESC does not appear to completely bear this out.

[121] See the definition of the Office of the High Commissioner for Human Rights (OHCHR): "...a human rights indicator derives from, reflects and is designed to monitor realization or otherwise of a specific human rights norm, usually with a view to holding a duty-bearer to account...Essentially, what tends to distinguish a human rights indicator from a standard disaggregated indicator of socio-economic progress is less its substance than (i) its explicit derivation from a human rights norm and (ii) the purpose to which it is put viz human rights monitoring with a view to holding duty-bearers to account"; *Draft Guidelines on Human Rights Approaches to Poverty Reduction Strategies* (2003) commissioned by OHCHR.

2006, the ECSR has considered State compliance across each of the subparagraphs of Article 11, although the reporting periods have dated back a number of years.[122] The approach taken by the ECSR focuses on avoidable risks identified through reporting on key health indicators (such as mortality rates) and can be seen in its consideration of Latvia's reporting period 2005-07, where the ESCR recalled that:

> Under Article 11§1 of the Charter, health systems must respond appropriately to avoidable health risks, i.e. ones that can be controlled by human action, and states must guarantee the best possible results in line with the available knowledge (Conclusions XV-2, Denmark).
>
> To comply with Article 11§1, the main indicators of a country's state of health must reflect an improvement and not be too significantly below the average for all European countries (Conclusions 2005, Lithuania, pp. 336-338), or between urban and rural areas or between regions."[123]

Here we are presented with first the need for indicators and second, an improvement in those indicators which should not be significantly below the European average. The ECSR will consider indicators on the following issues: life expectancy and principal causes of death; infant and maternal mortality; the health care system, one's access to health care without discrimination and the adequacy of health care professionals and facilities.[124] The onus to demonstrate compliance is placed on States: in its 2010 consideration of Hungary's report for 2005-07, the ECSR found that the absence of information/ data (indicators) advanced by the State on screening for the main causes of death meant Hungary had not "established that measures taken to reduce the

---

[122] According to the ESCR's Database, there is a two year gap between reporting date and consideration by the Committee: *hudoc.esc.coe.int/esc2008/document.asp?item=136&related=0* - accessed 19 March 2011.

[123] ESCR Conclusions XIX-2 – Latvia, 14/01/2010, Annual publication: XIX-2 - Non conformity, Article: 11,11-1, Document ID: 2009/def/LVA/

[124] Secretariat of the European Social Charter, *The Right to Health and the European Social Charter, Information document prepared by the secretariat of the ESC,* Council of Europe (2009) at 2-10.

mortality rate are adequate" there was accordingly a breach of Article 11(1) of the Charter.[125]

In contrast, the ESCR considered that the information provided by Ireland for the period 2005-07 on the causes of ill-health (which primarily concerned information on Traveller health) was sufficient to indicate conformity with Article 11(1) in its 2010 consideration of the State report.[126] It is not clear why the ESCR considered the State's response as adequate evidence of conformity with Article 11(1) though it may have considered that mortality rates were lower in Ireland than the EU average in the relevant period when drawing this conclusion. This concern that the ESCR insufficiently analyses State reports is also evident in the Committee's 2010 consideration of Ireland's report under Article 13 (concerning the right to social and medical assistance) in the period 2005-07. Here the ECSR considered that, on the basis of the information provided, the State had been in conformity with each of the subparagraphs. However, in the same session the ECSR considered that the State was not in compliance with Article 11(3) (prevention of diseases) on the basis that the State had not demonstrated that adequate measures were in place to prevent diseases or accidents.[127] Again it will be observed that failure to have in place indicators and to demonstrate how those indicators show an improvement will result in a finding of a violation of Article 11.

In addition to considering State reporting, the ESCR may adjudicate upon individual complaints to it. Under its jurisprudence, the ESCR has held that the prohibition of discrimination under Article E of the Revised Charter "establishes an obligation to ensure that any individual or group, who falls

---

[125] ESCR Conclusions XIX-2 – Hungary, 2/01/2010, Annual publication: XIX-2 - Non conformity, Article: 11,11-1, Document ID: 2009/def/HUN/

[126] ESCR Conclusions 2009 - Ireland - Document ID2009/def/IRL/ - Conclusion date 02/01/2010; see *www.coe.int/t/dghl/monitoring/socialcharter/Complaints/Complaints_en.asp* accessed 28 October 2012.

[127] Between 1966 and 2012, Ireland submitted 21 reports on the application of the Charter and 9 reports on the application of the Revised Charter. Its 8th report was submitted on 8 June 2011 concerning the accepted provisions relating to Thematic Group 4 "Children, families and migrants" (Article 7, 8§§1, 2, 4 and 5, 16, 17, 19 and 27§§1 sub-paragraph c, 2 and 3) and its 9th report submitted on 14 October 2011 concerning the accepted provisions relating to Thematic Group 1 "Employment, training and equal opportunities".

within the scope *ratione personae* of the Revised Charter, equally enjoy the rights of the Revised Charter."[128]

In *Defence for Children International v The Netherlands*[129], the RESC, recalling its previous jurisprudence, set out how it seeks to align its jurisprudence with that of the ECHR by invoking Article 14 of the ECHR. Although States could treat persons lawfully or unlawfully present on their territories differently, "in so doing, human dignity, which is a recognised fundamental value at the core of positive European human rights law, must be respected."[130]

Rights relating to health embodied in both the ECHR and RESC are inextricably linked, with a further reference to the commonality of human dignity enshrined in both instruments as set out by the ECSR:

> human dignity is the fundamental value and indeed the core of positive European human rights law – whether under the European Social Charter or under the European Convention on Human Rights - and health care is a[[131]] prerequisite for the preservation of human dignity.[132]

The ECSR has found that a private health insurance system can meet the requirements of the RESC where there is a State safety net for those who cannot contribute.[133] In *European Roma Rights Centre (ERRC) v Bulgaria*[134] it noted that in Bulgaria "there also exists a subsidiary "non-contributory"

---

[128] *Defence for Children International v The Netherlands*, Complaint No. 47/2008, 20 October 2009; at para 71.

[129] Complaint No. 47/2008, 20 October 2009; at para 73.

[130] Complaint No. 47/2008, 20 October 2009; at paras 74-75, citing its earlier decision in *Autism-Europe v France,* Complaint No. 13/2002, Decision on the merits of 4 November 2003; at para 52.

[131] See Appendix to both the 1961 ESC and the 1996 RESC.

[132] *International Federation of Human Rights Leagues (FIDH) v France,* Complaint No. 14/2003, Decision on the merits of 3 November 2004, at para 31.

[133] *European Roma Rights Centre (ERRC) v. Bulgaria*, Complaint No. 46/2007, Decision on the Merits 3 December 2008 at para. 41. See also Collective Complaint *European Roma Rights Centre (ERRC) v Bulgaria* No.48/2008 and Committee of Ministers Resolution CM/ResChS(2010)2 adopted on 31 March 2010 at the 1081st meeting of the Minister's Deputies noting the Government's abrogation of Article 12(c) of the Social Assistance Act, reported in International Human Rights Reports (IHRR) Vl. 18 No. 3 July 2011 at 870-871.

[134] Complaint No. 46/2007, Decision on the Merits 3 December 2008.

system, open to persons who do not benefit from the contributory system and which ensures them sufficient coverage, not only in situations of emergency or a threat to life."[135]

The responsibility of the State is clear: while it has a choice of means in combining private and public health care elements, there must be a safety net for those unable to access private health care. The situation of disadvantaged and vulnerable groups will place positive obligations on the State:

> "The Committee recalls that Article 11 of the Charter imposes a range of positive obligations to ensure an effective exercise of the right to health, and the Committee assesses compliance with this provision paying particular attention to the situation of disadvantaged and vulnerable groups (Conclusions XVII-2 – General Introduction)."[136]

Accordingly restrictions on the application of Article 11 may not be interpreted in such a way as to impede a disadvantaged groups' exercise of their right to health.[137] Measures governing access to health care must guard against unnecessary delay in the provision of the health care.[138] Further, access to treatment must be based on transparent criteria, agreed at national level, taking into account the risk of deterioration in either clinical condition or quality of life, the number of health care professionals and equipment must be adequate and the State has a specific duty to prevent, as far as possible, accidents and diseases.[139] Further, the State must ensure that its state-approved sexual and reproductive health information is adequate, objective and non-discriminatory.[140]

---

[135] Complaint No. 46/2007, Decision on the Merits 3 December 2008.

[136] Complaint No. 46/2007, Decision on the Merits 3 December 2008, at para. 45.

[137] See Council of Europe, *Digest of the Case Law of the European Committee of Social Rights*, Strasbourg (2008) at 82. This is stated to be "the logical consequence of the non-discrimination provision in Article E of the Charter, in conjunction with the substantive rights of the Charter."

[138] See Council of Europe, *Digest of the Case Law of the European Committee of Social Rights*, Strasbourg (2008) at 83.

[139] See Council of Europe, *Digest of the Case Law of the European Committee of Social Rights*, Strasbourg (2008) at 85 and 88.

[140] Complaint No. 45/ 2007, 30 March 2009, *International Centre for the Legal Protection of Human Rights (INTERRIGHTS) v Croatia* at paras 58-66, reported in International Human Rights Reports (IHRR) Vl. 18 No. 3 July 2011 at 872-887. See also Resolution of Committee of Ministers on Collective Complaint No. 45/ 2007, 30 March 2009, *International Centre for*

Illegal migrants and their children come within the scope of Article 13 of the RESC in relation to access to emergency assistance. The question of access to health care for this group was considered by the RESC in the case of *International Federation of Human Rights Leagues (FIDH) v France.*[141] This concerned a decision by France to end an exemption of low income illegal migrants from medical and hospital charges. The FIDH challenged this decision under both Article 13 and Article 17 (the right of the child to medical care) of the RESC. Recalling that human dignity is the fundamental value and indeed the core of positive European human rights law and that health care is a prerequisite for the preservation of human dignity, the ECSR linked the protection required under the RESC to those rights protected under the ECHR and stated that 'legislation or practice which denies entitlement to medical assistance to foreign nationals, within the territory of a State party, even if they are there illegally, is contrary to the Charter'. On the facts, the ECSR found no violation of Article 13, but a violation of Article 17 and in doing so drew on the principles of the Convention on the Rights of the Child.[142] Although not considering the question of discrimination directly (see below), the import of the ECSR's comparison of the adults and children in these groups led it to consider that additional protection was required for the children concerned. In effect, this was an implicit recognition of the principles underpinning indirect discrimination. Undoubtedly this vulnerable group had suffered disproportionately to others which led the CESCR to reach its conclusion of a violation of Article 17.[143]

---

the Legal Protection of Human Rights (INTERRIGHTS) against Croatia, Resolution CM/ResChS(2009)7, Adopted 21 October 2009 at the 1068th meeting of the Minister's Deputies, abhorring homophobic content in evidence submitted in case and welcoming the State Party's decision to withdraw the textbook in question.

[141] Complaint No 14/2003, 3 November 2004. International NGOs are competent to bring complaints under the RESC.

[142] M Ssenyonjo, *Economic, Social and Cultural Rights in International Law*, Oxford and Portland Oregon: Hart Publishing (2009) at 351.

[143] Gable suggests that both the American convention (the Protocol Of San Salvador) and the RESC "describe expansive conceptions of a right to health that encompass rehabilitation and social resettlement of people with mental or physical disabilities and 'satisfaction of the health needs of the highest risk groups", L Gable and L O Gostin, *Mental Health as a Human Right*, in Swiss Human Rights Book Vol. 3, Realizing *The Right To Health*, Andrew Clapham & Mary Robinson, Geneva (2009) at 33.

In the later case of *European Roma Rights Centre (ERRC) v Bulgaria*[144] which concerned the Roma, the ESCR considered that the failure of the State to take positive measures to ensure access to health care for this disadvantaged and vulnerable group will violate the right to health and to non-discrimination. It found:

> "that the failure of the authorities to take appropriate measures to address the exclusion, marginalisation and environmental hazards which Romani communities are exposed to in Bulgaria, as well as the problems encountered by many Roma in accessing health care services, constitute a breach of Article 11§§ 1, 2 and 3 of the Revised Charter in conjunction with Article E."[145]

Repeating the approach under the ECHR, the RESC's non-discrimination provision is linked to the substantive rights of the RESC and may be subsumed in the consideration of those provisions (here the right to health). In the same case, the ESCR considered that a violation of Article 13(1) would not necessitate re-examination under the non-discrimination provision in Article E:

> ... that a denial of the right to social assistance set out in Article 13§1 will inevitably constitute a denial of the fundamental right of persons belonging to socially disadvantaged groups to equality of respect and esteem. As a result, the allegations of a breach of Article E of the Revised Charter read in conjunction with Article 13§1 can be regarded as subsumed in the circumstances of this complaint within the wider question of whether Article13§1 has been breached by the impugned amendments to the Social Assistance Act.[146]

In addressing discrimination, the RESC will focus on "the conditions governing access to [health] care" and in doing so will take into consideration:

> Parliamentary Assembly Recommendation 1626 (2003) on "the reform of health care systems in Europe: reconciling equity, quality and efficiency", which invites member states to take as their main criterion for judging the success of health system reforms effective access to health care for all, without discrimination, as a basic human right.[147]

The RESC has set out how the right of access to health requires:

---

[144] Complaint No. 46/2007, Decision on the Merits 3 December 2008.

[145] Complaint No. 46/2007, Decision on the Merits 3 December 2008 at para 51.

[146] Complaint No. 46/2007, Decision on the Merits 3 December 2008 at paras 45-46.

[147] Council of Europe, *Digest of the Case Law of the European Committee of Social Rights*, Strasbourg (2008) at 82, citing Conclusions 2005, Statement of Interpretation on Article 11 para 5, at 10.

- that the cost of health care should be borne, at least in part, by the community as a whole[148];
- that health costs should not place an excessive financial burden on individuals. Steps must therefore be taken to reduce the financial burden on patients from the most disadvantaged sections of the population[149];
- that arrangements for such access must not lead to unnecessary delays in its provision. Access to treatment should notably be based on transparent criteria, agreed at national level, that address the risk of deterioration both in clinical and quality of life terms[150];
- the number of health care professionals and equipment must be adequate (the criterion is 3 beds per thousand population).[151]

Explicit in these requirements is the notion of positive measures to safeguard the rights of vulnerable groups and the need for the health system to ensure access to health care for all, if necessary through safety nets where health care is otherwise available through health insurance schemes. The RESC is important for establishing that a State may not overly rely on private health care provision if it is to meet its obligations and that safety nets must be in place to guard against discrimination of vulnerable groups. Despite its development of jurisprudence capable of finding the failure of States to take positive measures to ensure access to health care for vulnerable groups as violating the right to health and to non-discrimination and its clear focus on the importance of the right of access to health, the RESC has not enjoyed the benefits of its sister convention, the ECHR, in recognition across the Council of Europe. The reasons for this range from the under-resourcing of its

---

[148] Conclusions I, at 59-60, Statement of Interpretation on Article 11; Conclusions XV-2, Addendum, Cyprus, at 26-28.

[149] Conclusions XVII-2, Portugal, at 680-683.

[150] Conclusions XV-2, United Kingdom, at 599.

[151] Conclusions XV-2, Addendum, Turkey, at 257. This formulation is set out in Secretariat of the European Social Charter, *The Right to Health and the European Social Charter, Information document prepared by the secretariat of the ESC*, Council of Europe (2009) at 10 and more fully set out in Digest of the Case Law of the European Committee of Social Rights, 1 September 2008, at 83.

Secretariat when compared to the Registry of the European Court of Human Rights, to the manner in which economic and social rights are viewed by Member States and within the Council of Europe itself, to the fact that it is not a supranational judicial body. However, the RESC's right to health provisions are binding on Member States and are likely to gain increased attention when the right to health under Article 35 of the EU's Charter of Fundamental Rights is being interpreted.

1.2.1 European Union

The potential impact of European Union ("EU") law on the right to health is significant insofar as EU law takes precedence over domestic law under the doctrine of supremacy (see below) and EU competence in both public and private health is expanding.

Article 6 of the Treaty on European Union (TEU) provides that the Union "recognises the rights, freedoms and principles set out in the Charter of Fundamental Rights" which shall have the "same legal value as the Treaties" even if its provisions do not extend beyond Union competences. It further provides that fundamental rights under the ECHR and "as they result from the constitutional traditions common to the Member States" shall constitute "general principles of the Union's law".[152]

Under Article 20 of the Treaty on the Functioning of the European Union ("TFEU"), the concept of Union "citizenship" is introduced, with EU citizens benefiting from a range of EU rights.[153] The Charter of Fundamental Rights

---

[152] Consolidated Version of the Treaty on European Union, 9.5.2008 EN Official Journal of the European Union C 115/13. This Treaty was ratified by all States and entered into force on 1 December 2009. Article 13 of the Treaty sets out the Union's institutions as: the European Parliament, the European Council, the European Commission, the Court of Justice of the European Union, the European Central Bank, the Court of Auditors. Examples of relevant Regulations include Regulation (EEC) No 1612/68 concerning freedom of movement of workers in the EU, OJ L 28 30 January 1997, p1/OJ L 149, 5 July 1971, 2.

[153] These include the right to move and reside freely within the territory of the Member States, the right to vote etc. See also Title V of the Charter (Articles 39-54) which is entitled "Citizen's rights". O'Leary describes how citizenship rights under Article 20 of the TFEU is "one of the conduits through which EU law reaches deep into Member States' legal systems touching national legislation and policy on, for example, health [Case C-372/04 Watts (reimbursement of medical experiences incurred in another Member State)], education [Case C-76/05 Schwarz and Gootjes Schwarz [2007] ECR I-6849 (tax deductions as regards secondary and university education undertaken in another Member State)], taxation [Case C-

("the Charter") represents a new departure in EU law as for the first time an EU legal instrument is directly concerned with individual rights, rather than economic processes.

Two immediate matters present themselves post-Lisbon: the Charter now has binding effect as set out in Article 6(1), while ECHR principles, where superior to Charter standards, will prevail[154] and secondly, the Court of Justice now has jurisdiction in new areas such as asylum/ immigration and civil/ criminal judicial cooperation. These latest developments in the European project need to be understood in the context of the EU "as a complex polity unto itself"[155] and an acceptance of the EU as a system of governance "which does not readily lend itself to any singular theoretical categorisation".[156]

The Charter does not apply automatically, rather under Article 51 it applies "to the institutions and bodies of the Union" and to Member States "only when they are implementing Union law".[157] Although it appears that this provision limits the binding nature of the Charter to acts of Member States in the context of EU law (i.e. where they seek to transpose Directives etc.), the Court of Justice and its Advocate Generals have traditionally seen the Court's jurisdiction in broader terms and as EU competence in health grows, an

---

403/03 Schempp [2005] ECR I-6421 (tax rules applicable in respect of former spouse resident in another State)], demographic policy [Case C-111/91 Commission v. Luxembourg [1997] ECR I-817 (access of non-nationals to child birth allowances)], social welfare [Case C-287/05 Hendrix [2007] ECR I-6904 (access to incapacity benefit payable to young persons who are in employment)], or indeed criminal procedure [Joined Cases C-274/96 Bickel and Franz [1998] ECR I-7637 (right to use a particular language in criminal proceedings)]: S O'Leary, *Vindicating Citizens' Rights in the European Union*, IHRC & Law Society of Ireland 10th Annual Human Rights Conference, Promoting and Protecting Human Rights in Ireland, The Role of the Irish Constitution and European Law (draft paper) (October 2012) at 13, available at available at *www.ihrc.ie/publications* accessed on 21 October 2012 (draft paper).

[154] See H Roscam Abbing, *Editorial: Health Law: Facing the European Challenges*, 17 European Journal of Health Law (2010) at 7-8. Roscam Abbing considers that, along with EU accession to the ECHR, EU standards will not provide less protection than provided under the ECHR.

[155] E Mossialos and M McKee, *The Theoretical Basis and Historical Evolution of Health Policy in the European Union*, in *EU Law and the Social Character of Health Care*, P.I.E. Peter Lang (2004) at 44.

[156] Puchala, 1972, as cited by E Mossialos and M McKee, *The Theoretical Basis and Historical Evolution of Health Policy in the European Union*, in *EU Law and the Social Character of Health Care*, P.I.E. Peter Lang (2004) at 44.

[157] Under Article 4(3) of the TEU, the Union and the Member States (including national judges) owe a duty of fidelity which equates as a duty of mutual support and a duty of cooperation in tasks which "flow from the treaties".

expansive interpretation of shared competence is likely (see below). As to the right to health itself, Article 35 of the Charter provides:

> Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities.[158]

Article 3 of the Charter provides, *inter alia*, that everyone has the right to respect for his or her physical and mental integrity and the right to free and informed consent in medicine. Article 20 provides that all people are equal before the law while Article 21 provides for a wide prohibition against discrimination based on any ground.[159] The right of access to preventive health care and to benefit from medical treatment, guaranteed under Article 35, must be accordingly guaranteed on a non-discriminatory basis when the two provisions are read together. It is suggested that there are two elements to Article 35 which lend to a "super-mainstreaming expression of the values that underpin EU law and policy", namely an individual entitlement both to medical treatment in the case of ill-health, and to preventive health care (which could potentially encompass the notion of the preconditions (social determinants) for good health) and a "mainstreaming" requirement which includes union policies and activities.[160]

---

[158] The applicability of the Charter is discussed further below.

[159] The non-exhaustive grounds set out in Article 21(1) are "sex, race, colour, ethnic or social origin, genetic features, language, religion or belief, political or any other opinion, membership of a national minority, property, birth, disability, age or sexual orientation". In addition "any discrimination on grounds of nationality" is prohibited.

[160] T Hervey, *We Don't See a Connection: The 'Right to Health' in the EU Charter and European Social Charter*, in *Social Rights in Europe*, G de Búrca, B de Witte (eds.), Oxford University Press 315 (2005) at 315. Writing before the Charter became justiciable, Hogan suggested that "Articles 34 [which concerns social exclusion and poverty] and 35 [health] would seem to flatter to deceive... recognising and respecting these rights will do little for the poor and marginalised unless resources are provided. Here again the same dilemma is encountered. Are the courts to be the judges of this and, if so, who will provide them with the necessary resources to enable real teeth to be given to these rights? And if not, will not Articles 34 and 35 travel the same road to legal obscurity as Article 45 of the [Irish] Constitution, even if the Charter were subsequently to be made justiciable? In any event, the force of these guarantees is considerably diluted by the last lines which provides that this is 'in accordance with the rules laid down by Community law and national laws and practices.' What is the position if, in practice, national laws and practices do not adequately safeguard the right in question?"; G Hogan, *Directive Principles, Socio-Economic Rights and the Constitution*, 36 Irish Jurist (2001) 174 at 190-191.

Title X1V of the TFEU demonstrates how such "mainstreaming" may occur where it provides for union competence in public health under Article 168 stating that a high level of human health protection "shall be ensured in the definition and implementation of all Union policies and activities."[161] In conjunction with Article 114 TFEU, the EU is empowered to enact legislation on healthcare[162] with Article 168 providing for significant potential for expanding EU competence, when taken in the context of a wide range of Regulations and Directives now impacting on public health.[163] Under Article 168(1), the recent Directive on the Application of Patients' Rights in Cross Border Healthcare 2011/24/EU, will, from 2013, apply to the provision of healthcare to patients "regardless of how it is organised, delivered and financed."[164] This Directive is aimed at fostering cross border cooperation

---

[161] The Maastricht Treaty gave the EU competence in the field of public health for the first time under Article 129 (to coordinate national policies on the prevention of major diseases, drug dependence, health information and education). Article 152 of the Treaty of Amsterdam built on, but arguably did not extend this competence. Now Article 168 of the TFEU, while respecting the responsibilities of Member States for the organisation and delivery of health services and medical care in their States, provides the basis for expanded Union competences in public health. T Hervey and B Vanhercke, *Health Care and the EU: the law and policy patchwork*, in *Health Systems Governance in Europe, The Role of the European Union Law and Policy*, (eds. E Mossialos, G Permanand, R Baeten and T Hervey) Cambridge University Press (2010) 89 at 89.

[162] Article 114(1) allows the European Parliament and Council to adopt measures "for the approximation of the provisions laid down by law, regulation or administrative action in Member States which have as their object the establishment and functioning of the internal market." According to Directive 2011/24/EU, second paragraph, Preamble, Article 114 of the TFEU is the legal basis for Union legislation "even when public health protection is a decisive factor in the choices made insofar as it explicitly requires that, in achieving harmonisation, "a high level of protection of human health is to be guaranteed taking account in particular of any new development based on scientific facts"; Directive 2011/24/EU of the European Parliament and the Council of 9 March 2011, OJ L 88/45.

[163] See for example in relation to the free movement of patients and medical professionals, Directive 2005/36/EC coordinates the minimum requirement for specialist training including recognition of formal qualifications in medicine that comply with the conditions. See also Directive 2001/20/EC on medical trials. In relation to free movement of goods, medical devices are regulated by three directives: the Active Implantable Medical Devices Directive (90/385/EEC) OJ L 189, 20 July 1990, 17-36 (cardiac pacemakers and other active implantables), Medical Devices Directive (MDD (93/42/EEC, OJ L 169 12 July 1993, 1-43) covers all other devices and the In Vitro Diagnostics (IVD) Directive 98/79/EC OJ L 331, 7 December 1998, 1), all amended by Directive 2007/47/EC OJ L 247, 21 September 2007, 21-55, effective as of March 2010. Again, in relation to goods and products, Advanced Therapy Medicinal Products based on gene therapy, cell therapy or engineered tissue are subject to EU law by virtue of Regulation (EC) No. 1394/2007 OJ L324 10 December 2007. See too Directive on the application of patients' rights in cross border healthcare 2011/24/EU of the European Parliament and the Council of 9 March 2011 discussed below.

[164] Article 1(2), Directive 2011/24/EU of the European Parliament and the Council of 9 March 2011, OJ L 88/45, due to come into force by 25 October 2013. Under Article 3(a), healthcare is defined as "health services provided by health professionals to patients to access, maintain or

between various elements of national healthcare systems[165] and suggests a pathway for future Union competence on health.[166] Where the EU adopts policy or legislates, it will henceforth reflect the Charter's provisions which may provide for more focus on Article 35 of the Charter.

The Directive recognises a broad right to health encompassing "[i]n particular, decisions about the basket of healthcare to which citizens are entitled and the mechanisms used to finance and deliver that healthcare, such as the extent to which it is appropriate to rely on market mechanisms and competitive pressures to manage health systems" which must be taken in the national context.[167]

Prior to the Lisbon Treaty, health was viewed as being primarily a Member State concern[168] unless one of the 'four fundamental freedoms' (goods,

---

restore their state of health, including the prescription, dispensation and provision of medicinal products and medical devices". See also Directive 2001/20EC on the approximation of the laws, regulations and administrative provisions of the Member States relating to the implementation of good clinical practice in the conduct of criminal trials on medicinal products for human use, 4 April 2001, OJ L 121,11.5.2001, p.34.

[165] See P Quinn and P de Hert, *The Patients' Rights Directive (2011/24/EU) -- Providing (some) rights to EU residents seeking healthcare in other Member States*, 27 Computer Law & Security Review (2011) 497 at 497.

[166] Although the Directive refers to Council Directive 2000/43/EC 29 June 2000 OJ L 180, 19.7.2000, p. 22. implementing the principle of equal treatment between persons irrespective of racial or ethnic origin, the only reference to the Charter is the reference in paragraph 25 of the Preamble to the right to protection of personal data under Article 8 of the Charter. There is no reference to the right to health under Article 35, although such omission may change for future legislation following the Commission's Communication entitled *Strategy for the effective implementation of the Charter of Fundamental Rights by the European Union,* COM(2010) 573 final, (October 2010), in which it stated that all legislation would first require an impact assessment against the Charter's provisions and that following same, the Commission will check its legality, and in particular its compatibility with the Charter. Proposals that have a particular link with fundamental rights must include specific recitals that explain how the proposal complies with the Charter. The role of recitals is to explain the reasoning behind the adoption of the act in question and so enable and facilitate judicial review of its conformity with the Charter. This means that use of a standardised recital merely noting conformity with the Charter is to be avoided. The insertion of recitals is not a mere formality, it reflects the in-depth monitoring of the proposal's compliance with the Charter"; ibid at 7, available at *ec.europa.eu/justice/news/intro/doc/com_2010_573_en.pdf* accessed on 28 October 2012.

[167] Directive 2011/24/EU, Preamble, paragraph 6, citing OJ C 146, 22.6.2006, p. 1. The Directive recalls the European Council's Conclusions of 1- 2 June 2006 on *Common values and principles in European Union Health Systems* including the emphasis on the right to health; see para 21.

[168] Article 5 of the TEU employs the principle of "subsidiarity" (and "proportionality") which remains a cornerstone of EU-Member State relations and which is reflected in Article 168 of the TFEU, but the principle is somewhat modified in light of expanding EU competences. Subsidiarity has been referred to as "competitive subsidiarity" between executive authorities (i.e. the EU and Member States) where, unless a measure falls within the competence of the EU institutions, it is primarily a matter for domestic law. See P Craig, G De Búrca, *EU Law,*

persons, services and capital) found in the original 1957 EC Treaty were triggered. This occurs in relation to the free of movement of professionals, of patients and of services such as health insurance, providers of health care and pharmaceuticals. Accordingly key aspects of public health were implicitly covered by EU law prior to the TEU. Any limitations on these freedoms requires substantial justification. While States are specifically empowered under Article 36 of the TEU to limit trade in the movement of goods or services on health grounds, this is not unlimited. It must be justified on grounds of protection of public health and life and not breach other Union rules such as the anti-trust provisions of the right to competition[169] or the prohibition on State aids.[170]

EU competence in public health is expanding and a number of EU agencies further this expansion including the European Medicines Agency, the European Agency for Safety and Health at Work, the European Monitoring Centre for Drugs and Drug Addiction, the European Food Safety Authority, the European Aviation Safety Agency, the European Maritime Agency, the European Centre for Disease Prevention and Control and the European Chemicals Agency.[171] Under Article 6(a) of the TFEU, the protection and improvement of human health is one of a number of areas of Union competence "to carry out actions to support, coordinate or supplement the actions of the Member States". Article 168(2) of the TFEU provides for both some level of complementarity and shared competence between the EU and Member States, led by the

---

Text, Cases and Materials, (4th Ed.) Oxford University Press (2008) at 100-104. Directive 2011/24/EU, Preamble, paragraph 12 notes that the Court of Justice has likewise acknowledged that the objective of maintaining a balanced medical and hospital service open to all "may also fall within one of the derogations, on grounds of public health, provided for in Article 52 TFEU, in so far as it contributes to the attainment of a high level of health protection". The Court of Justice has also held that such provision of the TFEU permits Member States to "restrict the freedom to provide medical and hospital services in so far as the maintenance of treatment capacity or medical competence on national territory is essential for public health".

[169] See Articles 101-106 of the TFEU, OJEU C 83/47 (previously Articles 81 and 82 Treaty European Community (TEC)).

[170] See Articles 107-109 of the TFEU, OJEU C 83/47 (previously Articles 86-87 of the TEC).

[171] See G Permanand and E Vos, *EU Regulatory Agencies and health protection*, in *Health Systems Governance in Europe, The Role of the European Union Law and Policy*, (eds. E Mossialos, G Permanand, R Baeten and T Hervey) Cambridge University Press (2010) at 134-135. The authors structurally critique the European Medicines Agency and the European Food Safety Authority; at 164-182.

Commission allowing for expanded EU competence.[172] Even if such measures are merely interpreted as programmatic (rather than having a clear legal basis), if accompanied by funds, EU health measures will inevitably influence national policies in the field of health insofar as the Commission may claim implied powers to perform a task,[173] a clear implication of the Court of Justice decision in *Germany v Commission.*[174] In that case, the Commission was permitted to invoke implied powers in the field of migration (another area traditionally in the exclusive domain of Member States).[175]

As the phenomenon of contracting out public health services to the private sector continues alongside the creation of health markets, such as in health insurance, the principles of freedom of movement of workers, goods, services

---

[172] Article 168(2) empowers the Commission "in close contact with the Member States, [to] take any useful initiative to promote such coordination, in particular initiatives aiming at the establishment of guidelines and indicators, the organisation of exchange of best practice, and the preparation of the necessary elements for periodic monitoring and evaluation." Insofar as EU competence may extend to 'any useful initiative' of the Commission, this could arguably allow for specific public health-related measures to be adopted by the EU in areas where the scale or effects of the proposed action could be better achieved at Union level. Article 168(3) empowers the Union to foster cooperation with agencies such as the WTO in the sphere of public health.

[173] See M McKee, E Mossialos, P Belcher, *The influence of European law on national health policy*, in *Pluralism, Public Choice and the State in the Emerging Paradigm in Health Systems*, Dov Chernichovsky, Chapter 42 UK: Routledge (2005) at 38. To this should be added the observation that under the WHO's International Health Regulations (discussed below), Member States are obliged to act under WHO directives in the field of public health emergencies. It may be that the EU will consider becoming a Party to WHO (in similar fashion as under the Convention on the Rights of Persons with Disabilities and the ECHR) to ensure internal consistency of policies within the Union in the field of public health. Were that to occur, the EU's influence in Member States' public health policies would likely become considerable. For a discussion of EU implementation of its obligations under a multilateral treaty (namely the WTO Agreement on Implementation of Article V1 of the General Agreement on Tariffs and Trade 1994) see P Didier, *WTO Trade Instruments in EU Law*, Cameron (1999) at 190-196. The EC instrument of transposition was EC Regulation (EC) 384/96.

[174] Cases C-281, 283-285, 287/85 [1987] ECR 3202.

[175] The Court held that "it must be accepted that where an Article of the EEC Treaty... confers a specific task on the Commission it must be accepted, if that provision is not to be rendered wholly ineffective, that it confers on the Commission necessarily and per se the powers which are indispensable in order to carry out that task. Accordingly, the second paragraph of Article 118 must be interpreted as conferring on the Commission all the powers that are necessary in order to arrange the consultations. In order to perform that task of arranging consultations the Commission must necessarily be able to require the Member States to notify essential information, in the first place to identify the problems and in the second place in order to pinpoint the possible guidelines for any future joint action on the part of the Member States; likewise it must be able to require them to take part in any consultation"; Cases C-281, 283-285, 287/85 [1987] ECR 3202 at para 28.

and capital and indeed competition law, have implications for the extent of EU competence or indeed oversight by the Court of Justice of private health. Accordingly, both public and private health providers and health professionals may be subject to the rules on freedom of movement of workers, services, procurement policies and competition policy where health comes within the competence of the EU. Citing health, consumer protection, industry and research and technological development, it has been observed that the imprecision in definitions renders it "difficult to determine precisely which measures fall legitimately within the [EU's] competence".[176] Where shared competence exists, as under Article 168, the Commission may decide to assert competence.

While the primary institutions of the EU are the Commission, the Council, the Parliament and the Court of Justice,[177] it is the Court of Justice which guides the development of EU law including through its doctrine of the "supremacy of EU law" and its interpretation of secondary law (Directives, Regulations, Decisions).[178] Individuals have limited rights, however, before the Court of Justice as it is primarily EU institutions and Member States who are "privileged applicants" with a right of action.[179] Under Article 230, an individual or corporation must have a "direct and individual concern in the matter"; otherwise the privileged litigants before the Court are the Member

---

[176] P Craig, G De Búrca, *EU Law, Text, Cases and Materials*, (4th Ed.) Oxford University Press (2008) at 89-90.

[177] See generally, P Craig, G De Búrca, *EU Law, Text, Cases and Materials*, (4th Ed.) Oxford University Press (2008) at 38-81.

[178] Article 19(1) of the TEU provides that "The Court of Justice …shall ensure that in the interpretation and application of the Treaties the law is observed". Craig and De Búrca suggest that insofar as during the years of "so-called institutional malaise or stagnation" the Court was the glue in attempting to "render the Treaty effective when its provisions had not been implemented as required by the Community, and to render secondary legislation effective when it had not been properly implemented by the Member States", its case law cannot be properly understood "without an awareness of its approach to interpretation", namely purposive or teleological "although not in the sense of seeking the purpose or aim of the authors of the text"; P Craig, G De Búrca, *EU Law, Text, Cases and Materials*, (4th Ed.) Oxford University Press (2008) at 73. See too M Avbelj, *Supremacy or Primacy of EU Law - (Why) Does it Matter?* 17 European Law Journal (2011) 744 and S Morano-Foadi and S Andreadakis, *Reflections on the Architecture of the EU after the Treaty of Lisbon: The European Judicial Approach to Fundamental Rights*, 17 European Law Journal (2011) 595 at 610.

[179] This will likely change with the accession of the EU to the ECHR if the EU is to ensure effective domestic remedies a requirement under the ECHR; see Draft Article 4 of the Accession Treaty (Protocol No. 14 to the ECHR further providing for the EU to become a party to the ECHR).

States, the Council, the Commission, the Parliament and to a lesser extent the European Court of Auditors and the European Central Bank.[180] Since the Court of Justice's judgment in *Francovich and Bonafaci v Italy*[181], an individual may recover damages from their State if the provisions of a Directive are not correctly transposed into domestic law by a certain date.[182] The State will be liable where one of its organs is responsible for the breach.[183] The definition of 'public authority' is broad – it "includes all those empowered by the State to provide a public service and given special powers to do so".[184] As will be observed in Part 2 of this thesis, EU definitions of "public function" are increasingly important for the application of judicial review procedures in domestic law.

Regardless of domestic transposition, if the provisions of the Directive are sufficiently clear to be applied by the national court, it is bound to do so. The Court of Justice has held that there is a right to compensation for financial loss if three conditions were met: the rule of EU law infringed was intended to confer individual rights; the breach was sufficiently serious and there is a direct causal link between the breach of the obligation and the damage sustained.[185] This is significant insofar as individual rights may be conferred by Regulations and Directives and may apply to both State and non-State actors. In *Van Gend en Loos v Netherlandse Administratie der Belastingen*[186] the Court of Justice

---

[180] See D Chalmers, A Tomkins, *European Union Public Law,* Cambridge University Press (2007) at 418-429.

[181] Cases C-6 and 9/90 [1991] ECR 1-5357.

[182] P Craig, G De Búrca, *EU Law, Text, Cases and Materials*, (4th Ed.) Oxford University Press (2008) at 328-343. See generally, J Dickson, *Directives in EU Legal Systems: Whose Norms Are They Anyway?* 17 European Law Journal (2011) at 190-212. See also C McCrudden and H Kountouros, *Human Rights and European Equality Law*, in *Equality Law in an Enlarged European Union, Understanding the Article 13 Directives*, H Meenan (ed), Cambridge University Press (2007) at 73-116.

[183] R Davis, *Liability in Damages for a Breach of Community Law: Some Reflection on the Question of Who to Sue and the Concept of "the State"* 31 European Law Review (2006) at 69.

[184] Cases C-46/93 and 48/93 *Brasserie du Pécheur SA v Federation of Republic of Germany and R v Secretary of State for Transport, ex parte Factortame Ltd and others* [1996] ECR 1-1029 – see below.

[185] Cases C-46/93 and 48/93 *Brasserie du Pécheur SA v Federation of Republic of Germany and R v Secretary of State for Transport, ex parte Factortame Ltd and others* [1996] ECR 1-1029 at paras 20 and 22-29.

[186] Case 26/62 [1963] ECR 1.

held that EU law not only imposes obligations on individuals but also confers rights on them "which become part of their legal heritage".[187] Indeed from its earliest judgments, the Court of Justice has made clear that the provisions of EU law can give rise to "direct obligations on non-state actors, including individuals and corporations".[188] The concept of "horizontal direct effect" emanates from the Germany constitutional doctrine of *Drittwirkung*[189] which is also to be found under Irish constitutional law which provides for horizontal application of constitutional rights (see Part 2 of this thesis).

Individuals are afforded rights under a number of Directives on sex discrimination[190], racial discrimination[191] and discrimination on the basis of religion or belief sexual orientation age and disability.[192] These all apply to discrimination and harassment by private employers. The Court of Justice has held that anti-discrimination protection under the EU extends to the private sphere whether on grounds of sex or nationality[193] and the principle of non-discrimination under Article 48 "must be regarded as applying to private persons as well."[194] The Court highlighted the fact that the erection of a public/ private divide in this field between those subject to State and non-State actor

---

[187] Case 26/62 [1963] ECR 1, at 12.

[188] A Clapham, *Non State Actors under International Law*, Oxford University Press (2008) at 91.

[189] See S Rather, *Corporations and Human Rights: A Theory of Legal Responsibility*, 111 Yale Law Journal at 443 in *Human Rights and Corporations*, The International Library of Essays on rights, D Kinley (ed.) Ashgate Publishing (2009) 245 at 259.

[190] Council Directive 2002/72/EC of 23 September 2002 amending Council Directive 76/207/EEC [2002] OJ L269/15.

[191] Council Directive 2000/43 EC, [2000] OJ L180/22 came into force 19 July 2000 (States had 3 years to implement the Directive).

[192] Council Directive 2000/78 EC, adopted 27 November 2000 [2000] OJ L303/16, entered into force 2 December 2000; the latter coming into effect after 3 years, whereas age and disability had a 6 year introduction timeframe.

[193] In *Angonese v Cassa di Risparmio di Bolzano SpA* Case C-281/98 [2000] ECR 1-4139 the Court made clear that the prohibition in Article 48 EC of restrictions on the free movement of persons, applies to non state actors including private banks. Freedom of movement for workers within the Community "entails the abolition of any discrimination based on nationality between workers of the Member States as regards employment, remuneration and other conditions of work and employment"; at paras 29-30 and 36-42.

[194] C-281/98 [2000] ECR 1-4139 at para 36.

would result in discrimination. Redress is primarily through national law[195] which is obliged to establish effective domestic redress mechanisms.[196] Significant jurisprudence has developed under EU equality law, which invariably reverses the onus of proof onto the respondent once *prima facie* discrimination is demonstrated, in similar manner to the non-discrimination test employed under human rights law.

As noted earlier, domestic health care systems are coming under increasing pressure to privatise and "marketise" to allow competition. This is also the case under EU law where the Court of Justice has ruled that the principles of the internal market laid down in Article 49 of the Treaty also apply to health care services.[197] This suggests that Member States health systems are "not as shielded from the influence of EU law as originally thought".[198] Where the EU legislates, as under Regulation 1408/71/EC which provides for equal health care access for EU nationals when in another EU State, equivalent protection across Member States is required.[199] More fundamentally, where Member State health systems involve "interactions with people (i.e. staff and patients), goods (pharmaceuticals and devices) and services (e.g. provided by health care funders and providers)", the freedom of movement across borders applies[200] which means that national health activities "are in fact subject to EU law and

---

[195] With the possibility of a reference to the Court of Justice on a question of interpretation of EU law.

[196] See Equal Status Acts 2000-2012 and Employment Equality Acts 1998-2011.

[197] See *Kohll v Union des Caisses en Maladie* Case C-158/96 [1998] ECR 1-1931 and *Vanbraekeland Decker v Caisse de Maladie des Employes Prives* Case C-120/95 [1998] ECR 1831 where the Court of Justice applied market rules to health care in holding that EU citizens had a right both to hospital and non-hospital care under the principle of equal treatment of EU nationals.

[198] E Mossialos, G Permanand, R Baeten and T Hervey, *Health Systems Governance in Europe, The Role of the European Union Law and Policy*, Cambridge University Press (2010) at 1.

[199] In Case C-211/08, 2010/8, *European Commission v Kingdom of Spain*, 15 June 2010, the Court interpreted Article 22 of the Regulation to mean that for scheduled hospital treatment in a second Member State (where the treatment is not available in the first Member State), the first Member State needs to ensure a level of insurance cover equivalent to that which the person would be entitled to if s/he received the hospital treatment in the Member State of affiliation. See also Regulation 883/2004. Regulation 574/72 has a similar aim, providing for the European Health Insurance Card, which also includes European Economic Area state nationals coverage, namely Iceland, Liechtenstein, Norway and Switzerland.

[200] Such as Articles 18, 39, 43, 28 and 49 EC.

policy".[201] The twin principles of supremacy and direct effect of EU law mean that the penetration of EU-required health measures into the domestic system is of course compulsory.

With privatisation of healthcare systems comes competition law, increasingly relevant in the field of health care. Here Articles 101 to 106 of the TFEU prohibit both agreements between undertakings and concerted practices which have as their object or effect the prevention, restriction or distortion of competition within the internal market and an abuse of a dominant position within the internal market or in a substantial part of it by a company. Once an aspect of health is privatised and "marketised" into a service, it comes within the ambit of anti-trust law. A Member State can no longer assert exclusive competence. Policy decisions by a State to create a greater role for private-for-profit providers within a publicly funded health care system trigger competition law obligaions - whether under Articles 101-106 of the TFEU - or under domestic legislation (e.g. the Competition Act 1990).
One example is health insurance markets, increasingly introduced by States and currently contemplated in this State under which public-private partnerships operate in "blurred" circumstances.[202] In The Netherlands, with

---

[201] E Mossialos, G Permanand, R Baeten and T Hervey, *Health Systems Governance in Europe, The Role of the European Union Law and Policy*, Cambridge University Press (2010) at 4-5.

[202] Universal Health Insurance is contemplated by 2016 under Ireland's Current Programme for Government which asserts that "[a]s a statutory system of health insurance, guaranteed by the State, the Universal Health Insurance system will not be subject to European or national competition law"; at 31-37 see Programme For Government available at *per.gov.ie/wp-content/uploads/ProgrammeforGovernmentFinal.pdf* accessed on 8 February 2013. Flood and Thomas observe generally how "blurring" of the public/ private sectors appears to be occurring within health systems around the world through at least "three distinct pathways" which overlap: "First, blurring can occur in terms of the supply of services through reforms designed to allow a greater role for private-for-profit providers *within* a publicly funded health care system. This has recently been the case in England[] and there has been some tentative developments in this regard in Canada. At the purchasing level, blurring can occur again within a universal health insurance plan where competition is encouraged between purchasers/ funders (whether public, not-for-profit or for-profit), the idea being this will stimulate efficiency gains whilst still achieving redistributive goals (such purchasers/ funders being subject to heavy regulation to ensure access and varying degrees of equity). This kind of blurring is epitomized by recent reforms in the Netherlands which maintain a universal system, but achieve this through a heavily regulated system of competing private for-profit insurers. This model is related to that presently promoted by President Obama in the US.[] In Canada, this kind of reform has occurred in the province of Quebec, which has sought to ensure universal coverage of prescription drugs through mandates, a public plan, and regulation of private health insurers.[] Lastly, blurring can occur when reforms encourage a greater role for duplicative or parallel private health insurance or financing to facilitate queue jumping or wait times in the public sector and to supplement physicians' public sector pay with private funds. This kind of

the enactment of the Health Insurance Act 2006, health insurance reforms "were combined with deregulating hospital planning and liberalising health care price setting."[203] One author observes that despite the much-lauded UK's National Health Service, 12.7% of that State's total expenditure on health is directed towards private care.[204] In Ireland the figure is significantly higher at 50%.[205]

Can competition principles accommodate right to health concerns? When an organisation is considered an undertaking, it becomes subject to competition law. Certain actions by the undertaking are prohibited. The types with greatest implications for health care are health care cartels (prohibited under Article 101 of the TFEU) and abuse of a dominant position in the market (prohibited

---

blurring is often supported by tax subsidies that encourage the purchase of private health insurance, as in Australia and Ireland.[] In Canada, it is this last form of blurring of public/ private that is under active debate, particularly in light of the Supreme Court of Canada's decision in *Chaoulli [v Canada]* which found a regulation banning private health insurance for medically necessary care (such care being covered by the public insurance system) unconstitutional". Examples of such "blurring" in Canada are given as the growth of private for-profit clinics in such areas as IVF, cosmetic surgery etc. Flood and Thomas cite the second example of "blurring" in the growth of private financing, while the third is to be found in the State of Quebec where private health insurers are harnessed in the aim of achieving universal access; C Flood, B Thomas, *Blurring of the Public/ Private Divide: The Canadian Chapter*, 17 European Journal of Health Law (2010) at 257.

[203] Den Exter suggests that following the 2006 Act, for-profit health insurance companies "compete for the consumers and conclude selective contracts with risk-bearing health providers, where consumers have freedom of choice of both provider and insurer"; A den Exter, Health *System Reforms in The Netherlands: From Public to Private and its Effects on Equal Access to Health Care*, 17 European Journal of Health Law (2010) at 233.

[204] K Syrett, *Mixing Private and Public Treatment in the UK's National Health Service: A Challenge to Core Constitutional Principles*? 17 European Journal of Health Law (2010) 235, citing the WHO World Health Statistics 2009 on private health insurance coverage; ibid at Table 7. According to the Irish Times, "more than 134,000 people have cancelled their health insurance over the past three years. The documents indicate a further 120,000 are set to leave the market over the next two years..."; *Premiums at VHI could rise by 45%, says health insurer*, The Irish Times - Monday, October 29, 2012, available at *www.irishtimes.com/newspaper/frontpage/2012/1029/1224325868416.html* accessed on 28 October 2012.

[205] See the State's Third Periodic Report to ICESCR (2012) where it is stated that "[a]lmost 50% of the Irish population have private health insurance with 2.228 million having private health insurance policies at the end of 2010. The Irish private health insurance regulatory system is based on the key principles of community rating, open enrolment, lifetime cover and minimum benefit and aims to ensure that private health insurance does not cost more for those who need it most. The Government has a temporary scheme of tax relief/community rating levy in place which provides a significant degree of support for the cost of health insurance claims by older people. Preparations are ongoing to put in place a more permanent risk equalisation scheme that will equalise risk as far possible on age, health status and gender grounds. It is intended that this will be put in place at the start of 2013" at 75; see *www.dfa.ie/* accessed on 9 January 2013.

under Article 102).[206] Restraint of competition must however be perceptible, exempting minor cartels.[207]

The current Programme for Government asserts that planned compulsory health insurance system "will not be subject to European or national competition law".[208] EU legislation on non-life insurance under Directive 92/49 EC allows for exceptions to free-market principles but only "provided they are in the general interest, objectively justified, proportional, effective and subsidiary", for example "when health insurance is regulated as a replacement (wholly or partially) of a social public (State) scheme"[209] which could form the basis for this assertion. However, the same will not apply to supplementary or voluntary health insurance schemes insofar as "the more private elements within the social system, the more EU competition law comes into the picture".[210] This suggests that a minimal coverage system (paid for by the State out of social insurance contributions) may be exempted from competition law, but other health insurance schemes would not. The implications of policy decisions in the health insurance market has been stated to be "seriously reduc[ing] Member States' possibilities to develop a policy of promoting voluntary health insurance based on solidarity principles".[211] In order to prevent inequities resulting from a one-sided approach to the insurance market process and preserve health rights, coordination between the different policy

---

[206] See E Mossialos and M McKee, *Voluntary Health Insurance*, in *EU Law and the Social Character of Health Care*, P.I.E. Peter Lang (2004) at 171-172.

[207] Mossialos and McKee suggest that 5% of market share by a cartel will suffice: see E Mossialos and M McKee, *Voluntary Health Insurance*, in *EU Law and the Social Character of Health Care*, P.I.E. Peter Lang (2004) at 173.

[208] Programme for Government at 31-37; see *per.gov.ie/wp-content/uploads/ProgrammeforGovernmentFinal.pdf* accessed on 8 February 2013.

[209] H Roscam Abbing, *Editorial: Health Law: Facing the European Challenges*, 17 European Journal of Health Law (2010) at 7.

[210] H Roscam Abbing, *Editorial: Health Law: Facing the European Challenges*, 17 European Journal of Health Law (2010) at 7.

[211] E Mossialos and M McKee, *Voluntary Health Insurance*, in *EU Law and the Social Character of Health Care*, P.I.E. Peter Lang (2004) at 162.

areas is needed, especially since EU law is now focused on ensuring a high level of health protection.[212]

Whereas it has been suggested that the Netherlands reforms attempted to do precisely that in being based on the principles of equal access and solidarity and removing universal coverage from competition law rules,[213] enabling the right to health to coexist with the principles of competition law applying to voluntary health insurance, the difficulties and tensions in financing universal systems suggest that many areas of health care may be excluded. Where those areas come within the compass of the right to health identified in this thesis, a concern is raised that where conflict between right to health and competition rules arise, the latter principles are favoured. In a number of earlier Court of Justice decisions, it ruled that for social insurance institutions competing with private insurance companies, competition principles would apply. In cases of voluntary supplementary insurance, the Court has held that quantification as an economic activity "was unaffected even if a social purpose was being pursued".[214]

The consequence of these rulings is that health care institutions pursuing social objectives "do not have a blanket exemption from competition law" but must have their activities assessed individually as to whether they are "social or

---

[212] E Mossialos and M McKee, *Voluntary Health Insurance*, in *EU Law and the Social Character of Health Care*, P.I.E. Peter Lang (2004) at 162-163.

[213] Den Exter describes the Dutch health insurance as "based on the principles of equal access and solidarity. According to the principle of equitable access, governments are obliged to establish a health care system of appropriate quality and being universally accessible, taking into account the need for health care and the available resources. As access to health care is allocated solely according to medical criteria (i.e. medical need), non-medical factors (e.g. insurance, coverage, residency etc.) play no role in deciding whether to admit or treat a person (allocation of resources). This assertion has relevant consequences for both medical practice and national legislation in regard to the allocation of limited resources. The principle of equality lies at the root of this assertion and is manifest in the prohibition of discrimination of any form whatsoever"; A den Exter, Health *System Reforms in The Netherlands: From Public to Private and its Effects on Equal Access to Health Care*, 17 European Journal of Health Law (2010) 223 at 224.

[214] See Case C-244/94, *Federation francaise des societies d'assurance (FFSA)*, Judgment 16/11/95 which involved voluntary supplementary pension insurance and Cases C-67/96 and C-115/97, *Albany* and *Albany International BV v Stichting Bedrijfspensionefonds Textielindustrie, Brentjens* Judgment 21/09/99, Case C-219/97, *Bokken*, Judgment 21/09/99 and Case C-180/98, *Drijvende Bokken* and *Pavlov and others*, Judgment 12/09/2000. See E Mossialos and M McKee, *Voluntary Health Insurance*, in *EU Law and the Social Character of Health Care*, P.I.E. Peter Lang (2004) at 165-169.

economic." This will depend on the "objective of the activity in question and the manner in which it is carried out."[215] Insofar as the Court has held that a health care institution operates in an economic way if it competes with private undertakings, it is "irrelevant" whether it seeks to make a profit as an economic activity is defined as one that can be carried out to realise a profit, even if this does not actually happen; an activity "that is only possible on a non-profit-making basis is different from an economic one because it is not guided by economic motives but, instead, by the principles of solidarity and social protection".[216] The crucial distinction between a social and economic activity of a health care institution for Articles 101-102 purposes will be key. If the institution acts in a manner that is so different from private undertakings that a private company could not in principle hope to make a profit if acting in like manner, it may avoid competition law requirements but the intention and motivation of the institution are irrelevant and it is submitted, few private health care institutions could claim to be even mainly guided by "solidarity and social protection" principles.

Under competition law, national regulations that will require health care associations or institutions to conclude or favour prohibited agreements are incompatible with the Treaties insofar as agreements between health care associations and benefit providers are treated in a similar way and are lawful if the statutory provisions allow no scope for autonomous business conduct.[217] This approach by the Court of Justice suggests that the public-private model adopted by The Netherlands may in part be subject to competition law[218] unless

---

[215] E Mossialos and M McKee, *Voluntary Health Insurance*, in *EU Law and the Social Character of Health Care*, P.I.E. Peter Lang (2004) at 169.

[216] E Mossialos and M McKee, *Voluntary Health Insurance*, in *EU Law and the Social Character of Health Care*, P.I.E. Peter Lang 2004 at 169.

[217] E Mossialos and M McKee, *Voluntary Health Insurance*, in *EU Law and the Social Character of Health Care*, P.I.E. Peter Lang 2004 at 178 citing Advocate General Tesauro (1993) ECR 1-661, No. 8, and Advocate General Jacobs (1999) ECR 1-5751, No. 311.

[218] In particular the elements of the system which permit supplementary health insurance may become subject to competition law, bringing additional implications, insofar as supplementary insurance interacts with the basic compulsory health insurance package for all. In this regard, Roos and Schut, point out that "the role of supplementary insurance in health care financing is gradually expanding" with basic and supplementary health insurance founded on different principles, in the Netherlands, where the mandatory basic health insurance scheme is based on "principles of solidarity, universal access, consumer choice and regulated (or managed) competition, supplementary health insurance is exclusively voluntary and based on the

the Court employs Article 35 of the Charter as a "trump" guiding principle over competition law concerns (see below). The Dutch model has been criticised by some commentators as not sufficiently protecting the right to health on the basis that under the health insurance regime financing health care, factors "such as 'health care needs' and 'socio-economic status' become more important, whereas the 'ability to pay' principle has waned".[219] It has been argued that given limited options open to unhealthy and needy individuals, "a substantial inequality in access to health care between several socio-economic groups will occur".[220]

As noted, the Charter's provisions must now be considered by the Court of Justice when considering intersectionalities of health and competition law. The application of the Charter can be observed in a number of fields including data protection where in *Volker und Markus Schecke GbR and Hartmut Eifert v Land Hessen*[221], the Court ruled that the financing of the common agricultural policy under Council Regulation 1290/2005[222] was disproportionate where data

---

principles of a free insurance market in which insurers are free to set the terms of the insurance contract and are allowed to use medical underwriting". Accordingly, where both types of insurance are offered by the same health insurers (such as is the case in the Netherlands, Belgium, Switzerland, "the principles of supplementary health insurance market may interfere with the principles of basic health insurance… result[ing] in less favorable contracts and reduced choice for high-risk individuals in basic insurance"; A Roos, F T Schut, *Spillover effects of supplementary on basic health insurance: evidence from the Netherlands*, 13 European Journal of Health Economist (2012) 51 at 52.

[219] A den Exter, Health *System Reforms in The Netherlands: From Public to Private and its Effects on Equal Access to Health Care*, 17 European Journal of Health Law (2010) at 233.

[220] A den Exter, Health *System Reforms in The Netherlands: From Public to Private and its Effects on Equal Access to Health Care*, 17 European Journal of Health Law (2010) at 233.

[221] Joined Cases C-92/09 and C-93/09, 9 November 2010.

[222] At issue in the case were Council Regulation (EC) No 1290/2005 of 21 June 2005 on the financing of the common agricultural policy (OJ 2005 L 209, p. 1), as amended by Council Regulation (EC) No 1437/2007 of 26 November 2007 (OJ 2007 L 322, p. 1) ('Regulation No 1290/2005'), and, second, of Commission Regulation (EC) No 259/2008 of 18 March 2008 laying down detailed rules for the application of Regulation No 1290/2005 as regards the publication of information on the beneficiaries of funds deriving from the European Agricultural Guarantee Fund (EAGF) and the European Agricultural Fund for Rural Development (EAFRD) (OJ 2008 L 76, p. 28) and Directive 2006/24/EC of the European Parliament and of the Council of 15 March 2006 on the retention of data generated or processed in connection with the provision of publicly available electronic communications services or of public communications networks and amending Directive 2002/58/EC (OJ 2006 L 105, p. 54).

protection safeguards did not comply with Articles 7 and 8 of the Charter.[223] The transparency measures sought to be achieved in the Commission's legislation could have been achieved by other less intrusive means. This reasoning has significance to the balancing the Court of Justice will likely undertake when considering EU legislation or policy. If EU health legislation or policy does not address the right of access to health care as set out in Article 35 of the Charter, it runs the risk of being declared invalid.

The EU's competence in public health under Article 168 of the TFEU and the right of access to health care under Article 35 of the Charter are new implicit EU competences which, unlike environmental protection (where the EU has explicit competence) have been described as being affected by "constitutional asymmetry" between the EU policies on market efficiencies and those to promote social protection.[224] In addition to the Commission's new policy[225] and the Court's developing jurisprudence on the Charter, the Council delivered its 2006 Conclusions on common values and principles in European Union health systems[226] which elevate health in institutional responses. In light of the Court's priority role in filling in gaps that develop in the creation of the single market, it has been suggested that it may inadvertently erode sensitive national health systems structures in pursuit of perceived Union aims[227] with an

---

[223] The Court applied the Article 8 jurisprudence of the ECHR on right to respect for private life: "it does not appear that the Council and the Commission sought to strike such a balance between the European Union's interest in guaranteeing the transparency of its acts and ensuring the best use of public funds, on the one hand, and the fundamental rights enshrined in Articles 7 and 8 of the Charter, on the other"; at paras 80-81.

[224] Under title X1X of the EC Treaty (Articles 174-176); see E Mossialos, G Permanand, R Baeten and T Hervey, *Health Systems Governance in Europe, The Role of the European Union Law and Policy*, Cambridge University Press (2010) at 5-6 citing F Scharpf, *The European social model: coping with the challenges of diversity*, 40 Journal of Common Market Studies (2002) 645.

[225] *Strategy for the effective implementation of the Charter of Fundamental Rights by the European Union,* COM (2010) 573, available at *ec.europa.eu/justice/news/intro/doc/com_2010_573_en.pdf* accessed on 28 October 2012.

[226] OJ 2006 No. C146/1. See also the EU interventions to the WHO's Tallinn Charter on Health Systems, Health and Wealth, Tallinn, 17 June 2008, accessible at *www.euro/who.int/document/E91438.pdf*

[227] E Mossialos, G Permanand, R Baeten and T Hervey, *Health Systems Governance in Europe, The Role of the European Union Law and Policy*, Cambridge University Press (2010) at 16-17. Solanke suggests that the role of an "activist" Court of Justice is "entrepreneurial": I

institutional realignment facilitating health as a fundamental right of EU citizens.[228]

In 1970, long before the formulation of the Charter, the Court of Justice famously pronounced how

respect for fundamental rights forms an integral part of the general principles of law protected by the Court of Justice. The protection of such rights, whilst inspired by the constitutional traditions common to the Member States, must be ensured within the framework of the structure and objectives of the Community.[229]

In *Nold v Commission*[230] the Court cited international human rights treaties as another source of fundamental rights in EC law and in *Rutili v Ministre de l'Intérieur*[231], it referred to the ECHR as a particular source of human rights. The Court has also referred to the aim of the Community legal order "undeniably [being to] strive[s] to ensure respect for human dignity as a general principle of law..."[232] Since 2001, the Charter was relied on as a source of 'soft law' by the Court of Justice[233] whereas now its provisions are a source of primary law applied by the Court. This application can be seen in recent

---

Solanke, *Stop the ECJ'?: An Empirical Analysis of Activism at the Court*, 17 European Law Journal (2011) at 764.

[228] Hoppe states: "Two things are evident. First, health governance is a priority at EU level. Secondly, health law, both at domestic and at supranational levels, is an amalgamation of individual norms and jurisprudence, the combination of which creates something new which is more than simply the sum of its parts.[] It is also clear that there are not two distinct processes at work here, but that domestic health law influences European health governance[] and that European health governance influences domestic health law. The assertion that, because there is no treaty basis for EU health governance, all legislative influences on health law emanating from the EU must be accidental or collateral, is simply antiquated and bears no relation to reality. We can see an institutional realignment in the EU towards facilitating health as a fundamental right of EU citizens, resulting in policy making to ensure the accessibility of this right", N Hoppe, *Editorial - On the Europeanization of Health Law*, 17 European Journal of Health Law (2010) at 327-328.

[229] *Internationale Handelsgesellschaft v Germany* Case 11/70 í (1970) ECR 1125.

[230] Case 4/73 [1974] ECR 491.

[231] Case 36/75 [1975] ECR 1219.

[232] Case C-36-02 *Omega Spielhallen-und Automanatenaufstellungs v Oberbúrgermeistern der Bundesstadt Bonn* [2004] ECR 1-9609.

[233] See for example the Opinion of Advocate General Jacobs in Case C-112/00 Schmidberger [2003] ECR I 5659; see generally S Morano-Foadi and S Andreadakis, *Reflections on the Architecture of the EU after the Treaty of Lisbon: The European Judicial Approach to Fundamental Rights*, European Law Journal, Vo. 17, No. 5 (2011) 595 at 598-599.

judgments of the Court of Justice on EU citizen rights even where the Charter is not invoked. In *Zambrano v Office national de l'emploi (ONEM)*[234], the Court focused on the rights of EU citizen children to imply rights of residence to their non-citizen parents.[235] In *DEB Deutsche Energiehandels - und Beratungsgesellschaft MbH v Bundesrepublik Deutschland*[236] on a reference from the German courts, the Court of Justice invoked the effectiveness of the right of access to the courts provision under Article 47 of the Charter (and Article 6 of the ECHR) to state that the effectiveness principle enshrined in the Charter "must be interpreted as meaning that it is not impossible for legal persons to rely on" access to legal aid for access to the courts.[237] In a Slovenian reference, *Jasna Detiček v Maurizio Sgueglia*[238], the Court held that Regulation No. 2201/ 2003 which aimed at providing for inter-state enforcement of judgments concerning child custody had to be interpreted in light of the rights in Article 23(4) of the Charter on the rights of the child which prohibit a parent from wrongfully removing a child from the jurisdiction of the original country.[239] In an Italian preliminary ruling[240], the Court held that a reference to the Charter in the recital to Directive 2000/43/EC on equal treatment on racial

---

[234] Judgment of 8 March 2011 wherein the Court of Justice rules that parents of dependent child citizens of the European Union may not be refused a right of residence in the case: C 34/09. The This Judgment followed on from the previous Opinion of Advocate General Sharpston delivered on 30 September 2010.

[235] O'Leary records how the Charter has already been cited in over 170 cases by the Court of Justice post-Lisbon: S O'Leary, *Vindicating Citizens' Rights in the European Union,* IHRC & Law Society of Ireland 10th Annual Human Rights Conference, Promoting and Protecting Human Rights in Ireland, The Role of the Irish Constitution and European Law (October 2012) at 25, fn 89, available at *www.ihrc.ie/publications* accessed on 21 October 2012 (draft paper).

[236] Case C-279/09 [2010] All ER (D0 308 (DEC), cited by S Morano-Foadi and S Andreadakis, *Reflections on the Architecture of the EU after the Treaty of Lisbon: The European Judicial Approach to Fundamental Rights*, European Law Journal, Vo. 17, No. 5 (2011) 595 at 604-605.

[237] See also *CIlonka Sayn-Wittgenstein v Landeshauptmann von Wien* Case C-208/09 [2010] All ER (D) 105 in which the Court affirmed an equality argument about name (nobility) retention made by Advocate General Sharpston that there was a breach of Article 7 of the Charter/ Article 8 of the ECHR.

[238] Case C-403/09 PPU, 23 December 2009.

[239] The Court held that Article 20 of Regulation No 2201/2003 "cannot be interpreted in such a way that it disregards that fundamental right"; at para 55.

[240] Case C-571/10, *Servet Kamberaj v Istituto per l'Edilizia sociale della Provincia autonoma di Bolzano (IPES) and Ors,* 24 April 2012.

or ethnic origin grounds meant that Italy had to comply with the provisions of Article 34 of the Charter (social and housing assistance).[241]

Unlike other international human rights conventions which set out a right as balanced against legitimate interests of the State, proportionately exercised, possible countervailing arguments to Charter rights such as the right to health may include principles of the Union such as competition law. As noted above, competition law principles appear to inherently contradict the right to health, particularly where any economic activity can be identified in the activities of a health care institution.[242] In the absence of EU healthcare legislation clarifying the right to health under Article 35 of the Charter, the development of robust caselaw on the scope of the right to health under the Charter by the Court of Justice is anxiously awaited.

Some immediate conclusions pertinent to this thesis may however be drawn. Insofar as the protection and improvement of human health is a core aim of the Union, future EU legislation on healthcare will reflect the Charter's provisions. Such legislation is predicated upon an expansive interpretation of shared competence on public and private health between the EU and Member States, which is also likely, given the fact that it is Commission policy to elevate health in EU institutional responses, but provided Member States' concerns about competition law intrusions are met to allow for modified subsidiarity. This suggests an institutional realignment in the EU towards facilitating health as a fundamental right of EU citizens, resulting in policy making to ensure the accessibility of this right. Equally likely is the development of jurisprudence of the Court on both the right of access to preventive health care and the right to benefit from medical treatment, on a non-discriminatory basis as guaranteed under Article 35 of the Charter when read with Articles 3, 20 and 21. It is to be

---

[241] At issue in the case were Council Directive 2000/43/EC of 29 June 2000, implementing the principle of equal treatment between persons irrespective of racial or ethnic origin (OJ 2000 L 180, p. 22) and Council Directive 2003/109/EC of 25 November 2003 concerning the status of third-country nationals who are long-term residents (OJ 2004 L 16, p. 44). Of course these cases involved national courts referring questions of interpretation to the Court of Justice under the preliminary reference procedure (now Article 234), rather than individuals or corporations having *locus standi* for a right of direct petition to the Court. As to whether access to the Court of Justice itself will change under the Charter remains to be seen.

[242] Noting the decision in Joined Cases C-92/09 and C-93/09 *Volker und Markus Schecke GbR and Hartmut Eifert v Land Hessen*, 9 November 2010.

hoped that this will address competition law concerns by providing that right to health elements under Article 35 "trump" competition rules, particularly insofar as EU legislation and policy must now address Article 35 concerns when being framed.

Public and private health providers and health professionals are already subject to the rules on freedom of movement of workers, services and establishment. EU Directives already legislate for aspects of the right to health for EU citizens in other States and may be extended to core elements of the right on a non-discriminatory basis. Here equality law has developed a ready-made corpus on which future Directives may be based which extend beyond current employment protections.

EU law is also likely to address the privatisation of healthcare systems and which aspects are subject to competition law. This will have implications for Government plans for a compulsory health insurance system not subject to European competition law and for those elements of the right to health not covered by such a system but rather by private health actors. The Court's approach to the distinction between a social and economic activity of a health care institution will be key in this regard.

Perhaps the most important conclusions to draw are that the twin principles of supremacy and direct effect of EU law mean that the compulsory penetration of EU-required health measures into Irish law will likely have a major impact on both public and private health and here the right to health may come into Irish law through the rubric of EU law under the doctrine of supremacy of EU law.

3 The right to health on the Universal Level

Article 12 of the ICESCR and its seminal codification in General Comment 14 of CESCR provides the authoritative international standard on the right to health and will be considered in detail in this section.[243] It adopts a broad normative interpretation to encompass "public health, public care, and the underlying determinants necessary for healthy living."[244] Before considering the right to health under ICESCR, it is important to note how the right to health is interpreted under CEDAW and the CRC. Article 12 of CEDAW, as elaborated by General Recommendation No. 24[245] by the CEDAW Committee, provides for the elimination of discrimination against women in health care to ensure equality of access to health care services in particular pre, post and antenatal care. The rights guaranteed extend to the provision of proper information to women during prenatal care under Article 16. The right to health has also been set out in relation to the right to informed consent where in *Szijarto v Hungary*[246], the CEDAW Committee upheld an

---

[243] The Committee on Economic Social and Cultural Rights (CESCR) is the supervisory body charged with monitoring the implementation of the ICESCR by virtue of Resolution 1985/17 of 28 May 1985 of the United Nations Economic and Social Council (ECOSOC), which established the CESCR and mandated it to carry out the monitoring functions assigned to ECOSOC in Part IV of the ICESCR. The Committee performs this function through the adoption of General Comments on the Covenant's provisions and examination of periodic State reports under Article 16. In contrast to other international treaties, no individual or collective complaints system exists at present, although an Optional Protocol to the Covenant will provide the CESCR with competence to receive and consider individual communications. The optional protocol was adopted by the General Assembly on 10 December 2008 (Resolution A/RES/63/117) and was opened for signature in September 2009. Ireland ratified the ICESCR on 8 December 1989 but has yet to ratify the Optional Protocol.

[244] Committee on Economic, Social and Cultural Rights, Twenty-Second Session, Geneva, 25 April-12 May 2000, Agenda Item 3, General Comment 14 (2000), *The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights)*, E/C.12/2000/4. General Comment 14 takes an omnibus, all-inclusive approach to the right to health insofar as Part 1 of the General Comment focuses on the normative content of Article 12, Part 2 discusses States parties' obligations, Part 3 discusses violations, Part 4 implementation at the national level, while Part 5 sets out the obligations of non-State actors.

[245] General Recommendation No 24: Article 12 of the Convention (Women and Health) 1999, A/54/38/Rev 1.

[246] Communication No. 4/2004, UN Doc CEDAW/C/36/D/4/2004 (29 August 2006). See also Judgments of the European Court of Human Rights in *IG v Slovakia*, Application No. 15966/04, Judgment 13 November 2012 at paras 124-126. See also *VC v Slovakia*, Application No. 18968/07, Judgment 8 November 2011 and *NB v Slovakia*, Application No. 29518/10, Judgment 12 June 2012, discussed above.

individual communication/ application on the basis that an urgent Caesarean section of a Roma woman in labour led to her sterilisation written on a note in a language she did not understand.[247] Similarly in *VK v Bulgaria*[248], the failure of the State to ensure effective protection for a woman suffering from domestic violence was found to violate her rights under Article 2 (in conjunction with Article 1) and Article 5(a), in conjunction with Article 16(1), of CEDAW.[249] Article 24 of the CRC goes beyond Article 12 of the ICESCR in also requiring States to "strive to ensure that no child is deprived of his or her right of access to such health care services." The Committee on the Rights of the Child has yet to issue a General Comment on Article 24, however, any such comment is likely to mirror the protections of Article 12 of ICESCR and be guided by the CRC rights to non-discrimination (Aricle 2), consideration of the best interests of the child (Article 3(1)), life, survival and development (Article 6), and respect for the views of the child (Article 12).[250]

3.1 International Covenant on Economic, Social and Cultural Rights ("ICESCR")

We now turn to consider the main elaboration of the right to health which is set out in Article 12 of the ICESCR and General Comment 14 which also addresses the social determinants of health. The right to health is expansive in its scope and in this section we will consider those core non-derogable aspects of the right, namely non-discrimination in access to health and the need for a national health strategy policy and plan capable of delivering the right to health

---

[247] Communication No. 4/2004, UN Doc CEDAW/C/36/D/4/2004 (29 August 2006). The CEDAW Committee found that the State had failed to provide the complainant with appropriate information and advice on family planning and failed to "ensure that she had given her fully informed consent to the operation" recommending compensation. The need for informed consent in medical procedures is an increasingly commonly recognised principle in the interpretation of human rights conventions.

[248] *VK v Bulgaria*, 27 September 2011, Communication No. 20/2008, CEDAW/C/49/D/20/2008, Committee on the Elimination of Discrimination against Women, Forty-ninth session; at para 9.16.

[249] Interestingly the CEDAW Committee also found a violation of General Recommendation No. 19 of the Committee.

[250] See for example General comment No. 13 (2011), *The right of the child to freedom from all forms of violence*, Committee on the Rights of the Child, 18 April 2011, CRC/C/GC/13, at paras 59-63.

and comprising, *inter alia*, indicators and benchmarks to monitor progressive realisation of the right. Article 12 addresses both public and private health under the three obligations of "respect", "protect" and "fulfil". Justiciability is a key aspect of accountability of the right to health and will be considered in tandem with potential synergies between Article 12 and the programmatic work of the WHO and indeed the UN's international financial institutions.

Article 12 provides:

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

It will be observed from this that Article 12(1) sets out the definition of the right, while Article 12(2) sets out non-exhaustive examples of that right.

3.2 Dimensions of the Right to Health

As noted, General Comment 14 of the CESCR in 2000 was a seminal codification of the various aspects of the right in Article 12. The dimensions of the right to health can be divided into a number of categories: the overarching nature of the right, the content of and limitations to the right, the progressive nature of the right, the framework within which the right must be capable of being accessed and the framework of accountability within which the right can be accounted for. That said, the right to health has two main elements: the right of access to healthcare and the right to the underlying determinants of health

(i.e. the "variety of facilities, goods, services and conditions" which are stated to be a perquisite for the realisation of the right to health).[251]

Under paragraph 1, every human being is entitled to the enjoyment of the highest attainable standard of health "conducive to living a life in dignity." While the realisation of the right to health may be pursued through complementary approaches, it "includes certain components which are legally enforceable."[252] The main challenge is to bridge the legal and programmatic approaches, which although theoretically complementary (see the International Conference on Primary Health Care (Alma-Ata Declaration)[253], the 1990 UN Millennium Declaration and Millennium Development Goals[254], the 2001 Declaration of Commitment on HIV/AIDS[255] and the 2011 Rio Political Declaration on Social Determinants of Health) have yet to grapple with the weaknesses in the approach of the WHO identified earlier.[256]

Clearly programmatic approaches are complementary to the right to health: the actual delivery of health services are often progressively achieved through health programming, health system data and indicator collection. Programmatic approaches alone are not, however, a substitute for the right to health as a legal right. Health is stated to be not only a fundamental human right, but also indispensable for the exercise of other human rights (such as the rights to food, housing, work, education, human dignity, life, non-discrimination etc).[257] The right to health will extend to every human being, not alone citizens of a

---

[251] At paragraphs 3 and 11 of General Comment 14.

[252] General Comment 14, para 1.

[253] The Declaration of Alma-Ata affirmed the crucial role of primary health care, addressing the respective roles of promotional, preventive, curative and rehabilitative services.

[254] See *www.un.org/millenniumgoals/* accessed on 14 October 2012.

[255] General Assembly resolution S-26/2 of 27 July 2001.

[256] A common theme in discussions on the right to health involves a focus on external challenges and paragraph 10 of General Comment 14 notes how since the adoption of the two international covenants in 1966, the world health situation has changed dramatically and that in parallel the notion of health has widened in scope to include focus on the determinants of health such as resource distribution and gender differences. This wider definition of health also takes into account "socially-related concerns" such as violence and armed conflict, the proliferation of diseases, the rapid growth of the world population which "have created new obstacles for the realization of the right to health which need to be taken into account when interpreting article 12."

[257] At paragraph 3 of General Comment 14.

State.[258] Everyone is entitled to the enjoyment of the highest attainable standard of health to enable them live a life in dignity.

There is no right to be healthy insofar as an individual's biological preconditions or indeed risky lifestyle limits the State's obligations. A person with a disability either caused genetically or acquired during life cannot have a right to be healthy insofar as that would require the disability being removed: no State can ensure such a thing. However, the individual still has the right to have access to treatment which would facilitate the person attaining a certain level of dignity. This is also known as the right to "a minimum basket" of health-related services and facilities connected with the right to health. The right to health contains both freedoms and entitlements: freedom to make decisions about one's own health but also entitlement to a system of health care protection. So the "availability of health services, facilities and products of good quality represents a comprehensive dimension, while the actual individual rights guarantee represents another, equally important dimension".[259]

The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. These are classical liberal examples of freedom from State interference favoured by the courts. By contrast, entitlements contain greater complexity: this includes the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health. The entitlement dimension also "addresses such issues as the right to emergency medical services, and to the underlying determinants of health, such as adequate sanitation, safe and potable water, adequate food and shelter, safe and healthy working conditions, and a healthy environment." If these

---

[258] World Health Organization, *International Migration, Health & Human Rights*, Health and Human Rights Publication Series Issue No. 4, World Health Organization, Geneva (2003) at 8.

[259] E Riedel, *The Human Right to Health, Conceptual Foundations*, in Swiss Human Rights Book Vol. 3, *Realizing The Right To Health*, (eds.) A Clapham & M Robinson, Geneva (2009) at 26.

underlying determinants of health are unmet, "the right itself cannot properly be protected".[260]

The concept of "the highest attainable standard of health" in Article 12(1) takes into account both the individual's biological and socio-economic preconditions and a State's available resources. Both individual (freedoms) and individual and population-based (entitlements) approaches are necessary to secure the right to health.

3.3 The AAAQs

The AAAQs refer to the concepts of availability, accessibility, acceptability and quality as set out in General Comment 14 paragraph 12.[261] The General Comment restricts the right to health to the right to the enjoyment of facilities, goods, services and conditions necessary for the realisation of the right; "a minimum "basket" of health-related services and facilities".[262] Paragraph 12 of the General Comment makes clear that "health in all its forms and at all levels" contains the interrelated and essential elements of the AAAQs "the precise application of which will depend on the conditions prevailing in a particular State party". The application of the "interrelated and essential elements" set out in the AAAQs will depend on the economic conditions prevailing in a State.

AAAQs: Availability

Paragraph 12(a) of General Comment 14 places the emphasis on functioning and sufficient health services Facilities (designed buildings), goods (medication, medical equipment etc.), services (location-specific or community) and programmes are all referred to. The requirement that these

---

[260] Paragraph 8 of General Comment 14.

[261] General Comment No. 14 at para 12. See generally E Riedel, *The Human Right to Health, Conceptual Foundations*, in Swiss Human Rights Book Vol. 3, *Realizing The Right To Health*, (eds.) A Clapham & M Robinson, Geneva (2009) at 28.

[262] P Hunt, *Report of the United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, Geneva, Economic and Social Council, Commission on Human Rights (2008) at para 119.

public health and health care measures being available in sufficient quantity within the State party would appear at first glance to mean that health needs must be identified and following that, services match the needs. But a more subtle requirement is afoot, with the State's developmental level being key.[263] The "underlying determinants of health" form the second component of "availability" and perhaps surprisingly extend beyond "safe and potable drinking water and adequate sanitation facilities" to hospitals, clinics, trained medical and professional personnel (receiving domestically competitive salaries) and essential drugs. But what is this other than the practical functioning of a health system? A proper health system can ensure the underlying determinants to health.

Accessibility

The second AAAQ is set out at paragraph 12.b which states that health facilities, goods and services[264] have to be "accessible to everyone without discrimination, within the jurisdiction of the State party." Accessibility is stated to have four overlapping dimensions: a) non-discrimination, b) physical accessibility, c) economic accessibility (affordability) and d) information accessibility:

General Comment 14 also addresses discrimination in setting out how "the most vulnerable or marginalized sections of the population" must have access to the AAAQs.[265] This means physical access to health facilities, goods and services (within safe physical reach) must be ensured for all "especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS." Paragraph 12.c states that there must be economic accessibility (i.e. affordability), whether privately or publicly provided "including socially disadvantaged groups. Equity demands that

---

[263] Paragraph 12(a) General Comment 14.

[264] Unless expressly provided otherwise, any reference in this General Comment to health facilities, goods and services includes the underlying determinants of health outlined in paras. 11 and 12 (a) of this General Comment.

[265] Paragraph 12(b) General Comment 14.

poorer households should not be disproportionately burdened with health expenses as compared to richer households." The concept of affordability is a difficult one. The General Comment, as will be seen later, takes the world at what it is rather than what it should be. In this conceptualisation, States have a choice of means in delivering health services either by private or public provision. Notwithstanding this, payment both for health care services and for those services for the underlying determinants of health (such as potable drinking water, adequate sanitation facilities and access to WHO-prescribed drugs) must be based on the principle of equity, affordable to all, regardless of income or social advantage. This implies State intervention either through public health provision or through other means (such as tax, social assistance or private health insurance provision – e.g. the provision of free/ concessionary medical cards) which will grant the individual access to both health care and the underlying determinants of health even where privately provided. The fourth sub-component of paragraph 12 is information accessibility: "to seek, receive and impart information and ideas"[266] concerning health issues. Everyone has the right to seek, receive and impart information about their health issues but at the same time to have their personal health data treated confidentially.

Acceptability

The third of the AAAQs is acceptability as set out in paragraph 12.c. Here all health facilities, goods and services must be "respectful of medical ethics and culturally appropriate" i.e. respectful of all. This refers to being acceptable when viewed from the viewpoint of medical ethics[267] and indirectly introduces the role of regulation (see Part 4 of this thesis).

Quality: The final element of the AAAQs is that of quality as set out at paragraph 12(d) insofar as health facilities, goods and services must also be scientifically and medically appropriate and of good quality: "This requires,

---

[266] See too Article 19.2 of the ICCPR.

[267] Acceptability here does not mean being acceptable to all individuals except in respect of being culturally appropriate, which would require design flexibility for persons not of the dominant culture in a State.

inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation." This requirement links in with that of acceptability: health facilities, goods and services must be scientifically and medically appropriate and of good quality. What is needed is skilled personnel, proper drugs and hospital equipment in addition to safe water and proper sanitation.

The definition of the right to health is both "timely and appropriate health care" and access "to the underlying determinants of health" as elaborated further in the AAAQs in order to meet the requirements of Article 12(1).

Article 12(2) sets out non-exhaustive examples of the right to health.[268]

3.4 The progressive nature of the right

Although enjoyment of the AAAQs will depend on the conditions prevailing in a State, this does not mean that developing States may avoid their legal obligations under Article 12: health resources must be fairly distributed in a country in accordance with the principles under Article 12.[269] They must be subject to the three criteria on restrictions of rights set out in Article 4 of the ICESCR, namely any restrictions must be 'determined by law', be 'compatible with the nature of [the] rights restricted' and seek solely the legitimate 'purpose of promoting the general welfare in a democratic society'.[270] In addition,

---

[268] See paras 13-17 of General Comment 14 which elaborates on these examples in greater detail. Paragraphs 18 to 29 of the General Comment then focus on special topics of broad application under Article 12, such as non-discrimination. These themes were highlighted earlier in paragraph 12 of the General Comment under the AAAQs and in particular the accessibility of health facilities to disadvantaged groups identified as women, children and adolescents, older persons, persons with disabilities and indigenous persons

[269] International Federation of Health and Human Rights Organisations, *Our right to the highest attainable standard of health,* Human Rights Centre, University of Essex (2006) at 5.

[270] It will be observed that the latter criterion correlates to the principle of proportionality test employed by the ECtHR – i.e the least restrictive alternative, while Principle 56 of the Limberg Principles states that any restrictions 'compatible with the nature of the rights' requires that the essence of the right not be jeopardised; see Y Arai-Takahashi, *The Right to Health in International Law - A Critical Appraisal*, in R Martyn, & L Johnson (Eds), *Law and the Public Dimension of Health* London Cavendish Publishing Limited (Chapter 5) (2001) at 150.

enjoyment of the AAAQs is also predicated upon the concept of progressive realisation.

Article 2(1) of the ICESCR requires State Parties to take the necessary steps to progressively secure Covenant rights "to the maximum of its available resources". General Comment 3 elaborates on this provision which can be cited by States to justify inaction. In order for a State Party to be able to attribute its failure to meet its obligations under the ICESCR as being due to a lack of available resources, however, it must demonstrate that every effort has been made to use all resources that are at its disposition in an effort to satisfy, as a matter of priority, particularly its minimum obligations.[271] This is repeated in General Comment 14 concerning the right to health where the CESCR states that the burden of proof of claiming resource difficulties lies with the State Party.[272]

The precise contours of General Comment 3 has been the subject of extensive academic attention, partly in the absence of detailed analysis by the CESCR in the form of its jurisprudence.[273] There are two exceptions to the principle of permissible resource constraints: progressive realisation (taking steps) and "core principles" such as non-discrimination do not permit the "available resources" defence.

Applying General Comment 3's formulation on the meaning of "progressive realisation" of Covenant rights to the right to health, paragraph 31 of General Comment 14 makes clear that "progressive realisation means that States parties have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of article 12".[274]

---

[271] General Comment No. 3, *The nature of State parties' obligations (Art. 2, par.1)* (1990) at paras 1, 9 and 10.

[272] See paragraphs 30-33 of General Comment 14. Obligations of "immediate effect" are not covered by the "available resources" defence.

[273] Whether this will change once the Optional Protocol to the ICESCR comes into effect remains to be seen.

[274] See General Comment No. 3, para. 9; General Comment No. 13, para. 44.

What is meant by progressive realisation of the right to health? States must "take effective measures to progressively work towards the construction of an effective health system that ensures access to all."[275] Progressive realisation can also be understood as an assessment of whether the initial realisation of the right to health in the State party, present at the time of ratification, has been progressively realised according to the State's obligations under the Covenant. It does not demand "a comprehensive, integrated health system be constructed overnight".[276] The right is realistic and demands more of high-income developed States.[277] The concept of progressive realisation is accordingly linked to the state of a nation's development and resource availability, permitting a distinction between low and high-income States.

Nevertheless, there must be advancement and in assessing whether this has occurred, the Committee will consider whether the State has a national action plan with appropriate indicators and benchmarks, "disaggregated on suitable grounds, such as sex, socio-economic status and age, so that the State knows whether or not its outreach programmes for disadvantaged individuals and communities are working."[278]

If one takes a baseline measurement of an aspect of the right to health at the date of a State's ratification of the ICESCR, one can track the progression of the right over time. A baseline measurement of the right of access to primary

---

[275] P Hunt, *Report of the United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, Geneva, Economic and Social Council, Commission on Human Rights (2008) at para 46.

[276] P Hunt, *Report of the United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, Geneva, Economic and Social Council, Commission on Human Rights (2008) at para 46.

[277] P Hunt, *Report of the United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, Geneva, Economic and Social Council, Commission on Human Rights (2008) at para 46.

[278] P Hunt, *Report of the United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, Geneva, Economic and Social Council, Commission on Human Rights (2008) at para 48. See also P Hunt, *Mental Disability and the Right to Health*, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Geneva, Economic and Social Council, Commission on Human Rights (2005) at para 37 and P Hunt, *A human rights-based approach to health indicators*, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Geneva, Economic and Social Council, Commission on Human Rights (2006) at paras 22-61.

healthcare for a typical Traveller girl, for example, (an identified vulnerable group) in Ireland in 1989 (at which time the State ratified the ICESCR), can mark the starting part when evaluating whether progressive realisation has occurred. That is because at the time of accession to the Covenant, the right to health was recognised to the degree of that baseline and subsequent progressions (or retrogressions – see below) can be analysed against the baseline.

In terms of progression, one must then engage in an analysis of how the State has progressively realised this right since the time of ratification. Clearly the interpretation of the content of the right to health must be first established in order to measure the level of progression. The terms of the treaty right as elaborated by the CESCR is a starting point. The steps taken by the State Party to give effect to the right at and since ratification is the next point of consideration, with the State Party's interactions with the CESCR in its periodic reports, affording some (limited) insight into the matter (discussed further below).

There exists, in theory at least, a legal obligation measured against a concept which should not prove intractable, provided the key tools of a national plan, indicators and benchmarks can inform the assessment of whether progression has occurred. Here one may observe how the WHO, through its programmatic engagement with States may assist in the setting and tracking of national indicators and benchmarks and indeed it has set out a blueprint for such interaction on the right to health of women and girls under CEDAW.[279]

The progressive nature of the rights as described in Article 2(1) of the ICESCR does not mean that economic, social and cultural rights merely represent programmatic goals or non-self-executing "soft law" norms, affording States ultimate discretion in operationalising those rights. Since its General Comment No 3 in 1990, the CESCR has consistently emphasised that such an approach clearly contravenes the object and purpose of ICESCR and that States have to

---

[279] See World Health Organization, *Women's health and human rights: Monitoring the implementation of CEDAW,* World Health Organization, Department of Reproductive Health and Research, Geneva (2007) available at *www.who.int/reproductivehealth/publications/gender_rights/9789241595100/en/* accessed on 8 February 2013.

show how they have progressed in the realisation of rights protection "between two reporting phases, i.e. how the situation has improved" over the last four years. This is stated to be "not merely a programmatic obligation, but a clear and immediate obligation of the State Party."[280]

While a State may be free to choose some of the measures to be adopted to permit progressive realisation, this freedom is not unlimited: it has a duty to adopt those measures that are "most effective, while taking into account resource availability and other human rights considerations."[281] If no progress was made, or there is even regression, then the State Party is under a "stringent legal obligation to explain why it could not fulfil the Covenant obligation".[282] Paragraph 47 of the General Comment highlights the importance of distinguishing "the inability from the unwillingness" of a State party to comply with its obligations under Article 12.[283] A State which is unwilling to use the "maximum of its available resources for the realization of the right to health" will be in violation of its obligations under Article 12.[284] If, however, resource constraints render it "impossible"for a State to comply fully with its ICESCR obligations, paragraph 47 makes clear that it has "the burden of justifying that every effort has nevertheless been made to use all available resources at its disposal in order to satisfy, as a matter of priority, the obligations outlined above". Of note, however, States cannot under any circumstances whatsoever" justify its non-compliance with the core obligations set out in paragraph 43 of General Comment No 14 which are "non-derogable".[285]

---

[280] E Riedel, *The Human Right to Health, Conceptual Foundations*, in Swiss Human Rights Book Vol. 3, *Realizing The Right To Health*, (eds.) A Clapham & M Robinson, Geneva (2009) at 29.

[281] P Hunt, *Report of the United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, Geneva, Economic and Social Council, Commission on Human Rights (2008) at para 50.

[282] E Riedel, *The Human Right to Health, Conceptual Foundations*, in Swiss Human Rights Book Vol. 3, *Realizing The Right To Health*, (eds.) A Clapham & M Robinson, Geneva (2009) at 29.

[283] General Comment 14 at para 47.

[284] General Comment 14 at para 47. This repeats General Comment No 3 wherein the CESCR confirmed that every State has a minimum core obligation to ensure "the satisfaction of, at the very least, minimum essential levels of each of the rights" in the ICESCR. See ICESCR, General Comment 3, *The nature of States parties obligations (Art. 2, par.1)*, at paras 9-10.

[285] General Comment 3, at para 47.

States have the burden of justifying that every effort has been made to use all available resources at its disposal to ensure the right and the obligation to comply with its non-derogable aspects. In *Minister of Health v Treatment Action Campaign*,[286] applying the concept of progressive realisation, the South African Constitutional Court found that the relevant provisions of the South African Constitution required the government "to devise and implement" within its available resources a comprehensive and co-ordinated programme to "realise progressively the rights of pregnant women and their newborn children to have access to health services to combat mother-to-child transmission of HIV".[287] However the court baulked at the concept of a justiciable "core minimum" rights (discussed below). Notwithstanding this, under the Covenant the core non-derogable non-discrimination principle will apply regardless of whether a State is a developed or developing State.

Having established the content of the right to health norm, the second part of measuring progression is the State's measurement of the right. Without benchmarks or indicators, it is difficult to establish whether the right has progressed. It is noteworthy that the Special Rapporteur on the Right to Health[288] has suggested that indicators may be used to monitor aspects of the progressive realisation of the right to health[289] in the absence of a uniform approach from either the CESCR (see below) or the WHO.

---

[286] CCT 8/02, [2002] ZACC 15; 2002 (5) SA 721; 2002 (10) BCLR 1033 (5 July 2002).

[287] CCT 8/02, [2002] ZACC 15; 2002 (5) SA 721; 2002 (10) BCLR 1033 (5 July 2002) at para 135.

[288] The work of the Special Rapporteurs is guided by The Code of Conduct for Special Procedures Mandate-holders adopted by the Human Rights Council in 2007 and the Manual of Operations of the Special Procedures of the Human Rights Council, see Special Procedures of the Human Rights Council, Office of the High Commissioner for Human Rights, accessible at *www.2.ohchr.org/english/bodies/chr/special/index.htm* On the Special Rapporteur's role see generally J Rehman, *International Human Rights Law* (2nd Ed.) Harlow: Pearson Education Limited (2010) at 158-159 and S Subedi, *Protection of Human Rights through the Mechanism of UN Special Rapporteurs*, 33 Human Rights Quarterly (2011) at 201-228. The author records how 66 of the 192 members of the UN have standing invitations to special rapporteurs to visit their countries; at 221.

[289] See 2004 and 2006 reports of the Special Rapporteur to the UN General Assembly and UN Commission on Human Rights (as it then was). According to the Special Rapporteur, indicators could monitor progressive realisation provided a) there is a link between the indicator and the right to health norm, b) the indicators are disaggregated by at least sex, race, ethnicity, rural/urban and socio-economic status or standard (to meet the non-discrimination core obligation) and c) that they are supplemented by additional indicators that monitor "five essential and interrelated features of the right to health". These are listed as (i) a national

The manner in which progressive realisation is measured falls to be considered under General Comment 14 when considering violations of the right (right to respect, protect and fulfil, respectively (see below)). Unless indicators are present in the national health system, it may be impossible to properly monitor and assess progressive realisation of the right to health insofar as we require appropriate data to assess how the hypothetical Traveller girl accessed her right to primary healthcare in 1989 and in 2013. What form those data/ indicators should take will be discussed later, but it suffices for the present to note that, where adequate data is not adduced by the State, a procedural violation of the right to health may arise as is evident from the approach of the ECSR Committee to State reports to it.

3.5 Presumption against retrogression

While progressive realisation may be a difficult concept, the presumption against retrogressive measures set out in paragraph 32 of General Comment 14, at least introduces a burden of proof which requires the State party to justify measures which restrict or reduce an aspect of the right to health. This underlines the importance of baseline data insofar as once a baseline has been established, State measures to restrict or redact enjoyment of the right over time can be identified. An assessment of the right to health norm in a particular State both at the date of ratification of the ICESCR and as progressed at later dates may allow the CESCR to both monitor progression and "retrogression". There is a strong presumption that retrogressive measures taken in relation to the right to health "are not permissible", with the burden of proof resting with the State that such measures are warranted.[290] We are presented with a clear

---

strategy and plan of action, (ii) the participation of individuals and groups in the formulation of health policies and programmes, (iii) access to health information, (iv) international assistance and cooperation of donors in developing countries and (v) accessible and effective monitoring and accountability mechanisms; see 2006 Report, at paras 48-50.

[290] See P Hunt, *Report of the United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, Geneva, Economic and Social Council, Commission on Human Rights (2008) at para 49. In its May 2002 Concluding Observations on Ireland, the CESCR stated that in view of the favourable economic climate, there were no insurmountable barriers preventing the State from effectively implementing the ICESCR. CESCR *Concluding Observations on Ireland's Second Periodic Report*, 5 June 2002, at para. 11.

legal test, with an onus shifting to the State to justify any retrogressive measures similar to the non-discrimination test (see below). Cuts to access to primary health care for a vulnerable group (e.g. persons with intellectual disabilities) will *prima facie* offend this concept unless the State can discharge its burden of proof. Again there are practical difficulties in identifying a) how the State can prove a retrogressive measure is warranted and b) how to measure State's performances.

On proof, paragraph 32 of General Comment 14 states that at least the present level of enjoyment of the right to the highest attainable standard of health "must be maintained" and that if deliberately retrogressive measures are taken "the State party has the burden" of proving that they have been introduced after the "most careful consideration of all alternatives" and that they are duly justified "by reference to the totality of the rights provided for in the Covenant in the context of the full use of the State party's maximum available resources".[291]

How can this be measured? The supervisory treaty body is the CESCR, however in the absence of specific jurisprudence through (its pending) Optional Protocol[292], one must rely on its General Comments, Concluding Observations on State Parties reports and to a lesser degrees its Statements to glean what is required under progressive realisation. However, CESCR guidance on how to measure retrogressivity is poor. This is partly due to the "conceptual and methodological complications" which arise from the fact that State obligations are relative to levels of development and available resources.[293] Absent disaggregated data compiled by a State into comparable categories such as "gender, race, socio-economic or linguistic groups and

---

[291] See General Comment 14, para 32. The decision to introduce retrogressive measures is considered by reference to the "totality" of the rights provided for in the Covenant and against the "full use" of the State's maximum available resources. See also General Comment 3, para 9 and General Comment 13, para 45.

[292] Optional Protocol was adopted on 10 December 2008 and will come into force after 10 State Parties ratified the instrument (Article 18) same. Currently there are 8 ratifications and 35 signatories. See *treaties.un.org* accessed on 21 October 2012.

[293] Y Arai-Takahashi, *The Right to Health in International Law - A Critical Appraisal*, in R Martyn, & L Johnson (Eds), *Law and the Public Dimension of Health* London Cavendish Publishing Limited (Chapter 5) (2001) at 146.

urban/ rural divisions" which can inform indicators or benchmarks, domestic measurement tools the CESCR can rely on or enforcement mechanisms before the Committee to take such absence to task, it is difficult to come to grips with this task.[294] In this regard, it is notable that the CESCR has not adopted the same (albeit imperfect) measurement rubric now being favoured by the ECSR which requires the State to adduce evidence and draws conclusions where it is unwilling or unable to do so.[295]

---

[294] See A R Chapman, *A "violations approach" for monitoring the International Covenant on Economic, Social and Cultural Rights*, 18 Human Rights Quarterly (1996) 23 at 31.

[295] For a review of 2009-10 CESCR State reports see *tb.ohchr.org/default.aspx* accessed on 21 June 2012.

4 "Core" Obligations of immediate effect

As noted, besides progressive realisation and retrogressivity, there are obligations of immediate effect. State Parties cannot cite any resource allocation difficulties if these "core obligations" are not respected: States have no choice but to implement same immediately. Paragraph 43 of General Comment 14 recalls the CESCR's previous General Comment 3, where it was stated that States parties have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant. General Comment 3 had made clear that this includes essential primary health care insofar as if any significant number of individuals were deprived of this minimum core obligation, the Covenant would "be largely deprived of its raison d'etre."[296]

This is in recognition of the importance attached to primary health care as set out in the 1978 Alma-Ata Declaration and reinforced by paragraph 43 of General Comment 14 and General Comment 16 on equality (where the Committee states that Article 12 requires "at a minimum the removal of legal and other barriers between men and women which prevent the accessing and benefitting from healthcare on a basis of equality").[297]

Insofar as a number of the "core obligations" set out in paragraph 43, such as access to essential drugs, are being met by Ireland (see below), in this thesis we consider the two core obligations of non-discrimination and a national public health strategy and plan of action which *inter alia* protects vulnerable groups. However it is important to consider paragraph 43 of General Comment 14 in its entirety insofar as it sets out at least six "core obligations" which comprise the "floor" for Article 12 minimum core rights. These obligations are: access to the AAAQs without discrimination, access to food, shelter, housing, sanitation, water, essential drugs, equitable distribution of all health facilities, goods and services, a national public health strategy and plan of action.[298] General

---

[296] General Comment 3, at para 10.

[297] See paragraph 29.

[298] General Comment 14, para 43 (a) to (f). See also the *Health For All and Primary Health Care Strategies* of the WHO. As Arai-Takahashi observes, the CESCR took note of "international human rights jurisprudence, the WHO's Primary Health Care Strategy in the

Comment 14 also sets out obligations of comparable priority in paragraph 44.[299] These additional core obligations will appear self-evident from Article 12: the right to reproductive, maternal and child health care, immunisation against major diseases, epidemic and endemic controls, education and information and training for health personnel. Core obligations under Article 12 are non-derogable.[300]

This means that regardless of economic or other reasons, these rights cannot be avoided. Importantly the core obligations extend beyond access to minimum essential food, basic shelter, housing, sanitation and safe water, to include access to the AAAQs without discrimination, equitable distribution of all health facilities, goods and services and the right to the adoption and implementation of a national public health strategy and plan of action which must include "process" rights such as such the "right to health indicators and benchmarks".

In *Minister of Health v Treatment Action Campaign*,[301] the South African Constitutional Court baulked at the argument that under sections 26 and 27 of the South African Constitution there was a "minimum core to which every

---

Alma-Ata Declaration, and the Programme of Action of the International Conference on Population and Development" (Cairo, 1994) in proposing the six minimum obligations; Y Arai-Takahashi, *The Right to Health in International Law - A Critical Appraisal*, in R Martyn, & L Johnson (Eds), *Law and the Public Dimension of Health* London Cavendish Publishing Limited (Chapter 5) (2001) at 167-168.

[299] Namely "(a) To ensure reproductive, maternal (pre-natal as well as post-natal) and child health care; (b) To provide immunization against the major infectious diseases occurring in the community; (c) To take measures to prevent, treat and control epidemic and endemic diseases; (d) To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them; (e) To provide appropriate training for health personnel, including education on health and human rights."

[300] General Comment 14 at para 43. "Core obligations" are understood to be of immediate effect, rather than to be progressively realised, see para. 47. Paragraph 30 clarifies that States parties have imposed on them "various obligations which are of immediate effect", notwithstanding the principle of "progressive realization" as set out in Article 3 and "... constraints due to the limits of available resources". The legal obligations consist of "States parties hav[ing] immediate obligations in relation to the right to health, such as the guarantee that the right will be exercised without discrimination of any kind (art. 2.2)" and as noted already, the obligation to take deliberate, concrete and targeted steps towards full realisation of the right to health. The non-discrimination principle is set out in Article 2(2) of the ICESCR.

[301] CCT 8/02, [2002] ZACC 15; 2002 (5) SA 721; 2002 (10) BCLR 1033 (5 July 2002).

person in need is entitled" as advanced by the *amici curiae* in the case[302] Although it identified such a "minimum core" as arising from General Comment 3, formulated in terms of "the minimum decencies of life consistent with human dignity",[303] the Court considered, however, that "the socio-economic rights of the Constitution should not be construed as entitling everyone to demand that the minimum core be provided to them" insofar as it was "impossible" to afford everyone access even to a core service immediately.[304] All that was possible and could be expected of the State was "that it act reasonably to provide access to the socio-economic rights identified in sections 26 and 27 on a progressive basis."[305] Whereas there were "a wide range of possible measures which could be adopted by the State to meet its obligations", the courts were not institutionally equipped to assess such matters.[306] The role of the courts should rather be the "restrained and focused"

---

[302] CCT 8/02, [2002] ZACC 15; 2002 (5) SA 721; 2002 (10) BCLR 1033 (5 July 2002) at para 26. This argument was advanced by the first and second amici, whereas the Applicants argued that the State had acted wrongly in prohibiting administration of nevirapine (the anti-retroviral) and in failing to implement a programme to prevent mother to baby HIV transmission; at para 44. Section 26 of the South African Constitution concerns the right to housing and provides: "(1) Everyone has the right to have access to adequate housing. (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of this right." Section 27 concerns the right to health and provides: "(1) Everyone has the right to have access to - (a) health care services, including reproductive health care; ...(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights." Citing the Judgment of the Constitutional Court in *Soobramoney v Minister for Health (Kwazulu-Natal)* (CCT32/97) [1997] ZACC 17; 1998 (1) SA 765 (CC); 1997 (12) BCLR 1696 (27 November 1997) at para 11, where the court had distinguished between "the corresponding rights [under sections 26(1) and 27(1) of the South African Constitution which were] limited by reason of the lack of resources" and the "obligations" on the State under sections 26(2) and 27(2) which only required the taking reasonable measures within available resources to achieve progressive realisation of the rights involved.

[303] CCT 8/02, [2002] ZACC 15; 2002 (5) SA 721; 2002 (10) BCLR 1033 (5 July 2002) at para 28.

[304] CCT 8/02, [2002] ZACC 15; 2002 (5) SA 721; 2002 (10) BCLR 1033 (5 July 2002) at para 35.

[305] CCT 8/02, [2002] ZACC 15; 2002 (5) SA 721; 2002 (10) BCLR 1033 (5 July 2002) at paras 34 and 35. This approach to section 26 paragraphs 1 and 2 had been upheld by Yacoob J in *The Government of the Republic of South Africa v Grootboom* (CCT11/00) [2000] ZACC 19; 2001 (1) SA 46; 2000 (11) BCLR 1169 (4 October 2000) who considered that the test was "whether the measures taken by the State to realise the right afforded bys 26 are reasonable" at para 33. Accordingly the Court in *Treatment Action Campaign* held that the "minimum core was thus treated as possibly being relevant to reasonableness under section 26(2), and "not as a self-standing right conferred on everyone under section 26(1)"; at paras 31-34.

[306] "The courts are not institutionally equipped to make the wide-ranging factual and political enquiries necessary for determining what the minimum core standards called for by the first and second amici should be nor for deciding how public revenue should most effectively be

role of evaluating the "reasonableness" of State measures to meet its constitutional obligations.[307] The concept of "reasonableness" is linked to rationality and evident in judicial review jurisprudence as will be discussed in Part 2 of this thesis.[308]

Although the core non-derogable non-discrimination principle was not at issue in *Treatment Action Campaign,* the judgment marks a blow to the theory of "core" justiciable rights. Although all "core" rights under ICESCR are universal, indivisible and inalienable, the Judgment suggests that those central aspects of the "core right" to health such as access to food, shelter, housing, sanitation, water, essential drugs, equitable distribution of all health facilities, goods and services, as set out in paragraph 43 (b) to (e), are perhaps more capable of being met by developed States such as Ireland, which have the resource means to secure the right, rather than developing States whose health systems do not ensure minimal coverage across each aspect of the "core' right. Accordingly, the concept of justiciable "core" rights has not commended itself to national constitutional courts who prefer to exercise traditional functions of reviewing Executive acts or omissions against "reasonableness" criteria.

---

spent"; CCT 8/02, [2002] ZACC 15; 2002 (5) SA 721; 2002 (10) BCLR 1033 (5 July 2002) at para 27.

[307] "For policy to be 'reasonable', it was to be comprehensive, coordinated between levels of government and focused on those in greatest need"; see H Potts, *Accountability and the Right to the Highest Attainable Standard of Health*, Human Rights Centre, University of Essex (2008), at 18 available at *www.womenslinkworldwide.org/pdf_programs/en_prog_rr_col_pubs_accountability.pdf* and paras 95 and 135 of the Judgment.

[308] See *Soobramoney v Minister for Health (Kwazulu-Natal)* (CCT32/97) [1997] ZACC 17; 1998 (1) SA 765 (CC); 1997 (12) BCLR 1696 (27 November 1997) Chaskalson P held that "[a] court will be slow to interfere with rational decisions taken in good faith by the political organs and medical authorities whose responsibility it is to deal with such matters"; at para 29. See also *R (Otley) v Barking and Dagenham Primary Care Trust* [2007] CCL Rep 628 where the Court of Appeal held that a decision to prioritise certain resources lacked rationality as it "did not on any reasonable view put at risk the interests of other patients or, in the words of its own policy on difficult decisions require it to consider funding on the health of the whole population"; at 27.

4.1 Non-discrimination as a non-derogable core obligation

As noted, the *Treatment Action Campaign* judgment did not address non-discrimination arguments. The Preamble, Articles 1 (3) and 55 of the Charter of the United Nations and Article 2(1) of the UDHR prohibit discrimination in the enjoyment of economic, social and cultural rights. The prohibition of discrimination in the enjoyment of the right to health is set out in paragraphs 18-19 of General Comment 14 and later in paragraph 43.[309] For a full definition of non-discrimination under the ICESCR, we turn however to Article 2(2) of the ICESCR which provides:

> The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

As noted earlier, General Comment 14 when addressing the AAAQs "proscribes any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement" on any ground "which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health.[310]

Non-discrimination has been described as "linked to the marginalization of specific population groups and is generally at the root of fundamental structural inequalities in society" in turn, rendering these groups more vulnerable to poverty and ill health.[311] These inequalities mark the social determinants of

---

[309] Examples of vulnerable or disadvantaged groups as set out in General Comment 14 are Gender perspective (see para 20), Women and the right to health (see para. 21), Children and adolescents (see paras 22-24), Older persons (see para 25), Persons with disabilities (see para 26) and Indigenous peoples (see para 27).

[310] See also paragraph 18 of the General Comment. See CESCR's 2002 Concluding Observations on Ireland that States' National Health Strategies must "respect and embrace" the principles of non-discrimination and equal access to health facilities and services; CESCR, Concluding Observations: Ireland, UN Doc E/C.12/1/Add.77 (17 May 2002), para 35; CESCR, General Comment 14, para 12(b)(ii).

[311] The World Health Organization has observed: "Not surprisingly, traditionally discriminated and marginalized groups often bear a disproportionate share of health problems. For example, studies have shown that, in some societies, ethnic minority groups and indigenous peoples enjoy fewer health services, receive less health information and are less likely to have adequate

health. Clearly specific vulnerable groups can be identified at the outset, a fact which should allow States address the progressive realisation of the right to health and non-discrimination obligations in tandem.

The meaning of the prohibition of discrimination has most recently been elaborated by General Comment 20 of the CESCR, paragraph 7.[312] As to its definition, discrimination constitutes "any distinction, exclusion, restriction or preference or other differential treatment" that is "directly or indirectly based on the prohibited grounds" of discrimination and which has the "intention or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of Covenant rights".[313] Discrimination also includes incitement to discriminate and harassment.[314] The key points to note in the definition are that the "distinction, exclusion, restriction or preference or other differential treatment" must be on a prohibited ground.

The prohibited grounds set out in Article 2(2) are "race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status". A wide definition is to be afforded to "other status" as established under international law standards generally.[315] Paragraph 27 of General

---

housing and safe drinking water, and their children have a higher mortality rate and suffer more severe malnutrition than the general population"; World Health Organization, Office of the High Commissioner for Human Rights, *The Right to Health,* Fact Sheet No. 31 Geneva (2008) at 7. The CESCR has defined poverty as "a human condition characterized by sustained or chronic deprivation of the resources, capabilities, choices, security and power necessary for the enjoyment of an adequate standard of living and other civil, cultural, economic, political and social rights. While acknowledging that there is no universally accepted definition, the Committee endorses this multi-dimensional understanding of poverty, which reflects the indivisible and interdependent nature of all human rights"; *Poverty and the International Covenant on Economic, Social and Cultural Rights:* 05/10/2001, E/C.12/2001/10. (Other Treaty-Related Document), Twenty-fifth session Geneva, 23 April-11 May 2001, Agenda item 5; CESCR at para 8.

[312] Paragraph 7 confirms how non-discrimination "is an immediate and cross-cutting obligation in the Covenant" and how under Article 2(2) States are to guarantee non-discrimination in the exercise of "each of the economic, social and cultural rights" enshrined in the ICESCR.

[313] For a similar definition of what constitutes discrimination, see Article 1, ICERD, Article 1, CEDAW and Article 2, Convention on the Rights of Persons with Disabilities. The Human Rights Committee comes to a similar interpretation in General Comment No. 18, *Non-discrimination 11/10/1989 CCPR General Comment No. 18* at paras. 6 and 7. The Committee has adopted a similar position in previous General Comments.

[314] Non-Discrimination in Economic, Social and Cultural Rights (art. 2, para. 2), E/C.12/GC/20, Committee On Economic, Social And Cultural Rights, Forty-Second Session, Geneva, 4-22 May 2009. This defintion is in line with that in other international conventions such as the ICCPR (see its General Comments 2 and 18), CERD and CEDAW.

[315] See the approach of the Human Rights Committee to "other status" under the ICCPR. See also the other grounds cited in General Comment 14.

Comment 20 stresses that a "flexible approach" to the ground of "other status" is needed to "capture other forms of differential treatment that cannot be reasonably and objectively justified" and which are of a comparable nature to the expressly recognised grounds in Article 2(2). Further, these additional grounds are "commonly recognised when they reflect the experience of social groups that are vulnerable and have suffered and continue to suffer marginalisation."[316]

Paragraph 27 provides non-exhaustive examples of "other status" covering the grounds of disability, age, nationality, marital and family status, sexual orientation and gender identity, health status, place of residence and economic and social situation.[317] Both formal and substantive or *de facto* discrimination are prohibited.[318] Attention must be paid by the State to "whether a person is a member of a group characterized by the prohibited grounds of discrimination", echoing the points made by the OHCHR and WHO in Fact Sheet 31. Eliminating discrimination requires paying sufficient attention to "groups of individuals which suffer historical or persistent prejudice" instead of merely comparing the formal treatment of individuals in similar situations.[319] States must therefore immediately adopt the necessary measures to "prevent, diminish and eliminate the conditions and attitudes which cause or perpetuate substantive or de facto discrimination."[320]

Paragraph 10 of General Comment 20 distinguishes between direct and indirect discrimination[321] and provides examples of measures States need to take to

---

[316] Committee on Economic, Social and Cultural Rights, General Comment No. 20 (2009), Non-discrimination in economic, social and cultural rights (art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights) at para 27.

[317] See General Comment 20 paras 27 to 35.

[318] General Comment 20 at para 8.

[319] General Comment 20 at para 8.

[320] General Comment 20 at para 8. Paragraph 8 gives the example of "ensuring that all individuals have equal access to adequate housing, water and sanitation will help to overcome discrimination against women and girl children and persons living in informal settlements and rural areas".

[321] "(a) Direct discrimination occurs when an individual is treated less favourably than another person in a similar situation for a reason related to a prohibited ground; e.g. where employment in educational or cultural institutions or membership of a trade union is based on the political opinions of applicants or employees. Direct discrimination also includes detrimental acts or

tackle "substantive or de facto" discrimination. Where discrimination exists in a State, the State may be required to undertake "special" or "reverse" discrimination measures as set out at paragraph 9 for example to "suppress conditions that perpetuate discrimination" provided such measures are "legitimate to the extent that they represent reasonable, objective and proportional means to redress de facto discrimination and are discontinued when substantive equality has been sustainably achieved."[322]

The marginalisation of rural girls or women, for example, will place an onus on the State to take "positive" or "reverse discrimination measures" to ensure their right to health, such as ensuring adequate housing, water and sanitation and access to the AAAQs. This may imply "catchment policies" to ensure effective access to a quality health in an accessible clinic or hospital within the locality to ensure the enjoyment of AAAQs is on an equal basis with others. Proactive outreach or other positive measures to identify who and where marginalised groups are located is required to prevent substantive or "indirect" discrimination, needed to identify whether "reverse discrimination" measures are required. Where other barriers to equal access to healthcare on the basis of gender exist, the State will similarly be obliged to remove such barriers in accordance with its obligations under Article 3 of ICESCR.[323]

In what circumstances may discrimination occur? If the State introduces limitations to the right to health, such as any of the AAAQs, then under the non-discrimination test, those limitations "must be proportional, i.e. the least restrictive alternative must be adopted where several types of limitations are available." Further, even where such limitations on "grounds of protecting

---

omissions on the basis of prohibited grounds where there is no comparable similar situation (e.g. the case of a woman who is pregnant); (b) Indirect discrimination refers to laws, policies or practices which appear neutral at face value, but have a disproportionate impact on the exercise of Covenant rights as distinguished by prohibited grounds of discrimination. For instance, requiring a birth registration certificate for school enrolment may discriminate against ethnic minorities or non-nationals who do not possess, or have been denied, such certificates."

[322] "Such positive measures may exceptionally, however, need to be of a permanent nature, such as interpretation services for linguistic minorities and reasonable accommodation of persons with sensory impairments in accessing health care facilities"; at para 9.

[323] General Comment No. 16 articulates the equal right of men and women to the enjoyment of all economic, social and cultural rights under Article 3 of ICESCR, Thirty-fourth session Geneva, 25 April-13 May 2005, E/C.12/2005/4.

public health are basically permitted, they should be of limited duration and subject to review."[324] Discrimination may occur where the State remains passive, such as in the situation of housing, water and sanitation or even a local hospital access deficit for rural women and girls. Identified "reverse discrimination" measures should then be addressed in the State's national health policy and strategy and under the relevant domestic law.

Differential treatment may constitute discrimination under paragraph 13 of General Comment 20 if "based on prohibited grounds ... unless the justification for differentiation is reasonable and objective." The concept of least restrictive intrusion to the right of access to the AAAQs can again be observed. The determination of whether a difference of treatment will constitute discrimination will focus on the legitimacy of measures taken and the proportionality between means and aims and not least whether every effort is made to use all resources to address discrimination again suggesting a commonality with other international law standards.[325] Guidance on the scope of the test can be gleaned from the ECHR, the RESC and the jurisprudence of the Human Rights Committee under the ICCPR.[326]

General Comment 14 of the CESCR had united the prohibition on discrimination with the right to health. The right of access to the AAAQs without discrimination is a non-derogable "core" right. As noted, not all

---

[324] At paragraph 29.

[325] General Comment 20 at para 13 which sets out the test as "an assessment as to whether the aim and effects of the measures or omissions are legitimate, compatible with the nature of the Covenant rights and solely for the purpose of promoting the general welfare in a democratic society. In addition, there must be a clear and reasonable relationship of proportionality between the aim sought to be realized and the measures or omissions and their effects. A failure to remove differential treatment on the basis of a lack of available resources is not an objective and reasonable justification unless every effort has been made to use all resources that are at the State party's disposition in an effort to address and eliminate the discrimination, as a matter of priority."

[326] Established under Article 28 of the ICCPR, the Human Rights Committee supervises the implementation of the Covenant. See its General Comment No. 18, Non-discrimination, thirty-seventh session (1989). In its jurisprudence, the Human Rights Committee has found a difference on grounds of "other status" constituted discrimination in similar manner to the European Court of Human Rights. For example conscientious objectors to military service came within "other status" in *Foin v France*, 3 November 1999, 55th Session of the Human Rights Committee, Suppl. No. 40 (A/55/40), at para 10.3 and "nationality" in *Gueye v France*, 3 April 1989, 35th Session of the Human Rights Committee, Suppl. No. 40 (A/44/40), at para 9.4.

differences of treatment between groups are prohibited: "reverse" or "positive" discrimination measures may be required to target vulnerable groups and address historic disadvantage. However, the difference in treatment must be demonstrated to be reasonable and objective and the onus of proof will invariably lie with the State. As stated, in assessing individual complaints under the Optional Protocol to ICESCR (once it enters into force), the CESCR is likely to follow the approach of other treaty bodies with individual complaint mechanisms such as the Human Rights Committee and the CEDAW Committee. In *Szijarto v Hungary*[327] gender and race discrimination were at issue under Article 16(1)(e) with part of the Committee's conclusions based on the fact that the respondent State had been unable to justify the sterilisation or why it did not breach the complainant's rights. From a proactive standpoint, States should ensure health facilities for ethnic minorities are capable of meeting the AAAQs through targeted programmes, which in this case would include anticipated information needs when seeking the person's obtaining consent.

Insofar as discrimination may be on enumerated or 'other' status grounds, access to the AAAQs as simple as access to primary health care may not be denied on the basis of one's gender (for example the rural girl or woman) or immigration or even health status. In this regard, paragraph 33 of General Comment 20 focuses on discrimination on "health status" ground and cautions against differential treatment on this basis. Whereas health status refers to a person's physical or mental health,[328] States should be slow to cite the protection of public health "as a basis for restricting human rights in the context of a person's health status" insofar as a person's "actual or perceived health status" should not become "a barrier" to realising their rights under ICESCR, with HIV status being an example of a discriminatory health status ground which can restrict access to "education, employment, health care, travel, social security, housing and asylum".[329] States should adopt measures to

---

[327] Communication No. 4/2004, UN Doc CEDAW/C/36/D/4/2004 (29 August 2006).

[328] See General Comment No 14, at paras 12b, 18, 28, and 29.

[329] Office of the UN High Commissioner for Human Rights and Joint United Nations Programme on HIV/AIDS, *International Guidelines on HIV/AIDS and Human Rights, 2006 Consolidated Version* Geneva UNAIDS and OHCHR (2006). See

"address widespread stigmatisation" of persons on the basis of their health status "such as mental illness, diseases such as leprosy and women who have suffered obstetric fistula". Similarly, denial of access to health insurance on the basis of health status "will amount to discrimination if no reasonable or objective criteria can justify such differentiation".[330]

Discrimination on the ground of health status extends beyond the prohibition of discrimination in access to the AAAQs but covers a wide range of rights.[331]

Discrimination by private organisations is not omitted from scrutiny: paragraph 11 confirms that discrimination in the private sphere must be addressed by the State, including through legislation to prohibit any such discrimination.[332] Discriminatory practices at the hands of private actors must be regulated by State parties through measures such as legislation prohibiting such unlawful discrimination in the private sphere. In the Irish context, the Equal Status Acts 2000-2012 and the Employment Equality Acts 1998-2011 are examples of partial legislation prohibiting private actor discrimination.[333] Thus under the Equal Status Acts, once a complainant establishes the existence of a *prima facie* case of discrimination in the provision of a good or service, the burden of proof will shift to the respondent to rebut the inference of discrimination raised

---

http://data.unaids.org/Publications/IRC-pub07/JC1252-InternGuidelines_en.pdf accessed on 21 October 2012.

[330] Para 33 of General Comment 20.

[331] That this is so can be observed in the strong pronouncement in the General Comment that difference of treatment will be discriminatory where for example HIV status is used as the basis for differential treatment regarding access to these rights. This can be contrasted with denial of access to health insurance which will only be discriminatory "if no reasonable or objective criteria can justify such differentiation."

[332] Paragraph 11 of General Comment 20 states: "Discrimination is frequently encountered in families, workplaces, and other sectors of society. For example, actors in the private housing sector (e.g. private landlords, credit providers and public housing providers) may directly or indirectly deny access to housing or mortgages on the basis of ethnicity, marital status, disability or sexual orientation while some families may refuse to send girl children to school. States parties must therefore adopt measures, which should include legislation, to ensure that individuals and entities in the private sphere do not discriminate on prohibited grounds."

[333] In the case of this domestic legislation, providers of goods and services will be found in breach of the legislation and will have to grant compensation and/ or be required to take specific or general measures depending on the findings against them. In theory at least, the legislation is an example of how the State seeks to discharge its obligation to regulate discrimination by private actors, albeit it does not extend to private health.

(discussed further below); a test consonant with the international standard of non-discrimination.[334]

It has been suggested that the use of the term 'guarantee' in Article 2(2) of the ICESCR when read in conjunction with Article 12 connotes a "stronger operative force and effect than the term 'recognize'".[335] Another commentator has suggested that the right to health could for all its ambiguity on definition and scope "be regarded as a customary international law norm" requiring all States "to accord effect to this right by adopting legislative or other appropriate action".[336]

Where vulnerable groups who suffer discrimination can be identified, States have a legal obligation "to ensure that a health system is accessible to all without discrimination". Those "living in poverty, minorities, indigenous peoples, women, children, slum and rural dwellers, people with disabilities, and other disadvantaged individuals and communities" should be targeted under a responsive health system which encompasses the "twin human rights principles of equality and non-discrimination" so that outreach programmes ensure that "disadvantaged individuals and communities enjoy, in practice, the same access as those who are more advantaged".[337]

---

[334] There are nine exhaustive grounds of prohibited discrimination under section 3(2) of the Equal Status Acts, namely gender, civil status, family status, sexual orientation, religion, age, disability, race and Traveller community.

[335] Y Arai-Takahashi, *The Right to Health in International Law - A Critical Appraisal*, in R Martyn, & L Johnson (Eds), *Law and the Public Dimension of Health* London Cavendish Publishing Limited (Chapter 5) (2001) at 121-122 and 145 in turn citing S Jamar, *The international human right to health* 22 Southern UL Rev 1 (1994) at 25.

[336] See dissenting opinion of Judge Weeramantry in the advisory opinion by the International Court of Justice (ICJ) on the *Legality of the Use of Nuclear Weapons* that State duties in relation to health can be regarded as binding international law and that States owe an obligation *erga omnes* to all members of the international community: ICJ Legality of the Threat of Nuclear Weapons , Advisory Opinion, 8 July 1996 (1996) ICJ Reps, Dissenting Opinion of Judge Weeramantry, available at *www.icj-cij.org/docket/index.php?p1=3&p2=4&k=e1&p3=4&case=95* accessed on 29 December 2012.

[337] P Hunt, *Report of the United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, Geneva, Economic and Social Council, Commission on Human Rights (2008) at para 42 citing H Potts, *Human Rights In Public Health: Rhetoric, Reality and Reconciliation*, PhD thesis, Monash University, Melbourne, Australia, 2006 and at [18] E/CN.4/2006/48/Add.2 and E/CN.4/2005/51. See Resolution 2002/31, under which the then-Commission on Human Rights appointed a Special

Although the Special Rapporteur on the Right to Health has linked equality and non-discrimination to "the critical health concept of equity" which accords equal access to health care according to need,[338] the non-derogable right to health care without discrimination is a legal obligation which extends beyond the common law concept of equity insofar as both general and "special" health measures must be directed towards ensuring freedom from discrimination.

Minimum resource implications will allow for legislative change or dissemination of information to guard against discrimination and ensure equal treatment.[339] Paragraph 19 of General Comment 14 stresses that States have a special obligation to provide those who do not have sufficient means with the necessary health insurance and health-care facilities.[340]

Health resource allocation which is "inappropriate" can lead to discrimination, indirect if not direct, for example favouring expensive curative health services which favour a privileged few rather than primary and preventive health care benefiting a far larger part of the population. Paragraph 41 returns to the importance of indicators in monitoring "effectively" the implementation of measures to comply with non-discrimination under Article 2(2), with monitoring assessing "both the steps taken and the results achieved" in the elimination of discrimination. National strategies, policies and plans "should use appropriate indicators and benchmarks, disaggregated on the basis of the prohibited grounds of discrimination."

Rapporteur on health, renewed subsequently by the Human Rights Council; see: *www.ohchr.org/EN/Issues/Health/Pages/IndividualComplaints.aspx* accessed on 29 October 2012.

[338] P Hunt, *Report of the United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, Geneva, Economic and Social Council, Commission on Human Rights (2008) at para 43.

[339] General Comment 14, at para 18.

[340] Paragraph 19 states that "i]nappropriate health resource allocation can lead to discrimination that may not be overt. For example, investments should not disproportionately favour expensive curative health services which are often accessible only to a small, privileged fraction of the population, rather than primary and preventive health care benefiting a far larger part of the population"; General Comment 14, at para 19.

Nor should health be used as an excuse to limit rights.[341] As noted, the very need to address certain health rights must not be used by Governments as an excuse to restrict others. The requirement of proportionality, well known in international law, is introduced in paragraph 29 as "the least restrictive alternative" where options are available. Further, any such limitations permissible on the grounds of protecting public health must be "of limited duration and subject to review".[342]

4.2 The importance of non-discrimination in improving health outcomes

The right to health on a non-discriminatory basis approach which targets vulnerable groups is also supported by the literature. Simply put, the principle of non-discrimination is more than the mere application of a core principle of human rights: it actually impacts on lives and improves health outcomes for the poor, the disadvantaged and marginalised where it is applied because the literature demonstrates that these groups have lower health outcomes than the general population. In 2008, the WHO Commission on Social Determinants of Health stressed how the social conditions in which people live "powerfully influence their chances to be healthy" and how factors such as "poverty, food insecurity, social exclusion and discrimination, poor housing, unhealthy early

---

[341] Under "Limitations", General Comment 14 that "[i]ssues of public health are sometimes used by States as grounds for limiting the exercise of other fundamental rights. The Committee wishes to emphasize that the Covenant's limitation clause, article 4, is primarily intended to protect the rights of individuals rather than to permit the imposition of limitations by States. Consequently a State party which, for example, restricts the movement of, or incarcerates, persons with transmissible diseases such as HIV/AIDS, refuses to allow doctors to treat persons believed to be opposed to a government, or fails to provide immunization against the community's major infectious diseases, on grounds such as national security or the preservation of public order, has the burden of justifying such serious measures in relation to each of the elements identified in article 4. Such restrictions must be in accordance with the law, including international human rights standards, compatible with the nature of the rights protected by the Covenant, in the interest of legitimate aims pursued, and strictly necessary for the promotion of the general welfare in a democratic society"; at para 28.

[342] Paragraph 29 states: "In line with article 5.1, such limitations must be proportional, i.e. the least restrictive alternative must be adopted where several types of limitations are available. Even where such limitations on grounds of protecting public health are basically permitted, they should be of limited duration and subject to review."

childhood conditions and low occupational status" are important determinants of most disease, death and health inequalities between and within countries.[343]

The report concluded that "[t]he poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, goods, and services, globally and nationally...".[344] Social determinants influence health insofar as "[l]ow-income populations are sicker than high-income populations and require more care than average".[345] This led the 2011 Rio Political Declaration on Social Determinants of Health[346] to call for the reorientation of the health sector so as to reduce health inequalities and its recognition of ensuring the centrality of the AAAQs to this end.[347]

---

[343] Commission on Social Determinants of Health, *Note by the Secretariat*, World Health Organization, EB115/35, 115th Session 25 November 2004, Provisional agenda item 9.4, Geneva (2005).

[344] The Commission stated: "The poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, goods, and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of people's lives – their access to health care, schools and education, their conditions of work and leisure, their homes, communities, towns or cities – and their chances of leading a flourishing life. This unequal distribution of health-damaging experiences is not in any sense a 'natural' phenomenon but is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics. Together, the structural determinants and conditions of daily life constitute the social determinants of health and are responsible for a major part of health inequities between and within countries"; Final Report of the Commission on Social Determinants of Health, *Closing the gap in a generation, Health equity through action on the social determinants of health*, Geneva, World Health Organization (2008) at 1.

[345] D Rowland, A Salganicoff & P Keenan *The key to the door: Medicaid's role in improving health care for women and children*, 20 Annual Review of Public Health (1999) at 402. "Health inequalities arise from unequal distribution of underlying determinants, including income and assets, knowledge and literacy. They influence the intermediate risk factors, for example by constraining health-seeking behaviour. The underlying determinants of health include environment and infrastructure, which create or ameliorate direct risks or limit the ability of the poor to seek health care and practice healthy behaviour. Accessibility of health services (distance, cost, actual and perceived quality) also determines health outcomes"; World Health Organization, *Health in Asia and the Pacific*, Geneva, World Health Organization (2008), Chapter 2 at 1. See also M Hassar, *Social Determinants of Institution Building*, International Association of National Public Health Institutions (2011) available at *www.ianphi.org/uploads/file/Helsinki%202011_Tuesday_Hassar.pdf* accessed on 21 October 2012.

[346] World Conference on Social Determinants of Health, Rio de Janeiro, Brazil, 21 October 2011. The World Conference was on foot of the work of the WHO's Commission on Social Determinants of Health: see above.

[347] Paragraph 13 of the Declaration acknowledges that "accessibility, availability, acceptability, affordability and quality of health care and public health services are essential to the enjoyment of the highest attainable standard of health, one of the fundamental rights of every human

Research has consistently demonstrated how inequalities in health exist, "whether measured in terms of mortality, life expectancy or health status; whether categorised by socioeconomic measures or by ethnic group or gender".[348] Low income is strongly associated with poor health, while conversely, poor health also results in poor environmental living conditions and poverty.[349] Lower life expectancy and higher rates of illness are linked to poverty[350] with unemployment in men being linked to low health outcomes for them and their families.[351] Irish studies have found that peri-natal mortality is highest among children of unemployed men, while rates of admission to psychiatric hospitals are much higher in the unskilled manual group than in other socio-economic groups.[352] Further, education is linked to health

---

being, and that the health sector should firmly act to reduce health inequities"; see *www.who.int/sdhconference/declaration/en/* accessed 21 October 2012. See also the World Health Assembly Resolution *Reducing health inequities through action on the social determinants*, Sixty-second World Health Assembly, A62/9, Eighth plenary meeting, 22 May 2009, Committee A, third report WHA62.14 (discussed below).

[348] A Clarke, *The Sociology of Healthcare*, Longman, (2010), citing the United Kingdom's Independent Inquiry into Inequalities in Health, Acheson Report (1998) at 123. This was also the conclusion of the 1988 United Kingdom's influential Black Report.

[349] J Kim, B Yang, T Lee & E Kang, *A Causality Between Health and Poverty: An Empirical Analysis and Policy Implications in the Korean Society*, 25 Social Work in Public Health (2010) 210 who note how "[a]lthough it has been well-recognized that poverty breeds ill health, the other side of the causality [is] that ill health perpetuates poverty"; noting how the percentage of household respondents in their study who considered poor health to be the main factor contributing to poverty was "far greater than that of households that picked unemployment"; at 222.

[350] Research has established that people living in poor social and economic circumstances are "likely to face more illness during their lifetime and die at a younger age than those who are better off". In Ireland, there is a "six year difference in overall life expectancy between people in the highest social groups compared to those in the lowest"; *Briefing Paper on Health Inequalities for Elected Members of Local Government*, Institute of Public Health in Ireland (2010) available at *www.publichealth.ie/publications?page=1* accessed on 21 October 2012.

[351] See the 2011 international literature review conducted by Dillon and Butler on the impact of unemployment on men's health for the WHO which recorded findings of unemployment damaging physical and mental health; higher mortality rates for unemployed men , increased risk of both successful and attempted suicide, greater risk behaviour including of traffic accidents, increased levels of cardiovascular disease, depression and associated risk factors in the recently unemployed; B Dillon & P Butler *Facing the Challenge, The Impact of Recession and Unemployment on Men's Health in Ireland* (Eds. O Metcalfe & N Cotter), Institute of Public Health in Ireland (2011) at 4-6.

[352] The pattern of poverty sustains over a number of decades. McCluskey cites studies by Nolan (1990) involving an analysis of mortality rates by socio-economic class based on 1981 Irish census data and Balanda and White's study for the Institute for Public Health of occupational class gradients in all causes of mortality in Ireland which demonstrate a clear relationship between mortality and morbidity rates and social class, as measured by occupational status"; D McCluskey (ed.), *Health Policy and Practice in Ireland,* University

inequalities with young people "from socioeconomically disadvantaged backgrounds and young people from some ethnic groups … less likely to gain health benefits from education."[353]

Socio-economic and gender status impact on health: low-income children and children with special needs have been found to have high levels of unmet health needs[354] while "[a]ge compounds women's already disadvantaged status and increases gender-based inequality".[355] Persons from racial, ethnic or national minorities experience lower health outcomes. Life expectancy at birth is 15 years less for male Travellers in Ireland than settled males, and 10 years less for women Travellers than for settled women.[356][357] Similarly, "health

---

College Dublin Press (2006). See also *Briefing Paper on Health Inequalities for Elected Members of Local Government*, Institute of Public Health in Ireland (2010), ibid.

[353] C Higgins, T Lavin, O Metcalfe, *Health Impacts of Education, a review*, Institute of Public Health in Ireland (2008), see *www.publichealth.ie/files/.../Health%20Impacts%20of%20Education* accessed 21 October 2012; at 25.

[354] In a study of low-income children and their families in South Los Angeles, Tataw et al record how "regardless of insurance coverage, low-income children and children with special needs have been found to have high levels of unmet needs" and "experience poorer quality of primary care"; LD Tataw, S Bazargan-Hejazi, F W James, *Actualizing a Provider Alliance to Expand Health Services Access to a Low-Income Urban Community,* 26 Social Work in Public Health (2008) 651 at 653-654.

[355] F Tang, JG Heo and M Weissman, *Racial Differences in Social Engagement and Health Status Among Older Women*, 26 Social Work in Public Health (2011) 110 at 119-120. See also P Moen & K Chermack, *Gender disparities in health: Strategic selection, careers, and cycles of control* [Special issue II], 60 The Journal of Gerontology: Social Sciences, (2005) 99 who report how "greater stress, poorer health, and more years of disability accompany their late life experience"; at 112 and National Research Council, *Racial and ethnic differentials in health in late life*, Committee on Population, Division of Behavioral and Social Sciences and Education, Washington, DC: National Academies Press (2005).

[356] N A Hamid, L Daly, P Fitzpatrick, *All Ireland Traveller Health Study, Our Geels,* School of Public Health, Physiotherapy and Population Science, University College Dublin (ed.) C Kelleher, Department of Health (2010) Summary of Findings which compares Standardised Mortality Ratios (SMRs) for Travellers and the general population and finds that "[a]llowing for the age differences between the Traveller and general populations, overall Traveller mortality is 3.5 times higher. Traveller males have 3.7 times the mortality of males in the general population; for females the mortality is 3.1 times higher"; see *www.dohc.ie/publications/traveller_health_study.html* accessed 21 October 2012 at 88. See also the references to vulnerable groups' health status in the Department of Health's latest *Key Trends* 2010: "The recent *All-Ireland Traveller Health Study* provides striking evidence of health inequality showing life expectancy of Traveller males more than 15 years less than the general population and more than 10 years less for females. Infant mortality rates and rates for major causes of death are shown to be much higher in the Traveller population… Other selected data on equity and equality are also presented in this edition of Key Trends including a measure of self-assessed health by income level [], beast-feeding rates by social class [] and unmet need for medical examination by income[]"; see *www.dohc.ie/publications/pdf/key_trends_2010.pdf* accessed 21 October 2012 at 1.

disparities exist even when income, access, and insurance status of African Americans are comparable to those of the White population" in the United States.[358] According to US statistics, ethnic minorities experience "substantial disparities in the burden of disease and death when compared to White Americans."[359] Similarly, "health disparities namely, the racial inequalities in health across the life span - exist in a relatively healthy, physically functioning segment of the older population".[360] For ethnic minorities, health is affected by a complex combination of factors including "biological susceptibility,

---

[357] However "little is known about the experience of children growing up as members of ethnic minorities in Ireland"; *Report Growing Up In Ireland, Review of the Literature Pertaining to the First Wave of Data Collection with the Child Cohort at 9 Years;* Office of the Minister for Children and Youth Affairs (2006) at 24, the report of a national longitudal literature review of children aged 9 to 12 years in Ireland; available at *www.growingup.ie/fileadmin/user_upload/documents/Technical_Reports/Review_of_the_Literature_Pertaining_to_the_First_Wave_of_Data_Collection_with_the_Child_Cohort_at_9_Years_01.pdf* The study did recognise that Traveller children in school (representing 1% of the population) "are less healthy than settled children and suffer from discrimination and stigmatisation"; at 24, however it appears accepted both that vulnerable groups (including those with a lower socio-economic status) have lower health outcomes than the normal population and that disparities exist in relation to access to healthcare on the basis of ability to pay; at 59. This suggests that attention is paid more to socio-economic status than vulnerable populations identifiable by virtue of ethnicity, age, gender or other status.

[358] SS Martin, J Trask, T Peterson, BC Martin, J Baldwin and M Knapp, *Influence of Culture and Discrimination on Care-Seeking Behavior of Elderly African Americans: A Qualitative Study*, 25 Social Work in Public Health (2010) 311 at 312.

[359] Martin et al suggest that " African Americans are at greater risk for nearly every leading cause of death compared to White Americans"; SS Martin, J Trask, T Peterson, BC Martin, J Baldwin and M Knapp, *Influence of Culture and Discrimination on Care-Seeking Behavior of Elderly African Americans: A Qualitative Study,* 25 Social Work in Public Health (2010) 311 at 311-312, citing a wide field of research including the US National Institutes of Health (2001) and the US Institute of Medicine (2003). The authors conclude that "this study support[s] previous research suggesting that even for those African Americans who have the financial means and resources to seek modern healthcare, whether it be prescription medications, doctors, or other medical interventions, their spiritual and religious beliefs continue to guide their healthcare-related practices... [as did] the role of culture and discrimination in the care-seeking behaviors and service utilization of African Americans"; at 323-324.

[360] See for example Tang et al who stated that "a minority woman is more likely to experience health disparities in the aging process because of limited social resources, insufficient access to health care, and disadvantaged economic status"; F Tang, JG Heo and M Weissman, *Racial Differences in Social Engagement and Health Status Among Older Women*, 26 Social Work in Public Health (2011) 110 at 110-111. The authors cite a US sample study of 85 older women of 101 senior centre participants in the city of Pittsburgh, which study found that "racial differences existed in senior center activity participation and physical functioning between white and non-white women, and the sustained activity engagement was associated with physical functioning; at 122. Classification of one's race or ethnicity has been historically difficult for research purposes due to lack of death certificate classifications of a person's ethnic identity. Similarly Clarke cited research suggesting that ethnic inequality-based health exists: "the official data that are available on the health patterns of ethnic minorities in Britain indicate that ethnicity is a relevant dimension of health inequality... studies show that black and minority ethnic groups generally experience worse health than the overall population".

environmental factors prior to and following migration, lifestyle behaviours and cultural differences, poverty and social deprivation, experiences of racial discrimination and ethnocentrism in service planning and delivery".[361] Studies in the United States suggest that access to quality mental health treatment services imposes a greater burden on racial and ethnic minorities than on Caucasians.[362]

The view that individual choice and lifestyle affects health rather than socio-economic determinants is challenged by the literature which suggests that "social class, throughout the life course, has a powerful influence on behavioural, social and psychological variables" and that health-related and psycho-social behaviours "are never truly 'voluntary'; they are a product of and embedded in structures of society. Therefore, the unit of analysis is not the individual but the social-cultural context that shapes the individual".[363]

Some authors note how areas with high mortality and morbidity may be less well served by hospitals and have more overworked general practitioners than healthier areas, with middle classes tending to be the main beneficiaries of health services.[364]

---

[361] A Clarke, *The Sociology of Healthcare*, Longman, (2010), citing the United Kingdom's Independent Inquiry into Inequalities in Health, Acheson Report (1998) at 143.

[362] L Snowden, *Bias in mental health assessment and intervention: Theory and evidence*, 93 American Journal of Public Health (2003) 239 at 243 and C Copeland and K Snyder, *Barriers to Mental Health Treatment Services for Low-Income African American Women Whose Children Receive Behavioral Health Services: An Ethnographic Investigation*, 26 Social Work in Public Health (2011) 78 at 79 where the authors note how a number of studies indicated the high rate of depression in low-income African American women with children and their low rate of service utilization with barriers to mental health treatment services including "mistrust, economic status, cultural differences, stigma, and sometimes a lack of awareness of available services" in addition to poor quality services and doctors identifying mental illness in racial and ethnic"; at 79 and 92-93.

[363] A Singh-Manoux and M Marmot, *Role of socialization in explaining social inequalities in health*, 60 Social Science & Medicine (2005) 2129 at 2130.

[364] Weitz suggests that "for most people, personal behaviour is not the primary determinant of health status and it will not be very effective to intervene at the individual level without concomitant efforts to alter the broader economic, political, cultural, and structural components of society that act to encourage, produce and support poor health. The "lifestyle" approach [which focuses solely on individual decisions and behaviours] enables us to ignore the most difficult, but at least equally important, problem of the social environment which both creates some lifestyles and inhibits the initiation and/ or maintenance of others"; R Weitz, *The Sociology of Health, Illness and Health Care, a Critical Approach* (3rd Ed.) Wadsworth (2004) citing M H Becker, *A medical sociologist looks at health promotion*, 34 Journal of Health and Social Behavior (1993) at 1-6.

One common theme in the literature is a move towards focusing upon the poor within each country. Another is the issue of focus: whether inequalities are principally a matter of inequitable access to health services or of determinants of socio-economic differences in health status and disease. Here it is argued that "inequalities in health are not static or inevitable phenomena" but are "dynamic, driven by the interplay of biology, social organization, and health systems".[365] Addressing the allocation of finite resources, one author posits that while most people accept that rationing of health resources has become a fact of life with differences of treatment employed, this should occur in a transparent manner.[366] Decisions based on non-discriminatory criteria may be acceptable to the population if transparent and explained. However, this explanation would also need to capture the fact that equality of access instead "means that everyone with an equivalent health need should have equivalent access to appropriate care"; patients who are alike in relevant ways should be treated alike, and patients who are unlike each other should be treated differently"[367] allowing for the possibility of positive or special measures to address discrimination.[368] One author suggests that equality principles may

---

[365] D Leon and G Walt, (Ed), *Poverty, Inequality and Health, an international perspective*, Oxford University Press, Chap 1 Poverty, Inequality and Health, an international perspective, a divided world? (2001).

[366] Rationing refers to "the discretionary allocation of scarce resources, with deprivation generally distributed unevenly across society"; E Jackson, *Introduction to Bioethics* (Chapter 1), *Medical Law, Text, Cases and Materials* (2nd Ed.) Oxford University Press (2010) at 32. Elsewhere the explicit rationing policies of the UK have been compared favourably with the implicit policies which define the US and Irish approaches.

[367] E Jackson, *Introduction to Bioethics* (Chapter 1), *Medical Law, Text, Cases and Materials* (2nd Ed.) Oxford University Press (2010), citing A Gutmann, *For and Against Equal Access to Health Care*, Millbank Memorial Fund Quarterly/ Health and Society 59(4) (1981) in *Classical Works in Medical Ethics*, Gregory Pence (Ed.) McGraw Hill, Boston (1998) at 367-8.

[368] One author suggests that a principle of equal access to health care will suggest that "every person who shares the same type and degree of health need must be given an equally effective chance of receiving appropriate treatment of equal quality so long as that treatment is available to everyone" and that by definition it will place limits upon the market freedoms of some individuals, including the wealthy: "The principle does not permit the purchase of health care to which other similarly needy people do not have effective access... Thus, the rigorous implementation of equal access to health care would prevent rich people from spending their extra income for preferred medical services, if those services were not equally accessible to the poor"; E Jackson citing A Gutmann, *For and Against Equal Access to Health Care*, Millbank Memorial Fund Quarterly/ Health and Society 59(4) (1981) in *Classical Works in Medical Ethics*, Gregory Pence (Ed.) McGraw Hill, Boston (1998) at 367-8. See also C Farrell, H McAvoy, J Wilde and Combat Poverty Agency, *Tackling Health Inequalities An All-Ireland Approach to Social Determinants* (2009) which states that social determinants "contribute to health inequalities between social groups. This is because the effects of social determinants of health are not distributed equally or fairly across society… Social determinants operate at

supplement other rationing criteria by ensuring that consistency of application between patients in order to avoid arbitrary and unfair distribution of resources, whilst recognising that "it might also lead us to give particular priority to the needs of the most disadvantaged and vulnerable members of society.[369] An advantage here is that rationing may lead to resources directed "to those who are most disadvantaged by their ill health, perhaps to people with the greatest health needs."[370]

---

different levels. Structural issues, such as socio-economic policies or income inequality, are often termed 'upstream' factors. While 'downstream' factors like smoking or stress operate at an individual level - and can be influenced by upstream factors", see *www.publichealth.ie/publications?page=3* accessed 21 October 2012 at 15.

[369] C Farrell, H McAvoy, J Wilde and Combat Poverty Agency, *Tackling Health Inequalities An All-Ireland Approach to Social Determinants* (2009).

[370] I Kennedy, *Treat Me Right: Essays in Medical Law and Ethics*, Clarendon Press: Oxford (1998) at 291.

5 The framework within which the right must be capable of being accessed

General Comment 14 makes clear at paragraph 33 that "the right to health, like all human rights, imposes three types or levels of obligations on States parties: the obligations to "respect, protect and fulfil".[371] The obligation to respect requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health; the obligation to protect requires States to take measures that prevent third parties from interfering with article 12 guarantees, while the obligation to fulfil requires States "to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health." The obligation to fulfil in turn contains obligations to facilitate, provide and promote.[372] Paragraphs 33 to 37 of the General Comment consider the specific legal obligations on States under these three requirements.

5.1 The obligation to "respect": non-interference

Paragraph 33 requires States to "refrain from interfering directly or indirectly with the enjoyment of the right to health." Employing the phrase "in particular", paragraph 34 expands on the obligation to refrain by indicating a non-exhaustive list of vulnerable groups that States must refrain from denying or limiting equal access to "preventive, curative and palliative health services to". Further, such vulnerable groups are to be protected: States must abstain from imposing or enforcing discriminatory practices as a State policy[373] and

---

[371] According to General Comments Nos. 12 (Committee on Economic, Social and Cultural Rights, General Comment No. 12 (1999), The right to adequate food (art. 11) and 13 (Committee on Economic, Social and Cultural Rights, General Comment No. 13 (1999), The right to education (article 13 of the Covenant), the obligation to fulfil incorporates an obligation to *facilitate* and an obligation to *provide*. In the present General Comment, the obligation to fulfil also incorporates an obligation to *promote* because of the critical importance of health promotion in the work of WHO and elsewhere.

[372] See M Ssenyonjo, *Economic, Social and Cultural Rights in International Law*, Oxford and Portland Oregon: Hart Publishing (2009) at 323.

[373] General Comment 14 at para 34.

must not prohibit or impede traditional health care, access to sexual and reproductive health, or health-related information.

Unwillingness rather than inability of a State party to comply with its obligations under Article 12 is stressed. As noted, under its progression/ non-retrogression obligations, a State which is able but unwilling to use the maximum of its available resources for the realisation of the right to health will violate its obligations under Article 12 and whereas resource constraints may render it impossible for a State to fully comply with its obligations, the burden of proof rests with it.[374] The exception is non-compliance with the core non-derogable obligations as set out in paragraph 43 of General Comment 14 (which include non-discrimination) insofar as resource arguments do not provide a defence here. A violation of the "obligation to respect" refers to State actions, policies or laws that contravene Article 12 standards and which "are likely to result in bodily harm, unnecessary morbidity and preventable mortality". Examples cited include "the denial of access to health facilities, goods and services to particular individuals or groups as a result of de jure or de facto discrimination".[375]

Violations can be through acts of commission such as "the formal repeal or suspension" of legislation necessary for the continued enjoyment of the right to health or the adoption of legislation or policies which are "manifestly incompatible with pre-existing domestic or international legal obligations in relation to the right to health"). Violations may be by omission such as "the failure to take necessary measures arising from legal obligations". The direct action of States or private entities (insufficiently regulated) can result in a violation of the right to health.[376] The acts of private entities may render the State in violation of the right to health where, for example, they adopt "any retrogressive measures incompatible with the core obligations under the right to health" as outlined in paragraph 43. The only response of the State to such

---

[374] Para 47.

[375] At para 50.

[376] Para 48.

an ongoing violation by the acts of private entities is through clear "control" measures (see below).

5.2 The obligation to "protect": measures to be taken

Paragraph 35 sets out the duties of States "to protect" primarily through adopting legislation or other measures to ensure equal access to health care and health-related services provided by third parties. States are obliged to "ensure that privatization of the health sector does not constitute a threat" to the AAAQs and must for example "control" the marketing of medical equipment and medicines by third parties and "ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct."

From this it can be seen that the obligation is addressed to protecting individuals from harmful acts of non-State actors: "individuals, groups, corporations or other entities" and indeed to ensuring equal access to health care even where the State privatises health.[377] This "positive" obligation "to protect" requires the State to adopt a framework comprising legislation and other measures to, *inter alia*, prevent third parties or private companies from depriving people of equal access to health care or services. Such a framework should tie into the national health policy and strategy. Where violations occur by non-State actors, the obligation to protect will involve the State not acquiescing in such violations but exercising "due diligence to prevent, punish, investigate the harm caused" and "where appropriate, provide effective remedy".[378] Judicial mechanisms for justiciability are required (see discussion below). In relation to its "due diligence" preventative regulatory obligation, paragraph 51 states that "[v]iolations of the obligation to protect follow the failure of a State to take all necessary measures to safeguard persons within their jurisdiction from infringements of the right to health by third parties".

---

[377] M Ssenyonjo, *Economic, Social and Cultural Rights in International Law*, Oxford and Portland Oregon: Hart Publishing (2009) at 324.
[378] M Ssenyonjo, *Economic, Social and Cultural Rights in International Law*, Oxford and Portland Oregon: Hart Publishing (2009) at 324.

This will include such omissions as "the failure to regulate the activities of individuals, groups or corporations so as to prevent them from violating the right to health of others".[379] Accordingly, the State must have in place effective machinery to regulate private actors under the obligation "to protect". Equally, in order to prohibit discrimination, States must take "all necessary measures" to ensure the right to health where health care services are provided by private entities and this will by definition include a failure to regulate private health activities. It is suggested that where a State cannot adduce evidence of the framework measures it has in place to "protect" the right, it will breach Article 12. While the State's regulation of public and private health by the Health and Information and Quality Authority, the Mental Health Commission, the Medical Council of Ireland (and the delivery of private health by the Health Insurance Authority) is not the primary focus of this thesis, such regulation by these bodies will be considered in Part 4.

5.3 The obligation to "fulfil": legislation and national health policy and plan

Under paragraph 36 States must afford "sufficient recognition to the right to health in the national political and legal systems" and adopt "a national health policy with a detailed plan for realizing the right to health" which include ensuring "equal access for all to the underlying determinants of health, such as nutritiously safe food and potable drinking water, basic sanitation and adequate housing and living conditions".

The CESCR elaborates that there are additional dimensions of the obligation to fulfil: obligations to facilitate by taking "positive measures" that enable and assist "individuals and communities to enjoy the right."[380] Further, there is a

---

[379] In its General Comment No. 5 (1994), Committee on Economic, Social and Cultural Rights, General Comment No. 5 (1994) Persons with Disabilities, the CESCR makes clear that a State cannot "contract out" of its obligations, by transferring responsibility for service delivery to private parties: "...while it is appropriate for Governments to rely on private, voluntary groups to assist persons with disabilities in various ways, such arrangements can never absolve Governments from their duty to ensure full compliance with their obligations under the Covenant"; at para 12.

[380] At para 37.

requirement to "create, maintain and restore health" including of "vulnerable or marginalized groups". Paragraph 52 provides that a violation of "the obligation to fulfil" will occur "through the failure of States parties to take all necessary steps to ensure the realization of the right to health" with examples including "the failure to adopt or implement a national health policy designed to ensure the right to health for everyone" or "insufficient expenditure or misallocation of public resources which results in the non-enjoyment of the right to health by individuals or groups, particularly the vulnerable or marginalized". Further, a failure to "monitor the realization of the right to health at the national level" through right to health indicators and benchmarks, the failure to take measures to "reduce the inequitable distribution of health facilities, goods and services", or the failure to adopt a gender-sensitive approach to health and failure to reduce infant and maternal mortality rates, will similarly violate the obligation to fulfil.

Violations of the right to health will occur if a number of procedural obligations are not met, or in other words, if a number of processes are not pursued. States are obliged to employ a national health policy or strategy designed to ensure the right to health for everyone, although it has discretion as to what format these take.[381] A violation may occur if there is insufficient expenditure or misallocation of public resources which result in non-enjoyment of the right, particularly by the vulnerable or disadvantaged. A violation will occur if the national health policy is not adopted or implemented. We previously considered how a violation would occur if there was a violation of the right to "protect" in terms of the prevention of discrimination. When we further explore the implementation of a national health policy and the non-discrimination principle, it can be observed that a failure to monitor by, for example, not identifying right to health indicators and benchmarks or not addressing discriminatory distribution of the AAAQs will result in a violation of the obligation to "fulfil".

Paragraph 57 of General Comment 14 again stresses right to health indicators and benchmarks for an effective health system. Indicators require appropriate

---

[381] General Comment 14 at paras 43 and 53.

disaggregated data to inform the national strategy and assist in ensuring the health system is effective.[382] There is a direct link between the core obligation of non-discrimination, the principle of progression of rights and the effective implementation of a national public health strategy and plan of action as prescribed under paragraph 43 of General Comment 14. "Process" rights such as "right to health indicators and benchmarks" are again stressed.

[382] P Hunt and G Backman *Health Systems and the Right to the Highest Attainable Standard of Health*, in Gostin in Swiss Human Rights Book Vol. 3, *Realizing The Right To Health*, Andrew Clapham & Mary Robinson, Geneva (2009) at 45.

6 National Framework

It will be recalled how a core obligation under paragraph 43(f) of General Comment 14 is the requirement to adopt and implement a national public health strategy and plan of action which "shall give particular attention to all vulnerable or marginalized groups." Paragraph 54 makes clear that this obligation does not end once a formal strategy and plan of action are drawn up, it is an ongoing "participatory and transparent process" which includes the requirement of benchmarks and indicators and the need to combat discrimination through utilising the benchmarks: how else can the State devise positive measures to address discrimination if it has no data on the groups being discriminated against?

In its examination of Ireland's Second Periodic Report under the Covenant in May 2002, the CESCR recommended that Ireland review its National Health Strategy with a view to embracing a human rights framework, in line with the principles of non-discrimination and equal access to health facilities and services and in doing so explicitly referred to paragraph 54 of General Comment 14.[383]

Paragraph 56 goes further in stating that a framework law should operationalise the national strategy and include targets and benchmarks, establishing "national mechanisms for monitoring the implementation of national health strategies and plans of action" by way of targeted time-frames, the means by which right to health benchmarks could be achieved", institutional responsibility for implementing the national strategy and plan of action; and possible recourse procedures. Further, monitoring "should identify the factors and difficulties affecting implementation of their obligations".

---

[383] See CESCR *Concluding Observations on Ireland's Second Periodic Report*, 5 June 2002, at para 35. In its Third Periodic Report to ICESCR (2012), there is no reference made to a human rights framework in the State's report: see *www.dfa.ie/* accessed on 9 January 2013.

6.1 Benchmarks and Indicators

The requirement of indicators and benchmarks is set out not only in General Comment 14 but more generally in relation to non-discrimination under Article 2(2) of ICESCR. Under the Committee's Guidelines, States must provide "disaggregated and comparative statistical data on the effectiveness of specific anti-discrimination measures and the progress achieved towards ensuring equal enjoyment of each of the Covenant rights by all, in particular the disadvantaged and marginalized individuals and groups".[384] Under paragraphs 55 and 56 of the Guidelines, this data should be complemented by providing information on the national health policy and "whether a national health system with universal access to primary health care is in place" and access to the AAAQs "including for socially disadvantaged groups".[385] Under paragraph 57, the intention is to design indicators and benchmarks to monitor the State's obligations under Article 12. Paragraph 58 states that having identified the indicators, States parties are invited to set appropriate national benchmarks in relation to each indicator.

As noted earlier, the principles of progressive realisation and non-retrogression of the right to health means there must be an advancement of the realisation of the right over time and, in assessing whether this has occurred, the Committee will consider whether the State has a national action plan with appropriate indicators and benchmarks, disaggregated on suitable grounds to identify whether programmes for disadvantaged individuals and communities are working. However, as will be observed, the CESCR has been slow to condemn States who do not provide appropriate data to it.

---

[384] Committee on Economic, Social and Cultural Rights, *Guidelines on Treaty-Specific Documents to be submitted by States Parties under Articles 16 and 17 of the International Covenant on Economic, Social and Cultural Rights,* Note by the Secretary-General, Committee on Economic, Social and Cultural Rights, E/C.12/2008/2 (2009), at para 10.

[385] Committee on Economic, Social and Cultural Rights, *Guidelines on Treaty-Specific Documents to be submitted by States Parties under Articles 16 and 17 of the International Covenant on Economic, Social and Cultural Rights,* Note by the Secretary-General, Committee on Economic, Social and Cultural Rights, E/C.12/2008/2 (2009), at paras 55-56.

6.2 Complementary approaches: WHO

These are clear overlaps between a national public health strategy and plan of action identified as a core obligation under General Comment 14 and the definition of a functioning health care system as set out by the WHO where in 1991 it defined a health system as "the complex of interrelated elements that contribute to health in homes, educational institutions, workplaces, public places and communities, as well as in the physical and psychological environment and the health and related sectors".[386] In 2007, the WHO refined its definition: "A health system consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health."[387]

The central role of WHO is referred to by CESCR in General Comment 14 at paragraph 63 where it calls on States parties to avail themselves of technical assistance and cooperation of WHO when formulating and implementing their right to health national strategies including the "extensive information and advisory services of WHO with regard to data collection, disaggregation, and the development of right to health indicators and benchmarks". The clear exhortation from the CESCR for States to employ the functions of WHO regarding their right to health indicators and benchmarks including providing assistance to States in data collection and disaggregation does not end there. According to paragraph 64, the WHO itself has obligations and should, with other UN bodies, in conformity with Articles 22 and 23 of the Covenant "cooperate effectively with States parties, building on their respective expertise, in relation to the implementation of the right to health at the national level, with due respect to their individual mandates."

In its 2007 report *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes*, the WHO declared that there are "six essential building blocks" of a functioning health system, namely health services; health workforce; health information system; medical products; vaccines and

---

[386] E Tarimo, *Towards a Healthy District. Organizing and Managing District Health Systems Based on Primary Health Care*, World Health Organization (1991) at 4.

[387] World Health Organization, *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes*, World Health Organization, Geneva (2007) at 2.

technologies; health financing and leadership, governance, stewardship.[388] The report was guided by the "values and goals enshrined in the Alma Ata Declaration; WHO's commitments on gender and human rights and the World health report 2000."[389]

Under the first of its six building blocks, namely health service delivery, the WHO commits itself to influencing demand for care by communicating "international agreements on rights and responsibilities of citizens with regard to their health" and "support[ing] their incorporation into national policy and practice".[390] Under the sixth building block (financing and governance), leadership and governance, the WHO notes that there is "increased attention to corruption, and calls for a more human rights based approach to health"[391] and stresses that health systems should be regulated and have public accountability. It commits itself to assisting Governments in developing health sector policies and frameworks, regulatory frameworks and accountability.[392]

At the same time WHO further states that it is committed to both "the implementation of International Health Regulations, international agreements on trade, human rights and gender, by identifying their implications for the national health system" and to influencing international agreements that impact on health and health systems.[393]

---

[388] See *www.who.int/healthsystems/strategy/en/index.html* accessed on 14 October 2012.

[389] World Health Organization, *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes*, World Health Organization, Geneva (2007) at 2.

[390] World Health Organization, *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes*, World Health Organization, Geneva (2007) at 16.

[391] World Health Organization, *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes*, World Health Organization, Geneva (2007) at 23.

[392] World Health Organization, *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes*, World Health Organization, Geneva (2007) at 224.

[393] World Health Organization, *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes*, World Health Organization, Geneva (2007) at 29, 33. International Health Regulations have been promulgated since 1969, prior to this they were referred to as International Sanitary Regulations (1951): see T Murphy & N Whitty, *Is Human Rights Prepared? Risk, Rights and Public Health Emergencies*, Medical Law Review 17 (2009) at 221.

In May 2005 the World Health Assembly (the WHO's decision-making body) adopted a revised set of International Health Regulations (IHR (2005)) which came into force in June 2007.[394] Article 1 of the Regulations define a public health emergency of international dimensions as "an extraordinary event" determined to "constitute a public health risk to other States through the international spread of disease, and to potentially require a coordinated international response".

Addressing an "all risks" approach to public health emergencies (termed international health security), including outbreaks of emerging and epidemic-prone diseases, the Regulations impose obligations on Member States of surveillance (Article 5), notification (Article 6) and information sharing (Article 7) but also incorporate references to human rights for the first time.[395] Article 3(1) of its 66 provisions provides that the implementation of the Regulations is to be "with full respect for the dignity, human rights and fundamental freedoms of persons", while Article 42 provides for health measures to be applied in a transparent and non-discriminatory way. Similarly, Article 23 addresses informed consent for vaccinations etc.[396] Although the incorporation of human rights standards into the International Health Regulations by the WHO is to be commended, they focus mostly on negative rather than positive obligations leaving some commentators to continue to question the extent of "internalisation" of human rights within WHO.[397]

The 2007 commitments by the WHO suggest a re-consideration of its *Health for All* strategy, which is also evident in its 2008 *World Health Report 2008* -

---

[394] International Health Regulations (2005), WHA Res. 58.3 23 May 2005. World Health Organization, Geneva, 2008; available at *http://whqlibdoc.who.int/publications/2008/9789241580410_eng.pdf* acessed 14 October 2012. The Regulations, which entered into force on 15 June 2007 and are a binding international law instrument on WHO's 194 State Parties, were a response to the outbreak of SARS in 2003 and other Avian flu outbreaks: see G Laurie and K Hunter, *Mapping, Assessing and Improving Legal Preparedness for Pandemic Flu in the United Kingdom,* 10 Medical Law International (2009) at 103.

[395] See T Murphy & N Whitty, *Is Human Rights Prepared? Risk, Rights and Public Health Emergencies*, Medical Law Review 17 (2009) at 225-227.

[396] See also Article 45(1) which addresses confidentiality of one's health information.

[397] T Murphy & N Whitty, *Is Human Rights Prepared? Risk, Rights and Public Health Emergencies*, Medical Law Review 17 (2009) at 241.

primary Health Care (Now More Than Ever)[398] whose recommendations include a focus on health as a dimension of development and social cohesion but for all.[399] However, there is again limited specificity of right to health standards. This is unfortunate insofar as the WHO convened a meeting with public health experts, the UN Special Rapporteur on the Right to Health and a representative of the CESCR in 2003 with the purpose of advancing the identification of relevant indicators as described in General Comment 14.[400] This meeting is noteworthy as it records both the different approaches by WHO and human rights bodies such as the CESCR at the time, but also signifies the limited priority afforded by the WHO to the right to health in the succeeding decade. Despite challenges in monitoring State performances and accommodating "differences across and within countries and over time as well as the variable elements of progressive realization and resource availability", the meeting considered that "quantitative indicators" could be complemented through additional methodologies. However, improved capacity in many countries' data processing and reporting systems would be required if "disaggregating collected data on the grounds of non-discrimination in accordance with General Comment 14" was to be achieved.[401] Benchmarks and indicators employed in three areas of WHO work, namely essential medicines,

---

[398] See *www.who.int/whr/2008/en/* accessed on 11 January 2013.

[399] "Health constitutes an economic sector of growing importance in itself and a feature of development and social cohesion", *World Health Report 2008 - primary Health Care (Now More Than Ever)*, Chapter 6 at 12.

[400] The aim was to "bring[] together multi-disciplinary actors in health and human rights [to] seek common ground on how to monitor the right to health" with a view to "identifying simple but effective right to health indicators, drawing as far as possible upon existing health and development frameworks"; World Health Organization, *Consultation on Indicators for the Right to Health*, Château de Penthes, Health and Human Rights, Department of Ethics, Trade, Human Rights and Health Law, Sustainable Development and Healthy Environments, World Health Organization, Geneva (2004) at 3. While the CESCR would monitor indicators, difficulties in identifying agreed generic indicators included political challenges noting how developed countries may be concerned if right to health indicators were to incorporate international assistance and obligations towards poor countries linking to MDG 8 and the provision to engage in international assistance and cooperation to progressively realize the right to health in accordance with Article 2(1) of the ICESCR, while developing countries may fear that increased ODA and related financial decisions could be conditioned upon improved national indicators. "[C]larity and transparency" about the use of the right to health indicators can alleviate these fears"; ibid., 6.

[401] World Health Organization, *Consultation on Indicators for the Right to Health*, Château de Penthes, Health and Human Rights, Department of Ethics, Trade, Human Rights and Health Law, Sustainable Development and Healthy Environments, World Health Organization, Geneva (2004) at 3-4.

reproductive health and water were considered for the right to health, being set either by countries, by the CESCR, or by both in consultation. Such "health-topic specific" indicators could be part of a monitoring "toolkit" in addition to some generic indicators applicable to all countries[402] (as noted an approach favoured by the RESC).

The meeting recommended that monitoring the right to health should be based "as far as possible upon the analysis of currently available data" while noting WHO's five criteria "validity, reliability, comparability, an explicit data audit trail and country consultation" (WHO's accountability framework on country data) in order to ensure the quality of country health statistics.[403]

States may seek WHO assistance under paragraph 57 and four pillars were proposed to assess progressive realisation of the right to health, namely government commitment, government actions, government policy/ strategies and the impact of these three pillars on actual health outcomes. As to the role of WHO, the meeting considered that its health systems performance assessment framework could further integrate human rights aspects while monitoring could build upon the indicators developed by WHO for health systems performance.[404]

---

[402] World Health Organization, *Consultation on Indicators for the Right to Health*, Château de Penthes, Health and Human Rights, Department of Ethics, Trade, Human Rights and Health Law, Sustainable Development and Healthy Environments, World Health Organization, Geneva (2004) at 8.

[403] World Health Organization, *Consultation on Indicators for the Right to Health*, Château de Penthes, Health and Human Rights, Department of Ethics, Trade, Human Rights and Health Law, Sustainable Development and Healthy Environments, World Health Organization, Geneva (2004) at 5. Here the meeting neglected the fact that providing data on progression is a central aspect of the right to health.

[404] World Health Organization, *Consultation on Indicators for the Right to Health*, Château de Penthes, Health and Human Rights, Department of Ethics, Trade, Human Rights and Health Law, Sustainable Development and Healthy Environments, World Health Organization, Geneva (2004) at 5. It was further suggested that a human rights approach could be better integrated into the WHO's World Health Report 2000's three core goals of a good functioning health system, namely: health, responsiveness and fair financing. Further, it was recommended that "a useful handful of generic indicators" could be developed against which all countries should be monitored under the right to health, namely "good health, responsiveness and fair financial contribution"; at 4. The meeting suggested that existing WHO frameworks such as the WHO's "pro-poor health policies" could attach to the non-discrimination principle insofar as the WHO advocates for the better disaggregation of data to support such policies in its Poverty Reduction Strategy and in the Heavily Indebted Poor Countries initiatives by the WB. The meeting agreed that right to health monitoring and pro-poor health policy promotion

Arising from the foregoing, the question arises as to the progress made by WHO and CESCR in identifying right to health indicators and benchmarks since 2003. From a literature review it is not clear how these proposals have been brought forward. In 2007 the WHO collaborated with CEDAW to suggest how it could engage with States to assist in the setting and tracking of national indicators and benchmarks required for State reporting to that Committee.[405] In 2011, the WHO produced *Human Rights And Gender Equality In Health Sector Strategies: How To Assess Policy Coherence* which is addressed at national health systems and describes three assessment levels required of States to meet their right to health obligations. Included here are indicators and benchmarks.[406] It remains to be seen however whether these publications are being operationalised insofar as treaty reporting does not yet appear to be capturing behavioural change in the manner in which States report and are critiqued by CESCR (see below).

WHO activities continue to indicate ambivalence on whether an integration of human rights may occur in its core programmatic work and relations with States.[407] In its initiatives since 2008 to address climate change and its impact on health, there is no reference to "human rights" or the "ICESCR" in the

---

"share many issues and certain methods and methodologies" stressing stronger linkages between both; at 5.

[405] See World Health Organization, *Women's health and human rights: Monitoring the implementation of CEDAW,* World Health Organization, Department of Reproductive Health and Research, Geneva (2007) available at *www.who.int/reproductivehealth/publications/gender_rights/9789241595100/en/* accessed on 8 February 2013.

[406] World Health Organization, the Office of the High Commissioner for Human Rights and the International Development Cooperation Agency (Sweden). *Women's health and human rights: Monitoring the implementation of CEDAW,* World Health Organization, Departments of Ethics, Equity, Trade and Human Rights and Gender, Women and Health, World Health Organization, Geneva (2011) available at *www.searo.who.int/entity/human_rights/publications/en/* accessed on 8 February 2013. The report sets out three assessment levels, namely 1) State obligations and commitments made on human rights and gender equality; 2) translating human rights and gender equality obligations and commitments in the national legal, policy and institutional framework and 3) identifying human rights and gender equality obligations and commitments in national health sector strategies; ibid at 13.

[407] Although the WHO has started to pay more attention to human rights issues through, for example, its joint publication World Health Organization, Office of the High Commissioner for Human Rights, *The Right to Health,* Fact Sheet No. 31 Geneva (2008), another counterview suggests that the WHO's joint publications also include those with the WTO and do not suggest deeper internalisation of human rights.

WHO reports or resolutions which rather stress "human health" needs.[408] This contrasts with the WHO's follow-up work to its Commission on Determinants of Social Health which included the 2009 World Health Assembly Resolution *Reducing health inequities through action on the social determinants*[409] and the 2011 World Conference on Social Determinants of Health, which resulted in the Rio Political Declaration on Social Determinants of Health.[410] However, even in its Resolution and Declaration, there is no reference to how action to address the underlying reasons for poor health could attach to the legal (core non-derogable) non-discrimination principle, despite the earlier convened meetings with the UN Special Rapporteur on the Right to Health and a representative of the CESCR to examine this very point.

Clearer commitments to the core minimum rights outlined in the ICESCR by the WHO would undoubtedly assist the penetration of the right to health into domestic law in Member States and there now exists a political basis for such action under the Rio Declaration and its reference to ensuring the AAAQs. Insofar as benchmarks and indicators are core aspects of a national health policy, an ability to identify and combat discrimination in accessing the AAAQs and progressive realisation of the right to health, WHO action on these core aspects of the right to health in the health care system would not only be useful but now is arguably required both under General Comment 14 and following the Rio Declaration. Such WHO focus, suggested in its recent publications, could examine how the AAAQs intersect with a properly

---

[408] See for example its description in its 2008 Report, *Climate change and health, Report by the Secretariat, Sixty Second World Health Assembly* (2008) available at *www.who.int/globalchange/health_policy/wha_eb_documentation/en/index.html* accessed 21 October 2012; which makes no mention of human rights impacts; at para 2 and the same is true for the resulting report adopted by the World Health Assembly, *Climate change and health,* Sixty First World Health Assembly meeting report WHO (2008). See *www.who.int/globalchange/health_policy/wha_eb_documentation/en/index.html* accessed 21 October 2012; at 2. See too the follow-up reports *Climate change and health,* Report by the Secretariat, Sixty Second World Health Assembly A62/11, Provisional agenda item 12.7 (2009) available at *www.who.int/globalchange/health_policy/wha_eb_documentation/en/index.html* accessed 21 October 2012. See also Climate change and health resolution progress report, WHA61.19, A63/27, January 2010.

[409] Sixty-second World Health Assembly, A62/9, Eighth plenary meeting, 22 May 2009, Committee A, third report WHA62.14

[410] World Conference on Social Determinants of Health, Rio de Janeiro, Brazil, 21 October 2011: see above.

functioning health care system, how the right to progression/ non-retrogression could be merged with the technical assistance measurements on offer to States from the WHO on indicators and data systems to produce reports capable of being considered by the CESCR.

Programmatic goals such as those pursued by the WHO are not absent of course from General Comment 14. Community involvement in priority setting, decision making, planning, implementing and evaluating strategies is stressed in paragraph 55 insofar as effective provision of health services "can only be assured if people's participation is secured by States".[411]

[411] "In addition to ensuring oversight by the judiciary, States parties should also take appropriate steps to ensure that the private business sector and civil society are aware of, and consider the importance of, the right to health in pursuing their activities"; at para 55.

7 Accountability

There are two main components of accountability for the right to health as identified by General Comment 14, first a "preventative" obligation that the State regulate private actors who deliver health services, under the "obligation to protect" and second a "reparation" obligation under "[n]ational implementation" that the State provide remedies and accountability where a violation of the right occurs, also evident under recent jurisprudence of the European Court of Human Rights.[412] A violation of the right to health under Article 12 will occur if either of these obligations are unmet.

Accountability under human rights law may be described as the prevention of abuses by restraining power within established rules.[413] "Effective accountability" under the right to health has been described as the mechanisms by which States are held to account for a failure to realise the right.[414] Five

---

[412] Located in either judicial or quasi judicial mechanisms, the legal reparations accountability mechanism is a legal obligation on States under paragraph 59 of General Comment 14 and whereas the State has a choice of means in deciding how to vindicate the right to health, if it has not established effective quasi judicial mechanisms to ensure the right, it must do so by judicial means. Other headings under "National Implementation" in General Comment 14 are those of framework legislation and right to health indicators and benchmarks which are addressed below. As noted above, the line of jurisprudence of the European Court of Human Right in *Siemenska v Poland,* Application No. 37602/97, Admissibility Decision, *Calvelli and Ciglio v Italy*, Application No 32967/96, Judgment 17 January 2002 ECHR 2002-I and *Senturk v Turkey,* Application No.13423/09, Judgment 9 April 2013 (Hudoc 2013) under Article 2 of the ECHR has seen an increased focus on legal accountability mechanisms encompassing the need for hospital regulation and an effective judicial system for establishing the cause of a death which occurs in hospital and any liability on the part of the medical practitioners concerned; accordingly a clear focus on judicial remedies under Article 2 of the ECHR may be observed.

[413] "Beginning with the ancient philosophers, political thinkers have been concerned to prevent abuses by restraining power within established rules. In contemporary usage, the notion of accountability continues to express this concern, attempting to apply checks, oversight and institutional constraints on the exercise of power. It implies both a measure of answerability (providing an account of actions undertaken) and enforceability (punishment or sanctions for poor or illegal performance) []. In its broadest sense, then, accountability is about the construction of a grammar of conduct and performance and the standards used to assess them"; P Newell, *Taking accountability into account: the debate so far*, in Rights, Resources and the Politics of Accountability, *introduction*, Chapter 2 (2006) Zed Books: London , at 39, available at *www.drc-citizenship.org/system/assets/1052734518/original/1052734518-newell.2006-taking.pdf?1300098592*

[414] Potts describes the right to the highest attainable standard of health as requiring "accessible and effective accountability mechanisms at the national, regional and international levels. Under the right to health, those with obligations should be held to account so that misjudgments can be identified and corrected, problems can be exposed and reforms identified"; H Potts, *Accountability and the Right to the Highest Attainable Standard of Health*,

different types of accountability mechanisms for the right to health have been identified: judicial, quasi-judicial, administrative, political and social accountability.[415] Although right to health accountability may mirror accountability in the right to development,[416] "it does not always correspond:

Human Rights Centre, University of Essex (2008) at 27, available at *www.womenslinkworldwide.org/pdf_programs/en_prog_rr_col_pubs_accountability.pdf*

[415] See H Potts, *Accountability and the Right to the Highest Attainable Standard of Health*, Human Rights Centre, University of Essex (2008), Executive Summary. Besides judicial mechanisms the 4 other mechanisms are: "quasi-judicial, for example, national human rights institutions, regional and international human rights treaty bodies; administrative, for example, human rights impact assessment; political, for example, parliamentary committee review of budgetary allocations and the use of public funds, democratically elected health councils, healthcare commissions; social, for example, the involvement of civil society (independently or in collaboration with government) in budget monitoring, health centre monitoring, public hearings and social audits", available at *www.womenslinkworldwide.org/pdf_programs/en_prog_rr_col_pubs_accountability.pdf* Potts also stresses the importance of participation of the public in decision-making processes; ibid.

[416] Newell and Wheeler note how "[a]ccountability has come to assume a central place in contemporary development discourse over the last ten years in the context of increasing donor attention to the idea of good governance"; P Newell and J Wheeler, *Rights, resources and the politics of accountability: an introduction*, Chapter 1 (2006) Zed Books: London , at 1. The authors point out how "the right to claim accountability is fundamental to making other social and economic rights real... Existing work on accountability [in development studies] suggests there are two key dimensions to effective accountability mechanisms: answerability (the right to make claims and demand a response) and enforceability (mechanisms for delivering accountability, for sanctioning non-responsiveness)... Accountability ... is a means to achieving a wider set of goals such as broader forms of social and political change, including greater justice, equity and the redistribution of resources. This is an important point, given the often-technocratic and target-driven approaches to accountability, and the often-apolitical approaches to rights in development ... accountability is not only an outcome, but also a process, where both answerability and enforceability are achieved through ongoing engagement between citizens and institutions"; ibid at 7 and 13. Further, "Many conflicts in development can be understood as struggles by the poor to hold the powerful to account"; at 1, available at *www.drc-citizenship.org/system/assets/1052734522/original/1052734522-newell_etal.2006-rights.pdf* Hunt points out how one of the "central" features of human rights is accountability: "Without accountability, human rights can become no more than window-dressing". Despite this the author observes how "[c]uriously, however, the human rights literature devotes relatively little attention to accountability. And there is even less written about accountability and the right to the highest attainable standard of health... While it is often associated with judicial accountability, in practice there are many effective non-judicial forms of accountability. Accountability is similar to, but different from, responsiveness, responsibility, answerability and evaluation"; Paul Hunt, Professor, University of Essex, UN Special Rapporteur on the right to the highest attainable standard of health (2008), Preface to H Potts, *Accountability and the Right to the Highest Attainable Standard of Health*, Human Rights Centre, University of Essex (2008), available at *www.womenslinkworldwide.org/pdf_programs/en_prog_rr_col_pubs_accountability.pdf* Newell and Wheeler, noting how "[a]ccountability has come to assume a central place in contemporary development discourse over the last ten years in the context of increasing donor attention to the idea of good governance...", suggest how "there are two key dimensions to effective accountability mechanisms: answerability (the right to make claims and demand a response) and enforceability (mechanisms for delivering accountability, for sanctioning non-responsiveness)... Accountability ... is a means to achieving a wider set of goals such as broader forms of social and political change, including greater justice, equity and the redistribution of resources. This is an important point, given the often-technocratic and target-driven approaches to accountability, and the often-apolitical approaches to rights in

right to health accountability "is not the same as [right to development] responsiveness, responsibility, answerability or evaluation, as none of these concepts include a legal compulsion to explain and to provide remedies".[417] The five right to health accountability mechanisms identified above can be divided into preventative (*ex ante*) mechanisms such as administrative regulation, political and social mechanisms, which *inter alia*, seek to monitor right to health obligations and reparations (*ex post*) mechanisms "that enable right-holders to hold duty bearers to account if they have failed to meet their obligations".[418] While the legal reparations accountability mechanism is the focus of this thesis, we also examine how the preventative obligation

---

development ... accountability is not only an outcome, but also a process, where both answerability and enforceability are achieved through ongoing engagement between citizens and institutions"; P Newell and J Wheeler, *Rights, resources and the politics of accountability: an introduction*, Chapter 1 (2006) Zed Books: London, at 1 and 13, available at *www.drc-citizenship.org/system/assets/1052734522/original/1052734522-newell_etal.2006-rights.pdf* The authors describe accountability as "a narrative, albeit sometimes silent or subdued, running through the course of history, that describes the relations of power between those with more and less power. In this sense, the studies contained in this book suggest the need to reclaim the concept of accountability from the bureaucrats, the institutionalists and the development industry in general"; at 28. For Potts, "[a]ccountability in the context of the right to the highest attainable standard of health is the process which provides individuals and communities with an opportunity to understand how government has discharged its right to health obligations. Equally, it provides government with the opportunity to explain what they have done and why. Where mistakes have been made, accountability requires redress", H Potts, *Accountability and the Right to the Highest Attainable Standard of Health*, Human Rights Centre, University of Essex (2008), Executive Summary, available at *www.womenslinkworldwide.org/pdf_programs/en_prog_rr_col_pubs_accountability.pdf*

[417] H Potts, *Accountability and the Right to the Highest Attainable Standard of Health*, Human Rights Centre, University of Essex (2008), Executive Summary, available at *www.womenslinkworldwide.org/pdf_programs/en_prog_rr_col_pubs_accountability.pdf* The reason for development studies' antipathy to legal redress can be measured in the observation that while "legal redress provides a route for achieving social and environmental justice when a violation of rights or act of negligence takes place, there are many barriers which prevent poorer groups from using the law in this way, including financial disincentives, lack of legal literacy, distrust of legal processes and intimidation. Even if a legal case is successful, compensation is often received by only a small number of individuals within the community, for example those with a title to the land, and takes a long time to secure. Perhaps most importantly of all, compensation is by definition a reactive strategy, often of little use if livelihood alternatives have been destroyed'"; P Newell, *Citizenship, accountability and community: the limits of the CSR agenda*, 81 International Affairs (2005) 541 at 555.

[418] B Toebes and M San Giorgi, *Dutch realities: evaluating the Dutch health care reform from a human rights perspective* (draft chapter) in *The right to health: a multi-country study of law, policy and practice* (Eds B Toebes, R Ferguson, M Markovic and O Nnamuchi), TMC Asser Press/Springer (due 2014) at 6, where the authors cite Newell and Wheeler's observation that: "Since accountability is not just about promoting answerability but also about delivering enforceability, the process of how these rights can be realised is important"; P Newell and J Wheeler, *Rights, resources and the politics of accountability: an introduction*, Chapter 1 (2006) Zed Books: London , at 7, available at *www.drc-citizenship.org/system/assets/1052734522/original/1052734522-newell_etal.2006-rights.pdf*

mechanism of administrative regulation is ensured in the State, including the accountability aspect of the State's obligation "to protect" where private bodies deliver public health.[419]

7.1 The obligation to regulate private actors who deliver health services

Regulation, as with the notion of accountability itself, may have numerous dimensions (see Part 2 of this thesis).[420] Insofar as regulation arguably remains "the only tool available for action by authorities on markets", it remains a key aspect of regulating private bodies who have delegated State functions. Regulation is defined essentially as mechanisms to constrain and sanction unwanted behaviour.[421] However, insofar as regulators are effectively inserted

---

[419] "The obligations of States Parties according to this tripartite typology of State obligations are not static… The State obligation to ensure 'accountability' is closely connected to the above-mentioned legal State 'obligation to protect'… Privatisation of health care systems does not discharge States from their obligations in relation to health care. States can never be relieved from their obligations in the field of health care.[] When a State privatises certain elements of its health care system, as is the case with the privatisation of Dutch health insurers, there is a shift from the State's obligation to fulfil to the State's obligation to protect.[] In this regard, the State is in fact no longer the provider of health care, but the protector of a fundamental right. Consequently, in the health sector, where many non-State actors engage with each other in many dense relationships it is of the utmost importance that all these actors are supervised appropriately by the State. This requires that sufficient and adequate accountability mechanisms are in place"; B Toebes and M San Giorgi, *Dutch realities: evaluating the Dutch health care reform from a human rights perspective* (draft chapter) in *The right to health: a multi-country study of law, policy and practice* (Eds B Toebes, R Ferguson, M Markovic and O Nnamuchi), TMC Asser Press/Springer (due 2014) at 6.

[420] Potts describes accountability as being "often seriously misunderstood"; H Potts, *Accountability and the Right to the Highest Attainable Standard of Health*, Human Rights Centre, University of Essex (2008), Executive Summary, available at *www.womenslinkworldwide.org/pdf_programs/en_prog_rr_col_pubs_accountability.pdf* . Nihoul and Trigg state: "the meaning attributed to the concept of "regulation" is considerably vast. It encompasses all public activities giving rise to the adoption of rules - whatever the form of these rules and whatever the identity of the authority concerned, whether it be governmental, administration, independent agency, local authority, private attorneys' general, etc"; P Nihoul and B D Trigg, *What is Meant by Regulation: The Roles Devoted to Markets and Authorities in Times of Crisis*, 25 Global Business & Development Law Journal 425 at 427.

[421] "Within the realm of regulation, the most common type of measure … is where authorities prohibit a certain behavior… The actors that are subject to the regulation … by way of anticipation … tend to avoid the target behavior. If they are unaware of the constrain, or ... do not respect it, they expose themselves to the imposition of sanction. It is supposed that the experience of the sanction should permit the actors to avoid any repetition of the sanctioned behavior"; P Nihoul and B D Trigg, *What is Meant by Regulation: The Roles Devoted to Markets and Authorities in Times of Crisis*, 25 Global Business & Development Law Journal 425 at 433-434. The importance of public regulation is recognised throughout the literature.

between Government and citizen, regulatory design is key if long-term welfare gains are to result rather than shorter-term expedient policies.[422] Regulation of health care will differ from regulation of a solely economic market insofar as differing regulatory aims attach to either endeavour.[423] Regulation of public or

---

Thus addressing regulation of water in Yemen, van Steenbergen et al observe that although "not directly enforced, the fact that there is a Water Law and [a national water regulating body] ... has strengthened the hands of local initiatives" in ensuring public accountability"; F van Steenbergen, O Bamaga and A Al-Weshali, *Groundwater Security in Yemen: Who is accountable to whom?* 7 Law, Environment and Development Journal (2011) 164 at 176. However the design of regulation is also key, while the impact of competition law cannot be ignored. Thus it has been suggested how in some instances... regulators follow "the mandates of legislators when they implement policies"... in others "regulators are responding to the demands of well organized, politically powerful constituents when they implement policies that favor these constituents... Competition can limit a regulator's ability to redistribute surplus from one group of constituents to another"; D E M Sappington and D L Weisman, *Regulating regulators in transitionally competitive markets*, 41 Journal of Regulatory Economics (2012) 19 at 21. Thus "competition can complicate the design of industry policy and limit the ability of regulators to continue to respond as they have historically to the demands of their constituents"; ibid at 36. Nor should regulation of health insurance excessively limit competition. In a study of life insurance companies operating across State in the US, authors found that "the unfavorable regulatory impact on cost efficiency is offset to some degree by increased revenues in relation to benefits provided. The lack of regulatory impact on profit efficiency scores and return on assets also supports this finding. In other words, the higher costs associated with multiple regulators is passed along to insurance consumers to some extent in the form of higher premiums or fee"; S W Pottier, *Life insurer efficiency and State regulation: evidence of optimal firm behavior* 39 Journal of Regulatory Economics (2011) 169 at 191.

[422] Cooper, applying the theory of behavioral economics (i.e. the implications for decision-making when actors suffer from biases documented in the psychological literature) examined how biases affect regulatory decisions and proposed measures "that focus rewards to regulators on outcomes rather than outputs as a way to help ameliorate regulatory biases". In favouring "insulation and de-biasing" the author suggests removing political pressures from regulators (which tend towards short-termism such as high-visibility successes: "[r]egulators [become] influenced by future promotions, increased budgets, fewer hearings, good press - from political overseers for choosing policies that maximize their chances of reelection") in favour of longer-term "welfare" outcomes from an "an unbiased choice architect"; J C Cooper, W E Kov, *Behavioral economics: implications for regulatory behavior*, 41 Journal of Regulatory Economics (2012) 41 at 41-43 and 54. Here the author argues how behavioural economics ("increasingly visible in a modern antitrust scholarship that is skeptical of entry as a means to correct anticompetitive markets; doubts the inherent instability of cartels; disputes the efficiency of bundling; and challenges claims that restrictions on intra-brand price competition promote inter-brand competition in non-price dimensions") seeks to "replace the assumption of rationality with one of "bounded rationality", in which consumers' actions are affected by their initial endowments, their tastes for fairness, their inability to appreciate future costs, their lack of self-control, and the general use of flawed heuristics" and examines the implications for decision-making when regulators suffer from documented biases; at 42 and warns that "availability, representativeness, optimism and myopia probably push regulators to adopt more politically expedient policies"; at 51-52. The solution is thus to create "an institutional framework that makes regulators more accountable for the welfare of their policies may help provide the feedback needed to correct or ameliorate biases" although measuring a policy welfare's effect can be daunting; at 54.

[423] Insofar as regulatory competition theory "today represents the dominant academic thinking about regulatory structure", Esty et al express concern that "rather than welfare-enhancing competitive pressures, divergent regulatory standards may instead trigger a welfare-reducing 'race towards the bottom'" and recommend that regulatory theory "reflect the diversity and

private care bodies seeks to take the place of the individual in attempting the difficult task of ascertaining whether the care being provided by the organisation and its employees is adequate.[424] Monitoring the right to health

---

complexity of the world"; D C Esty and D Geradin, *Regulatory Co-opetition*, Journal of International Economic Law (2000) 235 at 235-237. In a study examining the cost impact of "varied regulatory policies and different degrees of privatisation" on airport charges, Bilotkach et al concluded that regulation of privatised airports in the form of price-cap regulation did not lead to "significant lower aeronautical charges" whereas other forms of regulation, namely "single-till and ex post regulatory innovations", namely subsequent monitoring by regulators, succeeded in lowering costs. Of course the aim of regulation for airports here focuses on cost rather than necessarily on other gains such as welfare gains for individuals: see V Bilotkach, J A Clougherty, J Mueller and A Zhang, *Regulation, privatization, and airport charges: panel data evidence from European airports*, 42 Journal of Regulatory Economics (2012) 73 at 90-92. In contrast an article examining the "highly regulated nursing home industry" in the United States, Bowblis and Lucas distinguish between different regulatory aims where regulation includes adherence to quality standards of care: "Regulation aims to achieve its objectives by providing appropriate incentives to the firm. In the health care setting, regulators are concerned with protecting the health of patients often by setting minimum quality standards. Since quality is multi-dimensional, very specific and stringent application of regulations can result in 'offsetting behavior', which may be counter to the intent of the regulators' goals. Specifically, more stringent regulation in one dimension of quality may improve quality in that dimension, but at the margin, have the opposite effect on quality in other dimensions that are under less regulatory scrutiny"; J R Bowblis and J A Lucas, *The Impact of state regulations on nursing home care practices*, 42 Journal of Regulatory Economics (2012) 42 at 53. Accordingly although "quality [as] measured as the care practices employed by [a] nursing home [comprise] inputs of production, they are also viewed as a measure of quality because each care practice can affect the physical and mental health of residents and have quality of life implications". The authors found that whereas nursing homes changed their use of care practices in response to regulation, responding "in ways that are consistent with the intent of each minimum quality standard", this could also lead to the reduction of quality "in other dimensions that are under less regulatory scrutiny to achieve the goals of the minimum quality standard. This simplifies that more stringent regulation, when quality is multidimensional, can both promote and hinder improvements in quality"; at 53 and 69. The study concluded that although "nursing homes improve quality when regulators increase the threshold of minimum quality standards" being responsive to "both specific regulatory deficiencies they receive and those received by their peer facilities over the prior year", they were most responsive "to the specific deficiencies they receive instead of those received by their peers", also finding evidence that "nursing homes improve quality in areas regulators issue deficiencies but may focus less attention on quality areas that receive less regulatory scrutiny" and that regulators need to be mindful of such offsetting behaviour and "whether the direction of the response from a deficiency is consistent with the complementarity or substitutability of care practices with the deficiency". This suggests that where additional regulatory scrutiny may lead to "little or no welfare gains, regulators need to limit the scope and scale of regulation to have an optimal effect on improving quality"; at 69-70. Although competition and consumer law are areas of law "where regulation plays a marked role in economic activity", even here there can be an exception to the general rule of markets operating freely, "antitrust theory provides broadly that intervention in the freely operating market becomes necessary when adverse consequences would otherwise result", the typical example being restrictive practices or abuse of a dominant position; P Nihoul and B D Trigg, *What is Meant by Regulation: The Roles Devoted to Markets and Authorities in Times of Crisis*, 25 Global Business & Development Law Journal 425 at 426-427.

[424] In a study to investigate the antecedents of unethical pro-organisational behaviours by employees, Matherne, suggests that unethical behaviours undertaken by employees include not only "a wide range of minor to major violations" to harm their organization, noting how "organizational members at all levels steal company property, mislead customers, cheat the government, as well as violate psychological contracts" but also behaviours "with the intent to help, or benefit the organization" even where such behaviours "violate some overarching social

means "consistently analysing and overseeing the process towards the realisation of the health-related rights".[425] This is mainly done by monitoring adherence to standard procedures guidelines, codes of conduct and professional standards as will be further considered in Part 4 of this thesis.

7.2 The obligation to ensure reparation for violations of the right to health

There are two aspects to the reparation obligation. As set out above, paragraph 51 of General Comment 14 addresses the State's "due diligence" preventative regulatory obligation. General Comment 14 also addresses this obligation under the heading "Remedies and accountability". For the CESCR Committee, remedies and accountability are to be considered together, with remedies extending to justiciability of the right to health (i.e. judicial accountability). Accordingly, paragraph 59 states that any "person or group victim of a violation of the right to health should have access to effective judicial or other appropriate remedies at both national and international levels"; further that "all victims of such violations should be entitled to adequate reparation, which may

---

norm"; C F Matherne 111, *Investigating the Relationship Between Affective Commitment and Unethical Pro-Organizational Behaviors: The Role of Moral Identity*, 9 Journal of Leadership, Accountability and Ethics (2012) at 35. This is important where core right to health services are privatised and where the acts or the omissions of the private body and its employees fall to be regulated. Noting how "an individual's moral reasoning is what predicts moral behavior" acting as it does as "a self-regulatory mechanism that motivates moral action"; at 38. The author found that "higher levels of affective [i.e. emotional/ social] commitment contribute to higher levels of unethical pro organizational behaviors and alternatively higher levels of moral identity contribute to reduced occurrences of unethical pro-organizational behaviors" thus suggesting that moral identity has a significant impact and that high moral identity moderates, deters and reduces such unethical behaviours; at 40-41.

[425] B Toebes and M San Giorgi, *Dutch realities: evaluating the Dutch health care reform from a human rights perspective* (draft chapter) in *The right to health: a multi-country study of law, policy and practice* (Eds B Toebes, R Ferguson, M Markovic and O Nnamuchi), TMC Asser Press/Springer (due 2014) at 6. Based on "the obligation to protect", the authors suggest 4 interlinked obligations: "1. The adoption of *legislation* to regulate all the actors in the health sector; 2. The adoption of *monitoring mechanisms* aimed at regulating the behaviour of insurance companies, health care providers, and the pharmaceutical industry; 3. The creation of (judicial and other) *accountability mechanisms* for individuals to complain about failures or malpractices by the actors in the health care sector, which should be followed by means of redress; 4. The establishment of *participatory mechanisms* in health-decision-making"; ibid at 7.

take the form of restitution, compensation, satisfaction or guarantees of non-repetition." Paragraphs 60-62 deal with domestic incorporation of the Covenant to permit remedial measures, judicial attention to right to health violations and promotion of civil society advocates, respectively, within this rubric of remedies and accountability.[426]

'Justiciability' refers to "the possibility of aggrieved individuals or groups" raising claims "involving alleged violations of the right to health for determination/ review before domestic judicial or quasi-judicial organs" including international organs.[427] Under paragraphs 59-62 of General Comment 14, victims of violations must be able to obtain reparation and this must be by way of judicial accountability (i.e. justiciability) unless alternative remedies are available. While paragraph 59 does not specify that remedies and accountability need be primarily judicial, alternative remedies, namely "[n]ational ombudsmen, human rights commissions, consumer forums, patients' rights associations or similar institutions [must otherwise]... address violations of the right to health".[428] However, "[a]ddressing" a violation must be effective, thus "all victims of such violations should be entitled to adequate reparation, which [as noted] may take the form of restitution, compensation, satisfaction or guarantees of non-repetition."[429] Otherwise stated, if the alternative remedy cannot provide the specified "adequate reparation", there must be an effective judicial response. As will be discussed in Part 4 of this thesis, in Ireland, the Ombudsman, the Irish Human Rights Commission, the Health and Information and Quality Authority, the Mental Health Commission, the Medical Council of Ireland, the Equality Tribunal and arguably the Health Insurance Authority would be the only relevant non-judicial bodies identified by General Comment 14 theoretically capable of providing an alternative remedy. However, as will be observed, it is doubtful whether these bodies,

---

[426] Thus without domestic incorporation, justiciability of the right before national courts will be limited: see the discussion in Part 2 of this thesis on the justiciability of international convention rights in Irish law.

[427] M Ssenyonjo, *Economic, Social and Cultural Rights in International Law*, Oxford and Portland Oregon: Hart Publishing (2009) at 343.

[428] See para 59.

[429] See para 59.

whether collectively or individually, are empowered to grant adequate reparation to victims of violations as defined under General Comment 14. This being so, attention will primarily turn in Parts 2 and 3 of this thesis to whether Irish judicial remedies can ensure reparation.

There is a second dimension to justiciability, namely insofar as the obligation to ensure reparation is also inherent in the preventive "obligation to protect" identified above; namely the obligation "to regulate the activities of individuals, groups or corporations so as to prevent them from violating the right to health of others".[430] While the preventive obligation focuses mainly on the regulatory framework, it does not preclude justiciability as part of the means to avoid omissions and violations through deterrence and/ or incentivisation. As will be discussed in Part 2, this aspect of justiciability arises primarily from the State's contractual obligations with non-State actors and the controls it places on delegating health services, but also concerns whether the State wishes to apply a constitutional or legislative control theory to such delegation, in order to strengthen its "obligation to protect" capacity where health services are delivered by private bodies health, through allowing individuals take right to health care claims against those bodies, for example under a framework right to health law.[431]

Turning to judicial remedies, the arguments against justiciability of economic and social rights are long-standing, springing from the splitting of the UDHR into two Covenants but today focus primarily on decisions on resource allocation which, it is argued under legal positivism (discussed below) should remain in the preserve of the Executive and Legislature rather than the Courts.

---

[430] At para 51; see above.

[431] Toebes and San Giorgi point out how the obligations of States Parties according to this tripartite typology of State obligations are not static…[w]hen a State privatises certain elements of its health care system … there is a shift from the State's obligation to fulfil to the State's obligation to protect"; B Toebes and M San Giorgi, *Dutch realities: evaluating the Dutch health care reform from a human rights perspective* (draft chapter) in *The right to health: a multi-country study of law, policy and practice* (Eds B Toebes, R Ferguson, M Markovic and O Nnamuchi), TMC Asser Press/Springer (due 2014) at 6, discussed further below. As discussed in Parts 2 and 3 of this thesis, where justiciability is in doubt, a key element of the right to health may have to be secured under either a framework law providing for a right of action for third party beneficiaries or in circumstances where the courts employ a functional approach to private delegation to permit judicial review scrutiny in the same way as public bodies under administrative law.

Such rights are portrayed as an amalgam of positive, resource-intensive, progressive, vague, unnmanageably complex, ideologically divisive, political, non-justiciable and aspirational when compared to immediate, precise, cost-free civil and political rights.[432] Ancillary arguments against justiciability juxtapose the supposed 'programmatic' goals or guidelines of ICESCR rights rather than creating legal obligations.[433]

Both arguments can be repudiated. First, economic and social rights which are clear, precise and 'immediate' "obligations that entail an immediate effect are capable of adjudication".[434] As will be recalled General Comment 3 as confirmed by General Comment 14, clearly states that such immediate obligations require concrete and clearly targeted steps 'within a reasonably short time after the Covenant's entry into force for the States concerned'. Indeed, social and economic rights are recognised in international law: to argue otherwise would be to ignore the breadth of jurisprudence of the European Court of Human Rights on social rights ranging from access to transgender reassignment surgery to rights of education of Roma children; this formulation of "positive obligations" on the State to take measures to secure such rights coming from an international court interpreting a classical 'civil and political rights' convention. Second, the protection of civil and political rights is seldom cost-neutral and so the balancing of competing rights undertaken by the national authorities is often considered by the European Court and the Human Rights Committee, for example.[435] Third, the CESCR has directly contradicted

---

[432] C Scott, *The Interdependence and Permeability of Human Rights Norms: Towards a Partial Fusion of the International Covenants on Human Rights* 27 Osgoode Hall Law Journal (1989) 769 at 833. See discussion below.

[433] See M Ssenyonjo, *Economic, Social and Cultural Rights in International Law*, Oxford and Portland Oregon: Hart Publishing (2009) at 344; E Riedel, *The Human Right to Health, Conceptual Foundations*, in Swiss Human Rights Book Vol. 3, *Realizing The Right To Health*, (eds.) A Clapham & M Robinson, Geneva (2009).

[434] Y Arai-Takahashi, *The Right to Health in International Law - A Critical Appraisal*, in R Martyn, & L Johnson (Eds), *Law and the Public Dimension of Health* London Cavendish Publishing Limited (Chapter 5) (2001) at 170.

[435] See the jurisprudence of the Human Rights Committee under the ICCPR where for example it has interpreted a requirement that a sufficient number of detention centres be constructed to secure Article 10(1) rights on humane treatment; see S Joseph, J Schultz & M Castan, *The International Covenant on Civil and Political Rights, Cases, Materials and Commentaries* (2nd Ed.) (2005) at 345.

the argument that Covenant rights are not justiciable stating that "all economic, social and cultural rights are justiciable".[436] Indeed, General Comment 14 calls for justiciability of the right to health where at paragraph 59 it states that any "person or group victim of a violation of the right to health should have access to effective judicial or other appropriate remedies at both national and international levels"; further "all victims of such violations should be entitled to adequate reparation, which may take the form of restitution, compensation, satisfaction or guarantees of non-repetition.[437] Under paragraph 60 justiciability can be enhanced through direct incorporation of the Covenant into domestic law as it can "enhance the scope and effectiveness of remedial measures and should be encouraged in all cases".[438]

The question arises as to why "access to effective judicial or other appropriate remedies at both national and international levels" does not occur in practice. The reasons are complex. At the international level it may be argued that economic, social and cultural rights have been traditionally neglected due to the ideological divide created by the Cold War, coupled with the absence of international supervisory mechanisms until very recently. Individual complaints processes and the ensuing jurisprudence arising under the ECHR, RESC and ICCPR have only properly developed in the past two decades and the delay in justiciable economic, social or cultural rights before international bodies has structurally disadvantaged the justiciability of those rights in domestic fora. Until recently, the lack of judicial precedent has led to negative cultural attitudes routinely prevailing. On the domestic level there are two dimensions. One is the fact that international law standards are not properly understood or integrated (at least in dualist legal systems) by domestic jurists. Secondly, generations of jurists, lawyers and academics - particularly in common law States with their formalist methods of litigation - have learnt as

---

[436] CESCR Concluding Observations on Ireland, UN Doc E/C.12.1/add.77 (5 June 2002), para 23 and Concluding Comments on United Kingdom of Great Britain and Northern Ireland, UN Doc E/C.12/1/Add.79 (5 June 2002), para 24.

[437] "National ombudsmen, human rights commissions, consumer forums, patients' rights associations or similar institutions should [also] address violations of the right to health"; at para 59.

[438] See para 61.

anathema the very notion of justiciable economic, social or cultural rights on the basis of legal positivism and strict separation of powers doctrines. These trends will be considered in Part 2 of this thesis when considering justiciability of the right to health in the Irish context.

7.3 State review by the CESCR

The paucity of enforcement measures for the right to health at international level is a significant factor in the slowness with which the right has been formulated and considered in the domestic law of States Parties. Absent individual complaints, State reporting to CESCR is the only form of supervision available. The current system of periodic State Reports is useful but has been criticised on the basis of the "insufficient and inadequate nature of State reports, lack of co-operation from States, and the inherently circumscribed vigour of the Committee's supervisory power exercised on the basis of a 'constructive dialogue' with a State suspected of infringing the rights of its citizens".[439] Delay is another significant factor.[440]

During the periodic reporting procedure the Committee is stated to engage in a process of "scoping" with the State party.[441] During the following five years, the State party is expected to "use these national benchmarks to help monitor its implementation of Article 12." Thereafter, the State and Committee "will theoretically consider whether or not the benchmarks have been achieved, and

---

[439] Y Arai-Takahashi, *The Right to Health in International Law - A Critical Appraisal*, in R Martyn, & L Johnson (Eds), *Law and the Public Dimension of Health* London Cavendish Publishing Limited (Chapter 5) (2001) at 169.

[440] See delay between the 2002 consideration of Ireland, Ireland's submission of its Third Periodic Report (December 2012) despite its obligation to report within 5 years and the subsequent delay in consideration of that report which may be 2014 or later.

[441] Y Arai-Takahashi, *The Right to Health in International Law - A Critical Appraisal*, in R Martyn, & L Johnson (Eds), *Law and the Public Dimension of Health* London Cavendish Publishing Limited (Chapter 5) (2001) at 169. By "scoping" is meant "the joint consideration by the State party and the Committee of the indicators and national benchmarks which will then provide the targets to be achieved during the next reporting period"; ibid.

the reasons for any difficulties that may have been encountered."[442] In common with other UN treaty monitoring bodies, the CESCR, after receiving the State Party's report will produce a List of Issues which it sends to the State Party[443] and which raises both general concerns and questions regarding Governmental targets expressed in the report. The State Party is then expected to submit written replies in advance of the hearing of the State Party's report which occurs before the CESCR in Geneva at one of its regular sessions. Prior to its consideration of the State report by the United Kingdom in 2009, the CESCR's pre-sessional working group in 2008 issued a List of Issues which the State Party was typically obliged to respond to prior to the hearing of the State report.[444] That reply addressed national strategies on health in both England, Wales and Scotland and provided statistical information on benchmarks set by the Government.[445]

The List of Issues on health sought further information on the implementation of measures such as access to the AAAQs for vulnerable groups and detailed information, including "recent statistical data disaggregated by age, gender, race, and ethnic or national origin". The reply by the State party addressed these questions in part,[446] providing disaggregated data on infant mortality and

---

[442] Y Arai-Takahashi, *The Right to Health in International Law - A Critical Appraisal*, in R Martyn, & L Johnson (Eds), *Law and the Public Dimension of Health* London Cavendish Publishing Limited (Chapter 5) (2001) at 169.

[443] See the Treaty Body Report description of the List of Issues process, available at *treatybodyreport.org/cescr.html#ls* accessed 21 October 2012.

[444] List of issues to be taken up in connection with the consideration of the fifth periodic report of the United Kingdom of Great Britain and Northern Ireland concerning the rights covered by articles 1 to 15 of the International Covenant on Economic, Social and Cultural Rights (E/C.12/GBR/5, E/C.12/GBR/5/Add.1, E/C.12/GBR/5/Add.2), E/C.12/GBR/Q/5, 19 – 23 May 2008 (10 June 2008). Available at *http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G08/424/51/PDF/G0842451.pdf?OpenElement*

[445] At para 26. See also para 27; List of issues to be taken up in connection with the consideration of the fifth periodic report of the United Kingdom of Great Britain and Northern Ireland concerning the rights covered by articles 1 to 15 of the International Covenant on Economic, Social and Cultural Rights (E/C.12/GBR/5, E/C.12/GBR/5/Add.1, E/C.12/GBR/5/Add.2), E/C.12/GBR/Q/5, 19 – 23 May 2008 (10 June 2008). Available at *http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G08/424/51/PDF/G0842451.pdf?OpenElement*

[446] Replies by the Government of the United Kingdom of Great Britain and Northern Ireland to the list of issues (E/C.12/GBR/Q/5) to be taken up in connection with the consideration of the fourth periodic report of the United Kingdom of Great Britain and Northern Ireland, 11 February 2009; at paras. 207-217; available at *www2.ohchr.org/english/bodies/cescr/docs/AdvanceVersions/E-C12-GBR-Q5-Add1.pdf*

the rate of deaths (for heart disease and cancer) and references to a number of strategies, policies and budget.[447] The information provided by the United Kingdom to CESCR on its strategies to reduce inequalities by 2010-2011[448] were deemed insufficient in the CESCR's Concluding Observations.[449] Its recommendations addressed both regressive measures taken in funding mental health services and a health target set by the State and monitored by it. However, the Concluding Observations differed on disaggregated data requirements, prompted by the benchmark targets the State Party has set itself.[450] This examination contrasts with the examination and Concluding Observations on The Netherlands one year later. Here in its 2010 Concluding Observations, the CESCR expressed its concern about the denial of health care for older persons, having regard to the AAAQs and separately raised concerns about mental health care for prisoners.[451] There was disparity in both the

---

[447] Replies by the Government of the United Kingdom of Great Britain and Northern Ireland to the list of issues (E/C.12/GBR/Q/5), at paras. 209 and 216.

[448] *Treaty Body Monitor*, International Service for Human Rights, Human Rights Monitor Series, Committee on Economic, Social and Cultural Rights, 42nd Session, United Kingdom of Great Britain and Northern Ireland, 4-5th Report 12-13 May 2009 at 7 available at *www.ishr.ch/treaty-body-monitor?task=view* accessed on 14 October 2012.

[449] Concluding Observations of the Committee on Economic, Social and Cultural Rights on the United Kingdom of Great Britain and Northern Ireland, the Crown Dependencies and the Overseas Dependent Territories, E/C.12/GBR/CO/5, Forty-second session, 22 May 2009, Geneva. CESCR was concerned "that health inequalities among various social classes in the State party have widened" especially with regard to access to health care, goods, facilities, and services and called on the State to "intensify its efforts to overcome the health inequalities and unequal access to health care, in particular for the most disadvantaged and marginalized individuals and groups" (at para 32). It also recommended that the State party gather appropriate disaggregated data on an annual basis "with a view to assessing the progress made" and expressed deep concern at the health outcomes of persons with mental disabilities and at "regressive measures taken in funding mental health services"; at para 33.

[450] The second part of Recommendation 32 omits the requirement to disaggregate data "by age, gender, race, and ethnic or national origin" which would assist in combating discrimination, replacing it with the measurement "…by infant mortality and life expectancy at birth as benchmarks" as these were the benchmark targets the Government has set itself. The Leader of the State's delegation pointed out in his address to the Committee that the United Kingdom had introduced a Race Relations Act some 40 years earlier whose purpose was to target race discrimination, while gender and disability discrimination had also been addressed in legislation. Statement of Dr Vijay Rangarajan, 12 May 2009 available at *www2.ohchr.org/english/bodies/cescr/docs/statement/Statement-UK_CESCR42.pdf* In light of these comments, on its developed legislative and policy framework, it is unclear why the State Party could not disaggregate data or otherwise demonstrate that it was combating discrimination in the right to health on the grounds of gender, race or ethnic or national opinion.

[451] Concluding Observations on The Netherlands and Netherlands Antilles Forty-fifth session, Committee on Economic, Social and Cultural Rights, Geneva, 1–19 November 2010, United Nations E/C.12/NLD/Q/4-5/Add.1 Economic and Social Council Distr; available at

questions put to and responses received from the two States Parties, with the Committee appearing to base its assessments on the basis of the information provided to it rather than focusing on core ICESCR right to health obligations.[452] This prompts the question whether States will choose to provide information of their own volition if to do so will only attract negative criticism.[453]

In its 2012 review of Spain, the 2011 List of Issues under Article 12 focused on two matters: the increase in involuntary committals to psychiatric institutions and "the steps taken to provide greater access to quality health care, without increasing waiting times, for disadvantaged persons, including temporary workers.[454] In its Concluding Observations of June 2012 on Spain, responding to recent austerity measures, the Committee recommended that: "the State party assess the impact of any proposed cuts on the access of the most disadvantaged and marginalized individuals and groups to health services".[455] Arguably there is a disconnect between the List of Issues and the Concluding

---

http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G10/457/00/PDF/G1045700.pdf?OpenElement accessed on 21 April 2012; at paras 29 and 30. At paragraph 33 the Government reply stated: "According to their professional association, the KNMG, medical professionals must take account of the ideological views and cultural background of their patients, and of any language barrier. Statutory safeguards also exist, including an obligation to accept patients and a ban on differentiated insurance premiums". See also para 172 and generally Replies by the Government of the Netherlands to the list of issue, see *daccess-dds-ny.un.org/doc/UNDOC/GEN/G10/465/69/PDF/G1046569.pdf?OpenElement* accessed on 21 April 2012.

[452] The written responses provided by the Netherlands to detailed questions in the List of Issues as expanded at the oral hearing were vague and included information provided by a doctor's association and a table showing waiting times in hospitals. Compare this to the data adduced by the UK in its examination.

[453] These disparities, it is suggested, do not assist the argument as to the justiciability of rights under the Covenant where there is such a range to be observed in the methodology of the CESCR.

[454] Committee on Economic, Social and Cultural Rights Working Group List of issues to be taken up in connection with the consideration of the fifth periodic report of Spain concerning the rights referred to in articles 1 to 15 of the International Covenant on Economic, Social and Cultural Rights (E/C.12/ESP/5) 23 to 27 May 2011; see *www.bayefsky.com/docs.php/area/issues/treaty/cescr/opt/0/state/161/node/4/filename/spain_e_c12_esp_q_5* accessed on 21 October 2012; at paras 20-21.

[455] Concluding Observations of the Committee on Economic, Social and Cultural Rights - Spain, Forty-eighth session, Geneva, E/C.12/ESP/CO/5, 30 April–18 May 2012, 6 June 2012; at para 19. The Committee also expressed concern at efforts of the State to curtail access to public health services to irregular migrants; at para 19.

Observations. If the issue of psychiatric committal was responded to satisfactorily, arguably this development could have been welcomed by the Committee. While the Concluding Observation on the need to take positive measures to assess the impact of any proposed cuts on the vulnerable groups is welcome, again there appears to be a slight disconnect with the issue asked, in addition to a lack of specificity on how such an impact assessment should be carried out or indeed whether the benchmarks and indicators employed by Spain are sufficient for the next reporting period.[456]

Uneven analysis in its Concluding Observations by a treaty supervisory body of State reports to it and, on the other hand, State inaction and apathy is a criticism that cannot be limited to the ICESCR.[457] However, it does not

---

[456] Similar observations can be made of the Concluding Observations on New Zealand (May 2012). In 2011, the CESCR had in its List of Issues focused on two areas, namely disparities in ethnic groups accessing the AAAQS and sexual and reproductive health; Committee on Economic, Social and Cultural Rights Working Group List of issues to be taken up in connection with the consideration of the third periodic report of New Zealand concerning articles 1 to 15 of the International Covenant on Economic, Social and Cultural Rights (E/C.12/NZL/3) 23-27 May 2011, 14 June 2011; see *tb.ohchr.org/default.aspx* accessed on 21 October 2012; at paras 16-17. In its May 2012 Concluding Observations, however, the CESCR focused on the rights of persons with a disability to primary health care and at paragraph 24 to the difficulties faced by communities in rural and remote areas in terms of access to some health services and to improved sewage systems; Concluding Observations of the Committee on Economic, Social and Cultural Rights - New Zealand, Forty-eighth session, Geneva, E/C.12/NZL/CO/3, 30 April–18 May 2012, 31 May 2012; at para 19. The disconnect between the List of Issues and the Concluding Observations can be observed again here.

[457] As with all UN treaty supervisory body, the CESCR's membership comprises (18) part-time members and it operates with minimal support from the OHCHR. The rigour of its supervision of the Covenant is supplemented by inputs from non governmental organisations and national human rights institutions who submit shadow reports and who can appear before Committee sessions: See generally General Comment 10: *The role of national human rights institutions in the protection of economic, social and cultural rights*, Nineteenth session, Geneva, Agenda item 3, E/C.12/1998/25, 10 December 1998. See also Committee on Economic, Social and Cultural Rights - *Working Methods: Overview of the present working methods of the Committee*, accessed at *www2.ohchr.org/english/bodies/cescr/workingmethods.htm* accessed on 21 April 2012. A similar review of other supervisory bodies, not least the Council of Europe's widely respected Committee on the Prevention of Torture, demonstrates some lack of follow-up and coherency in its reporting following successive State visits under the Convention. Compare the relative scrutiny of residential or other institutions for persons with intellectual disabilities in the 2003, 2007 and 2010 CPT reports on Ireland: European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, *Report to the Government of Ireland on the visit to Ireland carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)* from 20 to 28 May 2002 CPT/Inf Strasbourg (2003) at 36; European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, *Report to the Government of Ireland on the visit to Ireland carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)* from 2 to 13 October 2006 CPT/Inf Strasbourg (2007) at 40 and European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, *Report to the Government of Ireland on the visit to Ireland carried out by the European Committee for the Prevention of*

routinely employ, question or draw inferences from indicator and benchmark data on the right to health, unlike the practice of the ECSR.[458] Arguably the absence of "competitive complementarity" between the CESCR and WHO has resulted in this situation. Simply put, if the WHO were to place more emphasis on the legal rights element of its mandate, complementary legal and programmatic responses to health priorities may be enhanced. This could see the WHO engage systematically with States prior to their submission of State reports to the CESCR on benchmarks and indicators and mechanisms to address discrimination, as mooted in the 2003 meeting. WHO could be invited to participate at the hearing and deepen both the CESCR's review and authority of how the right to health is being implemented in States. For their part, States would be provided with clearer guidance on the measures needed to be undertaken and developing States could request WHO technical assistance.

7.4 Justiciability before national courts

While incorporation of the ICESCR into domestic law would "enable[] courts to adjudicate violations of the right to health, or at least its core obligations, by direct reference to the Covenant"[459], other mechanisms such as the presence of analogue provisions in national constitutions, domestic legislation with right of action clauses and/ or most importantly, judicial precedent permitting the adjudication of such claims, could also satisfy a State's obligations under the ICESCR. In this respect, it has been argued that human rights are superior to legal rights as they precede law and arise from the concept of human dignity.[460] However, when one considers the situation of private entities delivering a

---

Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 25 January to 5 February 2010, CPT/Inf Strasbourg (2011) at 3.

[458] Partly this may be due to the sheer scale of the rights covered by ICESCR and indeed the different aspects of the right to health, but surely a focus on the core minimum rights could be accomplished.

[459] General Comment 14, para 60.

[460] M Ssenyonjo, *Economic, Social and Cultural Rights in International Law*, Oxford and Portland Oregon: Hart Publishing (2009) at 348. See discussion on Natural Law in Part 2 of this thesis.

"minimum core" health service, it will be observed that domestic protection and enforcement are key to ensuring the State's duty to "protect" and "fulfil".

National courts have considered "progressive realisation" and resource constraints where a refusal of a treatment or service is deemed life-threatening. As noted, in *Minister of Health v Treatment Action Campaign*[461], the South African Constitutional Court found that the Government was required "to devise and implement within its available resources a comprehensive and co-ordinated programme to realise progressively the rights of pregnant women and their newborn children to have access to health services to combat mother-to-child transmission of HIV". In *Paschim Banga Khet Mazdoor Samity v State of West Bengal*[462] the Indian Supreme Court considered that denial of timely emergency treatment by a number of hospitals offended the right to life under Article 21 of the Indian Constitution, with the Court ordering the State to take a number of measures with resource implications in order to remedy the situation.[463]

However, in *Soobramoney v Minister for Health (Kwazulu-Natal)*[464], the Constitutional Court of South Africa held that a refusal to provide the Appellant with life-extending dialysis treatment did not violate his rights to life and health under the South African Constitution, citing resource-allocation grounds and distinguished *Paschim Banga Khet Mazdoor Samity* as concerning the refusal of emergency treatment. In *The Government of the Republic of South Africa v Grootboom*[465] the Constitutional Court of South Africa held that in "right of access to adequate housing" adjudication, what is required is that measures are reasonable.[466] One commentator suggests that the requirement of

---

[461] (CCT8/02) [2002] ZACC 15; 2002 (5) SA 721; 2002 (10) BCLR 1033 (5 July 2002).

[462] (1996) AIR SC 2426/ (1996) 4 SCC 37; (1996) SCJ 25, 29.

[463] See A Singhvi *India's Constitution and Individual Rights: Diverse Perspectives*, 41 George Washington International Law Review, No. 2 (2009) at 338.

[464] *Soobramoney v Minister for Health (Kwazulu-Natal)* (CCT32/97) [1997] ZACC 17; 1998 (1) SA 765 (CC); 1997 (12) BCLR 1696 (27 November 1997) per Chaskalson P.

[465] (CCT11/00) [2000] ZACC 19; 2001 (1) SA 46; 2000 (11) BCLR 1169 (4 October 2000).

[466] "[t]o be reasonable, measures cannot leave out of account the degree and extent of the denial of the right they endeavor to realise. Those whose needs are the most urgent and whose ability to enjoy all rights therefore is most in peril, must not be ignored by the measures aimed

providing emergency medical treatment is "a facet of the principle of equality itself".[467] In *R (Otley) v Barking and Dagenham Primary Care Trust*[468] the Court of Appeal struck down a decision to refuse a health benefit where resource constraints were not a proper concern. Clearly there will be limits to what a domestic court will review on resource allocation issues; however, these cases demonstrate that contested rights to health are capable of being litigated before the courts even where resource constraints are at issue.

A second category of justiciable rights comprises the principle of non-discrimination. Clear sex or race discrimination in access to the AAAQs is capable of justiciability: tribunals and courts are well versed in considering general equality and non-discrimination claims in domestic jurisdictions while both the European Court of Human Rights, the Court of Justice of the EU, the Human Rights Committee, the CEDAW Committee and the ECSR have all developed significant non-discrimination jurisprudence.[469]

---

at achieving realisation of the right"; at para 44. See also *Minister for Health v Treatment Action Campaign*, 5 July 2002 (CCT 8/02) at para 68. "[R]igid and inflexible polic[ies] that exclude[d]" the applicants from access to nevirapine in that case were clearly unreasonable; at para 47, particularly where access was limited to specified research and training sites; at para 95. To remedy the situation, if necessary, this would result in the courts making declaratory or mandatory orders that would impact on policy; at paras 98-122.

[467] A Singhvi in *India's Constitution and Individual Rights: Diverse Perspectives*, 41 George Washington International Law Review (2009) at 339. See also S Khilnani, *The Constitution and Individual Rights: A Comment on Dr Abhishek Singhvi's India's Constitution and Individual Rights: Diverse Perspectives*, 41 George Washington International Law Review (2009) at 361-366 who takes a less sanguine approach to what he disparagingly refers to as "government by judiciary"; at 366.

[468] [2007] CCL Rep 628.

[469] A violation of the principle of non-discrimination in access to the AAAQs was found for a vulnerable group (namely illegal migrants and their children) in *International Federation of Human Rights Leagues (FIDH) v France* by the RESC Complaint No. 14/2003, Decision on the merits of 3 November 2004, at para 31 although the ECSR considered a refusal of a benefit to migrant children constituted a breach, not of the right to health under Article 13, but of Article 17 of the RESC. As noted, in its reasoning, it was the ECSR's comparison of the adults and children in these groups led it to consider that additional protection was required for the children concerned; in effect an implicit recognition of the principles underpinning indirect discrimination. In *Szijarto v Hungary* Communication No. 4/2004, UN Doc CEDAW/C/36/D/4/2004 (29 August 2006)., the CEDAW Committee considered the intersectionality between gender and race in finding that coerced sterilisation by medical staff of a Roma woman, although deemed medically necessary by the domestic courts, violated Article 10(h) (specific information and informed choice), Article 12 (informed consent and dignity during pregnancy, confinement and post-natal services) and Article 16(1)(e) (prohibition of sex discrimination in taking decisions on children).

Clearly the prohibition of discrimination in access to the AAAQs requires States to take steps such as "special measures" to combat indirect discrimination against vulnerable groups. In considering groups such as persons with disabilities, children, women, migrant workers and ethnic minorities, specific treaty non-discrimination provisions also apply (namely the CRPD, the CRC, CERD, CEDAW and the CRMW, respectively). These non-discrimination provisions should be considered in tandem with the right to non-discrimination in health under the ICESCR.[470] The measures taken by States to combat discrimination on these grounds should be part of the State's formulation of its national health policy. To achieve the goals of combating discrimination, it is suggested the National Health Strategy and Plan of Action could include "health impact assessments before implementation of all policies and decisions that may have a detrimental effect on health, taking into account full public participation".[471]

If a complaint is made against the State, it should be able to demonstrate a) that it has undertaken - or at least considered - 'special measures' to guard against discrimination; b) that in doing so, it has indicators (disaggregated data) benchmarks within a national strategy/ plan of action which has as its goal the progression of health rights; c) that those indicators allow for a comparison of access to the health good or service in question on the discriminatory ground complained of and d) that in the circumstances of the case before it, while a difference of treatment between two comparators may have occurred, this has

---

[470] See also the discussion of "Affirmative Action" and "Reverse Discrimination" under Article 26 ICCPR in S Joseph, J Schultz & M Castan, *The International Covenant on Civil and Political Rights, Cases, Materials and Commentaries* (2nd Ed) (2005) at 728-732 where the authors suggest that "in certain circumstances, it is mandatory for the State to take such action"; at 728.

[471] M Ssenyonjo, *Economic, Social and Cultural Rights in International Law*, Oxford and Portland Oregon: Hart Publishing (2009) at 355 citing P Hunt, & G MacNaughton, *Impact Assessments, Poverty and Human Rights: A Case Study Using the Right to the Highest Attainable Standard of Health*, UNESCO (2006); see *www.humanrightsimpact.org* accessed on 21 April 2012. This is both a principled and practical approach which could be urged on States by CESCR. If such a health impact assessment had been undertaken in the cases cited above, the relevant State would arguably not have refused the medical benefit in an arbitrary fashion. If it could have shown that it had conducted impact assessments or had taken a proportionate response to the issues in the case, it would at least have a powerful defence to claims of discrimination, absent irrationality, insofar as it would be in a position to argue that account had been taken of the rights of the individual and that accordingly its decision/ act was proportionate to a legitimate public aim.

not resulted in discrimination. The manner in which the State would demonstrate non-discrimination would be to show that it has taken into account the aims (direct discrimination test) and the likely effects (indirect discrimination test) of the measures taken and concluded that the means employed are proportionate to the legitimate aim the State (for example prioritising access to cancer care by removing entitlement to another health service in the context of health system rationing and by justifying the removal of the benefit by taking into account the right to health of others).

7.5 Other remedies

As noted above, remedies and accountability are "core" elements of the right to health under Article 12 and are to be read together, as paragraph 59 of General Comment 14 makes clear. In addition, General Comment 20 (which as we have seen addresses non-discrimination) requires States to ensure all victims of right to health violations are entitled to adequate reparation, through effective remedies which will include compensation, reparation, restitution, rehabilitation, guarantees of non-repetition and public apologies.[472] The right

---

[472] General Comment No 20 at para 40. Potts summarises right to health remedies thus: "Governments have an obligation to ensure that: There are adequate legal or other appropriate remedies available to any rights-holder claiming that his or her right to health has been violated. These remedies take one or more of the following forms: restitution; rehabilitation; compensation; satisfaction; and guarantees of non-repetition. The right to a remedy for a violation of the right to health includes the right to access national, regional (if applicable) and international procedures for protection. The procedures to obtain a remedy for violation of the right to health are known by all rights-holders"; H Potts, *Accountability and the Right to the Highest Attainable Standard of Health*, Human Rights Centre, University of Essex (2008), at 28 available at *www.womenslinkworldwide.org/pdf_programs/en_prog_rr_col_pubs_accountability.pdf*

to an effective remedy mirrors that in other conventions such as the ICCPR[473] and ECHR.[474]

The need for remedies and accountability is accordingly a legal obligation on the State. Where non-judicial remedies (Ombudsmen, Tribunals etc.) cannot provide reparation, there must be available to individuals the possibility of judicial remedies. This is what is meant by the term the right to "have access to effective judicial or other appropriate remedies at both national and international levels". If, absent quasi-judicial reparation, the right to health cannot be domestically litigated, the State will be in violation of the right itself. If the State cannot demonstrate how reparation occurs, it will be in violation of the right to health.[475]

7.6 Privatisation and the UN Guiding Principles

A further category of potentially justiciable rights concerns private entities where a claim of discrimination in access to the AAAQs is made against their acts or omissions. This derives from the State's obligations to control the activities of non-State actors delivering health services under the obligation to "respect", to regulate their activities under the obligation to "protect" and to ensure private health activities come within the National Strategy and Action plan under a framework law, under the obligation to "fulfil". This suggests that a person claiming a right to health violation in these circumstances must be

---

[473] General Comment No 20 at para 40. See Article 2(3) of the ICCPR. See too Human Rights Committee General Comment No. 31 *Nature of the General Legal Obligation Imposed on States Parties to the Covenant*, 26/05/2004. CCPR/C/21/Rev.1/Add.13 at para 15. Reparation can involve *inter alia*, "restitution, rehabilitation and measures of satisfaction"; at para 16. The right to a remedy under Article 2(3) also requires the State to ensure there is non-repetition: see *Tcholatch v. Canada*, Communication No. 1052/2002, at para. 10; *Agabekov v. Uzbekhistan*, Communication No. 1071/2002, at para. 9; *Vuolanne v. Finland*, Communication No. 265/1987, at para. 11.

[474] Article 13 of the ECHR, see above.

[475] Hence the State will be required to demonstrate how the right to health can be addressed by "ombudsmen, human rights commissions ... or other institutions" and if, absent justiciability, these institutions cannot guarantee "restitution, compensation, satisfaction or guarantees of non-repetition", the State will be in violation of this aspect of the right.

able to sue the private entity or the State for a failure to regulate, control or ensure the right at issue.

There have been attempts to place legal obligations on transnational corporations ("TNCs") under international law since the adoption of UN standards. In the decades following decolonisation the UN established a Centre for Transnational Corporations in 1974 and drafted a number of versions of a Code of Conduct on Transnational Corporations in 1983 and 1990.[476] These Codes emphasised the need for foreign investors to obey host country law and avoid interference in the host country's domestic affairs.[477] However in response, the Organization for Economic Cooperation and Development (OECD) drafted its own set of guidelines for multinational enterprises with "far fewer and weaker obligations on [transnational enterprises] and [which] were not intended to be binding".[478] Following the collapse of the Cold War, a number of developing States, in light of international banks halting their lending to indebted nations, turned to bilateral investment treaties and were obliged to undertake "significant obligations to protect foreign investment".[479] The draft UN Code of Conduct which its advocates had hoped would become a treaty was discarded while the UN General Assembly's 1990 Declaration of

---

[476] S Rather, *Corporations and Human Rights: A Theory of Legal Responsibility*, 111 Yale Law Journal at 443 in *Human Rights and Corporations*, The International Library of Essays on rights, D Kinley (ed.) Ashgate Publishing (2009) at 245-247.

[477] 1990 United Nations Code of Conduct on Transnational Corporations U.N.ESOR, Spec. Sess., Supp. No.7, Annex 11, U.N. Doc. E/1983/17/Rev.1(1983), cited by S Rather, *Corporations and Human Rights: A Theory of Legal Responsibility*, 111 Yale Law Journal at 443 in *Human Rights and Corporations*, The International Library of Essays on rights, D Kinley (ed.) Ashgate Publishing (2009) at 245 fn 38.

[478] Declaration on International Investment and Multinational Enterprises annex 1 (1976), reprinting in the OECD *Guidelines for Multinational Enterprises* (1994); cited by S Rather, *Corporations and Human Rights: A Theory of Legal Responsibility*, 111 Yale Law Journal at 443 in *Human Rights and Corporations*, The International Library of Essays on rights, D Kinley (ed.) Ashgate Publishing (2009) at 245, fn 40. See also the ILO Tripartite Declaration of Principles Concerning Multinational Enterprises and Social Policy, cited in O Fauchald and J Stigen, *Corporate Responsiblity Before International Institutions*, 40 George Washington International Law Review (2009) at 1098.

[479] S Rather, *Corporations and Human Rights: A Theory of Legal Responsibility*, 111 Yale Law Journal at 443 in *Human Rights and Corporations*, The International Library of Essays on rights, D Kinley (ed.) Ashgate Publishing (2009) at 246. See also D Kinley and R Chambers, *The UN Human Rights Norms for Corporations: The Private Implications of Public International Law*, 6 Human Rights Law Review (2006) at 447, in *Human Rights and Corporations*, The International Library of Essays on rights, D Kinley (Ed.) Ashgate Publishing (2009) at 400-408.

International Economic Cooperation urged developing nations to achieve "favourable conditions of domestic and foreign investment".[480] In 2003, ECOSOC's UN *Norms on the responsibilities of transnational corporations and other business enterprises with regard to human rights* were greeted with considerable controversy and not pursued.[481] In 2005, following a UN Resolution, a UN Special Representative on the issue of human rights and business was appointed and his mandate has been subsumed into the UN Working Group on the issue of human rights and transnational corporations and other business enterprises.[482] Standards on TNCs have been developed under the Special Representative's *Guiding Principles on Business and Human Rights* ("UNGPs")[483], which although not binding in nature are universal and the most comprehensive statement on TNC responsibilities to date.[484]

---

[480] G.A. Res. S-18/3, U.N. GAOR, 18th Spec.Sess., Supp. No.2, at 6, U.N. Doc. A/S-18/15 (1990).

[481] Sub-Commission on the Promotion and Protection of Human Rights, Fifty-fifth session Agenda item 4, E/CN.4/Sub.2/2003/12/Rev.2, 26 August 2003, see J L Cernic, *Two Steps Forward, One Step Back: The 2010 Report by the UN Special Representative on Business and Human Rights*, 11 German Law Journal (2010) 1264 at 1266.

[482] The UN Working Group's mandate was established at the seventeenth session of the Human Rights Council in Resolution A/HRC/17/4 in which it established five independent experts, of balanced geographical representation, for a period of three years. See *www.business-humanrights.org/Documents/UNWorkingGrouponbusinesshumanrights* accessed 11 January 2013 For an overview of the Special Representative's mandate, see D Kinley and R Chambers, *The UN Human Rights Norms for Corporations: The Private Implications of Public International Law*, Human Rights Law Review, 6 447 (2006), in *Human Rights and Corporations*, The International Library of Essays on rights, D Kinley (Ed.) Ashgate Publishing (2009) at 405.

[483] *Guiding Principles on Business and Human Rights, Implementing the United Nations "Protect, Respect and Remedy" Framework,* UN Doc. A/HRC/17/31, 21 March 2011, see *www.business-humanrights.org/.../Home/Protect.../GuidingPrinciples* accessed on 11 January 2013.

[484] Keenan nonetheless identifies two "substantial" risks of TNC adherence to the UNGPs, namely that their efforts will be designed more to "showcase their values than actually to change their behavior" and citing the US Foreign Corrupt Practices Act 1977, the risk that any TNC deciding to implement the Guiding Principles may put itself at a competitive disadvantage with respect to its industry rivals"; P J Keenan, *The Future of the Guiding Principles*, in *Challenges for Corporate Lawyers Advising Clients on Human Rights,* ASIL Proceedings (2011) at 2. The author is optimistic however of industry-wide acceptance of the UNGPs particularly if and when backed by law. Indeed adherence to the UNGPs is likely to continue in parallel with good corporate and social responsibility reputation values. Here Strand notes how corporate and social responsibility "has been valued into the three dimensions of "1) shareholder/owner, 2) stakeholders and 3) community/state welfare"; R Strand, *Exploring the Role of Leadership in Corporate Social Responsibility: A Review*, 8 Journal of Leadership, Accountability and Ethics (2011) 85 at 91.

The UNGPs replicate ICESCR's "respect, protect, fulfil" pillars with "remedy" taking the place of "fulfil", with the emphasis squarely on the State's obligation as the sole "duty holder of rights", in contradistinction to the 2003 Norms. Although this allows for more agreement among TNCs, it reduces their legal accountability as was anticipated in the Norms.[485]

Under the UNGPs "respect" pillar, States are expected to protect against human rights abuses by third parties, including businesses, through its policies, regulation, and adjudication. Under the "protect" pillar, businesses are expected to respect human rights for example by undertaking due diligence to avoid violations and to uncover and mitigate the risk that their activities may adversely impact on human rights and under "remedy" pillar, greater access to remedies, both judicial and non-judicial, for victims of violations.[486]

The standing of the UNGPs as normative standards is likely to strengthen over time under the mandate of the UN Working Group, however, it may be that standard setting on private actors should also focus on national standards insofar as human rights are "best protected in national legal orders". Under this approach it is suggested that any examination of obligations and responsibility for human rights and any attempt to regulate corporations must focus "primarily on the domestic level and only secondarily within the approaches of international law".[487]

---

[485] Jaggers suggests that the UNGPs language is weak: "the frequent use of the word 'encourage' and phrases such as 'where appropriate', is unsettling. In fact, the State's duty to protect as formulated by the Special Representative can, to a certain extent, be considered a step backwards as it actually weakens existing human rights obligations"; N Jagers, *UN Guiding Principles On Business And Human Rights: Making Headway Towards Real Corporate Accountability?* 29 Netherlands Quarterly Human Rights (2011) 159 at 161. Jaggers points out that some of the commentary in the UNGPs is incorrect, citing the obligation under ICESCR that States have the duty to protect which "includes preventing third parties from violating human rights abroad as long as this does not infringe on the rights of other States to protect and fulfil human rights in their own territories"; ibid. Cernic points out how there is growing support for corporations also having "a normative obligation in national legal orders to protect human rights from potential violations of third parties"; see J L Cernic, *Two Steps Forward, One Step Back: The 2010 Report by the UN Special Representative on Business and Human Rights*, 11 German Law Journal (2010) 1264 at 1271.

[486] N Jagers, *UN Guiding Principles On Business And Human Rights: Making Headway Towards Real Corporate Accountability?* 29 Netherlands Quarterly Human Rights (2011) 159 at 159.

[487] J L Cernic, *Two Steps Forward, One Step Back: The 2010 Report by the UN Special Representative on Business and Human Rights*, 11 German Law Journal (2010) 1264 at 1279-1280.

In parallel, it is suggested that while international law (and the UNGPs) start from the perspective that States are responsible for human rights abuses, most corporate liability theorists start from the perspective of domestic civil and criminal law accountability to make a case for corporate liability and that the challenge is to "construct a theory both down from state responsibility and up from individual responsibility that, in the end, develops new primary and secondary rules.[488] One author proposes three sets of relationships: corporations as Governmental agents, corporations as complicit with Governments and corporations as commanders (where they assume responsibility for acts/ omissions done).[489] While current international law norms allow for private actor responsibility where they act as Government agents, the second and third scenarios are arguably not covered and will require a change to normative values. Some commentators argue that insofar as international courts have applied three principal modes of participation to punish offenders, namely in the forms of conspiracy, aiding and abetting and joint criminal enterprise/common purpose,[490] domestic penal codes in most States provide for third-party liability for each of these modes.[491] One author suggests that the arguments in favour of positive responsibilities for parent

---

[488] S Rather, *Corporations and Human Rights: A Theory of Legal Responsibility*, 111 Yale Law Journal at 443-545 in D Kinley (Ed.) *Human Rights and Corporations*, The International Library of Essays on rights, (2009 Ashgate Publishing) at 261 and 284 who cites domestic US jurisprudence such as *Gallagher v "Neil Young Freedom Concert"*, 49 F.3d 1442, 1447 (10th Cir. 1995), *Lugar v Edmonson Oil Co.*, 457 U.S. 922, 937 (1982), *George v. Pac.-CSC Work Furlough*, 91 F.3d 1227, 1230 (9th Cir. 1996) and *Gorenc v. Salt River Project Agric. Improvement & Power Dist.*, 869 F.2d 503, 508 (9th Cir. 1989). Rather also discusses use of the US Alien Tort Claims Act, noting that the plaintiffs in such cases face a relatively high standard of proof.

[489] S Rather, *Corporations and Human Rights: A Theory of Legal Responsibility*, 111 Yale Law Journal at 443-545 in D Kinley (Ed.) *Human Rights and Corporations*, The International Library of Essays on rights, (2009 Ashgate Publishing) at 286. Rather considers the 2003 WHO Framework Convention on Tobacco Control as being a positive example of multilateral action stipulating the responsibilities of TNCs.

[490] R Thompson, A Ramasastry and M Taylor, *Translating UNOCAL: The Expanding Web Of Liability For Business Entities Implicated In International Crimes*, 40 George Washington International Law Review (2009) at 841-902.

[491] R Thompson, A Ramasastry and M Taylor, *Translating UNOCAL: The Expanding Web Of Liability For Business Entities Implicated In International Crimes*, 40 George Washington International Law Review (2009) at 858-859. See also see also Appendix A which lists business entities liability for international crimes across 52 countries.

companies can be enriched by studying how negligence law has dealt with "culpable failures to act".[492]

The 2012 report of Professor Ruggie identified a "governance gap created by globalisation" which was also noted in the Human Rights Council's Resolution establishing the UN Working Group and which that group is likely to address during its 2012-2014 mandate.[493] The "remedies" element of the Special Representative's tripartite framework is probably the "most under-developed" as he noted where he observed how State regulation proscribing certain corporate conduct "will have little impact without accompanying mechanisms to investigate, punish and redress abuses".[494] The International Commission of Jurists suggests a three pronged framework consisting of causation/ contribution, knowledge and foreseeability and proximity, all tortious tests (discussed below).[495] Insofar as International Financial Institutions ("IFIs") such as the WB, the IMF and the WTO have the status of specialised agencies

---

[492] R Mares, *Defining The Limits Of Corporate Responsibilities Against the Concept of Legal Positive Obligations*, 40 George Washington International Law Review (2009) at 1179. Mares quotes the American Law Institute's Restatement of Torts where it explicitly finds that omissions can be a source of liability.

[493] The Resolution expressed concern that weak national legislation and implementation "cannot effectively mitigate the negative impact of globalization on vulnerable economies, fully realize the benefits of globalization or derive maximally the benefits of activities of transnational corporations and other business enterprises, and that further efforts to bridge governance gaps at the national, regional and international levels are necessary..." available at *ap.ohchr.org/documents/dpage_e.aspx?si=A/HRC/RES/17/4* accessed on 29 October 2012. The Special Representative (Professor John Ruggie) called on States to regulate the activities of companies through national regulatory frameworks to give effect to their clear obligations under international human rights law; as cited by A Kirk, *Corporations and human rights: Two key developments*, 33 South African Yearbook of International Law (2008) at 38-61.

[494]Final report available at *ap.ohchr.org/documents/dpage_e.aspx?si=A/HRC/RES/17/4* accessed on 29 October 2012; at para 82A.

[495] *Report of the International Commission of Jurists Expert Panel on Corporate Complicity in international Crimes* (2008); at 9, see *www.business-human.rights.org* accessed on 21 April 2012. One question is whether customary international law may be applicable to TNCs or other non state actors which if accepted, would require TNCs and other private entities to subscribe to the basic principles of international human rights law. One author argues that the first six of the UN's 2000 Millenium Development Goals "reflect norms of customary international law" and since IFIs are part of the normative UN system, it must be accepted that customary international law is binding on non state actors such as the IMF; P Alston, *A Human Rights Perspective on the Millenium Development Goals; Paper prepared as a contribution to the work of the Millenium Project Task Force on Poverty and Economic Development* (2004) at para 35. Clapham argues that as the goals are agreed by all governments and are goals for the whole UN system "it seems appropriate to consider that they can provide a normative framework for the international financial institutions"; A Clapham, *Non State Actors under International Law* (2008) at 149.

of the UN[496], they are obliged to respect the provisions of the UN Charter and indeed General Comment 14 (para 64) as a derivative text.[497] The Charter expressly declares the realisation of human rights to be a principal goal of international economic cooperation and some have argued it makes human rights (as set out in Article 55 of the Charter) the raison d'étre of the IFIs.[498]

A further argument is that insofar as customary international rules of treaty interpretation must clearly apply to interpretation of the IFI's Articles of Agreement with the UN as they apply for all international agreements) and as general international law applies to the IFI's operations, those institutions and the WTO are so bound, an important acceptance given the significance of their actions on human rights including their "potential to facilitate as well as impede a State's ability to fulfil the human rights of its people".[499] It is argued that in concluding Agreements with their Member States, the IFIs should "respect the obligations of the members according to Article 103 of the UN Charter, including giving priority to respect for human rights."[500] This is no more than the requirement under paragraph 64 of General Comment 14 for IFIs to pay greater attention to the protection of the right to health "in their lending policies, credit agreements and structural adjustment programmes" which will

---

[496] Agreement between the United Nations and the International Monetary Fund art.1 April 15 1948, 16 U.N.T.S. 328; Agreement between the United Nations and the International Bank for Reconstruction and Development art.1, April 15, 1948, 16 U.N.T.S. 346. These agreements were in accordance with Article 63 of the UN Charter.

[497] As to IFI source of obligations, see W van Genugten, P Hunt & S Mathews *Tilburg Guiding Principles on World Bank, IMF and Human Rights*, in *World Bank, IMF and Human Rights*, Nijmegen: Wolf Legal Publishers (2003) 247 at 249; available at *http://papers.ssrn.com/sol3/papers.cfm?abstract_id=957195* accessed on 21 April 2012. The Principles were drafted by a group of experts, meeting at Tilburg University, The Netherlands, in October 2001 and April 2002.

[498] B Rajagopal, *Crossing the Rubicon; Synthesizing the Soft International Law of the IMF and Human Rights,* 11 Boston University International Law Journal 81 (1993) at 94-95.

[499] A McBeth, *A Right By Any Other Name: The Evasive Engagement Of International Financial Institutions With Human Rights*, 40 The George Washington International Law Review (2009) at 1106. See also R Mares, *Defining The Limits Of Corporate Responsibilities Against the Concept of Legal Positive Obligations*, 40 George Washington International Law Review (2009) at 1157-1217.

[500] As to IFI source of obligations, see the *Tilburg Guiding Principles on World Bank, IMF and Human Rights*, W van Genugten, P Hunt & S Mathews (2003) at para 26; see *http://papers.ssrn.com/sol3/papers.cfm?abstract_id=957195* accessed on 21 April 2012.

come under CESCR review when examining State reports.[501] States should evaluate the human rights impact of their projects and policies, *ex ante* as well as *ex post*, through the collection of disaggregated data according to, *inter alia*, gender, race, religion, ethnicity, age and poverty level."[502]

Whereas earlier the IMF has been reluctant to accept that the CESCR may have jurisdiction over it[503] this view may be changing with increased IMF and WB interactions with the CESCR.[504] However the approach of the WTO is hugely significant as the impact of increased liberalisation of health markets increases across its 157 Member States.

7.7 The World Trade Organization ("WTO")

The 1947 General Agreement on Tariffs and Trade ("GATT") was created to help liberalise trade between States and laid the foundation for the establishment of the WTO and the rules that govern its multilateral trading

---

[501] The Tilburg principles also suggest that the IFIs should incorporate human rights operational clauses and not enter projects or agreements unless there is a conditionality clause included which protects human rights; see the *Tilburg Guiding Principles on World Bank, IMF and Human Rights*, W van Genugten, P Hunt & S Mathews (2003) at para 26; see *http://papers.ssrn.com/sol3/papers.cfm?abstract_id=957195* accessed on 21 April 2012.

[502] W van Genugten, P Hunt & S Mathews *Tilburg Guiding Principles on World Bank, IMF and Human Rights*, in *World Bank, IMF and Human Rights*, Nijmegen: Wolf Legal Publishers (2003) 247 at para 38; see *http://papers.ssrn.com/sol3/papers.cfm?abstract_id=957195* accessed on 21 April 2012. According to McBeth, the IMF and WB declined an offer from the then-UN Commission on Human Rights in 1951 to participate in the drafting process of the ICESCR on the basis that human rights were outside their mandates: see A McBeth, *A Right By Any Other Name: The Evasive Engagement Of International Financial Institutions With Human Rights*, 40 George Washington International Law Review (2009) at 1154. In 1993 at the Vienna World Conference on Human Rights, the WB's submission focused on its positive record but there was "studious avoidance of legal obligation": C Jochnick, *Confronting the Impunity of Non-State Actors: New Fields for the Promotion of Human Rights*, 21 Human Rights Quarterly (1999) 56 at note 104.

[503] Clapham highlights the 2001 Opinion of the IMF General Counsel Francois Gianviti and his "doomsday" scenario that the CESCR may seek to exercise jurisdiction over the Fund's activities and the decisions of its organs, whereas it should focus on providing balance of payments assistance instead in accordance with its principle of "uniform treatment"; Clapham citing F Gianviti, *Economic, Social and Cultural Rights and the International Monetary Fund*, 30 May 2001, Paper presented to a meeting organized by the UN Committee on Economic Social and Cultural Rights; A Clapham, *Non State Actors under International Law* (2008) at 147.

[504] A McBeth, *A Right By Any Other Name: The Evasive Engagement Of International Financial Institutions With Human Rights*, 40 George Washington International Law Review (2009) at 1154.

system in 1995.[505] Since 1995, in addition to taking over the role of GATT, the WTO covered additional areas, including intellectual property and trade in services including health-related services and has now moved from a primarily diplomatic to rules-based organisation.[506] A distinctive feature of the WTO's appellate system is that where the unsuccessful State in a dispute fails to comply with a ruling, an arbitral panel may award the other State the right to retaliate through trade restrictions.

Insofar as poverty and health are intimately intertwined, with individuals in lower socioeconomic classes having poorer overall health than their more affluent counterparts, it is clear that the international rules governing trade in health related services will have an impact on the social determinants of health and on health outcomes of individuals.[507] Controversies over the application of WTO trade rules on public health financing in developing States include the

---

[505] The WTO entered into force in 1995 at the end of the Uruguay Round of global trade negotiations and according to the Preamble of the Marrakesh Agreement (the agreement that established the WTO), was founded upon the premise of liberalising trade amongst nations, with a specific goal of opening up world markets to developing countries in order for those nations to decrease poverty and become developed." In 1995, it came into effect and immediately became the controlling organization of the international multilateral trading system established by GATT. The WTO began creating agreements that covered, among other things, product safety issues, food sanitation, anti-dumping issues, and subsidy concerns. By the mid-1990s, through the efforts of GATT, and now the WTO, industrialised member States had reduced their tariff rates on industrial goods to below four percent, proving that enhanced trade relations between member States was desired; see P Countryman, *International Trade and World Health Policy: Helping People Reach Their Full Potential*, 21 Pace International Law Review (2009) 241 at 259-260. According to the WHO/WTO, "so far the liberalizing effects have remained limited as most WTO Members have made relatively few commitments that go beyond existing levels of access"; see WHO/WTO, *WTO Agreements and Public Health: A joint study by the WHO and the WTO Secretariat.* Geneva, World Health Organization and World Trade Organization, 2002, at 47. Within the GATT framework, trade in health services means "the provision of specialized and general health personnel, nursing services, hospital services, ambulance services and physiotherapeutic and paramedical services provided by medical and dental laboratories"; Definitions and Debates for Health and Trade Policy Makers: A Glossary of 103 Health and Globalization Terms (unpublished document, available on request from Globalization, Trade and Health (GTH/ETH/SDE), World Health Organization, 1211 Geneva, 27, Switzerland). See P Countryman, *International Trade and World Health Policy: Helping People Reach Their Full Potential*, 21 Pace International Law Review (2009) 241 at 258.

[506] In the WTO system, however, parties can no longer block the process at any point. Panels must render their decisions within established time frames, and an Appellate Body has been established to review the initial decisions of the arbitral panels. Rulings by this higher court are final and automatically binding; S Esserman and R Howse, *The WTO on Trial,* Global Law, Global Politics, 82 Foreign Affair (2003) 130 at 132. The decisions of the Appellate Body of the WTO can be corrected only by a consensus decision of the organization's 157 members.

[507] P Countryman, *International Trade and World Health Policy: Helping People Reach Their Full Potential*, 21 Pace International Law Review (2009) 241 at 248.

question of access to vital drugs to combat pandemics such as HIV/ AIDS. Insofar as there is international "disarray" in protecting public health systems when they are impacted by WTO rules, this stems from the need to resolve the "legal, policy, and normative conflicts" between international intellectual property rights and the right to health in which the current unquestioning belief that patent law promotes the right to health in all situations is tempered by a focus on its impacts.[508]

The Appellate body has held that States have the right to "determine the level of protection of health" appropriate to protect their domestic health markets from foreign competition.[509] However, this principle is threatened. Although the WTO's 2006 Agreement on Trade Related Aspects of Intellectual Property Rights ("TRIPS") allowed for further flexibilities in trading, it brought about "significant" changes in international standards relating to intellectual property rights which arguably pose "a direct conflict with the international human right to health".[510] The threat of trade sanctions under "TRIPS-plus provisions"[511] is

---

[508] W *Chuan-feng, Raising the Right to Health Concerns within the Framework of International Intellectual Property Law*, 5 Asian Journal, WTO & International Health Law & Policy (2010) at 143. See also F Papadopoulou, *TRIPS and Human Rights*, in *Intellectual Property Rights in a Fair World System, Proposals for Reform of TRIPS*, (Eds. Kur & Levin) Edward Elgar, Cheltenham UK, Nothmpton MA, USA (2011) who recommends that human rights principles be incorporated into the TRIPS Preamble or in the WTO framework, arguing that the Doha Declaration may be a platform for such arguments; at 285 and 301. Other authors disagree that the TRIPS system is at fault. Pires de Carvalho argues that "the impairment of patent rights will not give better access to health for poor populations in developing countries", arguing three reasons: any attack on private patent rights act as a disincentive to research and development; "consumers" in developing countries should be willing to subsidise this cost with developed world consumers and the problem of access to pharmaceutical products in developing countries stem from poverty not patents; N Pires de Carvalho, *The Trips Regime of Patent Rights*, (3rd Ed). Wolters Kluwer (2010) at 228.

[509] See WTO Appellate Body in *European Communities - Measures Affecting Asbestos and Asbestos-Containing Products*, 1 168, WT/DS135/AB/R (2001) where it stated that WTO members "have a right to determine the level of protection of health that they consider appropriate in a given situation"; at para 168. See *www.wto.org/english/tratop_e/dispu_e/cases_e/ds135_e.htm* accessed on 11 January 2013. See also Appellate Body report in *Thailand – Customs And Fiscal Measures On Cigarettes From The Philippines, Report Of The Panel* available at *www.worldtradelaw.net/reports/wtopanelsfull/thailand* accessed 11 January 2013.

[510] See Article 27 (2) of TRIPS. Nguyen refers to the additional obligations imposed on new acceding States by members to open up additional markets as "WTO-plus obligations". Even without these additional obligations, the author notes how least developed country applicants face the "daunting challenge" to accelerate domestic legal and economic reform to adhere to the Multilateral Agreements within a relatively short time period; N Nguyen, *WTO Accession at any cost? Examining the use of WTO-Plus and WTO-Minus Obligations for Least-Developed Country Applicants*, 22 Temple International and Comparative Law Journal (2008) 243 at 253. Chuan-feng argues that individuals' rights to health, for example, patients' rights to

now seen as a powerful disincentive to developing States prioritising public health over trade liberalisation policies.[512]

While States theoretically have the flexibility to manage trade in services "in ways that respect, protect and fulfil the right to health by adopting regulatory strategies and enforcement mechanisms"[513], once a health market is opened, States are brought within the WTO's Dispute Settlement Understanding ("DSU")[514] in much the same way as health comes within the remit of EU competition law where privatised in a non-exclusive not-for-profit manner.

It has been suggested that the normative standards of the right to health may be transposed into the WTO system by firstly rendering WTO processes subject to its responsibilities under paragraph 64 of General Comment 14, secondly by introducing a human rights impact assessment in the DSU[515] and thirdly by rendering immune certain "core" aspects of the right to health so that transparent protective measures taken on that basis will be exempt from

---

access affordable medicines in developing countries, are "often sacrificed under the international intellectual property regime in order to pursue the general economic interests"; see W Chuan-feng, *Raising the Right to Health Concerns within the Framework of International Intellectual Property Law*, 5 Asian Journal, WTO & International Health Law & Policy (2010) 143 at 146.

[511] Abbott suggests that "ambiguous" pharmaceutical-related rules raise serious problems when procurement officials "try to do their work" issuing in a culture of trade dispute avoidance with consequent impacts on public health: F M Abbott, *The WTO Medicines Decision: World Pharmaceutical Trade and the Protection of Public Health*, 99 The American Journal of International Law 317 at 353. The author suggests that "stronger monopolies and reduced regulatory flexibility" threaten to exacerbate the already alarming disparity in medicinal treatment between rich and poor throughout the world; ibid.

[512] W *Chuan-feng, Raising the Right to Health Concerns within the Framework of International Intellectual Property Law*, 5 Asian Journal, WTO & International Health Law & Policy (2010) 143 at 168. Accordingly, patent-like barriers to the accessibility of affordable generic medications to tackle public health crises are introduced.

[513] See H Nygren-Krug, *25 Questions and Answers on Health and Human Rights,* Geneva, World Health Organization, Health and Human Rights Series No 1 (2002) at 15.

[514] See the WTO 1995 *Understanding on Rules and Procedures Governing the Settlement of Disputes* (DSU).

[515] Countryman asserts that the WTO must "require" its member States to be parties to the major international human rights treaties and further, that it must also "enforce those treaty obligations through the use of its dispute settlement system and trade sanctions". In this way, it is suggested, the WTO will improve its "short-term credibility", reestablish itself "as a fundamental international body" and enhance its long-term legitimacy; P Countryman, *International Trade and World Health Policy: Helping People Reach Their Full Potential*, 21 Pace International Law Review (2009) 241 at 243.

challenge.[516] This would allow developing States to avoid enforcing strict and highly protectionist intellectual property policies under TRIPS-plus provisions in favour of transparent rational exceptionalism under core right to health principles.

In 2003, the WHO expressed the hope that trade negotiations "will produce expansion of trade in health services but also an opportunity to attract foreign direct investment and make it responsive to national health priorities" but noted that there are "risks associated with liberalization, as not all countries are poised to transform the potential gains into health benefits for the majority of people".[517] In doing so, it cited human rights conditionality as a necessary pre-requirement to health service liberalisation being subject to trade rules[518] as otherwise trade in health services will aggravate existing problems of ensuring fair financing of, as well as equitable access to, health services in States.[519]

---

[516] *Chuan-feng* suggests this could include characterizing specific goals such as "access to low-cost antiretroviral medications effective against AIDS" as core aspects of public health through "an objective criterion then can elevate these goals above the rank and file of competing societal goals (e.g. intellectual property rights)" rendering them with a degree of immunity from challenge and endowing them "with an aura of absoluteness and universal validity". Another possibility is the CESCR's list of services approach; W *Chuan-feng, Raising the Right to Health Concerns within the Framework of International Intellectual Property Law*, 5 Asian Journal, WTO & International Health Law & Policy (2010) 143 at 160-167. To this could be added the non-derogable principle of non-discrimination which under a human rights impact assessment could look at access to the AAAQs in relation to discrete vulnerable groups. Indeed Chuang-Feng points to how human rights proportionality is similar to the "least restrictive means" test as set out in *Thailand - Restrictions On Importation Of and Internal Taxes On Cigarettes* (1990) where the Panel considered whether the public health concerns of Thailand on the importation of cigarettes could be met by "measures reasonably available to it and consistent, or less inconsistent, with the General Agreement"; at para 78, available at *www.wto.org/english/tratop_e/dispu_e/90cigart.pdf* accessed on 11 January 2013. In fact, the WTO test is redolent of non-discrimination proportionality, albeit with a superficial consideration of the public health aspects advanced by the respondent State.

[517] World Health Organization, *International Migration, Health & Human Rights*, Health and Human Rights Publication Series Issue No. 4, World Health Organization, Geneva (2003). See also World Health Organization and World Trade Organization, *Agreements and Public Health: A joint study by the WHO and the WTO Secretariat*, Geneva (2002) at 19.

[518] Nygren-Krug suggests that a human rights approach "requires governments to assess the potential impact of any trade agreement on the enjoyment of human rights, paying particular attention to the most vulnerable and marginalized population groups". In the context of the human right to health this would mean "assessing the impact of the trade agreement concerned on the availability, affordability, accessibility, quality and cultural acceptability of health facilities, goods and services, paying particular attention to the most vulnerable population groups"; H Nygren-Krug *25 Questions and Answers on Health and Human Rights*, World Health Organization, Geneva, Health and Human Rights Series No 1 (2002) at 15.

[519] WHO cited the example of poor countries expending resources on the treatment of foreign patients which may "divert resources that could meet domestic supply needs". It also noted

As noted, States are responsible for ensuring that non-state actors "such as private companies" act in conformity with human rights law within their jurisdiction through "control measures" which include "adopting legislation, policies and other measures to assure adequate access to health care, quality information, etc., and to provide an accessible means of redress if individuals are denied access to these goods and services".[520]

Such concern was set out in the 2008 report of the Special Rapporteur on the Right to Health to the Human Rights Council[521] who recalled the trend since the 1980s and 1990s of "a shift towards vertical (or selective) biomedical interventions" where "structural adjustment programmes led to reduced health budgets and the introduction of user fees" with the introduction of policies which "predictably" brought health systems "to the point of collapse".[522] The WHO also observed how the results were predictable with the poor "deterred from receiving treatment" and "a network of under-resourced hospitals and clinics, while human and financial resources were increasing pulled into vertical programmes, increased pressures on health systems sometimes to the point of collapse".[523]

---

how the needs of remote regions and disadvantaged populations "tend to be neglected as for-profit private, foreign-invested hospitals target more profitable markets"; World Health Organization, *International Migration, Health & Human Rights*, Health and Human Rights Publication Series Issue No. 4, World Health Organization, Geneva (2003) at 14, citing the WHO/ WTO report *Agreements and Public Health: A joint study by the WHO and the WTO Secretariat*, Geneva (2002) at112-113.

[520] See H Nygren-Krug *25 Questions and Answers on Health and Human Rights*, World Health Organization, Geneva, Health and Human Rights Series No. 1 (2002) at 15.

[521] P Hunt, *Report of the United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, Geneva, Economic and Social Council, Commission on Human Rights (2008) at para 27.

[522] P Hunt, *Report of the United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, Geneva, Economic and Social Council, Commission on Human Rights (2008) at para 27.

[523] World Health Organization, *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes*, World Health Organization, Geneva (2007); P Hunt, *Report of the United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, Geneva, Economic and Social Council, Commission on Human Rights (2008) at para 29, citing *www.gallialliance.org* While the 2000s saw more funding in health care systems, there was a realisation that health care systems had been degraded in many States which in turn led to large international funding initiatives in the form of the GAVI Alliance, Global Fund to Fight Aids, Tuberculosis and Malaria which

In an effort to strengthen the WHO, the UN Secretary General advanced the 2000 Millenium Development Goals ("MDGs") in 2000, the first six principles of which arguably form part of customary international law, as noted above. However, these much celebrated goals replicate the history of WHO's engagement in right to health discourses insofar as they were not codified but rather agreed as commitments of a non obligatory nature. As a consequence, they have arguably failed "to achieve programmatic specificity and legal accountability, enabling further drift away from the promise of Health for All".[524] As against this argument are the tangible achievements under the MDGs.[525]

This thesis will not consider in detail the transnational dimensions of private provision of health care. However, in discussing the domestic law implementation of international right to health standards, it is salutary to compare the WHO's engagement on multilateral trade agreements to its engagement on the right to health and whether the commitments by WHO are being operationalised by the organisation and in particular why WHO is yet to work with States Parties on structuring their reporting to the ICESCR on core obligations including right to health indicators, benchmarks and access to the AAAQs to guard against discrimination, particularly the discrimination against vulnerable groups. After all, this is a requirement on WHO clearly set out in General Comment 14 at paragraph 64. As importantly, these non-derogable rights are clearly linked to the social determinants of health and WHO's *Health for All* strategy. Clearer commitments by WHO to elaborating on and operationalising the core minimum rights outlined in the ICESCR in and beyond the right to primary health care would further assist the penetration of

---

focused on specific diseases and conditions and, according to Hunt, either exposed or aggravated these health systems; at para 30.

[524] B M Meier, *Global Health Governance and the Contentious Politics of Human Rights: Mainstreaming the Right to Health for Public Health Advancement*, 46 Stanford Journal of International Law (2010) 1 at 48.

[525] However, progress is uneven. Under MDG 3, which targets gender equality and women's empowerment, progress has been made in areas such as education and economic gains, however, according to UN Women, "persistent gender gaps remain and affect the achievement of other MDGs such as maternal mortality"; see *www.unwomen.org/2012/12/how-women-and-girls-are-faring-charting-progress-on-the-millennium-development-goals/* accessed on 11 January 2013. The MDGs will be replaced in 2015 under the UN's "post-2015 UN Development Agenda".

the right to health into domestic law in Member States. In this regard, it is to be hoped that its recent Rio initiatives on the social determinants of health may offer a political impetus to deepen its work on the right to health.

7.8 Obligations concerning the acts/ omissions of private entities

We turn then to the question whether private entities assume international law obligations or whether those obligations remain with the State Party. It is instructive to consider first how private entities may be contracted to deliver the AAAQs in a domestic State situation.

There are a range of private non-state actors whose acts or omissions may impact on the right to health. These are: health insurers, hospitals, the medical profession, pharmaceutical industry, suppliers of medical equipment, donor organisations and civil society.[526] As noted, insofar as private actors are now assuming some of the core functions of States in delivering health, States are obliged to "control" their activities to ensure the right to health including its justiciability. This "control" should be exercised through the principle of "due diligence",[527] a principle now applied under international law particularly where the prohibition of torture is at issue.[528]

---

[526] Toebes stresses the interrelationship between private actors and corruption, citing Transparency International as identifying three main characteristics of the health sector that make it so vulnerable to corruption: the imbalance of information that prevails in the health system (health care providers possess more information on health, drugs and illness than their patients); health markets are very uncertain; and health systems are highly complex: B Toebes, *The Impact of Acts of Corruption on the Enjoyment of the Right to Health*, Research Paper for the International Council on Human Rights Policy, Project: Corruption and Human Rights, Research consultant: Aberdeen, Scotland, UK (2007) at 21; citing Transparency International, *2006 Corruption Perceptions Index* at xvii.

[527] McCorquodale cites the endorsement of this concept of due diligence by the Human Rights Committee through its through its General Comment No. 31 which addresses non-state actors; R McCorquodale, *Non-state actors and international human rights law*, in Research Handbook on International Human Rights Law, (eds.) S Joseph and A McBeth, E Elgar (2010) 107. McCorquodale also cites the HRC's General Comment No. 20 on non-discrimination; see above.

[528] See the case of *Elmi v Australia* (2000) 7 International Human Rights Reports 603 before the UN Committee Against Torture, where the fact that the apprehended human rights violations by Mr Elmi would be at the hand of non-state actors in Somalia was considered enough to trigger Article 1 of the Convention Against Torture in relation to the right to protection against r*efoulement*. McCorquodale suggests that States can make non state actors

Insofar as domestic protection and enforcement are key to ensuring the State's duty to "protect" and "fulfil", arguably States must create arrangements with private actors under a national framework law which both allow the State to be in a position to effectively control private activities including through contractual arrangements and regulation and to allow justiciability against those non State actors. Privatisation of health through outsourcing and public private partnerships cannot be used as an excuse for the State not meeting health needs which come within the AAAQs on a non-discriminatory basis, particular regard being had to the rights of vulnerable groups. Similarly, where the private actor reaches a critical mass in the delivery of health care in a particular area, it may be that the private actor, through its contractual obligations with the State, will itself assume legal responsibility for the delivery of the right to health in question. If it cannot demonstrate that it is combating discrimination or is able to provide effective remedies, the State will be liable and this liability may lead States to increasingly place conditionality on privatisation, such as indemnification or making the non state actor financially liable for human rights violations which occurs under its licence.

While the traditional view of international human rights obligations is that it is States who freely assume obligations under international law, rather than private actors, this is changing. States are not the only subjects off international law as the status of intergovernmental organisations (such as the UN, Council of Europe, EU) and IFIs make clear. Similarly, non state actors' international legal capacity can be seen in their right to complain to international bodies under treaty law, as in the *Sunday Times v United Kingdom*[529] seminal judgment on sufficient personality.[530] Non governmental organisations,

---

directly responsible through Declarations in pursuance of a treaty convention and that non state actors in the form of armed opposition group could voluntarily seek to assume treaty obligations as a form of seeking international recognition; R McCorquodale, *Non-state actors and international human rights law*, in Research Handbook on International Human Rights Law, (eds.) S Joseph and A McBeth, E Elgar (2010) 107 at 113.

[529] Application No. 6538/94, Judgment 29 March 1979, 2 EHRR 245..

[530] A Clapham, *Non State Actors under International Law*, Oxford University Press (2008) at 76-91. However, corporations cannot claim a violation of all rights under the ECHR. "The artificial and essentially inhuman nature of corporations impedes their inclusion within the protective confines of these provisions which seek to protect individuals of flesh and blood"; W H A M van den Muijsenbergh and S Rezai, *Corporations and the European Convention on Human Rights* in *The Global Impact and Implementation of Human Rights Norm:*

companies, partnerships and associations can bring applications to both the European Court of Human Rights and the Court of Justice where an entity is individually affected by a measure under EU law.

Normative international human rights standards are now moving towards ensuring that the activities of non state actors are accountable, primarily by placing pressure on States to "control" their activities under its international obligations, but non State actors are also increasingly coming within the framework of international law including through the UNGPs and will increasingly under domestic law be accountable under international standards.[531] A parallel with international environmental law may be observed insofar as financial regulators are said to be under an obligation "to insist that financial institutions fully understand the environmental and social impacts of their policies and procedures and of their individual transactions".[532]

Non state actors are subjects of both national and international law.[533] However, the question of private entity justiciability, i.e. litigation of a claimed right against a private body is more problematic than litigation brought against the State. However, despite the fact that there is no authoritative acceptance of

---

Corporations and the European Convention on Human Rights, Symposium, University of the Pacific, McGeorge School of Law, Pacific McGeorge Global Business & Development Law Journal (2012) at 50.

[531] Backer suggests that "the Guiding Principles have opened a number of significant pathways to the development of law and governance frameworks". In making the case for "the interlacing of international law and domestic legal orders; they recognize the governance aspects of social norm systems and seek a method of institutionalizing that role; they broaden the scope of remediation in a systematic way and attempt to harmonize the principles that serve as markets of legitimacy and accountability for each. The Guiding Principles manage this within an overall framework that still grounds its operation in and through states and which continues to treat corporations and other actors as dependent on and subject to an exclusive (at least in the aggregate) control of states through law in ways that even States now find troublesome"; L C Backer, *From Institutional Misalignments to Socially Sustainable Governance: The Guiding Principles for the Implementation of the United Nations' "Protect, Respect and Remedy" and the Construction of Inter-Systemic Global Governance*, 25 Pacific McGeorge Global Business & Development Law Journal (2012) 69 at 171. Ssenyonjo argues in favour of a global ombudsman function capable of receiving complaints of the adoption of a Statute of an International Court of Human Rights, to which non state actors in addition to States could become parties: M Ssenyonjo, *Economic, Social and Cultural Rights in International Law*, Oxford and Portland Oregon: Hart Publishing (2009) at 108.

[532] D D Bradlow, *The Reform of the Governance of the IFIs, A Critical Assessment*, in *International Financial Institutions and Global Legal Governance* (eds.) H Cisse, D D Bradlow B Kingsbury, The World Bank, Geneva, Vol 3 (2012) 39 at 48-49.

[533] O Fauchald and J Stigen, *Corporate Responsiblity Before International Institutions*, 40 George Washington International Law Review (2009) at 1029.

the "responsibility" of non state actors under international law,[534] clearly a different situation arises under domestic law where States are free to regulate private actions by law.

A framework law could incorporate a justiciable right to health with horizontal effect or permit conditionality in the licencing or contracting of health services. Indeed, under its "control" and remedies obligations (see below), States must ensure this occurs, particularly where the private entity has assumed a certain "critical mass" in delivering the right to health. Indeed, as noted, rendering non state actors liable for human rights violations under domestic law may be necessary where the State is no longer the legal body delivering health goods or services which trigger human rights obligations but is the responsible body under international law.

Conclusions

The conclusions from this section are that a broad encompassing right to health exists under Article 12 of the ICESCR which places concrete legal obligations on States. These obligations include two core non-derogable obligations addressed to the State, namely access to the AAAQs without discrimination and a national health strategy, policy and plan comprising, *inter alia*, indicators and benchmarks to monitor progressive realisation of the right. The three obligations of "respect", "protect" and "fulfil" also address private health. Here, the State must ensure that violations by non-State actors are prevented and "controlled" including through a "preventative" obligation that the State

---

[534] O Fauchald and J Stigen, *Corporate Responsiblity Before International Institutions*, 40 George Washington International Law Review (2009) at 1096. As to NSAs unanswerability under international law, Mehra notes how "[t]he tremendous loopholes in coverage over [private military and security companies] actors under the [1989 UN] Convention Against Mercenaries [i.e. Convention Against Recruitment, Use, Financing, and Training of Mercenaries], the Geneva Convention and other international treaties showcase the urgent need for an international consensus on accountability for the corporate entity and not just for contractors. With expanding voices calling on governments to do more to protect their populations from harm, regulatory models need to be adopted to hold accountable those with the greatest power in today's world: the corporations themselves"; A Mehra, *Bridging Accountability Gaps – the Proliferation of Private Military and Security Companies and Ensuring Accountability for Human Rights Violations*, 22 Global Business & Development Law Journal (2010) 323 at 327. Further, "[i]t is by including corporations under the accountability framework that the obligation to respect human rights is shared across the different entities that can affect them. This is a view consistent with the case law of supervisory bodies of the principal UN human rights treaties [who] have found that privatizing a State's functions – for example the provision of drinking water – does not absolve the State from its responsibility to ensure respect for human rights"; at 331.

regulate private actors who deliver health services, under the "obligation to protect" and through a "reparation" obligation where a violation of the right occurs, which requires judicial or quasi-judicial remedies to victims of violations.

In this respect, legal accountability requires guarantees of "restitution, compensation, satisfaction or guarantees of non-repetition" which obliges the State to provide for a right to health to be litigated before its courts, whether against the State or horizontally against private actors. Where an individual cannot so litigate, this failure of the State will in itself constitute a procedural violation of the right to health unless there are other identifiable mechanisms to provide redress under the national system.[535] Litigation on right to health and resource allocation grounds already occurs in a number of States demonstrating that the right to health is justificiable and that national courts are capable of weighing claims against resource constraints. Domestic right to health litigation should by definition be accessible and include the possibility to claim discrimination in access to the AAAQs and here the respondent – whether State or non-State actor – may be called on to justify differences in treatment on the basis of one's identity. The positive measures required to address discrimination of vulnerable groups reflect the social determinants of health and recent programmatic responses of the WHO and the absence of such measures may also be germane to judicial assessment of differences in treatment.

From the non-State actor's perspective, the "control" obligations inherent under the State's obligation to "respect" will either result in their being rendered liable for violations of the right to health where they are delegated to deliver health services, or being required to indemnify or reimburse claims against the State under conditionality agreements containing "due diligence" protocols. Non-State actors face further regulatory control under the State's

---

[535] Such as the availability of quasi-judicial remedies: see discussion above. Unless such complaints mechanisms can meet the requirements of Article 12 (including access to the AAAQs) they will be insufficient as a remedy under Article 12. As Skogly notes, "the effeicient implementation of rights is more illusionary without redress possibilities"' S Skogly, *The Human Rights Obligations of the World Bank and the International Monetary Fund,* Cavendish Publishing Ltd London (2001) at 196.

obligation to "protect" and their activities will need to come within the National Strategy and Action plan under a framework law, under the State's obligation to "fulfil". Under developing international law, including the UN Guiding Principles, it is likely that justiciability against non-State health providers will increase as is already the case under EU competition law.

Building on the transformative jurisprudence of the positive obligations doctrine of the ECHR and the competence-driven jurisdiction of the Court of Justice, we identified the strengths and weaknesses of CESCR's oversight including its elaboration of what benchmarks and indicators are required under a national health system. We observed how this oversight may strengthen with the coming into effect of its Optional Protocol on individual complaints and through enhanced complementary approaches with the programmatic work of the WHO and indeed the UN's international financial institutions, including the WTO. Authoritative oversight by the ICESCR will invariably inform the approach of other treaties bodies, the European Court of Human Rights and the Court of Justice where it implements Article 35 of the Charter.

PART 2

8 The right to health under Irish law

In Part 1, we examined the scope of the right to health under international law including the two core non-derogable rights of prohibition of discrimination in health and the requirement of States for a national public health strategy and plan of action which *inter alia* protects vulnerable groups. International law clearly obliges States not only to refrain from interfering with the personal rights of individuals on health grounds unless proportionate, but also to ensure that individuals access entitlements to health such as the AAAQs without discrimination. We also considered the extent to which international law may place obligations on private bodies, whether directly or more commonly, indirectly through the "control" required to be exercised by the State. We considered the "reparation obligation" on the State comprising both regulatory and legal accountability mechanisms and in relation to legal accountability, the requirement that individuals whose right to health is violated by a public or private body be able to claim redress.

In Part 2, we turn to Irish law. We trace the scope of the right to health under domestic law, considering first the nature of the penetration of international law into domestic law. We then consider fundamental rights under the Constitution including the unenumerated right to bodily integrity and the sources of such a right. The sources of constitutional rights necessitate consideration of Natural Law theory and the role of Articles 45 and 6 in providing sources of justiciable unenumerated rights. We consider how a right to health may also be located under the enumerated right to the person.

Next we consider the Separation of Powers doctrine, how constitutional issues are pled where statute or common law rights may be available and the role of judicial deference in vindicating constitutional rights. Turning to private actors, we consider the role of judicial review where public functions are at issue and the potential role of constitutional and legislative control doctrines. We will conclude by examining the principle of equality under Article 40.1 and whether there is a horizontal constitutional right to health which unites constitutional and tort law. Insofar as the analysis will consider the intersectionalities

between constitutional and common law norms as they seek to regulate (or "control") the acts or omissions of private actors, the challenges facing other States with similar constitutional traditions will become apparent. Challenges include where legislative entitlements to a right to health are undefined and may lead to judicial restraint in recognising a justiciable right to health. Challenges may also include how the international right to health is given expression to and how EU competition law constraints may become activated in private health insurance markets weakening accessibility of health services for all regardless of ability to pay. The challenges facing Ireland are shared by other States in the formulation of domestic health systems and the domestic law which must underpin those systems and balance human rights law and anti-trust rules.

The protection of the right to health under Irish law can be located in three legal tiers in descending order: the 1937 Constitution: Bunreacht na hÉireann, legislative provisions such as those under the Health Acts 1947-2007 (or indirectly the European Convention on Human Rights Act 2003) and common law principles. Of these, constitutional law is superior.[536] Under constitutional law, there is no right to health *per se*. The right to life is set out in Article 40.3 subparagraphs 1 and 3 and within this formulation is included some elements of a right to health. However, it is under the unenumerated rights doctrine developed by the Irish courts, that the right to health has been implied, both under a right to bodily integrity and a right to autonomy/ privacy which will be discussed below.

As will be observed, this doctrine has, however, suffered a reversal in recent years. In *TD v Minister for Education*[537] Keane J articulated a significant reservation to the unenumerated rights doctrine and in light of the Supreme

---

[536] Save for those provisions of EU law which have direct effect - see Article 29.4.10 of the Constitution, discussed further below. See generally on the Irish Constitution J Kelly, *Fundamental Rights in Irish Law and Constitution* (4th ed.), Tottel Publishing (Hogan and Whyte) (2003), J Casey, *Constitutional Law in Ireland* (3rd Ed.) RoundHall (2000), O Doyle, *Constitutional law: Text, Cases and Materials* Dublin: Clarus Press (2008), M Forde, *Constitutional Law* (2nd Ed.) First Law (2004), D G Morgan, *Constitutional Law in Ireland* (2nd Ed.) Roundhall Press (1990).

[537] [2001] 4 IR 259.

Court judgments in both *Sinnott v Minister for Education*[538] and *TD*, the courts came close to an outright rejection of economic or social rights as justiciable rights under the Constitution.[539] Shortly prior to these cases, the same Supreme Court rejected the concept of natural law rights as being superior to the Constitution.[540]

It is to constitutional law that one primarily turns to determine the level of protection of human rights in Irish law. As we shall see, there is no definition of a right to health under statute law insofar as the Health Acts 1947-2007 provide for structural processes of treatment, but not a right to a particular aspect of health, save for persons who come within certain entitlement definitions (for example persons with a disability under the Disability Act 2005). A right to health under the European Convention on Human Rights Act 2003 ("the ECHR Act") may arguably be located under Strasbourg jurisprudence where no other remedy under Irish law exists, but as will be observed, there are significant limitations under the Act.[541] Neither is there a right to health under the common law *per se*. Rather, there is the possibility of justiciability through suing in contract where a private health arrangement exists or suing in tort for negligence, nuisance or trespass, but only where a duty of care is owed. Here the courts have held that the constitutional right to bodily integrity is mediated through the law of torts unless they are "basically ineffective." Of the available torts, medical negligence is the vehicle through which most right to health claims are adjudicated in Ireland. Whether domestic law remedies effectively vindicate the totality of the right to health as identified in Part 1 of this thesis will depend on an assessment of cumulative constitutional, legislative and tortious remedies available to individuals. Before

---

[538] [2001] 2 IR 545.

[539] In *TD*, Murphy J stated *obiter* that there were "serious arguments against inferring the existence of positive socio-economic rights (apart from the anomalous rights relating to education) but there are impressive authorities to the contrary"; [2001] 4 IR 259 at 318.

[540] See *In Re Article 26 and the Regulation of Information (Services Outside the State for Termination of Pregnancy) Bill 1995* Judgment [1995] 1 IR 1.

[541] The Irish Act, being sub-constitutional in its interpretative scope, compares unfavourably to its UK counterpart (the Human Rights Act 1998) on which it was based. However even the UK Act has limited applicability to right to health claims brought under the tort of negligence except where "positive duties" of the State may be inferred: see M A Jones, *Medical Negligence* (4th Ed.) Sweet & Maxwell (2008) at 59.

proceeding to discussion of the law of torts, it is necessary to first discuss the protection of rights under constitutional and statute law.

8.1 Dualism: The penetration of international conventions into domestic law

Identifying sources of law would not matter of course if the provisions of the RESC, ICESCR or ECHR were directly incorporated into domestic law permitting one to directly invoke their provisions before the High Court once the State ratifies the relevant convention, as is the case with many "monist" States.[542] However, the provisions of Article 29.6 of the Constitution provides that no international agreement shall be part of the domestic law of the State "save as may be determined by the Oireachtas."[543]

The provisions of international conventions do not form a part of Irish law until such time as an Act of the Oireachtas introduces the right, as confirmed in *In Re O Laighleis.*[544] A similar argument defeated the claim in *Kavanagh v Governor of Mountjoy Prison,*[545] where the applicant sought to invoke the ICCPR in aid of his argument that the impugned statutory provision was repugnant to the Constitution.[546] The State has incorporated parts of

---

[542] It should be noted, however, that some monist States do not permit not direct incorporation of convention rights. Rather, internal effect is to be given to those rights, with the precise nature of incorporation being a matter for the Executive: see B Toebes and M San Giorgi, *Dutch realities: evaluating the Dutch health care reform from a human rights perspective* (draft chapter) in *The right to health: a multi-country study of law, policy and practice* (Eds B Toebes, R Ferguson, M Markovic and O Nnamuchi), TMC Asser Press/Springer (due 2014) at 15.

[543] The Oireachtas is the Irish Parliament: Article 15(1) of the Oireachtas provides: "1° The National Parliament shall be called and known, and is in this Constitution generally referred to, as the Oireachtas. 2° The Oireachtas shall consist of the President and two Houses, viz.: a House of Representatives to be called Dáil Éireann and a Senate to be called Seanad Éireann."

[544] [1960] IR 93. The argument that the impugned statute were contrary to international law including the provisions of the ECHR was rejected by Maguire CJ who observed how "Clauses 1 and 3 of Article 29 of the Constitution clearly refer only to relations between states and confer no rights on individuals"; at 124.

[545] [2002] IESC 13.

[546] [2002] IESC 13. The plaintiff had had a prior complaint on the issue upheld by the Human Rights Committee under the Optional Protocol to the ICCPR and the Committee's findings are set out in paras 7-13 of the Judgment. In *Kavanagh*, Fennelly J noting how in *In Re O Laighleis* the court had held that "there was "an insuperable obstacle" to importing the provisions of the ECHR into domestic law. Insofar as Article 15.2.1 provides that the "sole and

international conventions into Irish law[547] through legislation as in the enactment of the ECHR Act, arguably, an obligation of the Belfast Agreement and incorporated subconstitutionally in an interpretive manner.[548] Nearly 10 years later, the limits of the ECHR Act are clear.[549] In *McD v PL and BM*[550],

---

exclusive power of making law for the State" is the Oireachtas, Article 29(6) set out a second obstacle which in Fennelly J's opinion meant that "[n]o argument can prevail against the express terms of section 6 of Article 29 of the Constitution before judges whose declared duty is to uphold the Constitution and the laws"; at para 33. See also *McD v PL and BM* [2010] 2 IR 199 per Murray CJ, discussed below.

[547] The Child Care Act 1991 implements aspects of the 1990 UN Convention on the Rights of the Child relating to matters such as separation of children from their parent(s). Article 9 of the Convention on the Rights of the Child provides that a child shall not be separated from his or her parents against their will, except when competent authorities subject to judicial review determine, where separation is necessary for the best interests of the child and the views of the child are sought. In similar manner, the Refugee Act 1996 was enacted to give effect to the provisions of the 1951 UN Convention relating to the Status of Refugees such as the prohibition of *refoulement* under Section 6. The Criminal Justice (United Nations Convention Against Torture) Act 2000 was enacted to give effect to parts of the convention of that name such as establishing the "offence of torture" under Section 2.

[548] 1998 Bilateral agreement between the United Kingdom and Republic of Ireland also known as The Good Friday Agreement; see the requirement of "equivalent" protection of human rights under Strand Three entitled 'Rights, Safeguards and Equality of Opportunity'; at para 9. See *www.nio.gov.uk/agreement.pdf* accessed on 21 October 2012. See also A Morgan, *The Belfast Agreement, a practical legal analysis*, The Belfast Press London (2000). The United Kingdom, a similar 'dualist' state and the last but one Council of Europe State to give effect to the ECHR in domestic law (Ireland being the last), had already incorporated the Convention into its law in 1998 in the form of the Human Rights Act. Ireland borrowed the limited form of incorporation in the UK legislation and even then did not go as far. In deciding not to incorporate the Convention at the constitutional level, the State was restricted in how it could incorporate the Convention, in particular the extent to which courts could strike down incompatible laws. See also J Kelly, *Fundamental Rights in Irish Law and Constitution* (4th ed.), Tottel Publishing (Hogan and Whyte) (2003), Preface. The ECHR Act was stated to be for the purpose of incorporating the Convention into domestic law but did not do so directly, rather introducing certain of the "convention provisions" (Articles 2-14 of the Convention and several Protocols) into Irish law on a sub-constitutional interpretative level. The recital to the ECHR Act states that it is an Act to "enable further effect to be given, subject to the Constitution, to certain provisions of the Convention…". The rationale behind the ECHR Act affords insight into the State's relationship with international law instruments generally. The rationale was stated to be that Ireland supplement constitutional rights insofar as "the list of rights" protected by the Constitution was considered "by contemporary standards incomplete" Minister for Justice, Equality and Law Reform John O'Donoghue T.D. referring to the consideration of the Constitutional Review Group 1996, at the Second Stage Debate, European Convention on Human Rights Bill, 2001: 14 June 2001 Dáil Eireann Debate, *Vol. 538 No. 2,* see *http//:debates.oireachtas.ie/dail/2001/06/14/00007.asp* accessed on 21 October 2012. It was also argued that sub-constitutional incorporation would mean there would be no dimunition in constitutional rights protection, a novel rationale for limiting the application of a human rights convention. Speaking at the Second Stage Reading of the Bill, Minister for Justice, Equality and Law Reform John O'Donoghue T.D. included the views expressed by the Constitution Review Group in its1996 report among the reasons advanced not to directly incorporate the Convention into Irish law: see Second Stage Debate, European Convention on Human Rights Bill, 2001: 14 June 2001 Dáil Eireann Debate, *Vol. 538 No. 2,* see *debates.oireachtas.ie/dail/2001/06/14/00007.asp* accessed on 21 October 2012.

[549] See the *ex tempore* remarks of Judge Laffoy who suggested the means of redress of violations of rights and the remedies available afford superior protection than is available under

Murray CJ stated that "the Convention does not of itself provide a remedy at national level for victims whose rights have been breached by reference to the provisions of the Convention", while Denham CJ in *MD (Minor) v Ireland, AG & DPP*[551] confirmed that it does not have direct effect.[552] In *Fleming v Ireland*[553] Kearns P clarified that "[p]utting it in simple terms, the Convention does not have direct effect in this jurisdiction" insofar as it "does not operate in a free standing way, nor can it override the provisions of the Constitution." In addition, the courts were required to give precedence to existing rules of law relating to such interpretation and application.[554]

The Constitution also provides for the possiblity of constitutional amendment to give effect to an international obligation, an example being the Twenty First

---

the ECHR Act 2003 or under the Convention generally: M Laffoy, *Human Rights Protection: The Role of the Irish Constitution* (2012) at 14, Paper at the 10th Annual Human Rights Conference of the Law Society of Ireland and the Irish Human Rights Commission, *Promoting and Protecting Human Rights in Ireland, The Role of the Irish Constitution and European Law* see *www.ihrc.ie/publications* accessed on 21 October 2012.

[550] [2010] 2 IR 199 at 255.

[551] [2012] 2 ILRM 305.

[552] [2012] 2 ILRM 305 at 324. The term "direct effect" was employed by the High Court to distinguish between those rights directly effective and thus capable of being directly invoked before the court under EU law and those rights available under the ECHR Act 2003 which are not capable of being directly invoked as a consequence of being sub-constittuional and indirect and which are not "necessitated" under EU law requirements. The distinction between dualist and monist States in terms of incorporation of human rights norms may sometimes be misleading: monist States give internal effect to such rights upon ratification insofar as the relevant convention provisions become part of the domestic legal order. This can be distinguished from "direct effect" which refers to rights which, given their wording and scope are justiciable before national courts and the courts are willing to adjudicate cases on the basis of these norms. An example of an internal as opposed to a direct effect for the right to health can be observed under Article 120 of the Constitution of the Netherlands (a monist State) which provides: 'The constitutionality of Acts of Parliament and treaties shall not be reviewed by the courts'. Thus, although there is a right to health both under the ICESCR, RESC (through the Netherlands monist system) and a promotional right guaranteed under Article 22(1) of the Constitution of the Netherlands (which states: 'The authorities shall take steps to promote the health of the population'), due to the supremacy of Dutch legislation, the courts are precluded from reviewing the constitutionality of domestic legislation even where aspects of the legislation (such as the 2006 Health Insurance Act (ZVW)) may not satisfy the international right to health; available at *www.wipo.int/wipolex/en/text.jsp?file_id=191759* See also The World Health Organization, *The new Dutch health insurance scheme: challenges and opportunities for better performance in health financing*, Discussion Paper No 3, World Health Organization (2007) available at *apps.who.int/iris/bitstream/10665/85673/1/HSS_HSF_DP.07.3_eng.pdf*

[553] 10 January 2013, unreported.

[554] 10 January 2013, unreported at paras 161-162.

Amendment to the Constitution in 2002[555] which prohibited the death penalty and gave effect to Protocol No. 6 Article 1 of the ECHR[556] and Protocol 2 Article 1 of the ICCPR.[557]

8.2 European Union law

It is noteworthy that in contrast to the ECHR Act, the Executive saw fit to amend the Constitution by successive referenda to incorporate EU treaties into the Constitution, most recently the Treaty of Lisbon which as noted in Part 1 of this thesis, now also incorporates the Charter of Fundamental Rights directly into Irish law.[558] Under the doctrine of supremacy and by virtue of Article 29.4.6, the provisions of EU law are superior to Irish law where acts or measures "are necessitated" by Ireland's obligations of membership of the EU.[559] Barrington J in *Crotty v An Taoiseach*[560] when considering the State's proposed ratification of the Single European Act, noted how without constitutional amendment

---

[555] See Twenty-first Amendment of the Constitution Act, 2001.

[556] Protocol No. 6 to the Convention for the Protection of Human Rights and Fundamental Freedoms concerning the abolition of the death penalty, Strasbourg, 28.IV.1983.

[557] Second Optional Protocol to the International Covenant on Civil and Political Rights, aiming at the abolition of the death penalty, Adopted and proclaimed by General Assembly resolution 44/128 of 15 December 1989. See also the Thirty First Amendment to the Constitution incorporating some aspects of Article 19 of the Convention on the Rights of the Child into Irish law; see Thirty-first Amendment of the Constitution (Children) Act 2012.

[558] See Article 29.4.6 of the Constitution. See generally O Doyle, *Constitutional law: Text, Cases and Materials* Dublin: Clarus Press (2008). Doyle notes how these amendments have been directed at securing full force and effect to Community law within the Irish legal order and, in the event of conflict, precedence: see Introduction to Chapter 14.

[559] Article 29.4.6 provides: "... No provision of this Constitution invalidates laws enacted, acts done or measures adopted by the State, before, on or after the entry into force of the Treaty of Lisbon, that are necessitated by the obligations of membership of the European Union...or prevent laws enacted, acts done or measures adopted by [the EU or its bodies] from having the force of law in the State", thus immunising laws acts or measures enacted or taken on foot of EU law obligations from constitutional challenge and giving effect to the doctrine of "supremacy" of EU law: see *www.taoiseach.gov.ie/eng/Publications/Publications_Archive/Publications_2012/Bunreacht_na_h%C3%89ireann-Aug2012.pdf* For an account of the history of Article 29.4.6 (formerly Article 29.4.3, Article 29.4.5, Article 29.47 and Article 29.4.10) since the 10 May 1972 Third Amendment of the Consitution to 2002, see J Kelly, *Fundamental Rights in Irish Law and Constitution* (4th ed.), Tottel Publishing (Hogan and Whyte) (2003) at 514, fn 101.

[560] [1987] IR 713.

> [t]he immunity from constitutional challenge conferred by the second sentence of the Third Amendment on laws enacted, acts done or measures adopted by the Community or its institutions would therefore have been meaningless as those laws, acts or measures would not have been part of the domestic law of this country.[561]

Following this constitutional amendment, it was necessary to introduce the European Communities Act 1972 which would have otherwise been unconstitutional,[562] so found by the Supreme Court in *Meagher v Minister for Agriculture*[563] where section 3(2) of the 1972 Act was upheld on the basis that "[t]he power of regulation-making ... is part of the necessary machinery which became a duty of the State upon its joining the Community and therefore necessitated by that membership".[564] Any ministerial exercise of the power of making regulations would be presumed constitutional.[565] The significance of Article 29.4.10 and the *Meagher* judgment is that EU law will have direct effect in Irish law even where the transposing law is in the form of secondary regulation.

8.3 The European Convention on Human Rights Act 2003

The European Convention on Human Rights Act 2003 ("ECHR Act") was enacted on a sub-constitutional basis. While the courts have made clear that its provisions do not of themselves provide a remedy at national level for victims whose rights have been breached by reference to the provisions of the

---

[561] [1987] IR 713 at 757.

[562] O Doyle, *Constitutional law: Text, Cases and Materials* Dublin: Clarus Press (2008), Chapter 14 at para 14.07.

[563] [1994] 1 IR 329.

[564] [1994] 1 IR 329 at 351-352. Section 3(2) of the 1972 Act provides that regulations may contain such incidental, supplementary and consequential provisions as appear to the Minister necessary including provisions repealing, amending or applying, with or without modification, other law, exclusive of the Act. See also *City View Press Limited v An Comhairle Oiliúna* [1980] 381 as interpreted in *Maher v Minister for Agriculture* [2001] 2 IR 139 per Keane CJ; discussed further below.

[565] The import of the court's decision is that Article 15.2 would not apply to such regulations, per Denham J in *Maher* at 364.

Convention insofar as they do not have direct effect (*MD v Ireland*[566]), this does not mean that the Act has no effect.

The main provisons of the ECHR Act are sections 2 to 5. Section 2(1) provides that a Court must interpret and apply any statutory provision or rule of law in a manner compatible with the State's obligations under the Convention provisions.[567] In *Donegan v Dublin City Council*[568], the Supreme Court considered that section 2 did not modify established principles concerning interpretation of statutes.[569]

---

[566] *MD (Minor) v Ireland, AG & DPP* [2012] 2 ILRM 305 at paras 42-44.

[567] Section 2 of the ECHR Act provides: " (1) In interpreting and applying any statutory provision or rule of law, a court shall, in so far as is possible, subject to the rules of law relating to such interpretation and application, do so in a manner compatible with the State's obligations under the Convention provisions. (2) This section applies to any statutory provision or rule of law in force immediately before the passing of this Act or any such provision coming into force thereafter." "Convention provisions" are defined in section 1 as "Articles 2 to 14 of the Convention" and the rights under Protocols 1, 4, 6 and 7. Sections 2 to 5 of the ECHR Act are based on the Human Rights Act 1998 albeit with further restrictions. Thus Section 3(1) of the UK's 1998 Act provides: "So far as it is possible to do so, primary legislation and subordinate legislation must be read and given effect in a way which is compatible with the Convention rights." Section 2 of the Irish legislation introduces a second caveat to "in so far as is possible" with the clause "subject to the rules of law..." The manner in which section 2 is applied has not been clearly set out in ECHR Act jurisprudence to date.

[568] [2012] 2 ILRM 233.

[569] Considering the impact of section 2 on the meaning of section 62(3) of the Housing Act 1966, McKechnie J for the majority held that, insofar as the principles in relation to the interpretation of statutes precluded an ability of the courts to adjudicate on issues, including issues of fact, extraneous to the specified requirements of the section and to exercise discretion of the type envisaged in the questions he had posed earlier, section 2 could not avail the plaintiffs: "105. It is quite clear that the Oireachtas has directed that every statutory provision or rule of law should be given a Convention construction if possible; that is a construction compatible with the State's obligations under the Convention. Therefore if such a construction is reasonably open it should prevail over any other construction, which although also reasonably open, is not Convention compliant. Even in cases of doubt, an interpretation in conformity with the Convention should be preferred over one incompatible with it. However, this task must be performed by reference to the rules of law regarding interpretation. These rules, have been variously described in many cases over the years such as *McGrath v. McDermott* [1988] I.R. 258 *and Howard v. Commission of Public Works* [1994] 1 I.R. 101. 106. The reason why it is not necessary to further explore the relationship between the provisions of s. 2 of the Act of 2003 and the rules of interpretation and application referred to in this section, is that if a violation of Article 8 should be found to exist, the only manner of rendering s. 62(3) of the Act of 1966 compatible with the Convention is to read into it a facility, accompanied by attendant supports, which has the capacity to deal with the applicants' complaints, as described at para. 98 supra. Such result could not be achieved by any manner of permissible interpretation. Therefore, at least for the purposes of this case, s. 2 of the Act of 2003 has no affect on s. 62(3) of the Act of 1966. Consequently, in accordance with cases such as *State (O'Rourke) v. Kelly, Hamilton* and *Fennell*, it remains the position that, on a s. 62 application, any challenge, intra-provision which can be made, is restricted to the conditions specified in subs (1) thereof. Therefore, neither the position of Mr. Donegan nor that of Mr. Gallagher is enhanced by reason of the Act of 2003". For a review of the judgment see M

This requirement on the courts to interpret and apply law in a convention compliant manner is supplemented by section 4 of the Act which requires the courts to take judicial notice and due account of Convention provisions and of the principles laid down in the decisions of the Strasbourg organs in interpreting and applying law, thus requiring a focus on both the principles and the reasoning underlying those principles.[570] In *Pullen & Ors v Dublin City Council*[571], Irvine J employed section 4 in aid of her finding that the plaintiffs'

Laffoy, *Human Rights Protection: The Role of the Irish Constitution* (2012) at 14, Paper at the 10th Annual Human Rights Conference of the Law Society of Ireland and the Irish Human Rights Commission, *Promoting and Protecting Human Rights in Ireland, The Role of the Irish Constitution and European Law* see *www.ihrc.ie/publications* accessed on 21 October 2012. The approach in *Donegan* differs from that of the House of Lords in *Ghaidan v Godin-Mendoza (FC)* [2004] UKHL 30 where the interpretative provisions of the Human Rights Act 1998 were invoked to allow the House of Lords to "read in" certain rights and to permit the court to have regard to the underlying social policy inherent in the statutory provision under scrutiny. The Court thus read words into the UK Rent Act 1977 (as amended) so as to extend entitlement to succession rights to a tenancy to Mr Ghaidan, the same-sex partner of a deceased tenant. Was this not an 'impossible' interpretation to give to the relevant statute? Nicholls LJ thought not: "...the mere fact the language under consideration is inconsistent with a Convention-compliant meaning does not of itself make a Convention-compliant interpretation under section 3 impossible. Section 3 enables language to be interpreted restrictively or expansively. But section 3 goes further than this. It is also apt to require a court to read in words which change the meaning of the enacted legislation, so as to make it Convention-compliant. In other words, the intention of Parliament in enacting section 3 was that, to an extent bounded only by what is 'possible', a court can modify the meaning, and hence the effect, of primary and secondary legislation."; at para 32. Commenting on the thin line between what is 'possible' and 'impossible', Nicholls LJ suggested this could be settled by having regard to the "*underlying thrust of the legislation being construed*" para 33., while Steyn LJ considered there was a strong rebuttable presumption in favour of a Convention interpretation: "What is necessary, however, is to emphasise that interpretation under section 3(1) is the prime remedial remedy and that resort to section 4 [a declaration of incompatibility] must always be an exceptional course. In practical effect there is a strong rebuttable presumption in favour of an interpretation consistent with Convention rights." at para 50.

[570] Section 4 provides: "Judicial notice shall be taken of the Convention provisions and of - (a) any declaration, decision, advisory opinion or judgment of the European Court of Human Rights established under the Convention on any question in respect of which that Court has jurisdiction, (b) any decision or opinion of the European Commission of Human Rights so established on any question in respect of which it had jurisdiction, (c) any decision of the Committee of Ministers established under the Statute of the Council of Europe on any question in respect of which it has jurisdiction, and a court shall, when interpreting and applying the Convention provisions, take due account of the principles laid down by those declarations, decisions, advisory opinions, opinions and judgments."

[571] [2008] IEHC 379. Here the plaintiffs had "every chance of becoming homeless at worst or at best spending a significant period of time living in bed and breakfast accommodation, jeopardising personal and family relationships".

rights had been violated. Otherwise, references to sections 2 and 4 of the Act have been limited in Irish jurisprudence to date.[572]

The two substantive provisions of the ECHR Act are sections 3 and 5. Section 3(1) introduces a statutory duty on "every organ of the State" to perform its functions in a manner compatible with the ECHR, absent any statutory provision or rule of law negating this statutory duty, with a claim in damages available where such a violation occurs.[573] Section 3(1) was applied in *O'Donnell v South Dublin County Council*[574] where Laffoy J found that the respondent had violated the rights of a Traveller family under Article 8 of the ECHR in not providing them with proper services.[575] Addressing a housing eviction for alleged anti-social behaviour, Irvine J found a violation of Article 8 of the ECHR when read with section 3(1) in *Pullen.*[576] However, in *Doherty*

---

[572] In *Pullen*, Irvine J concluded: "Having regard to provisions of s. 4 of the Act of 2003, I must pay particular regard to the most recent pronouncements of the European Court of Human Rights in relation to Article 6 and Article 8"; at para 21. "...(vii) The defendant did not comply with its obligations under s. 3 of the Act of 2003 and did not perform its functions in a manner compatible with the State's obligations under the Convention. (viii) The defendant, in performing its functions as an organ of the State, failed to have regard to the plaintiffs' rights under Article 6(1) of the Convention"; at para 21.4.

[573] Section 3(1) ECHRA provides: "Subject to any statutory provision (other than this Act) or rule of law, every organ of the State shall perform its functions in a manner compatible with the State's obligations under the Convention provisions", while section 3(2) provides for a residual remedy in damages: "A person who has suffered injury, loss or damage as a result of a contravention of subsection (1), may, if no other remedy in damages is available, institute proceedings to recover damages in respect of the contravention in the High Court (or, subject to subsection (3), in the Circuit Court) and the Court may award to the person such damages (if any) as it considers appropriate." Whereas section 3 is predicated upon section 6 of the UK 1998 Act, as with section 2, section 3 imports an additional conditionality, namely the stipulation that the statutory duty will only apply where a statutory provision or rule of law does not otherwise require a different response from the organ of State.

[574] Unreported, 22 May 2007.

[575] In *O'Donnell*, Laffoy J found that if there is no statutory protection for the plaintiffs in their current predicament, their situation must represent a failure of the State and its organs to function in a manner compatible with Article 8 of the ECHR. In *O'Donnell & Ors v South Dublin County Council & Ors* [2008] IEHC 454, Edwards J found that the Article 8 rights of the fourth named applicant, a Traveller child with cerebral palsy who was confined to a wheelchair had been violated, in the failure by the Council to address overcrowding in the family's caravan accommodation. The Judge otherwise endorsed the approach of Charleton J in *Doherty & Doherty v South Dublin County Council* 2 IR [2007] 696 who held that inadequate accommodation of elderly Travellers did not violate their Article 8 rights; see below.

[576] [2008] IEHC 379.

& Doherty v South Dublin County Council[577] Charleton J held against the plaintiffs' Article 8 arguments, citing *inter alia*, the separation of powers doctrine.[578]

Under section 5 of the ECHR Act, where a statutory provision or rule of law permits an organ of the State to act in a manner incompatible with the State's obligations under the Convention provisions, this invites a "declaration of incompatibility" leading to the declaration being laid before the Houses of the Oireachtas, with the prospect of consequential amending legislation.[579]

Despite the enactment of the ECHR Act in 2003, the first declaration of incompatibility under section 5 was made in *Foy v An t-Ard Chlaraitheoir & Ors*[580] in 2008, which concerned the refusal to recognise the new status of a

---

[577] 2 IR [2007] 696.

[578] In *O'Donnell* the inadequate caravan accommodation of elderly Travellers did not violate their rights under Article 8 of the ECHR, however the court did not directly address section 3 of the ECHR Act, preferring to rely on the jurisprudence of the European Court of Human Rights. Citing Hardiman J's judicial restraint comments in *TD*, Charleton J suggested that the relief available to the plaintiffs would have been declaratory rather than mandatory had a substantive violation of the Housing Acts 1966-1988 been found; 2 IR [2007] 696 at 725.

[579] Section 5(1) provides: "(1) In any proceedings, the High Court, or the Supreme Court when exercising its appellate jurisdiction, may, having regard to the provisions of section 2, on application to it in that behalf by a party, or of its own motion, and where no other legal remedy is adequate and available, make a declaration (referred to in this Act as ''a declaration of incompatibility'') that a statutory provision or rule of law is incompatible with the State's obligations under the Convention provisions." Article 5(2) provides that such a declaration, "shall not affect the validity, continuing operation or enforcement of the statutory provision or rule of law in respect of which it is made" or indeed interfering with an application to Strasbourg, thus leading to the question as to the rationale for having the provision in the first place, save on grounds of separation of powers principles. It is true that the Taoiseach is obliged to place the order of incompatibility before the Oireachtas within 21 days (section 5(3)) and that there is provision for a discretionary *ex-gratia* compensation being paid by the State in sections 5(4) and (5), however the fact that recent declarations of incompatibility have not resulted in relief for the plaintiffs or amendments to offending legislation has not been encouraging, while the limitations on section 5 relief were clearly set out in *Carmody v Minister for Justice* [2010] ILRM 157: "As can be seen from the foregoing the nature of the remedy, such as it is, provided by s. 5 of the Act of 2003 is both limited and *sui generis*. It does not accord to a plaintiff any direct or enforceable judicial remedy. There are extra-judicial consequences whereby the Taoiseach is obliged to lay a copy of the order containing a declaration before each House of the Oireachtas within 21 days. That is the only step which is required to be taken under national law in relation to the provisions concerned. Otherwise it rests with the plaintiff who obtained the declaration to initiate an application for compensation in writing to the Attorney General for any alleged injury or loss or damage suffered by him or her as a result of the incompatibility and then it is a matter for the discretion of the Government as to whether or not they should pay any such compensation on an *ex gratia* basis... a declaration of incompatibility pursuant to s. 5 of the Act of 2003 cannot be said to be a remedy which would resolve the issue between the parties"; at paras 41 and 46.

[580] [2007] IEHC 470.

transgender woman and in which McKechnie J found a violation of Article 8 of the ECHR.[581] The first grant of a section 5 declaration by the Supreme Court was in 2012 in *Donegan*, a case concerning summary eviction by a local authority without allowing the tenant refute anti-social allegations against him, where "in light of the decision given above and noting the absence of any other adequate legal remedy", the court granted such a declaration in relation to section 62(3) of the Housing Act 1966.[582] Right to health arguments have not been directly advanced in ECHR Act jurisprudence to date.[583] The efficacy of the Act has been unarguably limited. However, insofar as ECHR arguments can now be pled before the courts and will often be considered last[584], those arguments will inform the court's consideration of the constitutional arguments advanced in the case.[585]

8.4 The Equal Status Acts 2000-2012

Ireland has legislated against discrimination on the basis of one's status under the Employment Equality Acts 1998-2011 and the Equal Status Acts 2000-2012, thus arguably allowing the State to meet its obligations to "respect, protect and fulfil" the right to health under the Equal Status Acts.[586] Once a complainant establishes the existence of a *prima facie* case of discrimination in

---

[581] "As Dr. Foy cannot obtain from this Court any relief other than a declaration of incompatibility, I propose to issue such a declaration as in my opinion the circumstances of this case entirely justify it"; [2007] IEHC 470 at para 115 per McKechnie J. Section 25 of the Civil Registration Act 2004 has not been amended to date, despite the court's judgment.

[582] [2012] 2 ILRM 233 at para 159.

[583] The right to health in housing under section 24 of the Housing Act 1988 was raised in *O'Donnell*.

[584] See *Carmody v Minister for Justice* [2010] ILRM 157 in relation to section 5 relief where the court stated that "an issue as to the constitutionality of a statute should first of all be addressed by the court when the only other issue is a claim for a declaration pursuant to s. 5 of the Act of 2003"; at para 47.

[585] The argument that constitutional protections exceed those under the ECHR gains credence where the courts identify a constitutional right under the constitution. In doing so, the courts also avoid their judgments being subject to adverse scrutiny in Strasbourg as occurred in *McFarlane v. Ireland*, Application No. 31333/06, Judgment, 10 September 2010 (Hudoc 2010), at paras 120-124.

[586] The Employment Equality Acts concern employed-related discrimination.

the provision of a good or service, the burden of proof will shift to the respondent to rebut the inference of discrimination raised; a test consonant with the international standard of non-discrimination.[587] There are nine exhaustive grounds of prohibited discrimination under section 3(2) of the Equal Status Acts, namely gender, civil status, family status, sexual orientation, religion, age, disability, race and Traveller community.[588] However, discrimination of vulnerable groups in access to goods or services on "other status" grounds such as socio-economic or health status is not prohibited.

Whereas barriers in accessing health services exist for persons from vulnerable groups,[589] there are, however, limited remedies available under the Equal

---

[587] Section 38A was inserted under the Equality Act 2004 which provides: "(1) Where in any proceedings facts are established by or on behalf of a person from which it may be presumed that prohibited conduct has occurred in relation to him or her, it is for the respondent to prove the contrary. (2) This section is without prejudice to any other enactment or rule of law in relation to the burden of proof in any proceedings which may be more favourable to the person. (3) Where, in any proceedings … facts are established by or on behalf of the Authority from which it may be presumed that prohibited conduct or a contravention mentioned in that provision has occurred, it is for the respondent to prove the contrary." Otherwise put, "[w]hat must be shown for such discriminatory treatment to be established, on the balance of probabilities, is that such treatment is less favourable to the complainant. Therefore, it must be noted that in certain circumstances, difference of treatment is justifiable in law because the treatment, while different, is not de facto less favourable"; see *A Patient v Health Service Provider and a Hospital* File reference: ES/2008/0222 and ES/2009/0005, 1 December 2010 at para 6.3.4, available at *www.equalitytribunal.ie/en/Cases/2010/December/DEC-S2010-053-Full-Case-Report.html* See also *Gerard Byrne v Health Service Executive*, File Reference: ES/2011/001, Decision 5 September 2012 at para 5.1, available at *www.equalitytribunal.ie/en/Cases/2012/September/DEC-S2012-035-Full-Case-Report.html* In *Byrne* the Tribunal rejected the claim that non-nationals were more favourably treated than nationals in terms of assistance for door repairs in local authority housing; at paras 5.1-5.7. A similar test applies under section 11(5) of the Equal Status Acts 2000-2012 in relation to harassment claims where a *prima facie* case of harassment within the meaning of section 11 must be established by the complainant: see *Mr. John & Mrs. Roseanne O'Brien (and on behalf of their four children) v The Health Service Executive South,* File Reference: ES/2007/0162, decision 8 March 2010, where such a case was not made out; at para 5.1, available at

www.equalitytribunal.ie/en/Cases/2010/March/DEC-S2010-016-Full-Case-Report.html

[588] Individuals alleging prohibited discrimination may bring applications to the Equality Tribunal within 6 months of the act in question under the Employment Equality Acts 1998-2011 or the Equal Status Acts 2000-2012. The Equality Tribunal is to be replaced by a Workplace Relations Commission which will also comprise the Labour Relations Commission, the Rights Commissioner Service, the National Employment Rights Authority and first instance functions of the Employment Appeals Tribunal: see *www.citizensinformation.ie/en/employment/enforcement_and_redress/labour_relations_commission.html*

[589] See Part 1 of this thesis. In relation to same sex and transgender persons, one study in North West Ireland of the experiences of same sex persons accessing health services found that "a complexity of behaviours, beliefs and practices operate as barriers to access at many different levels of the health system and have a cumulative effect on the quality of care for many LGB

Status Acts insofar as cases brought under these Acts to the Equality Tribunal concerning access to health services cannot impugn treatment connected to medical opinion[590] but must relate to non-clinical aspects of the care and treatment.[591] Under sections 4 and 16 of the Acts, prior to establishing a *prima facie* case of discrimination, a complainant must overcome the significant hurdle of demonstrating that the impugned service was not treatment based on medical clinical judgment even before addressing issues of "reasonable accommodation" or "cost".[592] Thus in *A Complainant (on behalf of her*

---

people" with research participants in the study identifying "the assumption made by health care providers that they were heterosexual as a considerable barrier for them in accessing health-related services; M Gibbons, M Manandhar, C Gleeson and J Mullan, *Recognising LGB Sexual Identities in Health Services, The Experiences of Lesbian, Gay and Bisexual People with Health Services in North West Ireland,* Equality Research Series, Equality Authority, Health Service Executive (2007) at 104, available at *www.equality.ie/research* In an earlier study on transgender persons, the authors found that geographic accessibility, information, professional awareness, lack of family services and even "hostile or uninformed responses"; E Collins & B Sheehan, *Access to Health Services for Transsexual People*, Nexus Research, Equality Authority (2004) at 45-48, available at *www.equality.ie/research*

[590] Under section 5(1) of the Acts, "A person shall not discriminate in disposing of goods to the public generally or a section of the public or in providing a service, whether the disposal or provision is for consideration or otherwise and whether the service provided can be availed of only by a section of the public".

[591] Although theoretically "all health service providers have a duty of non-discrimination" as espoused by the Equality Officer in *A Patient v Health Service Provider and a Hospital,* File reference: ES/2008/0222 and ES/2009/0005, 1 December 2010 at para 6.2.4, in reality decisions or omissions which can be linked to clinical judgment cannot be impuged. Accordingly in *A Patient* evidence of "best possible medical care *available*" (emphasis added), visits to, rather than temporary release from, the institution in question and "security arrangements" taken by the institution were accepted on the evidence of a consultant psychiatrist as coming within her clinical judgment and were not interrogated, leading to the complainants case of gender discrimination being dismissed; at paras 6.3.1-6.5; available at *www.equalitytribunal.ie/en/Cases/2010/December/DEC-S2010-053-Full-Case-Report.html*

[592] A number of hurdles must be passed to satisfy the test of disability-related discrimination generally under section 4. Thus section 4(1) of the Acts provides that "For the purposes of this Act discrimination includes a refusal or failure by the provider of a service to do all that is reasonable to accommodate the needs of a person with a disability by providing special treatment or facilities, if without such special treatment or facilities it would be impossible or unduly difficult for the person to avail himself or herself of the service". However, under section 4(2), a "refusal or failure … shall not be deemed reasonable unless such provision would give rise to a cost, other than a nominal cost, to the provider of the service in question" or if "by virtue of another provision of this Act, a refusal or failure to provide the service in question to that person would not constitute discrimination" (subsection 3). Similarly under subsection 4, where a person with a disability is a danger to others there will be no discrimination where the person is treated differently "to the extent reasonably necessary to prevent such harm. Section 16(2) introduces a strict exemption for clinical judgment providing that treating a person differently does not constitute discrimination "where the person (a) is so treated solely in the exercise of a clinical judgment in connection with the diagnosis of illness or his or her medical treatment, or (b) is incapable of entering into an enforceable contract or of giving an informed consent and for that reason the treatment is reasonable in the particular case". A further exemption from the provisions of the Act is found under section 14(1)(a)(i)

daughter, J) v Health Service Executive[593], the complainant whose daughter had an intellectual disability and whose in-patient treatment (for 7 years) was being ended in favour of home care with respite support, claimed that this constituted disability-based discrimination but failed insofar as the medical opinion which directed her care and treatment in the case could not be impugned under the Equal Status Acts.[594] Where, however the claim " is not

---

which provides: "Nothing in this Act shall be construed as prohibiting - (a) the taking of any action that is required by or under - (i) any enactment or order of a court". This provision excluded the complainant's claim against the HSE in *Michael Dowd v Dr Paula Gilvarry & HSE West*, File Reference: ES/2008/107, 15 December 2011 where although the Equality Officer found that a *prima facie* case of disability discrimination had been established, she considered that she could not look beyond the interpretation and application of the medical assessment criteria in the case contained in the S. I. Disabled Drivers and Disabled Passengers (Tax Concessions) Regulations, 1994 as those Regulations were exempted from consideration by her pursuant to section 14 of the Act; available at *www.equalitytribunal.ie/en/Cases/2011/December/DEC-S2011-060-Full-Case-Report.html* In *A Patient v Health Service Provider and a Hospital* File reference: ES/2008/0222 and ES/2009/0005, 1 December 2010, having established that her detention in a psychiatric institution pursuant to section 62 of the Mental Health Act 2001 constituted a "health service", the complainant's case fell on the finding by the Equality Officer that, taking into account the provision of section 16(2)(a) of the Acts, "any treatment that the complainant has received [was] in accordance with treatment associated with clinical judgment"; at 6.3.1, available at *www.equalitytribunal.ie/en/Cases/2010/December/DEC-S2010-053-Full-Case-Report.html* here the Tribunal was presented with "compelling expert evidence on behalf of the respondent that indicated that the complainant is and has been receiving the best possible medical care available to her"; at 6.3.1.

[593] File Reference: ES/2009/025, Decision 14 December 2012, available at *www.equalitytribunal.ie/en/Cases/2012/December/DEC-S2012-043-Full-Case-Report.html*

[594] The Equality Officer in his decision did not proceed to consider the question of differential treatment, reasonable accommodation or cost under section 4 of the Act as the section 16 exemption applied: "... Section 16(2) must be interpreted in its strictest possible sense ... it is clear that, in the present case, any aspect of the treatment that J received from the respondent cannot be held to be discrimination if the diagnosis of her condition and/or the decision as to what her medical treatment should be was made solely in the exercise of a clinical judgment and the treatment she did receive was connected to that clinical judgment. Therefore, with respect to the present case, Section 16(2) sets an additional barrier to the complainant in establishing a prima facie case as discrimination cannot occur unless she can show that one of the following took place: i) The decision as to J's diagnosis and/or what her treatment should be was at least partially motivated by something other than a clinical judgment and/or ii) some aspect(s) of the treatment that J received was not related to that clinical judgment. If she can satisfy the Tribunal that one or other of these was the case, she must then show that there was adverse treatment of J by the respondent that was related to her disability. For the avoidance of doubt, it should be noted that Section 16(2) must also relate to the application of Section 4(1) to the present case. Thus, reasonable accommodation also does not arise unless the barrier to the complainant posed by the application of Section 16(2) is crossed"; at paras 5.5-5.6. In the instant case there was no question in the Officer's mind that the health care treatment involved was based on medical opinion, even where the doctors involved may not have agreed and may not have concluded a diagnosis as to whether J had Asperger's Syndrome or not (which would necessitate a particular form of treatment); at paras 5.7-5.11, available at File Reference: ES/2009/025, Decision 14 December 2012, available at *www.equalitytribunal.ie/en/Cases/2012/December/DEC-S2012-043-Full-Case-Report.html* See also earlier Tribunal decision in *Ms. A (on behalf of her brother, Mr. B) v A General Hospital* where the Equality Officer found that the complainant had failed to establish a *prima*

about the quality of medical care" a claim for discrimination on the basis of mal-organisation in the delivery of services may be upheld, for example, where no "reasonable accommodation" on the disability ground is undertaken.[595] Apart from some organisational health service related jurisprudence, most cases relating to health under the Equal Status Acts have tended to focus on access to social security benefits on a non-discriminatory basis rather than access to the AAAQs.[596]

---

facie case of discrimination on the disability ground in terms of sections 3(1) and 3(2)(g) of the Equal Status Acts 2000-2012 and contrary to sections 4(1) and 5(1) of those Acts; at para 5.1, available at Equality Authority. Annual Report (2010) Part VII at 20, available at *www.equality.ie/Files/Casework%20Summaries%202010.doc*

[595] See *A Patient v The Mater Misericordiae University Hospital* File No. ES/2006/0159, 25 August 2009, where the Equality Officer upheld the complainant's claim of disability discrimination on the basis that she was denied access to a wheelchair accessible toilet and shower during the period of her stay in the hospital. Here the respondent acknowledged and regretted "that due to unauthorised actions of staff, the existing wheelchair accessible toilet of Our Lady's Ward was placed beyond patient use at the time of the incident"; at para 4.2. Finding that the claim was not on the basis of "differential treatment in the exercise of clinical judgment" under section 16(2)(a), the Tribunal found that the complainant was not offered "reasonable accommodation" as defined by section 4(1) of the Act, concluding that there was "no evidence ... presented to the hearing to suggest that the service provider explored any alternatives to the catheter (with the exception of nappies). A service provider who has special facilities in place but who chooses to use these facilities as storage solutions or in order to convenience the staff, whatever the case may be, is clearly in breach of its obligations under section 4(1). A similar situation arises in relation to the showers. The respondent had an obligation to ensure that the complainant was able to avail of a shower during her 37 day stay in the respondent's facility... a hoist in the circumstances of this case, would have enabled the complainant to take better care of her personal hygiene"; at para 5.13. Thus the Acts permit reparations accountability in relation to the obligations to "respect, protect and fulfil" (the hospital providing a public health service under "respect"; the private hospital being capable of being sued under "protect" and the failure to provide a proper health service (access to facilities) coming under "fulfill" in limited cases.

[596] Thus in *Fizel v Health Service Executive* Case ref: ES/2010/0080, Decision 6 January 2012, the Tribunal dismissed the claim that the HSE was not entitled to ask questions about maintenance payments of a lone parent when considering payment of a discretionary rental supplementary allowance; at paras 5.3-5.5, available at *www.equalitytribunal.ie/en/Cases/2012/January/DEC-S2012-001-Full-Case-Report.html* In *Tadeusz Jedruch v The Adelaide and Meath Hospital*, Case ref: ES/2010/0114, Issued: 7 December 2011, the complainant claimed delays in his treatment was based on racial discrimination citing alleged racial abuse by a nurse he was seeking to schedule his surgery with (following an 18 month delayed appointment with a consultant with 15 postponements, accepted by the respondents who submitted that this was due to overcrowding in surgical referrals rather than any discrimination). The Equality Officer refused "to infer a discriminatory motive" to the effect that a comparator Irish person "would not have experienced such delays" and cited section 16(2)(a) as providing for "'clinical judgment' and differential treatment in relation to a medical treatment. When a service provider is exercising solely his or her clinical judgment in relation to a patient and treating the patient accordingly, such treatment cannot be construed as discrimination within the meaning of these Acts". In her view, the complainant's appointment "was rescheduled was because of an assessed clinical judgment, not because of the complainant's nationality"; at para 5.2. available at *www.equalitytribunal.ie/en/Cases/2011/December/DEC-S2011-058-Full-Case-Report.html* Thus the question of AAAQ accessibility to healthcare services was not substantively

8.5 The Health Acts 1947-2007

The potential for a legislatively defined right to health under the Health Acts 1947-2007 has not to date been pursued by the legislature, arguably because of the private origin of health care provison in Ireland. Public health care by the modern State had its origin in the public health movement of the nineteenth century, with its emphases on sanitation, occupational hazards and environmental health, while health care has traditionally been delivered by private doctors. In 1911 public compulsory health insurance was introduced in Britain. However, no insurance-based scheme was introduced in Ireland due to a number of factors until 1957 at which time a State monopoly insurer was introduced.[597] Unlike the situation in the United Kingdom, Ireland developed as a mixture of public and private health care service provision.[598]

The Health Act 2004 Act provides the HSE with the statutory responsibility to manage and deliver, or arrange to be delivered "health and personal social

---

considered by the Tribunal. Similarly in *Anthony Ronald Preston v H.S.E. Western Area Ambulance Service* File Ref ES/2007/111, 9 July 2009, the case concerned a claim of discrimination on the disability ground by the HSE when it withdrew free hospital transport facilities. The respondents successfully rebutted the allegation of discrimination by discharging the burden of proof in showing that the facility was withdrawn on the basis of budgetary cutbacks and after prioritising patients on the basis of medical needs; at paras 4.1-5; available at *www.equalitytribunal.ie/en/Cases/2009/July/DEC-S2009-046-Full-Case-Report.html*

[597] Namely the Voluntary Health Insurance; see below. Prior to the Health Acts 1947-2007, public health services were the responsibility of public assistance authorities, urban sanitary authorities and charitable bodies. A Department and Minister of Health were only established in 1947.

[598] As Bourke and Roper point out, the dual system of health care centres primarily in the provision of primary care. Thus "[t]he majority of Irish [General Practitioners] treat private patients but also hold a contract with the government to treat those patients who qualify for a Medical Card. Medical card or General Medical Services (GMS) patients are public patients who are entitled to attend GPs free of charge and also receive prescription medicines free of charge. Approximately, 30% of the Irish population are entitled to these means-tested medical cards; however, it has been estimated that the GMS patients account for approximately 50% of all GP consultations, and that government spending through medical card patients makes up a substantial part of general practices' funding. The remainder of the Irish population are classed as private patients, and they pay directly for each visit to a GP and for any additional services provided by each GP. Along with the discretion which Irish GPs have in terms of the nature and location of their practice, they also have considerable autonomy in relation to prescribing decisions. Once a particular drug has been approved for use by the Irish Medicines Board, GPs can prescribe it to their patients. In Ireland, there are no explicit guidelines in relation to prescribing decisions, such as the National Institute for Clinical Excellence (NICE) in the UK. The commercial and prescribing autonomy that characterizes Irish general practice suggests that the prescribing decisions of Irish GPs may reflect both medical and commercial factors"; J Bourke and S Roper, *In with the new: the determinants of prescribing innovation by general practitioners in Ireland,* 13 European Journal of Health Economics (2012) 393 at 394.

services".[599] However there is no entitlement to those services.[600] The Health Acts 1947-2004 are concerned primarily with the structure of the health services rather than the content of health services. They address what a health service is, who administers it and how it is accountable for the monies it discharges. The Irish health system differs significantly, however, from systems with universal healthcare access insofar as the Irish system is structured on ability to pay "at the point of delivery".[601] Whereas all persons resident in the State are entitled to receive certain health care through the public health care system (primarily through presentation in an Accident and Emergency Department at a publicly funded hospital), there is no statutory right to this. Rather, individuals may be entitled to free health care on the basis of income if they are covered by the General Medical Services Scheme which covers approximately 37% of the population (including all those aged over 70 years)[602] but otherwise are required to pay for healthcare treatment.

---

[599] The Chief Executive of the HSE is accountable to the Board and to Oireachtas and may be required to report to an Oireachtas Committee on written request in relation to the administration of the HSE. The Board of the HSE is chaired by the Secretary General of the Department of Health, with the HSE now fully accountable to that government department. Previously, under the Health Act 1947, local authorities were known as health authorities and designated as the primary provider of health care in local districts. Local authority responsibility transferred to Health Boards under the Health Authorities Act 1960 and the Health Act 1970. The Health Act 2004 dissolved the eleven existing health boards and transferred their functions and employees to a single executive body, the Health Service Executive ("the HSE"). The Minister for Health is ultimately responsible for whether the HSE conducts its operations in accordance with the policies and objectives of the Government. Section 7(1) of the Health Act 2004 sets out the functions of the HSE as "to use the resources available to it in the most beneficial, effective and efficient manner to improve, promote and protect the health and welfare of the public."

[600] *In the Matter of Article 26 of the Constitution & In the Matter of the Health (Amendment) (No.2) Bill 2004* [2005] 1 IR 105, the Supreme Court referred to the fact that no regulations had been made under section 45(3) of the Health Act 1970 on eligibility to services and that the determination of who is entitled to a medical card etc. is subject to a system of Departmental circulars, with the Health Board (now the HSE) deciding on applications.

[601] Department of Health and Children, *Report Growing Up In Ireland, Review of the Literature Pertaining to the First Wave of Data Collection with the Child Cohort at 9 Years;* Office of the Minister for Children and Youth Affairs (2006), at 59, available at *www.growingup.ie/fileadmin/user_upload/documents/Technical_Reports/Review_of_the_Literature_Pertaining_to_the_First_Wave_of_Data_Collection_with_the_Child_Cohort_at_9_Years_01.pdf*

[602] It was estimated that in 2011, 37% of the population were entitled to a medical card permitting free dental, aural, optician and general practitioner care under the scheme administered by the Health Service Executive. Eligibility for the scheme is described as "Persons who are unable without undue hardship to arrange general practitioner medical and surgical services for themselves and their dependants and all persons aged 70 years and over receive a free general medical service"; in Health Service Executive *National Shared Services Primary Care Reimbursement Scheme,* Health Service Executive (2006) at 6. Other schemes

Approximately 45% of the population avail of private insurance options which allows those covered to access speedier healthcare under private rather than public provision[603].

In Part 1 of this thesis, we considered how under paragraphs 43 and 44 of General Comment 14, there are at least six "core obligations" under Article 12 which include access to the AAAQs without discrimination, access to food, shelter, housing, sanitation, water, essential drugs, equitable distribution of all health facilities, goods and services, a national public health strategy and plan of action.[604] Insofar as access to food, shelter, housing, sanitation, water and essential drugs are available under the Irish health system, this thesis will focus on the two core elements which may not be available, namely access to the

---

include the General Practitioner Visit Card which allows allow qualifying individuals to visit their General Practitioner for free; *ibid.* Eligibility to these schemes is discretionary as decided by the Health Service Executive on the basis of income limit guidelines. Medicinal products and appliances are reimbursable under the parallel Drugs Payment Scheme; ibid. The General Medical Services Scheme also contains a Long Term Illness Scheme for persons suffering from a schedule of illnesses entitled to receive free medication and appliances; ibid at 13. See Department of Health, *Health In Ireland, Key Trends*, Department of Health (2012) available at
www.hse.ie/eng/Staff/PCRS/PCRS_Publications/Primary_Care_Reimbursement_Service_Financial_and_Statistical_Analysis_2005.pdf

[603] The dichotomy of public and private healthcare in Ireland is complicated by the fact that often the same physician can deliver either public or private care in the same health institution. This is because consultants' contracts have traditionally permitted them to hold private clinics in public hospitals insofar as they can be both employed by the State and conduct private practice: "Consultants are paid on a salary basis for public patients, and on a fee-for-service basis for private patients"; J O'Reilly, M Wiley, *The public/private mix in Irish acute public hospitals: Trends and implications*, Working Paper, The Economic and Social Research Institute, Dublin, No 218 (2007), The Open Access Publication Server of the ZBW – Leibniz Information Centre for Economics at 8.

Despite some recent reforms to this area, this peculiarity of the Irish system, described by one author as the "extraordinary symbiosis of public and private medicine"; R Barrington, *Health, Medicine and Politics*, Institute of Public Administration, Dublin (1987) at 285, cited by O'Reilly and Wiley who note that this peculiarity "is nowhere more evident than in the acute hospital system where both public and private patients can be accommodated in public hospitals and be treated by the same consultant' ibid. at 2. There is also some evidence that out of pocket health insurance policies are maintained by a large number of people due to their belief that they will receive speedier healthcare treatment under such policies than persons under the public system.

[604] General Comment 14, para 43 (a) to (f). as noted in Part 1, General Comment 14 also sets out obligations of comparable priority in paragraph 44, namely "(a) To ensure reproductive, maternal (pre-natal as well as post-natal) and child health care; (b) To provide immunization against the major infectious diseases occurring in the community; (c) To take measures to prevent, treat and control epidemic and endemic diseases; (d) To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them; (e) To provide appropriate training for health personnel, including education on health and human rights."

AAAQs without discrimination and an effective national health system, particularly since an effective health system which is not two-tiered to the exclusion of certain vulnerable groups, will ensure adequate access to the AAAQs.

8.6 The Health Insurance Acts 1957-2012

Private health insurance was first introduced in Ireland under the Voluntary Health Insurance Act 1957 which established the Voluntary Health Insurance Board.[605] This scheme operated a monopoly for health insurance in the State until the introduction of a health insurance market in 1994 to allow competition under the Health Insurance Act 1994 as required by the European Council Directive 92/49/EEC on non-life insurance.[606] In deciding to continue with private health insurance provision thereafter, the State was obliged to open the market to other insurers but could place restrictions on insurers for the "general good".[607] Since the 1994 Act, the State has aimed to optimise access to the health insurance market for all persons able to pay premiums regardless of their age, sex or sexual orientation or health status or health service use through

---

[605] According to O'Reilly and Wiley, the scheme was originally "instigated with the intention of providing coverage for hospital costs and consultants' charges to those in the top 15 per cent of the earnings distribution whose health care costs were not covered by the State"; J O'Reilly, M Wiley, *The public/private mix in Irish acute public hospitals: Trends and implications,* Working Paper, The Economic and Social Research Institute, Dublin, No 218 (2007) at 2. Current health insurance providers are the Voluntary Health Insurance, Laya Healthcare, Hibernian Aviva, GloHealth, HSF Health Plan and QUINN-Healthcare.

[606] See the European Council Directive 92/49/EEC of 18 June 1992 on the coordination of laws, regulations and administrative provisions relating to direct insurance other than life assurance and amending Directives 73/239/EEC and 88/357/EEC (third non-life insurance Directive).

[607] According to Article 54(1) of the Directive: "Notwithstanding any provision to the contrary, a Member State in which contracts covering the risks in class 2 of point A of the Annex to Directive 73/239/EEC may serve as a partial or complete alternative to health cover provided by the statutory social security system may require that those contracts comply with the specific legal provisions adopted by that Member State to protect the general good in that class of insurance, and that the general and special conditions of that insurance be communicated to the competent authorities of that Member State before use…" thus permitting the introduction of legal restrictions to health insurance which can be justified by reason of "the general good" where private health insurance schemes 'wholly or partially' replace the social security system. Article 54 has also been cited by other States where seeking to promote principles of solidarity in health insurance such as The Netherlands: see A Roos, F T Schut, *Spillover effects of supplementary on basic health insurance: evidence from the Netherlands*, 13 European Journal of Health Economist (2012) 51 at 52.

means of a risk equalisation scheme under the auspices of the Health Insurance Authority which acts as regulator.[608] Approximately 45% of the population

---

[608] Section 20 of the Health Insurance Act 1994 established the Authority. In deciding to continue with private health insurance provision in 1994, following the third non-life insurance directive, the State was obliged to open the market to other insurers. As the State could no longer direct all health insurance provision as heretofore through its ownership of the Voluntary Health Insurance company, it sought to, *inter alia*, minimise barriers to health insurance through a number of positive measures including the provision under section 7 of the 1994 Act for the introduction of a risk equalisation scheme. However, this scheme was introduced "without a corresponding provision regarding community rating" (only introduced by the Health Insurance (Amendment) Act 2001 (see Supreme Court Judgment in the case of *Bupa Ireland Limited & anor v Health Insurance Authority & ors* [2008] IESC 42 per Murray CJ)). Section 7 of the 1994 Act provided for risk equalization to the effect that premiums payable under such contracts could not be varied by reference to "the age, sex or sexual orientation or the suffering of prospective suffering" of persons, the frequency of their health service use or the amount of payments they become eligible to under the contract (section 7(2)). It also provided for the amounts of payments provided by health insurance contracts in respect of the health services to which it relates shall not be varied by reference to the age, sex or sexual orientation of a person to whom those services are provided (section 7(3)). This principle of risk equalisation was continued in successive legislative provisions in 1996, 1999 (by regulation), 2001, 2003 and 2006. Insofar as community rating was only added in 2001, accordingly the 2006 risk equalisation scheme and grounding regulations were struck down by the Supreme Court in *Bupa*. BUPA had entered the health insurance market in 1997 and the Supreme Court found that the risk equalisation scheme as introduced by the Minister in 2003 was founded on an "erroneous" basis, not being based on a statutory scheme but rather on a series of reports notwithstanding that with its concomitant version of community rating of premiums across the entire market it "would have serious impact on the economic and trading position of BUPA and potentially for any other recent or new entrant to the market of private health insurance"; per Murray CJ. Section 3 of the Health Insurance (Miscellaneous Provisions) Act 2009 sought to address this lacuna through providing expressly that a mix of income tax credits and stamp duty or other measures would be employed to ensure "access to health insurance cover" for all. This was further amended by the Health Insurance (Amendment) Act 2009 which provided that the principal objective of the Act was "to ensure that, in the interests of the common good and across the health insurance market, access to health insurance cover is available to consumers of health services with no differentiation made between them (whether effected by risk equalisation credits or stamp duty measures or other measures, or any combination thereof), in particular as regards the costs of health services, based in whole or in part on the health risk status, age or sex of, or frequency of provision of health services to, any such consumers or any class of such consumers, and taking into particular account for the purposes of that objective (a) the fact that the health needs of consumers of health services increase as they approach and enter old age, (b) the desirability of ensuring, in the interests of societal and intergenerational solidarity, and regardless of the health risk status or age of, or frequency of provision of health services to, any particular generation (or part thereof), that the burden of the costs of health services be shared by insured persons by providing for a cost subsidy between the more healthy and the less healthy, including between the young and the old, and, without prejudice to the generality of that objective, in particular that the less healthy, including the old, have access to health insurance cover by means of risk equalisation credits, (c) the manner in which the health insurance market operates in respect of health insurance contracts, both in relation to individual registered undertakings and across the market, and (d) the importance of discouraging registered undertakings from engaging in practices, or offering health insurance contracts, whether by segmentation of the health insurance market (by whatever means) or otherwise, which have as their object or effect the favouring of the coverage by the undertakings of the health insurance risk of the more healthy, including the young, over the coverage of the health insurance risk of the less healthy, including the old." See also Health Insurance Authority, *Policy Paper Risk Equalisation in the Private Health Insurance Market in Ireland*, Health Insurance Authority (2002), available at *www.hia.ie/assets/files/publications/Risk_Equalisation/Policy-Paper-on-RE-09-02.pdf*,

availed of private health insurance in 2012[609] which essentially entails out-of-pocket expenses for healthcare provision in hospital settings.[610] Notwithstanding the risk equalisation policy of access regardless of age, sex or sexual orientation, health status or health service use, barriers to timely access to healthcare under private insurance exist within the scheme. Older persons may be subsidised but companies are still entitled to penalise persons with existing health illnesses/ disabilities on the basis of their age or disability through placing them on waiting lists which can extend to a number of years.[611]

Updated Guide to the Risk Equalisation Scheme, 2003 as prescribed in Statutory Instruments No. 261 of 2003, No. 710 of 2003, No. 334 of 2005 and No. 220 of 2007, Health Insurance Authority (2010), available at *www.hia.ie/assets/files/publications/Risk_Equalisation/Updated-Guide-to-Risk-Equalisation-Scheme.pdf* See also Health Insurance Authority, *Report to the Minister for Health and Children on Risk Equalisation in the Irish Private Health Insurance Market*, Health Insurance Authority (2010), available at www.dohc.ie/publications/HIA_Report_2012.html As will be discussed in Part 4 of this thesis, the Mental Health Act 2001, the Health Acts 2004-07 and the Medical Practitioners Act 2007 provide for the regulation of elements of health service delivery and a limited administrative complaints system is available. The purpose of the Health Information and Quality Authority established under the Health Act 2007, is to promote safety and quality in the provision of health and personal social services for the benefit of the health and welfare of the public, aligning its work with the definition of those services under the 2004 Act. Its functions are supervisory and promotional: to set standards on safety and quality, to monitor compliance with the standards, to undertake investigations and to operate accreditation programmes. The Mental Health Commission was established with similar functions under the Mental Health Act 2001, while the Medical Council of Ireland was a pre-existing body which received an enhanced statutory basis under the Medical Practitioners Act 2007.

[609] The Health Insurance Authority records those with private health insurance as peaking in 2008 at 50.9% but falling to 45.8% by 2012, a still considerable percentage of the population: see Health Insurance Authority Annual Report 2012 at Appendix A, accessible at *www.hia.ie/assets/files/publications/Annual_Reports/HIA%20-%20Annual%20Report%20and%20Accounts%202012.pdf*

[610] Private health insurance does not cover primary care GP visits which are out of pocket expenses unless one is entitled to a medical card. Davidson et al have suggested that out-of-pocket payments "disproportionately impact on people with disabilities because of their higher levels of health needs" and suggest that "[w]ith regard to the impact on people with disabilities key concerns centre around equitable access to services, access to insurance and the potential for excessive supplementary or out-of-pocket payments for the individual"; G Davidson, B Kelly, G Macdonald, A Martin, M Rizzo, O Abogunrin and L Lombard, *Universal Health Insurance systems and the provision of health services for people with disabilities*, A National Disability Authority Working Paper, Dublin (2012) at 5.

[611] See Health Insurance Authority, *Private Health Insurance, My Rights, My Choices*, Health Insurance Authority (2008), which states that "once you take out health insurance for the first time, you may have to serve waiting periods before you are fully covered", describing the maximum waiting periods as ranging from 26 weeks for those aged under 55 years for new illnesses to 52 weeks for those aged over 65 years and 5 years to 10 years respectively for treatment of pre-existing conditions. While the community rating scheme system ensures that health insurance costs the same for persons regardless of their age, gender or health status, this only applies to persons who can afford the insurance itself. Insofar as persons from vulnerable groups cannot may not be able to afford private health insurance, this safeguard will apply to the 45% of the population who access health services through private health provision, at 2,

In considering whether access to healthcare, whether through the public or private system (i.e. for those with health insurance), meets the AAAQ obligations on the State, attention turns to what the difference between the two systems are. Those differences include speedier access to healthcare for those with insurance which raises AAAQ concerns about the accessibility and adequacy of health care. In addition, there remains a residual question concerning the health needs of those individuals not covered under either scheme.[612] It has long been recognised that there are differences in equity in the current "two tier" system which suggests that those without private health insurance have difficulty in accessing the AAAQs for some treatments in the same speedy manner as those with such insurance.[613] Whereas persons from disadvantaged communities may, on the basis of income, be able to access a medical card and thus have access to the public health system, this avails them

---

available at *www.hia.ie/assets/files/publications/Consumer_Info_Brochures/Final_HIA%20My%20Rights%20My%20Choices%202013.pdf*

[612] See for example J O'Reilly, M Wiley, *The public/private mix in Irish acute public hospitals: Trends and implications*, Working Paper, The Economic and Social Research Institute, Dublin, No 218 (2007) at 2. Insofar as both public and private systems utilise the same "quantity" of healthcare resources, with over-use of the private system impacting the public system and viceversa, the authors concluded that demand and supply-side factors were both found to be "statistically significant in explaining the ratio of private to public discharges across hospitals and over time. The regression analysis indicated that the private/public discharge ratio was higher in hospitals treating discharges who were, on average, younger, male, married and not medical card holders"; at 32. They also expressed concern that a number of private hospitals were "circumventing … controls. In almost a quarter of all hospitals, the treatment of private discharges was apparently in excess of estimated available private capacity", stating that "[g]iven fixed capacity constraints in the short term, such excess private utilisation implies a re-distribution of resources from public to private discharges and is consistent with allegations of crowding out of public patients by their private counterparts (although the results may also be compatible with the efficient use of scarce resources by hospitals where there is a relative lack of demand from public patients)"; at 33. The fact that the private health insurance market is underpinned by tax credits and stamp duty Exchequer measures also raises equity and access to AAAQ concerns.

[613] The 2001 Strategy of the Department of Health clearly recognised that: "The Strategy must address the 'two-tier' element of hospital treatment where public patients frequently do not have fair access to elective treatment. All patients should have such access within a reasonable period of time, irrespective of whether they are public or private patients. Public patients should also have reasonable access to the range of publicly funded services irrespective of where they happen to live". In relation to access, it stated: "While individuals may be eligible for services, this does not mean that they will receive the services when they need them or in a reasonable timeframe. The situation is most evident in the hospital system where public patients may have to wait considerably longer than private patients for certain elective (non-emergency) treatment. It also arises where some community-based services are available to public patients in one part of the country but less available in another"; see Department of Health and Children, *Quality and Fairness: A Health System for You. Health Strategy*, Department of Health and Children, Dublin, Stationery Office (2001) at 48.

only to a degree if their treatment is different from those able to pay health insurance who will predominantly come from a higher socio-economic class of persons (i.e. who are able to pay out-of-pocket health expenses). Insofar as the health insurance system as currently structured supports private health (hospital) treatment to the disadvantage of the public system, an ancillary argument is that this imposition hinders persons from disadvantaged communities gaining access to the AAAQs.

Official health data research is classified primarily by reference to social class status rather than vulnerable group status (research into Traveller and disability health being exceptions).[614] As observed in Part 1, it is clear that persons from such vulnerable populations experience lower health outcomes and that under

---

[614] See O'Reilly and Wiley who noted that most data is available from hospitals alone and even then when examining Hospital In-Patient Enquiry data there remained "...limited information is available on populations at county and health board levels, particularly in relation to their health status"; J O'Reilly, M Wiley, *The public/private mix in Irish acute public hospitals: Trends and implications,* Working Paper, The Economic and Social Research Institute, Dublin, No 218 (2007) at 11. Similarly in a national longitudal literature review of children aged 9 to 12 years in Ireland where it is stated that "little is known about the experience of children growing up as members of ethnic minorities in Ireland"; *Report Growing Up In Ireland, Review of the Literature Pertaining to the First Wave of Data Collection with the Child Cohort at 9 Years;* Office of the Minister for Children and Youth Affairs (2006) at 24, available at *www.growingup.ie/fileadmin/user_upload/documents/Technical_Reports/Review_of_the_Literature_Pertaining_to_the_First_Wave_of_Data_Collection_with_the_Child_Cohort_at_9_Years_01.pdf* The report found that "no nationwide study of prevalence rates for children and adolescents with mental health difficulties has been conducted to date" although local studies (1988 Co Clare and 1990 (Dublin)) indicated 9-12 year old evidence of psychological disorders; at 52. The study did recognise that Traveller children in school (representing 1% of the population) "are less healthy than settled children and suffer from discrimination and stigmatisation"; at 24, however it appears accepted both that vulnerable groups (including those with a lower socio-economic status) have lower health outcomes than the normal population and that disparities exist in relation to access to healthcare on the basis of ability to pay; at 59 ESRI report. Children from ethnic minority groups (eg. Travellers) experience health outcomes while high levels of material deprivation relative to other developed countries prevails. The report also stated that "little is known about the experience of children growing up as members of ethnic minorities citing the UNICEF wellbeing barometer 2007 where Ireland ranked 19 out of 21 OECD countries surveyed"; at 24. Lifestyle health risks associated with developing countries are also increasing. Citing international research in noting that the "socio-economic context clearly impacts health outcomes"; the report notes how the "highest percentage of low-weight babies was born to mothers in the unemployed socio-economic group, citing the S Bonham, Department of Education/ ESRI 2006 *Report on Perinatal Statistics* for 2003 (2006) accessible at *www.esri.ie/health_information/nprs/nprs_reports/Report_on_Perinatal_Statistics_for_2003.final.pdf* With the exception of specific Traveller and disability health studies, official health data outcomes are classified primarily by virtue of social class rather than vulnerable group status. Similarly the 2010 Department of Health Report note how there are "marked" social class differences between employed and unemployed mothers when it came to low birth rate, breast feeding initiatives Low birth weight was 9% in unemployed as opposed to 4.1% in employed mothers; at 86. Breastfeeding initiatives were higher in "professional" groups (67-69%) as opposed to unemployed mothers (35.3%); *Report Growing Up In Ireland* report, at 89.

the fundamental principle of non-discrimination in access to the AAAQs, positive measures are required of the State to remedy this situation. Insofar as access to the public health system by means of a medical card does not place those entitled on an equal footing as those with private health insurance, accordingly a *prima facie* case of indirect discrimination is raised. Here a difference in treatment arises based not on one's health need but on the basis of one's access to insurance.[615] Under the non-discrimination test, the onus then passes to the State to demonstrate absence of discrimination. Indeed the State has accepted that there is discrimination in access to the AAAQs in hospital care under the current system.

As noted in Part 1, Universal Health Insurance with "equal access to care for all" is to be introduced by 2016 under Ireland's Current Programme for Government with the specific aim of eliminating "discrimination between patients on the grounds of income or insurance status" and thus ending the current "two-tier system of unequal access to hospital care.[616] Under the proposal, health insurance will be compulsory with insurance payments related to ability to pay.[617] In its 2010 World Health Report, the WHO identified three

---

[615] "[W]hen health status is no longer decisive in prioritising and providing health care treatment, this could imply that the effect of such a difference in treatment leads to unequal access to health care when considering health status and health care needs… when certain patients are treated in preference of others with the same medical need, this could constitute discrimination 'in effect'… [t]he order in which patients are treated or placed on waiting lists should only be governed by medical criteria. This must never be based on discriminatory grounds, such as the ability of individuals to pay or their health status, as this could lead to a denial or delay of access to health care to a particular group or part of the population"; B Toebes and M San Giorgi, *Dutch realities: evaluating the Dutch health care reform from a human rights perspective* (draft chapter) in *The right to health: a multi-country study of law, policy and practice* (Eds B Toebes, R Ferguson, M Markovic and O Nnamuchi), TMC Asser Press/Springer (due 2014) at 11.

[616] *Programme For Government* at 31 see available at *per.gov.ie/wp-content/uploads/ProgrammeforGovernmentFinal.pdf* accessed on 8 February 2013.

[617] Under the proposal, Universal Health Insurance "will provide guaranteed access to care for all in public and private hospitals on the same basis as the privately-insured have now. Insurance with a public or private insurer will be compulsory with insurance payments related to ability to pay. The State will pay insurance premia for people on low incomes and subsidise premia for people on middle incomes"; at 34. The costing of the new system remains to be identified if one takes the figures of 45% of the population in private health insurance and 37% with a current medical card, leaving approximately 18% of the population who currently pay on a health needs basis. In the Netherlands, on whose basic model the Government proposal is based, since the introduction of the Health Insurance Act (HIA) in 2006 "all Dutch citizens are obliged to buy standardized individual basic health insurance from a private insurer. The Health Insurance Act replaced the former public health insurance scheme (available for two-thirds of the population) and the former voluntary private scheme (for the one-third of the population with higher incomes). The standardized basic benefits package covered by the HIA

inter-related barriers to universal health insurance guaranteeing health for all, namely sufficient financing[618], reducing the reliance on direct payments for health services and improving efficiency and equity.[619]

---

is rather comprehensive and includes e.g. hospital care, GP services, prescription drugs and maternity care. There is a limited annual deductible of 165 euro per adult individual (in 2010)"; A Roos, F T Schut, *Spillover effects of supplementary on basic health insurance: evidence from the Netherlands*, 13 European Journal of Health Economist (2012) 51 at 52. However, insofar as the current Irish system is basically one of supplementary health care (i.e. health care over and above that available through the public system, it is unclear whether supplementary health insurance is envisaged over and above the standard health insurance package. Here commentators express caution. Toebes and San Giorgi noting how supplementary health care insurance was introduced in The Netherlands as a "non-mandatory, private health care insurance", this is contrary to the basic health care insurance package insofar as "there rests no obligation on health care insurers to accept new applicants, nor are they restricted to a prohibition of differentiating the premium according to the risk profile of the patient"; B Toebes and M San Giorgi, *Dutch realities: evaluating the Dutch health care reform from a human rights perspective* (draft chapter) in *The right to health: a multi-country study of law, policy and practice* (Eds B Toebes, R Ferguson, M Markovic and O Nnamuchi), TMC Asser Press/Springer (due 2014) at 9. Roos and Schut, point out that "the role of supplementary insurance in health care financing is gradually expanding" with basic and supplementary health insurance founded on different principles, in the Netherlands, where the mandatory basic health insurance scheme is based on "principles of solidarity, universal access, consumer choice and regulated (or managed) competition, supplementary health insurance is exclusively voluntary and based on the principles of a free insurance market in which insurers are free to set the terms of the insurance contract and are allowed to use medical underwriting". Accordingly, where both types of insurance are offered by the same health insurers (such as is the case in the Netherlands, Belgium, Switzerland, "the principles of supplementary health insurance market may interfere with the principles of basic health insurance… result[ing] in less favorable contracts and reduced choice for high-risk individuals in basic insurance"; ibid at 51-52. The presence of supplementary insurance may thus have two negative spillover effects on basic insurance: "(1) it can be used as a tool for risk selection in basic insurance, and (2) it can reduce choice for high-risk individuals in the market for basic health insurance" meaning that where health insurers face incentives for risk selection in basic insurance, strategies to reduce the lock-in effect for high-risk individuals may be counteracted by increasing use of supplementary insurance as a selection device" will continue which requires that "the incentives for risk selection in basic health insurance … be largely eliminated" through "further improving the prevailing method of risk equalization"; at 60-61. Toebes and San Giorgi note how the rise of health insurance expenditure is leading the Dutch government to look into "the possibilities for restricting some of the conditions … and to increase payments by means of a personal contribution" leading to the elderly and patients with chronic diseases … confronted with increasing of out-of-pocket payments; B Toebes and M San Giorgi, *Dutch realities: evaluating the Dutch health care reform from a human rights perspective* (draft chapter) in *The right to health: a multi-country study of law, policy and practice* (Eds B Toebes, R Ferguson, M Markovic and O Nnamuchi), TMC Asser Press/Springer (due 2014) at 7.

[618] This additional dimension is introduced where the State, whether faced with higher health costs or an economic crisis, introduces austerity measures which impact on health financing and which may result in barriers to or delays in access to health care: see B Toebes and M San Giorgi, *Dutch realities: evaluating the Dutch health care reform from a human rights perspective* (draft chapter) in *The right to health: a multi-country study of law, policy and practice* (Eds B Toebes, R Ferguson, M Markovic and O Nnamuchi), TMC Asser Press/Springer (due 2014) at 9. In this respect, Ireland has repeatedly reduced its health budget in recent years.

[619] According to the WHO, three fundamental, interrelated problems restrict countries from moving closer to universal coverage: "The first is the availability of resources. No country, no

Accordingly, the question whether healthcare will be accessible for all without discrimination under the new system will need to address the "significant barriers" which are likely to remain[620] and much will depend on the structuring and financing of the system and the extent to which it will ensure vulnerable populations have access to the AAAQs in their entirety and not simply hospital beds.[621] In this regard, the experience of universal health insurance systems in

---

matter how rich, has been able to ensure that everyone has immediate access to every technology and intervention that may improve their health or prolong their lives. At the other end of the scale, in the poorest countries, few services are available to all. The second barrier to universal coverage is an overreliance on direct payments at the time people need care. These include over-the-counter payments for medicines and fees for consultations and procedures. Even if people have some form of health insurance, they may need to contribute in the form of co-payments, co-insurance or deductibles. The obligation to pay directly for services at the moment of need - whether that payment is made on a formal or informal (under the table) basis – prevents millions of people receiving health care when they need it. For those who do seek treatment, it can result in severe financial hardship, even impoverishment. The third impediment to a more rapid movement towards universal coverage is the inefficient and inequitable use of resources. At a conservative estimate, 20-40% of health resources are being wasted. Reducing this waste would greatly improve the ability of health systems to provide quality services and improve health. Improved efficiency often makes it easier for the ministry of health to make a case for obtaining additional funding from the ministry of finance. The path to universal coverage, then, is relatively simple - at least on paper. Countries must raise sufficient funds, reduce the reliance on direct payments to finance services, and improve efficiency and equity. These aspects are discussed in the next sections are being wasted. Reducing this waste would greatly improve the ability of health systems to provide quality services and improve health. Improved efficiency often makes it easier for the ministry of health to make a case for obtaining additional funding from the ministry of finance. The path to universal coverage, then, is relatively simple – at least on paper. Countries must raise sufficient funds, reduce the reliance on direct payments to finance services, and improve efficiency and equity. These aspects are discussed in the next sections"; The *World Health Report, Health Systems Financing, The path to universal coverage*, Executive Summary World Health Organization, Geneva (2010) at 9, available at *www.who.int/whr/2010/10_summary_en.pdf*

[620] G Davidson, B Kelly, G Macdonald, A Martin, M Rizzo, O Abogunrin and L Lombard, *Universal Health Insurance systems and the provision of health services for people with disabilities,* A National Disability Authority Working Paper, Dublin (2012) at 10.

[621] In relation to financing, a question arises as to how much of the Universal Health Insurance scheme will be underwritten by taxation or other public subventions in much the same way as the current health insurance system receives some Exchequer underwriting. In a recent report commissioned by the National Disability Authority, the authors noted how the funding of health services in Ireland was arranged: "The current system in Ireland uses a range of funding mechanisms: taxation, (which provides approximately 70% of health funding); fee-per-service payments (providing approximately 15% of funding); and private insurance coverage (used by around 50% of people in Ireland, although it accounts for just 10% of healthcare funding). Approximately 30% of people are eligible for a medical card. This facilitates free access to health care for certain disadvantaged groups including many people with disability, although these patients may have considerably longer waits for care than those with private cover (O'Ferrall, 2009). McDaid et al (2009) report a more detailed breakdown of total health expenditure by source of funding from 2006: 78% from taxation and other government income; 12% out of pocket payments; 8% private health insurance; 1% social insurance ; and 1% other private funds. The Department of Health and Children's report *Resource Allocation, Financing and Sustainability in Health Care: Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector* (Volume II) (2010), available at *www.dohc.ie/publications/resource_allocation/BKMNEXT167V1.pdf?direct=1* estimated

other countries will need to be taken into account including expenditure, control, solidarity and access.[622] The Health Insurance Acts 1957-2012 address aspects of the "obligation to protect" by providing some levels of risk equalization protection for those with private health insurance and permitting reparations accountability where entitlements are not provided. However, the legislation also raises issues pertaining to the State's "obligation to respect" insofar as the State has legislated for a two-tier health system under which indirect discrimination concerns arise. The Acts may assume further importance if the State replaces the General Medical Services Scheme with a compulsory insurance scheme as proposed. If the new system provides for access to health services for those currently entitled to free public healthcare,

---

direct out of pocket payments by households to be 10-15% of total expenditure"; G Davidson, B Kelly, G Macdonald, A Martin, M Rizzo, O Abogunrin and L Lombard, *Universal Health Insurance systems and the provision of health services for people with disabilities,* A National Disability Authority Working Paper, Dublin (2012) at 13-14. If the Government decides to continue with a health insurance market, it will likely be obliged (under competition law rules) to continue with a "range of insurance providers who are usually independent of the providers of health services". This is known as the "Bismarck" system as used in France and Germany; whereas "Beveridge systems" refer to managed single-payer systems (usually the Exchequer) as used in Canada and the UK; G Davidson et al, ibid., at 12. In relation to structure, the Government has a choice whether to continue with a health insurance model despite competition law risks (see Part 1 discussion) or to replace the system with a system funded through taxation as occurs with the National Health Service in the United Kingdom. It has been observed that "the main benefits of Universal Health Insurance systems may in fact, be due to this universal coverage and access rather than the insurance system per se", something found in the UK model; see G Davidson et al, ibid., at 11.

[622] See B Toebes and M San Giorgi, *Dutch realities: evaluating the Dutch health care reform from a human rights perspective* (draft chapter) in *The right to health: a multi-country study of law, policy and practice* (Eds B Toebes, R Ferguson, M Markovic and O Nnamuchi), TMC Asser Press/Springer (due 2014) at 6-10. Noting concerns raised in relation to the Dutch model on which the Irish universal health insurance proposal is based, Davidson et al state: "Vaillancourt Rosenau and Lako (2008) suggested that [the Dutch model] may not be very effective at controlling costs, as premiums are rising and insurance companies are reporting large losses. The NDA (2010, p. 53) has also identified that the managed competition between insurance providers does not necessarily increase competition and choice. The Dutch reforms may not have helped people to compare companies and move easily between them, and the system of managed competition may in fact have led to a less competitive market. In considering the application of the Dutch system to the Irish context, Borowitz et al. (2011, p. 25) have also urged caution, stating that, although the proposed system in Ireland seems more equitable, it is still not clear whether it will improve efficiency. The Dutch model, which was theoretically likely to improve efficiency, has struggled to show such improvements in practice. Expenditure has increased rapidly in the Netherlands because of a loss of central control over prices and quantity of health care provided. Competition has failed to make providers more efficient. The challenge for Ireland is to make the new system work well. Unless this happens, Borowitz et al. believe the reforms will lead to equitable access to an inefficient system"; G Davidson, B Kelly, G Macdonald, A Martin, M Rizzo, O Abogunrin and L Lombard, *Universal Health Insurance systems and the provision of health services for people with disabilities,* A National Disability Authority Working Paper, Dublin (2012) at 26-27.

yet permits supplementary health insurance for those who can afford to pay, the fault-lines of the current system will continue and competition law concerns in the health market would arguably favour private provision, placing further strain on the "public" system and thus further aggravating those indirect discrimination concerns.

Arising from the foregoing, the right to health under Irish legislation has limited scope and does not correspond to full access to the AAAQs without discrimination. The closest legislative right that approximates to the "respect", "protect" and "fulfil" typology requirements of the international right to health can be found under the Equal Status Acts 2000-2012, but even here any claim under the AAAQs cannot be considered where clinical judgment is connected to the impugned health service and even where this hurdle can be overcome, there is no socio-economic ground under the legislation. Indeed, under the Irish health system as currently constituted with its "two tier" public and private health provision, concern arises as to whether it does not violate the prohibition of indirect discimination in being structured in a manner which limits accessibility to the AAAQs for vulnerable groups who cannot afford private health insurance. Absent legislative right to health protection, attention turns to the protections afforded under the fundamental rights provisions of the Irish Constitution.

9 Fundamental rights under the Constitution

The right to health may be located under both the enumerated rights to life and the person and the unenumerated right to bodily integrity in the Constitution. We will first explore the enumerated right to life which has seen the courts address right to health issues primarily from the viewpoint of the woman's right to health when balanced against the right to life of "the unborn" and end of life issues, namely assisted suicide, active or passive euthanasia. As these cases have concerned health and medical treatment at the start and end of life, it is instructive to observe how the courts have framed the right to life protections and by corollary, elements of the right to health. However, the wider formulation of the right to health as set out in Part 1 of this thesis falls for consideration under the right to bodily integrity first identified under the unenumerated rights doctrine and more latterly under the enumerated right to the person.

It should be stressed, however, that constitutional rights usually fall to be interpreted in favour of an individual plaintiff or applicant rather than a vulnerable group of persons. As such, if a constitutional right to health can be identified, it is the protection of an individual's health which will be at issue rather than general access to healthcare services.[623]

As the source of the unenumerated rights doctrine in the Constitution is critical to understanding the scope of the right, this will necessitate consideration of Natural Law doctrine which formed the primary source of those rights from *Ryan v Attorney General*[624] until its disavowal in the *Regulation of Information* Judgment of the Supreme Court. With the relegation of Natural Law doctrine as a source of rights, attention will turn to other sources under Article 45 (directive principles) and Article 6 (popular sovereignty) of the Constitution. We will also consider whether international human rights law may not be a source of unenumerated rights.

---

[623] An exception is the consideration of whether there is a right to health under a reference to the Supreme Court made pursuant to Article 26 of the Constitution: see discussion below of *Re Article 26 and the Regulation of Information (Services Outside the State for Termination of Pregnancy) Bill 1995* [1995] 1 IR 1.

[624] [1965] IR 294.

The Irish Constitution, known as Bunreacht na hÉireann, was proclaimed by the People in 1937. Although its genesis was pre-World War II, pre-United Nations, it did contain broad anticipative fundamental rights provisions in Articles 38 and 40-44 of the Constitution (discussed below). In line with emerging democratic nations, the three arms of State are set out in the text as the Legislature (Article 15), the Executive (Article 28) and the Judiciary (Article 34 et al). Its separation of powers doctrine derive from this historic pre-World War 11, pre-United Nations, pre- justiciable human rights era.[625] Judicial independence is however recognised under Articles 34-37 as the third arm of the separation of powers.[626]

As to the values which underpin the constitutional text, the Preamble sets out the Christian nature of the State in no uncertain language where it states that all

---

[625] Morgan traces the evolution of the separation of powers doctrine as it evolved in the United Kingdom and in the United States to that pre-human rights era constitutional struggle between the Executive (the King) and the legislature. He notes how, developing the writings of John Locke and Baron Montesquieu, the concept of a "balanced constitution" (the notion that the legislature and the executive should be independent of each other) as opposed to a "mixed constitution" (the notion that each of the major interests of the day comprising "clergy, barons and commons" in the fourteenth century) emerged; D G Morgan, *The Separation of Powers in the Irish Constitution* Sweet & Maxwell, Dublin (1997) at 2-8. Se also J Locke, *Two Treatises of Government* (Laslett ed. 1960) VII, paras 87-88; IX, paras 124-131 and Montesquieu, *De l'Esprit des Loix* – Book XI (1758); see H Bok, *Baron de Montesquieu, Charles-Louis de Secondat*, The Stanford Encyclopedia of Philosophy (2003). See Murray J in *TD v Minister for Education* [2001] 4 IR 259: "It was Montesquieu's fear that "When the legislative and executive powers are united in the same person or body, there can be no liberty, because apprehensions may arise less the same monarch or senate should enact tyrannical laws to execute them in a tyrannical manner" He expressed the concern: "Were the power of judging joined with the legislative, the life and liberty of the subject would be exposed to arbitrary control, for the judge would then be the legislator. Were it joined to the executive power, the judge might behave with all the violence of an oppressor ..." *(De l'Esprit des Lois)*"; at 329.

[626] Judicial independence is stated to involve two aspects, both individual and institutional. "Individual independence" is reflected in a judge's security of tenure; whilst "institutional independence" is refers to "the independence of the court" in which the judge sitsD G Morgan, *The Separation of Powers in the Irish Constitution* Sweet & Maxwell, Dublin (1997) at 2-8. To the three arms of State enumerated, there is arguably a fourth estate: that of independent pro-rights forces: civil society organisations and independent regulatory bodies exercising rule of law funtions, such as the institutions of the Comptroller and Auditor General, the Director of Public Prosecutions, the Ombudsman and the Irish Human Rights Commission: see Morgan at 16 and at 201-215; ibid. Civil society organisations include independent professions (particularly lawyers) and non governmental organisations. Usman argues that there are four arms of Government, namely the executive, the legislature, the people, and the judiciary, with the people being representative democracy vindicated by the judicial space "to determine, promote, and pursue objectives, norms, values, and goals of the contemporary generation"; J Usman, *Non-Justiciable Directive Principles: A Constitutional Design Defect* 15 Michican State Journal of International Law (2007) 643 at 696.

authority derives from "the Most Holy Trinity".[627] The dignity and freedom of the individual is stated to be a core aim of the Constitution, as is the "common good" with reference to Prudence, Justice and Charity. Reinforced by Articles 5 and 6 of the Constitution, the characterisation of the State in near-theistic terms was important for the manner in which the recognition of personal rights by the courts evolved from the seminal judgment of *Ryan v Attorney General*[628] in 1963 (discussed below). Article 5 provides that "Ireland is a sovereign, independent, democratic state" while Article 6 affirms that the powers of Government "derive under God, from the People".[629]

As noted, the fundamental rights provisions of the Constitution are located in Articles 40-44 of the Constitution. Article 38 provides for due process of law in criminal trials, while Article 45 sets out general guidance for the Oireachtas in its *Directive Principles of Social Policy* stating, *inter alia*, in Article 45.4.1° "The State pledges itself to safeguard with especial care the economic interests of the weaker sections of the community, and, where necessary, to contribute to the support of the infirm, the widow, the orphan, and the aged." However, Article 45 itself makes clear that these principles "shall not be cognisable by any Court under any of the provisions of this Constitution". As will be observed, under the separation of powers doctrine, the courts have exercised particular restraint in reviewing legislative or executive omissions and accordingly these directive principles of social policy have been rarely drawn on by the courts in their jurisprudence on fundamental rights or in aid of the

---

[627] The full text reads: "In the Name of the Most Holy Trinity, from Whom is all authority and to Whom, as our final end, all actions both of men and States must be referred, We, the people of Éire, Humbly acknowledging all our obligations to our Divine Lord, Jesus Christ, Who sustained our fathers through centuries of trial, Gratefully remembering their heroic and unremitting struggle to regain the rightful independence of our Nation, And seeking to promote the common good, with due observance of Prudence, Justice and Charity, so that the dignity and freedom of the individual may be assured, true social order attained, the unity of our country restored, and concord established with other nations, Do hereby adopt, enact, and give to ourselves this Constitution."

[628] [1965] IR 294.

[629] Article 6(1) provides that all powers of government, legislative, executive and judicial, derive, under God, from the people. Authors differ on the extent to which communitarian values (emphasising the role of the community and shared values in defining and shaping individuals) and liberal individual democracy values (such as the characterisation by John Rawls of atomistic individuals (see J Rawls, *A Theory of Justice,* Harvard University Press (1971)) are reflected in national constitutions and the extent to which these values may be reconciled.

enumeration of rights under Article 40.3.1 as is the case in other jurisdictions such as India.[630] Nonetheless, they remain a key touchstone for the principles which the framers of the Constitution wished to have underpin the Constitutional text as will be discussed further below.[631]

9.1 The right to life

Article 40 is the personal rights provision of the Constitution. Article 40.3 contains both explicit and implicit personal rights providing:

> 1° The State guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate the personal rights of the citizen.
>
> 2° The State shall, in particular, by its laws protect as best it may from unjust attack and, in the case of injustice done, vindicate the life, person, good name, and property rights of every citizen.
>
> 3° The State acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right.[632]

Under Article 40.3.2 it will be observed that there are several enumerated personal rights. These are the rights to life (elaborated further in subparagraph 3), person, good name and property rights. There is no express right to health in the Constitution but rather a right to life, although more recently a right to health has been located under the right to the person (discussed below). Article 40.3.2 requires the State "by its laws [to] protect as best it may from unjust attack and, in the case of injustice done, vindicate the life [and] person ... of every citizen". Under subparagraph 3, the right to life includes the right to life

---

[630] An exception would be the judgment of Kenny J in In *Murtagh Properties v Cleary* [1972] IR 330; discussed below.

[631] See generally C O'Mahony, *Societal Change and Constitutional Interpretation,* Irish Journal of Legal Studies (2010) at 71.

[632] Article 40.3.3 was introduced pursuant to the Eighth Amendment to the Constitution in 1983: see Eighth Amendment of the Constitution Act 1983. See also Article 40.3.3 paragraphs two and three on travel and information services introduced pursuant to the Thirteenth and Fourteenth Amendments to the Constitution in 1992. This followed the Supreme Court Judgment in *Attorney General v X* [1992] 1 IR 1. The Fourteenth Amendment to the Constitution also proposed a tightening of Article 40.3.3 to exclude a risk of self-destruction from risk to a woman's life in pregnancy but was defeated. Also defeated was the Twenty-fifth Amendment to the Constitution in 2002 which proposed a new subsection (4) to Article 40.3 to protect the life of the unborn in the womb in accordance with the provisions of the Protection of Human Life in Pregnancy Bill, 2001.

of the unborn with due regard to the equal right to life of the mother, significant insofar as much of the early jurisprudence concerning aspects of the right to health focused on the balance between right to life and right to health concerns arising from abortion and end of life cases. The right to life as will be seen impacts on a number of aspects of one's right to health, whereas the significance of the doctrine of unenumerated rights for the right to health can be found in the fact that the courts have "read in" to Article 40.3.1 rights such as the right to bodily integrity. Questions remain as to whether a health-related right may be dealt with under the enumerated rights to life, person, family life or the unenumerated right to bodily integrity. In *McGee v Attorney General*[633], whereas Henchy J located the right to (marital) privacy in Article 40.3.1, Walsh J found for the plaintiff under both that provision and under her right to family life.[634] He also addressed her right to life holding that one of the personal rights of a woman in the plaintiff's state of health "would be a right to be assisted in her efforts to avoid putting her life in jeopardy" and that the State has the positive obligation to ensure by its laws as far as is possible the means whereby a conception which was likely to put the plaintiff's life in jeopardy might be avoided when the risk was high.[635]

In *Re a Ward of Court (withholding medical treatment) No. 2*[636] both the right to life and the (unenumerated) right to bodily integrity were addressed by the Supreme Court. In this end of life case which concerned ongoing life support for a severely disabled person with no capacity to speak or to communicate, lacking as she did mental capacity and being in a persistent vegetative state (PVS)[637], the approach of the courts to the circumstances in which medical care

---

[633] [1974] IR 284.

[634] Article 41.1 recognises the "Family" as the natural primary and fundamental unit group of society as a moral institution possessing inalienable and imprescriptible rights, antecedent and superior to all positive law.

[635] [1974] IR 284 at 315-316.

[636] [1996] 2 IR 79.

[637] The woman had been in a PVS for 20 years. Under this condition, also known as continuous vegetative state, the brain stem can continue to function even if the cortex, damaged through deprivation of oxygen, is destroyed. The condition is characterised by an irregular but cyclical state of circadian sleeping and waking unaccompanied by any behaviourally detectable expression of self-awareness, self-recognition of external stimuli, or consistent evidence of attention or inattention or learned responses: see D Madden, *Medicine, Ethics and the Law*

and treatment can be provided or withheld is instructive. The High Court authorised the removal of the tube.[638] Upholding on appeal, the Supreme Court considered the question from both the enumerated right to life and an unenumerated right to dignity/ autonomy perspective.

Hamilton CJ quoted the judgment of Finlay CJ in *The Attorney General v X*[639] who had stated that the right to life would take precedence over any other rights and that the right "imposes a strong presumption in favour of taking all steps capable of preserving it, save in exceptional circumstances."[640]

Hamilton CJ then went on to address the implications of this reasoning on end of life situations holding that although no person "has the right to terminate or to have terminated his or her life, or to accelerate or to have accelerated his or her death", the right to life included the right "not to have life artificially maintained".[641] This "naturalist" reasoning approach to life and death by Hamilton CJ has been described variously as dubious, paternalistic and unconvincing.[642] O'Flaherty J distinguished between the person in this case and "seriously mentally handicapped persons" who he stated obtained pleasure and enjoyment from life.[643]

(2nd Ed) (2009) at 539-540. Patients in a PVS can live for many years with mechanical support.

[638] In the High Court Lynch J applied the "best interest" test articulated in *Airedale NHS Trust v Bland* (1993) AC 789 (see below).

[639] [1992] IR 1 at 57.

[640] [1992] IR 1 at 57 and Hamilton CJ in *Re a Ward of Court (withholding medical treatment) No. 2* [1996] 2 IR 79 at 123.

[641][1996] 2 IR 79 at 124.

[642] See O Doyle, *Constitutional law: Text, Cases and Materials* Dublin: Clarus Press (2008) at 112, G Whyte, *The Right to Die and the Irish Constitution*, 2 European Public Law (1997) 235 at 236; D Feenan, *Death, Dying and the Law*, 14 Irish Law Times (1996) 90 and R Byrne and W Binchy, *Annual Review of Irish Law* Roundhall Press (1995) at 159 and 174.

[643] [1996] 2 IR 79 at 130. In focusing on quality of life as being determinative, O'Flaherty J emphasised letting nature take its course and that with the advance of medical technology there was otherwise the danger of being rendered "a prisoner in a ward from which there may be no release for many years without any enjoyment or quality of life"; at 130. O'Flaherty J also characterised withdrawal of consent for a person with capacity as being an absolute right even if it leads to death, citing *Walsh v Family Planning Services Ltd* [1992] 1 IR 496. Hamilton CJ suggested that if mentally competent, there was "no doubt" but that she had the right, if she so wished, to forego or direct that treatment be withdrawn even though such withdrawal would

Decisions regarding end of life decisions in other jurisdictions have centred on the competency of the individual, whether statutes prohibiting assisted suicide violate fundamental rights, whether decisions to terminate life were unlawful and whether advance directives were properly executed. They have not centred on a "quality of life" focus.[644]

The lawfulness of the ban on assisted suicide was at issue in *Fleming v Ireland*.[645] Here the plaintiff, a severely disabled person, challenged the constitutionality of section 2 of the Criminal Law (Suicide) Act 1993 under which it is an offence to "aid, abet counsel or procure the suicide of another".[646] A special Division of the High Court rejected the claim that the

---

result in her death; at 124-125. Denham J focused on the consent of the person being key; at 156. See also *Fitzpatrick v White* [2008] 3 IR 551, discussed below.

[644] In *Conservatorship of Wendland* 26 Cal 4th 519 (2001) the Supreme Court of California considered that the law required "clear and convincing evidence" that the person is incompetent but conscious for treatment to be discontinued; at 524.

[645] [2013] IEHC 2. At time of writing the judgment was under appeal to the Supreme Court.

[646] Section 2(2) of the Criminal Law (Suicide) Act, 1993 makes it an offence on indictment to imprisonment for a term not exceeding fourteen years, similar to the UK's Suicide Act 1961. The plaintiff, who suffered from degenerative multiple sclerosis which rendered it necessary for her to fulfil her wish to commit suicide through assistance argued that her rights to autonomy, dignity and self-determination under Article 40.3 were infringed by the blanket ban on assisted suicide. She also argued that there was a violation of Article 40.1 on the ground of discrimination on the basis of her disability status (discussed below). The manner in which doctors approach such questions is important insofar as there are three potential sanctions against doctors who engage in medical malpractice: criminal prosecution which is rare, civil (negligence) litigation where the standard of proof is one's peers (discussed below) and a professional misconduct complaint which is judged by a medical majority on the Medical Council's Preliminary Proceedings Committee (discussed below). Following *R (on the application of Pretty) v DPP* [2001] UKHL 61, Mrs Pretty brought an subsequent unsuccessful application to Strasbourg: see *Pretty v United Kingdom*, Application No. 2346/02, 29 April 2002, 35 EHRR 1. See also *Haas v Switzerland*, Application 31322/07, 20 January 2011 (Hudoc 2011), where the European Court held that the refusal by the applicant's psychiatrist or State authorities to prescribe or make available without prescrption sodium pentobarbital did not infringe his Article 8 rights on the basis of the State's "margin of appreciation"; at para 61. Following *Pretty*, in 2009, the Court of Appeal in *R (on the application Purdy) v DPP* [2009] EWCA Civ 92, while dismissing the application observed that "the court is part of the protective system which discourages and would prevent or extinguish the effect of any arbitrary or unprincipled exercise by the DPP of his responsibilities [to exercise discretion whether to prosecute or not]"; at para 82 per Judge LJ. The court required the DPP "to clarify what his position is as to the factors that he regards as relevant for and against prosecution" in cases of encouraging and assisting suicide; at para 55.The UK's DPP introduced its *Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide* in February 2010 (see paras 37-45) available at *www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.html* accessed 22 September 2012. The absence of such guidelines in Ireland were also challenged in *Fleming* and while stating that the DPP could not legislate for such guidelines by virtue of the separation of powers doctrine, the court indicated that she would need to exercise her discretion in light of the UK guidelines if a situation of assisted suicide arose in the case: "the

statutory provision was disproportionate, finding that the restriction on the exercise of her right to autonomy was proportionate "to the fundamental objective of protecting life" as espoused in Article 40.3.2.[647] In doing so, the court found that the legitimate aim of protecting the right to life through an absolute ban was supported by "slippery slope" concerns and that if attempting to craft a remedy to the plaintiff's situation, a "Pandora's box" could or might be opened "which thereafter would be impossible to close".[648]

There are a number of differences between the *Ward* and *Fleming* cases. In *Ward*, the application to end the person's life through her next friend was granted, whereas in *Fleming* the application by the individual with competence was not. In *Ward*, the Supreme Court while evincing the "fundamental objective of protecting life" as espoused in Article 40.3.2 in effect permitted "autonomy" and quality of life arguments to outweigh the common good in permitting the patient deny treatment. In *Fleming*, the right identified by

---

Director in this jurisdiction is nonetheless in as good a position as the Director in the UK as an incidental beneficiary of what happened in that jurisdiction: ibid at para 171.

[647] 10 January 2013, unreported. Applying the proportionality test of Costello J in *Heaney v Ireland* [1994] 3 IR 593 at 607 (discussed below), the court considered that the prohibition on assisted suicide under the 1993 Act was "rationally connected to the fundamental objective of protecting life" and was not remotely based on "arbitrary, unfair or irrational considerations". It impaired the right as little as possible and was proportional to its objective (the second and third of the Heaney tests). The "fundamental objective of protecting life" meant that the State had a "profound and overwhelming interest in safeguarding the sanctity of all human life" in Article 40.3.2, a right which the court noted had been described as "the pre-eminent personal right" by Denham J in *Ward*. Insofar as Article 40.3.2 commits the State to protecting the sanctity of all human life, it was a "normative statement of profound constitutional significance" since in conjunction with the equality guarantee in Article 40.1, it committed the State "to valuing *equally* the life of *all* persons" (emphases retained). The last days of the life of "an elderly, terminally ill and disabled patient facing death" have "the same value, possess the same intrinsic human dignity and naturally enjoy the same protection" as the life of the healthy young person on the cusp of adulthood and in the prime of their life. These were concerns which any "free and democratic society" should strive to protect and uphold; ibid at paras 73-75.

[648] 10 January 2013, unreported, at para 76. The court was persuaded by expert evidence in the case which had suggested that the ability to control "slippery slope" concerns was impossible. The State had provided "an ample evidential basis" to support the view that any relaxation of the ban on assisted suicide would be "impossible to tailor to individual cases and would be inimical to the public interest in protecting the most vulnerable members of society"; at para 67. Even the most rigorous system of legislative checks and balances could not, the court felt, ensure that "the aged, the disabled, the poor, the unwanted, the rejected, the lonely, the impulsive, the financially compromised and the emotionally vulnerable" would not disguise their own personal preferences and elect to hasten death so as to "avoid a sense of being a burden on family and society". The safeguards built into any liberalised system would be vulnerable to "laxity and complacency and might well prove difficult or even impossible to police adequately"; at para 67.

Hamilton CJ in *Ward* that if mentally competent, there was "no doubt" but that an individual had the right to forego or direct that treatment be withdrawn leading to their death, was differentiated from "physician-assisted" suicide.[649] Any autonomy right should give way to the societal concern to protect life having regard to the need to protect vulnerable individuals from "slippery slope" risks as identified in the legislation. The other main difference was that in the *Ward* case, the intention of the legislature was unknown whereas in *Fleming*, the court was able to defer to the legislative intent in considering the proportionality test.

There are similarities between both cases too. Both cases espoused the right to life and the need for procedural safeguards to minimise risks to the vulnerable. In both cases, the courts ultimately expressed concerns at the risk that medical practitioners would not take the correct decision to vindicate rights. In the *Ward* case, the hospital doctors opposed the application to remove the feeding tube, while in *Fleming*, the court was concerned at physician-assisted suicide in other States such as The Netherlands.[650] Whereas in both cases, the courts evinced a paternalistic approach to termination of life, in *Fleming* this was evinced even though the person had mental capacity to express her wishes, relegating her autonomy rights as subservient to the protection of life command in Article 40.3.2.

Important issues arise, notably from the *Ward* case. Can a person with more cognitive and relational capacity than the ward in this case but who is nonetheless deemed to lack capacity have life sustaining or enhancing treatment removed?[651] Here the decision to withdraw treatment would be that

---

[649] The court stated that "there is an enormous and defining difference between the decision of the competent patient to refuse treatment and physician assisted suicide". Whereas the State cannot constitutionally "compel the competent adult patient to accept medical treatment" on the basis that this would be "wholly at variance with the obligation to protect the person in Article 40.3.2" it would be a "fallacy" to suppose that physician assisted suicide "can be equated with this, precisely because it involves active participation by another in the intentional killing of that other, even if this is genuinely and freely consensual"; at para 93.

[650] 10 January 2013, unreported. The court expressed concern at 2005 figures from the country which suggested that "560 patients (some 0.4% of *all* deaths) were euthanized without having given their explicit consent"; at para 96. Many deaths in hospitals may not involve a post mortem on inquest and be recorded on death certificates in reductionist language such as "pulmonary failure".

[651] This question was posed by Egan J in his dissent in the *Ward* case: [1996] 2 IR 79 at 105.

of others, likely the High Court under its *parens patriae* Wards of Court jurisdiction.[652] Relatives, (as in the *Ward*) case, personal guardians (under capacity legislation) or doctors may apply to the courts for such an order but it is the court which will decide.[653]

Insofar as in the *Ward* case, Denham J viewed the feeding tube as being medical treatment while Hamilton CJ viewed it as medical treatment which was invasive of her right to bodily integrity,[654] intrusive medical treatment attains a constitutional dimension and this right to refuse treatment was distinguished from "active euthanasia" in *Fleming*.

This raises the question as to the circumstances in which technological ("artificial") life-sustaining or life-prolonging medical treatment[655] should commence and/ or end in what has been described as "medically futile" cases[656], a particularly contentious topic which may arise pre-birth, following

---

[652] Hamilton CJ considered that Lynch J's approach of "the standpoint of a prudent, good and loving parent" was correct; at 127-128. This *parens patriae* jurisdiction of the court to act in the best interests of a ward still operates unless displaced by statute such as the UK Mental Capacity Act 2005 and under the Heads of the Mental Capacity Bill 2013.

[653] The court, on receiving an application, may also appoint a guardian *ad litem*. In the *Ward* case, Lynch J appointed the General Solicitor for Wards to act as such a guardian with the function of contradicting the case being advanced by the ward's family in favour of termination of treatment. Such an approach is consistent with Articles 12 and 13 of the Convention on the Rights of Persons with Disabilities which concern the right to equal recognition before the law and the right of access to justice, respectively.

[654] Feeding through a gastrostomy or nasogastric tube was viewed as a form of medical treatment, per Denham J [1996] 2 IR 79 at 158. For Hamilton CJ such intrusive treatment constituted an interference with the integrity of the ward's body and could not be regarded as normal means of nourishment; at 124-125.

[655] Common forms of such treatment are nutrition, hydration or mechanical ventilation. See Law Reform Commission, *Bioethics: Advance Care Directives*, Law Reform Commission LRC 94 (2009) where the Commission considered that consistent with the autonomy principle, a person has the right to refuse medical treatment even if that treatment leads to death and, therefore, a person can refuse life-sustaining treatment in an advance care directive; at 60.

[656] Madden notes how there are many definitions of this term or the term "non productive treatment" including whether the treatment achieves its objectives; what the survival rates are or the quality of benefit to be achieved from the treatment. In the absence of consensus on a definition of futile treatment, consensus now focuses on the process (promoting communication, minimising conflict and avoiding legal avenues) by which consensus should be arrived at by those most closely involved. This can be observed in the Medical Council's guidance to doctors in end of life situations; see Medical Council's *Guide to Professional Conduct and Ethics for Registered Medical Practitioners* (2009) at sections 22.4 accessible at *www.medicalcouncil.ie/.../Professional-Conduct-Ethics/* accessed 9 September 2012. Consensus seeking here does not refer to prior consultation with families which is viewed by some doctors as even constituting a dereliction of their duty to take necessary decisions: "It is not good practice to ask relatives to be the primary decision makers and it is an abdication of a

birth or in cases of severe disability or elder age conditions. Despite "slippery slope concerns", decisions to limit or withdraw medical treatment in "futile" cases are common and have been traditionally taken by doctors without recourse to the courts.[657] Doctors, in seeking adherence to the traditional Hippocratic Oath and current medical ethical guidelines[658] seek to distinguish between withholding "futile" medical care and active euthanasia[659] on the basis that the former does not encourage, nor speed the natural onset of death.[660]

---

physician's responsibility to impose this on them"; D Phelan and B Kinirons, *Withdrawal of Futile Interventions in Intensive Care - an Everyday Ethical/Critical Care Issue*, 2 Medico-Legal Journal of Ireland (1996) 49 at 51-52.

[657] A 2006 study reviewing "futile" cases in the Mater Hospital in Dublin found that "45 patients (36%) had therapy withheld, 40 (33%) had therapy withdrawn, 26 (21%) had unsuccessful CPR and 11 (10%) were Brain Dead. SDP was not performed. In total, 85 patients had a limitation of life sustaining therapy. CPR was the main therapy withheld..."; N Collins, *End of Life in ICU Care of the dying or Pulling the Plug*? 4 Irish Medical Journal (2006) at 112. In the UK, "almost two-thirds of the cases of death occurred with a decision to limit medical treatment or withdraw mechanical ventilation, implying that additional or further therapy was considered futile"; see I M Balfour-Lynn and R C Tasker, *At the coalface - medical ethics in practice Futility and death in paediatric medical intensive care* Great Ormond Street Hospital for Children NHS Trust, London, 22 Journal of Medical Ethics (1996) 279 at 280. Writing in 1997, Luce noted how the incidence of withholding and withdrawal of life support from critically ill patients "has increased to the extent that these practices now precede well over half of all deaths in many intensive care units (ICUs)"; J M Luce, *Making Decisions About the Forgoing of Life-sustaining Therapy*, 156 American Journal of Respiratory and Critical Care Medicine (1997) 1715. Phelan and Kinirons cite up to 7% of withdrawal of invasive interventions in ICU admissions and in 40-60% of ICU deaths: see D Phelan and B Kinirons, *Withdrawal of Futile Interventions in Intensive Care - an Everyday Ethical/Critical Care Issue*, 2 Medico-Legal Journal of Ireland (1996) at 49. Luce argues in favour of "shifting decision-making from the patient, physician, and payor to a group level" so that futility policies can move "closer to a social consensus on the issues of what is truly beneficial and how limited resources should be allocated"; ibid at 1718.

[658] L Edelstein, *The Hippocratic Oath: Text. Translation. and Interpretation*, Supplements to the Bulletin of the History of Medicine No. 1 Baltimore: Johns Hopkins University Press (1943); also reviewed in 66 The American Journal of Philogy (1945) at 105. See too the Medical Council's *Guide to Professional Conduct and Ethics for Registered Medical Practitioners* at sections 22.2 and 22.23; Seventh Ed (2009) at Section 2.1 accessible at *www.medicalcouncil.ie/.../Professional-Conduct-Ethics/* accessed 9 September 2012.

[659] The act of deliberate and intentional administration (for example by lethal injection) by a doctor to end the life of the patient.

[660] The Medical Council's guidance states that there is "no obligation on you to start or continue a treatment, or artificial nutrition and hydration, that is futile or disproportionately burdensome": see Medical Council's *Guide to Professional Conduct and Ethics for Registered Medical Practitioners* at section 22.2; accessible at *www.medicalcouncil.ie/.../Professional-Conduct-Ethics/* accessed 9 September 2012. Families or next friends have not traditionally been consulted prior to such decisions but informed after the event: see Medical Council's *Guide* at section 22.4. Phelan and Kinirons argue that "the best guide is that futility should be a consensus decision of all substantive health care attendants" with the relatives "informed"; D Phelan and B Kinirons, *Withdrawal of Futile Interventions in Intensive Care - an Everyday Ethical/Critical Care Issue*, 2 Medico-Legal Journal of Ireland (1996) 49 at 51-52.

The Indian Supreme Court judgment of *Shanbaug v Union of India*[661] is noteworthy insofar as, as in the *Ward* case, the court had to consider an end of life petition in the absence of legislation. Both judgments emphasised the *parens patriae* role of the court as the ultimate decision-maker in such petitions. Rejecting a petition to end the life of a woman living in a hospital for 37 years in a PVS state,[662] the Indian Supreme Court in *Shanbaug* stated that at issue were the circumstances in which "non voluntary passive euthanasia" could occur.[663] The court reviewed the law on end of life in a number of jurisdictions including perhaps the first case on the right of patients to refuse "futile" treatment in *In re Quinlan*.[664] Persuaded by autonomy arguments, the court held that passive euthanasia "should be permitted … in certain circumstances" only.[665] However, unlike the Irish court, in the absence of action by the legislature, the Indian court refused the petition and also set out declaratory principles which would "continue to be law until Parliament makes

---

[661] Judgment of 11 March 2011, [2011] 2SC R8 69 Writ Petition (Criminal) No. 115/ 2009. See also S Rao, *India And Euthanasia: The Poignant Case Of Aruna Shanbaug*, 19 Medical Law Review (2011) 646.

[662] The woman was lying in this state in a hospital being cared for by hospital staff who resisted the petition. The court distinguished the case from *Airedale NHS Trust v Bland* (1993) AC 789 where the subject, Tony Bland (a victim of the Hillsborough disaster), was "totally unconscious" (see below).

[663] [2011] 2 SCR 869. The court distinguished between passive and active euthanasia. It gave as examples of passive euthanasia if a patient requires kidney dialysis to survive, not giving dialysis although the machine is available would be "passive euthanasia", the withdrawing of a life support machine from a patient in a coma; the withholding of life saving medicines such as antibiotics and denying food to a person in a coma or PVS. The court considered that euthanasia was the pursuit of a course of action where death is the intended outcome or the "medical management of death". Passive euthanasia could be "voluntary" (the action causing death is consented to by a competent and uncoerced patient), "non-voluntary" (the action causing death is neither consent nor objected to because the patient is unable to consent/object), or "involuntary" (the action causing death is not consented to by a competent patient). Active euthanasia would refer to where the actor intentionally and deliberately takes an action the result of which is death; at para 51. Whyte has defined involuntary euthanasia or "mercy killing" as murder and contrary to the Irish Constitution and the common law: G Whyte, *The Right to Die and the Irish Constitution*, 2 European Public Law (1997) 235 at 237.

[664] 70 N.J.10, 355 A. 2d 647 (1996). Mr. Justice Markandey Katju who delivered the judgement of the Indian Supreme Court reviewed the law in the Netherlands, Switzerland, Belgium, UK, Spain, Austria, Italy, Germany, France, the UK, Canada and the US, citing the "autonomy" cases of *Schloendorff v Society of New York Hospital*, 211 N.Y. 125, 129-30, 105 N.E. 92 (1914). *Cruzan v Director, MDH*, 497 U.S. 261(1990) and *In re Quinlan* 70 NJ 10, 355 A2d 647; 1976 NJ. The latter two cases were later cited by the Irish Supreme Court in the *Ward* case.

[665] [2011] 2SC R8 69 at para 226.

a law on the subject".[666] Those principles started from the presumption of self-determination and autonomy[667] but ultimately it was for the court to take the decision, although "due weight" would be afforded to the next friend and doctors involved.[668]

In *Anderson v St Francis-St George Hospital Inc*[669] the Supreme Court of Ohio addressed the situation where an advance directive order (a Do Not Resucitate (DNR) order) was disregarded in favour of medical treatment. Although the hospital nurse had resucitated the person against his wishes, the court found that there were "no damages as a result of the defibrillation of his heart, i.e., no tissue burns or broken bones" and consequently the person's Estate was unable to succeed in its claim.[670] There is no legislative or judicial guidelines on DNR use in Ireland although they do appear to be employed by doctors.[671]

The distinction between voluntary euthanasia and assisted suicide by doctors is narrow (what is an act and what is an omission?) and doctors who comply with

---

[666] [2011] 2SC R8 69 at para 226.

[667] The court quoted Lord Goff in *Airedale NHS Trust v Bland* [1993] AC 789; at 802-803.

[668] "However, it was the Court "alone, as parens patriae, which ultimately must take this decision, though, no doubt, the views of the near relatives, next friend and doctors must be given due weight"; [2011] 2SC R8 69 at para 132. Fears of "the slippery slope" in cases post-*Airdale* include reference to *Frenchay v Healthcare NHS Trust v S* [1994] 2 All ER 403 in which Bingham MR permitted a feeding tube to be removed where the patient was in a PSV state. The "best interests" of the patient test may allow for paternalistic approaches by the courts redolent of O'Flaherty J's enunciation of quality of life as a key criterion of life in the *Ward* case.

[669] 77 Ohio St.3d 82 (1996).

[670] 77 Ohio St.3d 82 at 87 (1996). The person had died subsequently and the suit was brought by his Estate. See also *Gilgunn v Massachusetts General Hospital* No 922-4820 (Mass. Sup Ct Civil Action April 1995) where a jury controversially decided doctors were not negligent in withdrawing treatment and issuing a Do Not Ressusitate order over the objections of the patient's daughter and the perceived wishes of the patient, on the basis of "futile" treatment; cited in JJ Paris, EH Cassem, G William, FE Reardon, *Use of a DNR Order Over Family Objections: The Case of Gilgunn v MGH* 14 Journal of Intensive Care Medicine (1999) at 41-45. Actions for wrongful birth or wrongful life would not appear to be actionable under Irish law given the strong protections available under Article 40.3, see *Byrne v Ryan* [2009] 4 IR 542 where Kelly J awarded damages following a failed tubal ligation for pain and suffering associated with two pregnancies but not for child-rearing expenses, following the precedent of the House of Lords in *McFarlane v Tayside Health Board* [2000] 2 AC 59.

[671] The Law Reform Commission recommended a Code of Practice be introduced to guide the use of DNRs: see *Bioethics: Advance Care Directives*, Law Reform Commission LRC 94 (2009) at 60-61.

a patient's refusal of treatment could in theory be prosecuted.[672] In the US, it is suggested that the actions of doctors comes under more intensive review where treatment is withdrawn rather than withheld[673] and that courts regularly validate "medically futile decisions" by hospitals that have already been implemented when the family later sues for wrongful death by employing the peer-review standard of care test.[674]

Other issues which arise from the *Ward* case include the case of an "unborn"[675] likely or certain to die at birth or within a number of days or birth or likely to be the second of "conjoined twins" whose continued "life" could threaten the dominant twin. The courts in England have considered the issue of "conjoined

---

[672] Madden notes how the law appears to allow a doctor to withdraw a treatment in response to a refusal to accept treatment but would not require a doctor to "respect a request to withhold or withdraw treatment where the patient's intention was suicidal"; D Madden, *Medicine, Ethics and the Law* (2nd Ed) (2009) at 558. Whereas the former "omission" by the doctor could be viewed as "the right to have nature take its course"; per Hamilton CJ in *Ward*, the fact that the doctor could still be prosecuted depending on the circumstances points to the need for relatives and decisions to seek a court order to follow a proposed course of action as happened in *Fleming*. Although the "object and end result of active and passive euthanasia are the same, the legal consequences are vastly different"; Madden at 562 quoting M Otlowski, *Voluntary Euthanasia and the Common Law* (Oxford University Press (1997) at 55. The focus here also returns to paternalism and autonomy and their limits: does one kill or let die? In Europe, the Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001 in the Netherlands decriminalised voluntary euthanasia and was followed by the 2002 Belgian Act on Euthanasia. In other jurisdictions the law is arguably that as set out by Rehnquist CJ who confirmed in *Washington v Glucksberg* 521 U.S. 702 that that insofar as assisted suicide was outlawed in most States, recognised in *Cruzan*, the Supreme Court had given no intimation that the right to refuse unwanted medical treatment could be somehow equated with such a right; at 703.

[673] Orentlicher, points out that although the law has rejected a distinction between withdrawing and withholding life-sustaining treatment " health care providers continue to feel that it is less acceptable to withdraw care than to withhold it"; D Orentlicher, *Health Care Law: A Field of Gaps* 19 Annals Health Law (2009-2010) at 2. The author points out how studies have found that physicians are "quicker to recommend" the discontinuation of ventilators, dialysis, and other treatments than the discontinuation of nutrition and hydration with families no different. "[E]ven after winning the right to have his daughter Karen's ventilator withdrawn, Joseph Quinlan did not agree to have her feeding tube withdrawn. When asked if he wanted to stop her feeding, he replied, "Oh no, that is her nourishment;" at 3, citing P Ramsey, *Prolonged Dying: Not Medically Indicated,* 14 Hastings Center Reports (1976) at 16.

[674] Although courts are reluctant to grant a hospital's request to withdraw or withhold life sustaining treatment because of futility, they "regularly validate futility decisions by hospitals that have already been implemented when the family later sues for wrongful death" with the question of futile treatment seen as "the standard of care to be determined by professional consensus"; D Orentlicher, *Health Care Law: A Field of Gaps* 19 Annals Health Law (2009-2010) at 3, citing *Causey v St Francis Med Ctr.*, 719 So. 2d 1072, 1076 (Louisiana Court of Appeals 1998). It is argued that "health care providers frequently camouflage rationing decisions as medical decisions,[] and lawmakers support them when they do so"; at 3-4.

[675] The rights of the "unborn" are afforded special status under Article 40.3.3 of the Constitution: see discussion below.

twins" in a number of cases.[676] In *Re A (Conjoined twins: medical treatment)*[677] the Court of Appeal approved a petition to separate the twins on medical advice although this was opposed by their parents.[678] The life of one twin (Mary) was sacrificed for the other (Jodie) and the grounds for doing so included Walker LJ's opinion that Mary's body "is not and never has been viable". This raises questions of bodily integrity and personhood and also the role of child or parental autonomy where societal views of personhood centre on an individual's "individual" status and where there is no recognition that the "lesser" twin possesses autonomy.[679] However, as with developing societal

---

[676] Conjoined twins develop from the same fertilised egg, and they share the same amniotic cavity and placenta. In the case of conjoined twins, the single egg does not fully separate after fertilisation, the developing embryo starts to split into identical twins during the first few weeks after conception, "but stops before the process is complete. The partially separated egg develops into a conjoined fetus"; University of Maryland *Facts About Conjoined Twins* available at *www.umm.edu/conjoined_twins/facts.htm#ixzz270BwwKiy* accessed on 22 September 2012.

[677] [2000] EWCA Civ 254. The twins were Jodie and Mary. Following the court-sanctioned separation, Mary died.

[678] All three judges reached their conclusion by different means. Ward LJ viewed the killing of Mary as justified on grounds of self defence"; at para 7. Brooke LJ held that the doctrine of necessity applied; at 280. Walker LJ considered that Mary's life was unviable and adopted a "best interests" approach"; at 290. The doctrine of "double effect" was rejected as a source of reasoning: "I simply fail to see how it can apply here where the side-effect to the good cure for Jodie is another patient's, Mary's, death, and when the treatment cannot have been undertaken to effect any benefit for Mary" per Ward LJ, Part IV, para 4. Kaczor questions this dismissal by the court; see C Kaczor, *The Tragic Case of Jodie and Mary: Questions about Separating Conjoined Twins*, Linacre Quarterly (2003) 159, available at *myweb.lmu.edu/ckaczor/jodiemary.pdf* accessed on 23 February 2013; at 163-164. Wenkel applies the doctrine of "double effect" (the permissibility of acts that have both good and bad effects) to suggest that one should not seek to separate conjoined twins where one twin is facing imminent death, but rather seek to do so after that twin dies; D H Wenkel, *Separation of Conjoined Twins and the Principle of Double Effect*, 12 Christian Bioethics (2006) 291 at 297-298. Here the doctrine of "double effect" justifies an action if "1. [t]he action in itself must be good or at least morally indifferent; 2. The agent must intend only the good effect and not the evil effect. The evil effect is foreseen, not intended: 3. The evil effect cannot be a means to the good effect: and 4. There must be a proportionality between the good and evil effects of the action"; D H Wenkel, *Separation of Conjoined Twins and the Principle of Double Effect*, 12 Christian Bioethics (2006) 291 at 292. Allmark et al suggest that the doctrine's applicability to certain decisions should be diminished arguing that the "is-it-or-is-it-not-euthanasia anxiety" that may attach to end of life decisions doctrine's is unhelpful. The authors do accept however that the doctrine's emphasis on the distinction between "intention and foresight" would remain important for those who wish to distinguish physician-assisted death from palliative care; P Allmark, M Cobb B J Liddle and A Todd, *Is the Doctrine of Double Effect irrelevant in end-of-life decision making?* Sheffield Hallam University (2010), available at *shura.shu.ac.uk/2341/2/NP_Resubmission_DDE_%232.pdf* accessed on 23 February 2013.

[679] Also described as the state of "singleton" by Overall: see C Overall, *Conjoined Twins, Embodied personhood, and Surgical Separation*, in L Tessman, *Feminist Ethics and Social and Political Philosophy: Theorizing the Non-Ideal* (Springer, Dordrecht) (2009) 69 at 70. Davis describes this view as "predicated on our understanding of a person as a bounded, separate

notions of gender and transgender[680], individual body forms should arguably not be a precondition for personhood.[681] Brainstem function may provide a clearer definition of personhood[682] possibly within a more flexible legal environment which recognises human difference in upholding the right to life.[683]

The reasoning by the Supreme Court in the *Ward* case, when addressing passive euthanasia, was expressed in absolutes and can be contrasted with the European Court of Human Rights judgements in *Pretty v United Kingdom*[684], *Vo v France*[685] and *Haas v Switzerland*[686], which ruled incrementally,

---

individual'; C Davis, C*onjoined twins as persons that can be victims of homicide*, 19 Medical Law Review (2011) 430 at 458.

[680] See the UK's Gender Recognition Act 2004 and *Foy v An t-Ard Chláraitheoir & Ors* [2007] IEHC 470.

[681] In *Re A*, the court accepted the medical evidence that physical separation was in the "best interests of the twins" but did not probe the implications of this assumption beyond the case before it. Davis argues that physical independence is not a useful criterion for deciding whether conjoined twins "are persons or not", arguing rather that the "individuation" focus should be less on bodily functions and rather on "having an embodied mind that can clearly be distinguished from another's"; C Davis, C*onjoined twins as persons that can be victims of homicide*, 19 Medical Law Review (2011) 430 at 460.

[682] Focusing on the life of the mind at the commencement of life possibly unites with the end of life discussion in *Shambaug* which focused on brain stem cell function and with religious or spiritual traditions focusing on the presence of the soul, the psyche, self-awareness, atmas, or the very subtle mind as the defining condition of life. Davis points out that rather than trying to "fit conjoined twins into a mould that is inappropriate for them", it may be more appropriate to accept the "unique nature of their embodiment", and to deny them the protection of the criminal law of homicide only where they are not born alive and with a functioning brainstem"; C Davis, C*onjoined twins as persons that can be victims of homicide*, 19 Medical Law Review (2011) 430 at 465.

[683] Critiquing the *Re A* case, Lucas and O'Donnell observe how conjoined twins can be seen as "inhabiting an intermediate category of embodiment between one and two, yet exist in a society which seems unable to contemplate with equanimity the degree of blendedness and interrelatedness which conjoined twins exhibit", or the idea that such intermediate categories "may exist or need to be constructed". Yet conjoined twins exist outside society's "perception of the normal, and are frequently described in terms which emphasise their abnormality, or suggest that their development is not natural (the judgments in *Re A* provide an excellent example…)'"; Lucas and O'Donnell *Conjoined Twins: the cutting edge*, [2002] 5 Web JCLI at 5; available at *webjcli.ncl.ac.uk/2002/issue5/clucas5.html* accessed on 22 September 2012.

[684] *Pretty v United Kingdom*, Application No. 2346/02, 29 April 2002, 35 EHRR 1 at paras 76-78. The Court held that "Article 2 cannot, without a distortion of language, be interpreted as conferring the diametrically opposite right, namely a right to die; nor can it create a right to self-determination in the sense of conferring on an individual the entitlement to choose death rather than life.[] The Court accordingly finds that no right to die, whether at the hands of a third person or with the assistance of a public authority, can be derived from Article 2 of the Convention"; at paras 39-40.

[685] Judgment 8 July 2004 (Application No. 53924/00) where the Court restated how "Article 2 of the Convention is silent as to the temporal limitations of the right to life and, in particular,

preferring to grant States a "margin of appreciation" in approaching sensitive moral issues in relation to when life begins and when it ends. Having set down two imprecise absolutes, namely to let nature "take its course" and the right of a competent person to refuse medical treatment even if it leads to death, the Supreme Court in *Ward* did not set out general principles as the Supreme Court of India did in *Shanbaug v Union of India.*[687] Following the *Ward* case there was some uncertainty in the law following O'Flaherty J's enunciation of quality of life as a key criterion of life.[688] In contrast, *Fleming* appears to favour a more quantity of life approach, however, whether this may be limited to "active euthanasia" type cases remains to be seen.

As noted, much of the right to life jurisprudence of the Irish Courts has been taken up with the interpretation of the right to life of the unborn and the competing rights of a mother. This jurisprudence reached a high-mark in the 1992 case of *Attorney General v X*[689], where the Supreme Court stated that the right to life of the unborn, specifically protected under Article 40.3.3, had to be balanced against the right to life of the mother in a situation where her life was at risk from suicide ("real and substantial risk" per Finlay CJ). It was perceived inaction by the State in response to this Judgment which resulted in the judgment of the European Court 18 years later in *A, B, C v Ireland.*[690]

Another reproductive case impacting on the rights to life and health can be seen in *Roche v Roche and others.*[691] At issue in this case was a dispute

---

does not define "everyone" ("toute personne") whose "life" is protected by the Convention; at para 80.

[686] Application 31322/07, 20 January 2011.

[687] Judgment of 11 March 2011, [2011] 2SC R8 69 Writ Petition (Criminal) No. 115/ 2009.

[688] The court's decision that treatment should be withdrawn led to the curious situation of the Medical Council refusing to review its guidelines on ethics to conform to the judgment. Both the Irish Medical Council and the Nursing Board stated that it was unethical for a doctor or a nurse to withdraw hydration or nutrition from a patient not dying. This stance mirrored the stance of the doctors in the case who had resisted the family's petition for the ward's life to be ended. The Council's latest guidelines restate this viewpoint which leave the conclusions on this matter firmly in the court of the doctor: see para 19.1.

[689] [1992] 1 IR 1.

[690] (Application No: 25579/05), Judgment of the Grand Chamber, 16 December 2010, discussed above.

[691] [2010] 2 IR 321.

between estranged spouses, with the question being whether six viable frozen embryos created *in vitro* in a clinic came within the meaning of protected life under Article 40.3.3 of the Constitution[692]. One estranged spouse contended that the embryos did come within the definition, whereas the other did not. The Attorney General intervened on the constitutional and contractual points, arguing that other jurisdictions tended to approach the matter from a contractual perspective.

In the High Court, McGovern J noted that Article 40.3.3 had been introduced into the Constitution to address the question of abortion rather than for the purposes of pre-IVF treatment.[693] The court took the view that rather than approach the matter from the constitutional dimension, it could be dealt with through the law of contract, namely the agreement arrived at between the estranged spouses when creating the embryos.[694] In the Supreme Court, Murray CJ drew in aid two European human rights conventions[695] in considering that the human embryo is generally accepted as having "moral qualities and a moral status".[696] However, having done so, he refused to apply Article 40.3.3 to the

---

[692] O Doyle, *Constitutional law: Text, Cases and Materials* Dublin: Clarus Press (2008) at 120.

[693] *R v R* [2006] IEHC 359. See also C O'Mahony, in *Societal Change and Constitutional Interpretation*, Irish Journal of Legal Studies (2010) at 71-114 and Healy who suggests that in light of the High Court judgment in the case "each of the two people required to create an embryo has a right to veto the progression to implantation": J Healy, *Medical Malpractice Law* Roundhall Press (2009) at 130. See also *Evans v Amicus Healthcare Ltd and others* [2004] 2 WLR 713 in which the Court of Appeal held that the Human Fertilisation and Embryology Act 1990 which permitted the male gamete provider to refuse to allow his partner access to the embryos for the purpose of transfer into her, constituted a proportionate interference with her right to respect for her private life under Article 8 of the ECHR. The European Court of Human Rights subsequently upheld this decision by the English courts in *Evans v UK* (Application No. 6339/05) Judgment 10 April 2007, 46 EHRR 728: "given the lack of European consensus on this point, the fact that the domestic rules were clear and brought to the attention of the applicant and that they struck a fair balance between the competing interests, there has been no violation of Article 8 of the Convention"; at para 92.

[694] Doyle criticises the narrowness of this approach, noting that the framers of the Eighth Amendment sought to articulate a philosophy around the right to life which, he argues, was not addressed by the High Court in *Roche*; O Doyle, *Constitutional law: Text, Cases and Materials* Dublin: Clarus Press (2008). Indeed, this criticism also holds true for the Supreme Court Judgment in *Roche* in which it dismissed the appeal.

[695] Curiously neither Articles 2 or 8 of the ECHR or the judgments of *Evans v Amicus Healthcare Ltd and others* [2004] 2 WLR 713 or *Evans v UK* (Application no. 6339/05) Judgment 10 April 2007 were invoked by the court.

[696] See [2010] 2 IR 321 at 350-351.

facts of the case, on the basis that this was a "policy choice for the Oireachtas" and an absence of competence in the courts to render it justiciable.[697]

Denham J dealt with the substantive issue. In her view, pre-implanted human embryos did not come within the definition of the unborn under Article 40.3.3 which referred to "the special relationship that exists uniquely between a mother and the child she carries".[698] Not being a constitutional issue, Denham J also considered the matter fell to be considered under contract law. Hardiman J also dismissed the appeal on the constitutional grounds "for the reason that the embryos now being cryogenically preserved are not "the unborn" within the meaning of Article 40.3.3".[699]

These cases suggest that where an aspect of the right to health also concerns commencement or end of life issues (such as pregnancy, suicide, or euthanasia), the right to life under Article 40.3.3 as interpreted by the Supreme Court in *X*, in *Re a Ward* and *Roche* will determine the right. To date however, the right to life under Article 40.3.2 as it applies to the right to health has only rarely been invoked in the Irish courts, perhaps due to the preponderance of focus in the caselaw on the right to life of the unborn and the fact that right to health cases are litigated under medical negligence.

9.2 The unenumerated right to bodily integrity and its source

In addition to the enumerated constitutional rights under Article 40.3.1 are a number of unenumerated rights which include the rights to bodily integrity and privacy which encompass aspects of the right to health. Unlike the Ninth

---

[697] [2010] 2 IR 321 at 351-352. Byrne and Binchy observe that the import of the Chief Justice's comments is that, where people disagree on fundamental moral and philosophical questions, "the courts are not entitled to determine the issue, even where that issue arises from the document that judges are sworn to uphold", R Byrne and W Binchy, *Annual Review of Irish Law* Roundhall Press (1995) at 159. A similar argument was advanced by the US Supeme Court in *Roe v Wade* 410 US 113 (1973) where Blackmun J stated: "We need not resolve the difficult question of when life begins. When those trained in the respective disciplines of medicine, philosophy, and theology are unable to arrive at any consensus, the judiciary, at this point in the development of man's knowledge, is not in a position to speculate as to the answer"; at IX B.

[698] [2010] 2 IR 321 at 370-371. See the criticism of this in R Byrne and W Binchy, *Annual Review of Irish Law* Roundhall Press (2009) at 251.

[699] [2010] 2 IR 321 at 382.

Amendment to the United States of America Constitution, the presence of unenumerated rights under Article 40.3 is not clearly set out and hence the manner in which the judiciary has embraced the doctrine has been controversial.[700]

The doctrine of unenumerated rights was first set out by Kenny J in *Ryan v Attorney General*[701] and approved by the Supreme Court on appeal. *Ryan* involved a right to health claim insofar as the plaintiff claimed that plans to fluoridate the public water supply pursuant to the Health Act 1960 would adversely impact on her right to bodily integrity and those of her children. Although no such right to health or bodily integrity was explicitly set out in the text of the Constitution, Kenny J recognised that there was such a right; the right to bodily integrity meaning "that no mutilation of the body or any of its members may be carried out on any citizen under authority of the law" except for "the good of the whole body and that no process which is or may, as a matter of probability, be dangerous or harmful to the life or health of the citizens or any of them may be imposed" by an Act of the Oireachtas.[702]

Both the doctrine of unenumerated rights and the right to bodily integrity in particular were recognised[703]: the latter in principle only insofar as the plaintiff's claim that there was a violation of the right was rejected. Indeed, the law after *Ryan* was left in an unsatisfactory state insofar as the right had been recognised, but its scope not determined by the Supreme Court.

---

[700] See below. The Ninth Amendment states: "The enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people"; see G Casey, *Are There Unenumerated Rights In The Irish Constitution?* (2005) 23 Irish Law Times.

[701] [1965] 1 IR 294.

[702] [1965] 1 IR 245 at 312-314. Kenny J's formulation of the right to bodily integrity was upheld by Ó'Dálaigh CJ in the Supreme Court who felt it unnecessary to define bodily integrity; at 345. Binchy has suggested that insofar as no mutilation may be carried out "under authority of the law" except for the good of the whole body, Kenny J's formulation is capable of embracing not actions by State and non-State agents alike: W Binchy, *Presentation to Forum on Fluoridation: The Legal Dimension*, Stationery Office, Government Publications, Dublin; Appendix 16 (2002) at 202.

[703] The doctrine of unenumerated rights has variously been described as "notorious" or "innovative" and "exciting and creative"; see G Casey, *Are There Unenumerated Rights In The Irish Constitution?* (2005) 23 Irish Law Times, citing also B Doolan, *Constitutional Law and Constitution Right in Ireland* Dublin (1994) at 156 and J Kenny (writing extra-curially), *The Advantages of a Written Constitution Incorporating a Bill of Rights*, 30 Northern Ireland Legal Quarterly Autumn (1979) 189 at 195 and 196; at 123.

Ryan is nevertheless important in two respects. First because it is the first explicit identification of the fact that there may be inherent or "moral" natural law rights to be implied from what Kenny J referred to as the "Christian and democratic nature of the State" and second because the case in fact concerned a right to health claim where the plaintiff claimed her health and that of her family was affected by oppressive State action and where in identifying a cause of action, the State permitted reparation accountability under its "obligation to respect" the right to health. *Ryan* was followed by *McGee v Attorney General*[704], in which Walsh and Henchy JJ in the Supreme Court invoked natural law to locate a right to marital privacy under two separate provisions of the Constitution, in circumstances where a married woman could not freely access contraceptives. Henchy, Budd and Griffin JJJ all located the right to marital privacy under Article 40.3.1 whereas Walsh J located the right both under Article 40.3.1 and under Article 41 (the right to family life).[705] Both Walsh and Henchy JJ stated that it was for judges to interpret the natural law.

The court found that section 17 of the Criminal Justice Act 1935 violated a woman's right to privacy in her marital relations by frustrating and rendering criminal any efforts "to avail themselves of a particular contraceptive method so as to ensure her life and health as well as the integrity, security and well-being of her marriage and her family".[706]

The natural law theory assertion that there are unwritten rules superior to positive law had been first raised by Kennedy CJ in his dissent in *The State (Ryan) v Lennon*[707] which concerned the import of Article 2A of the 1922 Free State Constitution. Under that Constitution, the legislature could amend the Constitution through statute (Article 50). Kennedy CJ was offended by the draconian nature of Article 2A and argued that there were certain inalienable

---

[704] [1974] IR 287.

[705] Budd J described the right as the right to "privacy relative to matters of the procreation of children and the privacy of married life and marital relations"; [1974] IR 287 at 322. In relation to Article 40.3.1, Walsh J stated that one of the personal rights of a woman in the plaintiff's state of health would be a right to be assisted in her efforts to avoid putting her life in jeopardy and that the State had a positive obligation to provide the means to this end"; at 315-316.

[706] [1974] IR 287, per Henchy J at 328.

[707] [1935] IR 170.

rights beyond the power of the legislature to amend. Indeed, much of the natural law jurisprudence of the courts has been an attempt to address cases of perceived injustice where the judge is unable to locate a right in the constitutional text yet believes the right to be protected by virtue of a higher form of law.

The Irish courts hold that the Constitution "is a constitution for the people expressing principles for its society ... it is a document for the people of Ireland, not an economy or a commercial company"[708] and one that must be interpreted in light of contemporary conditions. In *A v The Governor of Arbour Hill Prison*[709] Murray CJ recalled his previous comments in *Sinnott v Minister for Education*[710] that the Constitution may be viewed as a living document "which falls to be interpreted in accordance with contemporary circumstances including prevailing ideas and mores" where he had cited Walsh J in *McGee* as to how the Constitution was to be conditioned by "prevailing ideas" of prudence, justice and charity, as also cited by O'Higgins CJ in *The State (Healy) v Donoghue*.[711]

The approach of the Irish courts may be contrasted with the more "originalist" approach of positivist lawyers who object to judge-made law from the perspective of a "democratic legitimacy" concern.[712] The objection here is to unelected and unaccountable judges making law; the "danger" being that "judges engage[d] in such constitutional interpretation would consciously or unconsciously impute their own views to society at large[], which would be a clear abuse of judicial power, not to mention a failure to give effect to the views of the people".[713] The doctrine of unenumerated rights, in its quest to

---

[708] See *Sinnott v Minister for Education* [2001] 2 IR 545 at 664 per Denham J.

[709] [2006] 4 IR 88.

[710] See *Sinnott v Minister for Education* [2001] 2 IR 545.

[711] [1976] IR 325.

[712] See C O'Mahony, in *Societal Change and Constitutional Interpretation*, Irish Journal of Legal Studies (2010) at 73-80.

[713] See C O'Mahony, in *Societal Change and Constitutional Interpretation*, Irish Journal of Legal Studies (2010) at 77. O'Mahony makes the important point that much of the US commentary on judicial restraint is coloured by the virtual impossibility of amending the US Constitution which "effectively gives the Supreme Court the final say" with "no readily available majoritarian response to counter-majoritarian judicial review"; C O'Mahony,

locate and address rights not listed in the constitutional text, saw Irish judges engage in constitutional interpretation by invoking the arguably vague principles of natural law (rather than for example the social policy provisions of Article 45). This development was a clear concern for positivist lawyers for whom such a development threatened certainty and predictability in the law. Faced with such criticism, in recent years, the courts have deferred to this "democratic legitimacy" argument in developing an interpretation of the separation of powers doctrine which has seen the courts exercise considerable restraint in their interpretation of fundamental rights (discussed further below).

In *Ryan*, Kenny J invoked the "textual implication" in Article 40.3.2 that there were unenumerated rights protected by Article 40.3.1 (referring to the phrase "*in particular*") which allowed the courts to imply other, unenumerated rights which were protected under Article 40.3.1.[714] The other two sources advanced by Kenny J were "the Christian and democratic nature of the State" and the papal Encyclical letter "Peace on Earth". It is the latter formulation of a rather opaque test whose recognition resides with judges which led to much of the criticism of the unenumerated rights doctrine.[715]

Although *McGee* was decided in relation to the right to privacy, it will be clear that the plaintiff's right to health (as understood under international standards) was equally at issue as privacy in the case. The judgments have been described as "the traditional, Thomist line of Natural law thought" (in the case of Walsh J) and the "more secular, Enlightenment account of Natural Law" (in the case

---

Constitutional Amendment and Judicial Restraint: How Restrained should an Irish Court Be? Conference on "The Irish Constitution: Past, Present and Future", University College Dublin (June 2012) at 4. The author compares this situation with the relative ease of constitutional amendment pursuant to Article 26 of the Constitution insofar as the availability of a relatively accessible democratic response to such decisions removes much of the sting from any majoritarian concerns: at 9. The author cites *Brown v Board of Education* 347 US 483 (1954) as an example of a court's abilty to predict future trends in public opinion; at 15.

[714] O Doyle, *Constitutional law: Text, Cases and Materials* Dublin: Clarus Press (2008) at 86.

[715] See O Doyle, *Constitutional law: Text, Cases and Materials* Dublin: Clarus Press (2008) at 86-92.

of Henchy J).[716] The overlap between the right to privacy and the right to bodily integrity are also self-evident.

In contrast, in the later case of *Norris v Attorney General*[717] criminalisation in the case of same sex consensual sexual relations was not found to violate a right to privacy. In *McGee*, Henchy J had located the right to privacy under Article 40.3 in the human personality. Confirming that it was for the courts to decide whether an unenumerated right exists, Henchy J in that case stated that the lack of precision in Article 40.3.1 is reduced when it is read in light of what the Constitution "expressly or by necessary implication, deems to be fundamental to the personal standing of the individual in question in the context of the social order envisaged by the Constitution." The "infinite variety in the relationships between the citizen and his fellows and between the citizen and the State makes an exhaustive enumeration of the guaranteed rights difficult, if not impossible".[718]

In *Norris*, Henchy J cited "the purposive Christian ethos of the Constitution" as set out in the Preamble and Article 5 to ground his views considering that there is "necessarily given to the citizen, within the required social, political and moral framework, such a range of personal freedoms or immunities as are necessary to ensure his dignity and freedom as an individual in the type of society envisaged." The essence of those rights is that they "inhere in the individual personality of the citizen in his capacity as a vital human component of the social, political and moral order posited by the Constitution."[719] This right to privacy "inheres in each citizen by virtue of his human personality"[720].

---

[716] O Doyle, *Legal Positivism, Natural Law and the Constitution*, 31 Dublin University Law Journal (2009) at 209.

[717] [1984] IR 36.

[718] [1974] IR 284 at 325.

[719] [1984] IR 36 at 71. Henchy J was in the minority. The majority of the Supreme Court rejected a challenge to Section 61 of the Offences Against the Person Act 1861 and Section 11 of the Criminal Law Amendment Act 1885 which effectively criminalised homosexual relations, finding that there was no violation of the plaintiff's right to privacy (see equality discussion below).

[720] [1984] IR 36 at 71. Applying this test, Henchy J considered that the criminal law in question was in his view unconstitutional on the ground that "by their overreach and lack of precision and of due discrimination, they trench on an area of personal intimacy and seclusion which

This individual personality test as espoused by Henchy J is strikingly similar to the test enunciated by the European Court under the right to respect for one's private life under Article 8 of the EHCR.[721] This principle that individual choices of this kind taken by competent adults must normally be respected "absent compelling reasons to the contrary" is now taken to represent "current judicial consensus" on the question of fundamental rights.[722]

In *Norris*, Henchy J and McCarthy J dissenting, considered that the plaintiff's right to privacy had been violated. O'Higgins CJ noted how the plaintiff argued that the existence of the criminal prohibition with its capacity for injury to the plaintiff and others constituted a threat to the plaintiff's right to bodily integrity and was "inconsistent with the State's duty to defend and vindicate such right in accordance with Article 40, section 3" in light of *Ryan.* However, the majority (O'Higgins CJ, Finlay P and Griffin J) focused more on the counterveiling arguments of "public health".[723] In contrast, Henchy J argued that "where a constitutional challenge depends on expert opinion about the actual or potential effect of questioned statutory provisions, the constitutional point must be ruled on the basis of the facts or opinions as admitted to be correct or as duly found by the judge from the evidence given. Where the evidence given is entirely to one effect, it cannot be rejected." Here there was expert evidence as to the impact of the law on the mental and psychological health of the plaintiff. The court did not otherwise engage with the right to health as claimed other than citing the comments of Walsh J of the "power of the parent who has the primary natural rights and duties in respect of the child

---

requires to be treated as inviolate ... save in circumstances where the common good requires otherwise"; at 79.

[721] *Norris v Ireland*, Application 10581/83, 26 October 1988, 13 EHRR 186.

1988 where the court held that the maintenance in force of the impugned legislation constituted a continuing interference with the applicant's right to respect for his private life; at para 38.

[722] *Fleming v Ireland,* [2013] IEHC 2 at para 50, per Kearns P.

[723] O'Higgins CJ referenced the Article 8(2) ECHR legitimate aim of measures designed "for the protection of health or morals" before stating that, in light of *In re* Ó *Laighléis* [1960] IR 93, neither the ECHR nor the decision of the European Court in *Dudgeon v United Kingdom,* Application No. 7525/76, Judgment 22 October 1981, 4 EHHR 149 was in any way relevant to the question before the court. As noted in Part 1 of this thesis, this traditional approach of invoking public health to deny rights is prohibited: see General Comment 20 of CESCR at para 33; discussed above.

to exercise them in such a way as intentionally or by neglect to endanger the health or life of the child or to terminate its existence" in *G v An Bord Uchtála.*[724] Indeed, the reasons for the court's judgment in *Norris* is somewhat obscure and to understand the minority and majority judgments consideration of the role of natural law theory in the doctrine of unenumerated rights is required.

9.3 Sources of unenumerated rights: the role of natural law

Having established that there is a right to bodily integrity under the Constitution, the question turns as to the source of this right when it is not enumerated. Otherwise put, if the scope of the right to bodily integrity under Article 40.3 can be expanded to allow recognition of a right to health, from what sources is this to occur? Conceptual difficulties have unsurprisingly beset the doctrine of unenumerated rights since its conception in *Ryan* where Kenny J read in the right to bodily integrity by reference not only to the source of the textual wording of Article 40.3.2 (namely the term "in particular"), but also to the source of natural law.

The doctrinal origin of fundamental rights as arising from the natural law was most comprehensively set out by Walsh J in *McGee* in addressing the plaintiff's rights under Article 41 of the Constitution, Walsh J noted how both in its Preamble and in Article 6, the Constitution "acknowledges God as the ultimate source of all authority". The natural law was compromised of "natural or human rights"; a theological concept, the "law of God promulgated by reason" and the "ultimate governor of all the laws of men." The Constitution must have "intended the natural human rights" to have that status rather than being simply an "acknowledgement of the ethical content of law in its ideal of justice". This meant that is was sufficient for a court to "examine and to search for the rights which may be discoverable in the particular case before the court in which these rights are invoked".[725] Further, it was for the judges to interpret

---

[724] [1980] IR 32 per McCarthy J.

[725] [1974] IR 284 at 317-319.

the Constitution and to determine "the rights which are superior or antecedent to positive law or which are imprescriptible or inalienable." The individual has natural and human rights "over which the State has no authority" while the family "as the natural primary and fundamental unit group of society, has rights as such which the State cannot control".[726]

Justice was not "subordinate to the law" insofar as Article 40.3 "expressly subordinate[s] the law to justice." Both Aristotle and the Christian philosophers had regarded justice "as the highest human virtue and it was "but natural that from time to time the prevailing ideas of these virtues may be conditioned by the passage of time; no interpretation of the Constitution is intended to be final for all time. It is given in the light of prevailing ideas and concepts".[727] In this way, the natural law is viewed as the ultimate governor of all laws.[728]

Both *The State (Nicoloau) v An Bord Uchtála*[729] and *The State (M) v Attorney General*[730] expanded on this line of reasoning, Finlay P in *M* concluding that a *prima facie* right to travel without arbitrary or unjustified interference flowed from the Christian and democratic nature of the State.[731]

Natural law has been described as "... a supervening positive law, comprising principles or rights, to which appeal can be made in argumentation around positive human rights law".[732] The natural law doctrine has been drawn on in a

---

[726] [1974] IR 284 at 310.

[727] [1974] IR 284 at 317-319. Aristotle suggested two forms of justice, that distributive justice occurs in "distributions" and corrective justice occurs in "transactions"; see E J Weinrib, *Corrective Justice*, 77 Iowa Law Review (1992) 403 at 406 and discussion of law of torts in Part 3 of this thesis.

[728] See also *The State (Nicoloau) v An Bord Uchtála* [1966] IR 567, where Walsh J stated that it was "abundantly clear that the rights referred to in section 3 of Article 40 are those which may be called the natural personal rights and the very words of sub-section 1, by the reference therein to "laws", exclude such rights as are dependent only upon law"; at 642.

[729] [1966] IR 567.

[730] [1979] IR 73.

[731] [1979] IR 73 at 80-81. On this basis, Finlay P struck down Section 10 of the Adoption Act 1952 which prevented a non-marital child under age under one from being removed from the State.

[732] T Murphy, *The Cat Amongst The Pigeons: Garrett Barden And Irish Natural Law Jurisprudence*, Chapter 6 in E Carolan & O Doyle (Eds) *The Irish Constitution, Governance and Values*, Thomson Roundhall (2008) at 121.

number of cases concerning other provisions of the Constitution, including Articles 41 and 43.[733] It has always been a controversial doctrine, battling with the perceptions on the one hand of positivist lawyers holding strong views on the certainty of the law and on a strict construction of the separation of powers doctrine, who argue that it represents an egregious form of judicial activism into the domain of the legislature.[734] On the other hand the doctrine has been viewed with suspicion by secular jurists who object to natural law *per se* on the ground that the doctrine represents an unwelcome theological strand in Irish jurisprudence. Judgments by the courts in cases such as *Norris v Attorney General*[735] wherein the majority (per McCarthy J) cited natural law values in aid of their finding that criminalisation of same sex relations did not violate the Plaintiff's constitutional rights have supported this latter view.[736] Both forms of criticism focus on Walsh J's identification of the natural law as a source of constitutional rights in *McGee*.[737]

The "natural human rights" identified by Walsh J which are "superior or antecedent to positive law or which are imprescriptible or inalienable" was arguably undisoverable, but the task of discovering or determining the existence of these rights falls to the Judge. Justice being superior to the law, positive law is relegated below such rights whose interpretation is to be given in the light of prevailing ideas and concepts. Notwithstanding conceptual difficulties, an international lawyer examining the foregoing could be forgiven for concluding that its emphasis on justice being superior to positive law reflects the principles underpinning international human rights law evinced in the UDHR's focus on the individual and that in the absence of quite a number

---

[733] W Binchy, *Meskell, the Constitution and Tort Law* 18 Dublin University Law Journal (2011) 339 at 344-346.

[734] Daly describes natural law as a "controversial metaphysical doctrine": see E Daly, *Public philosophy and constitutional interpretation after natural law: republican horizons*, Conference on The Irish Constitution: Past, Present and Future, University College Dublin (June 2012) at 1.

[735] [1984] IR 36.

[736] O Doyle, *Constitutional law: Text, Cases and Materials* Dublin: Clarus Press (2008) at 92.

[737] [1974] IR 284 at 310, 317-319.

of enumerated human rights in the Constitutional text, here was a formula for recognising same.[738]

A number of US authors who identify with a libertarian view of Government advocate the more recent, natural law theory as formulated by John Locke which focuses on a limited conception of rights as comprising freedom from State action.[739]

Other natural law theorists favour the Kantian emphasis on dignity under the UDHR suggesting that "[a] human right, the existence of which derives from principles of natural law, is based in the dignity and worth of the human being." The right exists regardless of whether positive law has given it expression; a human right "not recognized by positive law is a failure in the law, not an absence of the right. A just government is compelled to recognize the rights of its citizens".[740] Others suggest that "[t]he moral judgment implicit

---

[738] W Binchy, *Dignity as a Constitutional Concept*, in *The Irish Constitution, Governance and Values, Dignity as a Constitutional Concept*, E Carolan & O Doyle (Eds) Thomson Roundhall (2008) at 314.

[739] J Locke, *Two Treatises of Government*, (Ed. P Laslett) Cambridge University Press (1988). See also J T Eberl, E D Kinney, M J Williams, *Foundation For A Natural Right To Health Care*, 36 Journal of Medicine and Philosophy (2012) at 537 who argue that Locke's promotion of a natural right to private property included a "proviso" that one should not appropriate goods beyond one's necessity if to do so would deprive others of the basic necessities of life; at note 18. These authors suggest that natural law rights are negative only, imposing a duty not to interfere with the actions of others. Sade argues that because negative rights "originate in human nature, they are natural rights, in the senses of existing prior to any law and being unrelated to membership in a particular community"; R M Sade, *Foundational Ethics of the Health Care System: The Moral and Practical Superiority of Free Market Reforms*, 33 Journal of Medicine and Philosophy, Routledge (2008) 461 at 466. Under this formulation of natural law rights, the author argues that government intervention in voluntary interactions among persons and organisations "cannot be justified; the concrete expression of natural rights in the social and economic context is the free market."; ibid at 467. in this conception natural rights are "metanorms", occupying a central role in society of linking individual morality with social life grounded in the dual character – both individual and social - of human flourishing; at 468. Smith argues that there is no such thing as the "neutral state" and that rights, structures or procedures are valuable only to the extent that they are "conducive to the realization of human goods"; S D Smith Natural Law and Contemporary Moral Thought: A Guide from the Perplexed, 42 American Journal of Jurisprudence (1997) 299 at 302-303. However, this view neglects the other part of Locke's thesis which was that in order to avoid "self-help" remedies, Government is obligated to provide indiviudals with an "alternative avenue of recourse against wrong-doers" such as claims in tort which recognise the wrong perpetrated. J Goldberg, B Zipursky, *Torts, the Oxford Introduction to US Law*, Oxford University Press (2010) at 64. See Part 3 of this thesis.

[740] B M McCrystal, *The various human rights in healthcare*, 25 Marquette University Law School Human Rights (1998) at 138. See *www.humanrights.unimelb.edu.au/download.cfm?DownloadFile=0585786D-9632-AF86-D1E13630A064F44A>*"; accessed on 21 March 2012. "[I]f we accept that natural human rights exist without any precondition or mandatory legal justification, there is no need to receive

in all international human rights law is that violating conduct is wrong because it has breached a universal moral standard subscribed to by the vast majority of states, if only in formal terms."[741].

It is suggested that the linkage with human rights law arises because natural law "mandates us to use our reasoning capacity to determine what is good in accordance with our nature as rational animals and go after it - thereby entailing certain *positive* obligations - and avoid whatever we determine to be evil because it is opposed to our flourishing as human beings - thereby entailing certain *negative* obligations."[742] This is said to be applicable to the right to health: "the positive obligation to preserve the life and health of others may support a *prima facie* right to health and health care that ought to be respected when feasible and insofar as other, more stringent, negative or positive rights are not violated".[743] However, this latter explanation lacks precision and unlike an international treaty text whose interpretation by a

---

common verification worldwide. Hence remains the problematic issue of establishing legal instruments and mechanisms of control; ibid. The author suggests that foremost amongst Kant's philosophy is the ideal of a universal community of rational individuals autonomously determining the moral principles for securing the conditions for equality and autonomy. He provides a means for justifying human rights as the basic conditions for self-determination grounded within the process of independent reasoning; ibid at 140.

[741] James (1994, 12), political scientist at Princeton University, cited by J T Eberl, E D Kinney, M J Williams, *Foundation For A Natural Right To Health Care*, 36 Journal of Medicine and Philosophy (2012) 537 at 539. Eberl et al argue that the "primary influence of natural law theory ... validat[es] the rights contained [in the UDHR]"; J T Eberl, E D Kinney, M J Williams, *Foundation For A Natural Right To Health Care*, 36 Journal of Medicine and Philosophy (2012) 537 at 538. The authors also quote the influential French philosopher Jacques Maritain who in 1947 during UDHR drafting negotiations argued in favour of the rights of man deriving from a rediscovery of the idea of natural law; at 542. The authors also cite Aquinas' emphasis on optimising (actualizing) the capacities of humans to allow their flourishing as a fulfilment of their shared nature by following the precepts of natural law (Aquinas, *Summa theologiae* Ia-IIae Q. 18, a. 5; Q. 49, a. 2; Q. 71, a. 1); at 543. One advantage of the Thomistic account of natural law is that it describes natural law as human beings' capacity to understand the general principles which underlie the existence of particular substances, actions, and events"; at 544. Finegan argues that insofar as "thirty-seven out of the fifty-eight UN member states at the time [1947-48] belonged to the Judeo-Christian tradition", the natural rights tradition was a major source of the document"; T Finegan, *Conceptual Foundations of the Universal Declaration of Human Rights: Human Rights, Human Dignity and* Personhood, 37 Australian Journal of Legal Philosophy (2012) 182 at 192. The author notes how this account conflicts with that of Johannes Morsink who in *The Universal Declaration of Human Rights: origins, drafting, and intent* (1999) University of Pennsylvania Press argued against existentialism natural rights at 290-5.

[742] J T Eberl, E D Kinney, M J Williams, *Foundation For A Natural Right To Health Care*, 36 Journal of Medicine and Philosophy (2012) 537 at 545.

[743] J T Eberl, E. D Kinney, M J Williams, *Foundation For A Natural Right To Health Care*, 36 Journal of Medicine and Philosophy (2012) 537 at 548. Further, balancing the strength of these various rights in relation to each other "is the mutual job of moral theorists, policymakers, and individual voters in democratic societies"; ibid.

supervisory court or mechanism may be expanded by reference to the constitutional traditions in Member States and evolving regional or international standards, in the absence of jurisprudential linkages with such sources, natural law theory has been unable to ground itself sufficiently in a form which is easily recognisable by jurists and practising lawyers alike. Indeed, in deriving recognition of the right based on natural law reasoning, Walsh J even went so far as to state in *McGee* that the individual has natural and human rights over which the State has no authority.[744]

The root of the orthodox view of natural law in Ireland was observed in the Report of the Constitution Review Group in 1996 where it stated that "the drafters of the 1937 Constitution clearly held natural law principles".[745] Its zenith was seen to be expounded in the 1993 O'Hanlon thesis[746] where the author argued that the judiciary had a duty to interpret the natural law, which he claimed fettered the power of "the people" to amend the Constitution based on their judicial oath.[747] The effect of such an over-riding doctrine of natural law whereby natural law rights outside the Constitution would "trump" all other rights and responsibilities (as advanced by Walsh J in *McGee*), could arguably over-ride Walsh J's emphasis on "the sovereign authority [of] the people" as set out in *Byrne v Ireland.*[748] The thesis prompted the question as to which takes primacy: natural law or the People? However, in *Re Article 26 and the Regulation of Information (Services Outside the State for Termination of Pregnancy) Bill 1995*[749]case, the Supreme Court favoured "the People" who

---

[744] [1974] IR 284 at 310, 317-319. In *Byrne v Ireland* [1972] IR 241 at 279-281 Walsh J had stated that the People were the ultimate authority under the Constitution.

[745] *Report of the Constitutional Review Group,* Dublin, Stationery Office (1996) at 249. That same group did not believe that the Constitution required substantial amendment to address a latency in human rights protections, but argued that it could rather be supplemented through legislative enactments such as the ECHR Act.

[746] R O'Hanlon, *Natural Rights and the Irish Constitution* 11 Irish Law Times (1993) 8 at 10.

[747] This thesis is redolent of Walsh J's statement in *McGee* and centred on the provisions of the Preamble and Articles 5 and 6 of the Constitution with their implicit references to the natural law - and in particular Article 6 which explicitly refers to the powers of government as "deriv[ing], under God, from the people".

[748] [1972] IR 241 at 263. Arguably the extension of the thesis could also negate the principle in Article 46 of the Constitution which clearly permits the People to amend the Constitution.

[749] [1995] 1 IR 1.

were stated to be sovereign and not limited by the natural law arguably relegating the role of natural law as a source of constitutional rights.[750]

A core question which arises is whether it is legitimate for the People to establish a constitution which includes normative non-derogable rights based on certain values in the form of a Charter or Bill of Rights where those rights are superior or antecedent to popular authority? And if it is legitimate to do so, how should a judge interpret those rights/ values? There is no easy response to this question. On the one hand, the People have established a constitution with a Bill of Rights (Articles 40-44) but they have done so with the option of preserving, enhancing or modifying those rights through Constitutional amendment. As to the nature of non-derogable rights, rights attain this status under human rights law (even the right to life is derogable in times of war or self-defence). Those rights which are non-derogable (such as freedom from torture or slavery) fall to be considered in light of a range of judicial sources as the jurisprudence of the European Court demonstrates which allows for a teleological approach which can take account of societal developments.[751]

The reasons why opponents of natural law theory have argued that the doctrine be discontinued have already been set out: on the one hand the fundamental concern of positivist lawyers who object to judge-made law from the perspective of a "democratic legitimacy" concern and on the other the specificity concern: which version of natural law theory should prevail in the case of contested rights? Here we consider the disagreement between Walsh J and O'Higgins J in *G v An Bord Uchtála*[752] over which version of natural law theory should be accorded constitutional law status under Article 40.3.2 - a natural law theory that provides rights to a natural mother that are difficult to waive or a theory that accords less strong rights to the mother.[753] In *Norris*, the

---

[750] See D Coffey, G Whyte *Natural Law and the Irish Constitution* 14 Irish Law Times (1996) at 8 and O Doyle, *Legal Validity: Reflections on the Irish Constitution* 25 Dublin University Law Journal (2003) at 56.

[751] See "positive duties" doctrine of the European Court of Human Rights in Part 1 of this thesis.

[752] [1980] IR 32.

[753] See O Doyle, *Constitutional law: Text, Cases and Materials* Dublin: Clarus Press (2008) at 94-96.

majority of the Supreme Court relied on their understanding of Christianity to hold against the Plaintiff, whereas the minority Judgment of Henchy J was reflective of a human rights approach. Such disparities raise the concern that "the net effect of Article 40.3.1, therefore, was to assign to judges a power not just to interpret the rights that were constitutionally protected but to decide what rights ought to be constitutionally protected."[754]

Commentators who may otherwise argue for a purposive interpretation of fundamental rights under the Constitution have viewed the grounding of the unenumerated rights doctrine in natural law with some unease. While acknowledging that the doctrine of unenumerated rights had breathed life into previously "underused" fundamental rights provisions, some commentators have expressed concern that "a theocratic ideology" may have influenced constitutional jurisprudence.[755] As against this, other commentators have defended the court's adherence to natural law principles as allowing for the protection of human rights.[756]

---

[754] O Doyle, *Constitutional law: Text, Cases and Materials* Dublin: Clarus Press (2008) at 92.

[755] See I Bacik, *Future Directions for the Constitution, Governance and Values* in *The Irish Constitution, Governance and Values*, E Carolan & O Doyle (Eds) in *The Irish Constitution, Governance and Values*, Thomson Roundhall (2008) at 138-141. In other jursidictions, commentators have expressed concern at judge-made law where the import may be to "cement" practices which violate human rights. Commenting on the interpretation of Directive Principles in India, Khilnani argues that it introduces too high of a degree of discretion in the courts' safeguarding of rights and uncertainty arising from the curtailment of rights of free expression "on the grounds of causing offense to sentiments" and the threat to individual freedom as embodied in preventive detention in India; S Khilnani, *The Constitution And Individual Rights: A Comment On Dr. Abhishek Singhvi's India's Constitution And Individual Rights: Diverse Perspectives* 41 George Washington International Law Review (2009-2010) 361 at 366.

[756] See Humphrey's response to Hogan's critique: R Humphreys, *Interpreting Natural Rights*, 28-30 Irish Jurist (1993-1995) at 224-225. See also O Doyle, *Constitutional law: Text, Cases and Materials* Dublin: Clarus Press (2008) at 99-100. Binchy has pointed out that, for better or worse, Articles 41, 42 and 43 have been influenced by a natural law understanding of rights in an attempt to explain the "group" or "concept" rights enshrined in those Articles which envisage the rights being rooted in a broad integrated theory of the individual, society and the common good: W Binchy, *Meskell, the Constitution and Tort Law* 18 Dublin University Law Journal (2011) 339 at 344-346. Doyle, in pointing to the tension between the human personality test, evident in *McGee* and *Norris* (per Henchy J) and the Christian and democratic nature of the State test, notes how the *McGee* finding was directly at odds with Roman Catholic teaching while Henchy J's conclusion in *Norris* was at odds with the vast bulk of Christian teaching: O Doyle, *Legal Validity: Reflections on the Irish Constitution* 25 Dublin University Law Journal (2003) 56 at 91. It will be noted that the plaintiff in *Norris* was subsequently successful in Strasbourg, effectively arguing that his rights were violated under Article 8 of the ECHR. This led to the Government amending the offending legislation through the introduction of Section 2 of the Criminal Law (Sexual Offences) Act 1993.

The lack of certainty in identifying how and what rights are protected is coupled with perceptions of a "lack of objectivity in the method whereby such unenumerated rights are arrived at" which are said to "seriously undermine the important legal values of objectivity and certainty" leading to a "somewhat unprincipled" expansion of judicial review.[757] The specificity of source concern merges with that of democratic legitimacy originally identified by Professor Kelly where he expressed concern that the legislature may have statutes "reviewed in the light of as yet undefined personal rights... with the Courts acting as a third House of the legislature".[758]

Positive law supporters place emphasis on a constitutional document's written text and the historical intention behind that text. Such commentators view the unenumerated rights doctrine as anathema to certainty in law. Other commentators argue that there is nothing remiss in judges interpreting law to render implicit rights explicit and this teleological approach to the identification of rights is at the heart of modern international human rights jurisprudence.[759]

But here commentators have voiced concern at the theoretical reasoning behind interpretation not clearly based on identifiable sources. That is to say, it is not that a judge rather than a legislator is rendering explicit that which is implicit in the law, but rather that one does not know the basis on which the judge reaches his or her conclusion.

The 1995 judgment of the Supreme Court in the *Regulation of Information*[760] case came as a sudden repudiation of the natural law doctrine. In that case the Supreme Court stated:

---

[757] G Hogan, *Unenumerated Personal Rights: Ryan's Case Re-evaluated* 25-27 Irish Jurist 95 (1990-92) at 114. Professor Kelly suggested that uncertainty in the law was repugnant to the central value of the very concept of law itself; J Kelly, *Fundamental Rights in Irish Law and Constitution* (2nd ed.), Dublin (1967) at 47.

[758] J Kelly, *Fundamental Rights in Irish Law and Constitution* (2nd ed.), Dublin (1967) at 45-46.

[759] See D M Clarke citing Ronald Dworkin's theories, *Interpreting the Constitution: Essentially Contested Concepts*, in *The Irish Constitution, Governance and Values*, E Carolan & O Doyle (Eds.) Thomson Roundhall (2008) at 104 and 112. An obvious example is the right to marry which arises from the protection afforded to the Family under Article 41

[760] [1995] 1 IR 1.

> The courts, as they were and are bound to, recognised the Constitution as the fundamental law of the State to which the organs of the State were subject and at no stage recognised the provisions of the natural law as superior to the Constitution.[761]

However, the reasoning in this judgment, in which the Supreme Court categorically asserted that the natural law had never been the doctrinal origin for the unenumerated rights doctrine, has been described as leaving "much to be desired" by commentators.[762] The preliminary view of the demise of natural law following the case may have been premature insofar as subsequent cases have shown some adherence to natural law principles (although in perhaps more measured tones). As is the wont of the Superior Courts, the *Regulation of Information* case did not fully repudiate natural law theory: the text of the Judgment simply stated that natural law provisions were not superior to the Constitution. However, if it is accepted that the natural law (or elements thereof) already forms part of the constitutional norms, an unsatisfactory circularity in reasoning may be observed.[763]

This development in the *Regulation of Information* case nonetheless resounds with the argument that the unenumerated rights doctrine has been abandoned by the courts in recent years. After all, within a short number of years, the Supreme Court handed down its Judgments in *TD* and *Sinnott*.[764] Again,

---

[761] [1995] 1 IR 1 at 43. The judgment was criticised by a number of commentators: see A Twomey, *The Death of Natural Law* 13 Irish Law Times (1995) 270 at 272 and R Byrne and W Binchy, *Annual Review of Irish Law* Roundhall Press (1995) at 145-154 and G Whyte, *Natural Law and the Constitution* 14 Irish Law Times (1996) at 11.

[762] O Doyle, *Legal Validity: Reflections on the Irish Constitution* 25 Dublin University Law Journal (2003) at 103.

[763] Daly argues that despite its apparent demise as a constitutional philosophy, natural law has not been replaced by any alternative public philosophy or overarching theory of constitutional justification and that instead courts have tended to resort to literal methods in constitutional interpretation akin to that of statutory interpretation. Daly argues that the demise of natural law coincided with and was perhaps inspired by a conservative trend in constitutional interpretation": E Daly, *Public philosophy and constitutional interpretation after natural law: republican horizons*, Conference on The Irish Constitution: Past, Present and Future, University College Dublin (June 2012) at 1.

[764] The Supreme Court in *Sinnott* refused to grant the mandatory injunction sought by the mother of the plaintiff, a 23 year old severely autistic person with related profound mental and physical disabilities, directing the defendants to provide for his free education, appropriate to his needs for as long as he was capable of benefiting from same and damages (discussed further below). In *TD*, the Supreme Court held that the mandamus order of Kelly J in the High Court directing that the executive should provide an appropriate special residential care unit for the applicants should be set aside on separation of powers grounds (discussed below). In *Carmody*, the Supreme Court granted a declaration that the plaintiff should not be tried for

however, the argument in favour of the demise of unenumerated rights is unclear, for, if the argument holds sway, how can one explain judgments of the courts in cases such as *Carmody v Minister for Justice*[765]? At best one can state that in circumstances where counsel for the State does not concede before the court that a clear unfairness occurred (as was the case in *Carmody* where at both hearings in January 2008 and April 2009 the court sought such a concession) and remove from the court the need to rule on an unenumerated right claim, the court will "fashion" a remedy to vindicate an unenumerated right where the justice of the case so requires.[766] However, there will be limits on whether the courts can fashion remedies "in a manner designed to respect" a plaintiff's "conscientious claims" where her rights are engaged, where the result would be to disproportionately impact on the rights of others.[767]

Walsh J had famously commented in *McGee* that the Constitution rejects legal positivism as a guide[768], expanding on this extra-judicially to state that "each of our judges must work from a philosophical conviction which does not differ from the philosophy underlying the Constitution".[769]

---

certain offences until he had opportunity to apply to for legal aid for counsel in addition to a solicitor where the prosecution against him was based on detailed EU law provisions.

[765] [2010] ILRM 157.

[766] [2010] ILRM 157 per Murray CJ.

[767] See *Fleming v Ireland* [2013] IEHC 2. In order to "relieve her acute suffering and distress, this Court might thereby place the lives of others at risk"; at para 76.

[768] In arguing that it falls to judges to interpret the Constitution, Walsh J also invoked the views of the United States Supreme Court as rejecting legal positivism "as a jurisprudential guide"; [1974] IR 284 at 318-319. Writing extra-judicially, Costello J agreed: "[h]uman positive law must not go contrary to the natural law. If it does, it is a "perversion" of law"; D Costello, *Natural Law, the Constitution and the Courts*, in Lynch and Meenan eds, *Essays in Memory of Alexis Fitzgerald,* The Incorporated Law Society of Ireland (1987) 105 at 112. Here "natural" rights were a synonym for human rights; ibid at 112 and 117. Doyle argues that, as Natural Law values legal certainty, the Constitutional interpretation of Natural Law, in not valuing legal certainty, is problematic unless Natural Law's authority is viewed as deriving from the positive legal system itself (where legal positivism "aims to describe and explain legal systems" rather than to indicate directions as to its substantive content); "; O Doyle, *Legal Positivism, Natural Law and the Constitution*, 31 Dublin University Law Journal (2009) 210 at 214 and 218.

[769] B Walsh, *The Judicial Power, Justice and the Constitution of Ireland* in Curtin and O'Keefe eds, *Constitutional Adjudication in European Community and National Law: Essays for the Hon Mr Justice T F O'Higgins* Butterworths (1992) 145 at 147; as cited by O Doyle, *Legal Positivism, Natural Law and the Constitution*, 31 Dublin University Law Journal (2009) at 211.

Is legal positivism descriptive rather than normative? Normative legal positivists avoid reference to any moral criteria in searching for legal validity: even an unjust law must be enforced.[770] However, any normative positivism which would result in unjust laws will arguably be rejected by the Supreme Court even following its recalibration of the position of natural law in the *Regulation of Information* case but where it still upheld the doctrine of unenumerated rights where such rights can be "reasonably implied from and ... guaranteed by the provisions of the Constitution, interpreted in accordance with its ideas of prudence, justice and charity".[771]

In *Ó Beoláin v Fahy*[772] Geoghegan J stated that a constitution is not simply a piece of legislation but "embodies the aspirations and emotional feelings of the people who have enacted it. Not everything in a constitution therefore is intended to have legal implications", citing the previous provision as to the special position of the Roman Catholic Church not having "any legal implications" but merely reflecting what was perceived to be a fact on the ground at the time of the enactment of the Constitution." The reference to the Irish language as "the national language" in Article 8.1 was to be similarly construed.[773]

---

[770] J Raz, *Authority, Law and Morality*, in J Raz, *Ethics in the Public Domain; Essays in the Morality of Law and Politic*, Oxford University Press (1994) at 1010, citing the work of Bentham. See too Waldron's description of "normative positivism" in J Waldron, *Kant's Legal Positivism*, 109 Harvard Law Review (1996) 1535 at 1540, J Waldron, *A Right-Based Critique of Constitutional Rights*, 13 Oxford Journal of Legal Studies (1993) at 18 and O Doyle, *Legal Positivism, Natural Law and the Constitution*, 31 Dublin University Law Journal (2009) at 219 and 222-223 who expresses concern that the unenumerated rights doctrine failed to identify any specific moral criteria that required to be interpreted; ibid.

[771] [1995] 1 IR 1 at 43, per Hamilton CJ. Doyle ascribes *Ryan* as "akin to a design decision": O Doyle, *Legal Positivism, Natural Law and the Constitution*, 31 Dublin University Law Journal (2009) at 224 although Binchy disagrees arguing that rather than a positivist compendium or list of the encapsulation of a socio-political philosophy, the Constitution sets out a philosophy primarily of natural law, albeit one capable of "transposition" into a code of positive legal rights, W Binchy, *Meskell, the Constitution and Tort Law* 18 Dublin University Law Journal (2011) 339 at 344-346.

[772] [2001] 2 IR 279. The case concerned whether Article 8 of the Constitution required Acts and Rules of Court to be available in Irish as well as English for those wishing to conduct litigation in court in that language.

[773] [2001] 2 IR 279 at 356. Daly suggests that following the Supreme Court's approach *Ó Beoláin*, Irish courts have arguably echoed the interpretivist theory of Ronald Dworkin in rejecting the positivist assumption that the only legal materials legitimately available to adjudicators are those enacted according to criteria of validity gleaned from official practice. The underlying poltical and moral justifications for those rules guide their application: E Daly,

Shortly after the *Regulation of Information* Judgment, the Supreme Court considered the right to life under Article 40.3.2 in *Re a Ward of Court (withholding medical treatment) No. 2*.[774] In this case, it will be recalled that Denham J focused on an unenumerated right to privacy/ dignity which could be located under Article 40.3.1. Denham J. declared that this was to be interpreted as the right "to be treated with dignity".[775] The person had a constitutional right to dignity in life and a right to dignity in death.[776] This conception of a right to dignity by Denham J may or may not be more limited than an inherent or intrinsic right to dignity, grounded in the natural law as suggested by one commentator, however regardless of the source of the right, it developed an aspect of the unenumerated right to bodily integrity/ autonomy/ dignity.[777]

The formulation of the enumerated right still falls to the courts to determine (per Henchy J and Walsh J in *McGee* and per Hardiman J in *TD*) and even if the doctrinal underpinning of the unenumerated rights doctrine by the natural law is now in doubt, rights remain to be "reasonably implied from and ... guaranteed by the provisions of the Constitution, interpreted in accordance with its ideas of prudence, justice and charity".[778] The difficulty is that it is difficult to identify the scope of this right to dignity, whether it is limited in nature, being subject to "the right to life" for example, or whether it has a superior or inherent constitutional hue along lines of natural law theory, in accordance with the constitutional values of prudence, justice and charity. Another possible interpretation of dignity as a constitutional value is arguably

---

Public philosophy and constitutional interpretation after natural law: republican horizons, Conference on The Irish Constitution: Past, Present and Future, University College Dublin (June 2012) at 3.

[774] [1996] 2 IR 79.

[775] [1996] 2 IR 79. "Decision-making in relation to medical treatment is an aspect of the right to privacy; however, a component in the decision may relate to personal dignity... Just as "the individual's right to privacy grows as the degree of bodily invasion increases", so too the dignity of a person is progressively diminished by increasingly invasive medicine"; at 163.

[776] [1996] 2 IR 79 at 167.

[777] W Binchy, *Dignity as a Constitutional Concept*, in *The Irish Constitution, Governance and Values, Dignity as a Constitutional Concept*, E Carolan & O Doyle (Eds) Thomson Roundhall (2008) at 316.

[778] See *Re Article 26 and the Regulation of Information (Services Outside the State for Termination of Pregnancy) Bill 1995* [1995] 1 IR 1 at 43.

that it comprises a loose "coordination" of the other unenumerated rights of privacy, bodily integrity and autonomy, allowing for adjudication in a language in which judges "can appear to justify how they deal with issues such as the weight of rights, the domestication and contextualization of rights, and the generation of new or more extensive rights."[779]

The conclusions from this episode of constitutional jurisprudence is that although natural law theory has been eroded as a source of unenumerated rights, neither it nor the unenumerated rights doctrine identified by Kenny J in *Ryan* have been entirely displaced. The constitutional values of prudence, justice and charity allow the courts to continue to develop the unenumerated right to health incrementally, although precise sources for this development remain obscured. In this way the constitutional counterweight of identifiable sources of rights (in Natural law) to judicial restraint is lessened and a search for complementary sources of rights entailed.

9.4 Article 45 as a source of interpretation

The directive principles of social policy set out in Article 45 of the Constitution may be another source for implying unenumerated rights under Article 40.3.1. Article 45(1) emphasises "a social order in which justice and charity shall inform all the institutions of the national life." Here may be observed clear echoes of the Preamble's reference to "due observance of Prudence, Justice and Charity, so that the dignity and freedom of the individual may be assured," and Denham J's reference to the right to dignity in *Re a Ward of Court (No. 2).*[780]

Although Article 45 makes clear that these directive principles are intended for the general guidance of the Oireachtas and "shall not be cognisable by any Court under any of the provisions of this Constitution", the courts have on occasion demonstrated their willingness to take the principles into account.[781]

---

[779] C McCrudden, *Human Dignity and Judicial Interpretation of Human Rights* 19(4) European Journal of International Law (2008) 655 at 724.

[780] [1996] 2 IR 79.

[781] For a comparison between Article 45 and Articles 37 to 39 and Article 46 of the Indian Constitution on which it was based, see O'Normain, *The Influence of Irish Political Thought on*

Certainly it appears that the intention of the drafters was that there would be some distinction between the fundamental rights provisions in Articles 40-44 and Article 45 and this view was upheld by the Supreme Court in *Buckley v Attorney General*[782] where the court distinguished between Article 43 and Article 45 by stating that "[i]f it were intended to remove this matter [the justiciability of Article 43] entirely from the cognisance of the Courts, we are of opinion that it would have been done in express terms as it was done in Art. 45 with reference to the directive principles of social policy, which are inserted for the guidance of the Oireachtas, and are expressly removed from the cognisance of the Courts".[783] In this regard, it should be recalled that a precursor to *Ryan* was *Tierney v Amalgamated Society of Woodworkers*[784] where Budd J invoked Article 40.3.1 to assert that "the right to work and earn one's livelihood is just as important a personal right of the citizen and just as much entitled to vindication, as a right of property"[785], a statement echoed by Kingsmill Moore J in *Educational Co v Fitzpatrick (No 2).*[786]

Of significance is the extent of the courts' willingness to consider directive principles in framing the scope of this unenumerated right. Judicial willingness to refer to Article 45 when interpreting rights under Article 40.3 can be traced

---

the Indian Constitution (1952) 1 Indian YearBook of International Law 156, cited by G Hogan, *Directive Principles, Socio-Economic Rights and the Constitution*, 36 Irish Jurist (2001) 174 at 175. Hogan notes how both the Irish and Indian courts have refused to treat socio-economic rights as being entirely non-justiciable in nature; at 175.

[782] [1950] IR 67.

[783] [1950] IR 67 at 83, per O'Byrne J. See G Hogan, *Directive Principles, Socio-Economic Rights and the Constitution*, 36 Irish Jurist (2001) 174 at 175-176 who quotes a lengthy memorandum prepared by JJ McElligott, the Secretary of the Departmetnt of Finance who expressed considerable concern at the prospect of justiciable socio-economic rights including in relation to Article 43 (property rights). See too draft by Gavan Duffy J dated 2 April 1937 which was reflected in the Preamble to Article 45.

[784] [1959] IR 254.

[785] In *Dunne v Fitzpatrick* [1958] IR 29 Budd J identified Article 40.3.1 as one of a number of constitutional rights which supported the rights of employer and worker respectively to deal with and dispose of their property and labour without arbitrary interference; at 34.

[786] [1961] IR 345. In *Educational Co* Kingsmill Moore J in the Supreme Court recognised a right to vindication under Article 40.3.2 as arising from an undertaking to protect the citizen's right to dispose of his labour as he wills and impliedly a right not to be forced against his will into a union or association; at 395. Hogan and White suggest these statements reflect a perception of the rights surrounding labour and livelihood as being aspects of the explicitly mentioned 'property rights' of Article 40.3.2.

to High Court cases in the 1970s and 1980s, which the Supreme Court has not elaborated on. Costello J in *Attorney General v Paperlink*[787], rejecting the argument that the right to earn a livelihood entitled the defendants to operate a postal service, followed the earlier approach of Kenny J in *Murtagh Properties v Attorney General*[788] that the courts were not precluded from considering Article 45 to ascertain the existence of an unenumerated right and any limitations to be imposed on such rights.[789] If the Directive Principles can inform the scope of the unenumerated right to earn a livelihood, why not the right to bodily integrity/ health? Or can it be said that by eliminating judicial review of violations of the Directive Principles, the constitutional norms enshrined therein are "de-constitutionalized" effectively emptying their normative value?[790]

Under Part IV, Article 37 of the Indian Constitution, entitled "Directive Principles of State Policy" is modelled on Article 45 of Bunreacht na hÉireann and similarly provides that the Directive Principles are not enforceable before the courts. Despite this exhortation of limited justiciability, the Supreme Court of India in *Bandhua Mukti Morcha vs Union Of India & Others*[791] used the Directive Principles to inform its understanding of the right to life under

---

[787] [1984] ILRM 373, [1983] IEHC 1 Costello J stated: "I am not precluded by the introductory words of [] Article [45] from considering the principles of social policy set out in it for a limited purpose, namely, for assisting the court in ascertaining what personal rights are included in the guarantees contained in Article 40.3.1° and what legitimate limitations in the interests of the common good the State may impose on such rights"; at para 46.

[788] [1972] IR 335.

[789] [1984] ILRM 373, [1983] IEHC 1 at para 46. In *Murtagh Properties v Cleary* [1972] IR 330 Kenny J granted an interlocutory injunction restraining a union picket on the basis that the plaintiffs had a reasonable prospect of success that the picket would infringe a constitutionally protected right to work and earn a livelihood, holding that the courts may take Article 45 into consideration when deciding whether a claimed constitutional right exists; at 336. Hogan suggested that *Murtagh* appeared to be introducing directive principles through the backdoor of Article 40.3.1°: G Hogan, *Directive Principles, Socio-Economic Rights and the Constitution*, 36 Irish Jurist (2001) 174 at 179.

[790] J Usman, *Non-Justiciable Directive Principles: A Constitutional Design Defect* 15 Michican State Journal of International Law (2007) 643 at 663. The author suggests that deference to legislative and executive arms of government "empowers" the political branches to undermine and strictly limit fundamental rights that come into conflict "with the pursuit of the expansive directive principles"; at 696.

[791] (1984) AIR SC 802.

Article 21 of the Constitution of India.[792] In *SR Bommai v Union of India*[793] the Supreme Court of India built on the earlier case of *In His Holiness Keesavananda Bharati Sripadagalvaru v State of Kerala*[794] to hold that the constitutional value of secularism was "more than a passive attitude of religious tolerance" but rather a "positive concept of equal treatment of all religions" and "one of benevolent neutrality" with equality as its aim and justiciable insofar as a measure incompatible with this value which impacted on individual rights would be "in plain words, unconstitutional".[795]

In *Ashoka Kumar Thakur v Union of India*[796], the Supreme Court of India went further and held that the Directive Principles of Part IV could become "transformed" into the justiciable rights in Part III "whereby it becomes enforceable".[797] In that case Balakrishnan CJ held that the Fundamental Rights and Directive Principles "are both complementary and supplementary to each other" with the Preamble to the Constitution a central part of the Constitution while "the edifice of our Constitution is built upon the concepts crystallized in the Preamble".[798] The Indian courts have sought to incorporate the values of the Directive Principles into its interpretation of justiciable fundamental rights provisions in an attempt to read its Constitution in a manner that makes

---

[792] (1984) AIR SC 802. Bhagwati J held that the right to live with human dignity, as enshrined in Article 21 of the Indian Constitution derives its "life breath" from the Directive Principles of State Policy in Articles 39, 41 and 42 and included the minimum requirements which must exist in order to enable a person to live with human dignity: at 103. See also the twenty-fifth (1971) and the forty-second (1976) Amendments to the Constitution.

[793] 1994 (2)SCR 644.

[794] 1973 (4) SCC 225.

[795] 1994 (2)SCR 644 at para 304 per Pandian J. See also *Jacob v Kerala Water Authority* (1991) 1 SCC 28.

[796] (2008) 6 SCC 1.

[797] (2008) 6 SCC 1 at para 43.

[798] (2008) 6 SCC 1 at para 39. The Directive Principles "are equally as important as Fundamental Rights" and whereas Part IV is made not enforceable by a court for the reason inter alia "as to financial implications and priorities", the Principles of Part IV "have to be gradually transformed into fundamental rights depending upon the economic capacity of the State"; at para 40. see S Khilnani, *The Constitution And Individual Rights: A Comment On Dr. Abhishek Singhvi's India's Constitution And Individual Rights: Diverse Perspectives* 41 George Washington International Law Review (2009-2010) 361 citing A Singhvi, *India's Constitution and Individual Rights: Diverse Perspectives*, 41 George Washington International Law Review (2009) 328 at 363.

meaningful the normative values which underpin it.[799] It has similarly been suggested that Article 45 offers considerable guidance to the courts in developing tort law in the light of constitutional requirements, and in seeking best to accommodate the separation of powers doctrine.[800] Following the *Regulation of Information* case the courts may be more willing to employ Article 45 as a source of interpretation, arguably in conjunction with the commonality of the Preamble's precepts of justice and charity, however it must be recognised that there has been little judicial enthusiasm for doing so in recent years. In this light it is equally possible that *Murtagh* and *Paperlink* will remain dormant or be overruled as opposed to forming the basis for a reinvigoration of Article 40.3 jurisprudence.

9.5 Article 6 as a source of interpretation

Might the invocation of popular sovereignty be a source of interpretation? Article 6(1) it will be recalled provides that [a]ll powers of government, legislative, executive and judicial, derive, under God, *from the people*".[801] *McKenna v An Taoiseach (No 2)*[802] followed the earlier direction of *Crotty v An Taoiseach*[803] where the Supreme Court granted an interlocutory injunction

---

[799] De Villiers suggests that in this the Indian courts have come to consider that the protection of rights are "fundamental" to the governance of the country and have employed the directives as an instrument to determine "the extent of public interest" in order to limit the extension of fundamental rights: B De Villiers, *Directive Principles of State Policy and Fundamental Rights: The Indian Experience,* 8 South African Journal on Human Rights (1992) 29 at 48-49.

[800] Binchy argues that the Directive Principles are important in spelling out a fairly specific picture of the society and social relationships that the Constitution envisages, arguing that Article 45 is a useful guidance to the courts in developing tort law in the light of constitutional requirements: W Binchy, *Meskell, the Constitution and Tort Law* 18 Dublin University Law Journal (2011) 339 at 339-340. For Phelan the philosophy of the Directive Principles of Social Policy is "tied to morality" and places "moral duties" on the State and prominent social actors alike. D R Phelan, *The Concept of Social Rights* 16 Dublin University Law Journal (1994) 105 at 107. This view of social relations is premised on the notion of moral duties placed on both the State and prominent social actors; at 107 and note 16.

[801] Emphasis added.

[802] [1995] 2 IR 10.

[803] [1987] IR 713. Finlay CJ's statement that the separation of powers involves for each of the three constitutional organs not only rights but duties, activity, function and boundaries. However, with regard to striking down legislation, the right of the courts to intervene were "clear and express"; at 772. This statement was later cited with approval by Hamilton CJ in *McKenna (No 2)* [1995] 2 IR 10.

against the Executive in order to preserve the plaintiff's constitutional rights. In *McKenna (No 2)* Hamilton CJ noted how "[i]t was the People who, in the words of the Preamble to the Constitution, adopted, enacted and gave to themselves, the Constitution, and under the terms of the said Constitution, it is the prerogative of the People to amend any provision thereof by way of variation addition or repeal in the manner provided by Article 46 of the Constitution."[804]

In the absence of any constitutional provisions on whether and if so, how, public funds should be employed by Government in a Referendum, the court was required to draw on interpretative constitutional principles. Hamilton CJ enjoined the democratic nature of the State and the concept of equality fundamental to that nature to the sovereignty of the People. The People as guardians of the Constitution were "entitled to be permitted to reach their decision "free from unauthorised interference by any of the organs of State that they, the People, have created by the enactment of the Constitution." The use by the Government of public funds to fund a campaign designed to influence the voters in favour of a "Yes" vote was such an interference with the democratic process and infringed the concept of equality which was "fundamental to the democratic nature of the State."[805]

In *Doherty v Government of Ireland*[806] Kearns P stated that a citizen's constitutional rights are "trenched upon and significantly diluted" when no effect is given to "rights for representation clearly delineated in the Constitution". These rights formed part of the "constitutional contract" between the citizen and the State".[807] This strand of constitutional interpretation with its

---

[804] [1995] 2 IR 10 at 37. At issue in *McKenna (No. 2)* was whether the Government was entitled to expend public funds for the purpose of promoting a campaign for a 'Yes' vote in the proposed referendum to amend the terms of the Constitution.

[805] [1995] 2 IR 10 at 42. This enunciation is reminiscent of Dworkian theory which eschews utilitarianism in favour of a focus on the dignity of the individual which will inform the design of the structure of society: see generally R Dworkin, *Taking Rights Seriously*, Cambridge, MA: Harvard University Press (1977), *The Philosophy of Law*, Oxford Readings in Philosophy, New York: Duckworth Oxford University Press (1977), *Law's Empire*, Cambridge, MA: Harvard University Press (1986), *Sovereign Virtue: The Theory and Practice of Equality*, Cambridge, MA: Harvard University Press (2000).

[806] 2 IR [2011] 222.

[807] 2 IR [2011] 222 at 241. In doing so, Kearns P invoked Article 5; at 222.

emphasis of democratic principles and equality as fundamental to the democratic nature of the State may offer an alternative source of interpretation following the demise of natural law.[808]

In light of these judgments it is noteworthy that *In His Holiness Keesavananda Bharati Sripadagalvaru v State of Kerala*[809] the Supreme Court of India had indicated that the basic structure of the Indian Constitution comprised six elements: the supremacy of the Constitution; a republican and democratic government and sovereignty; of secular and federal character; a demarcation of power between the legislature, the executive and the judiciary; the dignity of the individual secured by the various freedoms and basic rights and the mandate to build a welfare State and the unity and the integrity of the nation.[810] The nature of democracy, the demarcation of powers and the rights of the individual all comprise elements of the Constitution with the Supreme Court of India willing to derive justiciable directive principles from that basic structure.

Insofar as *McKenna (No 2)* and *Doherty* concerned claims as to participative democracy, it remains to be seen whether popular sovereignty offers a sufficiently rich source for the development of unenumerated rights over other strands of constitutional interpretation unless those republican principles espoused at the founding of the State were to be invoked in a manner not heretofore seen.

---

[808] In *Re Article 26 and the Regulation of Information (Services Outside the State for Termination of Pregnancy) Bill 1995* [1995] 1 IR 1 the Supreme Court had cited with approval the statement by Budd J in *Byrne v Ireland* [1972] IR 241 that it is the people who are paramount. Daly favours constitutional interpretation seeking to capture "moral rights" being "rooted in political tradition and institutional life" and advances the role of republicanism as a pluralist public philosophy for a modern, secular Ireland: E Daly, *Public philosophy and constitutional interpretation after natural law: republican horizons*, Conference on The Irish Constitution: Past, Present and Future, University College Dublin (June 2012) at 6 and 12. At the same time the author concedes that the Dworkian "principle" of affording judges greater latitude is an unhelpful, mystifying euphemism for judicial politics; at 7. Doyle has argued that the natural law argument and the popular sovereignty argument are both contingent on positive law and self-justify: O Doyle, *Legal Validity: Reflections on the Irish Constitution* 25 Dublin University Law Journal (2003) 56 at 65-66.

[809] 1973 (4) SCC 225.

[810] 1973 (4) SCC 225 at 280 per Shelat J.

9.6 Dignity and paternalism

The concept of dignity has been located under both the Constitution and international human rights standards. As noted, the Supreme Court in *Re a Ward of Court (No. 2)*[811] for the first time identified a specific right to dignity under the Constitution. One question not addressed directly in the case was how the right to life or right to dignity of a person lacking capacity could be vindicated before the courts. The court applied a paternalistic 'best interests test' in reaching its conclusion that this involved ending her life and in doing so followed a trend in which the Irish courts had identified "dignity" in paternalistic terms in mental disability cases. This has led to some genuine concern that one may "by reason of illness or incapacity ... lose [one's] objective worth, and thus [one's] dignity".[812] In contrast, in *Fleming v Ireland*[813] the High Court sought to uphold dignity of vulnerable persons at large in finding proportionate the State's grounds for legislating for an absolute ban on assisted suicide. Again, a paternalistic test was applied.

This paternalistic trend can be seen in *Re Philip Clarke*[814] where O'Byrne J, after recalling how the Constitution provided that "all citizens, as human beings, ar to be held equal before the law", nonetheless stated that the common good could not be promoted "or the dignity and freedom of the individual assured" by allowing persons with alleged mental illness "to remain at large to the possible danger of themselves and others".[815] This approach was reaffirmed by the Supreme Court in *Croke v Smith*[816] and in *EH v St Vincent's Hospital*

---

[811] [1996] 2 IR 79 at 88-89.

[812] W Binchy, *Dignity as a Constitutional Concept*, in *The Irish Constitution, Governance and Values, Dignity as a Constitutional Concept*, E. Carolan & O Doyle (Eds) Thomson Roundhall (2008) at 316.

[813] 10 January 2013, unreported.

[814] [1950] IR 235.

[815] [1950] IR 235 at 247.

[816] [1998] 1 IR 101.

and Ors[817] with dignity equated in *EH* as others deciding what is in one's best interests.[818]

Another way in which Denham J's formulation of an unenumerated right to dignity in the *Ward* case may be interpreted is to read her judgment in tandem with the approach adopted by the European Court of Human Rights to interferences with respect to "private life" under Article 8. This comparison is useful insofar as an interference with one's "inner private life" will bring a measure within the scope of Article 8(1) which must then be justified. This approach was also taken in *Fleming* where the High Court accepted that the plaintiff's Article 40.3 rights were engaged (including the enumerated right to the person: discussed further below) and although not explicitly stated, implied that the State may have positive obligations to the individual. In holding that the right to privacy included a right to die naturally in *Re a Ward*, Denham J had focused on the centrality of respect for the person's dignity: "A constituent of the right of privacy is the right to die naturally, with dignity and with minimum suffering. This right is not lost to a person if they become incapacitated or insentient."[819] The courts have repeatedly emphasised the reference to dignity in the Preamble when considering constitutional rights.[820]

---

[817] [2009] IESC 46 per Kearns J.

[818] Compare this to Article 12 of the Convention on the Rights of Persons with Disabilities.

[819] [1996] 2 IR 79 at 163.

[820] In *Buckley v Attorney General* [1950] IR 67 O'Byrne J stated that the emphasis on Prudence, Justice and Charity in the Preamble should inform the interpretation of the Constitution; at 80-81. In *The State (Healy) v Donoghue* [1976] IR 325 O'Higgins CJ noted how these concepts may gradually change or develop as society changes and develops and fall to be interpreted from time to time in accordance with prevailing ideas"; at 347. Similarly Henchy J in *G v An Bord Uchtála* [1980] IR 32 stated that the rationale for the right to bodily integrity is to assure the dignity and freedom of the individual within the constitutional framework; at 90-91. See also *Garvey v Ireland* [1981] 1 IR 80 per Henchy J; at 101. In *Norris v Attorney General* [1984] IR 36 Henchy J referred to the Preamble, Article 5 and the fundamental rights section of the Constitution which ensure those personal freedoms or immunities as are necessary to ensure the person's dignity and freedom as an individual insofar as they inhere in the individual personality of the citizen as privacy rights; at 71. In *Kennedy and Arnold v Ireland* [1987] IR 587 Hamilton P stated that the nature of the right to privacy must be such as to ensure the dignity and freedom of an individual in the type of society envisaged by the Constitution, namely, a sovereign, independent and democratic society; at 593. In *Molyneux v Ireland* [1997] 2 ILRM 1 Costello P stated that the Preamble seeks to promote the common good so that the "dignity and freedom" of the individual might be assured, and it required by Article 40(1) that all citizens "as human persons" should be held equal before the law; universal concepts enshrined under the UDHR; at 2. In *Attorney General v X* [1992] 1 IR O'Flaherty J similarly invoked the primary object of the Constitution, as stated in its Preamble, to assure the dignity and freedom of the individual; at 88.

This concept of dignity is important in "fashioning limits" on the potential remit of criminal responsibility, due process and privacy rights. In *CC v Ireland*[821] Hardiman J held that the court could not regard a provision "which criminalises and exposes to a maximum sentence of life imprisonment a person without mental guilt" as respecting the "liberty or the dignity of the individual" or as meeting the obligation imposed on the State by Article 40.3.1 of the Constitution.[822] The difficulty with a doctrine of dignity however, is that its precise meaning is unclear. It has been employed in both a paternalistic manner (in *Re Philip Clarke* and in *Re a Ward*) and in a classical civil rights non-interference manner (*CC*). Notwithstanding this, dignity then may be seen as a concept which captures a numer of unenumerated and enumerated rights such as privacy, autonomy, bodily integrity, the person and equality.

9.7 The rights to privacy and bodily integrity

The right to privacy under Article 40.3.1 was recognised in *Kennedy and Arnold v Ireland*[823] and *M v Drury & Ors*[824] which concerned media freedom and intrusion, respectively, in one's private life.[825] This understanding of privacy with a focus on the dignity of the individual's core personality emanates may also be found in aspects of the right to health as found by the European Court of Human Rights. In *Van Kück v Germany*[826] the burden

---

[821] [2006] 4 IR 1.

[822] [2006] 4 IR 1 at 80. See W Binchy, *Dignity as a Constitutional Concept*, in *The Irish Constitution, Governance and Values, Dignity as a Constitutional Concept*, E Carolan & O Doyle (Eds) Thomson Roundhall (2008) at 314, 322.

[823] [1987] IR 587. Concerning the application to private bodies, see *Herrity v Associated Newspapers (Ireland) Limited* [2008] IEHC 249, R Byrne and W Binchy, *Annual Review of Irish Law* Roundhall Press (2008) at 167-171 and E Carolan, *The Problems of Corporate Privacy*, 32 Dublin University Law Journal (2010) at 51-63.

[824] [1994] 2 IR 8.

[825] In *Kennedy*, Hamilton P stated that the right to privacy flowed from the Christian and democratic nature of the State; [1987] IR 587 at 592. Whereas courts extensively employ the tort of negligence to vindicate constitutional values in relation to right to health suits, here the courts were content to deal with a constitutional right to privacy as opposed to deferring to the tort of defamation, nuisance or malicious intent.

[826] *Van Kück v Germany*, Van Kück v Germany, Application 35968/97, Judgment 12 June 2003, 37 EHRR 51.

placed on a person to "prove the medical necessity" of transgender treatment "including irreversible surgery" in order to avail of health services was found to be disproportionate, concerning as it did "one of the most intimate areas of private life".[827] Indeed, some authors suggest that insofar as human rights are the rights necessary for the "development and exercise of autonomy", human rights development cannot be achieved without the development of human dignity and by corollary, "denial of the individual as the main master of his/her own life is the logical consequence of gross human rights violation in all societies."[828] Under this non-interference rubric, dignity is in interdependence with privacy. Autonomy is viewed as deriving from privacy in terms of a "privileged condition" which firstly guarantees "a minimum capacity of behavior, physical welfare sustenance, and a balancing of core needs and rights".[829] This right to privacy is said to "build[] the framework for personhood - the foundation of autonomy."[830]

Although the right to private life under Article 8 of the ECHR has been extended to right to health considerations by the European Court, the right to health under Irish law has been confined to the unenumerated right to bodily integrity and more recently the enumerated right to the person. Initially following *Ryan*, the scope of the right to health was unclear. In *The State (C) v Frawley*[831] and *The State (McDonagh) v Frawley*[832] the courts recognised the existence of the right to bodily integrity before finding on the facts that there had been no violation.[833] In *The State (C) v Frawley*[834], citing the right to

---

[827] Judgment of 12 June 2003, (2003) 37 EHRR 51, at para 82.

[828] J Gumbis, V Bacianskaite, J Randakeviciute, *Human Rights Today*, Faculty of Law, Vilnius University, Mykolas Romeris University (2010) at 131.

[829] J Gumbis, V Bacianskaite, J Randakeviciute, *Human Rights Today*, Faculty of Law, Vilnius University, Mykolas Romeris University (2010) at 131.

[830] J Gumbis, V Bacianskaite, J Randakeviciute, *Human Rights Today*, Faculty of Law, Vilnius University, Mykolas Romeris University (2010) at 131.

[831] [1976] IR 365.

[832] [1978] IR 131.

[833] In *The State (McDonagh) v Frawley* [1978] IR 131 O'Higgins CJ stated that as long as a prisoner is treated as such under sentence and in accordance with the regulations "he cannot be heard to complain"; at 135.

[834] [1976] 1 IR 365.

bodily integrity identified under *Ryan*, Finlay P could see "no reason why the principle should not also operate to prevent an act or omission of the Executive, which, without justification, would expose the health of a person to risk or danger."[835]

Finlay P was willing to concede the question of justiciability of the right to health. Although he set out the right in negative rather than positive terms,[836] he nonetheless embraced the principle of liability of the State where it failed to vindicate the right to bodily integrity/ health insofar as a plaintiff was entitled to seek relief where medical treatment was denied.[837] However, on the facts of the case, Finlay P deferred to the Executive, considering that the plaintiff, on the facts of the case, asked too much of the State.[838]

Prison cases may turn on narrow margins however. In *The State (Richardson) v The Governor of Mountjoy Prison*,[839] Barrington J found that the State had failed in its duty under the Constitution and the Prison Rules to protect the health of a woman prisoner "and to provide her with appropriate facilities to maintain proper standard of hygiene and cleanliness".[840] *The State*

---

[835] [1976] 1 IR 365 at 372.

[836] [1976] 1 IR 365. It was not the function of the court to "recommend to the Executive what is desirable or to fix the priorities of its health and welfare policy... I cannot conscientiously hold, no matter where my sympathy might lie, that an obligation to provide for prisoners in general the best medical treatment in all the circumstances can be construed as a duty to build, equip and staff the very specialised unit which Dr. McCaffrey has recommended and which might be appropriate to the needs of the prosecutor and four or five other persons"; at 372. In theory, Finlay P found that when the Executive imprisons an individual in pursuance of a lawful warrant of a court it may not, without justification or necessity, expose the health of that person to risk or danger, and that the Executive has a duty to protect the health of persons held in custody as well as is reasonably possible in all the circumstances of the case; [1976] 1 IR 365 at 372. This goes beyond Kenny J's formula in *Ryan* by providing that a process that may harm health or life "without justification" would violate the right to bodily integrity. See also *Holland v Governor of Portlaoise Prison* [2004] 2 IR 273 per MacKechnie J; see W Binchy, *Presentation to Forum on Fluoridation: The Legal Dimension*, Stationery Office, Government Publications, Dublin; Appendix 16 (2002) at 204.

[837] Finlay P stated that no absolute duty to provide the best medical treatment irrespective of the circumstances existing; [1976] 1 IR 365 at 373.

[838] [1976] 1 IR 365 at 373. Nor did the learned President consider that the conditions in the prison constituted a failure to protect him from torture or from inhuman or degrading treatment or punishment.

[839] [1980] ILRM 82.

[840] [1980] ILRM 82 at 93. The fact that the Prison Rules were also breached may have been decisive in the case. In *DG v Eastern Health Board* [1997] 3 IR 511 Denham J found that the

(Richardson) demonstrates how the State can ensure reparation accountability under its "obligation to respect" the right to health. Other dicta on the scope of the right to bodily integrity include Henchy J's statement in *G v An Bord Uchtála*[841] that "such a right arises for judicial recognition or enforcement only in circumstances which require that, in order to assure the dignity and freedom of the individual within the constitutional framework, he or she should be held immune from a particular actual or threatened bodily injury or intrusion".[842] In addition, in *Re a Ward of Court*, both Hamilton CJ and Denham J recognised that the ward's right to bodily integrity was that as set out in *Ryan*, with Denham J stating that "the right to bodily integrity must be recognised by private individuals as well as the State".[843]

This view that the right is enforceable against private individuals was also found by MacKenzie J in *Walsh v Family Planning Services*[844] where he awarded damages for injury caused by a vasectomy carried out without negligence, not under tort, but under the constitutional right to bodily integrity. On appeal, the Supreme Court did not address the constitutional issue, finding that the matter should be determined on ordinary negligence principles.[845] Following in *Re A Ward of Court,* the right to bodily integrity, originally

---

preventive detention of a teenager not charged or convicted with an offence in a prison constituted a breach of his right to bodily integrity and welfare.

[841] [1980] IR 32.

[842] [1980] IR 32 at 90-91. See also O'Higgins CJ in *Norris v Attorney General* [1984] IR 36 where he summarily disposed of the plaintiff's argument of violation of bodily integrity" at 84.

[843] [1996] 2 IR 79 at 156, citing *The People (DPP) v JT* (1988) 3 Frewen 141 at 158. As noted, Denham J placed considerable emphasis on consent for medically invasive treatment: "the individual's right to privacy grows as the degree of bodily invasion increases" (citing *In re Quinlan* 70 NJ 10, 355 A2d 647; 1976 NJ); at 163.

[844] [1992] 1 IR 496.

[845] [1992] 1 IR 496. The court ruled that the negligence ground was preferable to the grounds of assault and battery. Although in the minority, McCarthy J expressed doubt as to the constitutional finding of the High Court which the respondents had contested vigorously in their appeal. McCarthy J, noting how a breach of a constitutional right was "a very grave matter" suggested that "assault actions ... not be dressed up in a constitutional guise". Further, whereas "[d]efamation and trespass to property may theoretically offend against some of the guarantees in respect of personal rights contained in Article 40 of the Constitution... [i[] is ... the State which is enjoined by its laws to protect as best it may from unjust attack and in the case of injustice done to vindicate the life, person, good name and property rights of every citizen. Claims to attack such rights unjustly may well be resisted calling in aid the constitutional guarantee; the guarantee, however, is not to be used to elevate the status of a trifling cause of action"; at 522.

conceived in terms of protecting one from the concept of mutilation is now to be interpreted that any non-consensual contact may violate the right, be that interference by the legislature, executive or private individuals and whether by way of act or omission. The right to health expressed in this manner focuses both on public and private health (insofar as *Ryan* concerned public health fluoridation of water while in *Re a Ward of Court* concerned invasive medical treatment by doctors).

Although there is no definition of health care under the Health Acts 1947-2007 and no right to health care recognised by the courts, nor has such a right been expressly disavowed. In *the Matter of Article 26 of the Constitution & In the Matter of the Health (Amendment) (No. 2) Bill 2004*[846], an Article 26 reference, the Supreme Court considered whether the imposition of a charge on persons in nursing homes or hospitals was constitutional.[847] Counsel assigned by the court argued that there was a right to health care under Article 40.3.1 and that

---

[846] [2005] IR 105.

[847] Section 52(1) of the Health Act 1970 provided that "A health board shall make available in-patient services for persons with full eligibility and persons with limited eligibility". Section 53 provided that "charges shall not be made for in-patient services made available under section 52, charges shall not be made for in-patient services made available under section 52". Section 1(a) of the Health (Amendment) (No. 2) Bill 2004 amended s. 53(2) of the 1970 Act so as to require the Minister to make regulations for the imposition of charges in certain circumstances for in-patient services. The question before the Supreme Court was thus whether, given that there was a general entitlement to in-patient services under 52(1) of the 1970 Act, a constitutional right existed (whether emanating from a right to life or a right to health) to receive such services, including any maintenance elements involved, free of charges, irrespective of the means of such persons. This argument was advanced by counsel appointed by the court to advance arguments against the Bill's constitutionality but were discounted by counsel for the Attorney General. The Supreme Court, citing *Sinnott v Minister for Education* [2001] 2 IR 545, juxtaposed the right to free primary education under Article 42 of the Constitution with other constitutional rights stating: "[i]t is not contended that there is any equivalent provision of the Constitution applying to the rights asserted by counsel. Persons who avail of in-patient services pursuant to s. 52 of the Act of 1970 and who have the means to pay for maintenance charges related to those services are not denied access to them. The court does not consider that it could be an inherent characteristic of any right to such services that they be provided free, regardless of the means of those receiving the"; at 166. The court also found that the manner in which the legislation was framed adopted a policy choice of the legislature to guard against hardship: "the Oireachtas has been careful to insert into the Bill a cap on the maximum charge which the Minister can impose, as referred to above. In doing so it is clear that it sought to avoid causing undue hardship generally to persons who avail of the in-patient services. No doubt it could be said that the State could or should have been more generous, or less so with regard to persons of significant means, but that is the kind of debate which lies classically within the policy arena and is not a question of law. All the court is concerned with is whether the charges are such that they would so restrict access to the services in question by persons of limited means as to constitute an infringement or denial of the rights asserted by counsel", concluding that a requirement to pay charges of the nature provided for in the Bill could not be considered as an infringement of the rights; at 167-168.

accordingly both the retrospective element (the ability to recover monies for in-patient services charges) and the prospective elements (requiring the imposition of charges for such services to be provided in the future) of the Bill were unconstitutional.[848] The court eschewed any finding that there was a right to health care, being content to state that if such a right existed, it did not extend to a right to be automatically entitled to free health care.[849]

Further, if there was such a right, the court noted, the presence of a cap on contributions in the legislation suggested it was not unduly restricted with the court also noting the provision for discretionary waiver in the case of hardship by the Chief Executive of the Health Board. In finding that the retrospective provisions of the Bill were unconstitutional, the court rejected a claim on equality grounds but clearly felt it was on stronger grounds in invoking property rights to find those provisions repugnant to the Constitution.[850]

---

[848] The prospective provisions of the Bill required the imposition of charges for in-patient health services to be provided in the future, whereas the retrospective provisions of the Bill sought to retain monies paid for in-patient services which would otherwise be reimbursed to the persons concerned. The court held that the proposed retrospective charges "abrogated[] the right of persons, otherwise entitled to do so, to recover monies for charges unlawfully imposed upon them in the past for the provision of certain in-patient services"; at 207. Insofar as section 52 of the 1970 Act had provided that those services were to be free of charge, the court held that "the right to recover monies for the charges thus imposed is a property right of the persons concerned which is protected by Articles 43 and 40.3.2 of the Constitution from, *inter alia*, unjust attack by the State and that insofar as the retrospective provisions of the Bill contained in section 1(b) provided for such an unjust attack, they were repugnant to the Constitution; at 208.

[849] [2005] IR 105 at 106. Arguably an opportunity was lost to address, even by way of dicta, the extent (if any) of a right to health under the Constitution concerning health entitlements arising under the State's obligation to "fulfil" the right to health.See also R O'Connell, *Equality Before the Law to the Equal Benefit of the Law: Social and Economic Rights in the Irish Constitution*, in *The Irish Constitution, Governance and Values*, E Carolan & O Doyle (Eds) Thomson Roundhall (2008) at 333 and E O'Dell and G Whyte, *Is This a Country for Old Men and Women? - In re Article 26 and the Health (Amendment) (No.2) Bill 2004*, 27 Dublin University Law Journal 368 (2005).

[850] Article 26.1.1 provides that "The President may, after consultation with the Council of State, refer any Bill to which this Article applies to the Supreme Court for a decision on the question of whether such Bill or any provision or provisions of such Bill is or are repugnant to this Constitution or any provision thereof". An Article 26 reference accordingly allows unconstitutionally tainted legislation to be identified prior to enactment, removing the need to subsequently litigate any such unconstitutionality. By referring to the entire Bill, or certain provisons thereof, Article 26, when read in conjunction with Article 15.4.2, allows for suspect legislative provisions to be declared invalid by the courts or "severed" from the legislation prior to enactment (see further discussion below on invalidity and serverance). However, Article 26 references suffer from the disadvantage that where the legislative provision is upheld by the Supreme Court, its constitutionality cannot be later challenged. It can also be questioned whether an Article 26 reference is the optimum manner in which the courts should be expected to elaborate on constitutional rights generally or a right to health in particular,

It will be apparent from cases such as *Frawley* and *Re Health Amendment Bill* that there can be somewhat of a disconnect between the courts on the one hand recognising the existence of a right to bodily integrity, *obiter*, but then finding no violation of the right or stating that there may be a right to health but if so it is somehow not applicable in the case, often on deference grounds (the plaintiff asks too much of the executive). Whereas it is clear that public and private bodies alike can be held liable for a range of acts or omissions in relation to a breach of a constitutional right to bodily integrity/ privacy, the procedural rules of judicial restraint (discussed below) often mean that, even if acknowledging the existence of a (theoretical) right, the courts will not consider the right claimed in the case before them, having regard to the separation of powers doctrine. The decision in *Frawley* is an example of Irish jurisprudence which arguably does not allow for a reasoned judgment on the balancing of rights required in considering the arguments advanced.

To date the unenumerated rights to bodily integrity/ autonomy/ privacy/ dignity have been defined narrowly as being concerned with the right to freedom from bodily interference, a right to privacy in relation to marital rights[851], to include a right to die naturally[852], a right to know one's identity[853], a right to health in prison,[854] a right not to be ill-treated[855] and a right not to have one's telephone tapped.[856] It has however not been interpreted to recognise a right to privacy for same-sex couples,[857] a right to restrain the publication of distressful

---

given the Irish courts disinclination to set out declaratory statements of principle concerning positive obligations that may rest on the State to guarantee constitutional rights, in a similar manner to that of the Indian Supreme Court in *Shanbaug v Union of India*, Judgment of 11 March 2011, [2011] 2SC R8 69 Writ Petition (Criminal) No. 115/ 2009. On the other hand, the Article 26 procedure has the advantage of not being tied to the facts of a particular case and thus potentially affords the courts with the opportunity of setting out some general principles as attaching to constitutional rights addressed in the particular legislation under review.

[851] *McGee v Ireland* [1974] IR 284.

[852] *Re a Ward of Court (No. 2)* [1996] 2 IR 79.

[853] *O'T v B* [1998] 2 IR 321.

[854] *The State (Richardson) v The Governor of Mountjoy Prison* [1980] ILRM 82.

[855] *The State (C) v Frawley* [1976] 1 IR 365.

[856] See *Kennedy and Arnold and Arnold v Ireland* [1987] IR 587.

[857] *Norris v Attorney General*, [1984] IR 36.

material in the media[858] or indeed either a right to proportionality in medical interventions or a right to gain entitlement to healthcare.

A right to dignity is also being increasingly invoked in jurisprudence under the enumerated right to the person.[859]

9.8 The right to the person

In *Fleming v Ireland,*[860] the High Court considered the plaintiff's constitutional right to her "person" (one of the four enumerated rights under Article 40.3.2).[861] Citing Henchy J's dictum in *Norris*[862], the Court identified "the protection of personal autonomy … [as] a core constitutional value" albeit one that in the instant case had to be balanced in the case against the constitutional protection of the right to life.[863]

---

[858] *M v Drury & Ors* [1994] 2 IR 8.

[859] See also T Finegan, *Conceptual Foundations of the Universal Declaration of Human Rights: Human Rights, Human Dignity and* Personhood, 37 Australian Journal of Legal Philosophy (2012) 182 at 216-218 where the author links the UDHR to a right to dignity.

[860] [2013] IEHC 2, at para 76, see above.

[861] It will be recalled that Article 40.3.2 requires the State "by its laws [to] protect as best it may from unjust attack and, in the case of injustice done, vindicate the life, person, good name, and property rights of every citizen".

[862] For Kearns P "individual choices of this kind taken by competent adults must normally be respected absent compelling reasons to the contrary. The following passage from the (admittedly dissenting) judgment of Henchy J. in *Norris* … may be taken to represent the current judicial consensus on this question: "…there is necessarily given to the citizen, within the required social, political and moral framework, such a range of personal freedoms or immunities as are necessary to ensure his dignity and freedom as an individual in the type of society envisaged. The essence of those rights is that they inhere in the individual personality of the citizen in his capacity as a vital human component of the social, political and moral order posited by the Constitution….It is sufficient to say that there are [personal rights of this nature] which fall within a secluded area of activity or non-activity which may be claimed as necessary for the expression of individual personality, for purposes not always necessarily moral or commendable, but meriting recognition in circumstances which do not engender considerations such as State security, public order or morality, or other essential components of the common good"; [2013] IEHC 2, Kearns P at para 50.

[863] "49. At the heart of the plaintiff's case is her contention that inasmuch as Article 40.3.2 of the Constitution protects her "person", this also necessarily embraces decisions concerning her personal welfare, including medical treatment. It is, of course, perfectly clear that the protection of personal autonomy in matters of this kind is a core constitutional value. The protection of the person is accordingly juxtaposed with other rights which are key to the fundamental freedom of the individual – liberty, good name and the protection of property. To this may be added the Preamble's commitment to the dignity and freedom of the individual as a fundamental constitutional objective and the recognition by Article 44.1 of freedom of

Identifying rights under the right to the person is a more recent judicial phenomenon and may represent a response to the reverses experienced by the unenumerated rights doctrine. In two recent prison-related *habeas corpus* applications, the courts have considered the enumerated right to the person as it applies to the conditions of detainees and their right to health. In *Kinsella v Governor of Mountjoy Prison*[864], Hogan J stated that Article 40.3.2 protected "not simply the integrity of the human body, but also the integrity of the human mind and personality."[865] In the particular case of solitary confinement with sensory deprivation, the State "had failed to vindicate that right in the manner required by Article 40.3.2 of the Constitution" although the court did not order release.[866] *Kinsella* is significant insofar as it dealt not only with State

---

individual conscience. For good measure, one might here also include similar and over-lapping rights such as the right to bodily integrity and personal privacy which have been judicially held to be protected as implied personal rights for the purposes of Article 40.3.1. 50. All of this means that the State cannot prescribe an orthodoxy in respect of life choices of this fundamental nature and, moreover, that individual choices of this kind taken by competent adults must normally be respected absent compelling reasons to the contrary... 51. ... the Court would observe that there are profound and different moral, ethical, philosophical and religious views on the question of end-of-life decisions such as the issue in controversy here. These are questions which are best left to public discourse and political debate and do not in and of themselves directly impinge on our analysis. If, accordingly, the plaintiff's constitutional rights extend as far as the manner claimed, then the fact that she is exercising those rights in a manner and for a purpose which some might consider contrary to their own ethical, moral or religious beliefs – or even the prevailing *mores* of the majority - is irrelevant. 52. Inasmuch, therefore, as the plaintiff advances a conscientious and considered decision to seek the assistance of others to take active steps to end her own life in the face of a terminal illness which has ravaged her body and rendered her life one of almost complete misery, we consider that such a decision is *in principle* engaged by the right to personal autonomy which lies at the core of the protection of the person by Article 40.3.2. In that respect, therefore, such a decision is not really properly to be regarded as either an implied constitutional right in its own right or a right derived from an implied constitutional right in the manner discussed (and rejected) by the US Supreme Court in *Washington v Glucksberg* 521 U.S. 207 (1997): it is rather a facet of that personal autonomy which is necessarily protected by the express words of Article 40.3.2 with regard to the protection of the person"; [2013] IEHC 2 at paras 49-53. As noted, the countervailing right to life measures were considered proportionate in overriding the autonomy right invoked by the plaintiff: "the Court believes that the Oireachtas was fully entitled to adopt the solution which it did in enacting the 1993 Act, not least when regard is had to the wider public policy considerations to which the Court has already alluded and the parallel duty which is also placed on the State by Article 40.3.2 to safeguard the right to life"; at para 72.

[864] [2012] 1 IR 467.

[865] [2012] 1 IR 467 at 471.

[866] The prisoner in the case was subjected to "the mental anguish which would be entailed by a more or less permanent lock-up under such conditions for an eleven day period". This detention compromised "the essence and substance of this constitutional guarantee, irrespective

interference with the plaintiff's rights through its imprisonment regime under its "obligation to respect", but also the "obligation to fulfil" insofar as continued omission by the State was not permissible. In the later case of *Connolly v Governor of Wheatfield Prison*[867], Hogan J invoked the Preamble's guarantee of "dignity and freedom of the individual" in stating that while

---

of the crimes [the prisoner] has committed or the offences with which he is charged"; [2012] 1 IR 467 at 471. The Court had considered that detention in the padded cell involved a form of sensory, deprived the prisoner of any meaningful interaction with his human faculties of sight, sound and speech which were vital interactions "if the integrity of the human personality is to be maintained although he distinguished this sensory deprivation from the "five techniques" of sensory deprivation in *Ireland v United Kingdom*, Application No. 5310/71, Judgment of 18 January 1978, 2 EHRR 25 in breach of the then-standard of inhuman and degrading treatment under Article 3 ECHR; See Part 1 of this thesis for the evolving standards under Article 3 ECHR – simply put what would have been classified as inhuman or degrading treatment or punishment in the 1970s could be regarded as torture under Article 3 today in light of evolving standards. As to his claim for habeas corpus relief, the court demurred. Whereas the detention of the applicant in an observation cell for such a continuous period amounted to a breach of his constitutional rights, it could not *yet* be said that this breach was so serious as to vitiate the lawfulness of his detention insofar as O'Higgins CJ in *The State (McDonagh) v Frawley* (*habeas corpus* procedure was "not suitable for the judicial investigation of complaints as to conviction, sentence or conditions of detention which fall short of that requirement. These fall to be investigated, where necessary, under other forms of proceedings"; at 137 and by Clarke J in *JH v Russell (Mental Health)* [2007] 4 IR 242 (absent intentional violation, "anything other than a complete failure to provide appropriate conditions or appropriate treatment could render what would otherwise be a lawful detention, unlawful") at 261; cited by Hogan J at 472-475. In Hogan J's view however, were the breach of Article 40.3.2 to remain unresolved, "the applicant would be entitled to renew his [habeas corpus] application if the applicant's circumstances of detention were to continue as heretofore, then, of course, with each passing day, the present case would inch ever closer to the point whereby this court could stay its hand no longer. In this regard, it should be noted that were these conditions to continue for much longer, the applicant would be justifiably entitled to make a fresh application for release under Article 40.4.2 or to take such further legal steps as he might be advised"; at 475.

[867] [2013] IEHC 334. In *Connolly*, the applicant, a homosexual with HIV who suffered from epilepsy, claimed he had been raped by a cellmate in a previous prison and sought protection from other prisoners fearing homophobic victimisation. This led to his solitary confinement (there was no prosecution by the Director of Public Prosecutions of the alleged rape but Hogan J noted that this did not mean that the offence had not occurred and in fact proceeded on the basis that it had; at para 4). The applicant sought *habeas corpus* release on the basis that the imposed regime violated his right to the protection of the person under Article 40.3.2. Hogan J ultimately found no violation on the basis of his only being under a restricted 23 hour lock up regime in prison for a period of 3 months under the Prison Rules. Referring to his earlier judgment in *Kinsella*, it was held that applying Article 40.3.2 of the Constitution to the case of prisoners involved upholding the integrity of their personalities which included sufficiently meaningful use of sight, sound and speech. Hogan J distinguished *Kinsella* insofar as the conditions in that case were extreme with no sensory amenities such as access to radio or television, with sanitation facilities "of a cardboard box". Whereas the applicant in *Connolly* had superior conditions, "for example, a proper bed, in cell sanitation, some access to natural light and he has access to a television and to reading material", unlike *Kinsella*, the applicant was likely to be detained in circumstances of something approaching solitary confinement for several months; at para 11. In *Connolly*, the court found that insofar as professional psychologists were available to the applicant and had shown him considerable care and attention with his case being constantly reviewed, the conditions did not breach Article 40.3.2 of the Constitution but could occur at a future date if the regime was to continue.

prisoners lose their freedom following a trial and sentence in due course of law, "they are still entitled to be treated by the State in a manner by which their essential dignity as human beings may be assured."[868] This obligation to ensure that the dignity of the individual is maintained and the guarantees in respect of the protection of the person upheld was "even more acute in the case of those who are vulnerable, marginalised and stigmatised".[869]

The right to the person has also been considered in asylum and behavioural disorder cases. In *GH v Health Service Executive*[870], which involved civil detention for a minor, Hogan J stated that "the underlying object and purpose" of Article 40.3.2 was the same for the prisoner or the "young man whose personal circumstances cry out for care and attention".[871] In *Olorunyomi v*

---

[868] [2013] IEHC 334 at para 14.

[869] [2013] IEHC 334 at para 15 and the courts "must nevertheless exercise a supervisory function to ensure that the essence of these core constitutional values and rights – the dignity of the individual and the protection of the person – are not compromised", citing Fennelly J in *Creighton v. Ireland* [2010] IESC 50. The obligation to ensure the dignity of prisoners was what was meant by Barrington J in *State (Richardson)* and must "now be classified as a case where the substance of the applicant's right to the protection of the person in Article 40.3.2 had been violated, certainly as read in conjunction the Preamble's guarantee in respect of the protection of the dignity of the individual." at para 17. The Constitution "commits the State to the protection of these standards since it presupposes the existence of a civilised and humane society, committed to democracy and the rule of law and the safeguarding of fundamental rights" at para 18. The Court considered that the threshold under Article 40.3.2 for non-severe conditions would be measured only "in terms of an extended period of months" as exceptional measure, which might, in some instances, at least, compromise the substance of the detainee's right to the protection of the person and the safeguarding of his human dignity. Certainly, the indefinite detention of a prisoner under such circumstances for periods of years would undoubtedly violate the guarantee to protect the person in Article 40.3.2, since it would be hard to see how the integrity of the detainee's personality - the very essence of the guarantee of the protection of the person and preservation of the human dignity of the prisoner - could be preserved under such circumstances;" at para 22. Shorter periods would require "monitoring and regular review" by the prison authorities whereas complete sensory deprivations for short periods of time (a matter of days) would violate Article 40.3.2 thus if the applicant's detention "under these conditions were to continue indefinitely for an extended period of months with no sign of variation, the point might very well come in which the substance of these constitutional guarantees would quickly be compromised and violated. It would, however, be premature just yet to anticipate what might yet materialise at some future time or in some future case"; at para 27. Thus the application to release was refused; at para 28.

[870] [2011] 3 IR 315.

[871] In *GH*, at issue was a civil detention order for a 16 year old youth suffering from an acute behavioural disorder which did not come within the definition of mental illness under the Mental Health Act 2001. Citing his judgment in *Kinsella*, Hogan J held that by committing the state to protecting the "person", Article 40.3.2 protects the integrity of the human body and "the integrity of the human mind and personality"; at para 14. The High Court found that his parents, separated and both chronic drug addicts, had objectively failed in their constitutional duty towards the child under Article 42.5 of the Constitution and that in such exceptional cases the State must "endeavour to meet that challenge by taking such proportionate measures as are in that child's best interests" under its inherent jurisdiction as set out in the judgment of

Minister for Justice, Equality and Law Reform[872] Gilligan J quashed the deportation decision of the Minister on the basis of suicide risk.[873] However, in *Cosma v Minister for Justice, Equality and Law Reform*[874] Hanna J, though accepting that the applicant was entitled to unspecified personal rights under Article 40.3.2, ultimately considered the application as unconvincing.[875] In *BJN v Minister for Justice, Equality and Law Reform*[876], McCarthy J refused the application on the basis that there was no positive obligation on the State to provide medical treatment under Article 8 of the ECHR or under Article 40.3.2

MacMenamin J in *SS (a minor) v Health Service Executive* [2008] 1 IR 594. The court ordered the civil detention of the young man in St Patrick's Institution on the basis that this detentioin was not being imposed "for punitive or even preventative purposes" and that "[e]very step will be taken by the prison authorities to ensure that his welfare (including his medical needs) will be safeguarded and, should this prove necessary, this court remains as a general supervisory authority which will act to ensure that these constitutional rights are safeguarded"; at para 18. The court considered that its order would satisfy Article 5 of the ECHR in the light of the judgment of the European Court of Human Rights in *DG v Ireland* (Applic No. 39474/98) (2002) 35 EHRR 1153; however no periodic review of his detention by the court or a court-like body was ordered as required by Article 5(4) of the ECHR and thus the later reference that notwithstanding that the detention must be "limited in duration … and constantly reviewed", recourse "may" only be had to the court "should it prove necessary" with "decisions as to his welfare … reviewed by the court"; at para 20 (conclusions) may of themselves not in fact suffice for Article 5 purposes.

[872] [2004] IEHC 426.

[873] [2004] IEHC 426, the applicant whose asylum application was refused by the Refugee Applications Commissioner and the Refugee Appeals Tribunal on appeal, sought to quash a deportation order of the Minister for Justice on the basis of suicide risk if repatriation were to take place. The Minister refused to revoke the deportation order pending receipt of a medical report on the matter and Gilligan J, noting how the decision affected the right to life of the applicant, granted an order of certiorari quashing the decision of the Minister on the basis that a final decision on the application clearly warranted sight of the report.

[874] [2006] IEHC 36.

[875] [2006] IEHC 36. Cosma involved a similar claim of suicidal risk by an unsuccessful Romanian asylum seeker. The court, after considering the judgments of the European Court of Human Rights under Articles 2 and 3 of the ECHR in *Soering v The United Kingdom*, Application No. 14038/88, Judgment 7 July 1989, [1989] ECHR 14 (threat of extradition to the United States where the applicant was at risk of inhuman or degrading treatment on death row) and *D v The United Kingdom*, Application No. 30240/96, Judgment 2 May 1997, 24 EHRR 423 (threat of deportation to St Kitts where the applicant was at face of inhuman treatment as a consequence of his HIV status and the lack of appropriate medication to treat same "in the very exceptional circumstances of this case"; at para 54) found that on the facts, the applicant had not established a real and substantial risk of death, discounting the psychiatric report adduced as being *pro forma* and unconvincing. As such, although where a *prima facie* question of "possible compromise to core personal rights" is raised by an applicant. it "behoves the reviewing court to proceed with caution" ("the most careful scrutiny") where alleged threat to life and limb is at issue, this did not suffice to depart from the Wednesday principles of review set out in *O'Keefe v An Bord Pleanála & Others* [1993] 1 IR 39 (the judicial review test in place before the higher threshold of review now required since *Meadows v Minister for Justice, Equality and Law Reform* [2010] 2 IR 701; discussed further below.

[876] [2008] 3 IR 305.

which was such to lead to the court impugning the applicant's proposed deportation.[877] In *OAYA (A Minor suing by her Mother and Next Friend, MBO)*[878], the applicant was a 6 year old girl at risk of female genital mutilation ("FGM") if forcibly returned to Nigeria. Hogan J held that the applicant was "plainly entitled to be protected against a serious threat to her constitutional rights which would undoubtedly occur were she to be subjected to FGM following deportation to Nigeria".[879] In *MEO v Minister for Justice, Equality and Law Reform*[880] Cooke J found that the State had no obligation to continue

---

[877] The applicant was a South African national who sought a revocation of a Ministerial deportation order against on the basis of her medical condition and prognosis of treatment if returned to South Africa on the basis of her HIV/AIDS. McCarthy J stated that in the absence of a positive obligation on the State to provide medical treatment under Article 8 of the ECHR (which as noted does not provide for a right to health *per se*); at 323-324. The Court noted that it had not been argued that there was a constitutional right to remain in Ireland for the purpose of receiving medical treatment in circumstances of the kind referred to by Finlay Geoghegan J in the earlier case of *Makumbi v Minister for Justice* [2005] IEHC 403. As no authority was opened to McCarthy J "suggesting that the applicant's rights under Article 40.3.2 import of an entitlement to medical treatment in the State", on the evidence before him, he refused the application as he could not see "how it might be held that one could contend that one's constitutional right in this regard would be breached"; at 325. See also *O v Minister for Justice, Equality and Law Reform* [2002] 2 IR 16, the applicant was refused refugee status and sought to have a deportation order made in respect of her overturned on the basis that she was pregnant and that there was a risk to the life of her unborn child under Article 40.3.3 of the Constitution if deported. The Supreme Court held that as the Irish State was not seeking to terminate the applicant's pregnancy, the fact that the standard of ante-natal or post-natal care available to her in Nigeria was less than would be available to her in Ireland was irrelevant to the legality of her deportation insofar as there was no constitutional right to health which would override the deportation order; at 18.

[878] [2011] IEHC 373.

[879] [2011] IEHC 373. The risk was on account of the applicant's ethnic background (Yoruba tribe) at the hands of family members (non state actors). The "subjection of any female to FGM is an open assault on her person, the very right which by Article 40.3.2 of the Constitution the State expressly undertakes to defend and vindicate in so far as it is practicable to do so", noting by the same token that FGM "can be regarded as a form of torture and inhuman and degrading treatment, contrary to Article 3 ECHR"; at para 15, recalling also Fennelly J's description of FGM in *Meadows v. the Minister for Justice, Equality and Law Reform*, [2011] 2 ILRM 157 as "abhorrent" and as one which "amounted to torture"; at 193. Given the "nature of these risks and the potential grave impact on the constitutional rights (and, for that matter, the Convention rights) which the subjection of the applicant to FGM would entail", Hogan J stated that it behoved "any decision-maker clearly to identify and assess the nature of such risks and to weigh them fairly and properly"; at para 16, citing by analogy Murray CJ's observation in in *Meadows v Minister for Justice, Equality and Law Reform* [2010] 2 IR 701 that under the principle of proportionality, substantial "countervailing considerations" will be required to justify "grave or serious limitations on the rights and, in particular, the fundamental rights of individuals as a consequence of an administrative decision"; at 725; at paras 16-17. Hogan J accordingly quashed the decision to deport in "the absence of such a balanced assessment of these risks" by the Tribunal member "an agent of the State" insofar as the member had not "sufficiently discharged the State's obligations under Article 40.3.2 to protect and vindicate the applicant's constitutional right to the protection of her person"; at para 20.

[880] [2012] IEHC 394 the applicant was refused asylum and subject to a deportation order. While in Ireland, she had been diagnosed as HIV positive and was receiving retroviral

to treat the applicant who was HIV positive, unless it was shown that her deportation would result in a critical deterioration in her medical condition. Addressing the general right to health, the Court stated that whereas the constitutional protection obligation "might well be breached where a treatment which is generally available through the public health services of the State was denied to an individual for some arbitrary reason or on some irrational ground", this did not extend to imposing on the State "a duty for example, to fund the transfer of a citizen to a foreign country to avail there of a treatment for a life threatening condition which was not available within the State".[881] There was no "general right in the citizen to receive, or an obligation on the State to provide medical and social services as a constitutional obligation".[882]

From these cases can be delineated the general principle that while there is an amorphous constitutuional right to health, it remains largely undefined. Unless

---

treatment for same. She claimed that if deported she would face inferior medical treatment which would breaching her human rights. In granting the (judicial review) leave application, Hogan J had found that the applicant's constitutional rights were at issue. In refusing her application at the substantive review hearing, Cooke J held that, whilst information before the Court showed Nigeria had a widespread HIV problem, there was nothing to suggest the applicant would not receive adequate treatment for her condition and that in fact there was clear evidence that large numbers of people received treatment in that State. As a non-national, the State had no obligation to continue to treat the applicant unless it was shown that deportation would result in a critical deterioration in her condition. The constitutional obligation "to protect the life and person of every citizen from any attack which is unjust" was "not a general obligation to protect the life and person of citizens in all circumstances or from any attack or injustice from any source", rather the obligation "comes into play where the life or person of a citizen is attacked or threatened with attack and the attack is unjust"; at para 28.

[881] [2012] IEHC 394 at para 31. No judgment of the High Court or Supreme Court had to date held that Article 40.3.2 imposes upon the State "a general obligation to provide necessary medical treatment to a citizen who is need of such treatment in order to forestall the natural consequences of a life threatening illness or disease". The protection from unjust attack on the life or person guaranteed by Article 40.3.2 did not extend to "impose a positive duty on the State to ensure a particular quality of life (including health) for the individual citizen"; ibid.

[882] [2012] IEHC 394 at para 31. This was "clear from the manner in which the Courts have dealt with claims which have sought to enforce what have been called "socio-economic rights" on the basis of Article 40.3", citing both Costello J in *O'Reilly v Limerick Corporation* [1989] ILRM 181 and Murphy J in *TD v Minister for Education* [2001] 4 IR 259 where Murphy J, citing *The State (C) v Frawley* [1976] IR 365 and *The State (Richardson) v Governor of Mountjoy Prison* [1980] ILRM 82, while conceding that the State has a constitutional obligation in respect of the health of persons detained in prisons did not accept "the existence of any general right in the citizen to receive, or an obligation on the State to provide medical and social services as a constitutional obligation"; at para 31 (discussed further below). Insofar as no provision of the Constitution imposed a "positive obligation on the State to provide or to continue to provide any particular type of medical treatment to an individual citizen as a matter of right based upon the protection afforded by Article 40.3.2", it followed that no such right attached to non-citizens "who happen to the present in the State without permission"; at paras 33-34.

the State acts in a manner which oppressively violates the individual's unenumerated right to bodily integrity (as was the case in *The State (Richardson)*) or their enumerated right to the person (where the integrity of the human mind and personality is violated as was set out in *Kinsella*) under its "obligation to respect", it is unlikely that a finding of a violaton of the right to health will be found under these fundamental rights guarantees. However, *Kinsella* may suggest a willingness by the courts to consider the State's obligations to "respect and fulfil" by reparations accountability, even if the threshold for a finding is high. The difficulty, as noted above, is that there is no right to health under the Health Acts 1947-2007, only an implicit right under the Equal Status Acts 2000-2012, while the Health Insurance Acts 1957-2012 may aggravate indirect discrimination concerns. Accordingly, it is difficult to demonstrate how statute law or Article 40.3 recognises the right to access the AAAQs without discrimination. In that light, it cannot be stated with confidence that Article 40.3 respects the right to health insofar as *MEO* has stated that there is no constitutional obligation on the State to provide medical and social services.

10 Separation of powers doctrine

Éamon de Valera in his explanatory address to the 1937 Constitution stated that the Constitution was "avowedly more than a formal charter for government".[883] Although the constitutional dispensation allows for direct horizontality of rights with the State "the agent of the People [rather] than the People's master"[884], as noted, the unenumerated rights doctrine suffered a reversal in recent years which may explain the more recent jurisprudence under the enumerated right to the person.[885] One reason why the right to health has such difficulty in gaining recognition lies in the fact that the courts, under the separation of powers doctrine, now eschew claims based on legislative or executive omission rather than commission, particularly where resource allocation issues arise which is perceived to be the case in right to health litigation (see medical negligence discussion in Part 3).

In *TD v Minister for Education*[886] the Supreme Court adopted Keane J's scepticism of the unenumerated rights doctrine in his dissenting judgment in *O'T v B.*[887] In Kelly's comprehensive treatise on constitutional law, Hogan and Whyte suggest how the judgments of the Irish Supreme Court in both *Sinnott v Minister for Education*[888] and *TD* saw the Irish courts, albeit by way of *obiter dicta* per Keane CJ and Murphy J in *TD*, reject the concept that economic or social rights could be justiciable under the personal rights provisions of the Constitution. The term "economic or social rights" is often wrongly employed by commentators as shorthand for matters solely for legislative/ executive competence. Viewed in this manner, it may be more accurate to state that it was rather under the Separation of Powers doctrine that Hardiman J in *TD* felt the court could not intrude into matters of legislative primacy (for Hardiman J

---

[883] O Doyle, *Constitutional law: Text, Cases and Materials* Dublin: Clarus Press (2008) at 377-378.

[884] W Binchy, *Meskell, the Constitution and Tort Law* 18 Dublin University Law Journal (2011) 339 at 340.

[885] However, the Supreme Court has yet to rule definitively on the scope of the right to the person.

[886] [2001] 4 IR 259.

[887] [1998] 2 IR 321.

[888] [2001] 2 IR 545.

it was inappropriate that the courts should grant mandatory relief (mandamus) to the plaintiffs on foot of judicial review proceedings). Also significant is the fact that shortly prior to the *TD* and *Sinnott* cases, the same Supreme Court rejected the concept of natural law rights in the *Regulation of Information* case (discussed above).[889]

Keane J's articulation of judicial restraint to the unenumerated rights doctrine in *O'T v B*[890] was taken up by the Supreme Court in *TD*.[891] The tone was set by Murphy J in *TD*:

> It is my belief that this entirely desirable goal [of assisting the sick, the poor and the underprivileged] must be achieved and can only be achieved by legislation and not by any unrealistic extension of the provisions originally incorporated into Bunreacht na hÉireann.[892]

Previously Kelly J in *DB v Minister for Justice*[893] had held that the State had a positive duty to provide appropriate facilities to children at risk under Article 42.5 of the Constitution, a decision only taken following protracted executive inaction.[894] The *DB* approach was similar to that taken by the Constitutional Court of South Africa in *The Government of the Republic of South Africa v Grootboom*[895] where it made a Declaration requiring the State "to act to meet

---

[889] [1995] 1 IR 1.

[890] [1998] 2 IR 321.

[891] [2001] 4 IR 259.

[892] [2001] 4 IR at 259 at 322.

[893] [1999] 1 IR 29.

[894] *DB* followed the Judgments of O'Hanlon J *in O'Donoghue v Minister for Education* [1996] 2 IR 20 and Geoghegan J in *FN v Minister for Education* [1995] 1 IR 409 and indeed the Supreme Court Judgment in *Crotty v An Taoiseach* [1987] IR 713 where Finlay CJ held that, exceptionally, the interlocutory injunction sought by the plaintiff against ratification of the Single European Act and enactment of the European Communities (Amendment) Bill, 1986 was necessary as otherwise the court would be deprived of its jurisdiction or power to grant to the plaintiff the remedies necessary to protect his constitutional rights.; at 763. This trend in the jurisprudence of the court in favour of the supremacy of the "People" under Article 6 of the Constitution was as noted later followed in *McKenna v An Taoiseach (No 2)* [1995] 2 IR 10 and *Doherty v Government of Ireland* 2 IR [2011] 222. Kelly J's mandatory order in DB to build a high support unit for young offenders was only made after systemic delay by the authorities" see G Hogan, *Directive Principles, Socio-Economic Rights and the Constitution*, 36 Irish Jurist (2001) 174 at 183.

[895] (CCT11/00) [2000] ZACC 19; 2001 (1) SA 46; 2000 (11) BCLR 1169 (4 October 2000).

the obligation imposed upon it by section 26(2) of the Constitution" which included "the obligation to devise, fund, implement and supervise measures to provide relief to those in desperate need."[896]

The reversal in *TD* was also in part due to the identification of the unenumerated rights doctrine with a "distributive" rather than a "commutative" justice doctrine, which was strongly rejected by the Supreme Court. In *TD*, Hardiman and Murray JJ approved Costello J's dicta in *O'Reilly v Limerick Corporation*[897] that a claim for mandatory relief by a group of Travellers involved "the distribution of the nation's wealth" which was a matter for the executive rather than the courts. In that case Costello J had distinguished between "distributive justice" and "commutative justice".[898] A court could not impose its view that there had been an unfair distribution of national resources. To do so it would "make an assessment of the validity of the many competing claims on those resources, the correct priority to be given to them and the financial implications of the plaintiff's claim" which the courts were ill-suited to do.[899]

---

[896] (CCT11/00) [2000] ZACC 19; 2001 (1) SA 46; 2000 (11) BCLR 1169 (4 October 2000) at para 96 per Yacoob J. As noted, Article 26 of the South African Constitution provides for the right of everyone to have access to adequate housing and for the Sate to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of this right. Both declaratory and mandamus relief was ordered by the Court in the right to health *Minister for Health v Treatment Action Campaign*, 5 July 2002 (CCT 8/02); at para 135.

[897] [1989] ILRM 181.

[898] [1989] ILRM 181. According to Costello J, the courts could adjudicate upon the latter but not the former: "What is due to an individual from another individual (including a public authority) from a relationship arising from their mutual dealings can be ascertained and is due to him exclusively and the precepts of commutative justice will enable an arbitrator such as a court to decide what is properly due should the matter be disputed. This distinction explains why the court has jurisdiction to award damages against the State when a servant of the State for whose activity it is vicariously liable commits a wrong and why it may not get jurisdiction in cases where the claim is for damages based on a failure to distribute adequately in the plaintiff's favour a portion of the community's wealth"; at 194.

[899] [1989] ILRM 181 at 195. Whyte argues that Costello J rowed back on this view in his *ex tempore* judgment in *O'Brien v Wicklow UDC,* unreported, 10 June 1994, where he favoured judicial intervention where "a constitutional right to bodily integrity … is being infringed by the conditions under which [the plaintiffs] are living"; at 3-4. Costello J followed the reasoning of Barron J in *University of Limerick v Ryan,* unreported 21 February 1991, in holding that a statutory duty did exist under the Housing Act 1988. Whyte suggests that this bolsters the argument that the separation of powers doctrine can be accomodated with judicial intervention on behalf of marginalised groups insofar as both doctrines are both constitutionally and politically legitimate (the main thesis in *O'Reilly* was that the separation of powers could not

These principles were upheld in *MacMathúna v Attorney General*[900] where Finlay CJ stated that while it was "clearly conceivable that under certain circumstances statutory provisions, particularly those removing in its entirety financial support for the family, could constitute a breach of the constitutional duty of the State under Article 41", this was not such a case of "total removal of support or absence of support".[901] Is there not an incongruity in distinguishing between commutative vis-a-vis distributive justice by reference to a rigid separation of powers doctrine? The reluctance to address a constitutional rights claim simply because the enforcement of those rights would involve resource implications does not take account of the clear constitutional duties to provide free primary education (Article 42.2), an Irish translation of statutes (Article 8), property rights (Articles 40.3 and 43), the duty not to interfere with implied rights under Article 40.3 such as the right to

---

so accommodate judicial intervention); G Whyte, *Social Inclusion and the Legal System: Public Interest Law in Ireland*, Institute of Public Administration (2002) at 57.

[900] [1995] 1 IR 484.

[901] [1995] 1 IR 484 at 499. Finlay CJ also observed how "[i]n any event, these were "peculiarly matters within the field of national policy, to be decided by a combination of the executive and the legislature, that cannot be adjudicated upon by the courts"; ibid. These cases suggest a legal positivism: that there are certain disputations which, in the absence of explicit consittutional or legislative provisions, are non-justiciable. Elsewhere the courts have adopted different approaches. In *Re Reference by the Governor in Council concerning Certain Questions relating to the Secession of Quebec* (1998) [1998] 2 SCR 217 the Supreme Court of Canada declined to answer a reference question on the basis of non-justiciability where adjudication would take the court beyond its own assessment of its proper role in the constitutional framework of our democratic form of government or lacked the technical expertise to adjudicate; at para 26. The question whether socio-economic rights can be justiciable was addressed in *Certification of the Constitution of the Republic of South Africa* 1996 (CCT 23/96) Judgment where despite accepting that the inclusion of socio-economic rights may result in courts making orders which have direct implications for budgetary matters, the Constitutional Court of South Africa found that it was competent to do so without breaching the separation of powers doctrine. The court noted that civil and political rights adjudication (such as equality, freedom of speech and the right to a fair trial) often rendered orders with similar budgetary implications without compromising their justiciability; at paras 77-78. In *Sinnott*, Hardiman J sought to distinguish between three "absolutely unqualified" constitutional duties with resource implications, as advanced by the plaintiff, namely the duty to provide a residence for the President, the duty to hold elections and the duty to provide an official translations of Bills but unsatisfactorily disposed of the arguments on the basis that they were more specific, and limited, than the alleged duty in relation to education; *Sinnott v Minister for Education* [2001] 2 IR 545 at 694. The expense was tiny for these duties, while other examples "may be somewhat more expensive but are of the same general sort". Hogan sought to distinguish between budgetary implications of civil and political rights which he saw as an indirect consequence of a court's order if not already contemplated by the Constitution itself (such as election costs), neither triggering separation of powers and justiciabilty concerns"; G Hogan, *Directive Principles, Socio-Economic Rights and the Constitution*, 36 Irish Jurist (2001) 174 at 186.

work[902], the right to have provided free criminal legal aid at a level which does not render one at an unfair disadvantage to the prosecution[903] or arguably a right to apply for free civil legal aid in certain cases (as opposed to an entitlement to receive such aid).[904] The vindication of certain civil rights also has clear resource implications and so it is incorrect to solely characterise socio-economic rights as being resource-intrusive.[905] As set out in Part 1 of this thesis, the human rights to health, education or housing allow for a consideration of resource implications in an interdependent society. In *Grootboom*, the Constitutional Court of South Africa recognised that "the state is not obliged to go beyond available resources or to realise these rights immediately".[906] In *Soobramoney v Minister for Health (Kwazulu-Natal)*[907], the Court rejected the Appellant's claim that a refusal to provide him with life-extending dialysis treatment violated his rights to life and health under the South African Constitution, citing resource-allocation grounds.[908] Chaskalson

---

[902] *Tierney v Amalgamated Society of Woodworkers*[1959] IR 254.

[903] *Carmody v Minister for Justice, Equality and Law Reform* [2010] ILRM 157.

[904] See *Magee v Farrell* [2009] 2 ILRM 453 where the Supreme Court found there was no right to legal aid at an inquest into the suspicious death in Garda custody of a child. That case led to an application to the European Court of Human Rights which settled in 2012: see *Magee v Ireland* Application No. 53743/09, Friendly Settlement December 2012. In *Stevenson v Landy & Ors* Unreported, 10 February 1993 the High Court had found that the Legal Aid Board was obliged to make legal aid available to a mother who had a "worthwhile contribution" to make in wardship proceedings; per Lardner J. Indeed, a matter often overlooked is the fact that the Supreme Court in *Sinnott* held that the right to primary education under Article 42.4 of the Constitution should be construed to extend to the time one reaches 18 years of age; an interpretation not immediately self-evident from the text of that provision and one that has significant resource implications on the State for the education of children aged 12-17 years.

[905] In *Soobramoney v Minister for Health (Kwazulu-Natal)* (CCT32/97) [1997] ZACC 17; 1998 (1) SA 765 (CC); 1997 (12) BCLR 1696 (27 November 1997), Sachs J observed how health care rights fall to be considered not only in a traditional legal context structured around the ideas of human autonomy but in a new analytical framework based on the notion of human interdependence. Minow J stated that interdependence in health was not a social ideal, but an inescapable fact with the scarcity of resources requiring consideration of access to dialysis equipment or a kidney transplant; at para 54.

[906] (CCT11/00) [2000] ZACC 19; 2001 (1) SA 46; 2000 (11) BCLR 1169 (4 October 2000) at para 94 per Yacoob J.

[907] Case CCT 32/97 Judgment 27 November 1997 per Chaskalson P, Sachs J.

[908] The court distinguished the Judgment of the Supreme Court of India in *Paschim Banga Khet Mazdoor Samity and others v State of West Bengal and another* (1996) AIR SC 2426 where a hospital had refused the claimant treatment as dealing with the refusal of available (emergency) treatment, whereas the present case concerned the refusal of unavailable non-emergency treatment.

P noted how the right to health under section 27 of the South African Constitution entitled everyone to have access to health care services provided by the state "within its available resources".[909] He held that "[a] court will be slow to interfere with rational decisions taken in good faith by the political organs and medical authorities whose responsibility it is to deal with such matters."[910] In words resonant of Costello J, Sachs J also noted how judicial restraint should be exercised in medical cases insofar as courts were not the "proper place" to resolve "agonising" choices, citing institutional incapacity and deference.[911] This did not however mean that the right to health was not justiciable, rather that in the court's assessment, it would defer to other institutional experts. In *Minister of Health v Treatment Action Campaign*,[912] while granting mandatory and declaratory orders, the Court recognised that it was not "institutionally equipped to make the wide-ranging factual and political enquiries necessary for determining what the minimum core standards called for by the first and second amici should be nor for deciding how public revenue should most effectively be spent".[913]

In *Soobramoney* a Constitutional Court examined in detail the constitutional right to health claim by asking whether the right to life was at issue, by asking: was refusal of emergency treatment at issue? Were the dialysis guidelines properly formulated and followed according to the evidence before the High Court? The court was in a position to assess the reasonableness of the refusal in rejecting the Appellant's claim in circumstances where its decision meant that the Appellant would shortly die. It did so not on a strict separation of powers doctrine, but by careful examination of the argument as against the common

---

[909] Case CCT 32/97 Judgment 27 November 1997 per Chaskalson P at para 22.

[910] 1997 (12) BCLR 1696, at para 29.

[911] Case CCT 32/97 Judgment 27 November 1997. Sachs J considered that important though the review functions of courts are, there are areas where "institutional incapacity and appropriate constitutional modesty require us to be especially cautious". The provisions of the South African Bill of Rights should "not be interpreted in a way which results in courts feeling themselves unduly pressurized" by the fear of gambling with the lives of claimants "into ordering hospitals to furnish the most expensive and improbable procedures, thereby diverting scarce medical resources and prejudicing the claims of others"; at para 58.

[912] CCT 8/02, [2002] ZACC 15; 2002 (5) SA 721; 2002 (10) BCLR 1033 (5 July 2002).

[913] CCT 8/02, [2002] ZACC 15; 2002 (5) SA 721; 2002 (10) BCLR 1033 (5 July 2002) at para 27.

good defence and the evidence of institutional experts. This is the normal approach by the Irish courts when considering whether an interference by the State is proportionate or breaches a constitutional right and the courts have considerable experience in employing stricter criteria to refuse mandatory relief where insufficient funds are available to the State authority.[914]

Having to persuade a court that it is not overstepping a separation of powers demarcation line in reviewing the acts or omissions of the executive or executive suggests that the separation of powers doctrine has reduced the "judicial space" when it comes to vindicating fundamental rights. However this is at first glance misplaced given the zest with which the Superior Courts have located precisely that space in the vindication of rights in the cases set out above and in Article 38 (trial by due process), Article 40.3 (enumerated right to a good name), and Article 41 (right of the Family) cases, to name three discrete areas of constitutional law.[915] In their jurisprudence under those Articles, the courts have shown a willingness to vigorously uphold constitutional rights.[916] In this way, the Supreme Court places deeper store in "the classical liberal understanding of the State and, in particular, to the judicial function in overseeing the role of the State … in criminal proceedings."[917] Indeed, due

---

[914] See *Brady v Cavan County Council* [1999] 4 IR 99 where Keane J held that he would not be disposed to hold that the court should bring the rigours of *mandamus* to bear on a public authority where it is acknowledged that it has not the means to comply with the order and that its successful implementation depends on the co-operation of other bodies who are not before the court"; at 106.

[915] Jurisprudence on the right to a fair trial (trial in due course of law) includes *The State (Healy) v Donoghue* [1976] IR 325, *Heaney v Ireland* [1996] 1 IR 580, *King v Attorney General* [1981] IR 223 and *The People (Director of Public Prosecutions) v Quilligan* [1986] IR 495. Jurisprudence under the right to a good name includes In *Re Haughey* [1971] IR 217 in which O'Dálaigh CJ read into Article 40.3 a number of procedural rights in inquiries conducted against individuals; at 248-255. See also *Maguire v Ardagh* [2002] 1 IR 419 and *M v Medical Council* [1984] IR 485. Jurisprudence under the rights of the family include *O'B v S* [1984] IR 316, *The State (Nicolaou) v An Bord Uchtála* [1966] IR 567 and *North Western Health Board v HW* [2001] 3 IR 622.

[916] Judicial preference can be observed insofar as although the rights under Articles 41, 42 and 43 (dealing with the family and property) are described "in more robust terms" than the right to personal liberty in Article 40.4 and the guarantee of a fair trial in Article 38, those rights have been more forcibly articulated by the courts; G Whyte, *Case Notes and Recent Developments – A Tale Of Two Cases – Divergent Approaches Of The Irish Supreme Court To Distributive Justice*, 32 Dublin University Law Journal (2010) at 376.

[917] G Whyte, *Case Notes and Recent Developments – A Tale Of Two Cases – Divergent Approaches Of The Irish Supreme Court To Distributive Justice*, 32 Dublin University Law Journal (2010) at 378.

process rights are regularly vindicated despite having resource implications as per the judgments in *State (Healy) v Donoghue*[918] *Stevenson v Landy*[919] and *Carmody v Minister for Justice, Equality and Law Reform.*[920]

Indeed, if one accepts the premise that the Constitution "falls to be interpreted in accordance with contemporary circumstances including prevailing ideas and mores" [921] is it not the case that judicial review of executive action affords "the best available mechanism"[922] to vindicate the constitutional rights of the "socially excluded"?[923] The inevitable indeterminate nature of some constitutional protections and the context of an actual case coming before a court – both in temporal and societal terms - cannot be identified through "the views of the framers of the Constitution"[924] and this means that as Walsh J noted in *McGee v Attorney General*[925] only judges may determine those rights and their scope. The difficulty arises where charges are levelled against judges for being too activist and for acting as a legislature and where, faced with originalist and positivist theorists, judges find it difficult to locate sources of law to support their quest for justice where available sources such as natural law have fallen into abeyance.[926]

---

[918] [1976] IR 325 per O'Higgins CJ.

[919] Unreported, 10 February 1993 per Lardner J. However as noted the Supreme Court in *Magee v Farrell* [2009] 2 ILRM 453 found there was no right to legal aid at an inquest into the suspicious death in Garda custody of a child.

[920] [2010] ILRM 157.

[921] See *Sinnott v Minister for Education* [2001] 2 IR 545 per Murray J.

[922] M Perry, *The Constitution in the Courts: Law or Politics?* Oxford University Press (1994), cited by G Whyte, *Social Inclusion and the Legal System: Public Interest Law in Ireland,* Institute of Public Administration (2002) at 29.

[923] G Whyte, *Social Inclusion and the Legal System: Public Interest Law in Ireland* (IPA, 2001) at 29.

[924] M Perry, *The Constitution in the Courts: Law or Politics?* Oxford University Press (1994), cited by G Whyte, *Social Inclusion and the Legal System: Public Interest Law in Ireland,* Institute of Public Administration (2002) at 30.

[925] [1974] IR 287.

[926] Raz has suggested that both the arguments of Dworkin and those of legal positivists are similar, with both arguing that "courts are legally required to apply source-based standards and both claim[ing] that they are legally bound to follow certain moral standards, even when they are not source-based"; J Raz, *Authority, Law and Morality*, in J Raz, *Ethics in the Public Domain; Essays in the Morality of Law and Politics* Oxford University Press (1994) at 85.

And yet, is there any other mechanism to ensure justice for the breach of constitutional rights? As noted, Costello J's Judgment in *O'Reilly v Limerick Corporation*[927] may be contrasted with his *ex tempore* judgment of *O'Brien v Wicklow.*[928] Insofar as *O'Reilly*, while arguing against judicial enforcement of socio-economic rights, did not set out why such enforcement should not occur (apart from reiterating the argument about the primacy of the political process), it can be subjected to criticism. Judges will invariably exercise caution where "institutional incapacity and appropriate constitutional modesty" so require in the words of Sachs J. However, that is not to vacate the space required for reviewing whether constitutional rights have been upheld.

10.1 Constitutional litigation and judicial deference

Practice and procedure argumentation often take up a substantial portion of constitutional litigation.[929] Accordingly, a claim must take the form of Plenary Summons and particulars of the harm suffered or be grounded in an application for judicial review. If judicial review, there must be an act or omission of a "public body" which is impugned (discussed below).[930] The claim must also conform to the Rules of the Superior Courts and any relevant statutory provisions.[931] Presuming the action proceeds to trial, before the substantive

---

[927] [1989] ILRM 18.

[928] Unreported, 10 June 1994 at 3-4. Hogan refers to Costello P's 1998 address to a Conference on the UDHR where he argued for a constitutional amendment to guarantee explicitly social and economic rights of the poor: see G Hogan, *Directive Principles, Socio-Economic Rights and the Constitution*, 36 Irish Jurist (2001) 174 at 181.

[929] The obstacles facing a litigant seeking to articulate a right to health/ bodily integrity under Article 40.3 are described by Doyle as: "The ideas that not everyone may challenge the constitutionality of a statute, that the courts should show deference to the Oireachtas when interpreting legislation, that the effects of a declaration of unconstitutionality should be limited, all raise fundamental issues about our structure of government"; O Doyle, *Constitutional law: Text, Cases and Materials* Dublin: Clarus Press (2008) at 431.

[930] De Blacam defines judicial review as the means whereby the courts examine the legality of all public actions including their own; M De Blacam, *Judicial Review* (Second Edition), Tottel Publishing (2009) at 3.

[931] See the provisions of the Statute of Limitations Act 1957 (as amended). Where medical negligence is pled, the provisions of the Civil Liability and Courts Act 2004, including its two year time limit under Section 7 and its compulsory alternative dispute resolution requirements (discussed below) must be met (at least insofar as the tort element is concerned). Where the ECHR Act is pled, its one year time limit under section 3(2) must be met. Under the Rules of

claim can be considered by a court of law, the plaintiff must demonstrate that s/he has standing (*locus standi*) to bring the action and is personally prejudiced (*jus tertii)* insofar as constitutional litigants can only make arguments based on their own circumstances and not *in abstracto.*[932] Hypothetical arguments or arguments based on injury to third parties are not permitted.[933] The courts will also insist on specificity in judicial review applications.[934]

Only when a plaintiff/ applicant satisfies these procedures will the substantive claim be examined and the associated question of whether the particular relief sought would, if granted, offend the separation of powers doctrine.[935] Judicial deference to the other great organs of State has led the separation of powers doctrine to assume centrality in the litigation of both enumerated and unenumerated rights where resource allocation issues arise.

Considering first legislative acts or omissions, any declaratory relief sought that a legislative provision contravenes a constitutional right must, in addition to demonstrating that the impugned provision affects the applicant, overcome the presumption that it is constitutionally sound. A law passed by the Oireachtas "is presumed to be constitutional unless and until the contrary is

---

the Superior Courts, the applicant must apply for relief promptly, namely within 3 months or 6 months for certiorari relief (Order 84, Rule 21(1) of the Rules of the Superior Courts) unless statutory provisions provide otherwise, such as section 5(2)(a) of the Illegal Immigrants (Trafficking) Act 2000 (14 day). The courts otherwise retain an inherent jurisdiction to extend the time limits under Order 84 where special factors are at issue and the justice of the case demands it.

[932] *Cahill v Sutton* [1980] IR 269 demonstrates the difficulty a right to health claim can face. Here the plaintiff wished to sue her doctor for alleged breach of contract during medical treatment but did not bring her claim within the three year timelimit and challenged this stipulation in section 11(2)(b) of the 1957 Act as being unconstitutional. Henchy J held that she could not do so. Identifying both *locus standi* and *jus tertii* as rules of judicial restraint, he found that the plaintiff sought to advance the case of hypothetical plaintiffs which would be "to make an argument that was not hers to make".

[933] See *Cahill v Sutton* [1980] IR 269 and *Madigan v Attorney General* [1986] ILRM 136.

[934] In *AP v Director of Public Prosecutions* [2011] IESC 2 Murray CJ noting that judicial review constitutes a significant proportion of the cases before the Superior Courts indicated that a party seeking relief by way of judicial review is required to apply to the High Court for leave to bring those proceedings and "can only be granted such leave on specified grounds when certain criteria, required by law, are met." The applicant must demonstrate that he or she has an arguable case in respect of any particular ground for relief; at 3-4.

[935] The courts' deference to the Oireachtas and the Executive lies in the "respect which one great organ of State owes to another" as set out in *Buckley v Attorney General* [1950] IR 67.

clearly established".[936] The presumption of constitutionality is however rebuttable under Article 34.3.2 which assigns to the courts the power of ensuring no law is unconstitutional. Where the courts declare a statutory provision to be repugnant to the Constitution, they have the choice of either striking down[937] or "severing" the offending provision under Article 15.[938] What is required is to interpret the intention of the Legislature in light of the Constitution, noting the pre-eminence of Article 15.2.1 and the imperative that the court not "invad[e] a domain exclusive to the legislature and thus exceed[] the Court's competency".[939] Recently the courts have demonstrated their ability to avoid striking down and severance where it can "fashion" a remedy to vindicate a right, notably in the case of legislative omission.[940] While identifying and "fashioning" remedies has the advantage of allowing important legislative provisions to survive (and respects the intention of the Legislature)

---

[936] *Pigs Marketing Board v Donnelly* [1939] IR 413 per Hanna J. Despite a reverse in *Buckley v Attorney General* [1950] IR 67, this was revisited by the Supreme Court in *Attorney-General v Southern Industrial Trust* (1964) 94 ILTR 161. O'Dálaigh CJ in *Re Haughey* [1971] IR 217 stated that the presumption of constitutionality is not to be applied where it would "do violence to the plain meaning of the words"; at 254. A plaintiff seeking to strike down a law or its application must overcome not only the hurdle that the impugned law is presumed constitutional but also the hurdles of the "double construction" rule (which allows words to be "read in" to render a legislative provision constitutional), per Walsh J in *McDonald v Bord na gCon* [1965] IR 217 at 239 and 243 and the presumption that its application is also presumed constitutional. In *East Donegal Co-operative Livestock Market Ltd v Attorney General* Walsh J had extended the rule so that its application (i.e. the "proceedings, procedures, discretions and adjudications which are permitted" under the legislation) is also deemed constitutional [1970] IR 317. In *Dellway Investments Ltd & Ors v National Asset Management Agency* [2011] IESC 14 Murray CJ held that the Appellants were entitled to a declaration that NAMA had not made a decision to acquire the eligible bank assets represented by their loans as it could only do so after affording them natural justice rights. In *Ghaidan v Godin-Mendoza* [2004] 2 AC 557, the House of Lords "read in" words under section 3 of the Human Rights Act 1998 on the basis that it required a court to change the meaning of the enacted legislation, so as to make it Convention-compliant, having regard to the "underlying thrust of the legislation being construed"; at paras 32-33. The Irish courts have been slow to provide section 2 of the ECHR Act 2003 any such expansive application.

[937] This is the "judicial death certificate" referred to by Henchy J in *Murphy v Attorney General* [1982] 1 IR 241 309 at 343.

[938] See *Maher v Attorney General* [1973] IR 140 per Fitzgerald CJ. See also *Deaton v Attorney General* [1963] IR 170 per O'Dálaigh CJ.

[939] [1973] IR 140 at 147-150. See *Desmond v Glackin (No.2* (No. 2) [1993] 3 IR 67 and *CC v Ireland* [2006] 4 IR 1 where Hardiman J declined to sever on the basis that to do so would involve the court in a process akin to legislation; at 86.

[940] See *Carmody v Minister for Justice* [2010] ILRM 157, where the court, considering a legislative omission, made a declaration effectively prohibiting the defendant's trial and *BG v District Judge Catherine Murphy*, unreported, 8 December 2011 (HC) where the court, again responding to a legislative omission, made a declaration prohibiting the Circuit Court from sentencing the Applicant disproportionately.

while addressing instances of inadvertent legislative omission, the Supreme Court has chosen not to "read in" phrases to legislation nor to suspend a declaration of invalidity as has the Canadian Supreme Court[941], although Denham J in *A v Governor of Arbour Hill Prison*[942] stated, *obiter*, that a court "may consider it appropriate in certain extreme circumstances to suspend a declaration that a law is unconstitutional so that the Oireachtas might address the issue if it wished".[943] Rather the admonitory declarations in the legislative

---

[941] See *R v Bain* [1992] 1 SCR 91 and *Schachter v Canada* [1992] 2 SCR 679, discussed below.

[942] [2006] 4 IR 88.

[943] In *A v Governor of Arbour Hill Prison* [2006] 4 IR 88, at issue was the impact of a declaration of constitutionally validity (the striking down of section 1(1) of the Criminal Law (Amendment) Act 1935 by the court in *CC v Ireland* [2006] 4 IR 1 (where Hardiman J made a Declaration invalidating section 1(1) of the Criminal Law Amendment Act 1935 rather than arguably suspending the Declaration to allow the legislature amend the relevant provision). Should the *CC* judgment benefit the applicant by permitting his release under Article 40.4 if the statute grounding his conviction had "no legislative existence" (being pre-1937) in accordance with Article 50.1 of the Constitution, as ordered by Laffoy J in the High Court? The Supreme Court reversed the order finding that it was not a principle of constitutional law that cases which have been finally decided and determined on foot of a statute which was later found to be unconstitutional must invariably be set aside as null and of no affect. Once finality had been reached and the parties had in each case exhausted their actual or potential remedies, the judicial decision must be deemed valid and lawful. Citing Henchy J in *Defrenne v Sabena* [1976] ECR 455, Denham J noted the emergence of "a principle that declarations of unconstitutionality apply to the party in the litigation in which the decision is made, and prospectively, but that it does not apply retrospectively"; at 149. Denham J noted how O'Higgins CJ in *Blake v The Attorney General* [1982] IR 117, in declaring Parts II and IV of the Rent Restrictions Act 1960 void, had gone on to address the application of that decision to "thousands of families, who had relied upon the protection of their tenancies by the legislation". Similarly the court's finding in *The State (Byrne) v Frawley* [1978] IR 326, the effect of a finding of invalidity of sections of the Juries Act 1927 did not render convictions made in criminal trials under those provisions invalid; at 150. Nor did the striking down of the statute in *de Burca v Attorney General de Burca v Attorney General* [1976] IR 38 achieve the result sought by the applicant in *A*. Denham J noted how the court did not suspend the application of its decision, but had "made suggestions which, in effect, addressed the time pending new legislation" to address the justice of the situation; at 150. Turning to the impact of a declaration, Denham J considered that the development of a jurisprudence of suspended declarations in Canada (though not argued in *A)* could recommend itself in Ireland where a court "may consider it appropriate in certain extreme circumstances to suspend a declaration that a law is unconstitutional so that the Oireachtas might address the issue if it wished" with the advantage of aiding "organised society" as it would enable the legislature "to address the issue" and enable "dialogue in the community as to the best way to proceed"; at 153. Examples of such an approach cited were the judgments of the Supreme Court of Canada in *R v Bain* [1992] 1 SCR 91 where a declaration of invalidity concerning fair trials was "suspended by that court for six months in order to 'provide an opportunity for Parliament to remedy the situation if it considers it appropriate to do so'" with the application of the declaration postponed prospectively for six months and *Schachter v Canada* [1992] 2 SCR 679 where in the Supreme Court of Canada, Lamer CJ pointed out that striking down the statute in question "would have the result of denying the statutory benefit to adoptive parents and grant no rights to natural parents" thus finding that the court should "suspend the declaration of invalidity to allow the government to determine whether to cancel or extend the benefits"; at 716, cited by Denham J at 152. See also *Re Manitoba Language Rights Case* [1985] 1 SCR 721 at paras 156-163.

omission cases of *Carmody v Minister for Justice*[944] and *BG v District Judge Catherine Murphy*[945] have seen the courts set out what cannot occur in relation to individual applicants to ensure their constitutional rights.[946]

Although there is currently no articulated justiciable right to health entitlement under the Health Acts 1947-2007 or indeed the Health Insurance Acts 1994-2012, this could change if a public health agency akin to the United Kingdom Primary Care Trusts were to be enacted and mandated to take decisions on health care or treatment issues (discussed below). Were this to occur, the

---

[944] [2010] ILRM 157.

[945] Unreported, 8 December 2011 (HC). BG was both a legislative omission and executive inaction insofar as the High Court directed that the applicant's trial could not take place unless and until the correct range of proportionate penalties available in the District Court on a guilty plea (0 to 12 months) could be applied in the Circuit Court. This would arguably require either legislation to address the legislative omission or a prosecution by the Director of Public Prosecutions in the Circuit Court to lead to a custodial sentence of a proportionate range to that available in the District Court; the declaration by the court providing: "In the event that an accused including the applicant, in relation to whose case a District Court Judge has decided that it was suitable for summary disposal on a plea pursuant to s. 13(2) of the Criminal Procedure Act 1967 and the Director of Public Prosecutions had consented to summary disposal on a plea pursuant to the said s. 13(2), is found fit to be tried by a Judge of the Circuit Court in accordance with s. 4(4) of the Criminal Law (Insanity) Act 2006 and thereafter pleads guilty to the charge of sexual assault of a female, contrary to s. 2 of the Criminal Law (Rape) (Amendment) Act 1990, as amended, for the sentencing judge to apply a maximum sentence of more than the equivalent sentence that would have been available to the District Court under s. 13(3) of the Criminal Procedure Act 1967, as amended, would be to breach an applicant's constitutional right to be held equal before the law under Article 40.1 of the Constitution of Ireland"; at 773. An example of an executive act deriving from legislation but offending constitutional rights occurred in *Dokie v Director of Public Prosecutions, Human Rights Commission, Ireland and the Attorney General Notice Parties* [2011] 1 IR 805 where Kearns P found that an arbitrary arrest of an asylum seeker by An Garda Síochána on foot of section 12 of the Immigration Act 2004 rendered the provision unconstitutional: "While s. 12 was designed as an immigration control mechanism, its vagueness is such as to fail basic requirements for the creation of a criminal offence. As drafted it gives rise to arbitrariness and legal uncertainty. It also offends the principle that a person be not obliged to incriminate himself. I find it unconstitutional for those reasons… Even if I am mistaken in my conclusions on the first issue and the legislation is to be taken as constitutionally sound, I would regard the deployment of s.12 in respect of this applicant as an unconstitutional use of a legislative provision which was designed to be deployed in different circumstances"; at 823. In Dokie the High Court granted two reliefs: one against executive action and the other against legislative omission: "I propose at this stage to simply grant two of the reliefs sought which are set out at the beginning of this judgment, namely, an injunction restraining the respondent from taking any further steps in the prosecution entitled *Director of Public Prosecutions (at the suit of Garda Thomas Morley) v. Ebere Dokie*, and also a declaration that s. 12 of the Immigration Act 2004 is inconsistent with the provisions of Bunreacht na hÉireann and in particular Article 38.1 which provides that no person shall be tried on a criminal charge save in due course of law and with the guarantee in Article 40.4.1ø that no person shall be deprived of his liberty save in accordance with law"; at 824.

[946] Thus in both cases the criminal trials of the applicants were effectively prohibited until such time as the legislature (or Circuit Court in the case of *BG*) took measures to secure a fair trial and a right to equality before the law, respectively.

legislative framework would need to be shaped by principles of reasonableness and proportionality. In this regard, the "critical test by which to adjudge whether a person's constitutional rights have been infringed"[947] was enunciated in *Heaney v Ireland*[948] where Costello J in his landmark judgment stated that any "restriction" on the exercise of constitutional rights "must pass a proportionality test" in that they must: "(a) be rationally connected to the objective and not be arbitrary, unfair or based on irrational considerations; (b) impair the right as little as possible, and (c) be such that their effects on rights are proportional to the objective".[949] Costello J's proportionality test derived from the jurisprudence of the Supreme Court of Canada and the European Court of Human Rights under Article 8, i.e. that it be rational and fair, impair the right minimally and be proportionate in its effects in order to be deemed constitutional.[950] At issue in *Cox v Ireland*[951] was a legislative provision excluding persons convicted of certain offences from re-employment which the High Court and Supreme Court found to constitute an unjustified attack upon the plaintiff's unenumerated right to earn a livelihood. *Heaney* similarly concerned an interference by the Legislature with the plaintiff's constitutional rights which both the High Court and Supreme Court considered was proportionate.[952] In contrast, in *Tuohy v Courtney*[953] at issue was the balancing of the rights of two individuals: the plaintiffs right to sue against the

---

[947] *Dokie v Director of Public Prosecutions, Human Rights Commission, Ireland and the Attorney General Notice Parties* [2011] 1 IR 805 per Kearns P at 821.

[948] [1994] 3 IR 593.

[949] [1994] 3 IR 593 at 607.

[950] On appeal O'Flaherty J for the Supreme Court in *Heaney v Ireland* [1996] 1 IR 580 repeated that what was at issue was whether the power given to the Garda Síochána in the circumstances by the section was proportionate to the aim of the legislation: at 589-590.

[951] [1992] 2 IR 503.

[952] Both the High Court and Supreme Court found that the requirement under section 52 of the Offences Against the State Act, 1939 to provide an account of one's movements to An Garda Síochána, while an encroachment against the right not to have to say anything that might afford evidence that was self-incriminating (rather than the absolute entitlement to silence) was proportionate to the legitimate aim of the meausre namely the entitlement of the State to protect itself against serious crime.

[953] [1994] 3 IR 1.

defendant's right not to be encumbered by "stale" claims.[954] Whereas Finlay CJ favoured a deferential approach to reviewing the impugned legislation (the Statute of Limitations Acts 1957-1991) insofar as the role of the court was limited to determine whether the "balance" struck in the legislation "is so contrary to reason and fairness as to constitute an unjust attack on some individual's constitutional rights"[955], this was not a case of an impugned legislative provision permitting direct intrusion on the plaintiff's rights as in *Cox* or *Heaney*, but rather a legislative provision which sought to regulate the competing rights of individuals to litigate and to defend themselves, respectively.[956]

Turning to judicial review of executive acts or omissions, the Executive rarely takes health decisions save for those macro-level structural or budgetary

---

[954] The intention of the Statute of Limitations Act 1957 as amended being to protect defendants "against stale claims and avoid the injustices which might occur to them were they asked to defend themselves from claims which were not notified to them within a reasonable time"; [1994] 3 IR 1 at 48.

[955] [1994] 3 IR 1. "The Court is satisfied that in a challenge to the constitutional validity of any statute in the enactment of which the Oireachtas has been engaged in such a balancing function, the role of the courts is not to impose their view of the correct or desirable balance in substitution for the view of the legislature as displayed in their legislation but rather to determine from an objective stance whether the balance contained in the impugned legislation is so contrary to reason and fairness as to constitute an unjust attack on some individual's constitutional rights"; at 47.

[956] Indeed intrusive legislative provisions impacting due process rights are more likely to be struck down as disproportionate if the legislature could have adopted less intrusive means to secure the legitimate aim being sought to be achieved. In *DK v Crowley* [2002] 2 IR 744 the Supreme Court did not uphold section 4(3) of the Domestic Violence Act 1996 with Keane CJ emphasising, in striking down the provision, that although the Oireachtas in upholding the constitutional rights of others is entitled to abridge the constitutional right to due process of other persons, the extent of that abridgement must be proportionate, i.e. no more than is reasonably required; at 757-758. See B Foley, *Concepts of the Judicial Power over the past 75 Years* Conference on "The Irish Constitution: Past, Present and Future", University College Dublin (June 2012) at 4. Subsequent caselaw suggests that the courts, while ostensibly applying the *Heaney* test of proportionality, will also apply an additional layer of *Tuohy* deference. In *Re Article 26 The Employment Equality Bill, 1996* [1997] 2 IR 321, the Supreme Court applied both a stricter review test to proposed criminal liability in the impugned Bill and a deferential review test to proposed age discrimination (discussed below). Hamilton CJ held that even if the age limit chosen in the legislation did not clearly correspond to any recognised threshold or if the Oireachtas was shown to have made the wrong choice, that would not lead a court to decide that the classification was irrelevant, unfair or irrational; at 348-349. Yet when the Oireachtas attempted to introduce a criminal sanction under section 63(3) of the Bill, the court invoked the proportionality test of the Canadian Supreme Court in *R v Oakes* [1986] 1 SCR 103 (per Dickson CJ who also cited the ECHR) and *Chaulk v R* [1990] 3 SCR 1303 (per Lamer LJ) in finding there was no proportionality between the process of trial by certification and the objective of the Bill and the limitations of the right to trial in due course of law; at 383. See also *Rock v Ireland* [1997] 3 IR 484 and *In Re Article 26 and the Illegal Immigrants (Trafficking) Bill, 1999* [2000] 2 1R 360.

decisions set out in the Health Acts. Hence it is difficult to identify how precisely an action for legislative or executive omission would be framed.

Currently, the closest agency in the State to the UK Primary Care Trusts is the HSE[957] insofar as health treatment decisions are usually consultant-led within hospital institutions.[958] In the field of health, the HSE is one of the few public bodies clearly amenable to judicial review unless it can be argued that private bodies effectively perform public duties and are also so amenable (discussed below). Notwithstanding this, it is difficult to identify decisions or omissions of the HSE which could be impugned over and above those which impact on the Equal Status Acts 2000-2012 (discussed above). Simply put, the fact remains that health treatment acts and omissions are taken primarily by private actors. This combined with the constitutional doctrine of "taking constitutional issues last" under which claims in medical negligence will take precedence over constitutional actions[959] means that when considering a right to health claim, the courts will consider those non-constitutional elements first, namely any claims in contract or in tort (i.e. medical negligence) or any administrative law claim that a decision was improperly taken. A larger constitutional enquiry would only occur where there were exceptional circumstances.[960] Medical negligence claims must moreover be brought within strict timeframes which led to the plaintiff's action in *Cahill v Sutton*[961] falling foul of the Statute of

---

[957] See description of the HSE in *Health Service Executive v Commissioner of Valuation* [2008] IEHC 178, discussed below.

[958] This contrasts with the situation where housing rights (at issue in *O'Reilly v Limerick Corporation*) are legislated for and provide for a statutory duty on Housing Authorities under the Housing Act 1988 (as amended).

[959] The classic exposition of this principle was set out by O'Higgins CJ in *M v An Bord Uchtála* [1977] 2 IR 286: "[A]s a general rule the court should consider first whether the relief sought can be granted on the ground which does not raise a constitutional validity. If it can, then the court ought not to rule on the larger question of constitutional validity of the law in question. Normally, such a law as a statute of the Oireachtas will enjoy a presumption of constitutionality which ought not to be put to the test unnecessarily"; at 293. See also Fennelly J in *White v Dublin City Council* [2004] 1 IR 545: "[T]here is no overriding consideration, in the interests of justice, for departing from the normal rule [of taking constitutional issues last]. I am satisfied that it must be shown that [the Plaintiffs'] claim is well-founded, in short that [the planning claim] would succeed. If, on the other hand they fail on the planning issue, it will be unnecessary to consider the constitutional issue"; at 557.

[960] This was not considered to be the case in *M* which concerned the placing of the son of an unmarried mother for adoption and the mother's attempts to regain his custody.

[961] *Cahill v Sutton* [1980] IR 269. The plaintiff's claim that the three year timelimit under section 11(2)(b) of the 1957 Act was unconstitutional failed; discussed above.

Limitations Act 1957. The potential injustice arising from rigid procedural requirements was set out by Ryan J in *Kearney v McQuillan & North Eastern Health Board*[962] who observed how it was "disturbing" to consider how close the victim of grave medical malpractice "came to being sacrificed on the altar of fair procedures".[963]

That exceptional circumstances will be required to ground a larger constitutional inquiry can be observed following the decisions in *Boland v An Taoiseach*[964] and *TD v Minister for Education.*[965] In *Boland,* Fitzgerald CJ set out the power of the courts to review executive action only where "the circumstances are such as to amount to a clear disregard by the Government of the powers and duties conferred on it by the Constitution".[966] In *McKenna v An Taoiseach (No 2)*[967] the Supreme Court held that where the Government so acts, the courts are not only entitled "but obliged to intervene" but that "such fact must be clearly established".[968] In *Doherty v Government of Ireland*[969] Kearns P, granted a Declaration for executive omission in failing to apply a legislative provision (section 39(2) of the Electoral Act 1992 to move a writ to hold a bye-election) but only after identifying a high constitutional value (the "constitutional contract" between the citizen and the State).[970]

---

[962] [2012] IEHC 127.

[963] [2012] IEHC 127 at para 84. The case concerned an undisclosed symphysiotomy of the plaintiff in 1969 only discovered in 2002, which potentially ran foul of the Statute of Limitations Act 1957 (as amended) and is discussed further below.

[964] [1974] IR 338.

[965] [2001] 4 IR 259.

[966] [1974] IR 338 at 361. At issue was the signing by the Government of a communique with the British Government on Northern Ireland, a clear execise of executive prerogative which the courts had no power "either express or implied, to supervise or interfere with"; ibid.

[967] [1995] 2 IR 10.

[968] *McKenna (No 2)* [1995] 2 IR 10 at 32 per Hamilton CJ. At issue here was whether to grant an interlocutory injunction restraining the executive's use of public funds to promote a particular vote in a referendum.

[969] 2 IR [2011] 222.

[970] 2 IR [2011] 222. "A constitutional approach necessarily means that s. 39(2) of the Act of 1992 must be interpreted as being subject to a temporal requirement that a by-election motion be either moved by the Government or not resisted by it within a reasonable time of the vacancy arising"; at 242. There was "ample precedent for concluding that decisions or omissions which affect or infringe citizens' rights under the Constitution are*prima facie*

In *TD*, executive omission was also in issue. The Supreme Court reviewed the High Court's order of mandamus which compelled the executive to implement a particular policy following the State's omission to properly accommodate disadvantaged children. Murray J, with whom the majority of the Court agreed, stated that declaratory relief should ordinarily be sought. Although the power of the courts "to defend and vindicate rights guaranteed by the Constitution"[971] was ample, this power was nonetheless subject to the ambit of the role "conferred by the Constitution on the courts with due respect to the role and function of the executive and the legislature".[972] Thus a mandatory order "directing the executive to fulfil a legal obligation (without specifying the means or policy to be used in fulfilling the obligation) *in lieu* of a declaratory order as to the nature of its obligations could only be granted, if at all, in exceptional circumstances where an organ or agency of the State had disregarded its constitutional obligations in an exemplary fashion", namely following "a conscious and deliberate decision by the organ of state to act in breach of its constitutional obligation to other parties, accompanied by bad faith or recklessness".[973] The courts are more willing to impugn executive (and

---

justiciable", citing Ahern v Minister for Industry and Commerce (No 2) 1991 1 IR 462 (a decision to put a civil servant on compulsory sick leave held to be justiciable since it affected his right to work) and MacPharthalain v Commissioners of Public Works [1992] 1 IR 111 (the designation of certain lands as constituting an area of scenic interest held to give rise to a justiciable controversy as it affected a landowner's right to obtain certain types of grants): "It seems to me that a citizen's constitutional rights are trenched upon and significantly diluted when no effect is given to rights for representation clearly delineated in the Constitution. These are rights which might usefully be characterised as forming part of the "constitutional contract" between the citizen and the State"; at 241.

[971] [2001] 4 IR 259 at 336.

[972] Thus in Murray J's view, "[j]udicial statements as to the amplitude of the powers of the court in this regard ... can only be interpreted and applied within the ambit of the role conferred by the Constitution on the courts with due respect to the role and function of the executive and the legislature. Any other approach would introduce incoherence into the concept of the separation of powers as delineated by the Constitution. In my view the grounds relied upon by the learned High Court Judge did not entitle him to make the mandatory order... In coming to the conclusions above I do not wish to determine that the courts may never make a mandatory order in *any* form as opposed to a declaratory or other order, against an organ of state. In so far as McKenna v An Taoiseach No 2 [1995] 2 IR 10, Crotty v An Taoiseach [1987] IR 713 and District Judge McMenamin v Ireland [1996] 3 IR 100 might be said to be authority for the making of *some* form of mandatory order where there is "a clear disregard" by the State of its constitutional obligations, it must be borne in mind that in none of those cases was a mandatory order granted"; at 336-337.

[973] Referring to the "clear disregard" test espoused by Fitzgerald CJ in *Boland v An Taoiseach* [1974] IR 338, Murray J stated: "In my view the phrase "clear disregard" can only be understood to mean a conscious and deliberate decision by the organ of state to act in breach of its constitutional obligation to other parties, accompanied by bad faith or recklessness. A court

judicial) acts which encroach constitutional rights, however only through *certiorari* or declaratory relief.[974] In light of *TD*, few litigants would be advised to seek mandatory relief against the executive.[975]

A failure to translate the right to bodily integrity into practice through legislation would require the courts to identify a constitutional value which was violated by a legislative omission such as was evident in *Carmody* as opposed to legislative commission as was evident in *Cox v Ireland*.[976] As noted above, to date the courts have been content to only state that if a constitutional right to

---

would also have to be satisfied that the absence of good faith or the reckless disregard of rights would impinge on the observance by the State party concerned of any declaratory order made by the court... should the occasion arise for the courts to consider making a mandatory against an organ of state*in lieu* of a declaratory order, such an order could not be such as would involve the courts in actually exercising the functions constitutionally reserved to those organs of state"; at 337.

[974] In *Holland v Governor of Portlaoise Prison* [2004] 2 IR 573, McKechnie J held that Rules 59 and 63 of the 1947 Prison Rules violated the applicant's right to freedom of expression under Article 40.6.1 insofar as it was "an unwarranted and disproportionate interference" with his right to express freely his convictions and opinions and equally violated his rights under Article 40.3.1, all his constitutional rights accruing save for those which expressly or impliedly removed by reason of his imprisonment. [2004] 2 IR 573 at 582. He thus set aside the decisions of the respondent to refuse the applicant correspond with the media. In *Irish Times Ltd v Ireland* [1998] 1 IR 359 the Supreme Court granted an order of certiorari in quashing a High Court order restricting media coverage of a drugs trial, Keane J stressing the right of the public under Article 34 to be informed of court proceedings through the media; at 409.

[975] In *TD* Murray J cited Walsh J in *Murphy v Corporation of Dublin* [1972] IR 215 who had stated: "The division of powers do not give paramountcy in all circumstances to any one of the organs of State"; at 234; [2001] 4 IR 259 at 331.

[976] [1992] 2 IR 503. Walsh J in *East Donegal Co-Operative v Attorney General*[1970] 1 IR 317 had stated that to afford proper protection of constitutional rights, legislative provisions must enable the person invoking them not merely to redress a wrong post-facto but "also to prevent the threatened or impending infringement of the guarantees and to put to the test an apprehended infringement of these guarantees." [1970] 1 IR 317 at 338. See also the obiter High Court statement of Finlay Geoghegan J in *Bode v Minister for Justice, Equality and Law Reform*[2006] IEHC 341: "Where either the Oireachtas transforms what was policy into legislation or the Executive by an administrative or other act takes a decision, which impacts on an individual albeit in accordance with a policy then if it is alleged that such legislation or decision is contrary to constitutional or legally protected rights of the individual it is a matter for the courts to hear and determine that dispute"; [2006] IEHC 341 at 366. However, neither proposition suggests that the State may be subject to an order of mandamus to legislate. See also *Laurentiu v Minister for Justice* [1999] 4 IR 26, where at issue was an executive decision on foot of a legislative enabling provision intruding on the judicial sphere. Here the Supreme Court had no difficulty in upholding the High Court's decision to quash section 5(1)(e) of the Aliens Act 1935 which permitted the Minister for Justice to have unrestricted power to order the deportation of non-nationals as this would in effect permit the Minister to legislate for deportations contrary to Article 15.2.1 of the Constitution.

health exists, it does not extend to a right to be automatically entitled to free health care.[977]

In *TD*, Hardiman J, with whom Murray J agreed, held that the separation of powers was a "subordinate constitutional value" which meant that "[e]quality of the powers can only operate in practice on the basis that each has its discrete remit."[978] To "fit harmoniously" into the constitutional order as Henchy J had stated in *The People v O'Shea*[979] the courts could not assert a "paramountcy to the judicial branch of government".[980] A failure to recognise boundaries and exercise judicial restraint could bring the courts into unwarranted and unjustifiable conflict with the political branches of government which could not be countenanced.

Post *TD*, it is difficult to identify any circumstances where an order of mandamus may be granted by a court. In addition to Murray J's "exceptional circumstances", Hardiman J considered it would have to be an "absolutely final resort in circumstances of great crisis and for the protection of the constitutional order itself".[981] Might this suggest that other constitutional principles including the duty to "vindicate" personal rights through granting appropritate relief has been made subject to the doctrine of the separation of powers?

The importation of "conscious and deliberate" disregard and male fides/ recklessness raises the exceptional circumstances test to dizzy heights.[982] The

---

[977] In *the Matter of Article 26 of the Constitution & In the Matter of the Health (Amendment) (No. 2) Bill 2004* [2005] IR 105.

[978] [2001] 4 IR 259 at 371.

[979] [1982] IR 384.

[980] [2001] 4 IR 259 at 371.

[981] [2001] 4 I.R. 259 at 372. Hogan recorded how 2 of the 4 Judges who expressed a view, namely Denham and Geoghegan JJ, were prepared in *Sinnott* to consider mandatory orders in such cases to protect constitutional rights, while Keane CJ held that where the financial resources of a Minister was not an issue there was nothing to preclude the granting of mandatory relief directed to the Minister concerned ([2001] 2 IR 545 at 631): see G Hogan, *Directive Principles, Socio-Economic Rights and the Constitution*, 36 Irish Jurist (2001) 174 at 184. It may be that mandatory relief would be preceded by an unexecuted declaratory order.

[982] Doyle describes the test as one of "constitutional meltdown" and observes that these additional tests are "wholly inconsistent" with the natural meaning of the words and how the

recent judgment of the Supreme Court in *Carmody*[983] and of the High Court in *Doherty v Government of Ireland*[984] may suggest a willingness by the courts to consider a more flexible approach through the granting of declaratory relief following legislative or executive omission which clearly intrude on constitutional rights. Both judgments required the State to act with consequential costs to the public purse.[985] Similarly in *BG,*[986] Hogan J granted the applicant a declaration under Article 40.1 stating that, on account of his mental disability, if he pleaded guilty in the Circuit Court, he could not be sentenced in a manner disproportionate to the sentence he would have received in the District Court.

While Denham J in the minority in *TD* viewed a declaratory order as "the preferable procedure", for her the separation of powers doctrine was a functional doctrine, pliant to the needs of constitutional justice and not a "doctrine applied rigidly in the Constitution".[987] This separation of powers had to be balanced with the duty of the courts to guard constitutional rights.[988] This suggests a reasonableness criterion analogous to that employed in Canada and South Africa insofar as only where deference (or trust) breaks down (where the

---

phrase was employed in the earlier cases: O Doyle, *Constitutional law: Text, Cases and Materials* Dublin: Clarus Press (2008) at 370.

[983] *Carmody v Minister for Justice, Equality and Law Reform* [2010] ILRM 157.

[984] 2 IR [2011] 222.

[985] *Carmody* was in similar vein to *O'Donoghue v Legal Aid Board* [2004] IEHC 413 in which the High Court granted a Declaration that the plaintiff's right of access to the courts had been violated and awarded damages, extending the constitutional right to cover impoverished litigants who sought family law relief (a divorce and maintenance for a dependant child). As a consequence of the judgment, the State increased the funds available to the Legal Aid Board. *Doherty* led to the costs of a bye-election.

[986] *BG v District Judge Catherine Murphy,* unreported, 8 December 2011 (HC).

[987] [2001] 4 IR 259 at 298-299. Whyte argues that the fact that the court upheld the proposed charge for in-patient services only after satisfying itself that the statutory regime would not unduly deny access to these services suggests, by implication, that legislation that did unduly deny access to such services might be regarded as unconstitutional and implied socio-economic constitutional rights; G Whyte *Socio-Economic Rights in Ireland: Judicial and Non-Judicial Enforcement,* paper presented at the Irish Human Rights Commission Conference on Economic, Social and Cultural Rights (2005) at 4-5; available at *www.ihrc.ie/download/ecrgerardwhyte.doc* accessed on 22 September 2012.

[988] Doyle suggests that in contrast to Hardiman J's "rigid" conception of the separation of powers, Denham J's "functional" conception allowed greater innovation on the part of the courts; O Doyle, *Constitutional law: Text, Cases and Materials* Dublin: Clarus Press (2008) at 368.

executive unreasonably fails to comply with a declaratory order) will the court's patience become exhausted, opening up the possibility of it resorting to exceptional mandatory relief. In the 2005 *Health Bill Reference* case[989] the Supreme Court left open the possibility of a judicially enforceable socio-economic right holding that an issue "may well arise" where "public monies could be constrained by a constitutional obligation to provide shelter and maintenance for those with exceptional needs" and following *Kinsella v Governor of Mountjoy Prison* arguably there is scope for further elaboration of such a right to health under the rubric of the right to the person under Article 40.3.2, even if clear executive omissions will see the courts being cautious in granting the reliefs sought.[990]

10.2 Criticisms of judicial restraint

Judicial deference and restraint has been described as a "pernicious" doctrine which permits the abdication of judicial responsibility in favour of reliance on the good faith or special expertise of public officials, whose judgments may be incorrect.[991] The end result, it is argued, is insulation of decision-makers from judicial review with "the conferral on either Parliament or the executive of a wholly unfettered power to strip ... individual right[s] ... of any practical effect".[992]

Other authors argue that deference and non-justiciability are based on concerns about the institutional limits of the judicial role when compared to the competence, expertise and democratic legitimacy of the elected branches of government which, as noted, include legal positivists who inquire into the validity of judicial interpretation.[993] The courts are willing to put limits on

---

[989] [2005] IEHC 7 at para 34.

[990] [2012] 1 IR 467.

[991] T R S Allan, *Human Rights and Judicial Review: A Critique of Judicial Deference*, 65 Cambridge Law Journal (2006) 671 at 675.

[992] T R S Allan, *Human Rights and Judicial Review: A Critique of Judicial Deference*, 65 Cambridge Law Journal (2006) 671 at 692.

[993] A Kavanagh, *Defending Deference in Public Law and Constitutional Theory*, 126 Law Quarterly Review (2010) at 241 and 248-249. Doyle observes how arguments against

deference insofar as intrusions into the judicial sphere of a power characterised as judicial will not be tolerated under Articles 6, 34 and 37 which vest the power exclusively in the courts.[994] Accordingly, non-justiciability can be separated from deference which is a more flexible doctrine and arguably not antithetical to judicial scrutiny. There are degrees of deference and establishing the appropriate degree is a matter of balancing all the relevant factors in the individual case. *Meadows*-type scrutiny may not be needed where at issue is clearly a technical decision-making exercise in an area which does not impact fundamental rights. Rather than being a blanket rule preventing scrutiny, deference may have a role in requiring the courts to assess their institutional competence to deal with a particular issue.[995]

---

justiciability focus not only on concerns that judicial enforcement of distributive justice are undemocratic, but also that any such enforcement may be pragmatically unwise given the limited capacities of the courts: O Doyle, *Constitutional law: Text, Cases and Materials* Dublin: Clarus Press (2008) at 377.

[994] *Buckley v Attorney General* [1950] IR 67 at 84. A similar conclusion was reached in *Maher v Attorney General* [1973] IR 140 where the court held that insofar as the statutory provision in question attempted to remove the jurisdiction of the courts, it was an invalid infringement of the judicial power…"; at 145-146..

[995] The report of the Constitutional Review Group in 1996 employed strong language in rejecting justiciable rights to freedom from poverty and social exclusion or specific economic rights as a response to inequalities in society with a majority asserting that the main reason for its rejection was that "[i]t would be a distortion of democracy" to transfer decisions on major issues of policy and practicality "from the Government and the Oireachtas, elected to represent the people and do their will, to an unelected judiciary". A majority of the Constitutional Review Group expressed this view in response to considering whether the State should guarantee wide justiciable rights (namely to freedom from poverty and social exclusion or specific economic rights as a counterweight to economic inequality): *Report of the Constitutional Review Group*, Dublin, Stationery Office (1996) at 206-211. The majority provided three arguably unconvincing reasons: that these are essentially political matters; that conferring a constitutional right on everybody to freedom from poverty is not susceptible to objective determination and a repeat of the first reason: that democratic principles suggest that absolute personal rights should not be vested in the Constitution in relation to economic or social objectives; at 210. It conceded that it had no objection to expressing the substance of economic and social rights as directive non-justiciable principles and noted that it was open to Government and the Oireachtas to reduce inequalities of wealth and income by fiscal policy measures, and that *in extremis* the Constitution offers ultimate protection; at 210-211. There are clear parallels here with the "exceptionality" referred to by Hardiman, Murray and Denham JJJ in *TD*. One of the members of the group later conceded that the main reason given was that it would "tend to distort the separation of powers": G Hogan, *Directive Principles, Socio-Economic Rights and the Constitution*, 36 Irish Jurist (2001) 174 at 189. It is unclear why the Review Group's focus was on whether there should be a justiciable right to freedom from poverty, a highly controversial issue, rather than for example, a justiciable right to health or even a justiciable right to an adequate standard of living based on international standards, insofar as these are recognised human rights clearly subject to progressive realisation by the State and resource allocation defences by the State. In hindsight, the Review Group may have been wrong to speak in terms of absolute personal rights since almost none of the personal rights protected by Articles 40-44 of the Constitution or indeed international human rights conventions are absolute: see G Hogan, *Directive Principles, Socio-Economic Rights and the*

In this regard, in the right to health case of *Soobramoney,* the courts were shown to be capable of adjudicating on whether a refusal to provide the medical treatment violated the rights to life and health by balancing the claimed right against the common good as informed by resource allocation considerations which ultimately led to a denial of the claim. More generally, in the *Certification* case[996] the Constitutional Court of South Africa pointed out that insofar as civil and political rights also have resource implications which courts are called upon to adjudicate, it could not be said that "the task conferred upon the courts [is] so different from that ordinarily conferred upon them by a bill of rights that it results in a breach of the separation of powers".[997]

The "democratic" argument against justiciability of economic and social rights as advanced by Hardiman J in *TD* has been criticised as "inimical to an extensive judicial role" in defending rights[998] and as "misplaced" insofar as a clearer theory of democratic separation of powers could view it as a "system of checks and balances"[999], arguably its original purpose rather than its elevation with deference to a position where it is "detached from questions of moral and

---

Constitution, 36 Irish Jurist (2001) 174. Hogan also noted that "[t]here probably is some sort of middle way which the Commission has itself attempted to propound via qualified socio-economic rights"; at 190. See also Irish Commission for Justice and Peace, *Re-righting the Constitution: The case for new social and economic rights: housing, health, nutrition, adequate standard of living* (1998) Genprint, Dublin at 27 where the Commission argued for a right to health to be introduced into the Constitution.

[996] *Certification of the Constitution of the Republic of South Africa* 1996 (CCT 23/96) [1996] ZACC 26; 1996 (4) SA 744 (CC); 1996 (10) BCLR 1253 (CC) (6 September 1996).

[997] (CCT 23/96) at para 77. See also the South African Constitutional Court's Judgment in *Minister for Health v Treatment Action Campaign*, 5 July 2002 (CCT 8/02) where the court first conceded that courts may be ill-suited to adjudicate upon issues where court orders could have multiple social and economic consequences for the community. Notwithstanding this, it considered that the Constitution of South Africa contemplates rather a restrained and focused role for the courts, namely, to require the state to take measures to meet its constitutional obligations and to subject the reasonableness of these measures to evaluation; at para 38.

[998] G Whyte *Socio-Economic Rights in Ireland: Judicial and Non-Judicial Enforcement,* paper presented at the Irish Human Rights Commission Conference on Economic, Social and Cultural Rights, 9 December 2005 at 4; available at *www.ihrc.ie/dowload/doc.ecrgerardfwhyte.doc* accessed on 22 September 2012.

[999] D Langwallner, *Separation of Powers, Judicial Deference and the Failure to Protect the Rights of the Individual*, in *The Irish Constitution, Governance and Values*, E Carolan & O Doyle (Eds) in *The Irish Constitution, Governance and Values*, Thompson Roundhall (2008) at 258-259.

political principle".[1000] Even from a majoritarian viewpoint, it must be conceded that judicial review is a power expressly provided for under Article 34 which the People voted for.[1001]

Has the separation of powers doctrine withered the doctrine of unenumerated rights?[1002] The ability of the courts to imply unenumerated rights without explicit conceptual underpinning such as a philosophy of natural law is unsatisfactory as it renders the unenumerated rights doctrine vulnerable to the charge of it being other than a rule-based doctrine.[1003] Otherwise put, how can one respond to the question as to whether and if so what other doctrine has supplanted that of natural law in identifying such rights?

A common thread appears to be that the courts will recognise an implied right where the courts perceive an "injustice" may otherwise occur. The recognition of the right to know one's parent's identity was capable of being "reasonably implied" from Article 40.3.1 in *O'T v B*[1004] by Hamilton CJ. Can this be less the recognition of an entirely new right but rather a "derivative right" relying on the earlier constitutional recognition of the rights of natural parents in *G v An Bord Uchtála*?[1005]

The difficulty with "injustice" as a rationale for further development of the doctrine is that, as with natural law, it is difficult to identify its precise basis.

[1000] T R S Allan, *Judicial Deference and Judicial Review: Legal Doctrine and Legal Theory*, 127 Law Quarterly Review (2011) 96 at 116. Allan argues that a doctrine of deference, which is "detached from more substantive questions about the content and limits of constitutional rights" is likely to be "at least uninformative, if not indeed largely vacuous"; ibid at 117.

[1001] D Langwallner, *Separation of Powers, Judicial Deference and the Failure to Protect the Rights of the Individual*, in *The Irish Constitution, Governance and Values*, E Carolan & O Doyle (Eds) in *The Irish Constitution, Governance and Values*, Thompson Roundhall (2008) at 256-261.

[1002] O Doyle, *Constitutional law: Text, Cases and Materials* Dublin: Clarus Press (2008) at 108.

[1003] Allan argues that reasons for restraint or deference cannot justify adoption of a general doctrine of deference; a doctrine which has arguably occurred in Ireland, T R S Allan, *Judicial Deference and Judicial Review: Legal Doctrine and Legal Theory*, 127 Law Quarterly Review (2011) 96 at 96.

[1004] [1998] 2 IR 321.

[1005] [1980] IR 32. See O Doyle, *Constitutional law: Text, Cases and Materials* Dublin: Clarus Press (2008) at 108; see also D Coffey, *Article 28.3.3. The Natural Law and the Judiciary – Three Easy Pieces*, 20 Irish Law Times (2004) at 310.

Directive principles of social policy or popular sovereignty may be doctrines which emerge as sources underpinning rights but there is little clear evidence of this to date. Recent jurisprudence which have identified personal rights under the enumerated right to the person (*OAYA, Kinsella, Fleming*) suggests that Article 40.3.2 may become more widely used in interpreting rights enuring from the "integrity of the human body … human mind and personality"[1006], however again the question of the conceptual underpinning for those rights arises.

An intriguing source presents itself: that of international human rights standards. Could a doctrine emerge from this source of unenumerated or indeed enumerated rights recognition? In *State (DPP) v Walsh*,[1007] Henchy J expressed the view that domestic law is generally presumed to be in conformity with the (then unincorporated) ECHR and repeated this view in *Norris v Attorney General.*[1008] Similarly, O'Hanlon J considered that the provisions of the ECHR, then unincorporated, ought to be considered by Irish judges when determining public policy in *Desmond v Glackin (No.1).*[1009] In *O'Leary v Attorney General*, Costello J interpreted the presumption of innocence under Article 38 of the Constitution by reference to Article 6(2) of the ECHR and other international conventions.[1010] In *Rock v Ireland*[1011] and *Murphy v*

[1006] *Kinsella v Governor of Mountjoy Prison* [2012] 1 IR 467 at 471.

[1007] *State (DPP) v Walsh* [1981] IR 412 to the effect that our laws are generally presumed to be in conformity with the then unincorporated ECHR.

[1008] [1984] 1 IR 36 "… the persuasive influence that may be drawn from decisions of other courts, such as the European Court of Human Rights"; per Henchy J, dissenting at 69. See also Denham J in *O'Brien v Mirror Group Newspapers Limited* [2001] 1 IR 1: "The European Convention for the Protection of Human Rights and Fundamental Freedoms is not part of the domestic law of Ireland: *In re Ó Laighléis* [1960] I.R. 93. However, decisions of the European Court of Human Rights on the said European Convention may be persuasive authority in the analysis of similar constitutional rights in the same way as decisions of other constitutional courts; *Norris v. The Attorney General* [1984] I.R. 36 (per Henchy J. at p. 69)"; at 33 cited also in *Cosma v Minister for Justice, Equality and Law Reform* [2006] IEHC 36 where the Court also took into account the jurisprudence of the European Court of Human Rights when interpreting whether there was a possible compromise to the core personal rights of the applicant; per Hanna J.

[1009] *Desmond v Glackin* (No. 1) [1993] 3 IR 1 where O'Hanlon J stated: "I think it is legitimate to assume that our public policy is in accord with the Convention or at least that the provisions of the Convention can be considered when determining issues of public policy"; at 28-29. Thus even if not incorporated, the Convention could have "persuasive effect"; at 29.

[1010] [1993] 1 IR 102. These were Article 11 of the UDHR, Article 8(2) of the American Convention on Human Rights and Article 7 of the African Charter of Human Rights; at 107.

IRTC[1012] the principle of proportionality was adopted and employed by the courts prior to the incorporation of the ECHR. In *Nwole v Minister for Justice, Equality and Law Reform*[1013] Finlay Geoghegan J cited the CRC to inform interpretation of the Refugee Act 1996.[1014] In *MX v Health Service Executive*[1015] McMenamin J held that the interpretation of the Mental Health Act 2001 was influenced by the CRPD. As noted, Laffoy J in *McCann v Judges of Monaghan District Court & Ors*[1016] referred to the jurisprudence of the ECHR and ICCPR when reading in a right not to be imprisoned without due process under Articles 34, 38 and 40.[1017] The fact that ECHR rights are now regularly being pleaded under the ECHR Act 2003 suggests that its influence on constitutional jurisprudence is increasing.

The conclusions to be drawn here are that judicial preference to avoid constitutional issues act as additional barriers to claimants. This judicial preference – or restraint – takes the form of favouring contract law (*Roche*), tort (see Part 3) or indeed non-justiciability on procedural grounds (*Cahill*). When a constitutional issue is considered, declaratory orders are more likely to be provided insofar as they usually address acts rather than omissions, yet insofar as such orders are usually addressed to acts, decisions or legislative provisions, large aspects of the right to health predicated upon omission, such as refusal of access or entitlement to the AAAQs without discrimination, may fall outside this constitutional scrutiny. Simply put, the case would not advance beyond pleadings. The other difficulty with relying on declaratory orders is that

---

[1011] *Rock v Ireland* [1997] 3 IR 484.

[1012] *Murphy v IRTC* [1999] 1 IR 12. In both cases, the Supreme Court adopted Costello J's formula regarding the principle of proportionality in *Heaney v Ireland* [1996] 1 IR 580 (in which he cited *Times Newspapers Ltd v UK* (1979) 2 EHRR 245). See also *Bourke v Attorney General* [1972] IR 36.

[1013] [2003] 10 JIC 3103.

[1014] [2003] 10 JIC 3103 at 3116.

[1015] 23 November 2012, unreported.

[1016] [2009] IEHC 276.

[1017] [2009] IEHC 276. These arguments were urged on the court by the Irish Human Rights Commission acting as *amicus curiae* in this case: see its submissions at *www.ihrc.ie/enquiriesandlegal/amicuscuriae/civildebt.html* accessed on 21 October 2012.

they have traditionally been addressed to public rather than to private bodies as we will see below.

10.3 Judicial Review of public and private actors

Judicial review proceedings may only be made against "public action". Such "public action" has traditionally been taken by public rather than private bodies.[1018] Before considering how the courts consider such judicial review proceedings, it is important to identify how "public action" has been defined and whether it can extend to private bodies. In *R v Jockey Club, Ex parte RAM Racecourses Ltd*[1019] Simon Brown J differentiated between how "[a]t one end of the spectrum were reviewable decisions with a sufficient public element; at the other, non-reviewable decisions of a body 'whose sole source of power is a consensual submission to its jurisdiction'", citing Lord Donaldson MR, in *R v Take-over Panel, ex parte Datafin Plc.*[1020] Although there must be a "public aspect" to the decision under review[1021], and whereas a "public body" has been defined variously as not only referring to entities "financed partly or wholly by monies provided through a Minister" but also entities discharging specialised, national functions "at a distance from the Government and Ministers",[1022] Simon Brown J posed the key question of what constitutes a "sufficient public element" and whether a focus on the source or the function of the body's power should prevail.

It has been suggested that due to the increase of non-commercial state-sponsored bodies, problems arise concerning "accountability, patronage, staffing, control, organisation, legal status, and, particularly, relationship with

---

[1018] Administrative law has been defined as "the law regulating the organisation, composition, functions and procedures of public authorities, their impact on the citizen and the restraints to which they are subject"; D G Morgan, *Administrative Law in Ireland* (3rd Ed.) (1988) at 1.

[1019] [1990] Times Law Reports at 1.

[1020] [1990] Times Law Reports at 1, citing *R v Take-over Panel, ex parte Datafin Plc.* [1987] QB 815; see H Delany, *Judicial Review of Administrative Action* (2nd Ed.) Roundhall (2009) at 8-17.

[1021] M De Blacam, *Judicial Review* (Second Edition), Tottel Publishing (2009) at 3.

[1022] G Hogan and D Morgan, *Administrative Law in Ireland* (4th Ed, 2010) at 130.

the parent Minister and Department"[1023] but the problem extends to private non-state bodies who though private are still state-sponsored. Although the political rationale for private delegation of governmental tasks has been framed as creating the possibility of "greater flexibility, making it easier for government to experiment, to change course when needed, and to remain responsive to new needs" [1024], the primary rationale for private delegation has been described as "improv[ing] the operation of government by enhancing its effectiveness and efficiency"[1025], a rationale at the fore in the privatisation of health.

McMenamin J expressed a concern with definitional lacunae in *Health Service Executive v Commissioner of Valuation*[1026] where he stated that "the term semi-state body, absent a statutory definition, is not helpful in an area of law where taxonomy is at a premium".[1027] In that case, McMenamin J found that the HSE was a public body being "more akin to a government department"[1028] and adopted a functional approach to the powers exercised by the Executive. Similarly the Medical Council of Ireland has been found amenable to judicial review when considering malpractice claims against doctors.[1029]

As noted, there are no bodies such as the UK Primary Care Trusts in the State. Further, private health care providers (such as hospitals or care centres) which receive public monies and deliver "public" health services have not been traditionally identified as public bodies subject to judicial review which focused on the source (legal status) of the decision/ decision-taker. The

---

[1023] G Hogan and D. Morgan, *Administrative Law in Ireland* (4th Ed, 2010) at 130.

[1024] C Donnelly, *Delegation of Governmental Power to Private Parties*, Oxford University Press (2007) at 81.

[1025] C Donnelly, *Delegation of Governmental Power to Private Parties*, Oxford University Press (2007) at 77 who points out that while judgments as to "effectiveness" are typically made independently of costs", judgments as to "efficiency" involve a costs-benefits analysis.

[1026] [2008] IEHC 178.

[1027] [2008] IEHC 178 at para 63.

[1028] [2008] IEHC 178.

[1029] See *Phillips v Medical Council Fitness to Practice Committee* [1992] IRM 469 where Carroll J described judicial review as ensuring bodies carry out their duties in accordance with the law and in conformity with natural and constitutional justice; at 475, see below.

definition of public function becomes central to the justiciability of the right to health in the State. Although the courts traditionally determined public function in terms of the source of the decision in the case,[1030] in *R v Take-over Panel, ex parte Datafin Plc*[1031], Lloyd LJ disagreed that the source of the power was the sole test whether a body is subject to judicial review.[1032]

This approach with its focus on "public law functions" or "public law consequences" was considered in a number of English cases concerning employment-related decisions of the English Jockey Club where the courts differentiated between disciplinary decisions of that club as being matters of private not public law.[1033] However, the focus on the public function element pursued in *Datafin* was followed by the Supreme Court in *Beirne v Commissioner of An Garda Síochána*[1034], an employment case where a trainee garda's assignment was terminated by the Garda Commissioner. The court held that this decision had sufficient "public" elements to render it amenable to judicial review insofar as the Commissioner's decision was taken pursuant to

---

[1030] The traditional view of judicial review is that it that the government should be subject to the jurisdiction of ordinary Common Law courts: rather than reviewing legislation, judicial review should give effect to legislative intention in the tradition of Albert V Dicey: *An Introduction to the Study of the Law of the Constitution* (1885).

[1031] [1990] Times Law Reports at 1, citing *R v Take-over Panel, ex parte Datafin Plc.* [1987] QB 815; see H Delany, *Judicial Review of Administrative Action* (2nd Ed. Roundhall) at 8-17. See also *R v Criminal Injuries Compensation Tribunal e.p. Lain* [1967] 2 QB 864 per Lord Parker CJ at 882.

[1032] [1987] QB 815. It may be "decisive" insofar as "the source of power is a statute, or subordinate legislation under a statute" which would clearly render the body amenable to judicial review, while "at the other end of the scale, [where] the source of power is contractual" as in the case of private arbitration it would not. However, between these extremes "it is helpful to look not just at the source of the power but at the nature of the power" and whether the body in question "is exercising public law functions, or if the exercise of its functions have public law consequences" insofar as that may bring the "body within the reach of judicial review"; at 847.

[1033] See *R v Disciplinary Committee of the Jockey Club, ex parte Massingberd-Mundy* [1993] 2 All ER 207, *R v Disciplinary Committee of the Jockey Club, ex parte Agha Khan* [1993] 1 WLR 909 and *R (Mullins) v Appeal Board of the Jockey Club* [2005] EWHC 2197 Admin. In contrast, see *R v Advertising Standards Authority e.p. The Insurance Service plc* (1990) 2 Admin LR 77 (QB) 1041 where the Authority was found to exercise a public law function.

[1034] [1993] ILRM 1.

his statutory functions. Finlay CJ set out the test as where the act is one "coming within the public domain".[1035]

In *Eogan v University College Dublin*[1036], Shanley J held that an employment decision had a sufficient public element, having being made pursuant to statute and considered the factors which would render a decision subject to judicial review. These were whether the decision was made pursuant to a statute; whether the decision maker is performing a duty within the public domain; whether a decision concerning employment involves any statutory protections or "public rights" or whether the decision is being made by a decision maker whose powers, though not directly based on statute, depend on approval by the legislature or the Government for their continued exercise.[1037]

The source of a body's powers and duties will not be the only consideration, but a focus on the impact a decision has on individual rights may trigger "public rights" of judicial review. The functions the body discharges will inform the decision as to whether a body is exercising public functions and is amenable to judicial review. The earlier focus in cases such as *Murphy v Turf Club,*[1038] as being characterised as being a contractual dispute falling for consideration under a remedy lying in contract rather than judicial review, has given way to a focus on the nature of the powers being exercised.[1039] In

---

[1035] [1993] ILRM 1. Finlay CJ held that "Where the duty being carried out by a decision-making authority ... is of a nature which might ordinarily be seen as coming within the public domain, that decision can only be excluded from the reach of the jurisdiction in judicial review if it can be shown that it solely and exclusively derived from an individual contract made in private law"; at 2. Egan J noted that the real objection to the application was that the relationship between the parties was governed entirely by the contract with no other source or provenance, however this did not mean that relief must always be refused in such a case; at 13-14. See also *Browne v Dundalk UDC* [1993] 2 IR 512. For decisions not recognising a "public" element in a decision taken, see *Rajah v Royal College of Surgeons of Ireland* [1994] 1 IR 384 (college established by Royal Charter) and *Geoghegan v Institute of Chartered Accountants in Ireland* [1995] 3 IR 86 (no public element although Royal Charter amended by Oireachtas and under bye-laws.

[1036] [1996] 1 IR 390.

[1037] [1996] 1 IR 390 at 398.

[1038] [1989] IR 171. See also *State (Colquhoun) v D'Arcy* [1936] IR 641.

[1039] In *Murphy*, Barr J was satisfied that the respondent was not exercising a public law function but exercising a regulatory function over the applicant who had voluntarily submitted to its jurisdiction; [1989] IR 171 at 175. Delany suggests that undue emphasis on the source rather than nature of the power exercised by a body will clearly produce "anomalous results"; H Delany, *Judicial Review of Administrative Action* (2nd Ed.) Roundhall (2009) at 17.

Geoghegan v Institute of Chartered Accountants in Ireland[1040] Denham J found that "the contractual relationship in this case is sourced in public actions and also the functions of the Institute are for the benefit of the community".[1041] The Supreme Court found that in light of its source and functions, the Institute's activities were subject to judicial review.[1042]

The traditional rule precluding private law decisions from being amenable to judicial review is that the duty being discharged is a private one. Private law issues are left to private law remedies (such as contract or tort) and reliefs available under contract law or tort fall short of those available by way of judicial review.[1043] "The dilemma is determining the reach or boundary of judicial review and administrative law generally" and "the type of organisations whose decision-making process would be amenable to judicial review".[1044]

Moreover, the dichotomy of focusing on the source of power would risk injustice where a public function, amenable to judicial review one day, may not be so amenable the following day, if privatised.[1045] In circumstances where a private body exercises significant regulatory or decision-making power impacting on individuals' rights and there being no private law remedy against any abuse "it may be appropriate that private bodies should, insofar as they

---

[1040] [1995] 3 IR 86.

[1041] [1995] 3 IR 86 at 127.

[1042] "In view of factors including the nature of the source of the Institute, the functions of the Institute and its members, and the method of establishing the contractual relationship with the applicant, the activities of the Institute are, in principle, susceptible to the process of judicial review"; [1995] 3 IR 86 at 131 per Denham J. Similarly in *Beirne v Tipperary (South Riding) County Council* [2005] 2 IR 483, Denham J found that although there was a contract of employment in existence, "the employment of the station officer of a fire station is a matter within the public domain and amenable to judicial review"; at 487. However, see cases of *Rajah v Royal College of Surgeons in Ireland* [1994] 1 IR 384 and *Quinn v King's Inns* [2004] 4 IR 344 in which the High Court distinguished *Beirne* in holding that private law rights were only at issue in these private professional education bodies. See also *Rafferty v Bus Éireann* [1997] 2 IR 479 and *Bane v Garda Representative Association* [1997] 2 IR 449 (per Kelly J).

[1043] Namely the powers to "quash, prevent, require or declare as appropriate" under Order 84 of the Rules of the Superior Courts.

[1044] G Coffey, *Administrative Law* (2nd Ed. 2010) at 23 and 24.

[1045] De Blacam asks why the mere transfer of a service to the private sector should entail a reduction in the legal standards under which the service provider operates; M De Blacam, *Judicial Review* (Second Edition), Tottel Publishing (2009) at 67.

exercise public functions, be subject to judicial review".[1046] A constitutional or legislative control theory would permit such review (discussed below).[1047]

If it is accepted that a body performs public functions and is amenable to judicial review (see discussion below), attention will turn to the remedies available to the court where plenary or judicial review proceedings are brought. Most review of administrative decisions is by way of judicial review with evidence adduced by affidavit. The High Court has full jurisdiction to consider matters under Article 34 and has a range of "tools" with which to consider the claim. Henchy J in *Tormey v Ireland*[1048] recalled how "no justiciable matter or question may be excluded from the range of the original jurisdiction of the High Court."[1049]

Of the discretionary remedies available to the courts, the injunction is "the great equitable remedy which has been developed historically by the Chancery Courts" and is a form of preventative justice[1050] while Declarations are "conventionally used as an instrument to declare the rights of individuals" having been traditionally viewed as private law remedies under section 155 of the Chancery (Ireland) Act 1867.[1051]

[1046] M De Blacam, *Judicial Review* (Second Edition), Tottel Publishing (2009) at 79.

[1047] Donnelly cites the US federal Adminstrative Procedure Act 1946 as amended which provides that a person suffering legal wrong because of agency action, within the meaning of a relevant statute, is entitled to judicial review, but identifies the deficit of the US courts' reluctance to extend the definition of "agency" to private bodies in *Public Citizen Health Research Group v Department of Health, Education and Welfare* US Court of Appeals, District of Columbia Circuit (1981) 668 F.2d 537 215 US App DC 191; C Donnelly, *Delegation of Governmental Power to Private Parties*, Oxford University Press (2007) at 297-311 and 324. See also *O'Reilly v Mackman* [1983] 2 AC 237 and *R v East Berkshire Health Authority, e.p. Walsh* [1985] QB 152 where the House of Lords stated that judicial review should be used only for actions sufficiently "public".

[1048] [1985] IR 289.

[1049] [1985] IR 289, when considering the jurisdiction of the District and Circuit Courts held that where there has been such an "exclusive" devolution, while the High Court "will not hear and determine the matter or question" but may invoke its "full jurisdiction" in proceedings such as "habeas corpus, certiorari, prohibition, mandamus, quo warranto, injunction or a declaratory action" so as to ensure that the hearing and determination "will be in accordance with law"; at 296-297.

[1050] G Coffey, *Administrative Law* (2nd Ed.) Round Hall, Dublin (2010), at 313.

[1051] G Coffey, *Administrative Law* (2nd Ed.) Round Hall, Dublin (2010) at 313-314. See Order 19 Rule 29 of the Rules of the Superior Courts.

Tormey is authority for the proposition that the Oireachtas may confer on a body the authority to take health-related decisions on resource grounds, similar to the decisions taken by UK Primary Care Trusts and that any such decisions will be reviewable by the courts. Keane CJ confirmed as much in *Criminal Assets Bureau v Hunt*[1052] where, applying *Tormey*, he stated that the Oireachtas "may confer on such bodies, expressly or by implication, an exclusive jurisdiction to determine specific issues."[1053]

If such a public body were established, or if a private body were to exercise public functions under a constitutional or legislative control doctrine (see below), that body would be amenable to judicial review or plenary proceedings. Judicial review jurisdiction is supervisory, not appellate. The Supreme Court in its decision in *In Re Article 26 and the Illegal Immigrants (Trafficking) Bill, 1999*[1054] found that the legislature had a choice in how appeals to the courts against the decisions of such bodies could be framed. The argument that section 5 of the draft legislation infringed the right of access to the courts by prescribing that judicial review was the sole procedure whereby deportation orders could be challenged was not upheld as the Oireachtas could provide for remedies through secondary legislation.[1055]

This question may not be entirely closed, however. Given that there is a consitutional right to health, a decision by a public body impacting that right should not be unfairly fettered through restrictions on the right of access to the courts to seek constitutional relief. In *MacAuley v Minister for Posts and Telegraphs*[1056] where permission from the Attorney General was required for a constitutional challenge to be brought, the courts held that this constituted an

---

[1052] [2003] 2 IR 168.

[1053] [2003] 2 IR 168.

[1054] [2000] 2 1R 360.

[1055] [2000] 2 1R 360. "It is within the competence of the Oireachtas to regulate by law, by primary legislation or, in the due exercise of its powers, by way of secondary legislation, such as statutory instruments, procedural matters, including procedural remedies, before the courts provided constitutional rights and other provisions of the Constitution relating to the courts are not infringed"; at 387-388. The court concluded that judicial review as such was not an inadequate remedy in similar vein to its finding in *Hanrahan v Merck Sharp and Dohme* [1998] ILRM 629 that tort was not an ineffective remedy.

[1056] [1966] IR 345.

impermissible fetter on one's right of access to the courts to assert a constitutional claim.[1057]

As set out in *McDonald v Bord na gCon*[1058] by Kenny J, there are five "characteristic features" for the administration of justice which a court would consider in reviewing the decisions of a public body.[1059] As will be observed, these features, particularly the first two (dispute as to the existence of legal rights or a violation of the law or the determination of liabilities or penalties) refer to the determination of rights.[1060] The courts have jurisdiction to review how a decision of the body was taken.

One ground on which judicial review can be brought is the failure of a decision-maker to give reasons or identify considerations made. In *Mulholland v An Bord Pleanála (No 2)*[1061] Kelly J held that these must be sufficient to provide such information "necessary and appropriate" for to consider appealing or judicially reviewing the decision; to arm himself for such hearing or review; to know if the decision maker directed her/ his mind adequately and to enable the courts to review the decision.[1062]

The Irish courts have until recently followed the jurisprudence of the English courts in deferring to the decisions of public bodies absent unreasonableness or irrationality in the decision making process under a form of deference, following the Court of Appeal Judgments of Lord Greene MR in *Associated*

[1057] [1966] IR 345, where the court considered the plaintiff's right of access to the court had been infringed where permission of the Attorney General was required to litigate; at 356-357.

[1058] [1965] IR 217.

[1059] [1965] IR 217. These are: a dispute as to the existence of rights, the determination of rights or the imposition of penalties, a final determination, enforcement and the making of a court order; at 231.

[1060] There are striking parallels with the formulation in Article 6 of the ECHR. The courts are nonetheless slow to conclude that any investigative or determinative power assigned to a statutory body is actually a judicial power: see *Goodman International v Hamilton (No 1)* [1992] 2 IR 542; *Croke v Smith* (No 2) [1998] 1 IR 101 and *Deaton v Attorney General* [1963] IR 170; at 355.

[1061] [2006] 2 IR 453.

[1062] [2006] 2 IR 453 at 464-465.

Provincial Picture Houses Ltd v Wednesbury Corporation[1063] and that of Lord Diplock in *Council of Civil Service Unions v Minister for the Civil Service* ("GCHQ case").[1064] In *GCHQ* Lord Diplock stated that judicial review had developed to a stage where one could "conveniently classify under three heads the grounds upon which administrative action is subject to control by judicial review." These were illegality, irrationality and procedural impropriety.[1065] These authorities have been interpreted narrowly by the Irish courts who have afforded a significant degree of deference to administrative decision makers. In *State (Keegan & Lysaght) v Stardust Victims Compensation*[1066] Henchy J stated that the test of unreasonableness or irrationality in judicial review lies in considering whether the impugned decision "plainly and unambiguously flies in the face of fundamental reason and common sense". [1067] In *O'Keefe v An Bord Pleanála & Others*[1068] after noting how judicial review "is concerned, not with the decision, but with the decision making process"[1069], Henchy J stated that a power must be exercised in good faith, that the opinion or other subjective conclusion in the power must have been reached "by a route that does not make the exercise unlawful", citing examples of misinterpreting the law or misapplying it through considering irrelevant matters of fact, or through ignoring relevant matters.[1070]

Under this authority, courts will be reluctant to quash decisions by public bodies unless there is scant relevant materials before the decision-maker to

---

[1063] [1947] 1 KB 223. Lord Greene set out the test as one of judicial review not judicial interference; at 233-234.

[1064] [1985] AC 374.

[1065] [1985] 1 AC 374 at 410.

[1066] [1986] I IR 642.

[1067] [1986] I IR 642 at 658.

[1068] [1993] 1 IR 39.

[1069] Citing Lord Brightman in *Chief Constable of the North Wales Police v Evans* [1982] 1 WLR 1155 who emphasised judicial review is concerned with the decision-making process not the decision; at 1173.

[1070] [1993] 1 IR 39. In the *GCHQ* case, Lord Diplock stated that the term "irrationality" applied to "any decision which is so outrageous in its defiance of logic or or accepted moral standards that no sensible person who had applied his mind to the question to be decided could have arrived at it"; at 93.

support the impugned decision or unless s/he clearly overlooks relevant matters, or misinterprets the law.[1071] What impact will such cases have on a public Primary Trust-like body or indeed a private body exercising public functions? In similar terms to public bodies, such a decision-maker is entrusted with discretionary powers and will owe "several basic duties to the public".[1072] In the latter case, at the very least a private body exercising public functions must take into account all relevant considerations including an individual's constitutional rights. This is clear from *Law Society of Ireland v Competition Authority*[1073] in which O'Neill J held that the contents of a Notice made by the Competition Authority restricting the choice of one's legal representative "do not satisfy the proportionality test as that test was laid down by Costello J in Heaney".[1074]

The decisions in *Cox*, *Heaney* and *In Re Employment Equality Bill 1996* drew on the principle of proportionality deriving from the ECHR.[1075] The introduction of the ECHR Act may have further ameliorated judicial deference to administrative decision making where individual rights are at issue. Certainly the English courts have applied proportionality grounds more stringently after the introduction of the Human Rights Act 1998 in judicial review applications. In the *GCHQ* case Lord Diplock had suggested that proportionality may be an independent ground for judicial review. After setting

---

[1071] See also the Supreme Court decisions in *State (Keegan) v Stardust Victims' Compensation Tribunal* [1986] IR 642, per Henchy J and *In Re The Illegal Immigrants (Trafficking) Bill, 1999* [2000] 2 IR 360 where Keane CJ stated that to be impugned on the ground of unreasonableness or irrationality, a decision must be fundamentally at variance with reason and common sense, indefensible for being in the teeth of plain reason and common sense and where the court is satisfied that the decision-maker has flagrantly rejected or disregarded fundamental reason or common sense in reaching his decision. See also *Aer Rianta v Commissioner of Aviation Regulation* [2003] 4 JIC 0302 per O'Sullivan J.

[1072] N Connery and D Hodnett, *Regulatory Law in Ireland,* Tottel Publishing (2009) at 529.

[1073] [1996] 2 IR 262.

[1074] [1996] 2 IR 262. at 283 citing *Heaney v Ireland* [1996] 1 IR 580 at 607.

[1075] The principle of proportionality is both a principle under the ECHR and EU. See *R v Secretary of State for the Home Department ex parte Daly* [2001] 1 PLR 332 where Lord Steyn cited the 3 stage test adopted by the Privy Council in *de Freitas v Permanent Secretary of Ministry of Agriculture, Fisheries, Lands and Housing* [1999] 1 AC 69 as whether a limitation (by an act, rule or decision) is arbitrary or excessive the court should ask itself whether the legislative objective is sufficiently important to justify limiting a fundamental right; whether the measures designed to meet the objective are rationally connected to it and if so whether the means used to impair the right or freedom are no more than is necessary; (80) (per Lord Clyde); at 329.

out the three grounds of illegality, irrationality and procedural impropriety, he suggested that "on a case by case basis" the principle of "proportionality" as recognised in the administrative law of other European States. [1076]

Proportionality was applied by Laws LJ in *R (Mahmood) v Secretary of State for the Home Department*[1077] and Lord Steyn in *R v Secretary of State for the Home Department ex parte Daly*[1078] where he held that the doctrine of proportionality "may require the reviewing court to assess the balance which the decision maker has struck, not merely whether it is within the range of rational or reasonable decisions." It would also "go further" than the traditional grounds of review inasmuch as requires attention to be directed "to the relative weight accorded to interests and considerations". Even the heightened or "anxious" scrutiny test developed in *R v Ministry of Defence ex p Smith*[1079] was not necessarily appropriate to the vindication of Artilce 8 of the ECHR rights, noting how the European Court came to the opposite conclusion in *Smith and Grady v United Kingdom.* [1080]

The recent judgment of the Supreme Court in *Meadows v Minister for Justice, Equality and Law Reform*[1081] and that of the High Court in *Efe & Ors v Minister for Justice, Equality and Law Reform (No 2)*[1082] has significantly rolled back on the *O'Keefe* test.[1083] In *Meadows*, Fennelly J for the majority

---

[1076] [1985] AC 374 at 410.

[1077] [2001] 1 WLR 840.

[1078] [2001] 1 PLR 332. See too Woolf, Jowell and Le Seuer *De Smiths Judicial Review* (6th Ed 2007) at 596.

[1079] [1996] QB 517 at 554.

[1080] Judgment of 27 September 1999 (2000) 29 EHRR 493. The European Court had found that "the threshold at which the High Court and the Court of Appeal could find the Ministry of Defence policy irrational was placed so high that it effectively excluded any consideration by the domestic courts of the question of whether the interference with the applicants' rights answered a pressing social need or was proportionate to the national security and public order aims pursued, principles which lie at the heart of the court's analysis of complaints under Art 8 of the Convention"; at para 138.

[1081] [2010] 2 IR 701.

[1082] Unreported, 7 June 2011 per Hogan J.

[1083] See dissent of Hardiman J. Prior to *Meadows*, a number of asylum cases applied the Smith "anxious scrutiny" test. First mooted by Fennelly P dissenting in *L and O v Justice, Equality & Law Reform* [2003] 1 IR 1, it was applied in *COI v Minister for Justice, Equality & Law Reform* [2007] 2 ILRM 471 (per McGovern J) and in *M v Minister for Justice, Equality & Law Reform*, [2008] IEHC 390 (per McCarthy J).

noted how two fundamental principles must be respected in the rules for the judicial review of administrative decisions; that the decision is that of the administrative body "and not of the court" (which could not substitute its own view) and that the system of judicial review "requires that fundamental rights be respected." [1084]

After reviewing English and European Court jurisprudence, Fennelly J observed that where decisions "encroach upon fundamental rights" guaranteed by the Constitution, it is implicit from *East Donegal* that the duty of the decision maker is "to take account of and to give due consideration to those rights." Where a right is not considered at all or is misdescribed or misunderstood by the decision maker, "the decision will be vulnerable to attack on the grounds of a mistake of law or failure to respect the rules of natural justice." While it may not be necessary to establish that it is unreasonable, it may unlawfully affect fundamental rights "to such a disproportionate degree", having regard to the public objectives it seeks to achieve.[1085] This was what was meant by Henchy J in *Keegan* when he said it may "plainly and unambiguously fl[y] in the face of fundamental reason and common sense".[1086] This led Fennelly J to conclude that the English "sliding scale" of review should not be followed as it may lead to "a different standard of review for cases involving an interference with fundamental, constitutional or other personal rights".[1087] Rather "the principle of proportionality … can provide a sufficient and more consistent standard of review, without resort to vaguer notions of anxious scrutiny."[1088] The willingness of the courts to begin to unify constitutional and European concepts of proportionality to allow for a judicial review of administrative decisions which impact on human rights allows the courts to uphold constitutional rights. In *Efe (No 2)* Hogan J reviewed a number of decisions which challenged the restrictive *O'Keefe* test and in

---

[1084] [2010] 2 IR 701 at 817. The court split 3 v 2, Hardiman J and Kearns P dissenting.

[1085] This would occur where it "cross[ed] a threshold,[] to be justifiably labelled as so unreasonable that no reasonable decision-maker could justifiably have made it"; [2010] 2 IR 701 at 817.

[1086] [2010] 2 IR 701 at 825-826.

[1087] [2010] 2 IR 701 at 826.

[1088] [2010] 2 IR 701 at 826. The test will focus on whether justification for the decision is commensurate with the extent of the encroachment on the individual right at issue; at 827.

rejecting the application, concluded that the *Meadows* formulation was sufficient to ensure a proportionality assessment to vindicate constitutional rights.[1089]

Following *TD*, while there has been judicial reluctance to review executive or administrative decisions which impact on social as opposed to due process rights, this has not been across the board. As noted, in *O'Donnell v South Dublin County Council*[1090] Laffoy J applied the ECHR Act in finding that the respondent had violated the rights of a Traveller family under Article 8 of the ECHR in not providing them with proper services.[1091] Addressing a housing eviction for alleged anti-social behaviour, Irvine J found a violation of Article 8 of the ECHR in *Pullen & Ors v Dublin City Council*[1092] insofar as the plaintiffs had "every chance of becoming homeless at worst or at best spending a significant period of time living in bed and breakfast accommodation, jeopardising personal and family relationships."

Similarly in *McCann v Judges of Monaghan District Court & Ors,*[1093] Laffoy J struck down Section 6 of the Enforcement of Court Orders Acts 1926 and 1940 as being invalid having regard to the provisions of Article 34, Article 40.3 and Article 40.4.1 of the Constitution where a single mother faced imprisonment

---

[1089] In stating that the *O'Keefe* test had yielded to *Meadows* proportionality, Hogan J cited MacKechnie J's Judgment in *Holland v Governor of Portlaoise Prison* [2004] 2 IR 273 where the Judge felt he could not be found by *O'Keefe* where constitutional rights were at issue; *I v Minister for Justice, Equality and Law Reform* [2008] 1 IR 208 where McGovern J had held that there may be cases which do not fall for consideration under *O'Keefe* irrationality but might legitimately fall to be considered by the courts and *Clinton v Bord Pleanála (No 2)* [2007] 4 IR 710 where Geoghegan J held that it would insufficiently protect constitutional rights if the court merely had to be satisfied that the decision was not irrational or was not contrary to fundamental reason and common sense (at 741); at 14-16.

[1090] Unreported, 22 May 2007.

[1091] In *O'Donnell*, Laffoy J found that if there is no statutory protection for the plaintiffs in their current predicament, their situation must represent a failure of the State and its organs to function in a manner compatible with Article 8 of the ECHR. In *O'Donnell & Ors v South Dublin County Council & Ors* [2008] IEHC 454, Edwards J found that the Article 8 rights of the fourth named applicant, a Traveller child with cerebral palsy who was confined to a wheelchair had been violated, in the failure by the Council to address overcrowding in the family's caravan accommodation. The Judge otherwise endorsed the approach of Charleton J in *Doherty & Doherty v South Dublin County Council* 2 IR [2007] 696 who held that inadequate accommodation of elderly Travellers did not violate their Article 8 rights, whilst accepting that in appropriate cases declaratory relief would be granted.

[1092] [2008] IEHC 379.

[1093] [2009] IEHC 276.

for inability to pay a contractual debt.[1094] Cases decided differently include *Doherty & Doherty v South Dublin County Council*[1095] where Charleton J held that the inadequate caravan accommodation of elderly Travellers did not violate their rights under Article 8 of the ECHR.[1096]

The question arises whether the protection of health and/ or life may require "exceptional" intervention following *TD* where acts or even omissions of a public body are at issue. The constitutional rights to life and bodily integrity are subject to the interests of the common good and any impugned act or omission will be subject to such questions as well as issues of proportionality. As noted, in *Soobramoney,* the court adopted a midpoint between judicial deference and consideration of a reasonableness criterion in rejecting the Appellant's claim that a refusal to provide him with life-extending dialysis treatment violated his rights to life and health under the South African Constitution. In that case, Chaskalson P held that "[a] court will be slow to interfere with rational decisions taken in good faith by the political organs and medical authorities whose responsibility it is to deal with such matters."[1097] The Constitutional Court, recording how scarcity of resources in the field of health was a problem facing hospital administrators and doctors worldwide, cited with approval the dicta of Sir Thomas Bingham MR in *R v Cambridge Health Authority, ex parte B*[1098] where he stated that "[d]ifficult and agonising judgments have to be made as to how a limited budget is best allocated to the

---

[1094] The precise right under Article 40.3 was not identified specifically by the Judge in the case, but was forcefully argued by counsel for the plaintiff and counsel for the *amicus curiae* in the case. In *McCann* the entire machinery of the recovery of debt system was at issue. Severance was not considered possible and accordingly Laffoy J struck down the offending provision.

[1094] Of interest is that the reliefs granted in these cases were declaratory rather than in mandamus.

[1095] 2 IR [2007] 696.

[1096] Charleton J cited Hardiman J's restraint in *TD* and suggested that the relief available to the plaintiffs would have been declaratory rather than mandatory; 2 IR [2007] 696 at 725.

[1097] 1997 (12) BCLR 1696, at para 29.

[1098][1995] 2 All ER 129.

maximum advantage of the maximum number of patients. That is not a judgment which the court can make".[1099]

The response of the English courts to judicial review right of health resource allocation decisions of health authorities (Primary Care Trusts) has been applied in those jurisdictions which have incorporated socio-economic rights into their domestic jurisprudence. This approach has not been followed in the Irish courts as evidenced in *Brady v Cavan County Council*[1100] where Keane J held that *mandamus* could not be ordered against a local authority "having regard to the futility of granting the order where the respondent had not the means to carry out its undoubted statutory duty".[1101] Although the decision of the Supreme Court in *Carmody* resulted in resource implications ensuing for the State, the case involved a key concern of the courts, namely the right to personal liberty and thus not one concerning health resource decisions.

What appears critical is the attitude of the court and its willingness to step beyond strict separation of powers restraint and grapple with the constitutional values at issue, including their horizontal aspect where private bodies perform public functions. Only after considering the substantive claim, should separation of powers and judicial restraint principles be considered in its analysis of the competing arguments.

From the foregoing it is clear that on foot of the separation of powers doctrine, the courts are slow to recognise those entitlement rights arising from the AAAQs which require positive measures by the State und the "obligation to fulfil". Although no public body is tasked with delivering health services, it is possible that were a constitutional right to health to be identified, any acts or omissions of the relevant body - whether public or private (performing a public duty) - could be subject to judicial review. If a constitutional value could be so identified, it is arguable that clearly "unreasonable" decisions (or indeed omissions) could be impugned, allowing for a form of reparations accountability to be identified. However, as with the right to bodily integrity

---

[1099] [1995] 2 All ER 129 at 137 d–f.

[1100] [1999] 4 IR 99.

[1101] [1999] 4 IR 99 at 110.

and the right to the person, it is difficult to point to clear jurisprudence identifying how the right to health could benefit from an effective remedy in this regard.

11 Constitutional and legislative control doctrines

In this section we consider control doctrines on privatisation of health. Privatisation usually involves outsourcing of governmental functions, whether through legislation, contract or grant[1102] whereas historically the direction of healthcare has been from private to organisational to State provider (see Part 3 of this thesis).

While States have a choice of means in delivering health services either by private or public provision, it will be recalled that there is a clear obligation under international law to ensure that where the "content" of the right to health is transferred to private bodies, the legal framework effectively "controls" this "delegation" to ensure the substance of the right. As noted in Part 1 of this thesis, under the "obligation to protect", this includes placing "due diligence" requirements on private bodies on whom health service provision is delegated under regulation accountability. It also requires reparations accountability by bringing right to health claims against the private body.[1103] The phenomenon of private delegation is increasing in most States[1104] and raises the question as to

---

[1102] C Donnelly, *Positive Obligations and Privatisation*, 61 Northern Ireland Legal Quarterly (2010) 209 at 209. A secondary form of "bottom up" privatisation is described as involving either governmental withdrawal from service provision or "fostering" of private sector provision, for example the increase in security companies in a response to fears of crime; ibid at 201.

[1103] Donnelly defines "delegation" here as "transfer of authority" to a private body being an organisation not based on statute but rather companies, trusts, charities or associations; C Donnelly, *Delegation of Governmental Power to Private Parties*, Oxford University Press (2007) at 3-6. Private delegation occurs where the law draws a formalistic "source of law" distinction between 'public' and 'private' rather than a functional distinction. Since positive obligations bind the State, they cannot be "sidestepped by privatisation"; see C Donnelly, *Positive Obligations and Privatisation*, 61 Northern Ireland Legal Quarterly (2010) 209 at 216.

[1104] Normative perceptions of the roles of government and private citizen informed the traditional responses to private delegation. The traditional hierarchy of political and civil rights in eighteenth and nineteenth century national constitutions observed the formulation of rights as entailing a freedom of autonomy from Governmental power or intrusion with no role for private organisations as "actor". Free speech, due process, inviolability of the home are all freedoms from intrusion (by the State). This traditional approach continues today in much of the US discourse about "rights" and the role of Government but does not capture the contemporary interdependence, universality and indivisibility of human rights law norms which transcend this earlier conception of rights and which views society as a more complex algorithm where power vests increasingly with an array of actors but where the State remains the "duty bearer" to the individual. This complexity is arguably recognised in Bunreacht na hÉireann in its reference to the roles of other elements of society such as the Family and non-State actors. The difficulty here however is that societies and their social norms evolve and what may be true in 1937 may not hold true in 2037. From a human rights perspective, the emphasis and indeed the challenge remains on the State to ensure that it is in a position to

how the law responds to this changing societal phenonemon.[1105] Where delegation occurs, the most common form is on foot of either a grant or contractual arrangement and the controls on these arrangements are key.[1106] Of these two forms of delegation, contract is usually better regulated than grants.[1107]

Doctrinal controls on private delegation may be constitutional, legislative, administrative or contractual. Constitutional doctrines of control may include non-delegation clauses (such as US non-delegation doctrines[1108]), control techniques (such as attaching conditions to the exercise of a delegated

---

provide an appropriate remedy to individuals whose constitutional or other human rights have been violated, even where the exercise of the function in question is by a private body.

[1105] For Black, the law needs to adapt in three ways to this new phenomenon: a greater understanding of the nature of the "public" sphere in a restructured State, an understanding of the role of law in the context of a functionally differentiated society where political, economic and social spheres are integrated and a re-formulation by the courts of the law's role in addressing decisions of self regulatory associations which impact on rights; J Black, *Constitutionalising Self-Regulation*, 59 Modern Law Review (1996) 24 at 24. For Aman, "state centric theories" need to be amended so that the "province of administrative law" also includes administration by private entities and hybrid public/ private bodies, such as federal corporations; A C Aman Jnr, *Globalization, Democracy, and the Need for a New Administrative Law*; 49 UCLA Law Review 1687 (2002) at 1704.

[1106] For procurement contracts see for example the US Federal Grant and Cooperative Agreement Act 1977, sections 4-6 on use of contract, grant or cooperative agreements. A plethora of Executive Orders and Agency Regulations govern procurement: see Executive Circular A-76 (Office of Management and Budget, revised May 29, 2003); at Article 4.b. see *www.whitehouse.gov/omb/circulars_a076_a76_incl_tech_correction#1* accessed on 21 October 2012. See also Procurement Directive (Directive 2004/18/EC of the European Parliament and of the Council of 31 March 2004 on the coordination of procedures for the award of public works contracts, public supply contracts and public service contracts) Official Journal L 134, 30/04/2004 P. 0114 – 0240.

[1107] See for example *YL v Birmingham City Council & Ors* [2008] 1 AC 95 discussed below. This is Donnelly's conclusion after reviewing practice in the US, UK and EU: C Donnelly, *Delegation of Governmental Power to Private Parties*, Oxford University Press (2007) at 222.

[1108] This principle establishes that each of the three organs of State exercises the powers to which it has been assigned by the Constitution and includes prohibition of private legislative delegation as set out in *Schechter Poultry Corporation v US* (1935) 295 US 495 where Hughes CJ held: that such a delegation of legislative power was unknown to law and inconsistent with the constitutional prerogatives and duties of Congress; at 537: The Fifth and Fourteenth Amendments to the US Constitution require due process requirements in Federal and State delegations, respectively. However in contradistinction to Federal and State (executive) delegations, practically any legislative delegation to an agency or private entity, no matter how vague, will likely survive constitutional scrutiny: seee C Donnelly, *Delegation of Governmental Power to Private Parties*, Oxford University Press (2007) at 119.

power[1109]) and judicial attitudes to intervening in legislative or executive decisions to delegate (separation of powers doctrines).[1110]

At the heart of such doctrines is the question of the governance of delegation: how the delegation takes place (whether for public or private delegation) and what governance arrangements are in place between Government and the delegate pursuant to constitutional, statutory or contractual controls.

Constitutional controls

Constitutional doctrines can set an overarching framework for delegation. Strongly influenced by US State non-delegation doctrine (itself based on the US separation of powers doctrine), the Texas Supreme Court set out a 8-point test to determine the constitutionality of private delegation in *Texas Boll Weevil Eradication Foundation Inc v Lewellen:*[1111]

... we prefer to condense the various inquiries posed by scholars and courts to these eight factors:

1. Are the private delegate's actions subject to meaningful review by a state agency or other branch of state government?
2. Are the persons affected by the private delegate's actions adequately represented in the decision making process?
3. Is the private delegate's power limited to making rules, or does the delegate also apply the law to particular individuals?
4. Does the private delegate have a pecuniary or other personal interest that may conflict with his or her public function?
5. Is the private delegate empowered to define criminal acts or impose criminal sanctions?
6. Is the delegation narrow in duration, extent, and subject matter?
7. Does the private delegate possess special qualifications or training for the task delegated to it?
8. Has the Legislature provided sufficient standards to guide the private delegate in its work?

[1109] The control technique may differ depending on whether judicial, executive or administrative power is being delegated.

[1110] As noted, the Irish courts will be more willing to intervene where a delegation is seen as purporting to exercise a judicial power.

[1111] (1997) 952 SW2d 454, 469 per Phillips CJ.

In doing so, the court established a clear constitutional control doctrine test. Most constitutions and indeed Bunreacht na hÉireann are neutral on the question of private delegation unless constitutional rights are violated and it falls to the courts to establish the relevant principles. As noted previously, the Irish courts have set out a limited constitutional control doctrine in relation to both legislative and judicial delegations. Legislative delegation is permitted under Article 15.2.2° of the Constitution[1112] but does not extend to a Ministerial power to legislate for measures contrary to Article 15.2.1 which vests exclusive legislative powers in the Oireachtas.[1113] In *Dunne v Donohue*[1114] the Supreme Court held that where legislation set out certain conditions on firearm certificates, to add additional conditions was a usurpation of the legislative function[1115] while in *Buckley v Attorney General*[1116] the Supreme Court emphasised that the Constitution vests "the exclusive right to determine justiciable controversies between a citizen or citizens, as the case may be and the State" in the courts".[1117] This would suggest that the Constitution imposes limits on delegation, particularly where the constitutional rights of the individual are at issue.[1118] The guidance afforded by the Texas

---

[1112] Article 15.2.2° provides: "Provision may however be made by law for the creation or recognition of subordinate legislatures and for the powers and functions of these legislatures."

[1113] Article 15.2.1° provides: "The sole and exclusive power of making laws for the State is hereby vested in the Oireachtas: no other legislative authority has power to make laws for the State". See *Laurentiu v Minister for Justice* [1999] 4 IR 26 where the Supreme Court the upheld the High Court's decision to quash section 5(1)(e) of the Aliens Act 1935 which permitted the Minister for Justice to have unrestricted power to order the deportation of non-nationals as this would in effect permit the Minister to legislate. In contrast, section 38(1) of the Health Act 2004 clearly envisages executive delegation by the HSE to private bodies providing: "The Executive may, subject to its available resources and any directions issued by the Minister under section 10, enter, on such terms and conditions as it considers appropriate, into an arrangement with a person for the provision of a health or personal social service by that person on behalf of the Executive."

[1114] [2002] 2 IR 533.

[1115] Keane CJ held that for a Garda Superintendent to in effect add a fourth condition would be to legislate through preconditions; [2002] 2 IR 533 at 543.

[1116] [1950] IR 67.

[1117] [1950] IR 67 at 84.

[1118] In the EU context, Donnelly suggests that the early decision of the Court of Justice in *Meroni v High Authority of the European Coal and Steel Community* 1961 CJ 0021 Joined cases 21/61 to 26/61, 6 April 1962, as with *Texas Boll,* set conditions on the delegation and

Supreme Court suggests how a constitutional control doctrine could develop, building on the general principles of *Dunne* and *Buckley* and both the separation of powers and *Meskell* doctrines (discussed below).

The advantage of a constitutional doctrine is that it is more encompassing than legislative or contractual control techniques as it may require the private body to also act constitutionally and to be liable for any constitutional torts pursuant to the exercise of the delegation (see below) notwithstanding the fact that "the delegation of power to private actors puts even greater stress on the non delegation doctrines because private actors are not [normally] subject to the same system of constitutional, statutory and oversight restrictions as public bodies".[1119] A constitutional doctrine could thus satisfy the tripartite "respect", "protect" and "fulfil" typology requirements of the right to health.

Added to the fact that traditonally the delegation of power to private actors left the delegated power outside the scrutiny of law, concerns surrounding contracting out have also included moral objections that privatisation is "somehow corrosive of democratic values"[1120] or more practically that "private delegates exercising governmental power are different from individuals acting

---

limited the nature of the power to be delegated. Delegations could be no more than the power of the delegator and must be subject to strict review: C Donnelly, *Delegation of Governmental Power to Private Parties*, Oxford University Press (2007) at 142-148.

[1119] H I Abramson, *A Fifth Branch of Government, The Private Regulators and their Constitutionality*, 16 Hastings Constitutional Law Quarterly (1988-89) 165 at 188. Bamberger identifies the dangers of regulatory capture where the regulated parties are given wide discretion in deciding how to meet regulatory goals: K A Bamberger, *Regulation as Delegation: Private Firms, Decision Making and Accountability in the Administrative State*, 56 Duke Law Journal (2006) 377 at 379. It has been argued elsewhere that constitutional amendment may be required to ensure good regulation: "[T]he Kenya Constitution should be amended to have express provisions on the power of the government to regulate the use of privately owned land. Such provisions should expressly spell out the circumstances under which state and governmental or other public authorities may regulate the use of such land as well as the procedures to be followed"; N Sifuna, *Public Regulation of the use of Private Land: Opportunities and challenges in Kenya*, 5 Law, Environment and Development Journal (2008) 38 at 55; while in the context of the right to health "the national constitution ... may grant a specific right to health accountability mechanism which can provide access to the courts to enable rights-holders to challenge government legislation and policy"; see H Potts, *Accountability and the Right to the Highest Attainable Standard of Health*, Human Rights Centre, University of Essex (2008), at 18 available at *www.womenslinkworldwide.org/pdf_programs/en_prog_rr_col_pubs_accountability.pdf*

[1120] J Freeman, *The Contracting State*, 28 Florida State University Law Review (2000-2001) 155 at 173.

in the course of their inter-personal relationships".[1121] If one is not a party to a contract, how can one litigate an entitlement or claimed right except on foot of a constitutional (or legislative) command? An overarching constitutional control doctrine would appear the primary vehicle by which such justiciability (an obligation on the State) may be achieved. In the field of health, contract law is the vehicle for delegation of public functions to private bodies on foot of a legislative power under section 38 of the Health Act 2004. It is a limited legislative rather than constitutional control doctrine which regulates the delegation and it is unclear how it has been employed to control this delegation of power.[1122] Rather, the primary manner in which the public (health) function is regulated under section 38 arrangements is under the terms of the contract or "service agreement" between the private body and the HSE and the quarterly reviews which take place between the parties.

Legislative controls

Other control techniques may include legislative limits on the power to delegate or the attachment of contractual conditions to the exercise of delegation. Both allow for legislative and judicial (i.e. constitutional law) oversight insofar as controls may be placed on what may be delegated or how

---

[1121] C Donnelly, *Delegation of Governmental Power to Private Parties*, Oxford University Press (2007) at 227. Whereas "democratic" concerns about the former can only be met "where contracts for social service delivery are produced in a fair and open manner with sufficient public input, affording procedural protections for the citizen, "interpersonal" concerns can only be resolved if third party recipients of a delegated public service may challenge violations of rights through rights of action afforded to third party beneficiaries of such services. For example, residential care homes for the elderly or those with a medium to profound intellectual disability are typically run by private charities, registered as companies limited by guarantee, with the HSE effectively subcontracting the provision of health and social services under section 38 of the Health Act 2004 to those private care providers. Psychiatric institutions and general hospitals are in a similar situation. Apart from contractual obligations and the administrative complaints mechanisms, the only external regulation will be under Part 8 of the Health Act 2007 with selective inspections and licensing requirements by HIQA or the Inspector for Mental Health Services under the Mental Health Act 2001 (see Part 4 of this thesis). Other delegation concerns focus on favourable results, being "consequentialist" as opposed to necessarily "moral" concerns with the delegation itself: J Freeman, ibid, at 169 and 175.

[1122] For example, residential care homes for the elderly or those with a medium to profound intellectual disability are typically run by private charities, registered as companies limited by guarantee, with the HSE effectively subcontracting the provision of health and social services under section 38 of the Health Act 2004 to those private care providers. Psychiatric institutions and general hospitals are in a similar situation. Apart from contractual obligations and the administrative complaints mechanisms, the only external regulation will be under Part 8 of the Health Act 2007 with selective inspections and licensing requirements by HIQA or the Inspector for Mental Health Services under the Mental Health Act 2001 (see below).

the delegation is to be supervised. If specifically stipulated in legislation, such conditions may also require governmental delegators to act constitutionally in how delegations occur. Whether private bodies could be so compelled is discussed below.

In the EU context, strict legislative control is evident under the 2002 Financial Regulation[1123] which limits delegation to mere technical or administrative tasks for private bodies not having a public service component.[1124] In contrast, sections 38 and 39 of the Health Act 2004 provide for a "weak" form of legislative delegation control.[1125]

The focus under section 38 is very much on financial probity, with the delegate required to provide "all proper and usual accounts and records of income received and expenditure" and to submit to audit. Moreover, the HSE is only empowered to monitor the provision of "health or personal social services" where the private body has been exempted from audit requirements.[1126] There is little guidance on the legislative intent in private health delegation apart from the fact that the HSE can provide financial assistance to a delegate, subject to general Ministerial directions on reporting. Of note are the elements missing

---

[1123] Regulations No 1605/ 2002 and 2342/2002 (implementing regulation) laying down detailed rules for the implementation of Council Regulation (EC, Euratom) No 1605/2002 on the Financial Regulation applicable to the general budget of the European Communities (OJL 357, 31.12. 2002 at 1), 23 December 2002.

[1124] Article 57 of the Financial Regulation provides that the Commission may only entrust measures of implementation of funds deriving from the budget to external private-sector entities or bodies where specifically provided under Article 54 (prohibition of private delegation except for defined and fully supervised administrative tasks) or in specific cases where the payments involved are to be made to beneficiaries determined by the Commission, subject to conditions and amounts fixed by the Commission and do not involve the exercise of discretion by the entity or body making the payments, namely technical expertise and administrative tasks. The Regulation has arguably led to increased controls including under the Procurement Directive (Directive 2004/18/EC of the European Parliament and of the Council of 31 March 2004 on the coordination of procedures for the award of public works contracts, public supply contracts and public service contracts) which emphasises transparency and openness: see Chapter V1 (Rules on advertising and transparency); Official Journal L 134, 30/04/2004 P. 0114 – 0240.

[1125] Section 38 of the Health Act 2004 provides that the HSE may enter into an arrangement with a person for the provision of a health or personal social service by that person on behalf of it, subject to funding agreement.

[1126] Section 38(6). Otherwise it may request from a service provider any information on a service under section 38(7). Sections 49(2) and (3) envisage service providers establishing and being subject to comparable complaints mechanisms as established by the HSE under section 49(1) of that Act.

from this delegation: first there is little Parliamentary scrutiny, particularly as delegations may occur on foot of HSE as opposed to Departmental delegation.[1127] Second, there is little Executive scrutiny save for financial probity. Third, there is limited "control" of the manner in which health services should be provided. Fourth, there is no legal relationship prescribed between the private body and the individual seeking access to a health service (the third party beneficiary); rather the contract is between the delegator (HSE) and the delegate (private body).

Whereas the contract between the HSE and the private body could include meaningful controls to render the delegate accountable to the State, there is no facility for the individual to seek to have their right to health met by the private body which has no legal obligation to the individual unless they enter a contractual or tortious relationship with them.[1128] Otherwise, the private body may ignore an individual's petition and approach a health-related request for assistance on a "take it or leave it" basis. The only penalty available against the delegate is a review or cancellation of the contract. However, it is difficult to see how the HSE could seek damages for health services not delivered to an individual where there is no strictly defined obligation to do so. Without the

---

[1127] Noting that the Chairperson of the HSE is now the Secretary General of the Department of Health.

[1128] Under contract law, there is no justiciable right for an individual seeking a health service insofar as s/he is not a party to the contract. The parties to the contract are the government delegator and the delegate as contract law doctrine is predicated on the assumption of voluntary, self-imposed obligations. Under the common law, the duties owed by private bodies other than under contract or legislation will refer to internal obligations owed exclusively to the company itself. The English courts have held that fiduciary duties are owed exclusively by directors to the company, and not to shareholders individually; specific duties owed to shareholders can only be generated through voluntary assumptions of responsibilities or in relationship to specific transactions: see *Peskin v Anderson* [2000] EWCA Civ 326 per Mummery LJ. Outside duties can arise, but "are dependent on establishing a special factual relationship between the directors and the shareholders in the particular case"; at para 31. This differs from the situation in France where a private body contracting for a public service assumes responsibilities under the contrats administratifs doctrine, where administrative contracts with private bodies are also subject to review by Administrative Tribunals: see for example Article 2 of Law No. 2001-1168 (11 December 2001). A focus on the "public function" aspect of a contract allows administrative oversight in that jurisdiction. However, in Ireland, absent a clear constitutional doctrine, there will be no general obligation owed to the recipient of services unless voluntarily assumed or present under contract or legislation. Contract design is critical. While tort law (discussed below) offers a justiciable right, this is only where a duty of care is owed and does not normally arise in respect of third parties except in "emergency" or "Good Samaritan" cases (unless delimited by law: see below). Neither contract nor tort law may cover the issue of access to a health service for a vulnerable person. The question then returns full circle to how an individual seeking to vindicate their right to health may bring an action before the courts against a private delegated body.

option of seeking damages, the threat of litigation recedes with the sanction arguably being non-renewal of contract, but again, the grounds for any cancellation are unclear. This arguably contrasts with those provisions under the UK's Deregulation and Contracting Out Act 1994[1129] which set out boundaries for controlling delegation in the field of health, specifically by placing responsibility on the delegator.[1130] Without some stated statutory or contractual duty to the delegator and to the individual seeking health services, a private health body only owes fiduciary duties to itself and not to the public. Such duties are likely to involve standard company law duties of ensuring standards of care and avoiding conflicts of interest. It is suggested that the more an entity looks like a charity (with an unidentifiable and broad class of beneficiaries), the less likely it is that its beneficiaries can sue for relief.[1131]

Contract design is key.[1132] What must be controlled, if not avoided in contracts, are the use of discretionary terms such as "adequate", "reasonable" or "good faith" insofar as the interpretation of these terms by a court may differ depending on the public or private nature of the contract.[1133] This can be

---

[1129] As amended by the Regulatory Reform Act 2001.

[1130] Section 72(1) of the Deregulation and Contracting Out Act 1994 provides that in relation to contracting out functions responsibility remains with the delegator in relation to anything done or omitted to be done by a person or employee authorised. The 1994 Act is subject to the EU 2004 Procurement Directive (2004/18/EC of the European Parliament and of the Council of 31 March 2004 on the coordination of procedures for the award of public works contracts, public supply contracts and public service contracts) Official Journal L 134, 30/04/2004 P. 0114 – 0240 as transposed through the 2006 Public Contracts Regulations and the EU Remedies Directive (amending Council Directives 89/665/EEC and 92/13/EEC with regard to improving the effectiveness of review procedures concerning the award of public contracts) EN 20.12.2007 OJ L335/31.

[1131] E Brody, *Institutional Dissonance in the Non-profit sector* 41 Villanova Law Review (1996) 433 at 485, cited by C Donnelly, *Delegation of Governmental Power to Private Parties*, Oxford University Press (2007) at 331.

[1132] The difficulties with appropriate contract design are, on the one hand, permitting the contract framework the flexibility necessary to react to public policy concerns while on the other recognising how interpersonal relations are difficult to define in a contract design and why public-private contracts suffer from lack of precision (or "technocratic weaknesses"); AC Aman Jnr, *Globalization, Democracy, and the Need for a New Administrative Law*; 49 UCLA Law Review (2002) 1687 at 1713.

[1133] As to what meaningful contract terms are beyond these or other amorphous terms such as "quality health care", arguably relevant regulations and codes of conduct can be incorporated into contracts to specify the required standards. However, meaningful contract terms imported into a health service contract must balance a traditional low-trust relationship required where sensitive governmental matters are delegated and which is normally predicated on monitoring through policing and enforcement through sanctions, with a softer "partnership" model emphasising shared information, trust and persuasion as enforcement: C Donnelly, *Delegation*

demonstrated by consideration of the Irish model. The contract design inherent in the 2004 and 2007 Health Acts means that primary oversight/ supervision by the HSE is minimal. The HSE has limited statutory incentive to monitor the delivery of AAAQs by the private body insofar as its "control" functions under sections 38 and 39 of the Health Act 2004 are primarily financial when viewed against the functions and range of tools available to the Health Information and Quality Authority under the 2007 Act which permit it to focus more fully on standards. Indeed, arguably the incentive to ensure continuity of health services through the private bodies contracted to do so provides a strong disincentive for the HSE to keep contracts short, to seek a fee reduction, to apply penalties or even litigate in cases of malpractice. Short contracts require regular monitoring and even re-tendering, whereas rolling contracts only require formulaic annual review meetings which can focus on finance. Further, if a contract is voided and a care home shut down, emergency alternatives must be found for its residents, while contract renegotiations will have to ensue.[1134] This is far removed from the "partnership" model oft preferred in health settings. And yet, with proper contract design (including through incentivisation[1135]) and periodic monitoring, there is arguably more scope for the HSE to ensure AAAQ delivery and to limit the amount of external supervision necessary by ensuring that the private delegate is motivated to act in the proper manner.[1136] Indeed, given the fact that the State retains responsibility under the "protect" and "fulfil" obligations of the right to health, there is a strong incentive for it to draft these contracts in a manner which

---

of Governmental Power to Private Parties, Oxford University Press (2007) at 334-335. See also discussion below on no-fault torts.

[1134] Arguably introducing high penalties will act as a deterrent even where detection levels are low: C Donnelly, *Delegation of Governmental Power to Private Parties*, Oxford University Press (2007) at 341.

[1135] On incentives generally, Freeman makes the powerful suggestion of "a counterintuitive" way to view privatisation trends, namely as a mechanism for expanding government's reach into realms traditionally thought private. Under this paradigm, private actors would increasingly commit themselves to traditionally public goals as the price of access to lucrative delegated contracts otherwise provided directly by the state; J Freeman, *Extending Public Law Norms Through Privatization*, 116 Harvard Law Review (2002-2003) 1285 at 1285.

[1136] C Donnelly, *Delegation of Governmental Power to Private Parties*, Oxford University Press (2007) at 336-337.

ensures private party compliance, indemnification of the State and justiciabilty for service users.[1137]

Provided there is no usurpation of the legislative or judicial functions, it is constitutionally permissible to delegate in Ireland,[1138] allowing for legislative delegation under the Health Acts 1947-2007. It is of course open to the legislature to explicitly set supervision conditions on delegation.[1139] Most legislative controls in Ireland grant general permission to delegate but limit the conditions attached. Rather controls tend to focus on supervision of standards by independent regulators.[1140]

As noted in Part 1 of this thesis, the purpose of supervision and regulation is primarily to undertake monitoring of an entity's functions or individual behaviour to ensure that constitutional or statutory principles or policy concerns are being met by the delegate.[1141] Regulation is primarily achieved by administrative means and ironically it is usually the regulator rather than the regulated who is subject to judicial review controls on the basis of their public function.[1142] In similar manner to EU law limitations on justiciability for

---

[1137] C Donnelly, *Positive Obligations and Privatisation*, 61 Northern Ireland Legal Quarterly (2010) 210 at 222.

[1138] Privatisation is recognised in several parts of the Constitution in deference to how society looked in 1937: Article 42.4 recognises that primary education was provided by religious patrons rather than the State while Article 44.2.4° prohibits legislation from providing State aid for schools which discriminate between schools on the basis of religious denomination.

[1139] As in the case of Article 54(1) of the EU's Financial Regulation under which delegation tasks must be "clearly defined and fully supervised"; see *Financial Regulation and implementing rules applicable to the general budget of the European Communities, Synoptic presentation*, European Commission, Brussels (2008), available at *ec.europa.**eu**/dgs/secretariat_general/.../syn_pub_rf_modex_en.pdf* accessed on 21 January 2013.

[1140] See for example Inspector of Mental Health Services acting on foot of regulations enacted pursuant to the Mental Health Act 2001 and the Chief Inspector of Social Services acting on foot of regulations enacted pursuant to the Health Act 2007, discussed below. A striking exception to limited legislative control is legislation (whether primary or secondary) transposing EU law where the private delegate may be directly liable under the Court of Justice's direct horizontal effect doctrine or indirectly through application of the Charter of Fundamental Rights of the European Union (where the Charter has application under Article 51).

[1141] Regulation is defined essentially as mechanisms to constrain and sanction unwanted behavior and remains a key aspect of regulating private bodies who have delegated State functions.

[1142] See discussion of successful judicial review applications brought against regulatory actions of the Medical Council of Ireland, below.

individuals (see Part 1), judicial review controls in Ireland do not include a justiciable right for third party beneficiaries, only the regulated and the regulator.

Just as contract design will inform accountability of a private body delivering health services[1143], regulatory design will dictate the legislature's expectation of this form of control and its limits: not only how the regulation is to be conducted but also the rationale for regulation. Conceptually where cost/ efficiency is not the only criterion for the delegation but secondary aims are also pursued (such as quality of the care), regulation can increase "the potential of private delegation to enhance participatory democracy" and address a common criticism of private bodies and so supervisory obligations can ensure the "long-term success of the private delegation".[1144]

The delegator - delegate contract may of course be subject to legislative controls: for instance, there may be competitive procurement requirements (such as under the Procurement Directive) or the delegator may only be empowered by legislation to delegate certain powers (for example the ability to dispense welfare cheques) but not others (e.g. to determine eligibility for benefits).[1145] Further, depending on the regulatory framework, the contract may be subject to specific indirect legislative controls such as legal, financial or "standards" regulation, for example through inspections, monitoring or complaint consideration by external bodies. Alternatively, legislation may be silent but the contract itself may include provisions copied directly from statute

---

[1143] The contract design will determine the relationship between the State delegator and the delegate. In the health context, contracts or "service arrangements" under section 38 of the Health Act 2004 will typically cover the cost of the service, accounting for the service along with a description of the services to be provided and even the geographic scope of the area of territory to be covered: see *Report on the Human Rights Issues Arising from the Operation of a Residential and Day Care Centre for Persons with a Severe to Profound Intellectual Disability*; Irish Human Rights Commission (2010): available at *www.ihrc.ie/enquiriesandlegal/conductenq.html* accessed on 21 October 2012; at 89.

[1144] C Donnelly, *Delegation of Governmental Power to Private Parties*, Oxford University Press (2007) at 167-168. Dannin argues that accountability in the process of public provision of services is more than just a tool to safeguard against corruption and cronyism, it fosters substantive public input and participation in public life: E Dannin, *Red Tape or Accountability: Privatization, Publicization, and Public Values*, 15 Cornell Journal of Law and Public Policy (2005-2006) 111 at 155.

[1145] See however the UK's Social Security Administration Act 1992, the Contracting Out (Functions relating to Social Security) Order 2000 SI 2000/898 (Article 2) and the Deregulation and Contracting Out Act 1994.

or guidelines or may include indemnity or conditionality clauses. However, legal or reparations accountability through justiciability, a key element of the right to health, as noted in Part 1 of this thesis, may only occur under either a framework law providing for a right of action for third party beneficiaries[1146] or in circumstances where the courts employ a functional approach to private delegation to permit judicial review scrutiny in the same way as public bodies under administrative law, although here there would need to be some amelioration of procedural rules (*ius tertii*, *locus standi* etc.) in order to ensure the right to a remedy.

Where statutory controls are weak, constitutional and administrative law will be more important when acts of the delegator or delegate are brought into question. Courts in the UK have been slow to identify a concept of "the public sphere" or indeed to impose public law "burdens" on private delegates until recently and it is unclear whether public law obligations will be imposed outside the employment context in that jurisdiction. In *YL v Birmingham City Council & Ors*[1147] Lord Bingham stated that in the case of a body receiving public funds, it was "absurd" to suggest that the private care home in question may act as a "public authority" within the meaning of section 6(3)(b) of the Human Rights Act 1998.[1148] However, as noted, the Irish courts have taken a different approach, the main difference being Bunreacht na hÉireann. In light of *Beirne v Commissioner of An Garda Síochána*[1149]and *Geoghegan v Institute*

[1146] A further possibility is for the delegation contract to include reference to justiciability where the private body undertakes, on pain of penalty, to cooperate with complaint mechanisms or even not to object to the *locus standi* or *ius tertii* of third party beneficiary claimants. Here the private body would willingly subject itself to the court's jurisdiction and while it may fight the substance of the case, it would yield on procedural grounds.

[1147] [2008] 1 AC 95.

[1148] [2008] 1 AC 95. The court divided 3 v 2 with Lords Scott, Mance and Neuberger in the majority and Lord Binghman and Baroness Hale in the minority. *YL* followed the earlier Court of Appeal cases of *Poplar Housing and Regeneration Community Association Ltd v Donoghue* [2001] EWCA Civ 595 where the court held that the private housing body's function was "enmeshed" with the local authority's and *R (Heather) v Leonard Cheshire Foundation* [2002] EWCA Civ 366 where Lord Wolff characterised the power being exercised (decision to close a nursing home) by reference to its source (private) rather than its function. YL may have been modified somewhat following the Court of Appeal's Judgment in *R (Weaver) v London and Quadrant Housing Trust* [2009] EWCA Civ 587 where Elias LJ held that social housing subcontracted to a registered social landlord was held liable under the ECHR (Human Rights Act 1998): "In my judgment the Trust is a hybrid public authority and the act of terminating a tenancy is not a private act"; at para 84.

[1149] [1993] ILRM 1.

of Chartered Accountants in Ireland[1150] the Irish courts appear willing to extend judicial review to areas typically covered by private law only arguably where constitutional rights (natural justice, right to earn a livelihood) are at issue. Further, the Constitution allows for direct applicability of constitutional rights through the *Meskell* doctrine of direct horizontality (discussed below). At least in theory, Irish law mirrors EU law which applies direct horizontality to directly effective EU law and thus permits the State to discharge its reparations accountability obligation under the "obligation to protect". One solution is to favour multiple controls, namely where constitutional controls complement legislative and regulatory controls which are framed in light of the constitutional order (including the doctrine of horizontality) so that a "functional equivalence" between the private delegate and the public delegator it replaces could then be achieved under an accountability framework.[1151] In the Irish system, given the presumption of constitutionality for legislation and that administrators act reasonably, there is constitutional scope to ensure that effective judicial control to ensure private delegation is properly exercised under such a control doctrine.

A constitutional or legislative control doctrine centred on ensuring a justiciable right to health for violation of the constitutional right could set out the circumstances in which a breach of duty would be actionable before the courts. An example of a legislative control doctrine would be legislation similar to the Health Acts 2004-07 (i.e with regulatory, justiciable and complaints components) but which introduces a legislative control framework (a framework law: see Part 1 of this thesis) which places right to health obligations on private service providers through setting out the accessibility criteria such as how a right to access health services on a non-discriminatory basis should be achieved. Such legislation could permit of resource allocation arguments.

An example of a superior constitutional control doctrine would be a "non-delegation unless" principle akin to US non-delegate doctrines, which could

---

[1150] [1995] 3 IR 86.

[1151] C Donnelly, *Delegation of Governmental Power to Private Parties*, Oxford University Press (2007) at 394 and 398-399.

bind both delegator and delegate alike. Judicial review and liability in tort for breach of a doctrinal "public duty" where either a public body akin to the Primary Care Trusts in the UK or in circumstances where the HSE in delegating health service provision to a private body, failed to specify or ensure access to a particular health service as set out in the notional right to health legislation mooted above, could be possible under such a breach of duty doctrine.[1152] A declaration that a decision on access to treatment was unconstitutional or certiorari of a delegation to a private body are examples of remedies familiar to the courts under Order 84 of the Rules of the Superior Courts. Those rules, along with the inherent jurisdiction of the High Court to vindicate constitutional rights should allow sufficient flexibility for the application of fashioning appropriate remedies to meet a particular factual matrix where a constitutional right is imperilled. The courts would be enabled to avoid "nuclear" options of quashing contracts and closing care centres where a declaration may suffice. However, the courts already have the power to close such centres or to approve proposals to do so by the State's health regulators and this part of the armoury of enforcement should remain.[1153]

These, it is submitted, are superior forms of control than contract or tort control. If, however, there is limited constitutional or legislative control of delegation of public health services, one by definition falls back on contract or tort law as the control (discussed below).[1154]

In this section we considered available constitutional, legislative and contractual control theories and how the State, bound by its positive obligations to "protect" and "fulfil" the right to health, must ensure both "due diligence" of private bodies in the delivery of the right to health and accountability mechanisms which allows for a form of justiciability, whether vertical, horizontal or an amalgam of both. We considered the weak form of delegation

---

[1152] In the latter case, such a doctrine would compel properly designed contracts capable of making the delegate responsible to the State for the delivery of appropriate health services.

[1153] Namely the Mental Health Commission and HIQA: see below.

[1154] Of course there is a strong argument for rendering all private acts as subject to human rights law: if a private computer company is subcontracted to retain, collect and use private data on individuals, any disclosure of the data could involve the violation of those individuals' right to privacy. It is arguably unreasonable to provide human rights clauses in all such contracts. Rather, a public law prohibition may allow for a more unified legal response.

available under sections 38 and 39 of the Health Act 2004 and observed how a constitutional control doctrine employing the remedies available under Order 84 of the Rules of the Superior Courts could ensure that private delegation occurs only on strict conditionality and the assurance of the right to health.

Accordingly, this chapter suggests how either a constitutional or legislative control theory could see right to health legislation introduced which would permit horizontal justiciability in placing statutory duties on those public or private bodies responsible for delivering the right to health. A unified Health Act could provide for reparatations accountability under the "respect, protect, fulfil" typology. This leads us to consideration of the constitutional right to equality and non-discrimination, an area where on the legislative plain, the State has already provided for horizontal justiciability under the Equal Status Acts 2000-2012.

12 Equality and non-discrimination

Some commentators have argued that, insofar as the direct protection of economic and social rights has proved to be problematic to judges under the separation of powers doctrine, the trilogy of cases of *O'Reilly*, *Sinnott* and *TD* may rather suggest an approach to the recognition of such rights grounded in equality law under Article 40.1 of the Constitution.[1155] It will be recalled that non-discrimination in access to the AAAQs is a core non-derogable obligation on the State which leads to the question whether the jurisprudence under the Constitution's equality provision sufficiently guards against such discrimination in tandem with or separate to the right to bodily integrity.

Before considering how the jurisprudence under Article 40.1 has developed, it may be useful to first reconsider the non-discrimination test in access to the AAAQs as set out in Part 1 of this thesis. It will be recalled that discrimination constitutes "any distinction, exclusion, restriction or preference or other differential treatment" that is "directly or indirectly based on the prohibited grounds" of discrimination and which has the "intention or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of Covenant rights".[1156] A difference in treatment may constitute discrimination under paragraph 13 of General Comment 20 if "based on prohibited grounds ... unless the justification for differentiation is reasonable and objective." The burden of proof of demonstrating the justification for differentiation passes to the State and requires consideration of whether the measures taken were legitimate and proportionate to those aims. As part of this consideration it will be necessary to demonstrate that every effort was made to use all resources to address discrimination.

[1155] O'Connell argues that each case is also an equality case: R O'Connell, *Equality Before the Law to the Equal Benefit of the Law: Social and Economic Rights in the Irish Constitution,* in *The Irish Constitution, Governance and Values*, E Carolan & O Doyle (Eds) Thomson Roundhall (2008) at 335.

[1156] See General Comment 20 of ICESCR, Article 1 of CERD, Article 1 of CEDAW and Article 2 of the Convention on the Rights of Persons with Disabilities. The Human Rights Committee comes to a similar interpretation of Articles 2 and 26 of the ICCPR in General Comment No 18, at paras. 6 and 7.

Insofar as both formal and substantive (or *de facto*) discrimination are prohibited,[1157] attention will focus on whether the State took positive measures where a person affected by the difference in treatment is a member of a group characterised by the prohibited grounds of discrimination, which requires sufficient attention to "groups of individuals which suffer historical or persistent prejudice" instead of merely comparing the formal treatment of individuals in similar situations.[1158] States must therefore immediately adopt positive measures to "prevent, diminish and eliminate the conditions and attitudes which cause or perpetuate substantive or de facto discrimination."[1159] Clearly the justifications advanced by the State should include reference to the positive measures it has introduced to address the historic discrimination experienced by the vulnerable group to whom the person belongs.

The argument under equality and non-discrimination law is that the courts do not need to intrude into issues of distributive justice: resource allocation may remain a matter for the Executive, the courts merely ensuring that in the formulation and application of law, policy and practice including resource allocation rules and decisions, that persons are not discriminated against on the ground of their status. This would have the benefit of further aligning Irish law with international standards: even if the recognition of unenumerated rights was to proceed at its current slow pace, with the courts unwilling to read in rights such as aspects of the right to health under Article 40.3, an application of equality/ non-discrimination principles could ensure that persons are not discriminated against in access to health facilities on the ground of their status. The right to non-discrimination in health corresponds to concepts of equity in health facility provision and as noted also addresses the social determinants of health. This same equality principle is located in the first of the fundamental rights provisions of the Constitution, Article 40.1, which provides:

[1157] General Comment 20 at para 8.

[1158] General Comment 20 at para 8.

[1159] General Comment 20 at para 8. Paragraph 8 gives the example of "ensuring that all individuals have equal access to adequate housing, water and sanitation will help to overcome discrimination against women and girl children and persons living in informal settlements and rural areas".

> All citizens shall, as human persons, be held equal before the law.
>
> This shall not be held to mean that the State shall not in its enactments have due regard to differences of capacity, physical and moral, and of social function.[1160]

In *de Búrca v Attorney General*[1161] Walsh J clarified that Article 40.1 imports an Aristotelian or natural law understanding of equality:

> Article 40 does not require identical treatment of all persons without recognition of differences in relevant circumstances but it forbids invidious or arbitrary discrimination. It imports the Aristotelian concept that justice demands that we treat equals equally and unequals unequally.[1162]

In this way, both direct and indirect, formal and substantive discrimination appear prohibited. Article 40.1 protects both formal equality (an equal application of rules to those covered by the rules) and one part of Aristotelian equality (requiring that legislative differentiation should reflect real differences between persons or classes of persons). "Invidious or arbitrary discrimination" was recognised as prohibited under the early consideration of the equality principle.

In *Brennan v Attorney General*[1163] Barrington J expounded the test to be applied by the courts in considering whether legislation could offend the equality guarantee. Provided a legitimate public policy objective was evident in the legislation there would be no breach of Article 40.1. Barrington J's test was approved by the Supreme Court in *In Re Article 26 The Employment Equality Bill, 1996*[1164] and *In Re Article 26 The Planning and Development Bill,*

[1160] Other prohibitions of discrimination under the Constitution include Article 9.1.3 (discrimination on theground of sex in relation to nationality and citizenship), Article 16.1.1 (discrimination on the ground of sex - eligibility for membership of Dáil Éireann and voting for members of Dáil Éireann), Article 40.6.2 (discrimination on the grounds of political opinion, religion or class - freedom of assembly and of association), Article 44.2.3 (discrimination by the State on the grounds of religious profession, belief or status) and Article 44.2.4 (discrimination on the ground of religion in relation to the public funding of schools).

[1161] [1976] IR 38.

[1162] [1976] IR 38 at 68.

[1163] [1983] ILRM 449.

[1164] [1997] 2 IR 321 per Hamilton CJ at 346.

1999[1165] where Keane CJ held that Article 40 "does not preclude the Oireachtas from enacting legislation based on any form of discrimination" insofar as positive measures may be required. Provided classifications made by the Oireachtas are "for a legitimate legislative purpose, are relevant to that purpose and treat each class fairly, they are not constitutionally invalid".[1166]

The test was similarly upheld in *Re Article 26 and the Illegal Immigrants (Trafficking) Bill)*[1167] where a legislative purpose of ensuring better administration of justice or the proper functioning of an asylum system were considered legitimate public policy objectives. Evident in the Supreme Court's ruling in this case, however, is the deference afforded by it to another organ of State resulting in a weak standard of review.[1168] Barrington J's test was interpreted as stating that provided a classification may be formalistically described as being for a legitimate legislative purpose and relevant to the purpose (insofar as there is an adequate relationship between the purpose and the means chosen to pursue it), it will survive constitutional scrutiny.

A related test was set out in *Re Article 26 The Planning and Development Bill, 1999*[1169] where the court went on to state that in reaching the above test, Barrington J had regard to the presumption of legislative constitutionality as observed by Kenny J in *Ryan* until the contrary is clearly established. For Keane CJ this applied with "particular force" to legislation dealing with "controversial social and economic matters" as such matters "peculiarly" lie in the province of the Oireachtas which must seek to reconcile "the conflicting rights of different sections of society". Consequently, "a heavy onus" was placed on those who assert that the manner in which legislation has sought to reconcile those conflicting rights is in breach of the guarantee of equality.[1170]

[1165] [2000] 2 IR 321.

[1166] [2000] 2 IR 321 at 357.

[1167] [2000] 2 IR 360.

[1168] O Doyle, *Constitutional law: Text, Cases and Materials* Dublin: Clarus Press (2008) at 72.

[1169] [2000] 2 IR 321.

[1170] [2000] 2 IR 321 at 357-358.

This tread of judicial deference to classifications of the Oireachtas runs through Article 40.1 jurisprudence.

The courts have been quicker to strike down antiquated common law rules (women subservient to men: *State (DPP) v Walsh*[1171] (common law defence of coercion and *W v W*[1172]) and paramount nature of father's authority over a child (*Re Tilson*[1173]) than modern legislation. The case of in *McKinley v Minister for Defence*[1174] is a case in point: the Supreme Court developed the common law rule of action for loss of consortium so as to allow a right of action to wife as well as to husband. A difference in treatment on the basis of sex inherent in the rule was addressed. In *BG v District Judge Catherine Murphy*[1175] Hogan J suggested that such common law rules as in *McKinley* might be "inherently susceptible to modification by judicial decision".[1176]

As many of these cases were considered summarily no large body of jurisprudence has developed and until recently there was little requirement for the State to demonstrate a difference in treatment between classes of person as is the situation under international law.

Although *In Re Article 26 The Planning and Development Bill, 1999* suggested that the second part of the Aristotelian principle - that unequals be treated unequally – allows for positive measures to address discrimination, this has not always found favour in the Irish courts. In *Draper v Attorney General*[1177] the Supreme Court (per O'Higgins CJ) held that the absence of positive measures to allow a woman with a disability access to postal voting facilities did not violate Article 40.1.[1178]

[1171] [1981 IR 412.

[1172] [1993] 2 IR 476.

[1173] [1951] IR 1.

[1174] [1992] 2 IR 333.

[1175] Unreported, 8 December 2011, per Hogan J.

[1176] The Judge noted, however, that the matter would have to be fully considered by the courts; unreported, 8 December 2011, at para. 40.

[1177] [1984] IR 277.

[1178] [1984] IR 277.

Nor have the Irish courts readily accepted that indirect discrimination is prohibited by virtue of Article 40.1. In *Norris v Attorney General*[1179] - a classic example of indirect discrimination where the legislative measure, expressed neutrally, impacted disproportionately on same sex partners - the court held that Article 40.1 was not violated. In the High Court, McWilliam J was aware that such a disproportionate impact was "probably what the legislature had in mind" but considered this was not sufficient to constitute "an invidious or arbitrary discrimination".[1180]

The courts have also in a number of cases resiled from any in-depth consideration of the equality/ discrimination issues arising by characterising the relief being sought by the plaintiff as not being capable of benefitting her or him. In *O'Brien v Stoutt*[1181] which concerned differences in treatment under the Succession Act 1965 between children born inside and outside marriage, Walsh J stated:

> Even if the present rules were to be found to be invalid having regard to the provisions of the Constitution, it would avail the defendant nothing as the resultant absence of any rules would leave her without any claimable share.[1182]

Similarly in *Somjee v Minister for Justice*[1183] Keane J dismissed the equality claim stating that invalidation of the Irish Nationality and Citizenship Act 1956 would confer no benefit on the plaintiffs.[1184] It is submitted that in focusing on the form of relief which the court could order (certiorari as opposed to mandamus) the court considered it was capable only of levelling down statutory entitlements by striking down legislation which result will not benefit

---

[1179] [1984] IR 36.

[1180] [1984] IR 36 at 44. See also *Report of the Constitutional Review Group*, Dublin, Stationery Office (1996) at 195.

[1181] [1984] IR 316.

[1182] [1984] IR 316 at 336. The Supreme Court did consider the issue but in summary form.

[1183] [1981] ILRM 324.

[1184] The plaintiffs claimed a difference in treatment on the ground of sex between a non-national woman married to a citizen who could acquire citizenship immediately and a non-national man similarly married who could not.

a plaintiff, rather than focusing on the substantive question before it.[1185] However, more recently the courts have adopted a more enlightened approach. In *BG v District Judge Catherine Murphy & Ors*[1186], Hogan J, citing *Somjee*, likened the remedy of statutory invalidation as "a Samson-like collapsing of the legislative pillars which gave rise to the unconstitutionality in the first instance". Hogan J expressly disavowed the "conferring no benefit" argument in *Somjee*, noting that "if that were indeed the law, then the capacity of the courts to provide an effective remedy in those cases where the Oireachtas had breached Article 40.1 by unjustly conferring a privilege or a benefit on one select group of society might have been compromised." [1187]

The courts may "fashion" constitutional remedies with more flexibility when either reviewing common law rules to allow for equality on the ground of sex (per *McKinley*[1188]) or as in *Carmody* and *BG*, in making an "admonitory declaration" that a particular act or measure, pursuant to a legislative provision, will constitute a violation of a constitutional right.[1189] However, there is a limit to fashioning a constitutional remedy as set out in *Fleming v Ireland.*[1190]

Similarly, administrative acts may violate the guarantee in Article 40.1 if they do not faithfully follow the purpose of the legislative scheme which gave rise to them. Where the legislation evinces no intention to differentiate between persons affected by a scheme, the administration of the legislation must not import any such differentiation. In *McMahon v Leahy*[1191] O'Higgins CJ held that an escaped prisoner should be treated similarly to others in the same class

---

[1185] Keane J forcefully stated that it was not the function of the court to "indulge in an academic exercise which will be utterly futile so far as the plaintiffs are concerned"; see O Doyle, *Constitutional law: Text, Cases and Materials* Dublin: Clarus Press (2008) at 73.

[1186] Unreported, 8 December 2011, at para 36.

[1187] Unreported, 8 December 2011, at para 37.

[1188] [1992] 2 IR 333.

[1189] *BG v District Judge Catherine Murphy, the Director of Public Prosecutions and the Judge of the District Circuit (No.2), Ireland and the Attorney General (Notice Parties) and the Irish Human Rights Commission (Amicus Curiae)* Unreported, 8 December 2011 (HC), at para 44.

[1190] 10 January 2013, unreported, at para 76, see above.

[1191] [1984] IR 525.

as otherwise "it would mean contradictory declarations in relation to the same incident ... from the Courts."[1192]

There has been some criticism of the infusion of natural law doctrine into the earlier equality jurisprudence with concern that the Supreme Court judgments of Walsh J and O'Higgins CJ in *de Búrca v Attorney General*[1193] demonstrated the difficulties where judges' views might colour their conclusions as to whether a distinction between persons is relevant or not.[1194] More generally it is suggested that an absence of a coherent approach to equality "raises the danger that objectionable discriminations may be upheld and buttressed simply because they are so persistent and entrenched that they appear to the courts to be reflective of reality".[1195]

Discrimination on the basis of a person's attributes may constitute what was earlier referred to as "invidious or arbitrary discrimination".[1196] Irish courts have interpreted the phrase "as human persons" in Article 40.1 to recognise a human personality doctrine. In *Quinn's Supermarket v Attorney General*[1197], Kenny J interpreted the equality provision in Article 40.1 as relating to "the characteristics inherent in the idea of human personality".[1198] The fact that the measure being impugned introduced a difference in treatment between traders based on their religion (Kosher butcher shops were permitted to trade in the evenings) was disregarded by Kenny J in favour of the context of the trading activities where no inequality could be identified. The concept here was that,

---

[1192] [1984] IR 525 at 537-538. The court was clearly exercised by the perception of the administration of justice in the courts which in the view of the Chief Justice "would surely suffer".

[1193] [1976] 1 IR 38.

[1194] Doyle points out that the difference in treatment in this case concerned the application of section 3(1) of the Juries Act 1927 to men only, but that Walsh J "did not perceive" any broad or general distinction between the sexes whereas O'Higgins CJ did: O Doyle, *Constitutional Equality Law*, Round Hall, Dublin (2004) at 66.

[1195] O Doyle, *Constitutional Equality Law*, Round Hall, Dublin (2004) at 66.

[1196] The earlier equality jurisprudence employed the term "invidious" to denote the intentionality of the act. This is less commonly used today, arguably a development as an intentional purpose is irrelevant for the indirect discrimination test.

[1197] [1972] IR 1.

[1198] [1972] IR 1 at 31.

unless the difference in treatment impacted on one's inherent being (personality), there could be no inequality.[1199] More satisfactorily, Walsh J in the same case expounded a "basis of discrimination" interpretation to Article 40.1.

> [Article 40.1] is not a guarantee of absolute equality for all citizens in all circumstances but it is a guarantee of equality as human persons and ... is a guarantee related to their dignity as human beings and a guarantee against any inequalities grounded upon an assumption, or indeed a belief, that some individual or individuals or classes of individuals, by reason of their human attributes or their ethnic or racial, social or religious background, are to be treated as the inferior or superior of other individuals in the community.

Here the concept of positive measures to address discrimination was accepted. The enactment by the Oireachtas of a measure which differentiates between groups of persons in the community would not of itself be a violation of the guarantee of equality contained in Article 40.1 insofar as it expressly "allows for the recognition in legislation of differences of capacity, physical and moral, and of social function."[1200]

As noted, in *Re Article 26 The Employment Equality Bill, 1996*[1201], the Supreme Court quoted Walsh J's exposition in *Quinn's Supermarket* with favour and also referred with approval to its judgment in *Tuohy v Courtney*[1202] where Finlay CJ had favoured a deferential approach to reviewing legislation with the role of the court merely to determine whether the "balance" struck in the legislation "is so contrary to reason and fairness as to constitute an unjust attack on some individual's constitutional rights".[1203]

[1199] The Constitutional Review Group recommended deletion of this phrase on the basis that it was not found in the constitutional guarantees in other jurisdictions or under international conventions: *Report of the Constitutional Review Group*, Dublin, Stationery Office (1996) at 197-198.

[1200] [1972] IR 1, Walsh J at 13-14 citing the observations of Finlay CJ in *People (Director of Public Prosecutions) v Quilligan (No.3)* [1993] 2 IR 305 at 321.

[1201] [1997] 2 IR 321.

[1202] [1994] 3 IR 1.

[1203] [1994] 3 IR 1 at 47.

In *Quinn's Supermarket*, Walsh J had asserted that the attributes of ethnic or racial, social or religious background were proscribed discrimination. Leaving aside the requirement that the difference of treatment flows from an assumption or belief of inferiority and the difficulty in proofs which this formulation raises, a discrimination on the basis of one's status or perceived status or attributes ties in well with international non-discrimination tests. The grounds of ethnicity, race or religion are of course classical non-discrimination grounds as set out previously. Whether "social background" may refer to "social" or "socio-eocnomic" status under international law is unknown. Unfortunately, in *Quinn's Supermarket* Walsh J proceeded to conclude there was no inequality present, clouding understanding of the test he had just espoused.

Walsh J's basis of discrimination formulation was invoked by Barrington J in *Brennan v Attorney General*[1204]; however, Barrington J also cited the inferiority assumption/ belief formulation where Article 40.1 would only apply to "human beings in society" where this formulation was present.

In *Re Article 26 of the Constitution and the Employment Equality Bill 1996*[1205] Hamilton CJ, quoting Walsh J in *Quinn's Supermarket* stated that under Article 40.1 a number of forms of discrimination were *prima facie* invalid. Although "not particularised", "classifications based on sex, race, language, religious or political opinions were "presumptively at least, proscribed by Article 40.1".[1206] The court held that provided the *Brennan* criteria were met (namely that "the

---

[1204] [1983] ILRM 449 at 481.

[1205] [1997] 2 IR 321.

[1206] [1997] 2 IR 321. The Supreme Court considered that difference in treatment was clearly permissible under Article 40.1 as otherwise "it would mean that the State could not legislate so as to prevent the exploitation of young people in the work place or, at the other end of the spectrum, to make special provision in the social welfare code for the elderly." The "wide ranging" nature of the qualification which follows the general guarantee of equality "puts beyond doubt" the legitimacy of measures which place individuals in different categories for the purposes of the relevant legislation; at 347. An example of such positive measures was given as introducing or maintaining a special provision in the social welfare code for older persons. This was also the approach taken by the Canadian Supreme Court in *R v Kapp* [2008] 2 SCR 483 where "ameliorative" legislative measures were at issue; discussed below. The Constitutional Review Group recommended that there should be added to Article 40.1 a section enumerating prohibited grounds of discrimination on a wide number of grounds including "other status"; *Report of the Constitutional Review Group*, Dublin, Stationery Office (1996) at 205.

classification is for a legitimate legislative purpose, relevant to that purpose, with each class being treated fairly") the impugned provision would be upheld as constitutionally valid.[1207]

As noted earlier, the nomenclature of difference in treatment corresponds to presumptive discrimination, placing the onus of proof on the respondent of demonstrating that the difference of treatment did not constitute discrimination. The *Employment Equality Bill* case represents a significant advance in interpreting Article 40.1 on a number of levels. Building on Walsh J's formulation in *Quinn's Supermarket*, the court extended the grounds in which presumptive discrimination would occur to include the grounds of sex, language and political opinions - all proscribed grounds under international law. Second, the court adopted reasoning redolent of the Strasbourg Court where it has demanded particularly "weighty" reasons for presumptive discrimination on the grounds of sex or race. The Supreme Court considered that discrimination on the grounds of age "falls into a different constitutional category from distinction on grounds such as sex, or race" where the duties of the individuals concerned (army, police, prison service) were narrowed defined.[1208] This allowed the legislative difference to become more understandable and hence permissible.[1209]

In *JD v The Residential Institutions Redress Review Committee*[1210], O'Neill J found that, insofar as the setting of an age limit is [prima facie] discriminatory, "the burden of proof shifts to the State to justify the reason" for same. In the instant case, it had "not been demonstrated to the satisfaction of this Court that the decision to limit the scheme of redress to persons under eighteen years old had a legitimate legislative purpose".[1211]

[1207] [1997] 2 IR 321 at 349-50.

[1208] [1997] 2 IR 321 at 349.

[1209] [1997] 2 IR 321 at 349.

[1210] [2008] IEHC 350.

[1211] O'Neill J thus declared the definition of "*child* " contained in section 1(1) of the Act of 2002 "as repugnant to the Constitution and order it to be struck down accordingly." At issue in the case were sections 1(1) and 7(1)(b) of the (ameliorative) Residential Institutions Redress Act 2002 which excluded the applicant from the redress scheme where she had just turned 18 years when she entered a Mother and Baby home but where at the relevant time (1968) she was

Interestingly, the *Employment Equality Bill* case is also authority for the proposition that a positive statutory non-discrimination law (which treats equals equally and unequals unequally) permitting individuals to succeed in discrimination cases on the basis of their status (against the nine grounds in the Employment Equality Act 1998 and Equal Status Act 2000) meets constitutional standards insofar as the only parts of the Bill which were struck down were those relating to property rights. On that basis, "positive measure" anti-discrimination right to health legislation would be likely to pass constitutional scrutiny and indeed benefit from the presumption of constitutionality, if introduced.[1212]

In the *Employment Equality Bill* case, the court applied Marshall J's formulation in the US case of *Massachusetts Board of Retirement v Murgia*[1213]. Marshall J's test required the State to show a "reasonably substantial interest" and a scheme "reasonably closely tailored to achieving that interest" – a higher standard than Barrington J's legitimate legislative purpose. It has been suggested that if this is the standard applying to presumptive age discrimination, the standard demanded in difference of treatment cases based on sex or race must be higher.[1214] Further, if this test had been applied in the

---

classified as a child (still a minor "in law when in a residential institution"). O'Neill J cited *de Búrca and Quinn's* in favour of the proposition that "discriminations on certain potentially objectionable grounds require scrutiny before they can be considered to be constitutionally valid" and found that insofar as "classifications based on age … must … be capable of justification on the grounds set out by Barrington J. in Brennan" as espoused by Hamilton CJ in *Re Employment Equality Bill*, with the burden of proof passing to the respondent where such suspect criteria are employed.

[1212] The introduction of such "positive measure" anti-discrimination legislation may need to be transformative if to avoid the pitfalls of judicial restraint in requiring that positive measures be undertaken for vulnerable groups where appropriate: see Charleton J in *Doherty & Doherty v South Dublin County Council* 2 IR [2007] 696 where in relation to whether Section 2 of the Housing Act 1988 required such positive measures for Traveller accomodation, he stated: "I would find it impossible to hold that there is an untrammelled statutory right vested only in members of the Irish traveller community to opt in all and any circumstances for caravan accommodation and to reject bricks and mortar. Such an interpretation would mean that those who are very elderly, very infirm or very ill and who would be unsuited, for that reason alone, to caravan accommodation would be entitled to caravans adapted to their needs; and adapted ever more extremely as their disability grew. Such a right would be in contradistinction to the ordinary adaptations which every member of the community must make as they are stricken by age, infirmity or illness."; at 712.

[1213] 427 US 307 (1976). Hamilton CJ in *Employment Equality Bill* noted that the test adopted by Marshall J is similar to that adopted by Barrington J in *Brennan*; [1997] 2 IR 321 at 347-348.

[1214] O Doyle, *Constitutional Equality Law*, Round Hall, Dublin (2004) at 79.

subsequently decided case of *Lowth*, the State would have been required to produce statistics to demonstrate its difference in treatment between widows and widowers (i.e. based on sex) was justified. The fact that it was not applied casts doubt on whether the *Employment Equality Bill* case was the great leap forward suggested.

However, the subsequent judgment of the Supreme Court in *An Blascaod Mór Teoranta v Commissioners of Public Works*[1215] saw Barrington J again cite Walsh J's basis of discrimination test as well as his own legitimate purpose test from *Brennan*. Barrington J did not employ the "presumptively ... proscribed" test but one of "suspect" legislative criteria which would attract closer scrutiny by the court.

In *SM v Ireland*[1216], Laffoy J held that differences in legislative treatment must be "legitimated by reason of being founded on difference of capacity, whether physical or moral, or difference of social function of men and women in a manner" which was not "invidious, arbitrary and capricious."

That *Employment Equality Bill* and *Great Blasket* suggested a deeper standard of review akin to the European Court's consideration of Article 14, with the onus of justification likely to be reversed, while the proportionality test is deepened[1217] remains an open question in light of three recent cases.

In *MD v Ireland*[1218] Denham CJ held that "strict equality" is the norm laid down by Article 40.1 and that both paragraphs of the provision should be read together.[1219] The court accepted that differences in treatment between categories of people may be mandated, citing pregnancy discrimination

---

[1215] [2000] 1 IR 6.

[1216] [2007] 4 IR 369.

[1217] According to Doyle the doctrinal and rhetorical "underpinning" for the development of the equality guarantee has arguably been the basis of discrimination "interpretation of the human personality phrase" and that the justification for legislation potentially based on such assumptions attracts close scrutiny, primarily through the onus of justification (being placed on the respondent) and through raising the standard of justification": O Doyle, *Constitutional Equality Law*, Round Hall, Dublin (2004) at 80.

[1218] *MD (Minor) v Ireland, AG & DPP* [2012] 2 ILRM 305 at paras 42-44.

[1219] [2012] 2 ILRM 305.

legislation and that accordingly the public policy of protecting teenage girls from pregnancy (arguably a contentious belief) was an objective in the impugned legislation "which the Oireachtas was entitled to regard as relating to 'differences of capacity, physical and moral and of social function'" in Article 40.1.[1220] However, as noted in *Fleming*[1221], the "margin of appreciation permitted to the Oireachtas will be somewhat greater in matters of acute social controversy."[1222]

In *DX v Buttimer*[1223] Hogan J stated that in practical terms, Article 40.1 meant that the courts must ensure "where this is practical and feasible in the circumstances" that litigants suffering a physical disability such as the plaintiff in that case "are not placed at a disadvantage" as compared with their able-bodied opponents by reason of that disability, "so that all litigants are truly held equal before the law in the real sense which the Constitution enjoins."[1224] This suggests that to ensure equality, the State will be obliged to enact positive measures to ensure equality.

In *Fleming,* where the plaintiff claimed an unfair discrimination on the basis of her disability status[1225] the court accepted that the failure of the impugned legislative provision to make separate provision for persons in the plaintiff's position by creating "no exception to take account of the physical disability" which prevented her taking the steps which "the able bodied could take" engaged "the precept of equality in Article 40.1". The plaintiff's disability led to presumptive discrimination and required the State to justify the measures it had taken for the differential treatment and to demonstrate the proportionality of the measures. The court "for all the reasons which we have set out with

---

[1220] [2012] 2 ILRM 305 at paras 54-56.

[1221] *Fleming v Ireland* [2013] IEHC 2.

[1222] [2013] IEHC 2 at para 121.

[1223] [2012] IEHC 175.

[1224] [2012] IEHC 175 at para 14.

[1225] Whereas section 2(1) of the Criminal Justice (Suicide) Act 1993 had abolished the crime of suicide, section 2(2) retained the blanket prohibition on assisted suicide. The plaintiff argued that she was discriminated against on the basis of her disability in not being able to commit suicide (due to her degenerative condition) but needing assistance to do so in circumstances where her partner or a physician assisting wished to remain withint the law.

regard to the Article 40.3.2" considered that this differential treatment was "amply justified by the range of factors bearing on the necessity to safeguard the lives of others which we have already set out at some length" although the classification employed under Article 40.3 of all vulnerable persons was a broad one for non-discrimination purposes. It noted the "profound difference between the law permitting an adult to take their own life on the one hand and sanctioning another to assist that person to that end on the other" and this was so "even if the very disability under which the plaintiff labours is the very reason she needs the assistance of others to accomplish this task."[1226]

The courts seem to be moving towards a justification and proportionality criteria test; however, it appears to also permit significant deference to the legislature and a lack of specificity as to how classifications are formulated. Under Irish equality jurisprudence, it is invariably legislative provisions which are at issue.

Similar considerations may be observed in other jurisdictions. As noted above, the South African Constitutional Court's judgment in *Grootboom*[1227] is an example of a court balancing the common good against the individual interests at stake in the case where the court recognised that the South African Constitution "expressly provides that the state is not obliged to go beyond available resources or to realise these rights immediately."[1228]

In *Ashoka Kumar Thakur v Union of India*[1229], the Indian Supreme Court suggested that *de facto* inequalities in society "are to be taken into account" in considering the constitutionality of positive measures which sought either to give preference to "socially and economically disadvantaged persons" or to "inflict[] handicaps on those more advantageously placed" in order to bring about real equality".[1230]

[1226] 10 January 2013, unreported, at para 121.

[1227] (CCT11/00) [2000] ZACC 19; 2001 (1) SA 46; 2000 (11) BCLR 1169 (4 October 2000).

[1228] (2000) 11 BCLR 1169 at para 94 per Yacoob J.

[1229] (2008) 6 SCC 1.

[1230] (2008) 6 SCC 1 at para 41.

In *R v Kapp*[1231], the Supreme Court of Canada considered the application of the equality guarantee under section 15 of the Canadian Charter on Rights and Freedoms having regard to an impugned legislative provision which sought to ameliorate aboriginal rights. Having considered that the appellants had demonstrated that they were impacted on the basis of their status (race), the court considered whether the "law, program or activity" in question had as its object the amelioration of conditions of disadvantaged individuals or groups", requiring a justification from the State.[1232] However, where the measure is clearly ameliorative, this would satisfy the proportionality test.[1233]

Similarly, the judgment of the High Court in *BG*[1234] suggests that where a *prima facie* difference in treatment arises on the basis of a person's attributes, a violation of Article 40.1 will be found where the State does not advance meaningful arguments seeking to justify the measure in question. The benefit of this approach is that it can avoid separation of powers deference: the court is not adjudicating upon public policy defences advanced by the State, it simply asserts that in the absence of meaningful defence, the presumptive finding of discrimination becomes formalised. This, it is suggested, corresponds to international standards where a difference in treatment on the grounds of one's status requires justification if it is not to be classified as discrimination; freedom from discrimination which, in relation to the right to health, it will be recalled, is a core non-derogable right. The difference between legislative intent and omission can also be observed: the courts have to date been reluctant to focus its jurisprudence primarily on the individual rather than on the actor, affording deference concerns greater weight. The difficulty arises where what is being contended is not unlawful State interference (i.e. oppressive State action) in one's personal rights as was evident in *Carmody* and *BG*[1235] where

---

[1231] [2008] 2 SCR 483.

[1232] [2008] 2 SCR 483, at paras 29-30.

[1233] A programme would not violate the section 15 equality guarantee "if the government can demonstrate that: (1) the program has an ameliorative or remedial purpose; and (2) the program targets a disadvantaged group identified by the enumerated or analogous grounds"; at para 41.

[1234] Unreported, 8 December 2011, per Hogan J.

[1235] See also the similar case of State intrusion on constitutional rights in *McCann v Judges of Monaghan District Court & Ors* [2009] IEHC 276 where Laffoy J struck down Section 6 of

injunctive or declaratory relief restraining such action may vindicate the applicant's rights, but rather State inaction under the "obligation to fulfil", where the State's failure to take positive action to secure a right to health care is at issue. The courts have been slow to move beyond equality jurisprudence addressing legislative principles (whether acts or omissions), common law rules and acts of the executive to the sphere of the State's positive obligations which suggests that the right of access to the AAAQs without discrimination is not yet identified as a justiciable constitutional value.

Is there a horizontal right to equality? Apart from the legislative omissions cases identified above, there is some doubt over whether the courts can address executive inaction under the obligations to "protect" and "fulfil". The closest consideration of horizontal application of Article 40.1 to the right to health is arguably the *Re Employment Equality Bill* case which permits horizontality on a statutory basis including, as noted in some health-related cases.[1236] Otherwise, as was stated in relation to Article 40.3, it cannot be stated with confidence that Article 40.1 respects the right of access to the AAAQs insofar as there is limited reparations accountability where a violation of the right to health occurs. A legislative control theory which introduces horizontal equality law is permitted and is indeed arguably required, and has been enacted in the form of the Employment Equality Acts 1998-2011 and Equal Status Acts 2000-2012 (discussed above). As noted above, a case can also be made for a unified Health Act permitting horizontal justiciabilty under the "respect, protect and fulfil" typology requirements of the right to health, without the limitations found under the Equal Status Acts. Over and above this, as we will consider, a number of cases dealing with Article 40.3 and rights in tort suggest that there may be scope for developing a horizontal dimension to the equality guarantee. The Constitutional Review Group noting the underdevelopment of jurisprudence in this area, drew on the US authorities of *Burton v Wilmington Parking Authority*[1237] and *Moose Lodge v Irvis*[1238] in which the US Supreme

---

the Enforcement of Court Orders Acts 1926 and 1940 as being invalid having regard to the provisions of Article 34, Article 40.3 and Article 40.4.1 of the Constitutio; discussed above.

[1236] See discussion under the Equal Status Acts 2000-2012 above.

[1237] 365 US 715 (1961) per Clarke J.

Court held that even indirect State involvement in an activity would attract the application of the equal protection doctrine under the 14th Amendment. This led the Review Group to argue that "persons deriving their authority from statute or otherwise exercising public law functions probably constitute the State for the purposes of Article 40.1."[1239] Although the Review Group recommended that there should be "no enforceable constitutional obligation on the State to ensure respect for equality by persons or bodies other than the State and public bodies[1240] it is clearly that it envisaged a broad interpretation of the term "public bodies" to include "persons ... exercising public law functions" as currently subject to the guarantees of Article 40.1.

It will be observed that there remains some distance between the right of access to the AAAQs without discrimination and the equality guarantee under Article 40.1 which to date has only governed State acts rather than omissions (and even then only slowly out of judicial deference to the legislature). Nonetheless, some developments may be discerned. Positive measures to address discrimination are accepted. Differential treatment on grounds such as sex, race, language, religious or political opinions are presumptively proscribed and will require significant justification. Importantly, a violation of Article 40.1 will be found where the State does not advance meaningful arguments seeking to justify the measure in question, importing a justification and proportionality criteria test, notwithstanding difficulties which would arguably arise in identifying an appropriate comparator in cases of health privatisation.

As importantly, the equality guarantee is viewed as having high constitutional value and as such its continued development in tandem with international standards is likely. For the purposes of this thesis, it cannot be gainsaid that the courts will need to modify judicial deference if Article 40.1 is to exercise part of a constitutional control theory where privatisation of public functions

---

[1238] 407 US 163 (1972).

[1239] *Report of the Constitutional Review Group*, Dublin, Stationery Office (1996) at 199-200.

[1240] *Report of the Constitutional Review Group*, Dublin, Stationery Office (1996) at 200. The reasons against an explicit obligation on private bodies included that it would be an unjustified intrusion upon individual autonomy; it could conflict with other rights (such as freedom of expression and of association) and that it may be contrary to the separation of powers to require State action to ensure equality in private relations; at 201.

continues to impact on constitutional rights. Even then there is no guarantee that risks to equality would not continue where, subsequent to a successful suit, a legislative or executive "levelling down" of the equality outcome could be pursued, however, this is a general difficulty which equality law faces, premised as it is on seeking equality between comparator groups.

13 A horizontal constitutional right to health?

As under international law standards, public health hazards have been identified as actionable under the Irish Constitution even where the hazard occurs at the hands of a private individual. On one level this is unremarkable: health and safety legislation often proscribe privately-originating public health hazards such as asbestos.[1241] The significance, rather, is that the courts have implied an unenumerated right to bodily integrity as encompassing the right to health and have found that the right is enforceable against both the State and private actors, releasing the courts from the constitutional restrictions faced in other jursdictions and allowing it to fully meet its international obligations where health is privatised.

In *Hanrahan v Merck Sharp and Dohme*[1242], the plaintiff claimed a right to bodily integrity under Article 40.3 where a neighbouring factory was emitting noxious fumes; the claim being that this violated his right to bodily integrity. The plaintiff sued in nuisance and argued that the right to bodily integrity meant that the onus of proof, ordinarily required to be discharged by the plaintiff in such cases, should be relaxed as a consequence. As noted, the interesting point here is that the plaintiff's claim was not against the State but against a private body. *Hanrahan* followed the previous Supreme Court judgment in *Meskell v CIE*[1243] where the court had held that the constitutional right to associate (join a trade union) implied a right to disassociate and not to join a trade union. The right was also enforceable against a private actor. As Walsh J famously stated in *Meskell*:

> A right guaranteed by the Constitution or granted by the Constitution can be protected by action or enforced by action even though such action may not fit into any of the ordinary forms of action in either common law or equity and ... the constitutional right carried within it its own right to a remedy for the enforcement of it. Therefore if a person has suffered damage by virtue of a

---

[1241] See for example section 22 of the Safety, Health & Welfare at Work Act 2005 and associated 2010 regulations.

[1242] [1998] ILRM 629.

[1243] [1973] IR 121.

> breach of a constitutional right, that person is entitled to seek redress against the person or persons who have infringed that right.[1244]

In *Meskell* the Supreme Court had built on the earlier jurisprudence of *Burke and O'Reilly v Burke and Quail*[1245], *In re Blake Deceased*[1246] and *Educational Co of Ireland v Fitzpatrick (No 1)*[1247] in which O'Dálaigh CJ referred to the "correlative duty" on others to abstain from interfering with constitutional rights.[1248] This introduced into Irish law what has been described as "the doctrine of horizontality"[1249] i.e. a constitutional right could be invoked against a private body rather than against the State (the more traditional doctrine of verticality). However, to exercise *Meskell* rights, a person claiming a right to health had been violated by a private body would first have to demonstrate that such a right existed under Article 40.3. The difficulty in having this adjudicated upon was demonstrated in *Hanrahan.*

There are two forms of "horizontality" identified in the literature. "Direct horizontality" refers to the situation where constitutional rights may be enforced against both State and non-State actors. Walsh J addressed direct horizontality in *Byrne v Ireland*[1250] in stating that where the People by the Constitution "create rights against the State or impose duties upon the State", a remedy to enforce these must be deemed to be also available. It is "as much the duty of the State to render justice against itself in favour of citizens as it is to administer the same between private individuals".[1251] Prior to *Hanrahan*, the Irish courts had only referred to direct horizontality in *Byrne* and in *Meskell.*

[1244] [1973] IR 121 at 132-133.

[1245] [1951] IR 216.

[1246] [1955] IR 89.

[1247] [1961] IR 323.

[1248] [1961] IR 323 at 344. See also Budd J in *Educational Co of Ireland v Fitzpatrick (No 2)* [1961] IR 345 at 361. See also *Byrne v Ireland* [1972] IR 241 at 279-281 per Walsh J.

[1249] S Banda, *Taking Indirect Horizontality Seriously in Ireland: A Time to Magnify the Nuance* 31 Dublin University Law Journal (2009) 263 at 266-267. Horizontality can be direct or indirect: see below.

[1250] [1972] IR 241 at 263.

[1251] [1972] IR 241 at 281.

The second form of horizontality is that of "indirect horizontality" where a constitutional right "attaches to a different right or obligation found in the common law", so that for example the law of torts may uphold the constitutional right in question.[1252] Accessible justiciable horizontality may allow the State to discharge its reparations obligation under the right to health obligation "to protect".

In the wake of *Meskell*, a question arose as to whether the decision meant that nominate torts would be replaced with an innominate claim for breach of rights.[1253] This is because *Meskell* may have arrived as a surprising philosophical intrusion to Irish law:

> The idea that [undeveloped] tort law should be regarded as a judicial instrument for the vindication of constitutional rights was one that simply had not occurred to almost any Irish lawyer. Meskell forced judges to construct a new theory requiring jurisprudential depth and subtlety of an unprecedented kind.[1254]

However, the courts chose not to elaborate a new direction. Tort law was not to be replaced by a new remedy, or set of remedies, expressed exclusively in constitutional terms. Rather a "more modest, but complicated, outcome was envisaged".[1255] The modest, complicated and indeed minimalist outcome was set out in *Hanrahan*.

[1252] S Banda, *Taking Indirect Horizontality Seriously in Ireland: A Time to Magnify the Nuance* 31 Dublin University Law Journal (2009) 263 who cites the South African case of *Du Plessis v De Klerk* 1996 (3) SA 850 (CC); 1996 (5) BCLR 658 (CC) insofar as private disputes taken to court on causes of action under private law were nonetheless subject to the principles and rules of the Constitution including the normative principles and values of rights embodied in the Constitution; at 265- 267.

[1253] Heuston citing *Paul v Davis* 421 US 909 (1975) where the US Supreme Court held that the 14th Amendment to the US Constitution did not superimpose "a font of tort law" over libel law; R F V Heuston, *Personal Rights under the Irish Constitution*, 11 Irish Jurist (1976) 205 at 222. See also J Goldberg, B Zipursky, *Torts, the Oxford Introduction to US Law*, Oxford University Press (2010) at 397-398.

[1254] W Binchy, *Meskell, the Constitution and Tort Law* 18 Dublin University Law Journal (2011) 339 at 349. Binchy excepts the "prophetic voice" of J T Lang in *Private Law Aspects of the Irish Constitution*, 6 Irish Jurist (1971) 237 at 244-247; ibid at 349.

[1255] W Binchy, *Meskell, the Constitution and Tort Law* 18 Dublin University Law Journal (2011) 339 at 341-343.

The reluctance by the courts to engage in any close examination of the values attaching to either the right to bodily integrity or indeed to the values underpinning the tort in question to identify whether it could meet the "effective" test identified in *Hanrahan* (discussed below) was not inevitable. Indeed much of the substantial corpus of contemporary tort law was created by the courts with minimal legislative reforms. It is only recently that common law jurisdictions have begun to increasingly codify the law of tort.[1256] Even then, the rules of evidence and of procedure will usually remain in the province of the courts.[1257]

Indirect horizontality was at issue in *Hanrahan* where the question before the court was whether the tort of nuisance was "plainly inadequate" or "basically ineffective" to effectuate the constitutional guarantee of the right to bodily integrity. Relying on the tort of nuisance, the plaintiff argued that the courts should allow for a reversal of the burden of proof (i.e. a change to the rules of procedure) to vindicate his right under Article 40.3. In dismissing this claim, Henchy J held that the plaintiff had the choice of suing in negligence and availing of the tort doctrine of *res ipsa loquitur* (discussed below) and that in any event any change to the burden of proof under nuisance would prejudice the defendant during the exchange of pleadings. Henchy J stated that the application of the doctrine of *res ipsa loquitur* demonstrated that the vindication of the constitutional right in question (as required under Article 40.3.2) was capable of discharge under the tort of negligence rather than through requiring a "constitutional" re-reading of the rules on tort.

This statement is important for two reasons: first there was no repudiation of the plaintiff's argument that his right to health fell to be protected under Article 40.3. Rather it was how that right fell to be protected - that is under which tort - which was decisive.[1258] Simply put, the plaintiff argued the wrong tort and the

---

[1256] See for example the Defamation Act 2009.

[1257] An exception is statutory time limits, for example under the Statute of Limitations Act 1957 (as amended) and the Civil Liability and Courts Act 2004.

[1258] Of course a deeper question is whether the tort of negligence, if pled, would have been an effective remedy. This is the question currently before the Grand Chamber of the European Court of Human Rights in *O'Keefe v Ireland* (Application No. 35810/09). See submissions of the Irish Human Rights Commission at *www.ihrc.ie/enquiriesandlegal/thirdpartyinter/html* accessed on 21 October 2012.

court only dealt with the arguments put before it. The Supreme Court was only asked to change a procedural rule in *Hanrahan* rather than to carry out wholesale change to the law of torts and arguably did not deal with wider issues.

Commentators differ on whether there is evidence of indirect horizontal effect being incorporated into the evolution of private law remedies post-*Hanrahan*.[1259] The judgments of Costello P in *W v Ireland (No. 2)*[1260] and Finlay CJ in *L v L*[1261], both pre-*Hanrahan* suggested that the Irish courts had not considered indirect horizontality prior to that case. Henchy J, it will be recalled, employed the term "plainly inadequate" in addition to "failure to implement" when signalling the point at which the courts will intervene. The concept of a "plainly inadequate" common law remedy and the related concept of a "basically ineffective" tort to protect a constitutional right arguably differs from the direct horizontality term of "failure to implement" which was also employed by Henchy J.[1262] However, the court's reference to the implementation of constitutional rights as being "primarily a matter for the State" could be interpreted as merely authority for the proposition of judicial unwillingness to intervene where there is an established private law framework.

13.1 Presumption that constitutional rights can be vindicated through the law of tort

Is it legitimate to ask why the plaintiff in *Hanrahan* should not have been required to exhaust the options available to him in negligence before claiming indirect horizontality by suing in nuisance and requesting that the courts

---

[1259] O'Cinneide suggests that the Irish courts have showed greater caution in applying constitutional rights in the private sphere where existing law clearly regulates a matter within the scope of application of a constitutional right; C O'Cinneide, *Irish Constitutional Law and Direct Horizontal Effect - A Successful Experiment?* 213, in D Oliver and J Fedke eds, *Human Rights in the Private Sphere, A Comparative Study*, Routledge-Cavendish, 236 (2007).

[1260] [1997] 2 IR 132.

[1261] [1992] 2 IR 77 at 107.

[1262] [1998] ILRM 629 at para 24.

refashion that tort? After all, the constitutional doctrine of taking constitutional issues last directs that other remedies be exhausted before recourse to the constitutional right. However, in response to the above, one may ask whether the constitutional right to bodily integrity can be effectively vindicated as required under Article 40.3.2 if the courts are reluctant or unable to grapple with the substance of the right at issue due to procedural hurdles. It was arguably this sense of otherwise injustice which led the Supreme Court in *Kearney v McQuillan & North Eastern Health Board*[1263] to allow the pleadings to be amended and avoid being statute-barred once no injustice to the defendant could be shown.[1264]

Further, a substantive question arises as to whether the right to health can be effectively vindicated through the prism of the law of tort. The difficulties with suing in tort for right of health claims will be discussed further below, but it is far from clear that the plaintiff would have been successful in *Hanrahan*, had he sued in negligence. The dichotomy is that while the Constitution speaks largely a language of rights, "the lexicon of tort law is that of duties", notwithstanding the fact that "the courts have told us that there is a very important relationship between the Constitution and tort law".[1265] The interaction between constitutional rights and the pre-existing common law tort of negligence requires examination before one can form a view as its effectiveness.

The law of torts was viewed by the courts "as the obvious instrument for the righting of civil wrongs when the Constitution was enacted in 1937."[1266] However, whereas tort law may restore the normative equilibrium suggested by Aristotle where it provides redress for the victim of a tortfeasor, this is not guaranteed, as we shall observe in Part 3 of this thesis insofar as "the courts in tort law do not stand ready to facilitate the rectification of wrongdoing, or to

---

[1263] [2012] IEHC 127.

[1264] As noted, the application of the principles set out in *Dunne v National Maternity Hospital* [1989] IR 91 be applied to the situation pertaining at the time of the symphysiotomy in 1969.

[1265] W Binchy, *Meskell, the Constitution and Tort Law* 18 Dublin University Law Journal (2011) 339 at 339.

[1266] *McDonnell v Ireland* [1998] 1 IR 134 at 157 per Keane J.

restore a normative equilibrium".[1267] Although the norms of tort law, in specifying what is a wrong and the corollary "duties we have not to mistreat each other are public norms of conduct", suggest tort as "a hybrid or private and public law",[1268] on the face of it, the neutral role played by courts under tort law and the limited success of plaintiffs (see Part 3) modify Henchy J's presumption of tort law *qua* constitutional law in *Hanrahan*. However, following *Hanrahan*, it appears that a direct or parallel claim for breach of constitutional rights will only be entertained "in the absence" of a cause of action in tort (per Henchy J).

This reasoning does not explain why the courts' approach to the right to privacy was not restricted to consideration of whether "the torts of trespass to the person, goods and land, nuisance, negligence, malicious falsehood and breach of statutory duty, when taken together [would] give substantial protection to the right to privacy" rather than engaging in consideration of the constitutional tort.[1269] The fact that those torts were never designed to address the type of illegal phone tapping as occurred in *Kennedy and Arnold and Arnold v Ireland*[1270] demonstrates the limitations of tort to vindicating

---

[1267] Rather, tort law provides individuals with the ability to bring claims against the tortfeasor but ultimately it is the courts which adjudicate on the basis of the causation rules of medical negligence they have developed. This is because tort law is essentially private law, affording a means or entitlement for individuals to act, but not to be remedied; B Zipursky, *Civil Recourse, Not Corrective Justice*, 91 Georgetown Law Journal (2003) 695 at 755. Weinrib suggests that Aristotle presents corrective justice as a "transactional equality" but that such justice "remains opaque to the extent that the equality that lies at its heart remains opaque"; E J Weinrib, Corrective Justice, 77 Iowa Law Review (1992) 403 at 404. In attempting to illuminate this equality, the author employs the theories of Kant and Hegel to argue that the equality of corrective justice is the abstract equality of free purposive beings under the Kantian concept of right and the Hegelian abstract right. On this interpretation, the bipolar structure of corrective justice represents a regime of correlative right and duty, "with the disturbance of equality in Aristotle's account being the defendant's wrongful infringement of the plaintiff's rights." Aristotle's account of corrective justice in this way "coalesces with the great modern philosophies of a natural right in a single approach to the understanding of private law"; ibid. The "bipolar structure of correlative doer and sufferer is observed "; ibid, at 424. The author also argues that the Kantian principle "that the action of one party should be consistent with the freedom of another is satisfied when the action of one party does not violate a duty, the freedom of the other manifests itself in a right, and free will grounds both the right and the duty and connects one to the other"; E J Weinrib, *The Gains and Losses of Corrective Justice*, 44 Duke Law Journal (1994) 277 at 291.

[1268] B Zipursky, *Civil Recourse, Not Corrective Justice*, 91 Georgetown Law Journal (2003) 695 at 755.

[1269] W Binchy, *Meskell, the Constitution and Tort Law* 18 Dublin University Law Journal (2011) 339 at 355.

[1270] [1987] IR 587.

individual rights, when one considers how the courts were content to fashion a constitutional tort despite the fact that theoretical tortious remedies may have existed. In *Walsh v Ireland*[1271] the Supreme Court was content to find a constitutional breach of the plaintiff's right to personal liberty despite the availability of a number of torts for unlawful arrest, false imprisonment and negligence. Similarly, in *Shortt v Commissioner of An Garda Síochána, Ireland and Attorney General*[1272] the Supreme Court was again content to consider the constitutional claim for damages without regard to the existing torts. Accordingly, the approach of the courts to whether a matter falls within or without the "torts repertoire" may be a matter of "intuition (or oversight) rather than jurisprudential analysis".[1273] In the light of such inconsistencies, the requirement (and reluctance) to judge torts as "basically ineffective" for a constitutional tort to be considered is questionable.

Despite one strict liability case, claims of health-related injury appear to fall squarely within the tort of negligence.[1274] Barron J in *Sweeney v Duggan*[1275] summarily rejected a constitutional claim to bodily integrity in the occupational health context. Article 40.3.2, in the High Court's view, provided the plaintiff with "no more than a guarantee of a just law of negligence, which in the circumstances exists".[1276] In *McDonnell v Ireland,*[1277] Barrington J stated that if the general law provides "an adequate cause of action to vindicate a

---

[1271] Unreported, 30 November 1994.

[1272] [2007] 4 IR 587.

[1273] W Binchy, *Meskell, the Constitution and Tort Law* 18 Dublin University Law Journal (2011) 339 at 356.

[1274] A strict liability constitutional tort was employed in *Walsh v Family Planning Services* [1992] 1 IR 496 where MacKenzie J awarded damages for injury caused by a vasectomy carried out without negligence, holding that his right to bodily integrity had been violated and that consequently damages would be awarded for breach of constitutional rights. On appeal, the Supreme Court considered the matter under medical negligence principles and were mostly silent on the constitutional right although McCarthy J, dissenting, was of the view that the matter should not be elevated to constitutional law; at 522: discussed above.

[1275] [1997] 2 ILRM 211 affirming [1991] 2 IR 274.

[1276] [1991] 2 IR 274, affirmed by the Supreme Court at [1997] 2 ILRM 211 per Murphy J.

[1277] [1998] 1 IR 134. At issue was whether the constitutional right to a good name was actionable under the constitution or the tort of defamation. The court held that the tort must be actioned and that in doing so, one must confine oneself to the legal contours of that cause of action, here the procedural time limitation period under the Statute of Limitations Act 1957.

constitutional right it appears to me that the injured party cannot ask the court to devise a new and different cause of action."[1278]

In *W v Ireland (No. 2)*[1279] Costello P had invoked both *Hanrahan* and *Sweeney* to find that once a tort is not "ineffective" the courts should not fashion a new remedy. The existence of "a large body of law (both common law and statutory), which regulates its exercise, protects it against infringement and compensates its holder should the right be breached" would suffice.[1280] Again the formulation is a double negative - the courts are not seeking to identify whether the tort is "effective" but rather whether it is not "ineffective", an arguably impossible standard.[1281] Its mere existence may suffice. This contrasts with the position under international law where vindication of a right must be "effective" if it is not to breach the right to an effective remedy, for example under Article 13 of the ECHR, Articles 2 of the ICCPR and ICESCR, evident in the European Court judgments in *McFarlane v Ireland*[1282] and *A, B and C v Ireland.*[1283]

Costello P's willingness in *W* to address first the negligence claim and then the constitutional claim may not be without significance, yet there is little concrete evidence in the jurisprudence to date as to how this will occur.[1284] *Walsh v Family Planning Services*[1285], despite the Supreme Court silence on a

---

[1278] [1998] 1 IR 134 at 148.

[1279] [1997] 2 IR 141.

[1280] [1997] 2 IR 141 at 166-167.

[1281] See W Binchy, *Meskell, the Constitution and Tort Law* 18 Dublin University Law Journal (2011) 339 at 355-356.

[1282] Application No 31333/06, Judgment of 10 September 2010, discussed above.

[1283] Application No 25579/05, Judgment of 16 December 2010, discussed above. In both these cases, the European Court found that theoretical constitutional remedies were insufficient to meet ECHR requirements.

[1284] The difficulty with Costello P's distinction between constitutional "fundamental rights" (already protected under tort law) and those which were not protected is that the law of torts cannot be taken to necessarily protect every human right: see W Binchy, *Meskell, the Constitution and Tort Law* 18 Dublin University Law Journal (2011) 339 at 357. Extension of common law principles to encapsulate rights has occurred (*McKinley v Minister for Defence* [1992] 2 IR 333 on gender discrimination and a strict liability test in *Walsh v Family Planning Services*[1992] 1 IR 496, to vindicate bodily integrity) but the jurisprudence is patchy.

[1285] [1992] 1 IR 496.

constitutional tort, nonetheless raises an interesting question. Why should such cases not be considered under the constitutional right, at least in parallel to a claim in tort? Further, would the test for infringement of the right to bodily integrity be one of strict liability per *Walsh* or rather conduct more akin to the standard test for breach of duty of care under tort? If under tort, why should the traditional causation test under tort not apply (see below). In Part 3 of this thesis we consider the law of tort's requirements of causation and its "all-or-nothing" approach to proving liability. Where these requirements prove insurmountable, is it possible to pursue a right to health claim concurrently? After all, in *In re a Ward of Court,* Denham J had observed that "[i]f medical treatment is given without consent it may be trespass against the person in civil law, a battery in criminal law, and a breach of the individual's constitutional rights".[1286]

There has been little judicial analysis apart from the judgments of *P.H. v John Murphy & Sons Ltd*[1287] and *An Blascaod Mór Teoranta v Commissioners of Public Works*[1288] wherein the courts tended to favour a pragmatic approach. The courts have been clearer in terms of how compensation should apply, using applicable tort principles and stating that where a constitutional right is infringed they will be more likely to award exemplary damages.[1289] Walsh J in *Meskell,* it will be recalled, confirmed that a person who suffers damage on account of a breach of a constitutional right "is entitled to seek redress against the person or persons who have infringed that right".[1290] The concept of *ex post*

[1286] [1996] 2 IR 79 at 156. However, in *Fitzpatrick & Ryan v FK* [2008] IEHC 104, both Abbott J (on the *ex parte* application) and Laffoy J on the hearing held that consent could be overridden and that the non-consensual life-saving blood transfusion by the hospital to a Jehovah's Witnesss member and recent mother was justified. Abbott J in a paternalistic *ex tempore* judgment appears to have inferred the patient to have been both capable and competent when articulating her refusal to consent to treatment but still granted the orders in the belief that Irish law supported a compulsory intervention in the case: see J Healy, *Medical Malpractice Law* Roundhall Press (2009) at 838-839. The proceedings were pursued and Laffoy J gave judgment after 37 days of evidence and submissions focusing on misrepresentation of facts by the patient and her belief that the patient was incompetent at the relevant time.

[1287] [1987] IR 621.

[1288] [2000] 1 IR 6.

[1289] W Binchy, *Meskell, the Constitution and Tort Law* 18 Dublin University Law Journal (2011) 339 at 362-363 citing *Conway v Irish National Teachers Organisation* [1991] 2 IR 305.

[1290] [1973] IR 121 at 132-333.

facto redress is clearly set out as a core aspect of the constitutional right to be protected under Article 40.3.2.[1291] Indeed, in jurisdictions such as Germany, South Africa and Canada, the courts have reshaped common law "delictual principles" in order to vindicate constitutional rights, suggesting a hybrid between private and public law values and justiciability.

Closer to home, in two pre-*McFarlane v Ireland* cases, the House of Lords refused to modify the tort of negligence in *Smith v Chief Constable of Sussex*[1292] to accommodate Article 3 ECHR jurisprudence on the positive measures required by States to address omissions in investigations of child abuse. However, the House of Lords in *Savage v South Essex Partnership NHS Trust*[1293] and Supreme Court in *Rabone and another (Appellants) v Pennine Care NHS Foundation Trust (Respondent)*[1294] sidestepped this by accepting that there was a (parallel) procedural obligation under Article 2 of the ECHR to prevent suicide where hospital authorities "knew or ought to have known" of this, aligning these standards with institutional negligence standards.[1295]

13.2 Is there a doctrine of horizontality under Article 40.3?

Henchy J's comments in *Hanrahan* nonetheless raise doubt about the efficacy of a doctrine of horizontality under Article 40.3 insofar as he stressed that the "implementation of those constitutional rights is primarily a matter for the State". Did Henchy J exclude the courts from this reference to the State? This would appear to be the case with the effect of *Hanrahan* being that the courts should leave matters for the legislature from an "exclusive" competence

---

[1291] In response to the courts' deference to the Legislature, Binchy asks rhetorically whether, in light of the presumptive role of the law of torts in vindicating constitutional rights, whether *Meskell* would permit the Oireachtas in abolishing in part some or all tort law relating to personal injuries; W Binchy, *Meskell, the Constitution and Tort Law* 18 Dublin University Law Journal (2011) 339 at 356.

[1292] [2008] 3 All ER 977.

[1293] [2009] 1 AC 681.

[1294] 8 February 2012, unreported.

[1295] In *Savage*, Baroness Hale held that the trigger was a "real and immediate risk to life" about which the authorities knew or ought to have known at the time; [2009] 1 AC 681 at 717-719.

viewpoint, a contention reinforced by Barrington J's comments in *McDonnell v Ireland*[1296] to the effect that balancing of constitutional rights was primarily a matter for the Legislature.[1297] In fact there has otherwise been concern at the "absence of normative unity and coherence" in the post-*Meskell* judgments to date.[1298]

This has consequences for a plaintiff "unfortunate enough" to be classed as falling within the "torts repertoire" insofar as s/he must either succeed in tort or where this impossible, for example due to the rules on causation (see below), must persuade the court that the tort in question should be "stigmatised as 'basically ineffective'" under the *Hanrahan* test.[1299]

There is little doubt that casting constitutional rights as ordinarily coming under the prism of tort law presents a ready means by which the courts can maintain their attachment to common law precedent (with the attendant benefits deriving from the jurisprudence of other common law jurisdictions) but in certain cases address the "injustice" which may arise where the repertoire of tort law clearly does not vindicate constitutional rights.

The results are uneven. In 1957 the legislature enacted the Statute of Limitations Act which set timeframes in which a claim in negligence should be taken. This was to provide certainty for defendants and indeed the courts in adjudicating upon historic claims. As noted above, the Statute of Limitations Act 1957 was invoked to defeat the right to health claim in *Cahill v Sutton*[1300] on the basis that the plaintiff was out of time. Similarly, in *McDonnell v Ireland*[1301] the Supreme Court characterised a historic claim for breach of

---

[1296] [1998] 1 IR 134.

[1297] [1998] 1 IR 134. Barrington J stated that balancing constitutional rights is "in the first instance" a matter for the legislature"; at 147.

[1298] W Binchy, *Constitutional Remedies and the Law of Torts*, in J O'Reilly (ed.), *Human Rights and Constitutional Law* RoundHall (1992) at 201.

[1299] W Binchy, *Meskell, the Constitution and Tort Law* 18 Dublin University Law Journal (2011) 339 at 356-357. See also the House of Lords judgment *in Smith v Chief Constable of Sussex* [2008] 3 All ER 977 where Lord Hope held that both common law and ECHR (Article 2) remedies should stand side by side as alternative remedies; at para 82.

[1300] [1980] IR 269.

[1301] [1998] 1 IR 134.

constitutional rights as a claim in tort which fell foul of the Statute of Limitations. However, insofar as the legislature in 1957 could not have foreseen the Supreme Court's judgment in *Meskell* in 1973, the plaintiff in *McDonnell* had no constitutional claim against a private actor prior to *Meskell*. The later decision in *Devlin v Roche*[1302] suggests an unequal approach insofar as the court here characterised the action of intentional trespass as not coming within the scope of the Statute of Limitations (Amendment) Act 1991; the consequence being that for intentional infringement of the constitutional right to bodily integrity which can be dealt with under the tort of trespass there is a 6 year time-limit for bringing suit, whereas an unintentional infringement of the same right not characterised as a tort may attract the shorter 2 year time limit which arises in "breach of duty" litigation.[1303] In *Kearney v McQuillan & North Eastern Health Board*[1304] which concerned an undisclosed symphysiotomy of the plaintiff in 1969 only discovered in 2002, Ryan J, observed how "[i]t is disturbing to consider how close this victim of grave medical malpractice came to being sacrificed on the altar of fair procedures. The case is a salutary proof of the balance that must exist between legal rights and protections in the interest of justice".[1305] The case could only proceed on the basis of the application of the principles set out in *Dunne v National Maternity Hospital*[1306] to the situation pertaining at the date of the injury in 1969 and relied on the claim being reformulated.

[1302] [2002] 2 IR 360.

[1303] W Binchy, *Meskell, the Constitution and Tort Law* 18 Dublin University Law Journal (2011) 339 at 359.

[1304] [2012] IEHC 127.

[1305] [2012] IEHC 127 at para 84. The plaintiff learned she had a symphysiotomy in 1969 in 2002 and failed in the High Court under the Statute of Limitations. As noted, on appeal to the Supreme Court, it was only when her counsel reformulated her claim to remove any "prejudice to the Defendants" that the appeal was allowed. This was on the basis that the plaintiff could be defeated if the first defendant could establish any circumstances prevailing in 1969 which would have justified carrying out a symphsiotomy. This allowed the court to be satisfied that the first defendant could avail of the defence suggested by the second of the principles laid down by Finlay CJ, in [*Dunne v National Maternity Hospital* [1989] IR 91] (namely that no medical practitioner of like specialisation and skill would have acted in that way); at para 14.

[1306] [1989] IR 91.

Under the Civil Liability and Courts Act 2004[1307], the time limits for bringing (medical) negligence proceedings is now 2 years, in contradistinction to other personal injuries claims brought under the provisions of the Personal Injuries Assessment Board Act 2003 where longer periods may apply.[1308]

In horizontal doctrine cases what is at issue is private law and its defences rather than public law (i.e. legislation) and the courts "can therefore be expected to cast a watchful eye on the common law to ensure that it comports with constitutional provisions".[1309] Finlay CJ in *L v L*[1310] stated that the courts should only identify "a brand new right and to secure it to the plaintiff" where there is "something clearly and unambiguously warranted by the Constitution or made necessary for the protection of either a specified or unspecified right under it" as otherwise it would "constitute legislation and be a usurpation by the courts of the function of the legislature".[1311]

Identifying that something is clearly "warranted" or "made necessary" is of course a subjective matter for the courts. These terms are redolent of Henchy J's reference to "plainly inadequate" and "basically inadequate" in *Hanrahan* as a condition precedent for the operation of direct horizontality. However Henchy J may have entrenched direct horizontality in constitutional jurisprudence by distinguishing between a failure to implement constitutional requirements (which refers to direct horizontality - the person can sue directly for breach of constitutional rights, per *Meskell*) and his "plainly inadequate"

[1307] See section 7 of the 2004 Act.

[1308] Section 8 of the 2004 Act requires a plaintiff to serve notice of the nature of the wrong alleged within 2 months of its occurrence, if the court is not to draw negative inferences from a failure to do so. By virtue of S.I. 248 / 2005 proceedings can be commenced without an expert's report in certain circumstances. Section 2 of the Statute of Limitations (Amendment) Act 1991 provides an exception to the two year time limit where the date of knowledge accords to the first time one had knowledge of the harm occasioned. In *Gough v Neary* [2003] 3 IR 92 Geoghegan J allowed the claim to be brought on the basis that the plaintiff must hold enough relevant knowledge for time to run. In *Cunningham v Neary* [2004] 2 ILRM 498 the claim was defeated where the plaintiff had made a complaint to the Medical Council about the acts in question and demonstrated prior knowledge.

[1309] S Banda, *Taking Indirect Horizontality Seriously in Ireland: A Time to Magnify the Nuance* 31 Dublin University Law Journal (2009) 263 at 275.

[1310] [1992] 2 IR 102.

[1311] [1992] 2 IR 102 at 107.

reference which may be an implicit reference to indirect horizontality.[1312] While the courts have baulked at replacing pre-existing statutory and common law remedies by a new constitutional remedial regime, arguably they have not repudiated the principle.[1313] There would appear to exist a link between Finlay CJ in *L v L* and Henchy J in *Hanrahan*.

However, in other areas, it appears that the courts have tended towards judicial restraint, which may not be wholly appropriate when the private law "remedy" invoked is clearly ineffective. Once the tort in question exists in some form, the Supreme Court has invariably found that the State had vindicated its own obligation under Article 40.3.2. In *O'Keefe v Hickey*[1314] Hardiman J upheld the High Court's finding that the possibility that the plaintiff could exert a claim in tort for vicarious liability (or indeed negligence) vindicated the plaintiff's constitutional right to bodily integrity despite holding that "... it seems to me that the State defendants cannot be liable for the first-named defendants' tortious and criminal acts on the ordinary and established principles of vicarious liability".[1315]

13.3 The effectiveness of tort law

Here we are presented with the tort which is at once effective in theory but ineffective in practice. Is this not a difficulty of proof? Can the tort of vicarious liability effectively act for a constitutional right where another nominate tort

---

[1312] S Banda, *Taking Indirect Horizontality Seriously in Ireland: A Time to Magnify the Nuance* 31 Dublin University Law Journal (2009) 263 at 284-285.

[1313] B McMahon and W Binchy, *Law of Torts* (3rd Ed.) Butterworths (2000) at 1.60.

[1314] [2008] IESC 72.

[1315] [2008] IESC 72. In his judgment, Fennelly J, with whom Murray CJ and Denham J agreed, adopted the multi-factor "sufficient connection" test between the employer and the conduct (sex abuse) advanced by the House of Lords in *Lister v Hesley* Hall Ltd [2002] 1 AC 215 and the Canadian Supreme Court judgment in *Bazley v Curry* [1999] 2 SCR 534 in which McLaghlin J had focused on not only whether the employer had authorised the conduct but also created or enhanced the risk of the conduct occurring: "Vicarious liability is generally appropriate where there is a significant connection between the creation or enhancement of a risk and the wrong that accrues therefrom"; at para 41 (italics retained). There was no sufficiently close connection; ibid. The claim of negligence had been summarily dismissed by De Valera J in the High Court and not appealed in the Supreme Court. The case is currently before the Grand Chamber of the European Court of Human Rights.

cannot be identified? One needs proof of violation (act or omission) of a constitutional right but how does one demonstrate that a tort is basically ineffective to allow consideration of the constitutional claim? Arguably if one is serious about the supremacy of constitutional rights, one needs to apply scepticism as to whether traditional common law principles will automatically vindicate a constitutional right, particularly where the purpose of tort may not be aligned with the purpose of constitutional right in question. The question whether the law of tort can properly address right to health claims where a claim for violation is not capable of being adjudicated on is an open one. When viewed in light of the unmodified test of causation in tort law as framed in light of the judgments of the Supreme Court in *Dunne v National Maternity Hospital*[1316] and *Glencar Explorations plc v Mayo County Council*[1317] the argument in favour of tort vindicating all constitutional rights is difficult to sustain (discussed below).

There is circularity in the question whether tort law vindicates the constitutional implied right to bodily integrity and health. On the one hand, it is perhaps too simplistic to posit that, if a suit in medical negligence is successful in the courts, tort law is effective, whereas, if it is unsuccessful, tort law is not: the evidence in each case will differ and the evidence must be determinative of whether a right has in fact been violated or not. What can be discerned, however, is the confusion which exists as to whether the right to bodily integrity as implementing the right of access to the AAAQs without discrimination has any life outside the law of medical negligence. If so, it is incumbent upon the courts to set out, at least obiter, the scope and nature of the right and whether it should be pled in the alternative to the tortious claim. If not, the sensible approach is to ascertain whether the rules of tort law permit an individual to realistically have their right to health vindicated, as required by Article 40.3.2. To answer this question, one must turn to examine the law of tort as it applies to the right to health.

[1316] [1989] IR 91.

[1317] [2002] 1 ILRM 481.

PART 111 The Law of Tort

14 The relevance of tort law to the right to health

In Part 1 of this thesis, we considered how the obligation "to protect" requires the State to adopt a framework comprising legislation and other measures to, *inter alia*, prevent third parties or private companies from depriving people of equal access to health care or services. Further, the two dimensions of the State's accountability obligation under General Comment 14, the "preventative obligation" which requires regulation of private bodies delivering health services and the "reparation" obligation (which requires that where a violation of the right to health occurs, the individual has a right to judicial or quasi-judicial remedies) were identified. In relation to the reparation obligation, namely the ability to bring a right to health claim where one's core right to health (access to the AAAQs without discrimination) is violated, it was noted in Part 2 how, under the Irish system, health care is often delivered by the same doctor or health institution under the parallel public and private systems. Yet, in the absence of a statutory right to health, health is primarily delivered in a private manner between doctor or health institution and individual patient, which raises issues primarily under the obligations to "protect" and "fulfil" typology.

Concerning the amorphous constitutional right to health, Part 2 of this thesis concluded that there was no clear constitutional right to bring a health care claim outside tort law. The courts have been slow to identify the scope of the right apart from isolated "obligation to respect" prisoner and asylum cases where the right to health can be incidental to the core claim. Nor is there a public body delivering health services which is amenable to judicial review. Even if such a public body did exist, judicial reluctance to intrude into the executive's sphere would likely limit judicial review of executive omissions, negating the "obligation to fulfil". It was also observed how equality jurisprudence has focused primarily on legislative rather than executive review and similarly fails to meet the "obligation to fulfil".

Under the principle of taking constitutional issues last, medical negligence must first be pleaded in relation to right to health claims. Thus attention in Part 3 turns to whether justiciability under the law of tort and specifically medical

negligence can meet the State's obligations to "protect and fulfil", where health is delivered by private actors and to ensure reparation (or judicial) accountability for victims of a violation of the right to health.[1318] Although the law of tort cannot of itself satisfy the obligations to "protect or fulfil" through the requirement that positive measures be adopted to enable vulnerable or marginalised groups avail of the core right of access to the AAAQs without discrimination, its role will be critical to whether the State can meet its reparations obligation under both headings, given that constitutional and statutory remedies are minimal. Part 3 will thus consider whether the manner in which medical negligence justiciability is constructed satisfies the State's obligations by allowing for effective remedies against private actors delivering health services.

In the current chapter, we examine first the difference between the law of tort and contract, before considering the nature, purpose and function of the law of tort and whether it aims to secure interpersonal justice or more broader societal goals. Thus the chapter considers whether tort law has aims comprising an amalgam of compensation, deterrence and distribution and if so, whether the duty to one's neighbour test, is predicated upon more than the duty owed on foot of the interpersonal relationship encompassing also wider "policy concerns". Such wider policy concerns has resonances of both "separation of powers" doctrine arguments as per *TD* and *Sinnott* and constitutional concepts of "justice", insofar as the concepts of "reasonableness" and proportionality, inherent in non-discrimination law may suggest a consonance between the purpose of tort law and that of the right to health without discrimination.

14.1 How contract law differs from tort

In Part 2, we observed how the courts rely on tort to discharge the constitutional right to health unless it can be demonstrated to be "basically ineffective". Medical negligence is the primary means by which the right to

---

[1318] The "obligation to respect" is less applicable under the Irish system where the acts or omissions of private rather than State actors are at issue leading to primary focus on the obligations to "protect and fulfil".

health is vindicated under Irish law. In Part 3, we consider whether there is a purpose or rationale of the law of tort and if so, whether compensatory, deterrent or "other". We trace the journey of medical negligence law from its traditional unquestioned heights where solely at issue was grave malpractice in the relationship between physician and patient and the former's duty of care, to one increasingly focused on enterprise liability. Whereas jurisprudence has focused primarily on the traditional relationship and the requirement to prove causation of individual fault, enterprise liability offers a more practical response to the realities of modern medicine. However, difficulties of proving causation remain in malpractice suits, not least litigation against physicians who normally benefit from advantages in the "quantity and quality of law", including in the deference afforded to peer review evidence by courts. We also consider the adequacy of modified rules of causation and whether this may render it more or less likely that discharge of the right to health can be effective under tort law. In light of international concern of the low level of success in malpractice suits, we consider also non-fault systems and whether they provide greater means of redress from malpractice.

As noted in Part 1 of this thesis, "historically, the legal obligations of a doctor were derived from his status and 'common calling', that is, to exercise the skill and diligence expected of his calling".[1319] Rules regarding the malpractice liability of physicians commenced in the 1300s in England.[1320] It came to be recognised that an action in contract lay against a doctor who treated a patient for payment. [1321] Prior to the establishment of the National Health Service ("NHS") in the United Kingdom in 1948 and the local (health) authorities in

---

[1319] R Mulheron, *Principles of Medical Law* (3rd Ed.) Oxford University Press, (eds.) A Grubb, J Laing, J McHale (2010) at 135. Orentlicher suggests that traditionally the patient-physician relationship has been viewed as a fiduciary relationship in which the physician owes the patient a fundamental duty to place the patient's interests first, above not only the physician's personal interests but also the interests of other patients, arguing that the "duty of loyalty arises primarily from the unequal relationship between patients and physicians"; D Orentlicher, *Health Care Reform And The Patient-Physician Relationship* 5 Health Matrix (1995) 141 at 147.

[1320] J Mullis, *Medical Malpractice, Social Structure, and Social Control*, 10 Sociological Forum (1995) 135 at 136.

[1321] R Mulheron, *Principles of Medical Law* (3rd Ed.) Oxford University Press, (eds.) A Grubb, J Laing, J McHale (2010) at 135 citing *Everard v Hopkins* (1615) 80 ER and *Slater v Baker and Stapleton* (1767) 95 ER 860; at 136.

Ireland in 1947, medical treatment was either provided privately or on a charitable basis.

Unlike other forms of contract law, the courts have held that there need be no consideration passing between the parties: if the patient submitted to treatment, this would suffice for consideration purposes.[1322] However, since the establishment of the NHS, the English courts have held that no contractual arrangement will exist between patient and hospital doctor.[1323] Rather, any claim for breach of damages for public health must be located in tort law. The Irish courts have followed a similar course.

Before proceeding to consideration of medical negligence law, it should be noted that private health treatment will be subject to the law of contract. The nature of that contractual relationship will depend on the nature, scope and terms of the contract and on all the circumstances, including any consent forms and waivers signed.[1324] Referrals to private clinics for elective treatments are the clearest examples of such private health provision and in such circumstances, the contract may be between the patient and the clinic rather than the more traditional patient-doctor relationship. As discussed above, the weak legislative control delegation under sections 38 and 39 of the Health Act 2004 means that the law of contract will determine delegator and delegate relations. Here the individual seeking access to health has no cause of action unless accepted for private health treatment. Professional duties operate on the tortious horizontal level between individuals unless codified in law.[1325] These professional duties are owed once a doctor assumes responsibility to exercise medical care and skill in treating an individual and while the duty also extends

---

[1322] *Coggs v Bernard* (1703) 92 ER 107.

[1323] See *Pfizer Corporation v Ministry of Health* [1965] AC 512. See however *Pittman Estate v Bain* (1994) 112 DLR(4th) 257, where the Ontario General Divisional Court held that a contractual relationship existed between patient and hospital on the basis that the hospital received funding under the government-funded health insurance scheme.

[1324] R Mulheron, *Principles of Medical Law* (3rd Ed.) Oxford University Press, (eds.) A Grubb, J Laing, J McHale (2010) at 138.

[1325] See section 4 of the Civil Law (Miscellaneous Provisions) Act 2011 which was introduced provide immunity from suit for doctors who act as "Good Samaritans" in an attempt to codify the law of tort to avoid such liability in the wake of cases such as *Lowns v Woods* (1995) 36 NSWLR 344 and *Barnett v Chelsea & Kensington Hospital Management Committee* [1969] 1 QB 428 (discussed below).

to enterprises, if a consultant does not accept a patient, no duty exists. Where public health is delegated to private provision, judicial remedies become uncertain beyond the essential rubric of tort.

A doctor will not lightly warrant the success of a procedure. In *Thake v Maurice*[1326], a case concerning a failed vasectomy, Nourse and Neill LJJ in the Court of Appeal held that a doctor would only have guaranteed the success of an operation if s/he expressly stipulated same in clear and unequivocal language.[1327] Otherwise the matter fell to be determined under the "reasonable person" test under medical negligence (if pled) (see below). Unless the doctor fails to carry out the procedure it is suggested "there is little mileage in couching a claim in contract" as it will be "a wholly exceptional set of facts where the claimant will be able to persuade a court that the doctor was guaranteeing an outcome".[1328]

That said, implied terms in contracts have resulted in some success for plaintiffs. Under the UK's Supply of Goods and Services Act 1982 and the Irish Supply of Goods and Services Act 1990,[1329] statutory provisions such as "fitness for purpose" and "satisfactory quality" are introduced into medicinal products for example a device or vaccination. This will imply a duty of reasonable care by doctors in diagnosing, advising and treating a patient and may arguably also imply for hospitals the duty to provide adequate staff and facilities.[1330]

It should also be noted that theoretically relief may lie under the torts of trespass or nuisance or statutes codifying these torts such as the Health, Safety and Welfare at Work Act 2005.

[1326] [1986] 1 All ER 497.

[1327] [1986] 1 All ER 497, at 512, per Nourse LJ.

[1328] R Mulheron, *Principles of Medical Law* (3rd Ed.) Oxford University Press, (eds.) A Grubb, J Laing, J McHale (2010) at 141.

[1329] The Irish Act substantially followed the UK Act.

[1330] R Mulheron, *Principles of Medical Law* (3rd Ed.) Oxford University Press, (eds.) A Grubb, J Laing, J McHale (2010) at 142. Indeed, the finding by the Court of Appeal that a contract had implied into it a duty to exercise reasonable care and skill in performing the sterilisation procedure in *Thake* effectively replicates the duty of care owed under the tort of negligence.

14.2 The purpose and function of the law of torts

The Supreme Court clearly stated in *Hanrahan* that the (albeit amorphous) right to health under the Constitution may be vindicated under the law of tort. It is fitting then to consider how tort law reflects that right. One author has suggested that the question whether it is "just as between the parties for a duty to be recognised" is the issue Lord Atkin was seeking to identify in the seminal judgment in *Donoghue v Stevenson*[1331] when he asked: "Who, then, in law is my neighbour?"[1332] Tort here is described as "an injury other than a breach of contract, which the law will redress with damages".[1333] The law of torts allows one to sue one's neighbour where their breach of duty (or negligence) causes injury. However, this functional description of what tort law enables – or rather permits - does not allow one to identify the purpose of the law of tort, except that the courts have linked a tort to "neighborhood" and arguably interpersonal justice between individuals.

Is the purpose of tort law to secure compensation to the injured party, to act as a deterrent to other tortfeasors or for some other purpose (such as distributive justice)? Or rather, is it an amalgam of all the above? Or, being judge-made law over a number of centuries is it "meaningless" to discuss the function or goal of the law of torts at all?[1334] Rather, should one not focus on the fact that tort law "provides occasions for one person to haul another person into court, thereby conferring on judges and juries a power to attempt to accomplish one or more of a number of possible objectives by denying or granting relief to the person who has brought suit" where these objectives could include

---

[1331] [1932] AC 562.

[1332] A Robertson, *Justice, community welfare and the duty of care*, 127 Law Quarterly Review (2011) at 374.

[1333] G Fleming, *The Law of Torts* (9th ed.), The Law Book Company Ltd (1998) at 1. Fleming suggests that the entire field of liability may be divided according to its purpose into criminal, tortious, contractual and restitutionary categories, each distinguishable by the nature of the conduct or its consequences and the purpose for which legal remedies are given; at 1.

[1334] R Stevens, *Torts and Rights*, Oxford University Press (2007) at 326.

"compensation for victims, deterrence of undesirable conduct; reinforcement of social norms; expression of political protest; and redistribution of wealth".[1335]

If the purpose of tort law can be identified, attention can only then turn to whether the function – or rather its application - discharges the purpose. If it cannot be identified (or clearly identified) one is moved from any "grand theory" of tort law to an incremental approach favoured by Lord Bridge in *Caparo Industries plc v Dickman*[1336], which categorises the law according to fact-specific cases. From the right to health perspective, the question whether the function and application of the law of torts can vindicate access to the AAAQs on a non-discriminatory basis depends on identifying the salient characteristics of both systems and considering whether the law of torts is a suitable vehicle for the vindication of the right to health, as suggested in *Hanrahan* and *Meskell*. If the conclusion is that tort law deals with "pockets" of cases only, the argument for a separate or parallel justiciable right to health under the Constitution is strengthened.

In identifying salient characteristics of the law of torts, it becomes apparent that a clear moral dimension runs through the law of tort. While one author has described a tort as "a species of wrong ... a breach of duty owed to someone else … an infringement of a right they have against the tortfeasor" with the law of torts "concerned with the secondary obligations generated by the infringement of primary rights"[1337], this conception of the law of tort as a means of redressing the infringement of rights is not one which is always recognisable to scholars. Indeed the concept of rights lay in the distant future when Aristotle was formulating justice into the two classes of distributive and corrective (later commutative) justice.[1338] For those judges formulating the law

---

[1335] J Goldberg, B Zipursky, *Torts, the Oxford Introduction to US Law*, Oxford University Press (2010) at 6-7.

[1336] [1990] 2 AC 605.

[1337] R Stevens, *Torts and Rights*, Oxford University Press (2007) at 2. Goldberg and Zipursky suggest that "tort law's recognition of a special species of wrong - wrongs that have victims - goes hand in hand, conceptually and practically, with the notion that victims of these kinds of wrongs deserve a legal mechanism by which to respond against those who have victimized them. Tort is in these particular senses a law of wrongs and recourses"; J Goldberg, B Zipursky, *Torts, the Oxford Introduction to US Law*, Oxford University Press (2010) at 28.

[1338] R Stevens, *Torts and Rights*, Oxford University Press (2007) at 327-328. Noting how Aristotle's thinking on corrective justice antedates the evolution of rights as legal and

of torts as a species of wrong giving rise to *in personam* obligations, exigible only against the wrongdoer, the resulting "rights" of the injured party would have been sourced from those "moral rights" first identified by Grotius in the seventeenth century and the subsequent Natural Law (eighteenth Century) tradition which in turn led to the classical nineteenth and twentieth century "classical Common Law".[1339] Bunreacht na hÉireann, the UDHR and the ICESCR were but future constitutional ideals when the law of tort was being developed.

To describe the purpose of the law of torts as asserting "moral rights" is apt.[1340] How else can one describe a rationale which encompasses compensation (for a wrong), deterrence (from a wrong) and policy considerations of balancing burden to the defendant or community as against the *prima facie* right of the

---

conceptual rights, Weinrib notes how Aristotle describes corrective justice "through the correlativity of gains and losses" while accepting that "gain" may not be the correct term; E J Weinrib, The Gains and Losses of Corrective Justice, 44 Duke Law Journal (1994) 277 at 293. In this conception of relational rights, Aristotle was the first to point to the distinctive bipolar structure of "rectification of injury through the recognition and enforcement of one party's claim against the other" which was a familiar phenomenon in his time under private law; E J Weinrib, Corrective Justice, 77 Iowa Law Review (1992) 403 at 403. Weinrib argues that corrective justice involves two complementary ideas: correlativity (the idea that liability treats the parties as doer and sufferer of the same injustice) and personality (the idea that purposiveness without regard to particular purposes is implicit in the rights and duties of private law"; E J Weinrib, *Introduction* (E J Weinrib Ed.), 2nd Series, The International Library of Essays in Law & Legal Theory, Ashgate Dartmouth 1 (2002); Introduction at xvi. On this basis, he argues that the "parties equality under corrective justice confirms the link between Aristotle's account and Kant's legal theory. Whereas Aristotle regards equality as the baseline for gain and loss, Kant's notion of self-determining agency supplies the meaning of that equality"; at 291. Here corrective justice regards parties as equals on the basis of their equal moral status as self-determining beings viewed juridically, regardless of rank or status. Gains and loss become as much normative as material under this justice theory; ibid, at 293, 297. The private law relationship is explained in relational terms which correspond to rights and duties: "this is what Aristotle attempts to do"; E J Weinrib, *Corrective Justice*, 77 Iowa Law Review (1992) 403 at 425.pa.

[1339] R Stevens, *Torts and Rights*, Oxford University Press (2007) at 330-331. Finegan traces the development of such "moral" or "natural" rights from the Stoics to Grotius to the modern day and the adoption of the UDHR: see T Finegan, *Conceptual Foundations of the Universal Declaration of Human Rights: Human Rights, Human Dignity and* Personhood, 37 Australian Journal of Legal Philosophy (2012) 182 at 189-191.

[1340] Goldberg and Zipursky describe tort as "the violation of a norm of conduct"; J Goldberg, B Zipursky, *Torts, the Oxford Introduction to US Law*, Oxford University Press (2010) at 2 and note how the inquiry into whether a tort has been committed calls for the application of legal concepts such as the concepts of duty and intent "that bear a close relationship to counterpart concepts found in ordinary morality"; ibid, at 3. Zipursky also presents a model of "rights, wrongs and recourse" for tort law, see B Zipursky, *Civil Recourse, Not Corrective Justice*, 91 Georgetown Law Journal (2003) 695 at 698.

victim as being other than linked to morality?[1341] The principal objectives of medical negligence actions has been described as providing compensation; and deterring doctors from failing in their duties to patients[1342], with the rationale for tort law going beyond the mere compensatory for the injured individual but rather linked to ensuring minimum standards of health care are met by inducing the correct level of medical care in the medical practitioner, introducing the concept of "higher rights".[1343] The court is called upon to assess questions of interpersonal justice, which may involve difficult autonomy and personal responsibility questions which focus on "what is just as between two parties, or the question of what, in law, individuals should be regarded as owing to one another."[1344]

Others argue that assertions that in the absence of a duty to act there can be no liability avoid the real issue as to whether a moral imperative (such as to rescue) should be converted into a legal duty to act.[1345]

[1341] Goldberg and Zipursky argue that tort goes beyond compensation and deterrence and "embodies a basic political commitment to the idea that a person who has been wronged by another should be able to *respond* to the wrong and the wrongdoer, and that an actor who is deemed properly subject to this sort of response should be held *responsible* to the victim of the wrong" where the defendant responsibility for the wrong renders him, her or it "properly the object of a victim's response"; J Goldberg, B Zipursky, *Torts, the Oxford Introduction to US Law*, Oxford University Press (2010) at 63-64. As such, they disagree with idenfityfing tort law with a particular function; at 65. Levinas describes how we are responsible beyond our intentions: "It is impossible for the attention directing the act to avoid inadvertent action", with the "other" as our interlocutor; E Levinas, Entre nous, (2nd Ed. transl M B Smith and B Harshav) London Continuum (2006) at 3-4.

[1342] S Moloney, *Dealing with Medical Negligence Claims: a review of options for reform*, 5 Medico-Legal Journal of Ireland (1999) 79.

[1343] B Howell, *Medical Misadventure and Accident Compensation in New Zealand: An Incentives-Based Analysis* 35 Victoria University of Wellington Law Review (2004) 857 at 876. Mechanisms to induce the correct level of medical care in the medical practitioner are clearly linked to ensuring adequate medical care as the central component of ensuing access to the AAAQs without discrimination.

[1344] A Robertson, *Justice, community welfare and the duty of care*, 127 Law Quarterly Review (2011) at 389. Stevens does not favour attempts at categorisations, in part because he asserts that torts are primary, inherent and inalienable rights which cannot be simply removed by a legislature. He questions its deterrent or compensatory role; R Stevens, *Torts and Rights*, Oxford University Press (2007) at 326.

[1345] K Williams, *Medical Samaritans: Is There A Duty To Treat*? 21 Oxford Journal of Legal Studies (2001) 393 at 400. There is a strong counterview to tort's rationale, namely that it is based on economic rectification of loss between private parties and its nature as private law is controversial. Weinrib concedes how "some see private law as a mode of public regulation, others as the embodiment of economic efficiency, others as an opportunity for distributive justice, others as a way of obtaining justice between the parties, and still others as the

Social control theorists attempt to link societal morality, its norms and rules to individual behaviour and show how the law varies with different social-structural circumstances. The question is posed as to what occurs where an individual blames a medical provider for "malpractice": does the victim "tolerate" the malpractice, does s/he avoid the offender, contact a lawyer and initiate a tort claim, or adopt some other strategy of conflict management?[1346] Further, if a formal claim is made, social control theory seeks to predict whether the claim is dropped, settled out of court, or proceeds to a court verdict (and if to a verdict, what the the likelihood of success may be). It inquires into how much a compensatory award may be and, further, what are "the consequences of a successful lawsuit for the defendant's practice and reputation?"[1347]

Predicting and explaining such outcomes are important insofar as the medical malpractice literature, the origins and the outcomes of malpractice disputes are commonly explained by medical errors (did negligence actually occur?), tort doctrines pertaining to the law of negligence, the rational choices of disputants, the severity of patient injuries, and the sentiments and sympathies of judges and jurors.[1348] These explanations are inadequate as they explain neither normative principles nor behaviour.[1349] Indeed, for the purpose of this thesis, social control theory may provide some insight into whether the law of tort or

---

repository of our most persistent illusions about the autonomy of law and politics"; E J Weinrib, Corrective Justice, 77 Iowa Law Review (1992) 403 at 403. Stone observes how "functionalism presents tort law as 'public law in disguise'"; M Stone, On the Idea of Private Law, in Tort Law (E J Weinrib Ed.), 2nd Series, The International Library of Essays in Law & Legal Theory, Ashgate Dartmouth (2002) 235 at 235.

[1346] J Mullis, *Medical Malpractice, Social Structure, and Social Control*, 10 Sociological Forum (1995) 135 at 140.

[1347] Mullis explains how the theory of social control seeks to predict and explain outcomes from the grievance onward "within the social structure of the case"; J Mullis, *Medical Malpractice, Social Structure, and Social Control*, 10 Sociological Forum (1995) 135 at 140.

[1348] J Mullis, *Medical Malpractice, Social Structure, and Social Control*, 10 Sociological Forum (1995) 135 at 141. Juries were abolished in Ireland in 1988.

[1349] Mullis argues for example that the traditional conception of law, which assumes that cases are normally decided by a logical process of rules applied to evidence contrasts "sharply" with both the legal realism movement of the early Twentieth Century and American jurisprudence emphasising the idiosyncrasies of individual decisions and the sociological aetiology; J Mullis, *Medical Malpractice, Social Structure, and Social Control*, 10 Sociological Forum (1995) 135 at 140-141.

indeed other no-fault systems are capable of effectively vindicating the right to health insofar as predicting whether the individuals from vulnerable groups can access the AAAQs without discrimination, will inform the question of effective access to the right to health. Identifying the rationale of tort law to ascertain whether it is or can be aligned with constitutional rights, including vindication of the constitutional right to health per *Hanrahan*, is important. Indeed, as noted, the rationale of compensation, deterrence and other goals (such as distributive justice) are all elements of the concept of "remedy" or "redress" arising from an understanding of rights under both international and constitutional law (a clear moral dimension is evident in the Article 40.3.2 command for the vindication of personal rights).

Black explains social control theory as referring to the distribution of people in relation to each other, namely "their differentiation, intimacy, and integration".[1350] He suggests how four major styles of social control can be identified in law, namely "penal, compensatory, therapeutic, or conciliatory".[1351] It will be observed that these concepts have clear moral dimensions. Commenting on the social control "mechanisms through which

---

[1350] D Black, *The Behavior of Law*, New York Academic Press (1976) at 55. See also J Braithwaite and D Biles, *Empirical Verification and Black's The Behavior of Law* 45 American Sociological Review (1980) 334. See also A V Horwitz, *Toward a New Science of Sociology: A Retrospective Evaluation of The Behavior of Law*, 31 Contemporary Sociology (2002) 668.

[1351] D Black, *The Behavior of Law*, New York Academic Press (1976) at 29. Black describes law as "governmental social control" and defines "social control" as "the normative aspect of social life, or the definition of deviant behavior and the response to it, such as prohibitions, accusations, punishment or compensation"; D Black, *The Behavior of Law*, New York Academic Press (1976) at 1-2. In addition, the "quantity of social control also defines the rate of deviant behavior"; at 9 and 105-106. Later Black described social control as including "all of the practices by which people define and respond to deviant behavior"; D Black, *The Social Structure of Right and Wrong*, San Diego, London Academic Press, (1993), Preface at xi. Interestingly Black suggests that while over history law continues to increase, at a point in the future social life may evolve into a synthesis between the communal and situational, a society of equals in a unity of opposites. At that point, he posits that law may decrease or even disappear"; ibid (*The Behavior of Law*) at 132-37. Mullis defines "social control" as all actions that define and respond to deviant behavior, where deviant behaviour is conduct considered undesirable from a moral, as opposed to an intellectual or aesthetic, standpoint: J Mullis, *Medical Malpractice, Social Structure, and Social Control*, 10 Sociological Forum (1995) 135 at 137.

grievances are expressed", Mullis identifies five basic forms of mechanism: self-help, avoidance, toleration, negotiation and settlement.[1352]

It is contended that the social variables associated with doctor-patient conflict influence the manner in which medical malpractice grievances are resolved. By applying the sociological framework of Black's general theory of social control to medical negligence claims, the author explores the moral space in which the private relationship of Lord Atkin's "neighbourhood" operates, including, critically, how the law protects the disadvantaged.

Five "primary dimensions" of social control are identified: "the vertical, horizontal, cultural, organizational, and normative".[1353] Taken together these dimensions are stated to define a multidimensional space within which actors can be compared in terms of their structural positions, i.e. their social statuses and social distances from each other. Hence the relative position of health actors (the patient, the physician, any third parties) may make up the social structure of a given case of conflict and this structure will predict and explain variation in both the qualitative and quantitative aspects of social control.[1354] It is argued that this sociological perspective is critical if one is to understand the application of legal principles to individuals, including those from poorer backgrounds or lower social classes than doctors insofar as the rules of law do not by themselves yield sufficient theoretical predictions or explanations as to whether one resorts to law or whether litigation has a reasonable prospect of success.[1355]

[1352] J Mullis, *Medical Malpractice, Social Structure, and Social Control*, 10 Sociological Forum (1995) 135 at 138.

[1353] Here the vertical dimension refers to inequality of wealth; the horizontal the degree of intimacy and interdependence among people as well as their integration into social life; the cultural to variation in customs, belief and knowledge; the organisational to differential capacities for collective action; the normative by the extent and type of social control to which people are subject"; J Mullis, *Medical Malpractice, Social Structure, and Social Control*, 10 Sociological Forum (1995) 135 at 137.

[1354] J Mullis, *Medical Malpractice, Social Structure, and Social Control*, 10 Sociological Forum (1995) 135 at 138. The "quantity of social control" refers to the severity of a court punishment or the nature of an awards judgment.

[1355] J Mullis, *Medical Malpractice, Social Structure, and Social Control*, 10 Sociological Forum (1995) 135 at 141. Besides its qualitative aspects, the quantity of social control is the magnitude to which it is applied. The "quantity of law, or government social control" increases with longer prison sentences and higher monetary awards for damages"; Mullis at 139 or in the

It has been suggested that the vast majority of malpractice disputes in the United States never result in a court judgment and that of those disputes which proceed to a court verdict, the defendant is more likely to win.[1356] It is suggested that the vertical and organisational superiority of the physician inhibits the use of law by the aggrieved or put differently, that the lower status of the aggrieved party promotes toleration[1357] with available evidence confirming the expectation that the frequency of conduct regarded as negligent exceeds malpractice claims by a large ratio[1358] confirming that the relatively affluent are more likely to sue their doctors.[1359] This view corresponds with the observation that insofar as there is a malpractice crisis, it concerns the difficulties facing patients and their relatives bringing a claim against

---

words of Black, "the more compensation awarded, the more [quantity of] law"; D Black, *The Behavior of Law*, New York Academic Press (1976) at 3. Healy observes that the effect of the professional standard model may have placed the medical negligence action beyond the reach of patients for most of the common law's history. This is often attributed to the domineering effect of expert medical witnesses at hearing and to the disparity of resources between the patient and the medical practitioner; J Healy, *Medical Malpractice Law* Roundhall Press (2009) at 281.

[1356] J Mullis, *Medical Malpractice, Social Structure, and Social Control*, 10 Sociological Forum (1995) 135. "[S]ample data estimate that 43% of malpractice claims are dropped; of those not dropped, 88% are settled out of court. Where verdicts are rendered, the malpractice defendant wins 72% of the time ... other evidence suggests that the national victory rate for all medical malpractice defendants falls somewhere between 52% and 90%"; at 149. These statistics also reflect those invoked by proponents of no-fault compensation for medical injury: discussed below. Mullis also cites research findings indicating on the one hand that the severity of injury has a significant positive effect on the probability of filing a lawsuit while other research indicates a weak to non-existent effect of severity on the probability of the plaintiff being successful and receiving payment; at 154.

[1357] J Mullis, *Medical Malpractice, Social Structure, and Social Control*, 10 Sociological Forum (1995) 135 at 146. D Black, *The Behavior of Law*, New York Academic Press (1976) 21 at 92. Black later argued that "just as social control defines and responds to deviant behaviour, medicine defines and responds to illness, injury and related problems ... medicine varies with its location and direction in social space"; D Black, *The Social Structure of Right and Wrong*, San Diego, London Academic Press, (1993) at 164. Black further argued that medicine itself varied directly with the status of the patient and further varies "inversely with the relational and cultural distance between the patient and whoever may provide help"; at 165.

[1358] The ratio is between 8 and 15 to 1. This suggests that malpractice grievances rarely escalate to the level of a "dispute in the sense of a bilateral conflict" but tend to be handled with the techniques of moral minimalism, namely toleration, avoidance and gossip: J Mullis, *Medical Malpractice, Social Structure, and Social Control*, 10 Sociological Forum (1995) 135 at 147.

[1359] Blue-collar workers under litigate to their white-collar counterparts: J Mullis, *Medical Malpractice, Social Structure, and Social Control*, 10 Sociological Forum (1995) 135 at 147. Even where cases are taken, the tort of medical negligence compares unfavourably to other torts: see S Moloney, *Medical Misadventure: Compensation, Accountability and Regulating Standards of Practice*, 6 Medico-Legal Journal of Ireland (2000) 71 citing the Royal Commission of Civil Liability and Compensation for Personal Injury (Pearson Commission) 1978 which estimated that 85-90% of all tort claims are brought successfully whereas only 30-40% of medical negligence claims succeed; at 79.

doctors.[1360] In similar manner, the proportion of medical malpractice claims brought on foot of medical "mishap" incidents in Irish hospitals reported to the State Claims Agency is very low.[1361]

Whereas the law of tort is nonetheless difficult to pin down, compensation is its most famous rationale and this can be seen in the antithesis to tort liability: that of no fault liability providing compensation (discussed below). Although Stevens identifies compensation for loss as being commonly seen as the most important goal of the law of torts[1362] he nonetheless observes that torts is "patently defective" in ensuring compensation of either the deserving or the needy and argues that only economic loss is capable of eradication by compensatory awards of money and that this is the focus of other compensation schemes, such as social security.[1363]

Compensation need not be confined to monetary recompense. Compensatory social control through tort is identified as linking standards to the tortfeasor. Under this theory of social control, society seeks payment or reparation as a remedy for deviance with liability varying along the related dimensions of

---

[1360] S Moloney, *Medical Misadventure: Compensation, Accountability and Regulating Standards of Practice*, 6 Medico-Legal Journal of Ireland (2000) 71, quoting Ham et al *Medical Negligence, Compensation and Accountability*, King's Fund Institute (1988); at 5.

[1361] According to the National Treasury Management Agency, the State Claims Agency managed 2,697 new clinical claims in 2011 with an estimated liability against all active claims was €991.1 million (out of 5,306 claims under management): National Treasury Management Agency, Annual Report and Accounts for the year ended 31 December 2011 (19-22): available at *www.ntma.ie/publications* accessed 21 October 2012. However the total number of recorded incidents in hospitals are not provided in the report. Reid records how in 2010 there was a total of 83,483 recorded incidents notified to the State Claims Agency and that of these, 5,951 related to 'treatment incidences' and another 1,701 incidences were recorded as 'equipment or device incidences'; S Reid, *Product Liability & Medical Negligence*, Medical Negligence Litigation Conference, Royal Marine Hotel, Dun Laoghaire, Dublin, (September 2012).

[1362] R Stevens, *Torts and Rights*, Oxford University Press (2007) at 321.

[1363] R Stevens, *Torts and Rights*, Oxford University Press (2007) at 321. Stevens identifies four defects with tort as compensation: its extremely narrow coverage; its cost when compared with other compensation systems such as social security systems; the court's inadequate remedial responses and damages awarded for 'losses' incapable of being satisfactorily made good (such as the pain from the loss of a foot); ibid. The advent of compensation schemes displacing the need for tort is a twentieth century phenomenon demonstrating the impact of the modern State and public law on tort through worker's compensation and social security schemes. Similarly, the modern State has reduced reliance on tort law (at least for those in higher social ranks) in the creation of regulatory bodies generally seen to complement tort law and the adoption of nationalised health care in the UK and Canada which "by reducing the economic dislocation caused by injuries" reduce the need for recourse to tort; J Goldberg, B Zipursky, *Torts, the Oxford Introduction to US Law*, Oxford University Press (2010) at 22-24.

standards and identity of tortfeasor.[1364] Given that access to the AAAQs without discrimination implies positive measures to reach vulnerable group populations, of significance is the suggestion, based on a focus on vertical and organisational statuses, that in contrast with other forms of social control found in legal conflicts, the compensatory style is more likely to be invoked in upward conflicts, when the aggrieved has a generally lower status than the allegedly deviant party.[1365]

Compensation through law is suggested as a means through which less advantaged persons who are injured by medical malpractice may confront and seek redress from medical practitioners or medical institutions with superior vertical and organisational statuses. Indeed the law of tort is in this way well placed to meet the State's requirement of reparations accountability insofar as it permits those who deliver health services (individual doctors and hospitals) to be directly sued thus holding out the prospect of reparations accountability (i.e. redress) for the victims of health violations under the "obligation to protect".

The potential impact of tort law on conduct or behaviour and the presence/ absence of incentivisation for medical practitioners, hospitals and institutions leads us to the second of the identified goals of tort: deterrence theory as a rationale for tort law.[1366] Here the tort system can be compared to the no-fault New Zealand system where there are no costs of medical insurance facing the medical practitioner and nor can the negligent practitioner be sued. Under tort systems however, the costs of precaution are arguably priced into insurance premiums for medical practitioners and passed on to all patients in the form of

---

[1364] Mullis identifies three dimensions of liability - relative, strict and absolute liability, medical negligence being determined with reference to professional norms, not the state of the practitioner's mind and a dimension of relative liability; : J Mullis, *Medical Malpractice, Social Structure, and Social Control*, 10 Sociological Forum (1995) 135 at 142.

[1365] J Mullis, *Medical Malpractice, Social Structure, and Social Control*, 10 Sociological Forum (1995) 135 at 145. See also P A Clark and S B Gesell, *Using Patient Evaluations to Empirically Assess Medicaid Programs for Social Justice,* 25 Social Work in Public Health (2010) 486 at 489.

[1366] Turner notes how general deterrence theory argues that the primary goal of the tort process is to create incentives for behaviour so as to eliminate socially unwanted accidents or, in economic terms, as a mechanism for enabling society to "minimise the sum of the costs of accidents and the costs of avoiding accidents"; at 18.

service prices.[1367] Further, the practitioner has the cost of being dragged through a usually protracted litigation suit.[1368] The theory of deterrence in torts posits that while tort law cannot prevent all accidents, it will ensure the optimal level of safety precautions.[1369]

An argument against a deterrence of harm torts theory is the de-linkage between the quantum of liability imposed, the consequential encouragement to take care and the defendant's "blameworthiness" insofar as in certain circumstances the tortfeasor may be "lucky" enough to kill rather than to "maim" his or victim and limit the compensation payable. The evidence available for the deterrent impact of the law of torts is "equivocal".[1370]

This leads to the alternative of course which is to abolish the law of tort and replace it with no-fault or social security based compensation systems (discussed below). However, the fundamental question here is that if tort law deters medical malpractice, should it be abandoned?

An amalgam of compensation, deterrence and distribution

It is suggested that the true comparison is not between having the current law of tort and no fault (where "ineffective" per *Hanrahan*) parallel justiciable or regulatory structures, but between the current system and other methods of regulating behaviour and that the tort system should be considered not alone but in tandem with other regulatory approaches. Whether these cumulative "remedies" discharge the right to health is key.

It is contended that both fault-based medical tort law and a liability-based insurance system (placing relative risk on negligent medical practitioners) are

---

[1367] B Howell, *Medical Misadventure and Accident Compensation in New Zealand: An Incentives-Based Analysis* 35 Victoria University of Wellington Law Review (2004) 857 at 876. However, insofar as the vast majority of claims are paid out of liability insurance and the defendant does not personally pay, arguably the deterrence impact is lessened. However, the presence of 'no claims' bonuses or the possibility of a defendant's premiums being subsequently increased after a claim, means that liability insurance may influence conduct.

[1368] See C O'Mahony, *Clinician's Perspective of the Medico-Legal Process*, Medical Negligence Litigation Conference, Royal Marine Hotel, Dun Laoghaire, Dublin (September 2012) discussed below.

[1369] R Stevens, *Torts and Rights*, Oxford University Press (2007) at 321.

[1370] R Stevens, *Torts and Rights*, Oxford University Press (2007) at 322-323.

key elements in providing the correct balance of costs and incentives necessary to instil a sufficient level of medical precaution and risk to induce "the optimal level" of medical care for persons accessing health services.

Is there a grand theory of tort law incorporating greater societal goals than mere compensation provision? In favour of a general characterisation of the "protean nature of tort law", some authors point to the form and substance of the law of torts "as a law of wrongs and redress" which is distinct from other bodies of law, such as regulatory law, insurance law or tax law. Disagreements on tort law are described as identifying "the sort of wrong that entitles its victim to pursue recourse against her wrongdoer through the courts" rather than teleological disputations.[1371]

Some authors suggest there is and that in order to achieve such greater goals - an adequate and rational system of compensation for patients suffering injury, along with proper regulation and accountability within the medical profession, something beyond no fault tort reform is required[1372] and question a no fault system can effectively replace tort law. While high standards, robust regulation and accountability (all aspects of the right to health) are all required, there is also a right to justiciability under the right to health. Opportunity of redress is linked to both maintaining standards and perhaps more importantly, to the socio-economic status of the victim, while individual behaviour is linked to incentivisation.

In parallel with the direction from individual towards organisational medical negligence theory (discussed below) is how individual liability is distinguished from collective liability under social control theory. Turning to prospects of success in tort, collectivities are more likely than individuals to be held to strict and absolute standards of liability; a pattern evident throughout most of human history viewed in terms of the liability "of families and clans for virtually any

---

[1371] J Goldberg, B Zipursky, *Torts, the Oxford Introduction to US Law*, Oxford University Press (2010) at 7. Thus by "grasping and articulating the concepts of wrongdoing, legality, relationality, injuriousness, and civil recourse, among others, one can simultaneously acknowledge the complexity and protean nature of tort law while still providing a meaningful characterization of it"; ibid at 7.

[1372] S Moloney, *Dealing with Medical Negligence Claims: a review of options for reform*, 5 Medico-Legal Journal of Ireland (1999) 79 at 80.

harm befalling others".[1373] Indeed hospitals and institutions are now more likely to be successfully sued than individual doctors or physicians. Here social theory suggests that the origins and resolutions of malpractice lawsuits appear to be socially structured, with outcomes tending to favour defendants "in a manner that is theoretically predictable."[1374]

One author suggests that the organisational advantage of physicians and institutions is also reflected in written law, an example being that hospitals were historically not liable for the acts of attending physicians because the latter are legally regarded as independent contractors.[1375] Social theory suggests that the majority of cases are correctly predicted by the theoretical proposition that law is "minimised in a direction toward greater organization".[1376] However, there are exceptions and enterprise liability suits point to more success against institutions than against individual physicians (see below).

The 1990 Harvard Medical Practice Study employed an epidemiological approach and found that medical malpractice deaths accounted for more deaths "than all other kinds of acidents combined" but ironically resulted in tort reform which sought to limit the bringing of claims.[1377]

[1373] J Mullis, *Medical Malpractice, Social Structure, and Social Control*, 10 Sociological Forum (1995) 135 at 143. At the same time, Mullis points out how the "organizational distance" between patients and doctors is less than between patients and hospitals insofar as the latter have a greater collective capacity than individual doctors. Organizational status advantage suggests that the quantity of malpractice law brought against hospitals relative to physicians is less; at 148.

[1374] J Mullis, *Medical Malpractice, Social Structure, and Social Control*, 10 Sociological Forum (1995) 135 at 156.

[1375] J Mullis, *Medical Malpractice, Social Structure, and Social Control*, 10 Sociological Forum (1995) 135 at 148. Mullis points out how this conception nullifies the principle of *respondeat superior*" employers are responsible for the conduct of employees)"; at 148. See below for discussion of the disappearance of the charitable-immunity rule.

[1376] J Mullis, *Medical Malpractice, Social Structure, and Social Control*, 10 Sociological Forum (1995) 135 at 149. However, as Black notes, every theory of deviant behaviour "assumes that deviant behavior is the behavior of individuals" rather than organisations, insofar as they focus on the conditions that motivate an individual, rather than an organisation to deviate; D Black, *The Behavior of Law*, New York Academic Press (1976) at 99. This suggests that the literature has been slow to respond to the increasing corporatisation of law.

[1377] Harvard Medical Practice Study, *Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation and Patient Compensation in New York*, Harvard Medical Practice Study, Cambridge, MA (1990); cited in S Moloney, *Medical Misadventure: Compensation, Accountability and Regulating Standards of Practice*, 6 Medico-Legal Journal of Ireland (2000) 71 at 73. There were four main conclusions from the study: that medical injury accounts for more deaths than all other acidents combined, with more than a quarter caused by

Perhaps support for the preservation of tort law persists derives from the perception that other methods of ensuring a high quality of care and redressing patient grievances have proved to be inadequate, nor does the precluding of an individual from bringing a litigation suit a concept which corresponds with the constitutional right to a remedy.

14.3 The duty to my neighbour

The tort of negligence centres on the concept of "neighbourhood" and the duty owed by your neighbour, with the usual departure point being whether the test set out in Lord Atkin's dictum in *Donoghue v Stevenson*[1378] can be met, namely taking "reasonable care to avoid acts or omissions which [one] can reasonably foresee would be likely to injure [one's] neighbour" (persons so closely and directly affected by my act that I ought reasonably to have them in contemplation).[1379]

For a duty to be owed, the court must be satisfied that a reasonable person in the position of the defendant would have foreseen the risk of harm involved. Foreseeability alone is insufficient to establish even a *prima facie* duty, with proximity, or legal neighbourhood, also required. The proximity inquiry is one

---

substandard care; that the vast majority injured do not file a claim; that a substantial majority of malpractice claims filed are not caused by provider carelessness or even iatrogenic injury and that the outcome of claims was not linked to causation (whether negligence or by injury). The study had profound implications on medical malpractice policy responses which were not to move towards a broad no-fault approach to compensation for medical injury but rather to impose caps on damages and additional procedural hurdles for claimants. The policy response was the precise opposite to the Study's primary focus on widespread underreporting of malpractice and high injury rates during medical diagnosis or treatment: see T Baker, *Reconsidering the Harvard Medical Practice Study Conclusions about the Validity of Medical Malpratice Claims*; 33 Journal of Law, Medicine and Ethics (2005) 501 at 511.

[1378] [1932] AC 562.

[1379] [1932] AC 562 at 580. The additional limb to the negligence test of whether "it is just and reasonable to impose a duty of care" emanates from a line of appellate court jurisprudence in the 1980s (*Peabody Donation Fund v Sir Lindsay Parkinson & Co. Ltd* [1985] AC 210; *Yuen Kun-yeu v A.-G. of Hong Kong* [1988] AC 175; *Smith v Bush* [1990] 1 AC 831 at 865, per Lord Griffiths; *Caparo Industries plc v Dickman* [1990] 2 AC 605 which marked a retreat from the wide formulation of the test for the duty of care set out by Lord Wilberforce in *Anns v Merton London Borough Council* [1978] AC 728 at 751-752, overruled by the House of Lords in *Murphy v Brentwood District Council* [1991] 1 AC 398. The Irish courts initially followed the *Anns v Merton* test of Lord Wilberforce as evinced by McCarthy J's two-fold test in *Ward v McMaster* [1988] IR 337 in determining whether a duty of care was owed, however, a third "policy" test was added by the Supreme Court in *Glencar Explorations p.l.c v Mayo County Council* [2002] ILRM 481; discussed below.

of interpersonal justice between the parties.[1380] Identifying whether a duty of care exists will involve a "normative judgment" by the court.[1381]

Proximity focuses attention on the closeness of the relationship between the parties, allowing the court identify whether, on the basis of this private relationship, a duty should be identified.[1382] Proximity and foreseeability requirements being met, something more is yet required. Provided the welfare of the community does not require a denial of the duty it is suggested that "the legal relationship between the parties will be governed entirely by what is just as between them."[1383]

[1380] Describing torts as "relational wrongs", Goldberg and Zipursky Authors prefer a "relationality of breach of duty" to mere duty, arguing that it is our interpersonal relationships which suggest the duty and that in a tort claim, the plaintiff is complaining of "carelessness as to persons such as her". Here the authors cite the US case of *Palsgraf v Long Island Railroad* 162 NE 99 (NY 128), where it is argued the relationality requirement was buried within the ordinary duty and breach analysis of Cordosa J insofar as a finding of breach often implicitly assumes a finding of duty due to the relationality of the actors; J Goldberg, B Zipursky, *Torts, the Oxford Introduction to US Law*, Oxford University Press (2010); at 3 and 98-103. Weinrib argues that *Palsgraf* indicates how correlativity "has now become more or less thematic in the treatment of tort theory from a corrective justice perspective", linked as it is with a rights-based quality of justice, citing Cordoso J's positive function conception in the case which "conditions liability for negligence on the requirement that the injury suffered by the plaintiff be within the risk unreasonably created by the defendant"; E J Weinrib, Correlativity, *Personality, and the Emerging Consensus on Corrective Justice*, 2 Theoretical Inquiries in Law (2001) 107 at 406. Levinas suggests that an analysis of interrelationship based on proximity causing duty derives from "the right of the individual in the proximity and uniqueness of the *other*..." and the "'extension' of the human genus" is emphasised by E Levinas, *Entre nous*, (2nd Ed. transl M B Smith and B Harshav) London Continuum (2006); at 167.

[1381] As Robertson notes, proximity does not involve a question as to whether, all things considered, a duty "ought to be recognised", but a much narrower question whether, in light of the closeness and directness of the relevant aspect of the relationship between the parties, the defendant "ought to have had the claimant's interests in contemplation in deciding whether and how to act"; A Robertson, *Justice, community welfare and the duty of care*, 127 Law Quarterly Review (2011) at 395-396. The requirement of sufficient proximity between the claimant and the defendant may be artificial and lose its meaning: see *Alcock v Chief Constable of South Yorkshire Police* per Lord Oliver of Aylmerton [1992] 1 AC 310 at 411. However Robertson argues for the retention of proximity as part of the first part of his proposed two stage test for negligence on "justice" grounds; at 395-396.

[1382] McLachlin CJ and Major J in the Supreme Court of Canada in *Cooper v Hobart* [2001] 3 S.C.R. 537 focused on the closeness of the relationship: the "expectations, representations, reliance, and the property or other interests involved", factors that help determine "whether it is just and fair having regard to that relationship to impose a duty of care in law upon the defendant"; at para 34. See also *Sullivan v Moody* (2001) 207 CLR 562: "once one rejects the distinction between parents and everybody else, they can point to no relationship, association, or connection, between themselves and the respondents"; Gleeson CJ at para 64 and *JD v East Berkshire Community NHS Trust* [2005] 2 AC 373.

[1383] A Robertson, *Justice, community welfare and the duty of care*, 127 Law Quarterly Review (2011) at 396. See too Foreword by Lord Hoffman in R Stevens, *Torts and Rights*, Oxford University Press (2007).

The *Donoghue* test approach was, "subject to characteristically open-textured caveats and qualifications",[1384] adopted by Lord Wilberforce in his speech in *Anns v Merton London Borough Council*[1385] in which case the respondents argued that the failure of the appellant public body to ensure its builders carried out necessary inspections of a block of flats resulted in structural damage to the building occurring. A majority of the House of Lords held that this was negligence. Lord Wilberforce set out the test as follows:

> [I]n order to establish that a duty of care arises ... the question has to be approached in two stages. First one has to ask whether, as between the alleged wrongdoer and the person who has suffered damage there is a sufficient relationship of proximity or neighbourhood such that, in the reasonable contemplation of the former, carelessness on his part may be likely to cause damage to the latter - in which case a prima facie duty of care arises. Secondly, if the first question is answered affirmatively, it is necessary to consider whether there are any considerations which ought to negative, or to reduce or limit the scope of the duty or the class of person to whom it is owed or the damages to which a breach of it may give rise..."[1386]

The *Anns* approach departed from the previous approach of the House of Lords in *East Suffolk Rivers Catchment Board v Kent.*[1387] Here the court had held that although the defendant public body took on the task of repairing a sea wall, the delays in its work did not entitle the plaintiff farmer to establish a duty of care as there was no implicit assumption of responsibility which excluded anyone else from repairing the wall.

Anns was novel insofar as it suggested that, applying private law, a public body could owe a duty of care to others not directly within its compass. This departure from precedential incrementalism saw *Anns* subsequently overruled in *Murphy v Brentwood*[1388] on the basis that pure economic loss did not equate to a form of property loss.[1389] However, until the judgment of the House of

---

[1384] Foreword by Lord Hoffman in R Stevens, *Torts and Rights*, Oxford University Press (2007).

[1385] [1978] AC 728 at 751-752.

[1386] [1978] AC 728 at 751-752. See also 760.

[1387] [1941] AC 74.

[1388] [1991] 1 AC 398.

[1389] See A Robertson, *Justice, community welfare and the duty of care*, 127 Law Quarterly Review (2011) at 221.

Lords in *Stovin v Wise*[1390] and later *Caparo Industries plc v Dickman*[1391], the prospect remained that public bodies could be responsible to the public at large for omissions in the exercise of their powers.[1392] *Murphy*, *Stovin* and *Caparo* returned the position of the law to that of the interpersonal relationship in *East Suffolk*.

While foreseeability and proximity are clearly the principal issues to consider in order to determine whether it is just to recognise that a duty of care is owed under both *Donoghue* and *Anns*, other "policy" factors may be considered by the courts in determining whether it is "just" as between the parties for a duty to be owed, in circumstances where this consideration cannot be solely "accommodated within the inquiries as to foreseeability and proximity". These factors were considered by the Canadian Supreme Court in *Cooper v Hobart* in terms of the effect of recognising a duty of care.[1393] Acts of omission will only comprise a duty of care where the burden on the defendant is proportionate to "community" costs. The duty question is "framed narrowly as a duty to avoid a particular type of harm through identified means."[1394] Only if a *prima facie*

[1390] [1996] AC 923.

[1391] [1990] 2 AC 605.

[1392] See A Robertson, *Justice, community welfare and the duty of care*, 127 Law Quarterly Review (2011) at 221.

[1393] [2001] 3 SCR 537 at para 37 citing "residual policy considerations"; *Syl Apps Secure Treatment Centre v BD* [2007] 3 SCR 83 at para 32. The court identified the "residual policy considerations" coming within the second stage of the *Anns* test as including the effect of recognising a duty of care on other legal obligations, the legal system and society more generally; whether the law already provides a remedy and whether recognition of the duty of care may create the spectre of unlimited liability to an unlimited class. Other policy considerations included whether there are other reasons of broad policy precluding recognition of a duty of care such as an indeterminate class of people with such a duty; at paras 37-38.

[1394] Robertson cites *Stovin v Wise* [1996] AC 923 HL where Lord Nicholls of Birkenhead indicated that the degree of disproportion between the prospect of damage and the preventative steps required will sometimes be one of the features or circumstances to be taken into account in determining whether one person owes another a duty of care; at 930-931. Roberston suggests that this inquiry as to the burden on the defendant may be taken to raise a question of community welfare and proportion or disporportion between the cost (burden) and the harm occasioned; at 383. Lord Hoffman set out a tree fold justification for minimum duties in *Stovin*, discussed below. Robertson also cites *Blue v Ontario (Health and Long Term Care)* [2009] CanLII 18671 SC (Ont) in which the province was held not to owe a duty of care that would have required it to respond to every complaint received about an individual patient in the health care system on the basis that it would prove an unworkable burden. Those community welfare considerations clearly overlapped with issues of justice between the parties since the duty asserted was also held to be "unfair" and "unreasonable"; at para 19; A Robertson, *Justice, community welfare and the duty of care*, 127 Law Quarterly Review (2011) at 384.

duty exists does one proceed to the second part of the *Anns* test as to whether there are "anti-duty" policy factors which negate the duty being owed. Proximity and foreseeability are clearly not the only considerations to identify whether a *prima facie* duty of care exists as evident from the subsequent rejection of *Anns* by the House of Lords.[1395]

Lord Bridge in *Caparo,* citing *Governors of Peabody Donation Fund v Sir Lindsay Parkinson & Co Ltd,*[1396] *Yuen Kun Yeu v Attorney-General of Hong Kong,*[1397] *Rowling v Takaro Properties Ltd*[1398] and *Hill v Chief Constable of West Yorkshire,*[1399] observed how these decisions emphasised the inability of any single general principle to provide a practical test and that fault "in the sense of conduct causing foreseeable and avoidable loss was not enough". Rather the court had to consider it to be "fair, just and reasonable" to impose liability.[1400] A third "fair, just and reasonable" limb was added to the negligence test of whether the harm was reasonably foreseeable and whether there was a relationship of sufficient proximity.

Precisely what is meant by the third limb of *Caparo* is unclear. Lord Bridge himself appears to recognise that "the concepts of proximity and fairness embodied in these additional ingredients are not susceptible of any such precise definition" but attach to "features" which the law "recognises pragmatically as giving rise to a duty of care of a given scope."[1401] However, it is possible to identify a number of "policy rationales" or "community welfare

---

[1395] According to Lord Hoffman the breadth of Lord Wilberforce's generalisation in *Anns* placed too much of a strain on the caveats and qualifications which otherwise characterise the incremental approach to the law of torts: see Foreword by Lord Hoffman in R Stevens, *Torts and Rights*, Oxford University Press (2007).

[1396] [1985] AC 210, 239-241.

[1397] [1988] AC 175, 190-194.

[1398] [1988] AC 473, at 501.

[1399] [1989] AC 53, at 60.

[1400] [1990] 2 AC 605 at 617-618. Alternatively, the defendant had to have voluntarily assumed responsibility for careful conduct.

[1401] [1990] 2 AC 605 at 617-618.

considerations" negating a duty of care. These "operate to require the denial of a duty of care" in every case in which they arise.[1402]

One of several "lamentable aspects" of the decision of the House of Lords in *Anns* was the introduction by Lord Wilberforce, of a distinction between "policy and operational matters",[1403] the argument being that the closer an impugned decision came to a policy decision (such as resource allocation), the court should be reluctant as a matter of deference to substitute its own decision. The policy/ operational divide as set out in *Stovin* is, it is argued, elusive.[1404] In *Stovin*, Lord Hoffmann set out a threefold justification why omissions should not create liability and for minimum duties, these being based on political, moral and economic considerations. In political terms, it would be "less of an invasion of an individual's freedom" for the law to require him to consider the safety of others in his actions than to impose upon him a duty to rescue or protect. Morally, it was the "why pick on me?" argument. Economically, the individual could be liable to "a large and indeterminate class of people". This would not equate to the economics of an activity bearing its own costs with the consequence that "the market is distorted" because the activity "appears cheaper than it really is". In Lord Hoffman's view, "there is no similar justification for requiring a person who is not doing anything to spend money on behalf of someone else.... There may [only] be a duty to act if one has undertaken to do so or induced a person to rely upon one doing so."[1405]

This statement when applied in the context of medical care affirms the traditional position that there is no duty on a doctor unless the person in need is

---

[1402] A number of examples were cited in the interregnum jurisprudence between *Anns* and *Caparo*.

[1403] R Stevens, *Torts and Rights*, Oxford University Press (2007) at 228.

[1404] Stevens points out how the distinction between policy and operational matters was originally adopted in the U.S under the Federal Tort Claims Act 1946; where waiver of sovereign immunity was to occur save in certain areas such as for "any claim based on the exercise or ... failure to exercise ... a discretionary function or duty" on the part of the State: see R Stevens, *Torts and Rights*, Oxford University Press (2007) at 228-229. The distinction was also made by the Canadian Supreme Court in *Cooper v Hobart*: the "basis of this immunity is that policy is the prerogative of the elected Legislature"; [2001] 3 SCR 537 at para 38.

[1405] [1996] AC 923 at 943-944.

already their patient or they voluntarily undertake to provide treatment.[1406] The "omission" negation reasoning in *Stovin* has been criticised on the basis that while anything going beyond the bare minimum obligation not to cause harm by "active carelessness" will "restrict the freedom of the individual", the more "sophisticated 'political' judgment" is to view whether interpersonal and societal gains from recognising a wrong and its recourse should offset the "infringement of individual liberty that the imposition of the particular duty will represent."[1407] Lord Hoffman's second point, namely the "why pick on me?" argument is open to question where emergency treatment is needed and can be provided by a nearby doctor, there surely being a moral command to treat, while the third "cost" argument can be refuted on the grounds that one must examine not reductionist economic costs but both the overall social costs, as well as the costs to the individual victim in terms of personal suffering if no medical intervention is attempted. Should the law not balance the burden against the benefit where if the burden seems disproportionate, no duty is imposed?[1408] Indeed, the American Law Institute's 1965 Restatement of Torts suggests that the law of tort is well placed to identify omissions as a source of liability.[1409]

The attraction of a clear demarcation line between the arms of the legislature, executive and judiciary has proved attractive to courts in identifying non-justiciability as applying to not only public but also private bodies where there is no general right (or entitlement) to the conferral of a benefit. Similarly in

---

[1406] K Williams, *Medical Samaritans: Is There A Duty To Treat*? 21 Oxford Journal of Legal Studies (2001) 393 at 393.

[1407] K Williams, *Medical Samaritans: Is There A Duty To Treat*? 21 Oxford Journal of Legal Studies (2001) 393 at 397-398.

[1408] See P Atiyah, *Accidents, Compensation and the Law* London: Butterworths, (6th ed) (1999) P Cane (ed.) at 63. If the standard of economic efficiency held sway, the law would always compel 'easy rescue' where it was the cheaper cost-avoider.

[1409] See R Mares, *Defining The Limits Of Corporate Responsibilities Against the Concept of Legal Positive Obligations*, 40 George Washington International Law Review (2009) 1157 who suggests the law of tort as a model for regulating International Financial Institutions (IFIs); at 1179. Mares concludes that negligence is better suited for the treatment of omissions by IFIs (to get information and to reasonably act on it) in order to prevent and redress harm inflicted by third parties, while complicity is better suited for commissions by IFIs (when information exists and the company acted to assist third parties); at 1180.

tort, judicial restraint arises as a "trump" anti-duty factor which will negate a *prima facie* duty of care.[1410]

In the other corner there are "pro-duty" factors which the courts will weigh in considering whether a duty of care is present. These are stated to be deterrence, exposure of systemic failures, encouragement of desirable behaviour, efficient allocation of risk, vindication of a right and "encouragement of altruistic acts".[1411]

Whereas some may argue that the third limb of *Caparo* may be little more than the "convenient label" suggested by Lord Bridge, it underscores the "incremental" approach to developing tort law which, if followed strictly, may limit its scope to apply rights under a suprastructure which is sufficiently flexible to accommodate balancing interests of the victim of medical misadventure and the common good (the *Hanrahan* presumption). Due to the particular meaning afforded the [non-] justiciability of rights under Irish separation of powers jurisprudence where resource arguments arise, there may be suggested a tendency to limit justiciability of the right to health under tort, where resource allocation by the State is at issue.

[1410] See *Barrett v Enfield LBC* [2001] 2 AC 550 HL at 583 per Lord Hutton.

[1411] Recognition of the duty may deter harmful conduct, provide an incentive to take care or contribute to the maintenance of high standards of conduct amongst those by whom the duty would be owed: see *Barrett v Enfield LBC* [2001] 2 AC 550 at 568 (Lord Slynn of Hadley); *Arthur JS Hall & Co v Simons* [2002] 1 AC 615 at 681 (Lord Steyn). Recognition may assist in the identification, public exposure and correction of systemic failures within public bodies, such as police departments: see *W v Commissioner of Police* [2000] 1 WLR 1607 at 1619; *Hill v Hamilton-Wentworth Regional Police Services Board* [2007] 3 SCR 129. It may also have the effect of encouraging socially desirable behaviour, such as encouraging the repair of defective structures before they become unsafe: see *Winnipeg Condominium Corp No.36 v Bird Construction Co Ltd* [1995] 1 SCR 85 or encouraging citizens to rescue persons in peril: *White v Chief Constable of South Yorkshire* [1999] 2 AC 455 at 498 (Lord Steyn); also at 509 (Lord Hoffmann). Recognition of the duty may also result in the efficient allocation of a particular type of risk or the efficient distribution of particular losses by, for example, imposing the risk on the party who is best placed to prevent the harm or insure against it; *Edgeworth Construction Ltd v Lea & Associates Ltd* [1993] 3 SCR 206 SC (Can) at 221-222. It may serve an important vindicatory function in some instances, such as negligent police investigation; *Hill v Hamilton-Wentworth Regional Police Services Board* [2007] 3 SCR 129 at paras 35 and 58; see A Robertson, *Justice, community welfare and the duty of care*, 127 Law Quarterly Review (2011) at 390. It may also place a positive duty on doctors to intervene in medical emergencies: see K Williams, *Medical Samaritans: Is There A Duty To Treat*? 21 Oxford Journal of Legal Studies (2001) 393 at 399.

Although Lord Bridge spoke in favour of incrementalism in *Caparo*,[1412] there may be a linkage between the "policy" test enunciated therein and a "justice approach" insofar as "unlike the *Anns* test, the *Caparo* test is founded on the idea that foreseeability and proximity are not the only factors that need to be considered "in order to determine whether it is just as between the parties to recognise a duty of care".[1413] Arguing in favour of a two-stage, six part tort inquiry test (in effect a variation on the *Anns* test), one author suggests that in addition to foreseeability and proximity, the first stage of this suggested two-stage test "must ask whether it is 'fair, just and reasonable' *as between the parties* to recognise a duty of care."[1414] Here again we view tort as regulating relational interpersonal wrongs.

However, when scrutinised more closely, it will be observed that the "anti-duty" factors are permitted to be considered twice under this formulation: first in relation to whether there is a *prima facie* duty (which includes justice or policy considerations) and second in relation to whether there is a "welfare consideration" such as justiciability which will negate the duty being owed. Would such a formulation not place further barriers in the path of a litigant?

On the one hand *Caparo* may be viewed as a "retreat" from the wide formulation of the test for the duty of care set out by Lord Wilberforce in *Anns*[1415], on the other hand, its effect may be limited insofar as the underlying approach may essentially be the same. One author suggests that "[t]he first stage is otiose, whilst the second and third stages collapse into a search for the good reasons which can be given for denying liability."[1416]

[1412] [1990] 2 AC 605 at 618.

[1413] A Robertson, *Justice, community welfare and the duty of care*, 127 Law Quarterly Review (2011) at 370.

[1414] A Robertson, *Justice, community welfare and the duty of care*, 127 Law Quarterly Review (2011) at 370, emphasis retained.

[1415] [1991] 1 AC 398.

[1416] R Stevens, *Torts and Rights*, Oxford University Press (2007), Introduction.

In Canada, a "modified" version of the test laid down in *Anns* is usually applied[1417] while in Australia, the existence of a duty of care is identified after the examination of certain "salient features" of the case in question.[1418]

The Irish courts initially followed the *Anns* test as evinced by McCarthy J's two-fold test in *Ward v McMaster*[1419] in determining whether a duty of care was owed.[1420] McCarthy J rested his conclusion on the "fair and reasonable" test" and preferred to express the duty as arising from the proximity of the parties, the foreseeability of the damage, and the absence of any compelling exemption based upon public policy.[1421] In other words, McCarthy J, while not excluding the possibility, felt that the two stage test in *Anns* should continue given that any "compelling exception based upon public policy" would have to be a very powerful one to deny redress to the injured party.

[1417] A *prima facie* duty of care is owed if the harm suffered by the plaintiff was a "reasonably foreseeable consequence of the defendant's conduct and there was a relationship of proximity between the defendant and those to whom the duty is claimed to be owed"; A Robertson, *Justice, community welfare and the duty of care*, 127 Law Quarterly Review (2011) at 370 citing *Cooper v Hobart* [2001] 3 SCR 537; *Fullowka v Pinkerton's of Canada Ltd* [2010] 1 SCR 132 at para 18. Similar approaches are taken in Singapore (see *Spandeck Engineering (S) Pte Ltd v Defence Science and Technology Agency* [2007] SGCA para 37 and New Zealand - see *Couch v Attorney General* [2008] 3 NZLR 725, at paras 79 and 126 (per Tipping J.)). If such a *prima facie* duty of care is established, the court asks whether there are "residual reasons of policy for denying the duty"; ibid, at 370.

[1418] *Graham Barclay Oysters Pty Ltd v Ryan* [(2002) 211 CLR 540 at para 149. Insofar as the test for duty cannot be reduced to a precise formula and because different classes of case give rise to different problems, the High Court of Australia has said that in each case the court must engage in "a judicial evaluation of the factors which tend for or against a conclusion, to be arrived at as a matter of principle"; A Robertson, *Justice, community welfare and the duty of care*, 127 Law Quarterly Review (2011) 370, citing *Graham Barclay, Sullivan v Moody* (2001) 207 CLR 562 at paras 47 - 50, quoting G Fleming, *The Law of Torts* (9th ed.), The Law Book Company Ltd (1998) at 151; at 370. In both Canada and Australia, other factors identified as either "justice" or "community welfare factors" under the suggested reformulation test above may be considered during the proximity inquiry and at both stages of the *Anns* test. The Supreme Court of Canada has stated that "policy" is to be considered at both stages while in *Jaensch v Coffey* (1984) 155 CLR 549, the High Court of Australia suggested that the "identification of the content of the criteria or rules" that reflect the requirement of proximity should not be "either ostensibly or actually divorced from the considerations of public policy which underlie and enlighten it"; 549 at para 10 per Deane J. Robertson notes how the Supreme Court of Canada in *Cooper v Hobart* drew a clear distinction between the two sets of "policy" considerations, with one to be taken into account at the first stage of the *Anns* test and one at the second; the latter being concerned with broader considerations of community welfare (namely whether the *prima facie* duty owed should be denied for public policy reasons); ibid, at 378 and 386.

[1419] [1988] IR 337.

[1420] Although *Ward* predated *Caparo*, McCarthy J reviewed the English cases of *Peabody*, *Yuen* and *Hill* before reversing Costello J in the High Court.

[1421] [1988] IR 337 at 349.

The third "policy" test as set out in *Caparo* was, however, adopted by the Supreme Court in *Glencar Explorations plc v Mayo County Council*[1422] in which Keane CJ overturned *Ward.*[1423] This permitted the court to favour the dicta of Brennan J in *Sutherland Shire Council v Heyman*[1424] and the House of Lords judgment in *Caparo* over the *Anns/ Ward* two-fold test. Indeed Keane CJ invoked the distinction drawn by Lord Atkin in *Donoghue* between "the requirements of morality and altruism" on the one hand and the law of negligence on the other.[1425] This distinction he felt would be in grave danger of being eroded by *Anns.*[1426] Keane CJ was comfortable with the notion of a third limb to the test insofar as "no injustice will be done if they are required to take the further step of considering whether, in all the circumstances, it is just and reasonable that the law should impose a duty of a given scope on the defendant for the benefit of the plaintiff."[1427]

There are uncertainties inherent with all three approaches (the Irish approach now being that of *Caparo* post-*Glencar*). It has been pointed out how in England, there is uncertainty as to the interrelationship between the "proximity" and "fair, just and reasonable" limbs which conflate very different sets of considerations and which "require the courts to weigh incommensurable factors against one another." [1428]

Uncertainties in Canada also arise from "the content of and relationship between "proximity" and "policy"" while in Australia "the complete rejection

---

[1422] [2002] 1 IR 84.

[1423] [2002] 1 IR 84 at 137. In doing so, Keane CJ suggested that McCarthy J's observations on *Anns* did not constitute part of the *ratio* of the decision in *Ward*. However, this cannot be so: Finlay CJ in *Ward* agreed with the judgments of McCarthy J and Henchy J, while Walsh J agreed with the judgment of McCarthy J confirming that his was the ratio of the decision in the case.

[1424] (1985) 157 CLR 424 (namely that "the law should develop novel categories of negligence incrementally and by analogy with established categories"; at para 14. As noted, Brennan J's Judgment was also cited with favour by Lord Bridge in *Caparo*.

[1425] [2002] 1 IR 84 at 139.

[1426] [2002] 1 IR 84 at 139.

[1427] [2002] 1 IR 84 at 139.

[1428] A Robertson, *Justice, community welfare and the duty of care*, 127 Law Quarterly Review (2011) at 371.

of tests and formulae" leaves the courts "without any kind of framework to assist in identifying, distinguishing between and assessing the relative weight to be given to each of the different factors that must be taken into account."[1429] Robertson suggests that assessments of "proximity", "policy" and whether it is "fair, just and reasonable" that a duty be recognised "all attract criticism because the labels that are used create the inaccurate perception that the determination of duty is unprincipled or discretionary."[1430]

Despite the apparent differences between these approaches, it has been suggested that close examination of the cases reveal "considerable similarity between them as a matter of substance and practical application." The charge of uncertainty and confusion in England and Canada and the charge that the determination of duty of care in Australia is "unprincipled or discretionary" leads one author, as noted, to propose a unifying theory of duty of care centring on two questions: "first ... whether it is just as between the parties for a duty to be owed, and the second ... whether considerations of community welfare require the denial of the duty."[1431] The argument here is that where duty of care analysis proceeds along both of these dimensions, a court can first inquire into the "justice" duty before considering whether "community welfare" reasons such as justiciability or other public policy grounds justify the negation of the justice duty.

However, as with arguments of no-fault compensation (discussed below), a key unanswered question is that focused on the right to health: given that there is a right to health and a right to a remedy, would such an approach to duty of care place additional hurdles in front of the individual over and above the current *Caparo*/ *Glencar* dispensation?[1432]

[1429] A Robertson, *Justice, community welfare and the duty of care*, 127 Law Quarterly Review (2011) at 371.

[1430] A Robertson, *Justice, community welfare and the duty of care*, 127 Law Quarterly Review (2011) 370 at 371.

[1431] A Robertson, *Justice, community welfare and the duty of care*, 127 Law Quarterly Review (2011) 370 at 371.

[1432] A related argument which will not be explored here is whether additional hurdles to persons seeking right to health redress could constitute a "regressive" measure in relation to a core non-derogable right and itself be contrary to Article 12 ICESCR.

14.4 Statutory duties

As noted in Part 2 of this thesis, the approach of the English and Irish courts to the question whether a public authority can owe a duty to an individual in relation to the right to health may differ due to the different legal contexts in which right to health decisions are taken by public bodies. Whereas the Irish courts have long held that a public body is amenable to judicial review, both English and Irish courts have baulked at the concept of the State owing a duty of care for denial of a claimed benefit. In *Glencar*, Keane CJ stated that the court would only exceptionally locate such a duty of care but only where proximity and foreseeability arose: "the mere fact that the exercise of a power by a public authority may confer a benefit on a person of which he would otherwise be deprived does not of itself give rise to a duty of care at common law". Only the "reasonable foreseeability of damage arising from the non-exercise of the power and a degree of proximity between the plaintiff and the defendant ... would render it just and reasonable to postulate the existence of a duty of care."[1433]

This was "consistent" with the reluctance of the law to impose liability for negligence arising out of an "omission to act rather than out of the commission of positive acts which may injure persons or damage property."[1434] As discussed in Part 2, the presence of a statutory body in the form of Primary Care Trusts in England, which take decisions on health care provision according to resource allocations renders those bodies amenable to judicial review.[1435] This contrasts with the situation in Ireland where no specific statutory body takes such decisions, rather it is the decision of consultants and hospitals or institutions. The failure to provide health care is referable to these

---

[1433] [2002] 1 IR 84 at 140-141.

[1434] [2002] 1 IR 84 at 141.

[1435] Such decisions are often taken on the basis of quality-adjusted life year (QALY). A QALY may be employed to calculate the "cost" of a particular health care intervention which is then used to allocate healthcare resources. An intervention with a lower cost to QALY saved (incremental cost effectiveness) ratio (such as in the case of a non-smoking non-drinking person) may be preferred over an intervention with a higher ratio (such as a smoking, drinking person). See E Palmer, *Mechanisms Of Health Care Accountability, Marketisation And The Elusive State*, 11 Medical Law International (2011) at 69.

private actors rather than to a State body. State decisions impacting on the provision or non-provision of resources which may determine the provision of a particular health care service in question are difficult to challenge before the courts in circumstances where no statutory duty is assigned to a private body to deliver a particular health service.[1436] Further, it is difficult to envisage how public or private health omissions can be litigated where the doctor-patient relationship is not yet formed.

14.5 Linkages with the right to health

The *Caparo/ Glencar* "fair, just and reasonable" test has resonances of not only the "separation of powers" doctrine arguments as per *TD* and *Sinnott* (discussed above), but also the reference to "justice" in the Preamble to the Constitution, the vindication of personal rights under Article 40.3.2 and the social directive policy under Article 45. At the same time, the term "reasonable" denotes the concept of proportionality which itself implies the presence of the balancing test employed under non-discrimination law.

What is suggested by *Carparo/ Glencar* is in effect an additional policy hurdle test. It has been suggested that in addition to this extra hurdle now being placed in front of plaintiffs, the Supreme Court's "preference for incrementalism and its scepticism about grand theory" of tort law "makes it harder to establish a duty of care in previously unlitigated fact-situations and calls into question certain widely held assumptions as to the scope of the duty in such areas as pure economic loss, affirmative duties and the functions of public authorities".[1437]

However, on another level, the suggested formulation of a two test approach along the lines of a) is there a *prima facie* duty of care and b) if so are there factors which require its negation, in many respects mirrors the classic non-

---

[1436] This is separate from the issue of meeting standards of care: clearly the assumption is that the private body will be under an obligation to meet statutory guidelines concerning such standards of care as promulgated by the Mental Health Commission or HIQA.

[1437] W Binchy, *Recent Developments in the Law of Torts*, 4 Judicial Studies Institute Journal (2004) 1 at 10.

discrimination test established under human rights law. The statement on anti-duty factors during the second part of the proposed test is of note where it postulates that the question to be considered at this second stage "is whether that *prima facie* duty should be denied", it being necessary "to begin the second stage of the analysis with a consideration of anti-duty factors".[1438] If there are no anti-duty factors then a duty of care is established solely on the basis of considerations of justice between the parties (akin to presumptive discrimination in the absence of justification for measures introduced). In that situation under the second stage analysis, "there is no need to discuss pro-duty factors, other than perhaps to note the core idea underlying the *prima facie* duty, which is sometimes described as the "fundamental policy consideration" that wrongs should be remedied."[1439] We note here how it is only after the identification of a *prima facie* duty that wider public policy considerations are considered along the lines of those advanced in *Cooper*. It has been suggested that the advantage of this approach is that it "is consistent with the idea that private law obligations are not imposed simply to advance community welfare, except to the extent that the community welfare requires wrongs to be remedied" with the result that broader community welfare considerations "are not engaged unless the duty can first be justified as a matter of justice between the parties."[1440]

Under the prohibition of discrimination under the ICESCR (and indeed international law generally), it will be recalled that one will first consider whether there has been a difference of treatment on the basis of a person's status before turning to questions of proportionality. Where the person has been treated differently on the basis of their status, there will be a *prima facie* case that there has been discrimination. It will then be for the respondent to

---

[1438] A Robertson, *Justice, community welfare and the duty of care*, 127 Law Quarterly Review (2011) at 390.

[1439] A Robertson, *Justice, community welfare and the duty of care*, 127 Law Quarterly Review (2011) citing *W v Commissioner of Police* [2000] 1 WLR 1607 HL at 1618-1619. Roberston notes that it is also common for first instance and intermediate appellate courts to consider the second-stage question in case the first-stage analysis is found on appeal to have been wrong; at 390.

[1440] A Robertson, *Justice, community welfare and the duty of care*, 127 Law Quarterly Review (2011) at 394.

demonstrate that the difference of treatment (whether direct or indirect) was justified, with regard to having a legitimate aim and being proportionate to that aim. From the foregoing, it is clear that a symmetry exists between this two stage approach and that identified in *Anns* and indeed *Caparo* under the above formulation: if there is no justification (the anti-duty factor) for *prima facie* or presumptive discrimination, the case of discrimination is made. If there is justification, the court must balance the duty to the individual against the burden to the respondent and the community.

This suggested re-formulation of *Caparo* into a two-stage test is in part designed to avoid placing a court in a position where it has to weigh individual rights against the common good. A duty of care will only be recognised where the answer to the first question is positive and the answer to the second question is negative.[1441]

It is suggested that by considering justice welfare considerations at separate stages of the test, the courts will not be required to weigh them against each other. This concern is perhaps a valid one, when one seeks to distinguish the jurisprudence on tort. But are courts not to be trusted in weighing individual rights against public policy considerations per *Soobramoney*? Although not significantly developed, the jurisprudence of the Irish courts suggests that they are competent to balance those rights where they identify a core fundamental right at issue, not least in relation to due process rights. That this occurs at present mainly in the sphere of regulating commissions or intrusions rather than omissions of the State and then primarily in the the criminal justice sphere where oppressive State action was at issue, while not necessarily limiting the

---

[1441] A Robertson, *Justice, community welfare and the duty of care*, 127 Law Quarterly Review (2011) at 394-395. Robertson concludes that "three requirements" must be satisfied before pro-duty welfare considerations will become relevant: that a *prima facie* duty is established on the basis of considerations of justice between the parties; that there is no overwhelming anti-duty welfare considerations that operate to trump the *prima facie* duty regardless of any pro-duty considerations that might exist and that there must in the circumstances be some anti-duty welfare considerations that call for a balancing exercise to be carried out between the anti-duty and pro-duty welfare considerations in order to determine whether, on balance, the *prima facie* duty should be overturned. He argues that because these requirements must be satisfied before pro-duty welfare considerations become relevant, the courts will not engage in broad decisions as to whether liability is a good or a bad thing in the circumstances in question, but will rather decide whether the public interest requires "the denial of a duty that would otherwise be recognised because it is fair as between the parties"; at 394-395. Again there is clear consonance with equality law here.

courts from effectively vindicating a constitutional right as *East Donegal*, *Holland* and *Laurentiu* demonstrate, given the separations of powers doctrine and judicial reluctance to examine omissions of the Executive as espoused in *TD*, it is questionable whether the Irish courts will uphold a claim centring on the "obligation to fulfil" the right to health, even one made under tort law. We now turn to consider the parameters of the tort and whether it can effectively discharge right to health requirements.

15 Medical negligence: individual liability

To succeed in a claim for negligence, a plaintiff's action must be grounded in actual damage: s/he must demonstrate a duty of care to prevent the damage or injury caused; that the defendant breached his/ her duty of care by failing to exercise the standard of care required in the circumstances of the case and that the defendant caused the plaintiff to suffer damage or injury which had the potential to attract the remedy of compensatory damages at common law. The traditional medical negligence test mostly follows this general test, albeit with particular deference to medical practitioners. The test is whether there was a duty of care owed, being an interpersonal relationship based upon foreseeability of harm, but in the context of the standard expected of the doctor. In the doctor-patient relationship, the duty of care requirement is satisfied insofar as there is relational proximity and foreseeability present. It will be observed that the ability of the tort of medical negligence to discharge the reparation obligation, where a claim of a violation of access to the AAAQs without discrimination is made, may be limited. Although tort law benefits from its ready availability as a potential remedy, applying as it does to both private and public health actors and thus allowing the State to discharge its reparations "obligation to protect", questions arise as to whether its scope allows for effective remedies. Tort law is limited by both the scope of its interaction (being primarily based on an interactional relationship between patient and doctor (and more latterly a health institution) rather than on access to health services for vulnerable groups) and the high thresholds which must be met for a breach of a duty of care to be established. Although medical negligence can address omissions, it will be observed that these are limited and refer mainly to communications failures, rather than the consideration of preventive healthcare or the social determinants of health, both matters of non-justiciable public health policy. An omission in taking positive measures to ensure a vulnerable person comes within the parameters of the doctor-patient relationship (for example getting speedy care through lack of access to the private tier system) is accordingly not addressed and as will be observed, limits the ability of the tort to meet access to AAAQ concerns.

The physician's duty to the patient was set out by Lord Hewart CJ in *R v Bateman*[1442]:

> ... If [a doctor] .. accepts the responsibility and undertakes the treatment and the patient submits to his direction and treatment accordingly, he owes a duty to the patient to use diligence, care, knowledge, skill and caution in administering the treatment. No contractual relation is necessary, nor is it necessary that the service be rendered for reward.[1443]

In this way, medical negligence has been traditionally conceptualised as the duty of care owed by a doctor to a patient, being an interpersonal private law matter; proximity and foreseeability arising from the doctor undertaking treatment (and responsibility) and the patient submitting to same. That the dimension of liability arising from the relationship is relative can be observed from the traditional standard of proof required at common law when suing a doctor or physician. This standard was set out in *Bolam v Friern Hospital Management Committee*[1444] although curiously this case has never been cited in Irish jurisprudence.[1445] In *Bolam*, McNair J, in his direction to the jury, in setting out this standard of care, cited with approval the formulation of Lord President Lord Clyde in *Hunter v Hanley*[1446] where the Lord President, noting the "ample scope" for genuine differences of opinion in diagnosis and treatment, held that the "true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care".[1447]

[1442] [1925] 94 LJKB 791 at 794.

[1443] See also Denning LJ in *Cassidy v Minister for Health* [1951] 2 KB 343 at 359.

[1444] [1957] 2 All ER 118.

[1445] C Craven, *Medical Negligence: The Dunne Principles and their Application*, in *Medical Negligence Litigation: Emerging Issues*, (eds.) C Craven & W Binchy, First Law (2008) at 4.

[1446] 1955 SC 200 at 204.

[1447] [1957] 2 All ER 118 at 121-122.

The standard is one which would be reasonably expected of the doctor's peers[1448], within the traditional paternalistic concept of medical care, a standard favouring the physician when compared with other torts.[1449] As noted above, there are three dimensions of liability suggested: relative, strict and absolute liability. Medical negligence, being "determined with reference to professional norms" is a dimension of relative liability.[1450] The deferential *Bolam* test was modified in *Bolitho v City and Hackney Health Authority*[1451], which arguably was a step change in the judiciary's willingness to review medical malpractice

---

[1448] McNair's J formulation that a doctor "is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art" is of note insofar as its emphasis on responsible peers does not necessarily denote complete deference to medical practitoners: those giving evidence must do so responsibly under this formulation; [1957] 2 All ER 118 at 122. Such as focus on whether evidence proferred is suggestive of a "responsible body" is evident in *Sidaway v Governors of the Bethlem Royal Hospital* [1985] AC 871 concerning disclosure of risk (discussed below) and in the Indian Supreme Court's Judgment of *Vinitha Ashok v Lakshmi Hospital* 2001 (8) SCC 731, where after referring to *Bolam* and *Sidaway*, the Court stated that a doctor "will be liable for negligence in respect of diagnosis and treatment in spite of a body of professional opinion approving his conduct where it has not been established to the court's satisfaction that such opinion relied on is reasonable or responsible. If it can be demonstrated that the professional opinion is not capable of withstanding the logical analysis, the court would be entitled to hold that the body of opinion is not reasonable or responsible"; per Rajendra Babu J at para 28.

[1449] Moloney characterises the difficulty of successfully suing in medical negligence insofar as "the standard of care in medical negligence cases is still effectively defined by the profession itself"; S Moloney, *Medical Misadventure: Compensation, Accountability and Regulating Standards of Practice*, 6 Medico-Legal Journal of Ireland (2000) 71 at 79. The author notes how even where negligence cases are taken, the tort of medical negligence compares unfavourably to other torts and cites the Royal Commission of Civil Liability and Compensation for Personal Injury (Pearson Commission) 1978 which estimated that 85-90% of all tort claims are brought successfully whereas only 30-40% of medical negligence claims succeed; at 79. The Pearson Report rejected no-fault liability, arguing that "Liability was one of the means whereby doctors could show their sense of responsibility and, therefore, justly claim professional freedom"; Pearson Report, at para 1342.

[1450] J Mullis, *Medical Malpractice, Social Structure, and Social Control*, 10 Sociological Forum (1995) 135 at 143. In contrast to doctor or physician negligence, Mullis cites how in product-liability lawsuits, a substantial proportion of which are brought against the health care industry (e.g., contraceptive and vaccine manufacturers), the negligence criterion has been replaced since the 1960s by stricter liability standards where the plaintiff "need not demonstrate negligence on the part of the manufacturer, only that a causal relationship exists between a defective product and an injury"; at 143. As noted in Part 1, this is also the situation under EU Directives on product liability in the healthcare field.

[1451] [1998] AC 232.

cases.[1452] However even following *Bolitho*, the standard remains as the standard of care reasonably expected of the doctor's peers.[1453]

In Ireland also, the essential test in medical negligence suits is whether the doctor has behaved reasonably in the eyes of his or her peers. The *locus classicus* is *Dunne v National Maternity Hospital*[1454] where Finlay CJ, citing *O'Donovan v Cork County Council*[1455] and *Roche v Peilow*[1456] laid out six principles governing allegations of negligence against professional persons carrying out their professional duties in respect of treatment and diagnosis. The first three of these principles set a high threshold for a medical litigant and repeat the standard set out in *Bolam/ Bolitho*. Under *Dunne*, one must prove the medical practitioner guilty of such failure as no peer would be guilty of, acting with ordinary care; or that the practitioner deviated "from a general and approved practice", or that the practice in question has "inherent defects" which ought to be obvious to any person giving the matter due consideration.[1457] The last three principles deal with evidentiary matters.[1458]

[1452] In *Bolitho* the House of Lords ruled that the expert evidence provided by the defendants needed to have "logical force" to be accepted by the court going beyond the previous situation of being satisfied with its mere existence.

[1453] In *Bolitho*, Lord Browne-Wilkinson employed a test of Wednesbury-like unreasonableness to hold that it would very seldom "be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable"; [1998] AC 232 at 243.

[1454] [1989] IR 91.

[1455] [1967] IR 173.

[1456] [1985] IR 232. The case concerned professional negligence of a solicitor.

[1457] [1989] IR 91. The six principles are: whether the medical practitioner has been proved to be guilty of such failure as no medical practitioner of equal specialist or general status and skill would be guilty of if acting with ordinary care; whether no medical practitioner of like specialisation and skill would have so acted; whether the practice undertaken has inherent defects which ought to be obvious to any person giving the matter due consideration. An honest difference of opinion between doctors will not suffice, nor an alternative course of treatment. Laffoy J in *Mordaunt v Gallaher & anor* [1997] IEHC 123 cited the first of the *Dunne* principles as the "fundamental rubric" in considering medical negligence claims. Healy points out that the professional standards rules were also partly justified by the importance attaching to professional reputation: J Healy, *Medical Malpractice Law* Roundhall Press (2009) at 282.

[1458] Whereas the first *Dunne* principle sets out the stringent test involved in medical negligence claims against doctors, the fourth, fifth and sixth *Dunne* principles primarily refer to procedural or evidential matters and recognise the limited competence of the courts to decide the relative merits or demerits of a particular approach: see C Craven, *Medical Negligence: The Dunne Principles and their Application*, in *Medical Negligence Litigation: Emerging Issues*, (eds.) C Craven & W Binchy, First Law (2008) at 10. In relation to the fourth *Dunne* principle, namely

The *Dunne* principles are commonly applied by the courts to medical negligence suits against all medical specialties, namely physicians, surgeons, obstetricians and gynaecologists, paediatricians, psychiatrists and general practitioners.[1459] However, in certain cases of direct or organisational negligence of hospitals or institutions (discussed below), the *Dunne* principles may not apply. Insofar as the *Hanrahan* doctrine delegates (or subcontracts) the vindication of the constitutional right to health to the tort of medical negligence, a critical question will involve first whether the *Dunne* test, where it applies, is adequate to vindicate the right and second, whether the alternative negligence test applicable to hospital or institution malpractice, is adequate. If inadequate as in "basically ineffective", *Hanrahan* suggests that the constitutional right (perhaps in strict liability terms per *Walsh*) should be considered by the courts as an alternative standard. It is necessary to identify then where the current negligence tests are "effective".

The *Dunne* judgment has been criticised as relying on limited authority and analysis.[1460] Determination of the operative standard of care in negligence cases (even with a *Caparo/ Glencar* policy threshold) is foreclosed through a standard which elevates to special evidentiary status evidence of the defendant's peers and comparators not found in other professional negligence suits.[1461] The focus is not on whether the impugned conduct was reasonable,

---

mere "honest difference of opinion between doctors", this is clearly a matter for evidence, with medical witnesses being called by the plaintiff and defence to argue whether diagnosis or treatment accorded with standard practice or not. Craven argues in favour of the inclusion of "eminent" opinion (as in equivalence of specialisation and skill) from Kingsmill Moore J's original formulation in *Daniels v Heskin* [1954] IR 73; C. Craven, at 10. Insofar as the fourth *Dunne* principle is concerned with evidential matters, this would appear a self-evident approach in benchmarking expert opinion. The fifth *Dunne* principle is primarily an evidential principle while the sixth *Dunne* principle refers to the pre-1988 situation where the first goal of the plaintiff was to have the claim put to a jury. For many medical negligence cases, the tortious requirements of breach of duty of care and causation meant that many claims were never even put to the jury.

[1459] C Craven, *Medical Negligence: The Dunne Principles and their Application*, in *Medical Negligence Litigation: Emerging Issues*, (eds.) C Craven & W Binchy, First Law (2008) at 13-23.

[1460] C Craven, *Medical Negligence: The Dunne Principles and their Application*, in *Medical Negligence Litigation: Emerging Issues*, (eds.) C Craven & W Binchy, First Law (2008) at 5.

[1461] In other fields of negligence the ordinary principles in cases of negligence simpliciter is that the defendant's conduct should be appraised against the standards likely adhered to by the reasonable man in similar circumstances, namely a judicial preference for an objective determination of reasonable care that has regard to a broader array of considerations than the

but rather whether it was so unreasonable that no body of professional opinion would contemplate undertaking it.[1462] This is unsurprising insofar as the *Dunne* principles reflect the *Bolam/ Bolitho* approach of relative liability. The practice does not have to be universally approved but it must be approved by a substantial number of doctors.[1463] The reason for the poor rates of plaintiff success in negligence actions can be arguably traced directly to the *Bolam/ Bolitho* test, which only requires that a medical practitioner "produce" some others that might have done as s/he did to justify her/ his actions.[1464] Indeed, the opinion of the expert medical witness, if accepted by the court, will play a "pivotal" role in proving the issue before the court since under the fourth evidential *Dunne* test (honest difference of opinion) the defence, by employing such expert opinion, may "block" the plaintiff's expert medical evidence and frustrate the claim unless the court employs the evidence as mere assistance in

---

standards favoured by a defendant's peers or occupational representatives: see J Healy, *Medical Malpractice Law* Roundhall Press (2009) at 280.

[1462] See J Healy, *Medical Malpractice Law* Roundhall Press (2009) at 261.

[1463] N O'Carroll Kelly, *General Legal risks of clinical practice and learning lessons from claims*, Medical Negligence Litigation Conference, Royal Marine Hotel, Dun Laoghaire, Dublin (September 2012).

[1464] See J Miola, *Medical Law And Medical Ethics - Complementary or Corrosive?* 6 Medical Law International (2004) 251 at 253-254 (2004). Miola notes how *Bolam* grew and grew encapsulating sterilisation cases, withdrawal of life sustaining treatment and 'informed consent' and how it was only in *Bolitho v City and Hackney Health Authority* [1998] AC 232 that the House of Lords finally ruled that the expert evidence provided by the defendants needed to have "logical force" to be accepted by the court; at fn 7. Note also the approach in the United States where in *Daubert v Merrell Dow Pharmaceutical Inc.* 509 US 579 (1993) the US Supreme Court changed the standard for expert witnesses by requiring the trial judge to undertake a preliminary assessment of whether the reasoning or methodology for the expert testimony is "scientifically valid". Blackmun J's ruling stressed that in screening for reliability courts should look, not to an expert's conclusions, but to his or her "methodology". In *Jones v Young* 607 N.E.2d 61 (Conn. 2003) the Illinois Supreme Court held that a physician must be a licensed member of the school of medicine in question and be familiar with the methods, procedures and treatments ordinarily observed in the defendant physician's community or a similar community. In Ireland, the test is that set out by Finlay CJ in *Best v Wellcome Foundation et al* [1993] 3 IR 421 where he stated the function which a court must perform in the trial of a case in order to achieve a just result is to apply common sense and a careful understanding of the logic and likelihood of events to "conflicting opinions and conflicting theories"; at 462. See generally L Heffernan, *Expert Evidence in Medical Negligence Litigation*" in Medical Negligence Litigation: Emerging Issues, (eds C Craven & W Binchy) First Law 102 (2008) and L Heffernan and M Coen, *The Reliability of Expert Evidence: Reflections on the Law Commission's Proposals for Reform*, 73 Journal of Criminal Law (2009) 488, where the authors record how, in relation to criminal trials, "[s]cientific evidence is popularly perceived to be more reliable than conventional forms of evidence and has been hailed as a bulwark against traditional causes of miscarriage of justice such as fabricated testimony and coerced confessions" and how the Law Reform Commission of England and Wales favoured the *Daubert* test over a medical deference test. In the author' view, the *Daubert* inquiry "has a natural home" within pre-trial practice; at 488, 498 and 507.

making a fair decision rather than as a binding rule precluding the plaintiff's case.[1465]

Deference to expert medical opinion is clear in the jurisprudence of the Irish courts.[1466] The difficulty is that, despite judicial claims to the contrary,[1467] the standard permitted by the courts is that of peer-review and in the absence of a clear link between a stipulated standard of care to a strict or absolute liability test, litigation inevitably becomes bogged down in contrary expert witness testimony, which invariably favours the defendant medical practitioner due to the difficulty of proving causation, the difficulty in sourcing medical experts in the jurisdiction to testify for the plaintiff and the willingness of the courts to defer to medical opinion.[1468] For one author, the consequences of *Bolam/ Bolitho* is that the courts have basically medicalised and abrogated responsibility for decisions to doctors.[1469] However, in *Jones v North West*

[1465] Healy describes the honest difference of opinion principle as dissociating from medical negligence any clinical decision or choice that attracted a reasonable degree of choice in the doctor's specialty: J Healy, *Medical Malpractice Law*, Roundhall Press (2009) at 312-314 and 637-638.

[1466] See *Collins v Mid-Western Health Board* [2000] 2 IR 154 per Keane J; at 156. This is despite Finlay CJ in *Dunne* stating it "unjustifiable to accept as a matter of law a lax or permissive standard of care for the purpose of assessing what is and is not medical negligence"; [1989] IR 91 at 109-110. Indeed, in elaborating the six principles in *Dunne*, Finlay CJ set out two overarching principles: the need to allow medical professionals get on with their work without fear of "unsustainable legal claims" and the need to maintain a high standard of care for the purpose of assessing medical negligence; at 110.

[1467] The courts regularly assert that factual matters are for the judge, the trier of fact where a conflict of expert evidence exists, see for example Geoghegan J for a unanimous Supreme Court in *Griffin v Patton & anor* [2004] IESC 46 (considering that O'Donovan J in the High Court had been too deferential to the medical witnesses in the case). See also *Kelly v Lenihan* [2004] IESC 427.

[1468] See the dissent of Carter J in *Huffman v Lindquist* 37 Cal.2d 465 where he stated that anyone familiar with cases of this character knows that the so-called ethical practitioner will not testify on behalf of a plaintiff regardless of the merits of his case, largely due to the pressure exerted by medical societies and public liability insurance companies: "physicians who are members of medical societies flock to the defense of their fellow member charged with malpractice and the plaintiff is relegated, for his expert testimony, to the occasional lone wolf or heroic soul, who for the sake of truth and justice has the courage to run the risk of ostracism by his fellow practitioners and the cancellation of his public liability insurance policy"; see *http://scocal.stanford.edu/opinion/huffman-v-lindquist-26298* accessed on 21 October 2012.

[1469] Miola asks where the hypothetical doctor is to find the information which will help her reach her decision, noting that neither the General Medical Council, nor the British Medical Association "seem able or willing to offer directive guidance on this point"; J Miola, *Medical Law And Medical Ethics - Complementary or Corrosive?* 6 Medical Law International (2004) 251 at 269, stressing the importance of such decisions being subjected to some kind of regulatory process; at 270.

Strategic Health Authority[1470] Nicols J stated that, at least where there are alternative medical routes available in surgery, the role of the expert medical witness is limited to advising the court.[1471] Judicial statements on the limited role of expert witnesses become more pronounced in disclosure of risk cases where the focus moves from a doctor-centred to patient autonomy-centred approach (discussed below).

Whereas the six *Dunne* principles concern most medical negligence suits where they relate to diagnosis or treatment injury claims against medical practitioners, the principles are less applicable to other areas identified under the right to health such as the standard of care expected in a hospital or institution[1472]; disclosure of risk to the patient, the related question of informed consent to treatment (where the test is not peer review but the information needs of the patient) and the wider question of access to treatment for vulnerable groups, where a doctor does not undertake or assume treatment and responsibility and where what is at issue may be more omission than commission. These "other areas" will be explored below.

Challenges facing plaintiffs under the professional negligence standard are formidable insofar as it "protects all customary practices" save those involving inherent defects which ought to be obvious to anyone due consideration.[1473] The standard under *Dunne* is contextualised to their particular discipline.

[1470] [2010] EWHC 178.

[1471] In such cases the role of the medical expert is not to identify whether or not there is a body of responsible or reasonable medical opinion in accordance with which the doctor in question acted. That sets the bar too high in determining whether the risk was a matter which should have been disclosed. "Whether or not a risk is 'significant' is ultimately for the Court to decide"; [2010] EWHC 178 at para 24. According to Maclean, this relegates the experts to "their proper place as factual adviser to the judge"; AR Maclean, *From Sidaway to Pearce and Beyond: Is the legal regulation of consent any better following a quarter of a century of judicial scrutiny?* 20 Medical Law Review (2012) 108 at 118.

[1472] In *Glasgow Corporation v Muir* [1943] 2 All ER 448 this was held as being the standard of care objectively considerd by the "reasonable person"; per Macmillan LJ at 457.

[1473] W Binchy, *Issues of Proof in Medical Negligence Litigation: New Questions Posed in the Irish Courts*, in *Medical Negligence Litigation: Emerging Issues*, (eds.) C Craven & W Binchy, First Law (2008) at 56.

Walsh J in *O'Donovan v Cork County Council*[1474] stated that the standard is set at an ordinary level of skill relative to the practitioner's field:

> A medical practitioner who holds himself out as being a specialist in a particular field is required to attain to the ordinary level of skill amongst those who specialise in the same field. He is not required to attain to the higher degree of skill and competence in that particular field.[1475]

In treatment injury cases, an error of judgment by a doctor will not ordinarily constitute negligence as set out by Lord Fraser in *Whitehouse v Jordan*[1476] where the Court held that there will be no negligence if it is an error "made by a reasonably competent professional man professing to have the standard and type of skill that the defendant held himself out as having ... acting with ordinary care".[1477] Liability may be defeated by reference to a low threshold of proof, where there is evidence of any professional support for what the practitioner did. Breach of the "ordinary care" expected of medical practitioners as set out in both the first and second *Dunne* principles will not suffice to establish negligence if "any" professional support may defeat the claim, rather direct evidence of deviation will be required of the plaintiff to succeed.

Medical negligence claims against physicians often involve unsuccessful claims of failure to correctly diagnose or intra-operative injury.[1478] The application of the first *Dunne* principle (guilty of such failure as no similar medical practitioner acting with ordinary care) has seen the courts reluctant to find negligence. A finding of negligence in the failure to diagnose a fatal tumour in *Wolfe v St James' Hospital & ors*[1479] was overturned by the Supreme Court where Fennelly J found that the "loose ends" which Barr J had referred

---

[1474] [1967] IR 173.

[1475] [1967] IR 173 at 190.

[1476] [1981] 1 All ER 267.

[1477] [1981] 1 All ER 267 at 281.

[1478] See C Craven, *Medical Negligence: The Dunne Principles and their Application*, in *Medical Negligence Litigation: Emerging Issues*, (eds.) C Craven & W Binchy, First Law (2008) at 8.

[1479] [2002] 2 JIC 2003.

to in the High Court (as not having been cleared up) did not, in the view of the Supreme Court, mean that the "standard laid down in Dunne" had been breached.[1480]

A medical diagnosis is not required to be correct under the law, rather it suffices if it was a reasonable one made in the circumstances.[1481] Although varying depending on whether the doctor is a specialist or a generalist[1482], provided a doctor or surgeon follows standard practice, the courts will not make a finding of negligence on the basis of wrongful diagnosis under *Dunne*.

Treatment injury can be differentiated between intra-operative decisions of the surgeon where liability is rarely found and a failure to properly follow-up with or supervise vulnerable patients, where the courts are more sympathetic. In relation to intra-operative decisions, the courts on each occasion have upheld the validity of the surgeon's decision under the first of the *Dunne* principles. Medical treatment, reasonably undertaken, even if it is causative of injury will not constitute negligence on the basis that it is not for the courts to second-guess surgeon's decisions during surgery.[1483] This can also extend to an arguable claim that a surgeon failed to take adequate precaution prior to or during surgery which results in injury: the surgeon does not have to treat a

---

[1480] [2002] 2 JIC 2003. See also *Cleary v Cowley & anor* [2002] 12 JIC 2006 per Carroll J and the US case of *Helling v Carey* (1974) 83 Wash. 2d 514 where the Supreme Court of Washington found negligence where an optamologist failed to check for glaucoma through a simple and inexpensive test, per Hunter J. The context of the case may determine the standard of care owed and statistical unlikelihood of injury happening may not be determinative.

[1481] This is in addition to satisfying the 'but for' test: see *Quinn v Mid-Western Health Board* [2005] 4 IR 1 discussed below.

[1482] A doctor will not be liable for having and acting with appropriate knowledge and skill as found in the profession where this refers to "such knowledge and skill as conformed at that time to the recognised contemporary standard of his profession": see *Buckley v National Maternity Hospital* [1998] 12 JIC 2101 per Smith J. This case contrasts with *Philp v Ryan* [2004] 4 IR 241 where in the High Court, Peart J also applied the first *Dunne* principle, this time to impose liability following inadequate pre-operative investigations. This was upheld in the Supreme Court per Fennelly J, discussed below.

[1483] Craven also cites the cases in which the surgeon's decision was upheld in *Mordaunt v Gallaher & anor* [1997] IEHC 123 (surgical wires being removed from the plaintiff's hip), *Barrett v Southern Health Board* Professional Negligence Law Report 211 (removal of plates from plaintiff's arm) and *Conley v Strain* [1988] IR 629 (surgical packing to a haemorrhage in a road traffic head injury); See C Craven, *Medical Negligence: The Dunne Principles and their Application*, in *Medical Negligence Litigation: Emerging Issues*, (eds.) C Craven & W Binchy, First Law (2008) at 16-17.

patient successfully under the *Dunne* principles, provided s/he acts reasonably in providing the treatment.[1484]

However, the courts will be more disposed to finding for the plaintiff where medical follow-up is clearly inadequate[1485] or where proper supervision of a vulnerable patient does not occur.[1486]

[1484] In *Griffin v Patton & anor* [2004] IESC 46 what was at issue was whether a surgeon had engaged in a practice which had "inherent defects" under the third *Dunne* principle (as opposed to its being a "general and approved" practice). In the High Court, O'Donovan J took account of the fact that the medical procedure at issue was difficult and not routine in finding that it was incumbent on the surgeon to carry out an ultrasound to detect whether all foetal bone had been removed from the plaintiff following a miscarriage. In dismissing the defendant's appeal in the Supreme Court, Geoghegan J nonetheless concluded that a finding of negligence could not be sustained under the third *Dunne* principle, not least insofar as it had not been pleaded. The use of procedural argument to defeat medical negligence claims was also evident in *Shuit v Mylotte & ors* [2006] IEHC 89, where White J first found that a defendant gynaecologist was not negligent in carrying out a radical hysterectomy on the plaintiff on the basis that the onus of proof lay with the plaintiff who had failed to prove that no gynaecologist acting with ordinary care would have carried out the procedure. White J then proceeded to dismiss the inherent defects argument on the basis of the defendant's technical argument that it was never part of his case that his defence was one of "general and approved" practice. In *Edwards v Jenkins & Ors* [1989] IEHC 36 O'Hanlon J's finding was upheld in the Supreme Court to the effect that the defendant doctors were not negligent in providing treatment for a post-operative infection where the medical treatment under scrutiny was subscribed to by a substantial body of doctors and was not inherently defective. In contrast, organisational negligence claims adopt a more straight forward approach. In *Gottstein v Maguire & anor* [2004] IEHC 416, Johnson J cited Walsh J's comments in *O'Donovan* to find defective a hospital system practice which did not ensure that an expert in the replacement of a tracheostomy tube was located in the intensive care unit of a hospital where the plaintiff's husband had died following an operation. Considering that the defendant ear, nose and throat surgeon had overall responsibility for the patient, Johnson J found him negligent for the hospital's failure to have an expert in place during the patient's recovery to guard against such an eventuality: "[I]t was an emergency, but that is what Intensive Care Units are there to deal with, among other things, and indeed one could scarcely have envisaged a situation where a patient who has a nurse actually individually looking after him in such a hospital should not have the necessary training or a doctor properly trained to deal with this problem which was a known occurrence"; see further below.

[1485] In *Collins v Mid Western Health Board* [2000] 2 IR 154, the patient died from a haemorrhage. The Supreme Court found the doctor negligent not because of his misdiagnosis of the patient's condition, but rather because he did not follow up closely with the patient in light of the information he had received from the deceased's wife. In *Fitzpatrick v Midland Health Board* [1997] IEHC 76, another case concerning follow up to medical treatment, Johnson J followed the evidence presented and found a lack of unanimous professional opinion on the central question in the case: that of the immediate application of broad spectrum antibiotics to the plaintiff's condition. This lack of unanimity did not lend to a finding of negligence by the court. However, the High Court found that once it was agreed upon to prescribe antibiotics to the patient, there was unanimity in medical opinion as to the effects of delay (being partial amputation of the plaintiff's finger). This was negligence. Where antibiotics were not being employed, it was "necessary that (a) a report be delivered regarding the culture of the swab as soon as is practicable to the treating doctor (b) that it is brought to his attention and (c) that he is therefore enabled to act upon it as soon as possible"; at para 22. In *Kavanagh (A Minor) v Murphy & South Eastern Health Board* [2003] IEHC 105 O'Donovan J found the defendant obstetrician's attention to the infant plaintiff following his delivery inadequate and negligent and similarly found the hospital adminisrators negligent in not having in place any protocols for high-risk follow up: this was " both misguided and

Similarly arguments that treatment injury was negligently caused by delegating the treatment to a junior physician will not normally succeed under the *Dunne* principles where this is common practice.[1487] Only where a doctor does not act with ordinary care, does not follow a general and approved practice or does not give due consideration to medical practices which may suggest inherent defects, may s/he be guilty of negligence.

In addition to the procedural rules set out in *Dunne*, evidential rules focus on whether the probability standard of proof can be made out. Where the probabilities are equal in the arguments advanced by plaintiff and defence alike, the action will not succeed, unless the plaintiff is exceptionally relieved of proof under the doctrines of *res ipsa loquitur* or material causation (see below). In addition to evidential rules, procedural statutory provisions and rules of court have introduced some changes to the common law, usually to the benefit of the defence with the aim of cutting the costs of medical litigation. As noted, the Statute of Limitations Act 1957 (as amended) has introduced restrictions as to when a plaintiff may institute proceedings for a breach of a constitutional, statutory and/ or common law right or is otherwise debarred from doing so,[1488] while the Civil Liability and Courts Act 2004[1489] now provides that a medical negligence claim must be brought within two years of

---

without justification". See C Craven, *Medical Negligence: The Dunne Principles and their Application*, in *Medical Negligence Litigation: Emerging Issues*, (eds.) C Craven & W Binchy, First Law (2008) at 15-16. McMahon and Binchy note how general practitioners are not usually in the "front line" of litigation for negligence, partly because their main role is to diagnose serious cases and refer them to hospital, while the personal relationship element with the patient may also be relevant, the courts have made findings of negligence where a doctor fails to follow up with a sick patient; see B McMahon and W Binchy, *Law of Torts* (3rd Ed.) Butterworths (2000) at 370.

[1486] For a discussion of the second Dunne principle (deviation from a "general and approved practice" no other doctor would undertake) see C Craven, *Medical Negligence: The Dunne Principles and their Application*, in *Medical Negligence Litigation: Emerging Issues*, (eds.) C Craven & W Binchy, First Law (2008) at 20-21.

[1487] In *O'Donovan v Cork County Council* [1967] IR 173, Walsh J stated that although mere repetition of a practice would not cure an inherent defective practice, on the evidence that there were no "inherent defects" where there was a general and approved practice of permitting a house surgeon to perform an operation when the county surgeon was unavailable (he was at home 20 miles away); at 190-193.

[1488] See *Gough v Neary* [2003] 3 IR 92 and *Cunningham v Neary* [2004] 2 ILRM 498.

[1489] The 2004 Act was inspired by Lord Woolf MR's *Access to Justice Final Report, Final Report to the Lord Chancellor on the civil justice system in England and Wales* (1996) which had led to the UK Civil Procedure Rules 1998.

the accrual of the cause of action.[1490] Further, as medical negligence does not come within the ambit of the Personal Injuries Assessment Board Act 2003, the timeframe within which medical negligence proceedings must be initiated is now shorter than most other personal injury cases.

Out of deference to medical practitioners (inconvenience and potential damage to reputation), the courts increasingly insist that there be reasonable grounds to pursue a medical negligence claim. Barr J in *Reidy v The National Maternity Hospital*[1491] stated that initiation and prosecution of an action in medical negligence must be supported by appropriate expert evidence from the outset.[1492]

Other legislative reforms place further hurdles in front of plaintiffs. Under Section 8(1) of the 2004 Act, the plaintiff must serve a notice in writing to the defendant within 2 months from the date of the cause of the action, otherwise the court may draw inferences as to the plaintiff's costs.[1493] The issue of costs, under Irish litigation, may well be a determinant as to whether an impecunious litigant can avail of legal assistance on a *no foal no fee* basis. Where initial delay in bringing suit occurs a case may not even get off the ground.[1494]

Under the 2004 Act, the plaintiff must seek to engage in alternative dispute resolution through mediation (sections 15 and 16), with costs again capable of

---

[1490] This is a shorter period of time than apply for other torts such as trespass.

[1491] [1997] IEHC 143.

[1492] [1997] IEHC 143 at para 24. See also *Connolly v Casey* [2000] 1 IR 345 and *Cooke v Cronin* [1999] IESC 54. Under Section 10 of the Civil Liability and Courts Act 2004, a medical report will normally be required to substantiate the claim and provide sufficient particulars to enter into the endorsement of claim. This is similar to the position in the United States where there is a common current among all States on the fundamental requirements for establishing a *prima facie* case by setting out the facts, supported by a physician's affidavit: see *Jones v Young* 607 N.E.2d 61 (Conn. 2003) (Illinois Supreme Court) per Abrahamson J at para 89; and J H Scheid *Some Statutory Responses to the American Medical Malpractice Crisis*, in *Medical Negligence Litigation: Emerging Issues*, (eds C Craven & W Binchy) First Law (2008) at 223.

[1493] Section 8, in conjunction with section 10 of the 2004 Act, causes significant difficulties to plaintiffs who may need to secure an expert medical report within that period of time in order to correctly plead the particulars of negligence as required under Section 10.

[1494] See concerns expressed by Ryan J in *Kearney v McQuillan & North Eastern Health Board* [2012] IEHC 127.

being awarded against either party on the basis of their behaviour.[1495] Further, the plaintiff must serve a notice in writing under section 17 of an offer of settlement and the defendant must similarly serve a notice of any offer of settlement. Further reforms are planned under the Draft General Scheme of the Mediation Bill 2012 and the Draft Scheme of the Civil Liability (Damages) Bill 2012 (discussed below) and will likely extend to pre-trial protocols on admissibility of expert evidence reports to advance mediation initiatives.[1496]

It will be recalled however that toleration and tendency toward inaction of victims can be explained "partly with reference to the status superiority of physicians and hospitals"[1497] and in this context, arbitration experience in the United States appears to also favour health care providers. Such patterns reinforce the earlier propositions regarding "status asymmetry" where the higher the offender's status relative to the aggrieved, the increase in legal advantage which accrues.

An emerging area of the law are hospital acquired infections or nosocomial infection ("HAI").[1498] Claims of HAI hospital negligence "are arguably the

---

[1495] Mediation is to be introduced on a statutory basis under the draft General Scheme of the Mediation Bill 2012 which will introduce a new statutory obligation on solicitors and barristers to inform their clients, prior to commencing court proceedings on their behalf, about the possibility of using mediation as an alternative means of resolving the dispute. Other reforms under the 2004 Act include verifying affidavits (section 14), criminal sanctions for false evidence (section 25) and fraudulent actions (section 26) and the court's ability to appoint medical experts (section 20). Prior to hearing, under the Rules of the Superior Courts (No.6) (Disclosure of Reports and Statements) 1998, the parties are also obliged to exchange copies of their medical reports in advance of hearing. As to the purpose of pre-action protocols, according to Lord Woolfe speaking extra-judicially, they aim to resolve litigation at an early stage by creating conditions favourable to settlement with the court rather than the parties taking ultimate responsibility for ensuring that the proceedings are conducted with reasonable speed and in an open and proportionate manner: Lord Woolf *Are the courts excessively deferential to the Medical profession?* 9 Medical Law Review (2001) 1 at 15.

[1496] Section 19 of the 2004 Act currently gives the court the power to direct that evidence as to any matter may be given on affidavit but is obviously subject to the fair procedures dictates of the Constitution. Ryan suggests that mediation may allow for "justice" issues to be addressed beyond mere compensation, with an apology and explanation also possible. She also argues that mediation may "preserve" the relationship between the parties. Where mediation is not possible, she recommends the expedited procedures of the Commercial Court under Order 63A of the Rules of the Superior Courts which could be utilised in malpractice suits: R Ryan, *The future of medical negligence and claims management*, Medical Negligence Litigation Conference, Royal Marine Hotel, Dun Laoghaire, Dublin (September 2012).

[1497] J Mullis, *Medical Malpractice, Social Structure, and Social Control*, 10 Sociological Forum (1995) 135 at 142 and 150.

[1498] See R Hanly, *Hospital-Acquired Infection: The Challenges for the Law of Negligence* 32 Dublin University Law Journal (2010) at 70. Hanly addresses potential claims for HAI as a

most difficult of clinical negligence claims [to prove]".[1499] The plaintiff must prove on the balance of probabilities, often in the absence of clinical notes, that the harm occurred in the hospital and not before. S/he must prove that the defendant hospital or doctor was negligent and must satisfy the "all-or-nothing" causation test as set out in *Anderson v Milton Keynes General NHS Trust and Oxford Radcliffe Hospital NHS Trust.*[1500] However in *Miller v Greater Glasgow NHS Board*[1501] the court stated that in relation to infection negligent claims "... as a matter of principle, we see no insuperable obstacle to a claimant making a case against a hospital authority of the kind which has been undertaken in this action" although expressing reservations that liability not "flow from the mere presence of an infective agent within the hospital workplace".[1502]

In relation to infection suits, it is suggested that under the present duty of care test this is almost impossible due to the fact that scientific certainty is rare; the dynamics of HAI involve the interplay of the 'seed' (the microbe causing the infection), the 'soil' (the infected patient') and the 'climate' (all aspects of the environment)."[1503] Perhaps because of the near impossibility of discharging the

---

groundbreaking issue under medico-legal litigation, although she notes the paucity of cases which have been adjudicated upon to date both in Ireland and the United Kingdom. HAI is a good example of the justiciability of the right to health under Irish law insofar as it may identify whether the law of tort and State regulation may underpin the right in a meaningful way. For example, on the one hand risk control measures introduced further to the functions of the State Claims Agency to combat HAI are complemented by increased supervision by HIQA. Hanly notes how the States Claim Agency downgraded its estimate of 1,500 legal claims resulting in a bill of €500m for MRSA cases alone to approximately €75m over 15 years.

[1499] R Hanly, *Hospital-Acquired Infection: The Challenges for the Law of Negligence* 32 Dublin University Law Journal (2010), citing E Rawson, *The Tip of the Superbug Iceberg* 14(2) Clinical Risk (2008) 72 at 73.

[1500] [2006] EWHC 2249.

[1501] [2010] CSIH 40 Inner House Court of Session (Scotland).

[1502] [2010] CSIH 40 Inner House Court of Session. Lord Osborne stated that the operators of a hospital might owe a duty of care to patients in respect of infection which might be contracted within a hospital; at para 40.

[1503] R Hanly, *Hospital-Acquired Infection: The Challenges for the Law of Negligence* 32 Dublin University Law Journal (2010), citing B Cookson, *Hospital Acquired Infection* in M Power et al (eds), Clinical Negligence (4th ed, Tottel Publishing, 2008) 1733 at 1736; at 64 fn 8. Healy notes how the conventional means employed to address HAIs such as MRSAs (anti-baterial hand-washing by hospital staff and patients) is not monitored or recorded in its particulars rendering attempts at linking causation difficult, augmented by the uncertain aetiology of the MRSA bateria: J Healy, *Medical Malpractice Law* Roundhall Press (2009) at 244-245.

requirement of proving causation, France introduced tort reform including strict liability tests for HAIs in addition to defective medicinal products under Part IV of the Patients' Rights and Quality of the Health System Act 2002.[1504] As with asbestos injury, it may be that HAI injury should benefit from modified causation requirements insofar as the similarities between HAI infection litigation and the *Bonnington/ McGhee* and *Fairchild* line of jurisprudence (see below) is that the plaintiff cannot demonstrate the negligence of the defendant without the courts permitting a modified causation test.[1505] Whether this will occur in light of the third limb "policy" test in *Caparo/ Glencar* is unclear.[1506]

In *Barker v Corus*[1507] Lord Hoffman stated that "whether the other exposure was tortious or non-tortious, by natural causes or human agency or by the claimant himself" is irrelevant when "satisfying the requirement of a sufficient causal link between the defendant's conduct and the claimant's injury."[1508] This statement identifies the risks of exposure as being key, noting also that the court in *Barker* somewhat modified the previous reasoning in *Fairchild v Glenhaven Funeral Services Ltd*[1509] where the House of Lords had allowed the claim in the interests of justice. In *Barker* the court held that liability should be proportionate to the extent of the risk created by the employer. Lord Rodger's

---

[1504] Taylor notes how health organisations will be strictly liable for any loss caused to the patient by a bacterial infection contracted during a visit to their premises. The only defence is by showing that the infection was caused outside the medical establishment; S Taylor, *Clinical Negligence Reform: Lessons from France?* 52 The International and Comparative Law Quarterly (2003) 737 at 742.

[1505] J Healy, *Medical Malpractice Law* Roundhall Press (2009) at 246-247.

[1506] Binchy expresses concern about the burden of proof facing plaintiffs "in previously unlitigated fact-situations", taking into account the incrementalism now favoured post *Caparo/ Glencar*; W Binchy, *Meskell, the Constitution and Tort Law* 18 Dublin University Law Journal (2011) 339 at 344-346. One such "unlitigated fact-situation" is clearly a HAI injury, received in hospital from treatment of an illness or injury. Following *Glencar*, any suit in negligence for such injury must be in doubt mainly due to the high level of evidence required to satisfy the causation test, insofar as the third limb of Caparo may allow for a finding of negligence on policy grounds. A category of medical negligence known as "loss of chance" (see below) may offer some potential for emerging areas of law such as HAI, particularly in an occupational health context.

[1507] [2006] 2 AC 572.

[1508] [2006] 2 AC 572 at 585.

[1509] [2002] 3 WLR 89.

formulation in *Barker* may permit the *Fairchild* test to be applied outside the occupational context to other health areas such as HAI and if so, its focus on proportionate liability side steps the "all or nothing" approach.[1510] As against such a trend however is the observation that the courts may be reluctant to extend the *Fairchild* principle unless such cases are "so directly analogous to the current class of exceptions" that to refuse to take such a tiny incremental step "would be manifestly illogical and/ or unjust and that for an extension to occur, there will have to be compelling policy reasons".[1511]

A difficulty facing HAI claims may arise where a defence is based on allocation of insufficient resources with the question here as to whether the plaintiff would have to demonstrate that the lack of resources directed towards, for example, infection control, was as a result of the institution's negligence.[1512] Where the claim of negligence alleges institutional failure, perhaps a failure to follow national guidelines on infection control, might an inadequate resource allocation to the institution by the HSE, not raise a resources defence? However, insofar as Mustill J in *Wilshire v Essex AHA*[1513] held that inadequate funding should not afford such a defence, such a blanket defence arguably would not find favour with the Irish courts.

The *Dunne* principles, while ostensibly meeting the "obligation to protect" by permitting reparations accountability, in fact set a high threshold for proving medical negligence and do not allow for issues such as the speed or adequacy of healthcare access through the public as opposed to the private tier system. This limits the ability of tort law to meet access to AAAQ concerns apart from "pockets of cases" which are next addressed. It will be observed that in such

---

[1510] See R Hanly, *Hospital-Acquired Infection: The Challenges for the Law of Negligence* 32 Dublin University Law Journal (2010) at 91.

[1511] R Plowden, *The Socioeconomic Burden of Hospital Acquired Infection* 5(4) Euro Surveillance (2000), cited by R Hanly, *Hospital-Acquired Infection: The Challenges for the Law of Negligence* 32 Dublin University Law Journal (2010) at 66, 85 and 92. See also S Plowden and H Volpe, *Fairchild and Barker in MRSA cases: Do Fairchild and Barker Provide an Argument for the Relaxation of Causation Principles in Claims for Hospital-Acquired MRSA*? 3 Journal of Personal Injury in Law (2006) at 259. See also *Quinn v Mid-Western Health Board* [2005] 4 IR 1, discussed below.

[1512] R Hanly, *Hospital-Acquired Infection: The Challenges for the Law of Negligence* 32 Dublin University Law Journal (2010) at 80.

[1513] [1987] 1 QB 730.

cases, the courts have adopted a number of doctrines or principles to address the situation where it is near-impossible for a plaintiff to prove causation. Examples of such situations are where the plaintiff is unconscious during an operation, develops lung cancer after working with microbes or where the lack of timely diagnosis or surgical intervention increases the person's risk of morbidity. These principles, namely the doctrine of *res ipsa loquitur*, material causation of the injury and loss of chance, are next examined.

15.1 *Res ipsa loquitur*

The doctrine of *res ipsa loquitur* (things speak for themselves) may act as a counterpoint to the *Dunne* principles and offer some hope for patients insofar as it may assist the plaintiff in shifting the burden of proof to the defendant. The doctrine originated from the dicta of Pollock CB in *Byrne v Boadle*[1514] which were later elevated to a principle by Erle CJ in *Scott v London & St. Katherine Docks Co*[1515] where he held that although there must be reasonable evidence of negligence, where "the thing" is shown to be under the management of the defendant or his or her servants "and the accident is such as in the ordinary circumstances does not happen if those who have the management use proper care", it affords reasonable evidence, in the absence of explanation by the defendants, that the accident arose from want of care.[1516]

It has been suggested that in the healthcare context, the twin requirements of "the thing" and being under the control or management of the defendant are difficult to reconcile where "the thing" must refer to the patient, whereas an emphasis on the relationship of "reliance and dependency" would be preferrable.[1517]

[1514] 2 H&C 722, 159 ER 299 (1863).

[1515] (1865) 3 H&C 596 at 601, 159 ER 665.

[1516] (1865) 3 H&C 596 at 601, 159 ER 665 at 667.

[1517]Binchy questions the meaningfulness of considering whether a hospital controls every "object" (including patients and visitors) as opposed to controlling the "entire operation". This latter explanation of control ties in with the understanding of "control" under the ICESCR, i.e. as referring to macro "control" of the "entire operation" of a health service; W Binchy, *Issues of Proof in Medical Negligence Litigation: New Questions Posed in the Irish Courts*, in

Lord Hobhouse in *Ratcliffe v Plymouth and Torbay Health Authority*[1518] described the role of the *res ipsa loquitur* doctrine as enabling the plaintiff not in possession of all the material facts "to be able to plead an allegation of negligence in an acceptable form and to force the defendant to respond to it" at the peril of having a finding of negligence made if the defendant does not provide an adequate response.[1519]

The Irish courts have considered the *res ipsa loquitur* doctrine and whether the defendant should be required to provide an adequate response on a number of occasions, finding there may be such a requirement where there is high statistical unlikelihood of an injury. In *Daniels v Heskin*[1520] and *Griffin v Patton & anor*[1521] the question arose whether the doctrine could be triggered where the plaintiff adduced evidence of statistical unlikelihood of an injury occurring as being over 60%. Geoghegan J in *Griffin* doubted the efficacy of statistics alone without more. Both cases suggest some willingness to move from general statistical data to the imposition of an onus of proof on the defendant under the *res ipsa loquitur* doctrine, but arguably only where the percentage likelihood of injury is high; otherwise judgments evince reluctance to engage in statistical measurements.[1522]

The approach in the Irish courts has been to place an onus on the defendant to provide some explanation where the *res ipsa loquitur* principle applies. However, where a young girl lapsed into a coma during surgery and it was a mystery why this occurred, the Supreme Court in *Lindsay v Mid-Western Health Board*[1523], reversing Morris J (who had found negligence on the basis

---

Medical Negligence Litigation: Emerging Issues, (eds.) C Craven & W Binchy, First Law (2008) at 59.

[1518] [1998] Lloyd's LR Med. 162.

[1519] [1998] Lloyd's LR Med. 162.

[1520] [1954] IR 73.

[1521] [2004] IESC 46.

[1522] W Binchy, *Issues of Proof in Medical Negligence Litigation: New Questions Posed in the Irish Courts*, in *Medical Negligence Litigation: Emerging Issues*, (eds.) C Craven & W Binchy, First Law (2008) at 64.

[1523] [1993] 2 IR 147.

that the defendant's explanation was hypothetical and speculative), held that all that was required of the defendant was that it demonstrate that the surgeon exercised reasonable care.[1524]

In *Lindsay*, O'Flaherty J held that it would be an "unjustifiable extension of the law" to say that in the absence of a provable explanation, on the balance of probabilities, negligence on the part of the defendant must be inferred.[1525] He considered this would be "so onerous as to produce an unjust result".[1526] The relative liability standard of *Dunne* remains: any evidence of reasonable care will suffice, while lack of definitive proof of what happened while a patient was unconscious will prove fatal for a negligence claim. All the *res ipsa loquitur* doctrine requires is for the defendant to demonstrate per *Dunne* principles that there was no negligence by rebutting the relative onus of proof once the burden switches to him or her.

Lindsay was one of a number of cases which did not refer to the Supreme Court judgment in *Hanrahan* where, it will be recalled, Henchy J restated the *res ipsa loquitur* doctrine in support of the argument that the law of tort was effective to discharge the constitutional right to bodily integrity in that case. Although Keane J disposed of the case by way of the tort of nuisance in *Hanrahan*, for Henchy J the doctrine of *res ipsa loquitur* permitted a reversal of the burden of proof. In contrast to the later judgment in *Lindsay*, he stated that

> the rationale behind the shifting of the onus of proof to the defendant in such cases would appear to lie in the fact that it would be palpably unfair to require

---

[1524] [1993] 2 IR 147. The difficulty facing the plaintiff was that she could not prove negligence: what happened during surgery was a mystery to her. O'Flaherty J for the Supreme Court stated that there was no requirement on the defendant to prove on the balance of probabilities what had caused the brain damage once the *res ipsa loquitur* principle applied; reasonable care sufficed. Once the defendant established "decisively" that from the beginning to end of the anaesthetic procedure there was no negligence on its part, it "rebutted the burden of proof that rested on it to displace the maxim *res ipsa loquitur* and so the case returned to the plaintiff's bailiwick to prove negligence"; at 185.

[1525] [1993] 2 IR 147 at 185.

[1526] [1993] 2 IR 147 at 185.

> a plaintiff to prove something which is beyond his reach and which is peculiarly within the range of the defendant's capacity of proof.[1527]

Yet followed logically, such an unfairness is surely what occurred in *Lindsay* where the plaintiff could not possibly have proved negligence. Henchy J's formulation of a reversal of the burden of proof in *Hanrahan* has not been followed in practice by the Irish courts. In addition to the cases of *Lindsay*, *Merriman v Greenhills Foods Ltd*[1528] and *O'Shea v Tilman Anhold and Horse Holiday Farm Ltd*[1529], Hardiman J in *Rothwell v Motor Insurers Bureau of Ireland*[1530] approved Henchy J's perspective on *res ipsa loquitur* in *Hanrahan*[1531], before holding that the plaintiff could not demonstrate an oil spill by an unidentified driver as this was not "peculiarly within the range of the defendant's capacity of proof" or knowledge and that the doctrine was "inapplicable" in the case before him.[1532]

Indeed, due to the difficutlies of proving matters within a defendant's knowledge, it has been suggested that it is open to the Irish courts to follow the Supreme Court of Canada and the High Court of Australia in permitting the doctrine of *res ipsa loquitur* to be replaced by negligence *simpliciter* considerations.[1533]

In *Maitland v Swan and Sligo County Council*[1534], Barr J found that the defendant had negligently removed the plaintiff's right ovary without seeking prior gynaecological support and advice. Here the facts were within the

---

[1527] [1998] ILRM 629 at 634-635.

[1528] [1997] ILRM 46.

[1529] Unreported, 23 October 1996 (HC) at 5.

[1530] [2003] 1 IR 268.

[1531] "[*Hanrahan*] appears to me to be authoritative unless and until specifically considered in a case where its reversal is sought. In any event, it appears accurately to state circumstances in which, and the basis on which, the onus of proof may shift in civil litigation."; [2003] 1 IR 268 at 275.

[1532] [2003] 1 IR 268 at 275-276.

[1533] W Binchy, *Issues of Proof in Medical Negligence Litigation: New Questions Posed in the Irish Courts*, in *Medical Negligence Litigation: Emerging Issues*, (eds.) C Craven & W Binchy, First Law (2008) at 73-74.

[1534] Unreported, 6 April 1992 (HC).

plaintiff's province of knowledge, she was not unconscious when the damage occurred as in *Lindsay* and as there was no "mystery" as to what occurred, accordingly it was held that there was no need to have recourse to the *res ipsa loquitur* principle. In *Doherty v Reynolds and St. James's Hospital*[1535], the Supreme Court allowed an appeal against a High Court finding that a shoulder injury pain was attributable to traction injury suffered during the plaintiff's surgery to address his acid reflux and heartburn.[1536] At issue was whether the plaintiff fell off the operating table while under anaesthetic where hospital records were incomplete. Keane CJ held that in addressing the *res ipsa loquitur* principle, O'Donovan J had misdirected himself in law in giving insufficient weight to two aspects of the defendants' evidence in the case. Whereas the principle required the defendants to answer the plaintiff's case,[1537] the trial judge had weighed the evidence of two neurologists and not the "honest evidence" of some of the hospital staff[1538] who testified to the effect that they could not recall any of the hospital's procedures being departed from.[1539]

[1535] [2004] 7 JIC 1505.

[1536] The Supreme Court set aside the order of the High Court and ordered a new trial.

[1537] "In practical terms [the *res ipsa loquitur* principle] .. amounts to no more than saying that a plaintiff who is unable to prove a specific act or omission amounting to negligence against the defendant may, at the conclusion of his case, have established that he was injured as a result of the impact on him of a state of affairs under the control of the defendant - be it a premises, a surgical procedure or something else - in circumstances where he would not have suffered the injury if the defendant had used proper care. Where that much has been established, there will be a *prima facie* case for the defendant to answer"; [2004] 7 JIC 1505, Conclusions. The evidential burden would be that as set out in *Lindsay*; ibid.

[1538] O'Donovan J had described the plaintiff's witnesses as "basically honest people": see [2004] 2 JIC 1301.

[1539] In applying the *res ipsa loquitur* principle in this way, O'Donovan J "was in error in failing to take into account in resolving that issue the evidence adduced on behalf of the hospital as to the procedures normally adopted by them during the peri-operative period. The issue as to whether the plaintiff suffered a traction injury could not be determined solely by reference to the opinions of the two neurologists: it also depended on whether, as a matter of probability, an event happened during the peri-operative procedure which caused such a traction injury. It may even be the case that the onus of proof of establishing as a matter of probability that no such event occurred did not rest on the hospital, since, at the stage they adduced their evidence, for the reasons I have already indicated, the maxim *res ipsa loquitur* did not necessarily apply … The fact that the staff of the hospital cannot, at a particular remove of time, give honest evidence that they recall how a particular patient was dealt with is, of course, a fact to which the court must have regard. But it must also give the appropriate weight to evidence, such as was adduced in this case, as to the procedures which would normally be applied, the inferences that can properly be drawn from the hospital records and the evidence, if it exists, as it did in this case, of those concerned that, while they did not recall the specific operation, they had no recollection in any operation of the procedures being departed from with the consequences alleged to have resulted in this case."; [2004] 7 JIC 1505, Conclusions.

Keane CJ held that requiring the defence to "state positively that their admittedly safe system had been implemented in the case of the plaintiff" and in the absence of such evidence, to infer that an incident did occur causing the plaintiff the traction injury which in turn suggested hospital negligence, placed an "unfair and unreasonable" burden of proof on the defendants.[1540]

This judgment, which reduces the ability of the trial judge to judge, weigh and draw conclusions from the evidence before the court, represents one of the more stringent judgments of the doctrine and could have been grounded, not on the use of the maxim, but on the use of the maxim as ultimate or legal burden of proof.[1541]

Unsurprisingly, absence of any explanation or defence will result in a finding of negligence, once the *res ipsa loquitur* principle applies, as *Quinn v South Eastern Health Board*[1542] demonstrates. In that case, O'Caoimh J applied the *res ipsa loquitur* principle in circumstances where the evidence showed nerve damage was rare during appendectomy but where this had occurred in the instant case. In the absence of explanation by the defendant, he found for the plaintiff through inferential reasoning.

When weighed against the obstacles facing a plaintiff in medical negligence litigation, while imprecise and worthy of reform, the doctrine of *res ipsa loquitur* principle nonetheless allows a case to be "put to the jury" (under the sixth *Dunne* principle) i.e. the doctrine requires some statement of defence from the medical practitioners or hospital in whose care the plaintiff was

---

[1540] [2004] 7 JIC 1505, Conclusions.

[1541] J Healy, *Medical Malpractice Law* Roundhall Press (2009) at 677-678. Keane CJ's emphasis on affording due weight to a presumption that standard procedures were followed in unconscious injury cases may be contrasted with the approach of the US courts in *Maki v Murray Hospital*, 91 Mont 251 [7 P.2d 228 1932] as cited by Gibson CJ in the California Supreme Court in *Ybarra v Spangard* 25 Cal.2d 486 (1944). In *Maki*, an unconscious patient in a hospital received injuries from a fall, the court declared that without the ability to use the *res ipsa loquitur* principle, the maxim that for every wrong there is a remedy would be rendered nugatory, "by denying one, patently entitled to damages, satisfaction merely because he is ignorant of facts peculiarly within the knowledge of the party who should, in all justice, pay them"; ibid at 231, see *Ybarra* at 490. If the plaintiff could not rely on such a doctrine, Gibson CJ suggested that "the courts, to avoid gross injustice, would be forced to invoke the principles of absolute liability, irrespective of negligence, in actions by persons suffering injuries during the course of treatment under anesthesia"; at 490-491.

[1542] [2002] IEHC 43.

placed, even if it is merely that general practice was followed in the case. With the demise of juries, the trial judge must now weigh fact and law under the scrutiny of the appellate court which may have a chilling effect on his or her response to the evidence, as the cases cited above point out. If the approaches in *Lindsay* and *Doherty* are followed and trial judges limit the manner in which they weigh and draw conclusions from the evidence before them, the plaintiff's ability to prove causation will be limited. At this stage an argument advanced by Gibson CJ in *Ybarra v Spangard*[1543] is strengthened where he suggested that an absolute liability test may be required where no explanation is required of the defence, in order to avoid "gross injustice". The doctrine allows the plaintiff to pass the first part of the two-part test suggested by Robertson: evidence of a *prima facie* duty of care owing, with the defendant then being obliged to adduce "anti-duty" factors to negate the duty. Its call for (weak) justification of measures taken or omitted is also partly redolent of the non-discrimination test.[1544]

In this section we observed how, absent strict or absolute liability, the relative liability test under the *Bolam/ Bolitho/ Dunne* test will be difficult to discharge for most medical litigants and this difficulty is enhanced for individuals from vulnerable groups who have less access to the law than other members of society. Viewed in its entirety, this places doubt on the *Hanrahan* presumption that the right to health is capable of being effectively vindicated under the tort of negligence when one sues a medical practitioner, given the ratios of toleration (between 8:1 and 15:1) and likelihood of claims being unsuccessful as measured under the "quantity" of the law criterion as suggested by social control theory.

It will be recalled that individuals from vulnerable groups are at a further disadvantage to other malpractice litigants where they come within Mullis' definition of the poor, whom he concludes cannot or do not mobilise the law as

---

[1543] *Ybarra v Spangard* 25 Cal.2d (1944) 486 at 490-491: see above.

[1544] See conclusion of the court in *Ybarra v Spangard* 25 Cal.2d 486 (1944): "We merely hold that where a plaintiff receives unusual injuries while unconscious and in the course of medical treatment, all those defendants who had any control over his body or the instrumentalities which might have caused the injuries may properly be called upon to meet the inference of negligence by giving an explanation of their conduct"; at 494.

easily or effectively as those in higher income brackets.[1545] Further, it will be recalled that even where the poor succeed, appellate courts tend to favour the offending physician by often reversing or "substantially" reducing awards, with "the quantity of law" frequently held in check or "nullified in posttrial adjustments".[1546] The Irish cases set out above would appear to confirm how the quantity of law is directed against claimants.

The suggestion that the poor or disadvantaged, through their vertical and organisational inferiority, are likely to pursue strategies of toleration or inaction rather than any tortious propensity against doctor or physician, contradicts a widely held view which has underpinned the main thrusts of tort reform: that tortious claims and the costs of insuring against same are rising exponentially. Mullis suggests an interesting thesis: that it is the horizontal dimension of social structures which provide an explanation for increased tort claims, insofar as the distribution of relationships is changing: on the one hand, interrelationship distance is increasing with the medical profession's embracement of the biomedical model of disease and specialisation, while on the other hand current healthcare relationships may as often reside with an institution than with an individual doctor.[1547] This leads to a focus on the liability of hospitals and health institutions insofar as individual medical negligence suits against medical practitioners (as evidenced by cases such as *Lindsay*) pose significant obstacles for claimants and raise doubt as to whether reparations accountability under the "obligation to protect" can be fully met under the *Dunne* principles.

[1545] J Mullis, *Medical Malpractice, Social Structure, and Social Control*, 10 Sociological Forum (1995) 135 at 147. Barriers include the difficulty in attaining legal representation and pursuing a claim, costs, while the quantity of compensation tends to be lower than for the affluent due to income-based calculation of awards; ibid.

[1546] J Mullis, *Medical Malpractice, Social Structure, and Social Control*, 10 Sociological Forum (1995) 135 at 150. Black observed how "law is greater in a direction toward less organization than toward more organization"; favouring those with higher vertical status; D Black, *The Behavior of Law*, New York Academic Press (1976) at 92.

[1547] J Mullis, *Medical Malpractice, Social Structure, and Social Control*, 10 Sociological Forum (1995) 135 at 150-151.

15.2 Duty of care owed by hospitals and institutions

We turn now to the question of whether hospitals and institutions, rather than individual medical practitioners, may owe a duty of care to patients. The answer is in the affirmative: since *Gold v Essex County Council*[1548] the charitable immunity rule has been replaced with the related appearance of "enterprise liability" whereby hospitals and other health care organisations are accountable for all adverse consequences of treatment given by affiliated doctors, regardless of the question of the doctor's individualised negligence. It is now established that hospitals and institutions may be sued in tort for the acts or omissions of its employees; a duty of care is owed by both the hospital and its permanent staff and as will be observed, allows for reparations accountability under the obligations to "protect and fulfil".[1549]

The significance of being able to sue a hospital or medical facility for the acts or omissions of its full-time employees is a further cause of action in addition to the ability to sue a medical practitioner for breach of the duty of care to his or her patients. The difficulty in bringing successful suits against a medical practitioner resting on the restrictive *Dunne* principles is obviated. Once a duty of care is found to exist (proximity, foreseeability, justice arguments), this onerous standard of proof is lessened because peer evidence is reduced in importance where systems or organisational negligence are capable of being considered by the courts on terms they are more familiar with.

It is not untypical for both a doctor and a hospital administration to be joined in litigation and professional indemnity insurance is in place to guard against these risks. If there is a systems failure in a hospital - for example if the admissions procedure for prospective patients into a hospital is flawed - this may constitute negligence where injury occurs. In *Collins v Mid-Western Health Board*[1550] the Supreme Court held that a hospital system which placed

---

[1548] [1942] 2 KB 293.

[1549] See *Cassidy v Minister for Health* [1951] 2 KB 353 (CA) and *Kelly v The Board of Governors of St Laurence's Hospital* [1988] 1 IR 402 at 415. A higher duty of care may be owing in medicinal product liability cases where injury is likely: see *Best v Wellcome Foundation* [1993] 3 IR 421.

[1550] [2000] 2 IR 154. See also *Fitzpatrick v Midland Health Board*, unreported, 1 May 1997 (HC).

all authority in a senior house officer to determine who should be admitted was inherently defective in a manner "which should have been obvious to any person giving it due consideration".[1551]

Organisational negligence allows for a consideration of the right to health against a wider canvass than the doctor-patient relationship alone and, at least in theory, allow the courts to align standards to fault/ liability/ accountability; a key fault-line in understanding the requirements of the right to health as will be discussed below. It also may allow consideration of areas under the right to health where the *Dunne* principles militate against any individual liability, such as disclosure of risk to the patient, the related question of informed consent to treatment and the wider question of access to treatment.

Since 2002, the Clinical Indemnity Scheme managed by the State Claims Agency (discussed below) manages "enterprise liability' claims which means that for practical purposes, claims against public hospitals, their clinical staff and consultant doctors are defended by the same agency and it matters little in practical terms whether the institution or the member of staff is directly or vicariously liable. An enterprise liability approach (uniting direct and vicarious liability) has now arguably been adopted *de facto* in Ireland.[1552] In contrast, the law's traditional focus on the doctor-patient paradigm has led to a rich but less important body of case law on personal and professional fault, when compared to the jurisprudence on institutional liability of hospitals and healthcare providers.[1553]

[1551] [2000] 2 IR 154, per Keane J.

[1552] "It is now generally assumed by hospitals and insurers in the UK[] and Ireland that ordinarily a hospital is vicariously liable for the negligence of any member of its staff in and around the provision of services undertaken by the hospital on the patient's behalf, irrespective of the part-time/ full-time or professional status of the member of staff. This is not so for cases where the patient privately and personally engages the doctor"; J Healy, *Medical Malpractice Law* Roundhall Press (2009) at 221 and 224.

[1553] J Healy, *Medical Malpractice Law* Roundhall Press (2009) at 197.

15.3 Organisational or institutional liability

There are two ways in which a hospital or other institution may be liable for negligence: through the vicarious liability of its employees (or those deemed employees) or through a direct duty on the hospital or institution itself. Issues of organisational or systemic negligence may arise under either of these headings. After considering medical malpractice jurisprudence, we will also consider disclosure of risk to the patient, and the wider question of access to treatment (where a doctor or institution may not undertake or assume treatment and responsibility).

15.4 Vicarious liability

Originally, the courts were willing to make exceptions to the normal rules of vicarious liability where charities ran hospitals from a desire to relieve the charitable hospitals from liability which they could little afford.[1554] In *Gold v Essex County Council*[1555] Lord Greene MR found, however, that a hospital had a duty to treat a patient and hence that it was vicariously liable for the negligence of a radiographer.[1556]

One question which frequently arises in suits against hospitals is whether the actions of a surgeon who may not be strictly speaking an employee of the hospital results in the vicarious liability of the institution. As one author puts it "who exactly [is] a 'hospital employee'"?[1557] The courts have emphasised the need for flexibility in applying vicarious liability to situations outside the direct "control" of the hospital or institution. In *Cassidy v Minister for Health*[1558] Denning LJ went further than the majority in the case to state that the hospital was under a non-delegable duty to treat patients regardless of whether the

---

[1554] *Cassidy v Minister for Health* [1951] 2 KB 353 (CA) per Denning LJ.

[1555] [1942] 2 KB 293.

[1556] N Cox, *Suing Hospitals and Health Boards*, in Medical Negligence Litigation: Emerging Issues, (eds.) C Craven & W Binchy, First Law (2008) 83 at 91.

[1557] N Cox, *Suing Hospitals and Health Boards*, in Medical Negligence Litigation: Emerging Issues, (eds.) C Craven & W Binchy, First Law (2008) 83 at 91.

[1558] [1951] 2 KB 353.

consultant is employee or delegated under a contract for service. In *Roe v Minister for Health*[1559] he repeated this view. However, Morris LJ in *Roe* suggested that in light of Greene MR's judgment in *Gold*, the courts would inquire into the business relationship between surgeon and hospital where vicarious liability was claimed; it being a question of fact in each case.[1560] In both *Cassidy* and *Roe*, the majorities in the Court of Appeal treated the doctors as employees for whom the hospitals would be vicariously liable. It was the hospital's undertaking to treat that was critical and which led to the principle of *respondeat superior* being applied.[1561]

The instances where vicarious liability was held against medical practitioners include resident house surgeons, pharmacists, anaesthetics, resident medical officers and assistant medical officers, in addition to radiographers, doctors and nurses.[1562] Placing responsibility on the institution is a rational response when one considers that a patient invariably enters a hospital or similar institution for treatment or care with little knowledge of the contractual arrangements of various hospital personnel. Once the patient is treated, the hospital's responsibility is engaged even if some members of a multidisciplinary team may be employees and some contractors. In the latter situation, the same surgeon may be either employee or contractor depending on whether s/he has a public and private practice in the hospital and the time of day at which the surgery occurs.

[1559] [1954] 2 QB 66.

[1560] M A Jones, *Medical Negligence* (4th Ed.) Sweet & Maxwell (2008) at 777-779.

[1561] A potential difference arises between Ireland and the UK: in the latter consultants come within the terms of HC 89(34) which introduced "NHS indemnity" on the assumption they are members of staff rendering the hospital liable for their vicarious liability: see M A Jones, *Medical Negligence* (4th Ed.) Sweet & Maxwell (2008) at 779. In Ireland, defence of all claims is managed by the State Claims Agency.

[1562] *Mooney v Terrett* [1939] Irish Jurist Reports 56 where the owner of a nursing home was liable for a nurse's negligence, per O'Byrne J and *Morgan v Galway Board of Health* [1943] IR 255 where Sullivan CJ found the Health Board liable for the negligence of nurse employed, citing Lord Greene MR in *Gold v Essex County Council* [1942] 2 KB 293 at 301 to the effect that "the person accused of a breach of the obligation cannot escape liability because he has employed another person"; at 271-272. Enterprise liability is discussed further in Part 3 of this thesis. See also N Cox, *Suing Hospitals and Health Boards*, in Medical Negligence Litigation: Emerging Issues, (eds.) C Craven & W Binchy, First Law (2008) 83 at 92.

In the case of private hospitals (or public hospitals acting as private hospitals), where elective or quasi-contractual treatments occur, the vicarious liability claim will be strengthened insofar as while the requisite standard of care does not vary, the plaintiff's expectation of certain treatment does and may be a relevant factor "when considering the extent of the obligation assumed by the hospital".[1563]

The nature of the duty of care applies to health boards and professionals as set out by Murphy J in *Sheehan v Mid Western Health Board*[1564] where he held that the duty of care to patients "is very exacting both on Health Boards and Hospital Boards and on the medical, paramedical and nursing professions" with the primary duty being "to the patients" whose very infirmity "requires an exacting duty of care".[1565]

Direct liability of hospitals for negligence should, it is noted, obviate any difficulties which may arise by virtue of having to resort to either proving medical negligence by a physician or proving the existence of vicarious liability. Under the *Sheehan* test, there may be direct liability by the hospital or institution concerned where the starting point is "the patient's point of view".

In the child abuse cases of *Delahunty v South Eastern Health Board*[1566] and *L O'K v LH and others*[1567] the defence arguments to vicarious liability claims that the offendor was not acting in the course of his employment, was accepted. In *Byrne v Ryan*[1568], the defendant argued that what was determinative was not the nature of the contract but the level of "control" exercised by the hospital over the consultant, insofar as this would determine whether he should be viewed as an employee or not. Citing the English cases of *Cassidy* and *Roe*, Kelly J rejected this argument stating that "control" was not the determinative test but rather whether the consultant was part of the hospital organisation. The

---

[1563] *Roe v Minister for Health* [1954] 2 QB 66 per Morris LJ at 89.

[1564] [2002] IEHC 93.

[1565] [2002] IEHC 93.

[1566] [2003] 4 IR 361.

[1567] [2006] IEHC. See also the Supreme Court Judgment in *O'Keefe v Hickey* [2008] IESC 72.

[1568] [2009] 4 IR 542.

Judge considered that hospital cases are to a considerable extent sui generis the ordinary rules of vicarious liability.[1569]

The courts however have distinguished between this situation where the consultant is clearly part of the hospital organisation and that of a consultant surgeon engaging in private practice. Geoghegan J in *Bolton v Blackrock Clinic Ltd*[1570] found that vicarious liability would not arise where the plaintiff was a private patient of the doctors in a private hospital. However, as against this are the cases of *Roe, Sheehan* and *Byrne v Ryan* where the courts seemed to suggest that the expectations of the patient are key in determining the extent of liability.

In other jurisdictions, hospitals have been found to be vicariously liable for an emergency room physician's negligence under the doctrine of "apparent agency" - where a physician contractor appeared to be an employee of the hospital.[1571] In Ireland, as noted, the State Claims Agency operates the Clinical Indemnity Scheme and defends claims against public hospitals, their clinical staff and consultant doctors, where both the hospital and doctors are sued concurrently. In reality, then the defendant will be the same entity with the intention that the ligitation process be streamlined.[1572] An exception may however arise where private medical treatment is delivered in a public hospital and where the surgeon is not insured in this jurisdiction.[1573] In such a situation

---

[1569] [2009] 4 IR 542. Kelly J recalled that the plaintiff was referred not to a particular surgeon but to the Coombe Hospital with no say in the choice of who would carry out her sterilisation but where the performance of the operation "was part of a service provided by the hospital to the plaintiff"; at 573.

[1570] Unreported, 20 December 1994.

[1571] See *Gilbert v Sycamore Municipal Hospital* 622 N.E. 2d 788 (Ill. 1993) Illinois Supreme Court where the physician contractor appeared to be an employee of the hospital, cited J H Scheid, *Some Statutory Responses to the American Medical Malpractice Crisis*, in *Medical Negligence Litigation: Emerging Issues*, (eds C Craven & W Binchy) First Law (2008) at 243.

[1572] See *www.stateclaims.ie/ClinicalIndemnityScheme/introduction.html* accessed 22 September 2012.

[1573] See *Reilly v Moir* [2009] IEHC 164. The plaintiff underwent negligent breast surgery through a private health organisation she contacted in the United Kingdom. Although performed in Clane General Hospital, the surgeon (who admitted negligence) was insured in the United Kingdom but not in Ireland. Peart J held there was no vicarious or direct liability by the hospital or the company which provided administrative support (such as diary appointments and collection of fees etc). Rather, the surgeon was individually liable to the sum of €80,142.43.

neither vicarious nor direct liability may be found which suggests that the issue of clarifying medical professional insurance coverage lies with the patient.[1574]

The concept of direct liability of a hospital authority may be used in two distinct ways: organisational negligence "where the authority is itself at fault in the manner in which it has performed its functions" but where it is difficult to identify the negligence of any particular employee and the imposition of a non-delegable duty to establish the health service's "responsibility for the negligence of an independent contractor".[1575] We will consider each of these in turn from the perspective of access to the AAAQs.

15.5 Organisational negligence

Organisational negligence (i.e. occupational duties) may arise for breaches of the Health, Safety and Welfare at Work Act 2005 or *qua* employer under the Occupiers Liability Act 2005.

As noted above, there has been only one judgment of the Irish courts which addressed the right to health from a strict liability basis. In *Walsh*[1576], MacKenzie J awarded damages for injury caused by a vasectomy carried out without negligence, holding that the plaintiff's right to bodily integrity had been violated and that consequently damages would be awarded for breach of constitutional rights on the horizontal level. Organisational negligence was at issue, albeit the test applied was one of strict liability. Arguably such a test should be applied in right to health cases not capable of being vindicated under the *Dunne* test.

The *Dunne* principles have been applied in some organisational negligence cases. In *Kelly v Lenihan*[1577], Abbott J found a hospital liable, invoking the

---

[1574] See *Reilly v Moir* [2009] IEHC 164.

[1575] See M A Jones, *Medical Negligence* (4th Ed.) Sweet & Maxwell (2008) at 777-779.

[1576] *Walsh v Family Planning Services* [1992] 1 IR 496.

[1577] [2003] IEHC 427. See below.

second *Dunne* principle, where it had deviated from its general approach to such cases.[1578]

A clear exposition of organisational duties was set out in *A (A Child) v Ministry of Defence*[1579] by Lord Phillips MR in the Court of Appeal. The duties owed by a hospital to a patient once accepted for treatment are a duty to use reasonable care to both provide access to hospital care and to ensure that the hospital staff, facilities and the organisation can provide a safe and satisfactory medical service for the patient, a duty to ensure that treatment is administered with reasonable skill and care and a duty to ensure that the patient comes to no harm while in the hospital. This was a duty that amounts to a "guarantee that the patient will receive the appropriate treatment" and would be "broken if there is a failure to administer the appropriate treatment, even if this does not involve negligence on the part of anyone".[1580] The latter two duties appear to be non-delegable duties, whereas the former two were organisational duties.[1581]

This passage by Phillips MR is of course redolent of the AAAQs (access to hospital, availability, quality of health service) and suggest that an adequate framework of accountability and remedies to address a violation of the non-derogable right to the AAAQs without discrimination may exist under organisational negligence principles, at least where a patient is accepted for treatment in the hospital or institution.

Prior to *A (A Child)*, Browne-Wilkinson VC in *Wilshire v Essex AHA*[1582] had held that a health organisation could be directly liable for mal-administration

---

[1578] In *Kelly*, the plaintiff suffered an obstetric injury (perineal tear) during the surgery but Abbott J was only in a position to find negligence after clear evidence of what the plaintiff had been told by a student midwife emerged which suggested that the hospital had deviated from its general approach. Such evidence is often not forthcoming in such suits and without this arguably inadvertent admission, the plaintiff would not have succeeded under the *Dunne* principles.

[1579] [2005] QB 183.

[1580] [2005] QB 183 at 196.

[1581] See M A Jones, *Medical Negligence* (4th Ed.) Sweet & Maxwell (2008) at 794, fn 95.

[1582] [1987] 1 QB 730.

where it "so conducts its hospital that it fails to provide doctors of sufficient skill and experience to give the treatment offered at the hospital".[1583]

The following examples of organisational negligence (analogous to the latter two AAAQs of acceptability and quality health care) are suggested: where an individual tort is sanctioned by the hospital; where the hospital negligently appoints an incompetent private contractor; where an inadequate quantity of quality staff are appointed; a failure to provide against errors in the administration of drugs; where the hospital permits an inexperienced doctor to administer anaesthetics without supervision; where the hospital interferes with the manner in which work is performed and thereby causes damage; where it condones negligence or fails to inform a patient and take remedial action; where there is an absence of policy concerning best practice in an area or where the hospital fails to provide staff with adequate training.[1584] Of these examples, a number of positive obligations placed on hospital authorities as identified merit further scrutiny insofar as they replicate some elements of the right to health.

A case where a hospital was found to have condoned negligence in failing to inform a patient of an adverse outcome and to take remedial action was *Byrne v Ryan*[1585] where the High Court found the hospital negligent in failing to inform the plaintiff that the tubal ligation procedure had failed. Under the AAAQs this would correspond to acceptability (informed consent) of health care.

An example of where an absence of policy of best practice can give rise to direct liability on organisational negligence grounds is *Kavanagh (A Minor) v Murphy*.[1586] Here only one twin born in Wexford General Hospital was transferred to a specialist unit at Waterford General Hospital, whereas the second twin was poorly cared for and developed cerebral palsy. O'Donovan J found there should have been a policy on transfer and that the absence of same

---

[1583] [1987] 1 QB 730 at 778.

[1584] N Cox, *Suing Hospitals and Health Boards*, in Medical Negligence Litigation: Emerging Issues, (eds.) C Craven & W Binchy, First Law (2008) 83 at 101-102.

[1585] Byrne v Ryan [2009] 4 IR 542.

[1586] [2003] IEHC 105.

caused the plaintiff's injuries insofar as it allowed the general practitioner in question make decisions which should not have been made.[1587] It will be observed that the quality of health care under the AAAQs was evident in this case.

In *Fitzpatrick v National Maternity Hospital*[1588] Herbert J found that the hospital's delivery of the plaintiff was substandard and negligent on account of delay, miscommunication and inaction by both a senior midwife and obstetrician.[1589] In *Pyne & Pyne v Western Health Board & Egan*[1590], another catastrophic birth injuries case, De Valera J eschewed findings of fault against individual medical practitioners, rather finding the theatre surgery staff *qua* team negligent on a number of grounds which rendered the hospital liable.[1591]

What of the other two AAAQs: those of availability and accessibility?

Accessibility under both individual and organisational negligence tests will be dependant on whether the patient was accepted for treatment, either by an individual doctor or by the hospital or institution. As noted, this is because the requirements of proximity, foreseeability and causation for the tort of negligence may not be present where a person is not accepted for treatment. There have only been two cases in which the courts have found that a good Samaritan duty of care is implied where a doctor-patient relationship is not yet formed but where the doctor's "physical, circumstantial, and causal proximity" established the duty, usually in an emergency situation.[1592] In *Lowns v Woods*[1593], the New South Wales Court of Appeal found a doctor liable for not

---

[1587] See N Cox, *Suing Hospitals and Health Boards*, in Medical Negligence Litigation: Emerging Issues, (eds.) C Craven & W Binchy, First Law (2008) 83 at 102.

[1588] [2008] 3 JIC 0704.

[1589] Delay in delivery in the emergency situation was "seriously substandard" contributing to irreversible brain damage: [2008] 3 JIC 0704.

[1590] [2005] 4 JIC 1506.

[1591] Successive failures "were caused by the negligence of some members of the theatre staff for whose actions the first defendant is liable"; [2005] 4 JIC 1506.

[1592] K Williams, *Medical Samaritans: Is There A Duty To Treat*? 21 Oxford Journal of Legal Studies (2001) 393 at 403.

[1593] (1995) 36 NSWLR 344.

coming to the aid of an11-year-old boy suffering his sixth epileptic attack in the vicinity of his medical practice.[1594] In the second case of *Kent v Griffiths*,[1595] the Court of Appeal again relied on proximity to ground the duty of care but did not refer to *Lowns*. Here the 26-year-old pregnant claimant had a serious asthma attack at home. Her GP placed a 999 call for an emergency ambulance to take her to hospital. This failed to arrive and Mrs Kent suffered brain damage and a miscarriage.[1596] The trial Judge found that the ambulance service had been negligent and this was upheld by Lord Woolfe in the Court of Appeal who noting both the regulations governing professional practice for GPs, stated that while breaches of either duty are not necessarily synonymous with negligence it is "legitimate for courts to look to these sources for guidance".[1597] It has been suggested that a duty to treat should be imposed in a "social" as well as in a "professional context" given the unpredictable nature of medical emergencies[1598], however even the incremental recognition of a duty of emergency intervention suggesting deeper relational tortious obligations resulted in the codification of the law to immunise treating doctors.[1599]

Despite the "incremental" cases of *Lowns* and *Kent*, the law appears to remain more inclined to the viewpoint that "mere physical proximity" between a doctor and a sick person, of itself, creates no duty to treat[1600] as evidenced by

---

[1594] (1995) 36 NSWLR 344. The trial judge found that Dr Lowns had had the gravity and urgency of the situation su□ciently explained to him by the boy's sister and should have intervened.

[1595] [2000] 2 WLR 1158.

[1596] Turner J found that the ambulance's log had been falsified to show an earlier arrival time.

[1597] [1999] Lloyd's Rep Med 424. See, also *Egedebo v Windermere District Hospital Association* (1993) 78 BCLR (2d) 63 where the duty was based on the ethical obligation of Canadian physicians to render aid. For a discussion of the relationship between negligence and professional misconduct generally, see R G Smith, *Medical Discipline,* Oxford: Clarendon Press (1994) at 37-40.

[1598] K Williams, *Medical Samaritans: Is There A Duty To Treat*? 21 Oxford Journal of Legal Studies (2001) 393 at 409-410.

[1599] See section 4 of the Civil Law (Miscellaneous Provisions) Act 2011.

[1600] *Capital and Counties plc v Hampshire County Council*, [1997] QB 1004 Lord Stuart-Smith (obiter) concerning the liability of a fire brigade. Concerns arising from the direction of the common law saw section 4 of the Civil Law (Miscellaneous Provisions) Act 2011 introduced which provides immunity from suit for doctors. See also paragraph 11 of the the Medical Council's *Guide to Professional Conduct and Ethics for Registered Medical Practitioners*; Seventh Ed (2009) accessible at *www.medicalcouncil.ie/.../Professional-Conduct-Ethics/*

Lord Hoffmann's threefold justification for minimum duties based on political, moral and economic considerations in *Stovin v Wise*[1601] (discussed above), the Australian case of *Ellis v Wallsend District Hospital*[1602] and the Canadian case of *Yepremian v Scarborough General Hospital*[1603] (discussed below).

The "availability" AAAQ is connected with resources. The courts have on occasion found that the failure to provide adequate resources results in negligence. The question of the appointment of an adequate quantity of quality staff was raised in *Kelly v Board of Governors of St Laurence's Hospital.*[1604] Here a patient suffering from epilepsy and from violent seizures and who was taken off medication was left unattended and threw himself out a toilet window. The court found the hospital negligent in not providing adequate staff to accompany the plaintiff to the bathroom.

As noted, Browne-Wilkinson VC alluded to potential direct negligence for staffing in *Wilshire v Essex AHA.*[1605] Lord Slade suggested that the *Bolam* test on professional standards would judge such a situation in *Bull v Devon AHA*[1606], while in the same case, Lord Dillon simply commented that staffing levels should be "reasonably sufficient for the foreseeable requirements of the patient". In that case, Lord Mustill expressed concern that public medicine not become *sui generis* on the basis of allocation of resources arguments. What is essential is that the plaintiff prove that the lack of resources "was a consequence of negligence in the organisation of the hospital itself".[1607]

---

accessed 21 October 2012. Although there may be an ethical duty, this will not correlate to a legal duty.

[1601] [1996] AC 923 at 930.

[1602] (1989) 17 NSWLR 553, discussed below.

[1603] (1980) 110 DLR (3d) 513, Ont. CA, discussed below.

[1604] [1988] IR 402.

[1605] [1987] 1 QB 730.

[1606] [1993] 4 Med LR 117 (CA). See also *Colwill v Oxford Radcliffe Hospital NHS Trust* [2007] EWHC 2881.

[1607] See Browne-Wilkinson VC in *Wilshire v Essex AHA* [1987] 1 QB 730 at 778.

In *Collins v Mid-Western Health Board*[1608] Barron J gave the main judgment and found the hospital directly liable under normal negligence principles for organisational negligence (mal-administration) and on that basis did not engage in consideration of medical mal-practice. For Barron J it was clear that it was a matter for the hospital authorities themselves "to indicate a scheme to provide under what circumstances a house officer would be required to seek the advice of somebody more senior".[1609] However, Keane J in the same case held that the hospital's admissions policy had "inherent defects", drawing in the third of the *Dunne* principles, an approach criticised by commentators.[1610]

It is unclear whether the approach of Barron J or Keane J is to be preferred, but clearly areas of hospital systems failures will by definition be inherently defective. In light of the limitations of the *Dunne* principles, it has been suggested that "practical strategic questions" as to health delivery to patients should be determined not by the *Dunne* test "but rather on the basis of straightforward negligence principles."[1611] Insofar as medical hierarchy theory traditionally dictated that responsibility for the junior doctor engaging in malpractice shifted to the consultant who should be supervising or not delegating responsibility, similarly organisational hierarchy theory dictates that the hospital will be liable for the medical teams operating under its aegis.[1612]

The approach to organisational negligence in other jurisdictions has been to consider whether a medical negligence claim against a hospital may fall to be considered under negligence *simpliciter* standards, i.e. to obviate the need to

---

[1608] [2000] 2 IR 154.

[1609] [2000] 2 IR 154 at 167.

[1610] Hanly criticises recourse to this test given the fact that "inherent defects" was constructed to moderate a physician's defence that s/he acted within general or approved medical practice; R Hanly, *Hospital-Acquired Infection: The Challenges for the Law of Negligence* 32 Dublin University Law Journal (2010) at 75.

[1611] B McMahon and W Binchy, *Law of Torts* (3rd Ed.) Butterworths (2000) at 377.

[1612] In *Jones v Manchester Corporation* [1952] QB 852 Denning LJ apportioned liability 80:20 between a hospital and junior doctor; at 869.

prove individual physician negligence in medical negligence or vicarious liability of employees.[1613]

In *Vancouver General Hospital v McDaniel*[1614] where the plaintiff contracted smallpox in a hospital due to exposure to smallpox sufferers and nurses treating those patients, the Privy Council recognised that the plaintiff was not alleging medical mal-practice, rather a systems failure in its infection controls. The courts may find organisational negligence through drawing inferences, for example an inference that the operation of a communication system for contacting an obstetrician in an emergency was inadequate as found by the Court of Appeal in *Bull v Devon AHA*[1615] while an inference of negligence was drawn in *Colwill v Oxford Radcliffe Hospital NHS Trust*[1616] where there was no record made of a device being inserted into the patient's arm and hence no communication with other doctors and nursing staff. These cases would correspond to the AAAQ quality principle.

15.6 Non-delegable duty of care

Can there be a non-delegable duty of care regardless of one's status as employee? It will be recalled that in *Cassidy v Minister for Health*[1617], Denning LJ advanced the proposition of a non-delegable duty of care owed by hospitals but that in fact in that case and in *Roe v Minister for Health*[1618], the majorities in the Court of Appeal treated the doctors as employees for whom the hospitals would be vicariously liable. However, the proposition that a hospital will be

---

[1613] Such negligence *simpliciter* has been defined as "a breach of a legal duty to take care which results in damage to the plaintiff": see R Hanly, *Hospital-Acquired Infection: The Challenges for the Law of Negligence* 32 Dublin University Law Journal (2010) at 69 citing W V H Rogers, *Winfield and Jolowicz on Tort* (17th ed.) Sweet & Maxwell (2006) at 132.

[1614] (1934) 152 LT 56; cited by R Hanly, *Hospital-Acquired Infection: The Challenges for the Law of Negligence* 32 Dublin University Law Journal (2010) at 74-75.

[1615] [1993] 4 Med LR 117 (CA).

[1616] [2007] EWHC 2881.

[1617] [1951] 2 KB 353. See also Denning LJ in *Jones v Manchester Corporation* [1952] QB 852 at 869.

[1618] [1954] 2 QB 66.

liable even where it seeks to delegate or contract out a function has not been entirely dispelled.

English jurisprudence sympathetic to Denning LJ's approach in *Cassidy* include *X (Minors) v Bedfordshire County Council*[1619] and *Robertson v Nottingham Health Authority*[1620] where the Court of Appeal stated that a hospital would be directly liable in negligence if a patient was injured "by reason of a negligent breakdown in the systems for communicating material information to the clinicians responsible for her care". Redress could not be denied "merely because no identifiable person or persons are to blame for deficiencies in setting up and monitoring the effectiveness of the relevant communication systems".[1621] As noted above, in *A (A Child) v Ministry of Defence*[1622] Lord Phillips MR appeared to accept that a hospital providing the treatment itself could owe a non-delegable duty insofar as there were "strong arguments of policy" in favour a hospital offers treatment to a patient and accepts responsibility for the care with which that treatment is administered "regardless of the status of the person employed or engaged to deliver the treatment".[1623]

In Ireland, the courts have on occasion adopted a similar approach. In *Byrne v Ryan*[1624], Kelly J held that a hospital could not escape liability by arguing that the physician who carried out the sterilisation of the plaintiff worked under a contract for services arrangement and was self-employed. Rather, vicarious liability applied, while as noted the court made a separate finding that the hospital organisation was negligent in failing to inform the plaintiff that the tubal ligation had failed.

[1619] [1995] 2 AC 633 at 740.

[1620] [1997] 8 Med L R 1, CA.

[1621] [1997] 8 Med L R 1. The plaintiff was "entitled to say, like the successful plaintiff in Bull: 'You, the health authority were responsible for my care: you are responsible if there is a breakdown reasonably attributable to improper practice, in the systems used at your hospital for communicating material information to the clinicians responsible for my care: and I was injured as a result of this negligence"; at 13.

[1622] [2005] QB 183.

[1623] [2005] QB 183 at 205.

[1624] [2009] 4 IR 542.

Denning LJ in *Cassidy* et al had eschewed the distinction between contracts for service and contracts of service on the premise that once the hospital accepts the plaintiff as a patient for treatment (and perhaps because there is a corresponding expectation of this by the patient) the hospital should be liable for the organisation of the treatment. Hence the "AAAQ" concept of "acceptability" by the patient is implicitly included in the formulation. This eschewing of a distinction of "control" in favour of one based on "organisation" was the approach taken by Kelly J in *Byrne*.

Mustill J in *Wilshire v Essex AHA*[1625] suggested such a non-delegable duty approach where he stated that once it was known that excess oxygen causes the injury alleged in the case (retolental fibroplasias), the onus of discharging proof lay with the defendant.[1626] Similarly it will be recalled that in *Bull v Devon AHA*[1627] (referred to in *Robertson* above), the Court of Appeal drew an inference of direct organisational negligence.

In contrast to where a hospital accepts a patient for treatment, the Australian New South Wales Court of Appeal in *Ellis v Wallsend District Hospital*[1628] rejected the concept of a non-delegable duty owed by a hospital where a patient approached the surgeon privately and where the surgeon arranged for her admission to hospital and treated (and injured) the plaintiff. In this situation, the hospital was mere facility provider. The court in *Ellis*, however, accepted that a non-delegable duty may arise where the hospital provides treatment and where patients are referred and accepted for the treatment. In contrast, a majority of the Ontario Court of Appeal in Canada in the earlier case of *Yepremian v Scarborough General Hospital*[1629] had held that a hospital does not undertake a non-delegable duty to a patient regardless of whether s/he presents directly at the door of the hospital.

[1625] [1987] 1 QB 730.

[1626] [1987] 1 QB 730 at 764 and 771.

[1627] [1993] 4 Med LR 117 (CA).

[1628] (1989) 17 NSWLR 553.

[1629] (1980) 110 DLR (3d) 513, Ont. CA per Arnup J, available at *aix1.uottawa.ca/~srodgers/3375/yepremian.rtf* accessed on 21 January 2013.

The authorities on non-delegable duty suggest an approach redolent of estoppel where the hospital or institution in accepting the patient cannot then suggest it holds no duty. Accessibility is equated with acceptance of the patient, while the patient's expectations also provide the "underlying justification[s]" for the duty.[1630] Under the *A* and *Ellis* approach, a private consultant, if approached by the patient could accept the patient and the hospital's liability would be limited under the more traditional "control" test. Of course a private patient will likely have a claim under contract for any medical malpractice which may occur under a private arrangement.

As noted, the House of Lords and Supreme Court judgments in *Savage v South Essex Partnership NHS Trust*[1631] and in *Rabone & Another (Appellants) v Pennine Care NHS Foundtaion Trust (Respondent)*[1632] held that hospitals whence suicidal patients escaped and were discharged were liable not in negligence but under Article 2 of the ECHR focusing on the alleged failure of the hospital authorities to protect the patient from foreseeable death. In *Savage*, Lord Rodger aligned the ECHR standard with an organisational duty of care finding that insofar as a State "is under an obligation to adopt appropriate (general) measures for protecting the lives of patients in hospitals", this would involve ensuring certain organisational standards; "that competent staff are recruited, that high professional standards are maintained and that suitable systems of working are put in place."[1633] Once hospital authorities perform these obligations, "casual acts of negligence by members of staff will not give rise to a breach of Article 2".[1634]

This approach also resounds with the non-delegable duty of the hospital as it is the hospital, in ensuing competent staff, adequate standards and suitable systems, which assigns the medical team attending the patient, as advanced by Lord Greene in *Gold* and Lord Denning in *Cassidy*. This also ties in with how

---

[1630] M A Jones, *Medical Negligence* (4th Ed.) Sweet & Maxwell (2008) at 797.

[1631] [2009] 1 AC 681.

[1632] Unreported, 8 February 2012.

[1633] [2009] 1 AC 681 at 701-702.

[1634] [2009] 1 AC 681 at 701-702. See too *Rabone & Another (Appellants) v Pennine Care NHS Foundtaion Trust (Respondent)* 8 February 2012.

medical claims are defended by the State. In the UK, the National Health Service is an insurable respondent. In Ireland, the State Claims Agency will defend the claim unless it is private treatment. Similarly if a hospital in the United Kingdom is under the financial control of a health board then that Health Authority is the correct defendant in respect of any liability for the staff of that hospital.[1635] This raises important implications for Ireland where most hospitals and care institutions are run by private charities, often incorporated as companies limited by guarantee in recent years partly in an attempt to limit one's liability, but who nonetheless receive public funds to treat public patients. This leads to the question of whether there may be any legal responsibility on the HSE qua State when it enters arrangements with private bodies to deliver health-related services under sections 38 and 39 of the Health Act 2004.

Under the United Kingdom's National Health Service Act 2006 and associated regulations, the Secretary of State and, by delegation, an individual Primary Care Trust ("PCT") has a duty to commission medical services as it considers necessary to "meet the health care needs of the local population as a whole and within allocated resources".[1636] Resource decisions are taken under an explicit "rationing" system under the guidance of the National Institute for Health and Clinical Excellence ("NICE").[1637]

[1635] N Cox, *Suing Hospitals and Health Boards*, in Medical Negligence Litigation: Emerging Issues, (eds.) C Craven & W Binchy, First Law (2008) 83 at 97.

[1636] E Palmer, *Mechanisms Of Health Care Accountability, Marketisation And The Elusive State*, 11 Medical Law International, (2011) at 69. Palmer notes how under UK Government plans, PCTs are to be phased out and replaced by Foundation Trusts and that commissioning will occur under the control of GPs. See also E Palmer, *Judicial Review Socio-economic Rights and the Human Rights Act*, Hart Oxford (2007) at 197.

[1637] NICE was established in 1999 to reduce variation in the availability and quality of NHS treatments and care. See NICE guidelines at: *www.nice.org.uk* accessed on 21 October 2012. Since 2002, the NHS has been required to pay for NICE approved treatment and medications and conversely does not usually provide treatment and medications that are not NICE approved. Nelson notes how, prior to the creation of NICE, rationing was accomplished primarily through local decisions by GPs and hospital consultants rather than through NICE's formalised evidence based approach. NICE has been controversial on account of its use of cost-effectiveness to determine whether the NHS should pay for certain medication such as refusal to approve kidney or breast cancer drugs because of their cost, despite the fact that clinical research showed the drug's effectiveness. In October 2010, the UK government announced it would revoke NICE's power, abolish PCTs and empower physicians to make treatment decisions, arguably an abandonment of explicit rationing: see LJ Nelson, *Rationing Health Care in Britain and the United States*, 7 Journal of Health & Biomedical Law (2011)

Unlike the implicit rationing system in Ireland, prioritisation decisions by PCTs can be challenged by way of judicial review in the UK albeit with limited prospects of success where the body receives public funding alone, following the House of Lords decision in *YL*.[1638] In that case, Lord Mance for the majority held that the injection of capital or subsidy into an organisation, in return for undertaking a "non-commercial role or activity of general public interest" must attract a high degree of democratic accountability in the manner of its administration but would not render the body subject to judicial review.[1639]

UK cases which have tackled the parameters of judicial intervention in challenges against the refusal (rationing) of health care on grounds of lack of resources[1640] include *R v Cambridge Health Authority ex parte B (Re B)*[1641]

210-212. Nelson predicts that implicit rationing will emerge from current review processes in the UK and the US despite the US Patient Protection and Affordable Care Act 2011 becoming fully effective in 2014, under which the US aims to provide universal access to health care for its citizens through a combination of public programs (e.g. Medicare, Medicaid), subsidisation of private insurance and tax subsidies; at 231-232.

[1638] *YL and others v Birmingham City Council and others (Secretary of State for Constitutional Affairs intervening (YL)* [2007] 3 WLR 112, discussed above.

[1639] Lord Mance's heavy reliance on a source-based test ("the usual source of the 'functions of a public nature' are legislative or governmental" (at para 102)) is criticised by Palmer who suggests that his rationale for this reliance upon the source of any special powers or duties to determine a public law jurisdiction was arguably based on a mis-reading of Strasbourg jurisprudence under which the European Court determines the scope of State responsibility as a Fourth Instance review court; see S Palmer, *Public, Private and the Human Rights Act 1998: An Ideological Divide* 66 Cambridge Law Journal (2007) 559 at 568. The author suggests that the "the ghost of Dicey still haunts the development of public law in our legal tradition"; at 559. See in contrast minority opinion of Lord Bingham, who rejected any reliance upon judicial review authorities on the basis that the requirements of section 6(3)(b) f the 1998 Act extends the definition of public authority so that bodies not amenable to review would be nonetheless included. See also E Palmer, *The Liability of Functional Public Authorities for Breach of ECHR Rights: the House of Lords condones a palpable gap in human rights protection*, 18 Medical Law Review (2008) 141.

[1640] "Rationing" may be explicit: decisions employing a process that acknowledges cost-related concerns as a justification for limiting access to particular treatments and impacting specific individuals, an example being the NICE's use of cost effectiveness analysis for denying approval of a drug. It may also be implicit where decisions to limit access to care for cost considerations are not articulated in a transparent process, for example, a clinician's decision to deny a treatment to stay within a budgetary limit "or through a queue for access to treatments"; see LJ Nelson, *Rationing Health Care in Britain and the United States*, 7 Journal of Health & Biomedical Law (2011) at 180-181. Nelson records how health policy experts customarily refer to the health care "Iron Triangle," used in the US and the "Inconsistent Triad", used in the UK, where the three angles of the triangle or triad are cost, access, and quality and where performance of a health care system along any one of these dimensions can compromise the other dimensions, regardless of the amount spent on health care: "The essential point here is that it is very difficult to simultaneously increase access, decrease costs, and improve the quality of a health care system;" ibid. Nelson cites Hayek, the classical liberal economist and

where the Court of Appeal distinguished between the "rigorous scrutiny" which would be undertaken in a matter of life and death as opposed to the minimal scrutiny where an "experimental treatment" is in issue and resource allocation difficulties are cited.[1642]

Prioritisation by PCTs was accepted by the Court of Appeal in *R v North West Lancashire Health Authority ex parte A, D and G*[1643] provided individual cases are properly assessed on their merits. As with the "margin of appreciation", discretion is not unlimited however and the formula was tightened in *Re B* and in *Rogers v Swindon National Health Service PCT*[1644] where the court concluded that such a prioritisation policy would only be rational "if it is possible to envisage and the decision-maker does envisage, what those exceptional circumstances might be". If it was not possible to do this "then the policy will be in practice a complete refusal of assistance: and irrational as such because it is sought to be justified not as a complete refusal but as a policy of exceptionality".[1645] In *R (Ross) v West Sussex Primary Care Trust*[1646] the Court of Appeal stipulated that where an exceptionality policy (under NICE) was so stringent that no patient within the cohort could satisfy same, it would be unlawful. This was applied in *R (Otley) v Barking and Dagenham Primary Care Trust*[1647] to strike down a decision where resource constraints were not a proper concern. Although the policy properly provided that the allocation of resources "is an element in every decision of this kind" it was considered that

---

philosopher argued that while reliance on the market may result in inequality, its impersonal nature is less likely to result in an exacerbation of social tensions, whereas explicit ("deliberate and consciously directed") government decisions to limit an individual's access to resources are more likely to precipitate significant reaction and resentment by those affected;" at 187, citing also F A Von Hayek, *The Road to Serfdom*, University of Chicago Press (1944) 106 (2007 reprint).

[1641] [1995] 2 All ER 129.

[1642] [1995] 2 All ER 129. See E Palmer, *Mechanisms Of Health Care Accountability, Marketisation And The Elusive State*, 11 Medical Law International (2011) at 73-74.

[1643] [2000] 1 WLR 977.

[1644] [2006] EWCA Civ 392.

[1645] [2006] EWCA Civ 392 at 62.

[1646] [2008] EWHC 2252 (Admin).

[1647] [2007] CCL Rep 628.

the course proposed "did not on any reasonable view put at risk the interests of other patients or, in the words of its own policy on difficult decisions require it to consider funding on the health of the whole population".[1648]

It has been suggested that in serious cases the notion of 'heightened scrutiny' developed in *Re B* means that greater weight may be given to "any individual factors that tend to exceptionality" in decision-making.[1649] The situation in Ireland is different. As noted, allocation decisions are not taken by any authority but rather by consultant-led multidisciplinary teams, reducing the possibility of a rationality-based judicial review action being brought unless the courts consider that public health has been "functionally" delegated but that the public duty remains to be fulfilled (see discussion above).[1650] A plaintiff may be advised to seek relief under both vicarious and direct (organisational or non-delegable duty) liability of the hospital/ institution. Under both headings s/he will need to prove duty of care and causation but s/he may avoid the more rigorous *Dunne* principles where, for example, organisational negligence can be dealt with under negligence *simpliciter* principles and where access to a treatment is denied by the institution based on poor administration, noting the higher likelihood of success in an organisational claim.

In this section, we considered organisational negligence suits against enterprises. Through not focusing on individual fault of physicians, but rather enterprise obligations which may be non-delegable, the courts have been on firmer territory in weighing the evidence and allowing better accessible reparations accountability. However questions remain whether this relative

---

[1648] [2007] CCL Rep 628 at 27, cited by E Palmer, *Mechanisms Of Health Care Accountability, Marketisation And The Elusive State*, 11 Medical Law International, (2011) at 74.

[1649] E Palmer, *Mechanisms Of Health Care Accountability, Marketisation And The Elusive State*, 11 Medical Law International, (2011) at 74. Palmer juxtaposes judicial reluctance to intervene in politically sensitive resource allocation decisions as a new phenomenon post the Human Rights Act but their "readiness" to intervene in such decisions indirectly through the exercise of statutory interpretation of local authority duties; at 79-80. She notes the 2004 report of the UK Joint Committee on Human Rights on justiciability under ICESCR – JCHR ICESCR Report, Twenty-first Report of Session (2003-2004) HL 183, HC 1183 para 7 in this regard. See *www.publications/parliament.uk/pa.jt200304/jtrights/183/18302.htm* accessed on 21 October 2012.

[1650] This is quite apart from the question whether the judicial review test as set out in *O'Keefe v An Bord Pleanála & Others* [1993] 1 IR 39 or the wider test in *Meadows v Minister for Justice, Equality and Law Reform* [2010] 2 IR 701 would permit the substance of a decision by a public body on health rationing to be effectively reviewed; discussed above.

liability test is adequate to meet right to health requirements. Insofar as the remedy for breach of the right to bodily integrity under Article 40.3.1 is guaranteed under Article 40.3.2 (where the right must be vindicated), the strict liability precedent of *Walsh* is suggested. Where clear breach of the right to health is litigated under the tort of medical negligence but can be successfully (and predictably) defended under the *Dunne* principles or similar relative liability grounds, a doctrine of strict, direct hospital liability and, in the situation of private health providers, a non-delegable duty of care to the plaintiff will be important as it may be only under this element of the tort that the constitutional right to health identified can be vindicated per *Meskell* and *Hanrahan*. For the publicly funded but resource-restricted hospital, it is suggested that it could either seek to join the HSE as a co-respondent or to suggest to the court that it be joined as Notice Party to proceedings brought against it where resource allocation is the main dispute in the case. The benefit here is that the issue of access to the AAAQs can be fully ventilated before the court insofar as the State can set out the resource allocation considerations if at issue, but if the matter relates rather to organisational maladministration or negligence, this will swiftly become clear to the court and any empty resource allocation defence will be viewed as such.

There is another reason why horizontal right to health claims framed against private organisations rather than individuals may provide a better source of redress for medical malpractice victims, namely that there appears to be a higher likelihood of success premised on the willingness of courts to apply *negligence simpliciter* standards where individual medical practitioners are not impugned. Higher litigiousness may also lie in the challenges to medical authority posed by the patients' rights movement "and the social consequences of medical specialisation".[1651]

[1651] "J Mullis, *Medical Malpractice, Social Structure, and Social Control*, 10 Sociological Forum (1995) 135 at 150-151. Mullis's reference to medical specialisation is perhaps unsurprising if one accepts the proposition that the vertical and organisational inferiority of patient to doctor as a defining aspect of that interpersonal relationship leading to toleration and acquiescence. Mullis suggests that the medical community's embracement of the biomedical model of disease and specialisation "have increased relational distance" in their own right by fostering a greater clinical detachment, with medical specialisation essentially partitioning the patient population "according to sex, age, diseases and organs" resulting in a fragmented patchwork of "caregiving sewn with a bureaucratic thread". This, he argues, has weakened the dependency of a patient on any one doctor while "the scope, duration, and frequency" of

Right to health complaints differ according to the area of medicine concerned insofar as where there is little relational distance, litigation lessens.[1652] Insofar as psychiatrists tend to interact more and longer with patients, emphasise emotional and social factors in addition to the physical, grievance is "lessened".[1653] As against this, it is suggested that the "exceptionally high" number of malpractice claims against obstetricians concerning labor and delivery problems suggests that the "scope" of interaction may be more important than its "frequency" when predicting malpractice suits, insofar as the scope of interactions narrows where the "biomedical model of pregnancy-as-pathological" occurs with its routinised doctor-patient encounter, allowing for little "flexibility or individuation".[1654]

Obstetrics injury results in high costs to States' health systems and regularly figures in tort reform proposals, as evidenced in the no-fault systems introduced in Virginia and Florida (see below).[1655] It has been argued that any

---

doctor-patient interaction have all decreased. The result is an increased relational distance with reliance on law to handle conflicts more likely under these new conditions: within a given set of relationships, law varies positively with relational distance. Specialisation "has indirectly contributed to the aggregate rise in malpractice relationship by increasing the relational distance between doctors and patients". Now virtually all communication between doctors and patients is channelled through a mechanical medium "ranging from the stethoscope to magnetic resonance imaging" with pathogenesis and healing seen as "biological, physiological and ultimately physical events"; at 152-153. This applies Black's observation that relational distance "predicts and explains the outcomes of legal proceedings" and "the style of law" (whether accusatory or remedial); D Black, *The Behavior of Law*, New York Academic Press (1976) at 44 and 47.

[1652] "Law is inactive among intimates"; D Black, *The Behavior of Law*, New York Academic Press (1976) at 41.

[1653] Psychiatrists, according to Mullis, have a "notably lower vertical status than surgeons, as measured in the aggregate by income", which may further explain the litigious response to malpractice; J Mullis, *Medical Malpractice, Social Structure, and Social Control*, 10 Sociological Forum (1995) 135 at 154-157.

[1654] J Mullis, *Medical Malpractice, Social Structure, and Social Control*, 10 Sociological Forum (1995) 135 at 154.

[1655] J Mullis, *Medical Malpractice, Social Structure, and Social Control*, 10 Sociological Forum (1995) 135 at 154, citing S Daniels and L Andrews, *The Shadow of the Law, Jury Decisions in Obstetrics and Gynecology cases*, in V Rostow and R Bulger (eds) *Medical; Professional Liability and the Delivery of Obstetric Care: An Interdisciplinary Review*, Washington DC, National Academy Press (1989) at 161-198; M Gonzales, *Medical Professional Liability Claims and Premiums, 1985-91*, Socioeconomic Characteristics of Medical Practice, Chicago, American Medical Association (1993) and S K Danzinger, *The medical model in doctor-patient interaction: the case of pregnant care*, in J A Roth (ed), *Research in the Sociology of Health Care*, 1 Professional Control of Health Services and Challenges to Such Control: 263-304, Greenwich, CT: JAI Press (1980); ibid at 302.

no-fault compensation for cases of "catastrophic" obstetrics injury should be preceded by a review of accountability mechanisms.[1656]

These developments suggest a social trend with the meaning of "fault" broadening and shifting from the individual actor back to the collective with formal organisations increasingly held accountable for the adverse experiences of individuals perhaps in response to the more general pattern of an organisation's "advantage in the law".[1657] Although hospital and health care organisations may be sued less often than individual physicians, they "may in fact lose more often" in those cases.

Even with this shift to organisational responsibility, the courts have considered the need to develop further doctrines to provide some burden of proof relief for plaintiffs where proof of causation is particularly onerous. These modified tests appear on the continuum between relative and strict liability. Their rationale stems from the principle advanced by Gibson CJ in *Ybarra v Spangard*[1658] that modified causation rules (namely the *res ipsa loquitor* principle in *Ybarra*) will be required in order to avoid "gross injustice" where the plaintiff is in a situation of dependency (such as being unconscious) vis-à-vis the medical practitioners. By focusing on the individual's vulnerability in such situations, the courts have shown themselves willing to modify causation in the name of justice to address the unfairness which would otherwise arise.

[1656] See S Moloney, *Medical Misadventure: Compensation, Accountability and Regulating Standards of Practice*, 6 Medico-Legal Journal of Ireland (2000) 71 at 72 citing O Quick, *Disaster at Bristol: Explanations and implications of a tragedy*", 21 The Journal of Social Welfare and Family Law (1999) at 307-434; Treasure, *Lessons from the Bristol Case*, 316 British Medical Journal (1998) 1685-6 and C Dyer, *Tighter control on GP's to follow doctor's murder convictions*, 318 British Medical Journal (2000) 320 at 331. The author cites the argument advanced by the Irish Medical Defence Unit which stated that prospective obstetrics and gynaecology claims 45% of its case reserves although obstetrics represent only 2% of its total membership.

[1657] J Mullis, *Medical Malpractice, Social Structure, and Social Control*, 10 Sociological Forum (1995) 135 at 144.

[1658] *Ybarra v Spangard* 25 Cal.2d 486 (1944), discussed above.

15.7 Modified tests: material causation of the harm occasioned

In the next sections we consider how the courts have identified modified tests to deal with such situations of potential injustice, both where the plaintiff has no means to prove material causation, where a missed diagnosis contributed to but did not cause the injury and where the lack of proper disclosure of risk negated informed consent to treatment. These cases demonstrate how reparations accountability under the obligations to "protect and fulfil" can be met in "pockets of cases".

In relation to material causation, the difficulty in proving causation in occupational injury cases saw the courts adopt a modified or "material contribution to harm" test.[1659] In these cases, the struggle by the courts to address the perceived injustice of the case is to loosen the rules of evidence while limiting the extension of any new doctrine of causation. It is for this reason that this avenue of liability in negligence was described as "divid[ing] courts and commentators throughout the common law world".[1660]

Lord Reid considered the "material contribution to harm" test in *Bonnington Castings Ltd v Wardlaw*[1661] where the appellant constantly inhaled noxious dust at work. Lord Reid considered that insofar as the work tools contributed a quote of silica dust which helped to produce the disease, that was material causation sufficient to establish liability.[1662] Lord Reid's formulation of this material contribution to harm test is viewed as an exception to the usual "but for test".[1663]

[1659] This is in no small part attributable to the fact that the law of tort is an "all or nothing" affair - the plaintiff either succeeds or fails totally. Matters of gradation - which would reflect the reality of the practice of medicine - are left for assessment of damages only. One either causes negligence under the tort or one does not.

[1660] *Gregg v Scott* [2005] 4 All ER 812, per Lord Nicholls.

[1661] [1956] AC 613.

[1662] [1956] AC 613 at 622-623.

[1663] It has been suggested that the "but for" test operates best where the medical evidence satisfactorily isolates the possible causalities and where the "net question is whether the plaintiff's injury was avoidable" where reasonable care and skill was exercised. However, it may be less appropriate where "contextually ... cases of medical negligence necessarily engender consideration of partial causes" multiplied in accordance with the medical personnel involved: J Healy, *Medical Malpractice Law* Roundhall Press (2009) at 691.

One commentator argues that what Lord Reid actually held in *Wardlaw* was that the disease was caused by the whole of the dust, both guilty and innocent combined "so that in the absence of one source of the dust, the disease would not have occurred".[1664] It is contended that *Wardlaw* and *Bailey v Ministry of Defence and Another*[1665] dealt with more than one source of the harmful agent (the illness) and can be distinguished from the subsequent cases of *Hotson v East Berkshire Area Health Authority*[1666] and *Gregg v Scott*[1667] where no liability was found for "loss of chance" (discussed below) as these cases involved only one such source. The other difference is that *Wardlaw* and *Bailey* involved actualised harm, whereas *Hotson* and *Gregg* concerned risk of future harm.

In *McGhee v National Coal Board*[1668], the plaintiff contracted dermatitis due to exposure to dust working in a brick kiln. The difficulty he faced was one of causation: how could he prove that his injury resulted from the dust? Lord Reid for the majority in the House of Lords, citing *Wardlaw*, held that it sufficed for the plaintiff to demonstrate that the defendant's breach of duty materially increased not the injury but the risk of injury insofar as the defendants while not responsible for one source "could and ought to have prevented the other".[1669]

Wardlaw, *McGhee* (and later *Fairchild* – see below) saw the English courts, in order to avoid potential injustice to plaintiffs, develop a "material contribution to harm" test whereby negligence was established once the plaintiff demonstrated that the defendant's acts or omissions materially contributed to

---

[1664] G Turton, *A Case for Clarity in Causation? Bailey v Ministry of Defence and Another*, 17 Medical Law Review (2009) at 142-143. Turton disputes the reading of *Wardlaw* as an exception to the 'but for' test and notes how this interpretation was repeated by Waller LJ in the subsequent Court of Appeal in *Bailey v Ministry of Defence and Another* [2008] EWCA Civ 883; ibid at 140.

[1665] [2008] EWCA Civ. 883.

[1666] *Hotson v East Berkshire Area Health Authority* [1987] AC 750.

[1667] [2005] 4 All ER 812.

[1668] [1973] 1 WLR 1.

[1669] [1973] 1 WLR 1 at 4. Lord Wilberforce stressed that this loosening of the causation test was a policy ground decision of the court in the interests of justice.

the injury. This was a departure along similar lines to the *res ipsa loquitur* doctrine from the all-or-nothing approach: the plaintiff has difficulty in proving causation but certain matters are within the knowledge of the defendants and the justice of the case demands that a justification be provided.

That the test was controversial and ultimately exceptional was confirmed by Lord Bridge in *Wilsher v Essex Area Health Authority*[1670], who argued that *McGhee* laid down no new principle of law but merely adopted "a robust and pragmatic approach to the undisputed primary facts of the case" which allowed the court make a legitimate inference of fact of material contribution to the pursuer's injury.[1671] Here the court was concerned to ensure that the burden of proving causation remains with the plaintiff.[1672] Notwithstanding this, the broader perspective in *McGhee* and its modified causation requirement in occupational health injury cases was confirmed by the House of Lords in *Fairchild v Glenhaven Funeral Services Ltd.*[1673] Once breach of duty was established against the employers, Lord Bingham favoured a "less stringent test" in such circumstances where there was injustice of denying redress to a victim."[1674] The duty would be imposed on an employer where there was a material increase in the risk to plaintiffs contracting the disease. Lord Bingham quoted Lord Hoffman in *Kuwait Airways Corporation v Iraqi Airways Co (Nos*

[1670] [1988] 1 AC 1074.

[1671] [1988] 1 AC 1074 at 1086.

[1672] In *Wilshire*, the plaintiff was blinded at birth due to a junior doctor mistakenly inserting a catheter into the umbilical vein in the hospital's special care baby unit with the result that oxygen levels read incorrectly. The House of Lords, reversing the Court of Appeal, held that the defendant could be held liable only if the oxygen caused or substantially contributed to the injury and found that the plaintiff had not established this on the balance of probabilities, Lord Bridge stating: "whether we like it or not, the law, which only Parliament can change, requires proof of fault causing damage as the basis of liability in tort." [1988] All ER 871 at 883.

[1673] [2002] 3 WLR 89. Here the plaintiffs suffered lung disease (mesothelioma) following exposure to asbestos dust in more than three factories. Causation was impossible to prove as the precise source of the injury could not be identified insofar as there were different employers.

[1674] [2002] 3 WLR 89. Lord Bingham was of the view that such "injustice" as may be involved in imposing liability on a duty-breaking employer was "heavily outweighed by the injustice of denying redress to a victim" as otherwise an employer exposing his employee to asbestos dust could obtain complete immunity against mesothelioma (but not asbestiosis) claims "by employing only those" who had previously been exposed to excessive quantities of asbestos dust. Such a result "would reflect no credit on the law"; at 120.

4 and 5)[1675] in aid of the argument that there may be "varying causal requirements, depending upon the basis and purpose of liability".[1676] It was argued that in order to guard against the floodgates argument, the reasons (or policy) in departing from the general rule, must be "sufficiently weighty" and it "must be plain and obvious that this is so".[1677] Notwithstanding this, Lord Steyn in *Chester v Afshar*[1678] observed how where justice and policy "*demand* it a modification of causation principles is not beyond the wit of a modern court",[1679] thus demonstrates how the courts can provide a remedy where the "obligation to fulfil" the right to health, through taking positive measures, is unmet.

The dicta of Lord Nicholls in *Fairfield* where he called for considerable restraint in relaxing the 'but for' test of causal connection on the basis that one needed good reason to depart from this test so as not to cause injustice to the defendant was taken up by the Irish courts. One such good reason was identified in *Fitzpatrick v National Maternity Hospital*[1680] where Herbert J found that part of the hospital's negligence could be attributed to the obstetrician's failure, once notified of the danger, to promptly deliver the baby which "materially contributed" to the catastrophic injuries suffered.[1681]

As opposed to multiple causation, *Wilshire* and later *Gregg v Scott*[1682] and *Rothwell v Chemical & Insulating Co Ltd*[1683] saw the House of Lords adopt a

---

[1675] [2002] 2 WLR 1353.

[1676] [2002] 2 WLR 1353. According to Lord Hoffman, questions of liabilitycannot be separated from questions of causation as they are inextricably connecte: "One is never simply liable; one is always liable for something and the rules which determine what one is liable for are as much part of the substantive law as the rules which determine which acts give rise to liability"; at 1388.

[1677] *Fairchild v Glenhaven Funeral Services Ltd* [2002] 3 WLR 89 per Nicholls J.

[1678] [2005] 1 AC 134.

[1679] [2005] 1 AC 134 at 146, emphasis retained. As Healy points out, the inference of fact in a party's favour under modified causation rules is provisional only, it does not entail any effect for the legal burden of proof and that even where the defendant fails to rebut the inferred fact, the court is not required to find for the plaintiff if it considers the fact insufficiently proved: J Healy, *Medical Malpractice Law* Roundhall Press (2009) at 705-706.

[1680] [2008] 3 JIC 0704.

[1681] [2008] 3 JIC 0704.

[1682] [2005] 4 All ER 812.

strict approach to consequential injury in cases where only one source of the harm was in question, usually that of delayed treatment.[1684]

15.8 Loss of Chance

The courts have adopted a loss of chance doctrine to situations where a missed diagnosis contributed to but did not cause the injury. This allows for a modification of the all-or-nothing causation test[1685] and could allow claims for healthcare omissions (loss of health outcome) to be litigated where the failure or omission contributes to a negative health outcome without being its sole cause. Following *Chaplin v Hicks*[1686] if an individual can claim that they suffered loss of chance or partial disadvantage - such as reduced life expectancy - by virtue of medical malpractice or through an inability to access a quality (enterprise) health service and that this occurred as a result of prohibited discrimination, s/he may avoid the requirement to point to individual physician negligence, with the need to meet the *Dunne* principles and prove causation. This is the approach taken in the United States where "the proportional damages approach is the most widely accepted method to calculating damages".[1687]

[1683] [2006] 4 All ER 1161.

[1684] Kearns J in *Quinn v Mid-Western Health Board* [2005] 4 IR 1 pointed out how a difficulty may rise in cases where the injurious event occurs first and "there is *then* negligence, whether by way of misdiagnosis or delay in providing appropriate treatment". In the latter situation, the negligence "may perhaps better be characterised as giving rise to the "loss of a chance" or "loss of an opportunity" of avoiding most, or at least a significant part, of the ensuing damage"; at 14.

[1685] It will be recalled that even where the plaintiff can prove on the balance of probabilities that physical injury caused by negligence may result in consequential injury, this will not suffice for a finding of negligence where the all-or-nothing approach to negligence is followed. Here the loss of chance - or discounted or proportionate form of liability – doctrine may, similar to material causation, offer a potential gateway for the right to health insofar as a considerable aspect of the right to the AAAQs without discrimination will focus on whether a right of access to health facilities and health care exists for individuals from vulnerable groups.

[1686] [1911] 2 KB 786. The case concerned a failure to notify the plaintiff of a beauty competition and the loss she suffered as a result.

[1687] S Buckler, *Medical Malpractice Law-Loss of Chance: Recovery for the Lost Opportunity of Survival - Matsuyama v Birnbaum 890 N.E.2d 819 (Mass. 2008)* 5 Journal of Health & Biomedical Law (2009) 117 at 124. In the US, loss of chance has been recognised in some States as allowing for recovery for less than 51% loss of chance. Buckler points how how in *Matsuyama v. Birnbaum* 890 N.E.2d 819 (Mass. 2008), the Supreme Judicial Court of

The House of Lords has however twice refused to take a loss of chance analysis, though by narrow and arguably reversible margins. In *Gregg v Scott*[1688] there was an omission: a failure to diagnose the plaintiff's cancer by his doctor which occasioned a delay of seven months in treatment. The House of Lords declined to make a finding of negligence on the basis of a "loss of chance" as the prospects of recovery were less than 50% at the time of the misdiagnosis.[1689]

Three months prior to *Gregg*, the House of Lords judgment in *Chester v Afshar*[1690] had a different outcome. In *Chester* the court found that the failure of a surgeon to inform a patient of a risk of elective lumbar surgery constituted negligence with the House of Lords splitting 3 v 2 in favour of *Fairchild* flexibility. Yet in *Gregg* the court split 3 v 2 in the other direction, following the precedent of *Hotson v East Berkshire Area Health Authority*[1691]. In the

---

Massachusetts determined that a plaintiff could recover damages when a defendant's negligence caused the victim to lose an opportunity of surviving, even if that chance was less than fifty-one percent". Buckler also cites *Hicks v United States* 368 F.2d 626 (4th Cit. 1966) as the seminal case for loss of chance in medical malpractice where the court reasoned that when there is a substantial possibility of survival but this is destroyed by the defendant's negligence, recovery is possible. In this scenario, the plaintiff may not recover 100% of damages under an all-or-nothing approach where the loss of chance exceeds 51% but such a doctrine would allow more persons (i.e. those with a loss of chance below 50%) recover for a lost health opportunity (as in increase in risk of health injury); ibid.

[1688] [2005] 4 All ER 812. The plaintiff sued, not for general damages in negligence, but for "loss of chance" (calculated at 17% in the "prospects of a cure") arising from the delay in diagnosis and treatment.

[1689] In the words of Lord Hoffman the "but for" rule applied as a wholesale adoption of possible rather than probable causation as the criterion of liability "would be so radical a change in our law as to amount to a legislative act"; [2005] 4 All ER 812 at 833. By the time the case came before the House of Lords, eight and a half years had passed and Mr Gregg was still alive, with his prognosis unknown.

[1690] [2005] 1 AC 134.

[1691] [1987] AC 750. The Court considered the plaintiff "doomed" to develop the disability at the time of admittance to hospital. However, this arguably does not take account of the concern raised by the Court of Appeal that an identical plaintiff to *Hotson* in a private hospital for breach of contract could have succeeded. In *Wardlaw v Farrar* [2003] EWCA Civ 1719 the Court of Appeal had awarded moderate damages where the medical evidence was inconclusive as to the value of the lost opportunities occasioned by the negligent delay in the case. In *Chappel v Hart* [1992] HCA 55 (concerning medical non-disclosure), in the Australian High Court the defendant argued that all that his negligence had occasioned was the loss of an insufficiently valuable chance for the plaintiff which did not constitute material contribution to the harm. Although this argument was not allowed by the court, it offers a glimpse of how loss of chance could be argued for both plaintiff and defendant where only modified damages were available under the doctrine. Surprisingly, *Chester* was only referred to in passing by one of the five judges in *Gregg*, Baronness Hale. In *Hotson*, the health authority admitted negligence in failing to diagnose and treat with sufficient promptness the boy plaintiff's injury. The Court of

minority, Lord Nicholls pointed out that if a patient's prospects of recovery were less than 50% they would be "treated as non-existent" under the all-or-nothing approach.[1692] What was required was a test where a dimunition in one's prospects of recovery caused by negligence, could be captured.[1693] However, the majority favoured general policy considerations[1694] with Lord Hoffman concerned that the exceptional nature of the rule in *Fairchild* might be generalised to where there was an increased likelihood of injury, which would amount to a legislative act of the court.[1695]

In Ireland there has similarly been conflicting jurisprudence on loss of chance. In *Philp v Ryan*,[1696] Fennelly J favoured proportionate recovery for loss of

---

Appeal applied *Chaplin*, Dillon LJ considering that had the boy been promptly treated he had a 25% chance of avoiding the disability he acquired. This did not meet the "all-or-nothing" test. Healy suggests that the "novelty" of the loss of chance approach was that it redefined the injury as "an interest that had been lost or destroyed due to the defendant's fault"; J Healy, *Medical Malpractice Law* Roundhall Press (2009) at 771.

[1692] According to Lord Nicholls, "the way ahead" would be to recognise that where a patient is suffering from illness or injury and his prospects of recovery are attended with a "significant degree of medical uncertainty" and he suffers a "significant diminution of his prospects of recovery" on top of this by reason of negligence, "that diminution constitutes actionable damage"; [2005] 4 All ER 812 at 824.

[1693] "This is so whether the patient's prospects immediately before the negligence exceeded or fell short of 50%. 'Medical uncertainty' is uncertainty inherent in the patient's condition, uncertainty which medical opinion cannot resolve. This is to be contrasted with uncertainties arising solely from differences of view expressed by witnesses. Evidential uncertainties of this character should be resolved in the usual way"; [2005] 4 All ER 812 at 824-825 per Lord Nicholls.

[1694] Baroness Hale expressed concern that under a "loss of chance" doctrine "the claimant would always get something. It would be a 'heads you lose everything, tails I win something' situation"; [2005] 4 All ER 812 at 867.

[1695] [2005] 4 All ER 812. This would be "a wholesale adoption of possible rather than probable causation as the criterion of liability... It would have enormous consequences for insurance companies and the National Health Service"; at 833. Similarly Lord Phillips rejected any extension of "the conventional approach to causation" as was applied by the trial judge"; at 859. The problem with this reasoning is that "... if the principle in Fairchild is not applicable to a case such as Wilsher, then, a fortiori, it is not applicable to Chester": S Green, *Coherence of Medical Negligence Cases A Game of Doctors and Purses* 14 Medical Law Review (2006) at 20. Lord Phillips did however did hold out the prospect that in other cases "there may be a case for permitting a recovery of damages that is proportionate to the increase in the chance of the adverse outcome"; ibid at 859. In *Gregg*, Baroness Hale referred to *Fairchild* and *Chester* as dealing with "particular problems", presumably individual injustices; at para 192.

This has led some commentators to suggest that there may be some future for loss of chance cases grounded in actual adverse outcomes (such as death). Indeed, Lord Phillips's for the majority considered that in other cases where there was an adverse outcome (in his view not present here) "there may be a case for permitting a recovery of damages that is proportionate to the increase in the chance of that outcome"; at para 190.

[1696] [2004] IESC 105.

chance where the damage suffered by the plaintiff "consists of the loss of an opportunity to avail of treatment".[1697] However three months later in *Quinn v Mid-Western Health Board*[1698] Kearns J cited *Gregg* with approval, albeit as *obiter dicta*[1699] and stated that it was "eminently sensible" that *McGhee* flexibility be reserved for highly exceptional cases.[1700] In *Fairchild,* the defendants' fault was not in issue, whereas in *Quinn* it was and thus the 'but for' test must be followed.[1701] Insofar as Lord Scott described *Fairchild* in

---

[1697] [2004] IESC 105. This, Fennelly J reasoned might "with equal logic, be described as an increased risk of shorter life expectancy" due to negligence. He stated that it was "contrary to instinct and logic that a plaintiff should not be entitled to be compensated for the fact that, due to the negligent diagnosis of his medical condition, he has been deprived of appropriate medical advice and the consequent opportunity to avail of treatment which might improve his condition", being unable to identify any "contrary principle of law or justice". Fennelly J constrasted the "commonplace" nature of awards for risks as low as 15% that an injured plaintiff may in the future develop arthritis in an injured joint. The learned judge did not agree that this was any different from what is sought in the present case. Further, it was "illogical to award damages for a probable future injury as if it were a certainty, as to withhold them where the risk is low on the basis that it will not happen"; at 249. Statistics are finding increasing favour as evidence in hypotethcal lost chance cases: see the dissent of Nicholls J in *Gregg v Scott* [2005] 2 AC 176 where he pointed out that courts "habitually use statistics as an aid when compensating claimants for a risk of an outcome which may materialise, whether the risk is more than 50% or less than 50%"; at 187. Glance argues in favour of codified guidelines and statistics informing medical litigation who argues insofar as the healthcare system has codified clinical guidelines and digital data gathered across thousands of clinicians and their patients, "it is possible to compute adequate levels of care and expect clinicians and the healthcare system in general to meet these minimum standards: D G Glance, *A systems approach to accepted standards of care: Shifting the blame*, 4 Australasian Medical Journal (2011) at 490.

[1698] [2005] 4 IR 1.

[1699] [2005] 4 IR 1. The plaintiff was unable to discharge the burden of proof as to what caused her brain damage *in utero* but argued for modified causation insofar as the explanation must rest with the defendants. Kearns J distinguished *Fairchild* as being premised on a unique set of facts where it would have been "patently unjust not to allow the appeal". *Quinn* involved a girl born with severe brain damage. Whereas the defendant Health Board accepted on the 17th day of the trial that there had been negligence in the management of the pregnancy, it contended that the brain damage had been sustained in the 28-30 week period of pregnancy and prior to any negligence at her birth – that the plaintiff would still have been born with a disability. There was a mystery as to why the injury occurred as the plaintiff had no means of demonstrating causation, however there was agreement that there was a single cause - a chronic irreversible injury suffered in utero. At issue was whether the injury was preventable by the defendants. The Supreme Court dismissed the plaintiff's appeal from the High Court's finding of no negligence on the basis that O'Sullivan J had been entitled to favour one expert witness' testimony over others; at 17.

[1700] [2005] 4 IR 1 at 94. Kearns J, citing Wilshire, distinguished between negligence ex ante and negligence ex post facto. Regarding the latter form of negligence the court considered that the appropriate avenue to be pursued is that of loss of chance.

[1701] It has been suggested that insofar as these views against modifying the causation test were strictly *obiter* (they had not been advanced in the High Court), it is unclear whether *Gregg* will be followed in Ireland in all loss of chance cases, given the amorphous nature of the three majority opinions in the case and given Fennelly J's Judgment in *Philp*: R Ryan, *The future of medical negligence and claims management*, Medical Negligence Litigation Conference, Royal Marine Hotel, Dun Laoghaire, Dublin, (September 2012). As against this is the Supreme

Barker v Corus[1702] as a "pragmatic judicial response to what would otherwise have been an unjust and unsatisfactory denial of a remedy",[1703] it remains to be seen whether loss of chance and proportionate liability per *Philp* will continue as a source of remedy following *Quinn* and the future approach of the English courts will likely prove influential. Any modification of the but-for test increases the likelihood of acceptable justiciability of the AAAQs under the law of torts without having to face insurmountable causation requirements. However, loss of chance, being predicated upon both failure and omissions of medical responses, does allow the means for proportionate recovery in access to healthcare without discrimination.

Both the English and Irish courts have invoked policy reasons for limiting liability of healthcare authorities for psychiatric harm caused due to abuse or fear of future illness from occupational hazards. Following the House of Lords judgments in *D v East Berkshire Community Health NHS Trust & others*,[1704] and *Rothwell v Chemical & Insulating Co Ltd*[1705], the Irish Supreme Court similarly held against the plaintiff in cases where psychiatric injury resulted from occupational hazards in *Fletcher v Commissioners of Public Works in Ireland.*[1706] This signalled the court's preference for a pragmatic rather than principled approach in its reluctance, on policy grounds, to allow liability in negligence for psychiatric injury arising from an "objectively irrational" even if reasonably foreseeable fear.[1707] In *Fletcher*, at issue was not future injury, but

---

Court's decision in *Best v Wellcome Foundation Ltd* [1993] 3 IR 421. upholding the principle that the burden of proof remains with the plaintiff when there are different possibilities as to the cause of the injury, which suggests that *Fairchild* principles will only be applied exceptionally in Ireland.

[1702] [2006] 2 AC 572.

[1703] [2006] 2 AC 572 at para 47.

[1704] [2005] 2 AC 373.

[1705] [2006] 4 All E R 1161.

[1706] [2003] 1 IR 465. Here a five strong House of Lords unanimously held that three consequences of exposure to asbestos dust (two physical and one psychiatric anxiety) could not be aggregated to constitute the minimum actionable damage for negligence: a fear of future pulmonary illness was not a recognisable form of damage.

[1707] Geoghegan J stated that the court should not permit compensation for irrationality: [2003] 1 IR 465 at 518. Healy notes how in *Lawson v Lafferiére* (1991) 78 DLR (4th) 609, a case concerning uncommunicated cancer diagnosis and delayed treatment, the Canadian Supreme Court rejected the loss of chance doctrine but did award damages for mental distress arising

the fear of future injury. Keane CJ suggested that if the objectively irrational fear became rational (i.e. became likely future injury) in circumstances where the risk of contracting a disease was probable, the claim could succeed. This neither addresses those cases falling in the 30%-50% bracket, nor provides insight "into the aetiology of mental illness".[1708]

In similar vein to *Philp,* the High Court had permitted recovery for pure psychiatric injury in *Delahunty v South Eastern Health Board*[1709] where O'Higgins J favoured the plaintiff's evidence that it was 70% probable that his psychiatric injury resulted from sex abuse which the respondent had not prevented. However, an opposite conclusion was reached in *O'Connor & Tormey v Linehan*[1710] where absence of psychiatric evidence of injury to ground the "anger and distress" of the parents of dead babies whose organs were routinely retained by Irish maternity hospitals without their knowledge or consent precluded recovery in negligence.

These cases returns us to the conundrum evident in the *res ipsa loquitur* and material contribution to harm doctrines: once negligence is proved, should the plaintiff be always required to prove causation even where the evidence is within the domain of the defendant? And if so, should causation of harm exceed 50% in likelihood for recovery to occur even where the rule may "subvert the deterrence objectives of tort law"?[1711] The advantage of avoiding the all-or-nothing approach means that omissions ("obligation to fulfil") of the right to health can be addressed under reparations accountability.

---

from the negligence. Whereas the Australian High Court indicated, *obiter dicta*, an open mind to loss of chance in *Naxasis v Western General Hospital* [1999] HCA 22 per Gibson CJ, in *Tabet v Gett* [2010] HCA 12, Gummow ACJ held that the plaintiff was not entitled to recover for loss of chance where a 15% chance of a better medical outcome was established but where no causation was demonstrated; J Healy, *Medical Malpractice Law* Roundhall Press (2009).

[1708] W Binchy, *Recent Developments in the Law of Torts*, 4 Judicial Studies Institute Journal (2004) 1 at 16.

[1709] [2003] 4 IR 361.

[1710] [2005] IESC 176. There was no fear of injury to self: see J Healy, *Medical Malpractice Law* Roundhall Press (2009) at 758-759 and *Devlin v National Maternity Hospital* [2008] 2 IR 222.

[1711] Healy citing King, *Causation, Valuation and Chance in Personal Injury Torts Involving Preexisting Conditions and Future Consequences* 90 Yale Law Journal (1981) 1353 at 1377; J Healy, *Medical Malpractice Law* Roundhall Press (2009) at 794.

While authoritative resolution is awaited by the Irish courts to *Philp* and *Quinn,* it appears that modified causation theories are gaining ground in responding to clear "justice" cases in medical negligence. This is clearest in the recent informed consent cases, as will be observed below.[1712]

15.9 Disclosure of risk/ informed consent

Another category of potential medical negligence concerns the issue of informed consent to treatment.[1713] The courts in Canada, Australia and England have preferred to characterise the tort as one of negligence as opposed to battery medical treatment. Consent to treatment is seen as an autonomy right which trumps paternalistic medicine, with the jurisprudence centring on the duty of the doctor to disclose various levels of injury risk to ensure informed consent. A very high level of disclosure and explanation is necessary for consent in relation to medical research, which is obviously linked to historic concerns about eugenics and human experimentation.[1714] However, insofar as clear informed consent is a condition precedent to clinical drug trials, this thesis will not discuss medical research.

[1712] This suggests how medical negligence claims are capable of vindicating the constitutional right to bodily integrity by modifying the traditional doctor-centred approach in favour of health/ autonomy principles where the justice of the case requires. Key of course will be developing the caselaw in a foreseeable manner so as to allow would-be-defendants to modify their behaviour accordingly.

[1713] As noted in Part 1 of this thesis, informed consent to medical treatment is a human right recognised in a number of international standards as a component of the right to participate in health decisions. Healy describes its ascension in medical negligence law as an important practical expression of a broader societal demand to "reclaim the right to participate in matters traditionally entrusted to the professions and public authorities". The process has greatly influenced medical education and clinical practice, encouraging ampler disclosure than heretofore; J Healy, *Medical Malpractice Law* Roundhall Press (2009) at 500.

[1714] B McMahon and W Binchy, *Law of Torts* (3rd Ed.) Butterworths (2000) at 397-398. International standards now prohibit medical experimentation without informed consent and such consents are required in clinical trials for regulatory approval. See Article 1 of the Council of Europe Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine ("Oviedo Convention") and its protocols; 1997 ETS No 164, 1998 ETS No 168 (cloning), 2002 ETS NO 186 (organs and tissue), 2005 CETS NO 195 (biomedical research), 2008 CETS NO 203 (genetic testing). Although neither the Convention nor its protocols have been signed or ratified by Ireland, their provisions increasingly inform the jurisprudence of the European Court of Human Rights.

For consent to be valid it must be voluntary, given by someone with the requisite capacity (mental and age) and be informed.[1715] It will be recalled that in *Szijarto v Hungary*[1716] the CEDAW Committee described informed consent in terms of receiving appropriate and understandable information and advice on family planning, an approach also taken by the European Court.[1717] Informed consent may be understood today as a substantial understanding of the medical facts such as "the success rates, risks, alternatives, costs, experience of the doctor and the doctor's recommendation" and information in response to a patient's "concerns and wishes".[1718]

The previous paternalistic benevolent deception approach evident in *Daniels v Heskin*[1719] has been overtaken by the House of Lords judgment in *Chester v Afshar*[1720] and the Irish Supreme Court judgments in *Geoghegan v Harris*[1721] and *Fitzpatrick v White*[1722] which stress a "reasonable patient" or a "patient centred" approach and which favour a test focusing on a "significant risk which would affect the judgment of a reasonable patient".[1723]

[1715] S Mills, *Informed Consent; Current law and outstanding issues*, Medical Negligence Litigation Conference, Royal Marine Hotel, Dun Laoghaire, Dublin (September 2012).

[1716] Communication No. 4/2004, UN Doc CEDAW/C/36/D/4/2004 (29 August 2006).

[1717] In *IG v Slovakia*, Application No. 15966/04, Judgment 13 November 2012, the European Court found that the requirement of obtaining informed consent from ethnic minorities (here a Roma woman who was sterilised by doctors) was heightened insofar as it required "safeguards giving special consideration to the reproductive health of the first and second applicants as Roma women", the absence of which "resulted in a failure by the respondent State to comply with its positive obligation to secure to them a sufficient measure of protection enabling them to effectively enjoy their right to respect for their private and family life", thus resulting in a violation of Article 8 of the ECHR in additon to Article 3; at 145-146. See also *VC v Slovakia*, Application No. 18968/07, Judgment 8 November 2011 and *NB v Slovakia*, Application No. 29518/10, Judgment 12 June 2012, discussed above.

[1718] D Madden, *Medicine, Ethics and the Law* (2nd Ed) (2009) at 386-387. Madden cites five elements crucial in the concept of consent to medical treatment: disclosure, comprehension voluntariness, competence and consent; also commenting that studies demonstrate that good communication is significantly lacking in healthcare decision-making: at 387.

[1719] [1954] IR 73.

[1720] [2005] 1 AC 134.

[1721] [2000] 3 IR 536.

[1722] [2008] 3 IR 551.

[1723] [2008] 3 IR 551 at 561-564.

In *Sidaway v Governors of the Bethlem Royal Hospital*[1724] the majority of the House of Lords held that a doctor should answer the questions of an inquisitive patient, with a "reasonable patient" rather than a "reasonable standard" test favoured by Lord Scarman in *Sidaway* and by Lord Woolf MR in *Pearce v United Bristol Healthcare NHS Trust.*[1725] The House of Lords judgment in *Chester v Afshar*[1726] addressed the patient's right to autonomy holding that although the plaintiff may have proceeded with the surgery had she known the risks attaching to elective lumbar surgery, she was nonetheless entitled to compensation for the failure of a surgeon to inform her of the risks.[1727] This failure constituted negligence, with Lord Hope identifying the duty of the doctor to warn having "at its heart" the right of the patient to make an informed choice "as to whether, and if so when and by whom, to be operated on". The duty was owed as much to the patient who, if warned, would find the decision difficult as to the patient who would find it simple and could give a clear answer to the doctor one way or the other immediately.[1728]

Both *Pearce* and *Chester* marked a departure from the strict causation and standards test of *Bolam* as they sidestep the question of causal connection and focus rather on whether adequate information was provided or not to the "reasonable patient". In *Walsh v Family Planning Services Ltd*[1729], Finlay CJ stated that the test for medical treatment, advice and risk disclosure was as set out in *Dunne.*[1730] However, his judgment clearly goes beyond *Dunne* in distinguishing the issue of medical judgment on the one hand with the issue of disclosure of risk to patients on the other where elective treatment was

---

[1724] [1985] AC 871.

[1725] [1999] ECC 167. Lord Woolf's speech was cited with approval by Kearns J in *Fitzpatrick v White* [2008] 3 IR 551 who noted how it modified *Sidaway* by introducing a patient-focused test.

[1726] [2005] 1 AC 134.

[1727] Maclean suggests that the majority adopted a liberal vision of autonomy, relying primarily on Dworkin's approach; AR Maclean, *From Sidaway to Pearce and Beyond: Is the legal regulation of consent any better following a quarter of a century of judicial scrutiny*? 20 Medical Law Review (2012) 108 at 124.

[1728] [2005] 1 AC 134 at para 28.

[1729] [1992] IR 496.

[1730] [1992] IR 496 at 510-511.

concerned. O'Flaherty J, with whom Hederman J agreed also favoured the approach of Lord Scarman and Lord Woolf MR and this approach later found favour in *Geoghegan v Harris.*[1731] In Kearns J's view, the test was as set out in *Roche v Peilow*[1732] that the defect in consent "ignored or tolerated by the approved practice of a profession, relates to an obvious risk or danger".[1733] Very remote risks would be excluded from this test, but if there was a "known complication" which would lead to "foreseeable or predictable consequences arising from such complications" to the patient, there should be disclosure. The test involves a very wide range of disclosure of risk: for Kearns P disclosure of a risk of "one in thousands".[1734]

In *Geoghegan*, Kearns J employed a hybrid test with both objective and subjective elements - what would a reasonable person in the plaintiff's position have done if properly informed and what would the plaintiff have done.[1735] In *Flynn v Suleiman and Adavanced Cosmestic Surgery Limited*[1736] O'Neill J focused not on professional standards but on what the plaintiff as reasonable patient was entitled to know before a liposuction procedure finding the doctor

---

[1731] [2000] 3 IR 536 where Kearns J described Lord Scarman's "refinement" of the *Bolam* test in *Sidaway:* disclosure of a particular risk may be so obviously necessary to an informed choice on the part of the patient that "no reasonably prudent medical practitioner would fail to make it"; at 564.

[1732] [1985] IR 232.

[1733] [2000] 3 IR 536 at 542.

[1734] Kearns J citing both Finlay CJ and M A Jones, *Medical Negligence* (2nd Ed.) Sweet & Maxwell (1996) at 121; [2000] 3 IR 536 at 544. The Indian Supreme Court has advanced the concept of "real consent" in *Samira Kohli v Dr Prabha Manchanda* (2008) 2 SCC 1, at para 32. Although holding that a doctor must "seek and secure the consent of the patient" before commencing medical treatment the court held that the "nature and extent of information to be furnished" to secure this consent was relative. It "need not be of the stringent and high degree mentioned in [Canterbury v Spence - 1972 [464] Federal Reporter 2d. 772] but should be of the extent which is accepted as normal and proper by a body of medical men skilled and experienced in the particular field" having regard to "the physical and mental condition of the patient, the nature of treatment, and the risk and consequences attached to the treatment" but also "having regard to the ground realities in medical and health-care in India"; at paras 32-33. See D Singh, *Informed vs Valid Consent: Legislation and Responsibilities*, 5 Indian Journal of Neurotrauma (2008) 105 at 106.

[1735] As noted above, the courts could be assisted in identifying a patient informational test by relevant research conducted on what information reasonable patients expect and need.

[1736] [2006] 6 JIC 2101.

guilty of negligence.[1737] In *Fitzpatrick v White*[1738], Kearns P stated that a warning need not be given in all cases, but a warning must "in every case be given of a risk, however remote, of grave consequences involving severe pain continuing into the future and involving further operative intervention".[1739] However, in cases where there is no risk of ongoing severe pain, the test was modified to whether "there is a significant risk which would affect the judgment of a reasonable patient". If so, then in the normal course it was the responsibility of a doctor "to inform the patient of that significant risk". This was still an onerous test and the words "significant risk" and "material risk" were interchangeable. A risk "may be seen as material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it". [1740]

Arising from *Geoghegan, Flynn* and *Fitzpatrick*, Irish law appears to have moved to a "patient centred test" where the focus is on the patient and where a risk is deemed significant or material if a reasonable person would, if warned of the risk, likely attach significance to it. Not yet considered in the Irish courts is whether among the matters a patient should be warned of is surgeon inexperience[1741] or whether a patient should be informed of the risks of not undergoing treatment.[1742]

[1737] O'Neill J concluded the plaintiff went into this procedure "wholly bereft of the knowledge derived from qualified medical practitioners" necessary for an informed consent; [2006] 6 JIC 2101.

[1738] [2008] 3 IR 551.

[1739] Emphasis added. [2008] 3 IR 551 at 562-563. Kearns P also noted the analysis undertaken by both Kirby J in the High Court of Australia in *Rosenberg v Percival* (2001) 205 CLR 434 as supporting the argument that the giving of an adequate warning, far from being a source of nuisance for doctors, should be seen as an "opportunity to ensure they are protected from subsequent litigation at the suit of disappointed patients."; at 562.

[1740] [2008] 3 IR 551. On the facts, the plaintiff's claim was dismissed, there being no risk of "ongoing severe pain" while the judge considered plaintiff was not actually disadvantaged in some material way by the lateness of the warning he received; at 564. This finding is arguably similar to *Jones v North West Strategic Health Authority* [2010] EWHC 178 where the Court of Appeal employed the prudent patient test; at para 100.

[1741] Mills cites the competing US jurisprudence of *Johnson v Kokemoor* 545 N.W.2d 495 (1996) where the Supreme Court of Wisconsin found a doctor was obliged to disclose comparative inexperience and *Whiteside v Lukson 947 P.2d 1263* (1997) where the Washington Court of Appeal found there was no duty on the doctor to disclose his inexperience: S Mills, *Informed Consent; Current law and outstanding issues*, Medical

Consideration of where the patient may contribute to the harm, for example, in refusing to undertake timely treatment, may be another area which would benefit from permitting a recovery of damages proportionately reduced by the level of the plaintiff's contributory negligence.[1743] In *Sinnott v Quinnsworth*[1744] the Supreme Court reduced the damages accuring to a plaintiff left paraplegic in a road traffic accident by considering policy grounds for limiting general damages in such cases.[1745] In *Myles v McQuillan & Ors*[1746] Quirke J took into account the fact that the plaintiff's pre-existing disease (for which no one was liable) was exacerbated by negligent treatment so that her additional injuries could be categorised "as catastrophic".[1747] The award took into account the pre-existing condition in awarding damages proportionate to the negligence. Under this principle, pre-existing conditions or a plaintiff's tardiness in seeking treatment or abiding by medical advice could be evidence of the proportionate damages which should be due, avoiding again the all-or-nothing approach.

Negligence Litigation Conference, Royal Marine Hotel, Dun Laoghaire, Dublin (September 2012).

[1742] In *Truman v Thomas,* 27 Cal 3d, 611 P.2d 902 (1980) the Supreme Court of California found that where a patient died from cancer of the cervix, the doctor owed a duty of care to inform a patient of the material risks of not consenting to a recommended pap smear, so that the patient might make an informed choice: "the burden is "significant" risks rather than "all relevant" information"; at para 83 per Bird CJ.

[1743] Patients may contribute to their injuries through lack of communication or poor recall. Mills observes how "poor patient recall is a consistent and reproducible observation", citing M Guerin and M O'Keefe, *Informed Consent in Refractive Eye Surgery: Learning from Patients and the Courts,* 105 Irish Medical Journal (2012) 282 which concluded that patients understanding and recall of the consent process was poor rendering it "imperative for the surgeon to outline laboriously and in detail the procedure and all potential risks;" see Mills, *Informed Consent; Current law and outstanding issues*, Medical Negligence Litigation Conference, Royal Marine Hotel, Dun Laoghaire, Dublin (September 2012). Mills also cites an Australian study which found that 2/3 of all informed consent cases were surgical cases and that the main categories of risks identified in the study were "(a) need for further surgery, (b) poor cosmetic result, (c) impaired vision or hearing, (d) chronic pain, and (e) infertility or sexual dysfunction"; ibid.

[1744] [1984] ILRM 523.

[1745] [1984] ILRM 523. O'Higgins CJ reduced the jury award of IR£800,000 for general damages to IR£150,000; at 531-532. See also *Shortt v Commissioner of An Garda Siochana* [2007] 4 IR 587 where Hardiman J focused on damages attainable under "contemporary standards".

[1746] [2007] IEHC 333.

[1747] [2007] IEHC 333. The nature of the ulcerative colitis "decreed that the quality of her life would have been significantly diminished by reason of the disease". Even if it "had been properly and appropriately managed and treated", it would have "significantly diminished the quality of her life"; ibid.

Perhaps one interesting aspect of *Geoghegan* and *Fitzpatrick* is the development of the law away from the peer-review professional standard rules of *Dunne* to broader objective notions of reasonable care with the individual as subject, nor object of the law. Such an approach is entirely congruous with human rights law under which informed consent to medical treatment is recognised as a fundamental right.[1748]

The timing of the warning given is also key: a warning given only shortly before an operation is undesirable particularly where the procedure is elective. This approach ties in with the guidance provided by the Medical Council of Ireland in its *Gude to Professional Conduct and Ethics for Registered Medical Practitioners* on how a doctor should obtain an informed consent to medical treatment.[1749] Accordingly non-disclosure of risk litigation represents another "pocket of cases" under which omissions ("obligation to fulfil") of the right to health can be addressed under reparations accountability.

It has been suggested that weight should attach to standards set by professional bodies in medical litigation.[1750] In Australia, legislation has been recommended to address whether adequate risk information was disclosed to a patient in a medical malpractice suit.[1751]

[1748] Involuntary and coerced sterilisation constitute a violation of a number of rights including the prohibition of discrimination and all forms of violence against women (CEDAW Committee, General Recommendation 19, 1992; CEDAW General Recommendation 24, 1999; CRC General Comment 13, 2011). Involuntary and coerced sterilization has been regarded as a method of medical control of a woman's fertility that violates a woman's physical integrity and security: see also UN Special Rapporteur on Violence Against Women, 1999) UN Special Rapporteur on Torture, 2008; CAT Committee, General Comment 2, 2008).

[1749] 7th Edition (2009) at paragraph 35, accessible at *www.medicalcouncil.ie/.../Professional-Conduct-Ethics/* accessed 9 September 2012 accessed 9 September 2012.

[1750] M A Jones, *Informed consent and other fairy stories* 7 Medical Law Review (1999) 103 at 133-134.

[1751] See Recommendation 3 of the joint report *Informed Decisions About Medical Procedures,* Law Reform Commission of Victoria (Report 24); New South Wales Law Reform Commission (Report 62) and Australian Law Reform Commission (Report 50); available at *www.austlii.edu.au/au/other/alrc/publications/reports/50/* accessed 5 September 2012.

15.10 Compensation

Following a finding of negligence, the plaintiff is usually entitled to recover both general (pain and suffering) and special (loss of future earnings, cost of treatment) damages. One difficulty which has arisen in obstetrics injury resulting in severe disability for the child has been the inaccuracy of the once-off lump sum awards. Special damages are calculated on life-expectancy for infants and it has been suggested that the one virtual certainty about a lump sum award to pay for future care is "that the wrong amount will be awarded."[1752] The concept of periodic payments orders seek to operate over the lifespan of the individual and were introduced in the UK in 1996. In Ireland, pending legislative reform, the High Court has, since 2010, approved a settlement in catastrophic injury cases on the basis of an "interim" payment, with the matter being re-entered into the list at a future date.[1753]

This chapter examined the ability of tort law to vindicate the right to health unde the obligations to "protect and fulfil". While tort law offers much improved prospects for vindicating the right to health than exists under constitutional or statute law, the high thresholds of proof required and the fundamental requirement to establish a causal relationship between the deliverer of health services and the victim of a right to health violation places some doubt as to whether access to the AAAQs can be clearly met under the law of tort, notwithstanding that the reparations obligation may be met in "pockets of cases". In the next chapter we consider this question more deeply and look at no fault alternatives.

[1752] Working Group on Medical Negligence Payments and Periodic Payments (2010). The Working Group was established by the President of the High Court Kearns P and chaired by Quirke J and had catastrophic injuries as its third term of reference. This followed the Law Reform Commission report *Personal Injuries: Periodic Payments and Structures Settlements* (1996) and the 2002 report of the Motor Insurance Advisory Board which both recommended periodic payment facilities. See the Draft Scheme of Civil Liability (Damages) Bill 2012.

[1753] In the UK, periodic payments were introduced under section 2 of the Damages Act 1996 which allows courts to award such payments with the consent of the parties.

16 Can Tort vindicate the constitutional right to health?

As has become clear, a claim for breach of a constitutional right to bodily integrity under Article 40.3 can be brought against an individual or organisation but it must ordinarily be through the prism of the law of torts. Tentative conclusions are that, first, in the case of alleged physician negligence, the *Dunne* principles will apply to the medical negligence suit. This will normally involve causation, deviation from a "general and approved practice" and presence of "inherent defects". This remains in *Bolam* territory and as noted earlier, these are difficult tests to overcome particularly where critical information on how medical injury occurred lies with the defendants. If the plaintiff cannot prove causation in such a medical negligence suit, s/he will be unsuccessful unless s/he can invoke the *res ipsa loquitur* principle or a relaxation of the causation test under the material contribution to harm or loss of chance doctrines. Even then the plaintiff will have to prove causation.

However, an increased focus on the one hand on organisational or enterprise liability and on the other on individual rights (informed consent, preference of the individual) means that in "pockets" of cases, tort law can vindicate the right to health. Moreover, insofar as the duty of care in medicine orginated in private law, the law of tort allows for justiciabilty on the horizontal plain so that non-State actors such as hospitals or institutions may be directly accountable for violation of right to health norms under the tort of organisational negligence. In parallel, *Walsh v Family Planning Services*[1754] demonstrates that the Constitution may allow a horizontal suit under strict liability principles.

An argument that relaxation of the causation principle is required under the horizontal constitutional right to bodily integrity as per *Meskell* and *Hanrahan* to guard against an unfairness would explain why the doctrine of *res ipsa loquitur* was elevated to a higher constitutional plain (where injustice would otherwise occur). This was implicit in Henchy J's command in *Hanrahan* that the tort in question must not be "basically ineffective to protect [the] constitutional right".[1755] In similar fashion, it is also arguable that the material

---

[1754] [1992] 1 IR 496.

[1755] [1998] ILRM 629.

contribution to harm principle should likewise be elevated to allow the *Fairchild* "justice" principle apply to right to health litigation such as infection (HAI) injury and to loss of chance cases where proportionate liability could be matched by proportionate damages. Although such relaxation of causation requirements may be linked to the constitutional right to vindicate the right to bodily integrity and permit alignment with international standards, it is noted that the Irish courts have not sufficiently grappled with the principles to date and indeed in their *obiter dicta* have not taken the opportunity to set out whether there is a right to health per se (see *Re Health Amendment Bill,* discussed above).

The attraction of a strict liability test approach is clear: the defendant hospital or institution is in a position to demonstrate that guidelines and record keeping were observed as these are matters peculiarly within its range of capacity of proof. Once it rebuts the inference, the plaintiff is then forced to demonstrate either professional negligence or vicarious liability. In this calculus, the question of fault is not personalised around the physician. It is rather the organisational negligence which is in issue and the relational distance may allow more likelihood of success for the victim of the malpractice. The parallels with consideration of the right to equality under Article 40.1 are also clear: where there is a presumption of a *prima facie* breach of duty, it may be rebutted. The more cogent and reasonable the reasons for refusing the health benefit claim in question, the more likely it is that the refusal will be seen to have been legitimate, proportionate and justified, but weighty reasons will be required if on *prima facie* discriminatory grounds. Resource allocation decisions, if properly formulated in a non-discriminatory manner, would however be justified. The final benefit of this approach is that it allows the State to demonstrate how it is ensuring justiciability of the core non-derogable principle of non-discrimination in access to the AAAQs.

In contrast, where a claim for injury directed at a hospital or institution arises from a long delay in an emergency room waiting corridor for example, or the inability of a person from a disadvantaged group to access treatment, which denial causes or exacerbates the injury, it would be more difficult for the refusal of the health benefit to be justified. As noted, the quantum of damages could be assessed proportionate to the loss of chance occasioned.

The "incremental" development of the Supreme Court into the traditional jurisprudence of the law of torts in *Glencar*, however, suggests that policy considerations may take on a particular significance when coupled with the judicial deference to the executive evident from *TD* and *Sinnott*. This incrementalism suggests that the concern of Lord Mustill in *Wilshire v Essex AHA*[1756], that public medicine not become *sui generis* on the basis of allocation of resources arguments and that what is essential is that the plaintiff "prove that the lack of resources was a consequence of negligence in the organisation of the hospital itself", may present additional hurdles to prove negligence. In such circumstances, it is appropriate to consider no-fault compensation models and their potential to vindicate the right to health.

16.1 No fault compensation

If the all-or-nothing approach, incrementalism and judicial restraint act as a brake on tort law's ability to vindicate the right to health, can a no-fault system fare better? In *Hegarty v O'Loughran*[1757] McCarthy J observed that the case for a no-fault system of compensation for those who suffer medical treatment injury was "virtually unanswerable".[1758] A common rationale for no-fault compensation is twofold: first it is argued that it is more just because it ensures that compensation "reaches those in need, and reaches them more quickly and for less administrative cost than under the present law" with its all-or-nothing approach on duty of care and causation.[1759] Second, it is argued that the costs of the tort system are excessive and penetrate health budgets, while the fault

---

[1756] [1987] 1 Q.B. 730.

[1757] [1990] ILRM 403.

[1758] [1990] ILRM 403 at 418. Healy describes how no fault theory was seriously considered in the 1970 and 1980s by proponents of 'law and economics' theory"; J Healy, *Medical Malpractice Law* Roundhall Press (2009) at 50-51.

[1759] S Moloney, *Dealing with Medical Negligence Claims: a review of options for reform*, 5 Medico-Legal Journal of Ireland (1999) 5(2) 79 at 81. Citing the 1990 Harvard Medical Practice Study and the suggestion that 1 in 3 malpractice claims do not succeed, Weiler notes how "a large majority of iatrogenic injuries are not due to anyone's negligence"; P C Weiler, *Medical Malpractice On Trial*, Harvard University Press (1991) at 149. These statistics suggest high procedural and causation hurdles under the tort of negligence.

culture damages the doctor-patient relationship.[1760] These are clear "moral" arguments which underpin no-fault: that it reaches more deserving victims of medical misadventure than under tort law and that it reduces costs and allows the doctor-patient relationship flourish without the fear of litigation.[1761] No-fault systems were seriously considered in the 1980s and 1990s after being introduced fully in a number of countries (New Zealand, Sweden). It has since been introduced partly in others (Denmark, France, Poland, some US states (usually for high-risk specialties such as obstetrics injury)).

16.2 Individual versus community response: the "justice" argument

Tort law, as judge-made law, may be modified or even abolished by the legislature, hence the attraction of a codified law which can set parameters and determine eligibility levels for medical malpractice.[1762] New Zealand's Accident Compensation Act 1972 established the no-fault Accident Compensation Scheme for medical injury on the principles of "community responsibility" and "comprehensive entitlement".[1763] Provided one suffered

---

[1760] Reid cites 2012 statistics from the Oireachtas Committee on Health which demonsrate that medical negligence litigation increased in both volume and level of damages in the period 2009-2011 from €47,562,429 (2009), to €79,283,418 (2010) and €81,203,568 (2011): S Reid, *Product Liability & Medical Negligence*, Medical Negligence Litigation Conference, Royal Marine Hotel, Dun Laoghaire, Dublin (September 2012). Maclean cites the UK's 2001 National Audit Office report that new litigation claims rose by 72% in the period 1990-1998 in the UK and that in 2010-11 figures from the NHS Litigation Authority put the cost of clinical negligence at £863 million, however it noted that this was still "a tiny fraction of the NHS budget"; in AR Maclean, *From Sidaway to Pearce and Beyond: Is the legal regulation of consent ay better following a quarter of a century of judicial scrutiny*? 20 Medical Law Review (2012) 108 at 109.

[1761] Studdert et al make the point that under current tort law in the United States, the "vast majority" of injured patients never receive compensation. Studdert et al. base this analysis on two major studies of medical injury, citing the studies *California Med. Ass'n & Cal. Hosp. Ass'n, Report On The Medical Insurance Feasibility Study* (1977) and P C Weiler, *A Measure Of Malpractice*, 52 Maryland Law Review (1993) 908 whose early proposal for enterprise liability was predicated upon deterrence objectives, at 916; D M Studdert, E J Thomas, B I W Zbar, J P Newhouse, P C Weiler, J Bayuk and T A Brennan, *Can the United States Afford A "No-Fault" System of Compensation for Medical Injury?* 60 Law and Contemporary Problems (1997) at 1. See also O S Gray, Symposium - Future Prospects for Compensation Systems – Introduction, 52 Maryland Law Review (1993) at 893.

[1762] The Defamation Act 2009 is an example of legislative amendment of tort law.

[1763] The scheme was on foot of the Woodhouse Report following the Royal Commission of Inquiry into Compensation for Personal Injury, *Compensation for Personal Injury in New Zealand* (1967). Oliphant juxtaposes an individual tortious system with what he perceives as a collective system based on compensation and learning. Citing the New Zealand no-fault

"medical misadventure" one was entitled to compensation and was precluded from suing in tort. However, "medical misadventure", was not initially defined which meant that it came to embrace two distinct categories, namely medical error (failure to observe proper standard of care) and medical mishap (a rare adverse treatment outcome).[1764] The 1972 Act was amended on a number of occasions.[1765] Whereas 2002 reforms introduced a "treatment injury" rather than an "endurability" requirement out of concern not to discriminate against vulnerable groups,[1766] further reforms in 2005 introduced major changes with "medical misadventure" replaced by "treatment injury"[1767], which arguably further increased the distance between the qualifying criteria and the attribution of wrong-doing as the cause of the injury will not result in any consequence for the medical practitioner.

In Sweden, no fault compensation for medical injury was introduced in 1975 in the form of the Patient Insurance Compensation Fund which compensates victims of iatrogenic (adverse medical) injury through administrative means,

---

system, he suggests that the focus is now on "systems and collective action" rather than the individual and that the search for a culpable individual may "actually undermine efforts to inculcate the learning culture necessary to reduce the incidence and cost of personal injury" insofar as a pre-occupation with individual responsibility may "impede the pursuit of patient safety: K Oliphant, *Beyond Misadventure: Compensation for Medical Injuries in New Zealand*, 15 Medical Law Review (2007) 357 at 389.

[1764] See G Palmer, *Compensation for Incapacity: a Study of Law and Social Change in New Zealand and Australia*, Oxford University Press (1979) who pointed out that outside deliberate or negligent error or physical mishap in the actual medical treatment administered which would be covered, "establishing a claim is likely to be difficult"; at 258.

[1765] Namely in 1992, 1999, 2002, 2005 and 2010.

[1766] Oliphant states that this was on the basis of concern that "unendurable injury" while a flexible concept, could discriminate against particular social groups such as Maori, Pacific peoples and older people as a result of their "poor underlying health status relative to other New Zealanders": K Oliphant, *Beyond Misadventure: Compensation for Medical Injuries in New Zealand*, 15 Medical Law Review (2007) 357 at 374, citing the Department of Labour, *Summary of ACC Medical Misadventure Consultation* (2003) at 8-9.

[1767] Injury Prevention, Rehabilitation and Compensation Amendment Act (No. 3) 2005. The definition of "treatment injury" in New Zealand is formulated first from a costs containment perspective and second excludes resource allocation decisions from its ambit, redolent of the defence of "resource allocation". Under section 32(2) of the 2005 Act, personal injury attributable to one's "underlying health condition" is excluded, injury caused by a person "unreasonably withholding or delaying their consent to undergo treatment" and notably injury that is "solely attributable to a resource allocation decision". Accordingly, "diagnosis, treatment decisions, failure to treat, information for informed decisions and equipment failures" are all actionable provided the injury is not solely caused by a resource allocation decision, which will likely defeat the claim.

without regard to provider fault.[1768] In New Zealand and Sweden, patients are not precluded from bringing a malpractice action in court where the no-fault scheme does not cover the claim.[1769]

Denmark adopted a medical injury compensation system under its Patient Insurance Act 1992, modelled after Sweden's 1975 voluntary scheme. Danish regional hospital authorities are required to pay the costs of malpractice claims on a self-insured basis. In 2005, Denmark introduced a single "treatment injury" standard under which there must be a physical injury "causally related" to treatment by a registered health professional that is not a "necessary part or ordinary consequence of the treatment"; a standard that as with Sweden focuses on avoidability of the harm.[1770] The scheme compensates victims of medical accidents occurring in public hospitals but only where the physical harm suffered is valued over a certain threshold and a number of qualifying criteria are met.[1771] France operates parallel systems of enhanced insurance

---

[1768] In 1975, Sweden established a voluntary scheme in which public and private health care providers assumed responsibility for compensating injured patients through a consortium of insurers. In 1995, the voluntary system was restructured and a mutual insurance company created with a government contract to comply with EU competition law. Legislation in 1997 made it mandatory for all health care providers to carry liability insurance. As in New Zealand, the compensation system in Sweden is part of a larger, tax-funded system of social insurance, including a national health care system with universal access: see MM Mello, A Kachalia, and DM Studdert, *Administrative Compensation for Medical Injuries: Lessons from Three Foreign Systems*, Issues in International Health Policy, The Commonwealth Fund, London (2011), see *www.commonwealthfund.org/Publications/Issue-Briefs/2011/Jul/Medical-Injuries.aspx* accessed on 21 October, at 3.

[1769] In the case of Sweden, a claim can be brought against a health insurance provider at any stage during or after the claims process: D M Studdert, E J Thomas, B I W Zbar, J P Newhouse, P C Weiler, J Bayuk and T A Brennan, *Can the United States Afford A "No-Fault" System of Compensation for Medical Injury?* 60 Law and Contemporary Problems (1997) at 23.

[1770] MM Mello, A Kachalia, and DM Studdert, *Administrative Compensation for Medical Injuries: Lessons from Three Foreign Systems*, Issues in International Health Policy, The Commonwealth Fund, London (2011), see *www.commonwealthfund.org/Publications/Issue-Briefs/2011/Jul/Medical-Injuries.aspx* accessed on 21 October, at 4.

[1771] Taylor cites these as comprising either an experienced doctor would have acted otherwise; the injury caused by defective equipment; the use of other methods or techniques would have avoided injury; or the complication is very rare, or much more serious than could have been anticipated: S Taylor, *Clinical Negligence Reform: Lessons from France?* 52 The International and Comparative Law Quarterly (2003) 737 at fn 17, citing also R Lahti *The Finnish Patient Injury Compensation Scheme*, in S McLean (ed), *Law Reform and Medical Injury Litigation*, Dartmouth (1995) at 147. World Health Organization, *Health Care Systems in Transition*, European Observatory on Health Care Systems, WHO Regional Office for Europe (2002), available at *www.observatory.dk* accessed 29 August 2012.

compensation to run in parallel with fault liability.[1772] Poland has introduced a fault-based compensation scheme applicable to "medical events (incidents)" for personal injury claims arising from a medical incident aimed at enabling hospital patients to seek compensation directly from relevant insurers but only provided causation is shown.[1773]

In the United States, since 1975 California operates a no fault system.[1774] In addition, two U.S. States, Virginia and Florida, introduced limited no-fault compensation systems, wherein victims of severe neonatal injury are compensated for their injury. [1775] In the United Kingdom, the 1978 Royal Commission on Civil Liability and Compensation for Personal Injury Report recommended against a no-fault system similar to New Zealand's on the basis that a fundamental transformation in liability was deemed impractical. In tandem with legislative and procedural tort reforms in the UK and Ireland, the fact that the State now underwrites the cost of liability (through the State Claims Agency in Ireland) means that the no-fault option has "waned" in the UK and Ireland.[1776]

[1772] See Part IV of France's Patients' Rights and Quality of the Health System Act 2002. There are two exceptions to this where strict liability will apply: HAI infection and liability for defective medical products.

[1773] 2011 Revision of the Act on Patients' Rights and the Patients' Ombudsman; see section 67a. However, the scheme is limited and not entirely no-fault: 'medical incident' is narrowly defined with the law focusing on contagious diseases (such as Hepatitis B incidents prevalent in Poland) and inflicting personal injury or causing death. Further, the burden of proving causation remains with the patient in order to qualify for compensation; see E Bagińska, *The New Extra-Judicial Compensation System for Victims of Medical Malpractice and Accidents in Poland*, 3 Journal of European Tort Law (2012) 101 at 103-104 and 116.

[1774] Medical Injury Compensation Reform Act 1975. See U E Reinhardt, *Changing the Malpractice System*, New York Times, October 1, 2010. In Canada, the provinces of Quebec and Manitoba have no fault systems.

[1775] See the Florida Birth-Related Neurological Injury Compensation Scheme ("NICA"). One of the highest rate of tortious claims relates to obstetrician negligence at birth: see D M Studdert, E J Thomas, B I W Zbar, J P Newhouse, P C Weiler, J Bayuk and T A Brennan, *Can the United States Afford A "No-Fault" System of Compensation for Medical Injury?* 60 Law and Contemporary Problems (1997) at 14.

[1776] The Pearson Report rejected no-fault liability, arguing that liability was one of the means "whereby doctors could show their sense of responsibility and, therefore, justly claim professional freedom"; Lord Pearson, *Report of the Royal Commission on Civil Liability and Compensation for Personal Injury* 3 vols (Cmnd 7054) (1978) at para 1342. Proposals for the introduction of a non-fault scheme were made in the early 1990s by the British Medical Association and the Royal College of Physicians, and a private members' bill, sponsored by Rosie Barnes MP, was defeated in 1991.

In Sweden, Denmark and Finland the no-fault schemes are financed by insurers and compensate the victim of medical accidents in defined circumstances. The role of private actors and the State in securing the right to health is interlinked with no-fault compensation for injury/ acquired disability being funded by private insurance, whereas State-funded social security systems provide for residual acquired disability benefits.

Insofar as the rationale for no-fault systems include the arguments of universality and justice, they will likely remain a policy option for legislators. And here medical tort reform is nothing new. Whereas the jurisprudence of the courts is a form of (albeit "incremental") reform, insofar as one judgment clarifies and distinguishes previous law, legislative reform, focusing on tightening procedural rules to bringing claims or requiring exhaustion of alternative dispute resolution mechanisms, often have more immediate goals such as reducing costs.[1777]

United States tort reforms are stated to have had a significant impact with claims rates falling significantly, though the reasons for this decrease is contested and "cannot be attributed to changes in the underlying rate of medical injury due to negligence."[1778] Cost containment is after all a rationale for the system with much depending on how social insurance arrangements interact with tort or no-fault systems.[1779]

[1777] Tort reform here refers to an amalgam of legislative, procedural and judicial reform with techniques ranging from statutory caps on attorney fees and damages to compulsory mediation and enhanced accountability.

[1778] D M Studdert, E J Thomas, B I W Zbar, J P Newhouse, P C Weiler, J Bayuk and T A Brennan, *Can the United States Afford A "No-Fault" System of Compensation for Medical Injury?* 60 Law and Contemporary Problems (1997) at 10. Epidemiological studies have demonstrated that changes in liability rules are associated with decreases in both claims rates and premiums.

[1779] Studdert et al. suggest that the no-fault reforms in Sweden and New Zealand have tackled the problem of rising costs "from the other direction" through increasing disability thresholds (Sweden), imposing a thirteen-week threshold period before the entitlement is available and ending compensation for those who retain a certain percent of their work capacity (New Zealand): D M Studdert, E J Thomas, B I W Zbar, J P Newhouse, P C Weiler, J Bayuk and T A Brennan, *Can the United States Afford A "No-Fault" System of Compensation for Medical Injury?* 60 Law and Contemporary Problems (1997) at 11. Cost is viewed as arguably the overarching rationale underpinning the no-fault system: compensation to those who come within the relevant criteria (which may change over time) but who come within a certain ceiling of cost on the one hand; the overall ceiling determining the qualifying criteria. This is so although other redistributive goals also form the rationale of the system. Following the 2005 reforms, the numbers of victims eligible to claim compensation in New Zealand rose.

If the rationales of tort law are compensation, deterrence and other distributive justice aims, what is the rationale for no-fault compensation? The New Zealand system has demonstrated the parallels in the rationales between fault and no-fault systems, insofar as both have, on their face, elements of compensation, "justice", "cost containment", "accountability and learning" and "welfare" policy rationales (including the need to discourage defensive medicine).[1780]

16.3 No fault and accessibility

However, one commonality between a number of no fault systems is that subsequent to the replacement of a tortious system with the no fault system, increasing restrictions to eligibility to compensation for medical injury are introduced. While "treatment injury" is now the criteria employed in New Zealand, such injury is specifically linked to the level of one's acquired disability from the medical injury. Similarly, under the 2002 French reforms, up to ninety seven per cent of injured persons may be excluded from the scheme.[1781] In Sweden, one cannot access compensation unless one meets certain threshold requirements[1782] which is designed to channel available funds

---

[1780] In New Zealand, arguments had been made that the reporting requirements of the government-indemnified accident compensation scheme ("ACC") authority encouraged defensive medical practice, the 2005 reforms increased the relational distance of non-attribution of blame to encourage education and nurture a "learning" environment: see K Oliphant, *Beyond Misadventure: Compensation for Medical Injuries in New Zealand*, 15 Medical Law Review (2007) 357 at 377. Palmer argues that the challenge is how to design an income maintenance system "both humane and fiscally sustainable" (for medical malpractice) which deals with all forms of incapacity and to find innovative ways of addressing the problems of safety and preventing accidents; however he concludes that the "ultimate issues" are not about the law but values and insofar as they concern social priorities, the choices are "political"; G Palmer, *New Zealand's Accident Compensation Scheme: 20 Years on* 44 University Toronto Law Journal (1994) 223 at 272.

[1781] Taylor notes how all but the most seriously injured are excluded under permanent disability requirements: S Taylor, *Clinical Negligence Reform: Lessons from France?* 52 The International and Comparative Law Quarterly (2003) 737 at 743, citing Y Lambert-Faivre, *La loi n' 2002-303 du 4 mars 2002 relative aux droits des maladies et a la qualité du systeme de santé*, L'indemnisation des accidents médicaux' Le Dalloz (2002) 1367 at 1370 and C Rade, *La réforme de la responsabilité médicale aprés la loi du 4 mars 2002 relative aux droits des malades et 'al a qualite du systéme de santé*, Responsabilité civile et assurances (2002) 4 at 5; ibid at fn 73.

[1782] Namely spending at least 10 days in hospital or more than 30 sick days in full. See P M Danzon, *The Swedish Patient Compensation System: Lessons for the United States*, 15 Journal of Legal Medicine (1994) 199 at 200.

into the hands of the more seriously injured patients within a ceiling of cost, while Poland's new system is limited in access.

Cost containment is a common pressure and strategy in the reform of both fault and no-fault systems, with the degree of international uniformity in strategies adopted to deal with these pressures noteworthy. Legislators, courts, and tribunals respond to perceived rising costs of compensation by narrowing compensation criteria and setting upper limits on award levels, even where studies find that medical malpractice has at its core widespread underreporting and high injury rates during medical diagnosis or treatment.[1783]

Nor can it be said that the costs of no-fault system are lower than the tort system. Researchers applying the Swedish criteria approach to compensation claims in the US states of Utah and Colarado concluded that the resulting "totals are larger than the costs of the current medical malpractice systems in each state."[1784]

The corollary of higher costs is greater "reach" with more victims of medical misadventure eligible for compensation under the no-fault scheme as was evidenced in Sweden.[1785] However, it has been suggested that proponents of no-fault liability invariably argue for its adoption on grounds of equity and efficiency by the offset of "significant savings in administrative expenses."[1786] Affordability may become the inadvertent rationale.

[1783] See Harvard Medical Practice Study, *Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation and Patient Compensation in New York*, Harvard Medical Practice Study, Cambridge, MA (1990), discussed above.

[1784] D M Studdert, E J Thomas, B I W Zbar, J P Newhouse, P C Weiler, J Bayuk and T A Brennan, *Can the United States Afford A "No-Fault" System of Compensation for Medical Injury?* 60 Law and Contemporary Problems (1997) at 19.

[1785] Studdert et al note how, as expected, use of the Swedish approach led to higher direct costs than the negligence approach, while compensating a substantially larger number of victims of medical injury; the larger budget compensated twice the number of injured patients; D M Studdert, E J Thomas, B I W Zbar, J P Newhouse, P C Weiler, J Bayuk and T A Brennan, *Can the United States Afford A "No-Fault" System of Compensation for Medical Injury?* 60 Law and Contemporary Problems (1997) at 19.

[1786] D M Studdert, E J Thomas, B I W Zbar, J P Newhouse, P C Weiler, J Bayuk and T A Brennan, *Can the United States Afford A "No-Fault" System of Compensation for Medical Injury?* 60 Law and Contemporary Problems (1997) at 1.

This leads one to question whether the original "justice" rationale for no-fault system were based on anything sustainable and reinforces the argument that cost is the primary driver of tort reform.[1787] Although some proponents argue that justice reasons attach to no-fault systems given the lottery of litigation whereas (lesser) compensation for all is more equitable[1788], in fact the policy decisions for no-fault systems appear more concerned with keeping costs in check, limiting accessibility criteria over time and responding to criticisms from medical associations as to the unreasonable demands being placed on medical practitioners.[1789]

One author suggests that the gains from no-fault cannot be justified, arguing that the law of torts is not a "proxy" for the achievement of the same sort of goals.[1790] The reasoning here is that if one were to abolish tort, replacing it with nothing, "individuals would then be free to take out first party insurance to protect themselves against harm as they saw fit".[1791] Quite apart from the fact that not all can afford private insurance, one author suggests that is only when one contemplates the "abolition of most of our legal rights" that the error becomes plain. The law of torts must be viewed as "the secondary obligations generated by the infringement of primary rights" and as such is an essentially legal subject, rather than a discretionary social security policy.[1792] Thus the

---

[1787] If one accepts the proposition that no-fault should replace tort, one must accept Stevens' observation that when such systems are cut back they lack "the moral underpinnings necessary to be secure against a change in political climate"; R Stevens, *Torts and Rights*, Oxford University Press (2007) at 324.

[1788] See K Oliphant, *Beyond Misadventure: Compensation for Medical Injuries in New Zealand*, 15 Medical Law Review (2007) 357 at 377.

[1789] See American Medical Association Policy Document 435.004MSS *A No-Fault Professional Liability System*, American Medical Association Annual Meeting 2011 at Appendix 1. That these same associations may also act as the regulatory body for the same practitioners often passes unremarked.

[1790] R Stevens, *Torts and Rights*, Oxford University Press (2007) at 324. The author points out how social security schemes often already provide for persons with an acquired disability following medical misadventure; ibid.

[1791] R Stevens, *Torts and Rights*, Oxford University Press (2007) at 324, citing P Atiyah, *Personal Injuries in the Twenty-First Century: Thinking the Unthinkable*, in P Birks (ed) Wrongs and Remedies in the Twenty-First Century (1996) 1. Atiyah argues that damages are "not a requirement of the system" of tort; ibid, at 24.

[1792] R Stevens, *Torts and Rights*, Oxford University Press (2007). For Stevens, viewing tort as a right allows one to view no-fault through the prism of the vindication of rights and "for a

moral relational duty of redress for wrong becomes lost where the tort is removed.

16.4 Other rationales for no-fault

The Swedish, French, New Zealand and Polish systems maintain a tort option where their no-fault scheme does not apply and this "valve" becomes more important as eligibility criteria for no-fault systems increase.[1793] Where no-fault systems do apply, can "justice" rationales other than compensation (such as injury prevention, deterrence, patient safety, monitoring, enforcement and/ or education) be located? After all, as noted, tort law pursues compensatory, deterrence and distribution goals and has the potential to link societal standards to the tortfeasor. Here tort can only be abolished if its no-fault replacement can ensure these "justice" goals are achieved in addition to the compensation goal. Yet here arguments against abolition of tort include the clear cost containment and restrictive eligiblity criteria of higher no-fault costs; the absence of incentives in the tortfeasor which may result in the lowering of standards and similarly the absence of deterrence measures which a fault-based system brings (unless parallel accountability mechanisms to sanction negligent medical practitioners are introduced: see below).

The importance of incentives is identified in both fault-based medical tort law and a liability-based insurance system (placing relative risk on negligent medical practitioners) as being the key elements in providing the correct balance of costs and incentives necessary to instil a sufficient level of medical precaution and risk to induce "the optimal level" of medical care for persons accessing health services.[1794] Without incentivisation under no-fault, the

---

court, or a reformer, to try and bend rules concerned with the vindication of rights to fulfil any of the goals set out above will lead to incoherence"; at 325.

[1793] Commencing with the compensation rationale, in circumstances where a no-fault system devises tighter criteria to qualify for acquired disability no-fault compensation, the corresponding need for an available claim in tort to provide redress for persons excluded from this scheme becomes clear and indeed a requirement if the right to health is to be vindicated. The difficulty of course is that the cumulative cost of compensation (fault and no-fault rises) in proportion to higher qualifying no-fault criteria.

[1794] B Howell, *Medical Misadventure and Accident Compensation in New Zealand: An Incentives-Based Analysis* 35 Victoria University of Wellington Law Review (2004) 857.

likelihood of a negligent action rises, while the level of health care decreases, not alone in the individual case, but also for the collective (a key aim of the original Woodhouse Commission proposal in New Zealand).[1795] It is suggested that the doctor has little incentive to be careful in her/ his observance of medical standards.[1796]

Although some question how much the presence of liability in tort, insofar as "it will not, and cannot, prevent all accidents" will ensure the optimal level of safety precautions[1797], in a recent study undertaken in Ireland, 55% of medical professionals surveyed "believe that their practice is continuously influenced by the fact that they have been involved in some way in the legal process".[1798]

[1795] Howell argues that although the certainty of compensation is a valid objective in a no-fault system such as the New Zealand ACC scheme, this objective of certainty of compensation should not be pursued at the cost of lower standards of care and consequently higher levels of misadventure which may arise from "reduced levels of precaution"; B Howell, *Medical Misadventure and Accident Compensation in New Zealand: An Incentives-Based Analysis* 35 Victoria University of Wellington Law Review (2004) 857 at 876.

[1796] Simanowitz suggests that in New Zealand it is generally accepted that the demise of the threat of litigation led to doctors to being "somewhat cavalier": A Simanowitz, *Accountability, in Medical Accidents (eds.) C Vincent, M Ennis and R J Audley Oxford Medical Publications* (1993) 209 at 217, cited in S Moloney, *Dealing with Medical Negligence Claims: a review of options for reform*, 5 Medico-Legal Journal of Ireland (1999) 79-83. Moloney argues that no-fault schemes are by their very nature "defective as a means of securing medical accountability" where there is no need to establish a particular individual's error or fault in order to acquire compensation. Howell suggests that removing good practice incentives from doctors means the medical insurance costs of negligent actions "are shifted from the individual practitioner alone onto all contributors to the insurance scheme" so that the level of health care decreases as a whole, bringing with it additional costs of higher instances of medical misadventure and no-fault compensation which are "disproportionately borne by the smaller subset of patients who become victims of these adverse events"; B Howell, *Medical Misadventure and Accident Compensation in New Zealand: An Incentives-Based Analysis* 35 Victoria University of Wellington Law Review (2004) 857 at 876.

[1797] R Stevens, *Torts and Rights*, Oxford University Press (2007) at 321.

[1798] C O'Mahony, *Clinician's Perspective of the Medico-Legal Process*, Medical Negligence Litigation Conference, Royal Marine Hotel, Dun Laoghaire, Dublin (September 2012). The study was conducted by O'Mahony with staff working in maternity hospitals. It was not a requirement that the legal case pertain to their current organisation. "Fear" was the most commonly felt emotinon reported during the legal process followed by "frustration" and "sadness". Other findings included a recognition of the need to improve self and colleague's documentation and "the importance of recognising and debriefing patients as deemed necessary". For example, 81.8% agreed or strongly agreed "that they are more inclined to complete incident forms now having been involved in the legal process". One of the recommendations of the study was a learning goal, namely to "recognise the hospital risk or claims managers as a valuable part of the team around the table. Their role may be limited in the line of case management, but they are the key people in bringing learning back to the hospital, for improvement and the benefit of other patients"; ibid.

While a no-faults system may deliver compensation (arguably at lower levels than under tort law), it is argued that it will be efficient only if the effects of reduced incentives to exercise care can be "adequately offset by effective monitoring, enforcement and education mechanisms."[1799] Insofar as one of the goals of a no-fault compensation system is to separate compensation and blame in an attempt to encourage "learning" from mistakes, New Zealand, Sweden and Denmark have chosen to de-link their patient compensation system from their systems of physician accountability and regulation, with no sharing of information between either part of the system.[1800] Administrative complaints mechanisms are introduced: in New Zealand, the Office of the Health and Disability Commissioner may provide redress for patients who complain about the quality of health care and disability services by importantly considering quality of health claims.[1801] Sweden and Denmark also operate separate systems of physician discipline, with boards for patients' complaints empowered to investigate complaints and refer cases to disciplinary authorities.[1802]

It is questionable whether a system of separating compensation and accountability can secure the right to health unless a combination of methods (such as no-fault in tandem with other accountability mechanisms) can

---

[1799] However, Howell points out that this "may not be feasible because in most instances it is impossible to reconstruct the effects of incentives using other tools" noting also the combination in New Zealand of no-fault insurance and high level of public funding for medical treatments which may reduce available incentives; B Howell, *Medical Misadventure and Accident Compensation in New Zealand: An Incentives-Based Analysis* 35 Victoria University of Wellington Law Review (2004) 857 at 876.

[1800] Howell points out that in contrast, under a tort-based system, the "costs of precaution" are priced into insurance premiums for medical practitioners and passed on to all patients in the form of service prices"; B Howell, *Medical Misadventure and Accident Compensation in New Zealand: An Incentives-Based Analysis* 35 Victoria University of Wellington Law Review (2004) 857 at 876.

[1801] See section 2 of the Health and Disability Commissioner Act 1994. By law, all patients who file a compensation claim with ACC must be informed of the availability of the complaints process. The Commissioner investigates patient complaints pursuant to sections 40-57 of the Act and may pursue a variety of remedies where complaints are found to have merit. The impact of the system on accountability is unclear however. It differs significantly from the administrative complaints system in Ireland under the Health Act 2004 insofar as it includes complaints as to the quality of health services.

[1802] MM Mello, A Kachalia, and DM Studdert, *Administrative Compensation for Medical Injuries: Lessons from Three Foreign Systems*, Issues in International Health Policy, The Commonwealth Fund, London (2011), see *www.commonwealthfund.org/Publications/Issue-Briefs/2011/Jul/Medical-Injuries.aspx* accessed on 21 October, at 7.

vindicate the right.[1803] Otherwise a no-fault system may hinder and deny adequate medical care, if information deficits under a tort-less, insurance-free and reduced monitoring system leads to information on malpractice only being derived from "whistleblowers" who lack incentives and must take on the risk.[1804] States which have resisted the no-fault system have stressed conventional tort reforms while retaining the personal liability of the physician as these are viewed as "more likely to be successful in limiting the direct costs of malpractice"[1805]. But even here the limitations of tort in altering physician behavior is accepted with greater use of "practice guidelines" recommended.

As noted, the 1990 US Harvard Medical Practice Study suggested that although malpractice litigation may fulfil its social objectives crudely, support for its preservation persists in part because of the perception that other methods of ensuring a high quality of care and redressing patient grievances has proved to be inadequate. It suggested that the abandonment of malpractice litigation is "unlikely unless credible systems and procedures, supported by the public, are instituted to guarantee professional accountability to patients".[1806] On this basis, arguably any reform of the compensation system must be matched by a "thorough review" of complaints procedures, investigative mechanisms and internal and external regulation arrangements.[1807] Indeed, any reduction in

---

[1803] S Moloney, *Dealing with Medical Negligence Claims: a review of options for reform*, 5 Medico-Legal Journal of Ireland (1999) at 83.

[1804] Howell cites the Ministerial Inquiry into the case of negligent pathologist Dr Michael Bottrill which found that not only had the doctor acted negligently, but that the design and operation of the New Zealand National Cervical Programme was substandard, while the Royal Australasian College of Pathologists may have had a conflict of interests: see B Howell, *Medical Misadventure and Accident Compensation in New Zealand: An Incentives-Based Analysis* 35 Victoria University of Wellington Law Review (2004) 857 at 868-870.

[1805] U.S. Congress, Office of Technical Assessment, *Defensive Medicine & Medical Malpractice*, Washington, DC, U.S. Government Printing Office (1994) at 92.

[1806] Harvard Medical Practice Study, *Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation and Patient Compensation in New York*, Harvard Medical Practice Study, Cambridge, MA (1990).

[1807] S Moloney, *Medical Misadventure: Compensation, Accountability and Regulating Standards of Practice*, 6 Medico-Legal Journal of Ireland (2000) 71-72. Other literature suggests the ineffectiveness of educational efforts in changing physician practices. Orentlicher states that it is unsurprising that educational efforts to instill greater cost consciousness among physicians have shown "mixed results at best", citing "substantial literature on the ineffectiveness of educational efforts in changing physician practices"; D Orentlicher, *Health Care Reform And The Patient-Physician Relationship*, 5 Health Matrix (1995) 141 at 171

standards of medical care or the related accountability of medical practitioners raises issues under the right to health which in turn focuses attention on professional standards, their regulation and how this may complement justiciability of the right to health under a no-fault system.

It is submitted that where one is unable to pursue a civil suit under fault-based tort law (whether for procedural restrictions, causation, all-or-nothing or judicial restraint reasons) to secure compensation, distribute loss and induce deterrence for medical misadventure, other rationales such as monitoring, enforcement and education of health care may prove inadequate to address the other elements of the "remedy" required under General Comment 14. It will be recalled that the requirement here is that all victims of such violations are entitled to adequate reparation "which may take the form of restitution, compensation, satisfaction or guarantees of non-repetition."[1808]

The law of tort is what it is, however and while it may have ancillary rationales of patient safety, standards and education, these are by-products of the tort. Can it be said that the requirement of causation in the light of *Dunne* and *Glencar* and the all-or-nothing philosophy of the courts do not place significant hurdles in front of plaintiffs which negates the possibility of a "remedy" or is it possible to draw on the better elements of both tort (enterprise liability and modified or strict liability causation) and no-fault systems in order to meet the right to health?

As discussed in Parts 1 and 2, the tort system must be considered in tandem with other judicial and quasi-judicial accountability mechanisms and in doing so a rights model approach in which the law of torts is situate is suggested.

[1808] See paragraph 59 of General Comment 14, discussed in Part 1 of this thesis. At the same time, the non-cost rationales of no-fault systems of injury prevention, patient safety, monitoring, enforcement and/ or education also form elements of the right to health, if accompanied by redress and accountability/ deterrence. Insofar as compensation under no-fault becomes linked to acquired disability benefits under social insurance schemes, a cost carried by the community and not the tortfeasor, the question arises whether compensation alone can suffice for the purpose of the right to health. Under the formulation of General Comment 14 compensation may arguably suffice to vindicate the right to health of the individual but only if a compensation-based system does not otherwise negate access to the AAAQs without discrimination or negate the other core elements of the right, including its focus on the accountability of the health system, which by definition imports the notion of deterrence and an individual or systems responsibility where violations occur. It is suggested that the removal of justiciability would only be permissible under General Comment 14 in circumstances where all the other elements of the right to a remedy can be cogently demonstated to be available.

This ties in with the argument that in order to achieve greater goals, tort reform alone without more will not be enough.[1809]

Would a no fault system mean victims of medical malpractice be more likely to obtain reparation accountability in the form of redress than under the high thresholds evident in tort law? Abolishing medical negligence and replacing it with no fault compensation would mean that the moral relational duty of redress for a wrong would be removed meaning that the important components of restitution and guarantees of non-repetition would be lacking. Given that no fault systems are often introduced in the name of cost containment and become increasingly aligned with social security systems whose funding may decrease over time, it is likely that individuals would become incentivised to turn to private health insurance. This could aggravate the different treatment between those who can pay for health care and those who cannot raising the prospect of indirect discrimination over and above the present situation. This suggests that even were a non-fault compensation system to be introduced providing compensation for victims of malpractice, the reparation obligation on the State under paragraph 59 of General Comment 14 may not be fully met.

If a no fault system were to be introduced in Ireland, there would be fewer justiciable claims than under the current law of tort. Under the reparations accountability obligation, a quasi-judicial mechanism under a no-fault scheme may not necessarily ensure a remedy where a violation of access to the AAAQs on a non-discriminatory basis occurs under the typology of the obligations to "respect and fulfil". Much would depend on the scope of the mechanism and its ability to reach vulnerable populations and ensure the right to "restitution, compensation, satisfaction or guarantees of non-repetition" as set out in General Comment 14. Under the other accountability mechanism, namely the preventative accountability mechanism of regulation, it was noted in Part 3 of this thesis how any departure from a fault-based compensation system must be balanced by parallel "accountability procedures" to deal with allegations of malpractice and to help maintain standards. This would be necessary both to ensure the obligation to "protect" and the obligation to "fulfil" insofar as a

---

[1809] S Moloney, *Dealing with Medical Negligence Claims: a review of options for reform*, 5 Medico-Legal Journal of Ireland (1999) 79 at 83.

parallel process to obtaining compensation (such as no-fault) would, if introduced, also need to ensure that the appropriate level of professional care was not transgressed under the preventative obligation. Where substandard care is discovered, regulation accountability suggests that disciplinary action should ensue to ensure deterrence concerns are met.

It will be recalled here that the vertical and organisational status superiority of the offending physician or institution over the patient may inhibit the use of law by the aggrieved and promotes toleration of malpractice. If the incentive of precaution arising from tort-based liability (already restricted from a malpractice to litigation ratio of between 8:1 and 15:1 for the disadvantaged), is removed, the "right" of the individual is much reduced.

PART 4

17 Accountability: regulation

In Part 4 we consider the preventative accountability mechanism of regulation as identified in Part 1 of this thesis. While preventative accountability is not a substitute for reparation accountability under General Comment 14, it is clear that both forms of accountability reinforce the other.

In Part 3, we considered how the rationale advanced for preserving the law of tort over a no-fault scheme is that tort law goes beyond the mere compensatory for the injured individual and is also linked to raising standards by inducing the correct level of medical care in the medical practitioner through deterrence, otherwise lacking where "fault"- based inducements are removed from the law. It also allows the "moral" wrong of the tortfeasor to be addressed under interpersonal justice considerations. Whether one argues for or against tort or no-fault schemes, what appears clear is that in order to prevent and address medical malpractice in all its forms, effective regulation of healthcare services - whether individual (doctor) or enterprise (hospital) regulation - is key.

As noted in Part 1, in parallel to the right of victims of violations to adequate reparation (which may take the form of restitution, compensation, satisfaction or guarantees of non-repetition), a parallel regulatory process for medical practitioners and health institutions who cause the violation is essential if non-repetition is to be ensured under the obligations to "protect and fulfil".[1810] If a dangerous driver causes death and is sued in negligence by the deceased's next of kin, no one can suggest that the matter should end in the civil courts, but rather that a criminal process should run in parallel. As a corollary, where a death was not caused intentionally, there may be no need for a criminal sanction, but civil law and disciplinary responses will normally be required, not least to meet developing Article 2 standards.[1811]

[1810] Whether a fault or no-fault system operates, it should be accompanied by a parallel disciplinary process to ensure deterrence/ guarantees of non-repetition.

[1811] See *Vo v France*, Application No. 53924/00, Judgment 8 July 2004, 40 EHRR 259 and *Reynolds v UK*, Application No. 2694/08, Judgment 13 March 2012 (Hudoc 2012).

As noted in Part 2, regulatory design is key to raising standards. The medical profession has historically been self-regulated and it is only with the Medical Practitioners Act 2007 that this form of regulation is yielding slightly to statutory regulation.[1812] Reasons for delegating regulation to professional public regulators is primarily expertise, but also to reduce political influence, to ensure flexibility and task-based activities by the regulator whose outlook may be more aligned with the interests of a private body and its membership. However, care is required to minimise regulatory "capture" by the regulated industry or profession.[1813] Regulation in Ireland is conducted by the medical profession (e.g. regulation of medical practitioners by the Medical Council of Ireland), by HIQA and the Mental Health Commission (regulation of hospitals and institutions) and by the Health Insurance Authority (regulation of health insurance providers).

An effective regulatory regime usually has three components: standard-setting, monitoring and compliance/ enforcement. At one end of the scale of enforcement are formal enforcement actions which may include the application of civil or criminal penalties to a regulated entity or the revocation of a licence

---

[1812] In the UK, the General Medical Council (GMC) acts as a private regulator although itself regulated by the Council for Healthcare Regulatory Excellence under section 25 of the National Health Service Reform and Health Care Professions Act 2002: see below. Black describes four different types of regulation: "mandated self-regulation" in which a collective group, an industry or profession is required or designated by government to formulate and enforce norms within a framework defined by the government but where the primary decision-taking remains with the group (e.g. the Medical Council of Ireland); "sanctioned self-regulation", in which the collective group itself formulates the regulation, which is then subjected to government approval (e.g. the UK's GMC); "coerced self- regulation", in which the industry itself formulates and imposes regulation but in response to threats by the government that if it does not the government will impose statutory regulation; and "voluntary self-regulation" where there is no active state involvement, direct or indirect, in promoting or mandating self- regulation"; J Black, *Constitutionalising Self-Regulation*, 59 Modern Law Review (1996) 24 at 27.

[1813] Using data taken from the World Business Environment Study (WBES) (a survey developed by the World Bank and administered to thousands of firms from around the world during the 1998–2000 period), Macher and Mayo argue that "understanding the determinants of firms' influence over the regulatory agencies that oversee them is an important element in the quest to understand regulatory outcomes"; J T Macher and J W Mayo, *The World of Regulatory Influence*, 41 Journal of Regulatory Economics (2012) 59 at 76 and conclude that "variations in regulatory processes affect the degree to which firms perceive that they are influential over regulatory agencies. These results are not only intriguing, but also to our knowledge novel. At first blush, these results would seem to suggest ready-made policy levers for regulatory agencies that seek to provide firms with more (or less) influence"; at 76. Similarly the *Bolam/ Bolitho* peer review test (the standard of care reasonably expected of the doctor's peers) shows the potential dangers arising where one is reviewed solely by one's peers against a high threshold test: see discussion below.

for continued operations. At the other end are "partnership" strategies such as "education, advice, and even warnings".[1814]

The Mental Health Act 2001, the Health and Social Care Professionals Act 2005[1815], the Pharmacy Act 2007, the Health Act 2007 and the Medical Practitioners Act 2007 all introduced reforms to the regulation of different aspects of medical treatment. In parallel, efforts to align defence litigation during the 1980s and 1990s saw the Clinical Indemnity Scheme introduced[1816] with the intent of such enterprise liability reforms being to allow for a rationalised, homogenous defence of medical malpractice claims.[1817]

The immediate impetus for the Health Act 2007 and the Medical Practitioners Act 2007 was arguably the failure of self-regulation to regulate medical practitioners in recent scandals into unregulated paternalistic practice by consultants, in particular the practice of unnecessary hysterectomies by some consultants culminating in the 2006 Lourdes Inquiry report. [1818]

[1814] C Scott, *Private Regulation of the Public Sector: A Neglected Facet of Contemporary Governance*, 29 Journal of Law and Society (2002) 56 at 71.

[1815] Section 4(1) of the Act designates the health or social care professions of clinical biochemist, dietician, medical scientist, occupational therapist, orthoptist, physiotherapist, podiatrist, psychologist, radiographer, social care worker, social worker, speech and language therapist as being subject to regulation under the Act. Other medical professionals are subject to professional misconduct complaints mechanisms to specific regulatory bodies under other legislative provisions such as opticians under the Opticians Act 1956, nurses under the Nurses Act 1985, dentists under the Dentists Act 1985 and pharmacists under the Pharmacy Act 2007.

[1816] Following enactment of the National Treasury Management Agency (Amendment) Act 2000.

[1817] See *The Road to Enterprise Liability*, Department of Health (2001). The scheme applies to claims against public hospitals, their clinical staff and consultant doctors and according to the State Claims Agency, the State assumes full responsibility for the indemnification and management of all clinical negligence claims: see *Introduction to the Clinical Indemnity Scheme*, State Claims Agency, accessible at *www.stateclaims.ie/ClinicalIndemnityScheme/introduction.html* accessed 22 September 2012.

[1818] The Lourdes Hospital Inquiry, *An Inquiry into peripartum hysterectomy at Our Lady of Lourdes Hospital, Drogheda*, Government Publications (2006) at 56. The Medical Practitioners Act 2007 updated the 1978 Act of that name. Its main innovations are to increase non-medical membership of the Medical Council, holding professional misconduct enquiries in public unless the Committee decides otherwise, increased sanctions of medical practitioners and the continued registration of medical specialists by reference to continued education. The Council maintains a General Register of Medical Practitioners Under Part 6 of the 2007 Act, the General Register is divided into the General Division, the Specialist Division, the Trainee Specialist Division and the Visiting EEA Practitioners Division (a requirement of EU law). The Council has a duty to both set and publish standards of medical education and training "for basic and specialist medical qualifications" and to monitor adherence to those standards: see section 88 of the 2007 Act. Under section 88(2) the Council approves programmes of basic

The Medical Council is, *inter alia*, responsible for considering complaints against medical practitioners which are considered first by its Preliminary Proceedings Committee (PPC)[1819] (which can refer the person to the administrative complaints scheme under Part 9 of the Health Act 2004[1820]), and then by the Council or the Fitness to Practice Committee (FPC) where the PPC is of the opinion that there is a *prima facie* case to warrant further action.[1821] FPC inquiries must reflect fair procedures and its report of an inquiry may lead to the Council deciding to impose a sanction if confirmed by the High Court.[1822] Sanctions can range from advice or admonition to suspension or

---

medical education and training, accredits the bodies which may deliver those programmes, prepares and publishes guidelines on curriculum issues and content to be included in programmes and it may also inspect those bodies. It also has a duty to satisfy itself as to the ongoing maintenance of the professional competence of registered medical practitioners Although the Medical Practitioners Act 2007 permits the Council to set standards, this is usually carried out by the relevant medical college (such as the Irish General Practitioners College or the Royal College of Psychiatry). On standard alignment, the Commission on Patient Safety and Quality Assurance observed standard "should also take account of the patient experience in order to identify gaps between the safety measures possible and the actual level of safety being experienced by patients"; Commission on Patient Safety and Quality Assurance, *Building a Culture of Patient Safety*, Department of Health, Government Publications (2008) at 63. Healy notes how investigations by the Institute of Obstetricians and Gynaecologists and the Medical Council of Ireland commenced from 1999 after concerns were raised in 1998 by two whistleblowing midwives, some 24 years after the hysterectomies commenced: J Healy, *Medical Malpractice Law* Roundhall Press (2009) at 18. See also Commission on Patient Safety and Quality Assurance, *Building a Culture of Patient Safety*, Department of Health, Government Publications (2008) whose recommendations will require significant legislative action regarding the licensing of all health-care providers if enacted.

[1819] Part 7 of the 2007 Act. This committee must have a medical majority.

[1820] The PPC can make other recommendations including mediation if with the consent of the parties under section 62 of the 2007 Act.

[1821] Insofar as the procedures under the Medical Practitioners Act 2007 are adversarial, the burden of demonstrating a *prima facie* case lies with the complainant: see section 62 of the 2007 Act. In contrast to the situation in the UK, there is a double procedure for a complainant in Ireland whose complaint must be considered by the PPC and the FPC before proceeding to decision of the Council. This is done arguably to insulate the Council from judicial review challenges on grounds of want of fair procedures under Article 40.3 of the Constitution and Article 6 of the ECHR: see *Kiely v Minister for Social Welfare* [1977] IR 267 where Henchy J stressed the medical assessor could not make the case against the appellant under natural justice rules; at 282-283 and *Prendiville v Medical Council* [2008] 3 IR 122 where Kelly J held that the Council acted *ultra vires* in regarding itself as bound by the substantive decision of the FPC (acting under the 1978 Act) and "was obliged to give reasons for coming to the conclusion, which it did"; at 173-174. Similar concerns are lessened under HIQA's procedures insofar as institutions, rather than individual reputations are subject to review and sanction. Under both 2007 Acts, there is provision for review by the courts – either to confirm or overturn a decision - and this assists in insulating the procedures from challenge.

[1822] The High Court hears the complaints of misconduct *de novo*: see section 75(2) of the 2007 Act. See also *ex parte* application by the Council to the High Court to confirm a sanction under section 76.

cancellation of the practitioner's registration.[1823] However, recommendations that the investigation and adjudication functions of the Medical Council be separated (members of the FPC also sit on Council decisions) have not been yet been addressed.[1824]

A complaint brought for medical malpractice will mostly focus on either "professional misconduct" or "poor professional performance".[1825] The standards against which complaints are judged are not defined in the legislation but rather peer reviewed.[1826] The Medical Council's *Guide to Professional Conduct and Ethics for Registered Medical Practitioners* defines "professional misconduct" as either conduct which other doctors consider "disgraceful or dishonourable" or conduct where the doctor has "seriously fallen short" by omission or commission of the standards of conduct expected among doctors.[1827]

The first part of this formulation is peer review, while the second part suggests a more objective standard, but still one of seriously falling short of standards considered by one's peers. The emphasis is very much on bringing the profession into disrepute and reflects the High Court's formulation of professional misconduct in *O'Laoire v Medical Council*[1828] where Keane J

[1823] See section 71 of the 2007 Act.

[1824] See *Building a Culture of Patient Safety*, Department of Health, Government Publications at 8 (2008). See too the UK's Fifth (Shipman Inquiry) Report *Safeguarding Patients: Lessons from the Past - Proposals for the Future*, Command Paper Cm 6394 Crown Copyright (2004) which recommended it would be preferable for the GMC to appoint FPC members on a full or nearly full time basis ensuring consistency and separation of investigative and adjudicative functions; at paras 27.204 - 27.210.

[1825] See section 57(1) of the 2007 Act.

[1826] Review of clinical errors which become evident during Medical Council competency reviews are notably excluded: see sections 95 and 104 of the 2007 Act. The Commission on Patient Safety and Quality Assurance recommended that all clinicians be obliged to "actively participate in clinical audit in compliance with national standards and priorities"; Commission on Patient Safety and Quality Assurance, *Building a Culture of Patient Safety*, Department of Health, Government Publications (2008) at Recommendation 7.5, 30. As noted above, clinical judgments are excluded from the ambit of the administrative complaints mechanisms set up under Part 9 of the Health Act 2004.

[1827] Seventh Ed (2009) at Section 2.1 accessible at *www.medicalcouncil.ie/.../Professional-Conduct-Ethics/* accessed 9 September 2012 accessed 9 September 2012.

[1828] 27 January 1995, unreported, cited by R Byrne and W Binchy, *Annual Review of Irish Law* Roundhall Press (2007) at 106-113.

suggested a "moral turpitude" and "expected standards" test for professional misconduct.[1829]

The Guide defines "poor professional performance" as a failure by the practitioner to meet the standards of competence that can "reasonably be expected of medical practitioners practising medicine of the kind practiced by the practitioner". In *Prendiville v The Medical Council*,[1830] Kelly J aligned the expected standards test with the definitions in the *Guide*. Not only does the burden of proof remain with the complainant, the evidential burden of proof in Ireland is set close to the criminal, rather the civil liability standard, as is the situation in the UK.[1831]

As noted, the Medical Council's *Guide to Professional Conduct and Ethics for Registered Medical Practitioners* has the potential to align standards to regulation and accountability.[1832] This is already evident in some areas of the Guide, for example on obtaining an informed consent to treatment. Such alignment of ethical professional standards to consideration of tortious

---

[1829] 27 January 1995, unreported. The test was: "1. Conduct which is 'infamous' or 'disgraceful' in a professional respect is 'professional misconduct'...2. Conduct which would not be 'infamous' or 'disgraceful' in any other, if done by a medical practitioner in relation to his profession, that is with regard to either his patients or to his colleagues may be considered as infamous' or 'disgraceful' conduct in a professional respect. 3. 'Infamous' or 'disgraceful' conduct is conduct involving some degree of moral turpitude, fraud or dishonesty. 4. The fact that a person wrongly but honestly forms a particular opinion cannot of itself amount to infamous or disgraceful conduct in a professional sense. 5. Conduct which could not properly be characterised as 'infamous' or 'disagraceful' and which does not involve any degree of moral turpitude, fraud or dishonesty may still constitute 'professional misconduct' if it is conduct connected with his profession in which the medical practitioner concerned has seriously fallen short, by omission or commission, of the standards of conduct expected among medical practitioners".

[1830] [2008] 3 IR 122.

[1831] Healy describes the standard as "proof that is more convincing than the greater probability standard that otherwise pertains in civil proceedings"; J Healy, *Medical Malpractice Law* Roundhall Press (2009) at 35-37. Madden suggests that there is nothing in the 2007 mandating this and that the Council may decide to apply the civil standard in the future; D Madden, *Medicine, Ethics and the Law* (2nd Ed) (2009) at 67. Indeed, in *Lawlor v The Members of the Tribunal of Inquiry into Certain Planning Matters and Payments* [2010] 1 IR 170 Murray CJ endorsed O'Flaherty J's statement in the Supreme Court appeal of *O'Laoire v The Medical Council*, unreported, 25th July 1997, that the standard of "beyond a reasonable doubt" should be confined to criminal cases; at 5.

[1832] Moloney notes how the *Guide* could be incorporated into law with departures from stipulated professional standards constituting negligence: S Moloney, *Medical Misadventure: Compensation, Accountability and Regulating Standards of Practice*, 6 Medico-Legal Journal of Ireland (2000) 71 at 78.

malpractice has the potential to effectively address compensation and deterrence requirements of the right to health.

Whereas the Health Act 2004 had established the HSE and provided for a limited complaints mechanism under Part 9 of the Act (see below), its main thrust was to seek to separate national policy (the responsibility of the Department of Health) from operational health (the HSE). The Health Act 2007 established HIQA to address the regulation of "health and social care services".

HIQA's regulatory functions include setting standards for health and social services in the State and monitoring the implementation of those standards through registration and inspection of residential centres for children, older people and (yet to be brought into law) residential centres for persons with disabilities.[1833] The Chief Inspector of Social Services registers and supervises the operation of these centres.[1834] Standards set are those established by HIQA and the Chief Inspector has a number of sanctions available including cancelling, varying or attaching conditions to the registration of a designated centre or applying to the District Court for an order halting business of the designated centre where there is a "risk to the life, or a serious risk to the health or welfare" of the persons resident in a designated centre "because of any act, failure to act or negligence".[1835]

The 2008 Commission on Patient Safety and Quality Assurance recommended a mandatory licensing system to cover both public and private healthcare providers under the auspices of HIQA.[1836] In 2011, HIQA introduced the

---

[1833] Under section 41 of the 2007 Act, the Office of the Chief Inspector of Social Services is responsible for inspecting the HSE in relation to children detention schools, nursing homes, foster care services. See the Health Act 2007 (Commencement) No 2 Order 2009 (SI 237/2009), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (SI 236/2009) See HIQA's 2009 *Quality Standards For Residential Care Settings for Older People in Ireland.* Its *Draft National Standards for Residential Centres for People with Disabilities Consultation Document* were published in October 2012 ahead of its planned remit on inspecting residential disability centres in 2013.

[1834] Under section 48, a person seeking such registration must apply to the Chief Inspector. Registration occurs under section 50 if the Chief Inspector is satisfied that the applicant "is a fit person" and HIQA standards or other regulations are being met in the centre. A certificate of registration to carry out operations may have conditions attached.

[1835] See sections 51-55 and 58-59 of the 2007 Act.

[1836] Commission on Patient Safety and Quality Assurance, *Building a Culture of Patient Safety,* Department of Health, Government Publications (2008). See

National Standards for Safer Better Healthcare to this end.[1837] The Standards are very much person-centred, providing *inter alia*, that the planning, design and delivery of services are "informed by service users' identified needs and preferences"; that "service users have equitable access to healthcare services based on their assessed needs" and that "service users experience healthcare which respects their diversity and protects their rights."[1838] The Standards will be enforceable under the new monitoring and licensing healthcare system recommended by the Commission on Patient Safety and Quality Assurance and will be applied to both public and private healthcare providers.[1839] How these standards will be applied by HIQA to public and private bodies will be critical in ensuring non-discriminatory access to the AAAQs in Ireland.

The sanctions available to HIQA - such as closing of nursing homes on foot of an inspection - suggest a strong compliance model which can be employed where critical quality of care is at issue.[1840] Mental health services are not monitored by HIQA but rather by the Inspector of Mental Health Services

---

www.dohc.ie/issues/patient_safety/ accessed 15 September 2012). The Department of Health also records that the Department's Chief Medical Officer was to chair an Implementation Steering Group"; ibid.

[1837] June 2012 available at *www.hiqa.ie/standards/health/safer-better-healthcare* accessed 15 September 2012. The implementation of the Standards are to enable and support the implementation of national safety and quality initiatives such as the recommendations from the Commission on Patient Safety and Quality Assurance.

[1838] This Standard also refers to the exercise of "civil, political and religious" rights as enshrined in Irish law when receiving healthcare and that ongoing access to healthcare should not "discriminate according to age, gender, sexual orientation, disability, marital status, family status, race, religious belief, or membership of the Traveller Community"; *National Standards for Safer Better Healthcare* at 23-24.

[1839] This was to have taken place "[o]nce mandated by the Minister for Health in 2012"; see Chairman of HIQA's Introduction to its Annual Report 2012, a available at *www.hiqa.ie/publications/annual-report-2011* accessed 15 September 2012.

[1840] According to its latest Annual Report, in 2011 HIQA inspected 513 designated centres for older persons with 769 inspection visits undertaken in total. Of these, the most common types of inspections were follow-up inspections (52%) and registration inspections (36%): see Annual Report 2012, at 37, available at *www.hiqa.ie/publications/annual-report-2011* accessed 15 September 2012. See for example *St. Anne's Nursing Home, 282, Inspection report 1 - 2 December 2011*, Health Information and Quality Authority, Social Services Inspectorate, Inspection report, Designated centres for older people, available at *www.hiqa.ie/inspection-reports/st-annes-nursing-home-282-inspection-report-1-2-december-2011* accessed 15 September 2012 and reported on in *Nursing home shut after residents found in cold rooms,* Irish Times 30 August 30 2012, available at *www.irishtimes.com/newspaper/ireland/2012/0830/1224323262993.html* accessed 15 September 2012.

under the auspices of the Mental Health Commission.[1841] The Commisson's *Quality Framework for Mental Health Services in Ireland* sets out the standards which the Inspector of Mental Health Services conducts his or her inspections against.[1842] These standards, which pre-dated those of HIQA, similarly provide for a person-centred approach to mental health services.[1843] The Inspector may refuse to certify an approved centre following an inspection if the requisite standards are not met.[1844] Prior to its monitoring of disability centres, HIQA has assisted the HSE with its internal monitoring mechanisms, the robustness of which may dictate the future level of inspections undertaken by HIQA.[1845] Insofar as monitoring occurs in relation to approved or designated centres[1846], the issue of non-discrimatory access to the AAAQs for

---

[1841] Under sections 51 and 52 of the Mental Health Act 2001.

[1842] The *Quality Framework* incorporates the Mental Health Act 2001 (Approved Centres) Regulations 2006. See *www.mhcirl.ie/Standards_Quality_Assurance/Quality_Framework/Quality_Framework.html* accessed 21 October 2012.

[1843] See the 8 themes in the Mental Health Commission's *Quality Framework, Mental Health Services in Ireland*, Dublin; available at *www.mhcirl.ie/Standards_Quality_Assurance/Quality_Framework.pdf* accessed on 21 October 2012.

[1844] See for example Report of the Inspector of Mental Health Services 2010 on St. Conal's Hospital, June 2010, *www.mhcirl.ie/Inspectorate_of_Mental_Health_Services/Approved_Centre_Inspection_Reports/AC_IRs051012.html* accessed 21 October 2012. More typically, institutions will need to demonstrate how they plan to raise standards to ensure continued approval. The Inspector undertakes investigations under sections 51-52 of the 2001 Act. "Approved centres" are as defined in sections 2 and 63 of the Act but do not include privately run institutions which are unregulated. The 2001 Act is now subject to a review by an Expert Group established by the Minister for State, Department of Health and Department of Justice, Equality and Defence with responsibility for Disability, Equality, Mental Health and Older People on foot of a report of a Steering Group on the 2001 Act: see *www.dohc.ie/press/releases/2012/20120802.html* accessed 15 September 2012.

[1845] According to its Annual Reports, HIQA does not inspect all care homes in the State. Section 38 of the Health Act 2007 permits HIQA to give assistance to a body which "performs or proposes to perform a function similar or ancillary to a function that the Authority may perform." This may allow HIQA to provide assistance to the HSE in conducting internal reviews of health services.

[1846] As noted in Part 1 of this thesis, a study by Bowblis and Lucas concluded that although "nursing homes improve quality when regulators increase the threshold of minimum quality standards" being responsive to "both specific regulatory deficiencies they receive and those received by their peer facilities over the prior year", they were most responsive "to the specific deficiencies they receive instead of those received by their peers", also finding evidence that "nursing homes improve quality in areas regulators issue deficiencies but may focus less attention on quality areas that receive less regulatory scrutiny" and that regulators need to be mindful of such offsetting behaviour and "whether the direction of the response from a deficiency is consistent with the complementarity or substitutability of care practices with the deficiency". This suggests that where additional regulatory scrutiny may lead to "little or no

vulnerable groups including access to preventative health services (i.e. outside the doctor-patient relationship) may not fall within the remit of either body, suggesting a more subtle regulatory design may be required.

The Health Insurance Authority acts as regulator of private health insurance providers in Ireland by virtue of the Health Insurance Acts 1994-2012.[1847] However, as noted in Part 2 of this thesis, insofar as it applies only to the 45% of the population who can avail of private health insurance, its monitoring role is restricted to ensuring access to contracts on a risk equalisation basis which would not be available to those from a disadvantaged background. Argubly the Authority's regulatory role will increase if Universal Health Insurance is introduced as proposed by Government.

---

welfare gains, regulators need to limit the scope and scale of regulation to have an optimal effect on improving quality"; J R Bowblis and J A Lucas, *The Impact of state regulations on nursing home care practices*, 42 Journal of Regulatory Economics (2012) 42 at 69-70.

[1847] The functions of the Authority are to monitor the health insurance market and to advise the Minister (either at his or her request or on its own initiative) on matters relating to health insurance; to monitor the operation of the Health Insurance Acts and, where appropriate, to issue enforcement notices to enforce compliance with the Acts; to carry out certain functions in relation to health insurance stamp duty and age related tax credits and in relation to any risk equalization scheme that may be introduced; to take such action as it considers appropriate to increase the awareness of members of the public of thei rights as consumers of health insurance and of health insurance services available to them; and to maintain the register of health benefit undertakings and contracts: see The Health Insurance Authority Annual Report and Accounts 2011, at 8, available at *www.hia.ie/assets/files/publications/Annual_Reports/Annual%20Report%20and%20Accounts%202011%20%28Final%20English%20Version%29.pdf* Section 3 of the Health Insurance (Miscellaneous Provisions) Act 2009 provides that "The principal objective of the Minister and the Authority in performing their respective functions under this Act is to ensure, in the interests of the common good, that access to health insurance cover is available to consumers of health services with no differentiation made between them (whether effected by income tax or stamp duty measures or other measures, or any combination thereof), in particular as regards the costs of health services, based in whole or in part on the respective age range and general health status of the members of any particular generation (or part thereof), and taking into particular account for the purposes of that objective: (*a*) the fact that the health needs of consumers of health services increase as they approach and enter old age, (*b*) the desirability of ensuring, in the interests of societal and intergenerational solidarity, and regardless of the age range or health status of any particular generation (or any part thereof), that the burden of the costs of health services be shared by insured persons by providing for a cost subsidy between the young and the old and, without prejudice to the generality of that objective, in particular that the old have access to health insurance cover by means of a tax credit, and (*c*) the manner in which the health insurance market operates in respect of health insurance contracts, both in relation to individual registered undertakings and across the market". In order to carry on the business of health insurance in Ireland, it is necessary for health insurers to be registered and to obtain a certificate of registration from the Authority under Section 14 of the Health Insurance Act 1994: see *www.hia.ie/regulation/register-of-health-benefit-undertakings/*

17.1 Administrative complaints

Administrative complaints can be brought under Part 9 of the Health Act 2004 against either the HSE or private bodies coming under sections 38 or 39 of the Act.[1848] The complaint is considered first by the HSE or private body's internal mechanism usually by a complaints officer.[1849] Complaints must concern "fair and sound administrative practice" only, not clinical judgments, negligence, matters subject to legal proceedings[1850] or refusal of treatment or inability to access the AAAQs. This, as noted, contrasts with the siutation in New Zealand where the Health and Disability Commissioner may investigate patient complaints which can include complaints as to the quality of health services. Under Part 9 of the Health Act, only recommendations can be made by a complaints officer and the nature of recommendations are limited – s/he cannot make a recommendation that would involve a change to a service plan or arrangement.[1851] The HSE (or private body) is obliged to put an action plan in place for the implementation of the recommendations of a complaints officer. Where the complainant is dissatisfied with a recommendation made or step

---

[1848] Namely bodies receiving funding grants or a contract arrangement: see section 45 of the Act. The Irish Human Rights Commission has stated that it is both a statutory duty and a condition of all service agreements with the HSE that service providers "adhere to the complaints and review procedures as established by the HSE and also as determined by the Minister for Health by way of regulation pursuant to section 53 of the Health Act 2004"; *Report on the Human Rights Issues Arising from the Operation of a Residential and Day Care Centre for Persons with a Severe to Profound Intellectual Disability*; Irish Human Rights Commission (2010): see *www.ihrc.ie/enquiriesandlegal/conductenq.html* accessed on 21 October 2012; at para 9.19.

[1849] See section 47(2) of the Act.

[1850] Under section 46 of the 2004 Act, the complaint must concern "fair and sound administrative practice" and it must have "adversely [] affected that person". Section 48(1) sets out excluded matters including "a matter relating solely to the exercise of clinical judgment" by a person acting on behalf of either the HSE or a service provider or an action taken on the advice of such a person. The Health Act 2004 (Complaints) Regulations 2006 provide further guidance on procedural requirements, *inter alia*, on the appointment of Complaints Officers, the investigation of complaints, the making of requests for review of investigation outcomes and the undertaking of reviews. Administrative complaints procedures can involve (a) local resolution of verbal complaints; (b) local investigation by the HSE or private body; (c) a HSE Internal Review and (d) an independent review by. Complaints that cannot be resolved at a particular stage are progressed to the next stage.

[1851] Section 51 of the 2004 Act. Non-administrative complaints such as allegations of abuse against HSE staff members are managed under HSE policies which may involve reporting to An Garda Síochána.

taken, they may seek an independent review by the Ombudsman or the Ombudsman for Children who are empowered to make recommendations to Government but who are again limited in what they can review.[1852]

However, complaints made in respect of residents in designated centres under the 2007 Act can lead to follow-up action by HIQA. Although not a complaints-body p*er se*, HIQA receives complaints/ communications each year and may decide to act on them including through renewing inspections by the Chief Inspector.[1853] Similarly the Mental Health Commission may decide to act on complaints/ communications received. Both bodies may also receive "whistleblowing" information, often seen as a critical element of any regulatory regime[1854] and possesses a number of potential information tools to assist enforcement strategies.[1855]

The administrative complaints process under the Health Act 2004 does not lend to justiciability. The most that can result from complaints is a recommendation from the complaints officer or the Ombudsman which may be accepted by the health institution involved. If not accepted, the Ombudsman has the option of publishing a summary of the complaint in her/ his annual report to Parliament

---

[1852] Section 54 of the 2004 Act. Either Ombudsman may instigate a preliminary examination followed by a formal investigation, where merited. A twelve month time limit applies to the making of complaints to the Ombudsman, while a two year time limit applies in respect of the Ombudsman for Children: see Ombudsman Act 1980 (as amended) and Ombudsman for Children Act 2002. Under Article 2(b) of the Ombudsman Act (First Schedule) (Amendment) Order, 1984 (S.I. No. 332/1984) the exercise of clinical judgement "in connection with the diagnosis of illness or the care or treatment of a patient" cannot be reviewed by the Ombudsman. See *Report of Investigation under section 4(2) of the Ombudsman Act 1980 of complaints made by ten complainants about Nursing Home Subvention Payments against the Health Service Executive*, Office of the Ombudsman, September 2010.

[1853] In relation to desigated centres for older persons run by private bodies, HIQA received 426 complaints in 2011 according to its Annual Report 201. HIQA locates these complaints under the requirement on the registered provider under the 2009 Regulations to have a complaints process and procedure in place to deal with and investigate complaints and inform the complainant of the outcome: see Annual Report 2012, at 40, available at *www.hiqa.ie/publications/annual-report-2011* accessed 15 September 2012.

[1854] See section 103 of the 2007 Act which permits an employee of a relevant body to make a *bona fide* disclosure to a range of authorised persons or organisations and to use the disclosure as a defence if the employer seeks to dismiss them on that basis. There is no sanction however on an employer if s/he seeks to dismiss or harass the whistleblower.

[1855] The extent of "whistleblowers" drawing information to the attention of the Commission is unknown. It may be expected that the new National Advocacy Service will prove a relevant source of information for the Commission: see *www.citizensinformationboard.ie/services/advocacy_services/* accessed on 21 October 2012.

or publishing a special report.[1856] As such, it cannot be considered as a substitute to justiciability as required under Article 12 of ICESCR.

It will be observed that this administrative complaints process and the parallel regulatory processes of HIQA, the Mental Health Commission, the Medical Council of Ireland or the Health Insurance Authority are limited in their review of matters coming within the clinical judgment of doctors and are also not empowered to grant reparation to victims of violations as defined under General Comment 14.[1857]

[1856] See sections 6(7) and 6(5) of the Ombudsman Act 1980 and sections 13(7) and 13(5) of the Ombudsman for Children Act 2002.

[1857] Neither can the other two potential quasi-judicial authorities named in the literature grant adequate reparations: the National Human Rights Institution (the Irish Human Rights Commission) is not empowered to do so, while as noted in Part 2, the Equality Tribunal's remit is limited by virtue of sections 4 and 16 of the Equal Status Acts 2000-2012.

PART 5

18 Conclusions

Overall, the concept of a normative human right to health is emerging in law. As a right, it attaches to the individual rather than the physician or State. It extends beyond the traditional conception of rights as comprising freedoms from State intervention, to a broader conception of both freedoms and entitlements. There is no right to be healthy, nor a right to automatic entitlement based on perceived need. Rather, the core elements of the right are the right of access to available, accessible, acceptable and quality health care (AAAQ) on a non-discriminatory basis and to an effective health system which can deliver health care. The State has obligations to "respect, protect and fulfil" the right to health and to provide accountability where violations of the right occurs.

In this thesis, we considered how the international right to health was established in the context of healthcare being traditionally a private interpersonal matter, provided by a physician to a patient and arising from his "status and "common calling". It was only with the public health movement of the nineteenth century that health widened from a mere private interpersonal affair to one incorporating the concept of public health provided by the nation state. It was only with the proliferation of disease that public health became an international concern and it was this international concern which saw the development of both inter-governmental approaches to health and an international right to health emerge in the context of the United Nations, the UDHR and its successor treaties which, in parallel with developments at the Council of Europe, formed part of emerging international human rights law.

The law developed on the basis of the traditional "medical model" which focused on illness and cure and the paternalistic status of the physician whose duty was one in contract or tort alone. There was little State involvement as the right to health was being elaborated in the UDHR and in Article 12 of the ICESCR. However, with the elaboration of General Comment 14, the right to health gained multi-dimensional codification. The right to health contained not alone freedoms but also entitlements: freedoms included the right to control one's health and body from State interference, while entitlements included

access to the AAAQs under the umbrella of an effective health system. There was no right to be healthy but a right to tackle the social determinants of health through access to the AAAQs. The right was also an indirect right, being dependent on the enjoyment/ realisation of other rights such as the right to food, clothing and shelter. Whereas in developed countries, central aspects of the "core right" to health such as access to food, shelter, housing, sanitation, water and essential drugs were more easily satisfied than in developing States, fundamentally for States such as Ireland, even where it provided access to shelter, housing, sanitation, water and essential drugs, there remained the core right of access to the AAAQs without discrimination and a right to an effective health system through a national health strategy and plan of action. This twin focus is supported by the health literature which endorses a principle of non-discrimination insofar as the social determinants of health are now firmly established, with individuals from vulnerable groups recognised as having lower health outcomes and as requiring higher State interventions to address and indeed reverse these trends through positive measures. For health measures to be successful, they must be coherent and the WHO has long advocated for effective health systems where financing and accountability are two elements of an accessible system.

Internationally, WHO and the international community are slowly moving towards an anti-discrimination/ social determinants access to AAAQ approach and this suggests that the rights espoused in Article 12 of ICESCR may progressively become realised. At the same time, the jurisprudence of the European Court of Human Rights, the ECSR, the Court of Justice and UN Committees continue to increase the scope of the right to health, focusing on a reparations (or remedies) accountability doctrine under the positive "operational" and "due diligence" obligations of States to exercise control and accountability of non State actors such as hospitals, private places of detention and care homes, where aspects of the right to health is invoked.

This transformative culture, evident in the jurisprudence of the European Court of Human Rights, increasingly introduces right to health norms into Irish law. Where domestic law provides for a "right" or "entitlement", the positive obligations doctrine of the ECHR will place additional obligations on the State,

significant where it decides to legislate for aspects of the right to health or for public or private bodies to deliver or regulate healthcare provision.

Under General Comment 14, the right to health may be delivered either through public or private provision, or indeed a mix of both, provided the State ensures the right to health. Insofar as national health activities are increasingly subject to EU law and policy, the twin principles of supremacy and direct effect allow for the penetration of EU-required health (and competition) law. The deepening of EU competence under Article 168 of the TFEU and the emergent right of access to health care under Article 35 of the Charter will likely have a major impact on both public and private health in the State, including where supplementary voluntary health insurance is provided for under a universal system.

Although this thesis focuses on the two core right to health obligations of immediate effect, namely non-discrimination and a national public health system which *inter alia* protects vulnerable groups under an accountability rubric, we have also observed how the principles of progressive realisation and non-retrogression allow for complementary approaches under which States may "protect", "respect" and "fulfil" the right regardless of whether health is delivered by public or private bodies. Despite its previous failings to shape the contours of the developing right to health to include focus on the social determinants of health and marginalised communities, we considered the potential for the WHO to deepen its complementary measures to provide access to the AAAQs in its focus on properly functioning health care systems. Further, we considered how WHO can deepen the measurement base for the right to progression/ non-retrogression in the technical assistance measurements it offers States on indicators and data systems so that States can produce reports capable of being meaningfully considered by the CESCR and so render State action more measurable under the right. Such an approach, focused on health system coherence, could also assist in identifying and modifying policies which threaten the right to health, including any liberalisation policies supported by the IMF, World Bank and WTO which result in poorer health outcomes.

As to the test for the right of access to the AAAQs without discrimination, the international test that differential treatment may constitute discrimination if based on prohibited grounds, unless the justification for differentiation is reasonable and objective, allows for State interests to be examined by a court under a right to health claim. The corollary is that the absence of "reverse" or "positive" discrimination measures to target vulnerable groups with measurable lower health outcomes may also render a State liable.

Although the State is legally obliged under international law to ensure observance of the right to health under an accountability framework, as identified in Part 1 of this thesis, the right has not been directly incorporated into domestic law through constitutional amendment or insertion into the Health Acts 1947-2007. While some indirect aspects of the right to health may be considered under the Equal Status Acts 2000-2012 provided the clinical judgment of a medical practitioner is not impugned and provided a prohibited ground of discrimination (such as disability discrimination) is identified and reasonable accommodation efforts lacking. Under the Health Acts and the Health Insurance Acts 1957-2012, health care is delivered under a parallel two-tier system which prioritises access to the AAAQs for those who can pay for private insurance, giving rise to indirect discrimination concerns. Possible redress for any such discrimination requires a focus on whether an unenumerated or enumerated right to health can be located and its justiciability. Insofar as international human rights standards require justiciability of the right to health where other reparation obligation mechanisms (such as quasi-judicial mechanisms) do not guarantee redress, there is accordingly an obligation to provide a separate justiciability route where existing domestic law (the law of tort or administrative complaints mechanisms) are ineffective in vindicating the right. As observed, the administrative complaints mechanism under Part 9 of the Health Act 2004 may be considered as ineffective insofar as it addresses maladministration only and, as with the Equal Status Acts, cannot address such matters as clinical judgments.

In considering the justiciability of the right to health, at issue is both the nature of the right being claimed and whether it is an identifiable constitutional right capable of vindication. An albeit amorphous constitutional right to health has been identified in "pockets of cases" under a right to bodily integrity/

autonomy/ privacy/ dignity rubric, although one which primarily concerns intrusions or interferences with a person's physical or mental integrity, rather than omissions by the State. While there is scope for an extensive right to equality under Article 40.1, to date it has primarily addressed direct or indirect discrimination in the adoption or implementation of legislative provisions, whereas as noted, there is no entitlement to access to the AAAQs without discrimination under the Health Acts 1947-2007.

The emergence of an unenumerated and latterly enumerated right to health under the right to the person, is nonetheless significant as is the growing conceptualisation of dignity as a core constitutional value. This value is also found in human rights jurisprudence and may provide a rich source for the development of the right to health. The need for identifying normative values is key. With the relegation of natural law doctrine as a source of unenumerated rights, a lacuna has developed in the doctrine of unenumerated rights. In this thesis it is suggested that international human rights law become a source of both unenumerated and enumerated rights and that this could satisfy both natural law theorists (with human rights' emphasis on the inherent rights of the individual) and legal positivists (insofar as a precise source of law is identified, permitting the right to the person being interpreted in light of similar international standards which focus on the integrity of the core personality of the person such as under Article 8 of the ECHR). It is accepted that this will not in itself address competency or separation of powers concerns, however, such concerns may become modified where the doctrine of "positive" obligations arises and insofar as both EU law and European Court of Human Rights jurisprudence continues to develop, the Irish courts need to respond to demonstrate a constitutional doctrine of effective remedies.

In light of the *Meskell/ Hanrahan* command, there is both a vertical and horizontal constitutional right to health. This right must be exercised under medical negligence unless the tort is ineffective. The tort is thus actionable against public and private bodies alike but must be "basically []effective" if it is not to trigger a strict liability constitutional tort. Insofar as the need to vindicate constitutional rights would explain why the doctrine of *res ipsa loquitur* was elevated to a higher constitutional plain (where injustice would otherwise occur) in *Hanrahan*, this thesis argued that a relaxation of causation

requirements may be necessary for the tort to meet the horizontal constitutional right and the international right to health.

In short, tort may vindicate the right to health if modified where an injustice would otherwise arise. In normative terms, two "reparation" areas identified for vindicating the right to health focus on compensation and non-recurrence (deterrence) are located in both constitutional law and the law of tort. A focus on whether tort law is basically effective or ineffective is thus key.

Tort law is concerned with interpersonal justice and provides a means by which all persons (including those with a lower status in society) may challenge and seek redress from tortfeasors through the courts. Traditionally the physician owes a duty of care to his or her patient which is to act morally and reasonably in the eyes of the physician's peers. As an (albeit unequal) horizontal interpersonal relationship, the practice of medicine has until recently been able to satisfy the law through adherence to customary practice and peer review (whether in evidence or regulatory accountability). This is because the law promoted/ tolerated private medical interactions and viewed State intrusions into the private sphere as undesirable. Rights were a concept of the future and the duty to provide medical assistance was viewed as a dispensation. When rights were enshrined in law, their vindication was to be balanced against the public good and the need to guard against "defensive medicine".

However, with the advent of hospitalisation and multidisciplinary teams ushering the rise of doctrines of organisational and entrerprise liability and the associated focus on patients' rights to information and disclosure of risk, the law of tort has come to offer more prospects for the victims of medical malpractice. Deeper questioning of customary practice may be observed, allied with moves towards some modified causation tests and an increased focus on the rights of patients (rather than necessarily the faults of physicians as judged by his or her peers) in areas such as disclosure of risk and informed consent, which also accords with reparations accountability under the "obligation to protect". This may allow claims for healthcare omissions to be litigated where the failure or omission contributes to a negative health outcome without being its sole cause.

However, the incrementalist all-or-nothing approach to causation, coupled with "policy" restraint by the courts continue to act as significant barriers to malpractice victims. A combination of high causation thresholds, the need to overcome strict procedural rules, the all-or-nothing approach, incrementalism and the peer-review standard of customary practice suggests that modified or strict liability causation tests may be required to vindicate the right to health where otherwise injustice would occur.

Whereas in other jurisdictions no-fault systems have sought to counteract the limited reach of tort law to provide compensation to eligible victims of malpractice, the absence of other goals of tort law (deterrence and accountability) and the introduction of some tort reform (legislative restictions, focus on alternative dispute resolution etc.) within the fault rubric, have limited the number of jurisdictions introducing a no-fault system. Some no fault systems have over time introduced restrictive eligibility criteria thresholds while becoming more aligned with social security systems. In separating compensation from accountability, they may also reduce a key aim both of the levels of compensation payable and the inducement to high standards brought about by higher penalties associated with a finding of liability. Of the categories of medical malpractice arguably most suited to no-fault compensation schemes are high-risk situations such as catastrophic obstetrics injury, but only where deterrent/ incentivisation/ accountability mechanisms are present, if both regulatory and reparations accountability is to be ensured as required by General Comment 14.

In parallel with the response of the laws of contract and tort to malpractice incidents, constitutional and legislative doctrines permit delegation of health services to private bodies. Although the right to health, as with other constitutional rights, has been espoused by the Supreme Court as attaching to each citizen but as being capable of being vindicated vertically and horizontally through tort or indeed legislation, concerns remain about the "reach" of the law of tort into the right to health identified in this thesis. Simply put, the doctor-patient relationship omits large areas of the right to health, such as access to the AAAQs in areas such as preventive healthcare or access to positive health measures arising from a focus on the social determinants of

health, including those measures required for vulnerable populations at risk of discrimination.

In addition, there seems to be little judicial appetite for testing the effectiveness of tort law under a justiciable constitutional right to health, when one considers judicial reluctance to vindicate social rights deriving from both a lack of identifiable sources of these rights (since the relegation of Natural Law theory) and a rigid focus on the separation of powers doctrine resting on judicial deference and competence concerns over the courts' ability to review Executive omissions. This closing of judicial space has seen the courts espouse a default preference for vindication of constitutional rights by the common law without inquiring into its effectiveness. While horizontal torts are recognised by the courts, there has been but one instance of direct applicability of a strict constitutional standard to medical malpractice and little evidence of the willingness of the courts to extend the stand-alone equality protection under Article 40 to private or public body health acts or omissions, despite the fact that under both modified causation and equality jurisprudence, once a presumptive violation is found, it falls to the respondent to justify the measures or omissions taken. In part, the reason for the foregoing is the relegation of Natural law as a source of rights, with its emphasis on antecedent rights superior to positive law. Following this relegation, the normative underpinning for constitutional rights is unclear, with the courts largely (but not entirely) limiting vindication of rights to those rights traditionally associated as civil and political rights rather than social rights. This normative underpinning is also unclear in recent jurisprudence on the enumerated right to the person.

In this way, one is by default forced to plead and be adjudicated under tort. Here the trend towards modifying causation tests under tort law in "pockets" of case where "justice" appears to demand vindication of a right (to health - particularly where autonomy rights are at issue) is promising. However, tort law was never meant to vindicate human rights and where it cannot vindicate a constitutional right, the attraction of a strict liability test approach becomes clear. This arises where the plaintiff is at a disadvantage in proof such as being unconscious and dependent upon medical care. Under modified causation, the defendant hospital or institution is in a position to demonstrate that guidelines and record keeping were observed and any errors explained, as these are

matters peculiarly within its range of capacity of proof. Once it provides an explanation, the plaintiff is then forced to demonstrate either professional negligence, vicarious or direct liability. In this calculus, the question of fault is not personalised around the physician. It is rather the organisational negligence which is in issue and the relational distance may allow more likelihood of success for the victim of the malpractice. The parallels with consideration of the right to equality under Article 40.1 are also clear: where there is a presumption of a *prima facie* breach of duty, it may be rebutted. The more cogent and reasonable the reasons for refusing the health benefit claim in question, the more likely it is that the refusal will be seen to have been legitimate, proportionate and justified, but weighty reasons will be required if on presumptive discriminatory grounds. Resource allocation decisions, if properly formulated in a non-discriminatory manner, would however be justified. The final benefit of this approach is that it allows the State to demonstrate how it is ensuring justiciability of the core non-derogable principle of non-discrimination in access to the AAAQs under its reparations obligation to "protect and fulfil".

Here it will be recalled that the legal reparations accountability mechanism requires that either judicial or quasi judicial mechanisms be established to ensure that victims of the right to health can seek redress. Where quasi-judicial mechanisms cannot ensure redress, this must be by judicial means.

In light of judicial restraint to vindicate constitutional rights and limitations on tort, a strict liability test under tort law may thus be required to ensure justiciability of the right to health insofar as the reparation obligation under General Comment 14 must ensure "restitution; rehabilitation; compensation; satisfaction; and guarantees of non-repetition". In addition to being liable for acts or omissions of State bodies, the State has obligations to "control" through regulation the activities of non-State actors delivering health services under the obligation to "protect" and to ensure private health activities come within a framework law or national health strategy under the obligation to "fulfil". This suggests that a person claiming a right to health violation in these circumstances must be able to sue the private entity or indeed the State for a failure to regulate, control or ensure the right at issue, particularly where, as

noted, quasi-judicial accountability mechanisms cannot address the substance of the right to health.

However, even a strict liability test may not be of benefit where health has been privatised and there is no interpersonal relationship between the individual seeking access to a healthservice and the private provider. Third party beneficiaries are excluded from suits in contract and must overcome the hurdles of tort to succeed but this will be impossible if there is no interpersonal relationship with the provider to trigger the tort. Judicial review of private bodies may offer some respite where it has been established that the body has public characteristics and operates in a functionally public and responsive manner to individuals, however the courts have yet to apply this to right to health situations, other than reviewing the actions of health regulators such as the Medical Council. Similar concerns arise over access to the health system if individuals who can afford private health insurance are prioritised over those in the public system who cannot afford private insurance, leading to delayed healthcare for vulnerable populations and indirect discrimination concerns.

On the other hand, State regulation of the field of health by HIQA and the Mental Health Commission will discharge the State's obligation to ensure both the "preventative" obligation that the State regulate private actors who deliver health services, under the "obligation to protect" and, if effective regulation occurs, will also reinforce the reparation obligation through ensuring deterrence, non-repetition and accountability.

One solution advanced in this thesis is the introduction of constitutional or legislative control doctrines. While at present the absence of control doctrines leaves the law of tort (or any no-fault alternatives) as the only means by which the right can be vindicated, it is suggested that in tandem with both the "pockets" of tort law which allow for meaningful vindication of rights, framework health legislation could be introduced which would place significant controls on public and private actors delivering health services, while at the same time specifying what the content of the right to health, under a tripartite "respect", "protect" and "fulfil" typology framework law. This would, it is submitted, go a long way towards demonstrating how the State is effecting its right to health obligations, particularly if it permitted horizontal

non-discrimination suits similar to those under the Equal Status Acts 2000-2012.

A framework law could incorporate a justiciable right to health with horizontal effect and permit conditionality in the licencing and contracting of health services. Rendering non state actors liable for human rights violations under domestic law may be necessary where the State is no longer the legal body delivering health goods or services which trigger human rights obligations but is the responsible body under international law. Here a unified Health Act could introduce both modified and strict causation and recovery strands for varying aspects of the right under a modified tort. In addition, it could address regulatory accountability of medical malpractice by seeking to align standards to accountability. In particular, it could introduce a requirement that every person is entitled to access to health services (namely the AAAQs) without discrimination on the basis of their status/ identity. Introduced in this manner, justiciabilty of the right to health would, it is submitted, focus less on arguments of resource allocation (which can be justified if reasonable and proportionate) but rather focus on whether there was equal access to the services. Further, a unified Health Act could provide that vulnerable groups are to benefit from "positive" health measures for appropriate periods, taking into account the social determinants of health for those groups and programmatic responses by the health authorities including preventative healthcare. Introduced in this manner, the legislation would likely be constitutionally permissive under Articles 40.1 and 40.3 in light of the Supreme Court's judgments in *Re Health Amendment Bill* and *MD*. As to the form of the legislation, it could incorporate Universal Health Insurance as proposed by Government, but with adequate safeguards to guard against discrimination.

The right to health is a human right not a dispensation. Once its contours are understood, it is suggested that it will in time come to form a core component of Irish law, buttressed by the Constitution. The penetration of the right to health into domestic law from the direction of both international human rights and European Union law suggests that this time may be fast approaching.

END

Appendix

Right to health provisions in national constitutions

Article 36 of the Constitution of Afghanistan, Article 55 of the Constitution of Albania, Article 54 of the Constitution of Algeria (as amended), Article 30 of the Constitution of Andorra, Article 47 of the Constitution of Angola, Article 41 of the Constitution of Argentina (as amended), Article 34 of the Constitution of Armenia, Article 41 of the Constitution of Azerbaijan (as amended), Article 8a of the Constitution of Bahrain, Article 18 of the Constitution of Bangladesh, Article 23 of the Belgian Constitution (as amended), Article 8 of the Benin Constitution, Article 34 of the Constitution of Bolivia (as amended), Article 52 of the Bulgarian Constitution (as amended), Article 26 of the Constitution of Burkina Faso, Article 68 of the Constitution of Cape Verde, Article 6 of the Central African Republic's Constitution, Article 9 of the Chilean Consitution, Article 21 of the Chinese Constitution (State provision), Article 44 of the Constitution of Colombia, Preamble of the Constitution of Comoros, Article 30 of the Congolese Constitution, Article 73 of the Constitution of Costa Rica (as amended), Article 58 of the Croatian Constitution (as amended), Article 5 of the Constitution of Cuba (as amended), Article 15 of the Constitution of the Dominican Republic (as amended), Article 57 of the Constitution of East Timor, Article 43 of the Constitution of Ecuador, Article 43 of the Constitution of Egypt, Article 35 of the Constitution of El Salvador, Article 22 of the Constitution of Equatorial Guinea, Article 21 of the Constitution of Eritrea, Article 28 of the Constitution of Estonia, Article 41 of the Constitution of Ethiopia, Section 19(3) of the Finnish Constitution, Article 1 of the Constitution of Gabon, Article 37 of the Constitution of Georgia, Article 21 of the Constitution of Greece (as amended), Article 51 of the Constitution of Guatemala (as amended), Article 15 of the Constitution of Guinea, Article 15 of the Constitution of Guinea-Bissau, Article 24 of the Guyana, Article 19 of the Constitution of Haiti, Article 145 of the Constitution of Honduras (as amended), Article 70D of the Hungarian Constitution, Article 76 of the Constitution of Iceland, Articles 39(e) and (f), 46 and 47 of the Indian Constitution (as amended), Article 29 of the Constitution of Iran (as amended), Article 14 of the Constitution of Iraq, Article 32 of the Italian Constitution, Article 25 of the Constitution of Japan, Article 29 of the Constitution of

Kazakhstan (as amended), Article 15 of the Constitution of Kuwait (as amended), Article 34 of the Constitution of Kyrgyzstan (as amended), Article 20 of the Constitution of Laos, Article 111 of the Constitution of Latvia (as amended), Article 27 of the Constitution of Lesotho, Article 14 of the Constitution of Liberia, Article 15 of the Constitution of Libya (as amended), Article 18 and 26 of the Constitution of Liechenstein, Article 53 of the Constitution of Lithuania, Article 11(5) of the Luxembourg Constitution, Article 19 of the Constitution of Madagascar, Article 13(c) of the Constitution of Malawi (as amended), Ninth Schedule of the Constitution of Malaysia (as amended), Article 17 of the Constitution of Mali, Article II of the Constitution of the Marshall Islands (as amended), Article 4 of the Constitution of Mexico (as amended), Article 8 of the Constitution of Micronesia, Article 36 of the Constitution of Moldova, Article 26 of the Constitution of Monaco (as amended), Article 16 of the Constitution of Mongolia (as amended), Article 89 of the Mozambique Constitution, Article 149 of the Constitution of Myanmar, Article 95(j) of the Constitution of Namibia (as amended), Article 26(1) of the Constitution of Nepal, Article 22(1) of the Netherlands Constitution, Article 59 of the Constitution of Nicaragua (as amended), Article 11 of the Constitution of Niger, Article 17 of the Constitution of Nigeria, Article 61(1) of the Constitution of Niue, Articles 56, 71 & 72 of the Constitution of North Korea (as amended), Articles 12 of the Constitution of Oman, Article 6 of the Constitution of Palau (as amended), Article 105-106 of the Constitution of Panama (as amended), Article 1 of the Constitution of Papua New Guinea (as amended), Article 57 of the Constitution of Paraguay (as amended), Article 7 of the Constitution of Peru, Article 2 of the Constitution of Philippines (as amended), Article 68 of the Constitution of Poland (as amended), Article 64(1) of the Portugese Constitution (as amended), Article 23 of the Constitution of Qatar, Article 33 of the Constitution of Romania, Article 41 of the Constitution of Russia, Article 41 of the Constitution of Rwanda, Article 49 of the Constitution of Sao Tomé & Principle, Article 31 of the Constitution of Saudi Arabia, Article 17 of the Constitution of Senegal, Article 29 of the Constitution of Seychelles, Article 8 of the Constitution of Sierra Leone, Article 40 of the Constitution of Slovakia (as amended), Article 51 of the Constitution of Slovenia (as amended), Article 55 of the Constitution of Somalia, Article 27 of the South African Constitution, Article 36 of the Constitution of South Korea,

Article 43 of the Spanish Constitution, Article 13 of the Constitution of Sudan, Article 36 of the Constitution of Suriname, Article 12 of the Constitution of Switzerland, Article 47 of the Constitution of Syria, Article 157 of the Constitution of Taiwan (as amended), Article 38 of the Constitution of Tajikistan, Article 9(i) of the Constitution of Tanzania (as amended), Article 52 of the Constitution of Thailand (as amended), Article 34 of the Constitution of Togo (as amended), Preamble to the Constitution of Tunisia (as amended), Article 57 of the Constitution of Turkey, Article 33 of the Constitution of Turkmenistan (as amended), Preamble to the Constitution of Uganda, Article 3 of the Constitution of Ukraine, Article 19 of the Constitution of the United Arab Emirates, Article 44 of the Constitution of Uruguay, Article 40 of the Constitution of Uzbekistan, Articles 83-84 of the Constitution of Venezuela, Article 61 of the Constitution of VietNam, Article 64 of the Constitution of Yemen and Article 113(b) of the Constitution of Zambia (as amended).

Source: D Kinney & B A Clark, Provisions for Health and Health Care in the Constitutions of the Countries of the World, 37 Cornell International Law Journal (2004) 285 at 305-355.

SOURCES

Jurisprudence

Ireland

A v The Governor of Arbour Hill Prison [2006] 4 IR 88.

Aer Rianta v Commissioner of Aviation Regulation [2003] 4 JIC 0302.

An Blascaod Mór Teoranta v Commissioners of Public Works [2000] 1 IR 6.

AP v Director of Public Prosecutions [2011] IESC 2.

Attorney General v Paperlink [1984] ILRM 373.

Attorney-General v Southern Industrial Trust (1964) 94 ILTR 161.

Bane v Garda Representative Association [1997] 2 IR 449.

Barrett v Southern Health Board [1998] IEHC 12.

Beirne v Commissioner of An Garda Síochána [1993] ILRM 1.

Best v Wellcome Foundation et al [1993] 3 IR 421.

BG v District Judge Catherine Murphy, unreported, 8 December 2011 (HC).

BJN v Minister for Justice, Equality and Law Reform [2008] 3 IR 305.

Blake v The Attorney General [1982] IR 117.

Bode v Minister for Justice, Equality and Law Reform [2006] IEHC 341.

Bode v Minister for Justice, Equality and Law Reform [2008] 3 IR 633.

Boland v An Taoiseach [1974] IR 338.

Bourke v Attorney General [1972] IR 36.

Brady v Cavan County Council [1999] 4 IR 99.

Brennan v Attorney General [1983] ILRM 449.

Browne v Dundalk UDC [1993] 2 IR 512.

Buckley v Attorney General [1950] IR 67.

Buckley v National Maternity Hospital [1998] 12 JIC 2101.

Bupa Ireland Limited & anor v Health Insurance Authority & ors [2008] IESC 42.

Burke and O'Reilly v Burke and Quail [1951] IR 216.

Byrne v Ireland [1972] IR 241.

Byrne v Ryan [2009] 4 IR 542.

Cahill v Sutton [1980] IR 269.

Carmody v Minister for Justice [2010] ILRM 157.

CC v Ireland [2006] 4 IR 1.

City View Press Limited v An Comhairle Oiliúna [1980] 381.

Cleary v Cowley & anor [2002] 12 JIC 2006.

COI v Minister for Justice, Equality & Law Reform [2007] 2 ILRM 471.

Collins v Mid-Western Health Board [2000] 2 IR 154.

Conley v Strain [1988] IR 629.

Connolly v Casey [2000] 1 IR 345.

Connolly v Governor of Wheatfield Prison[2013] IEHC 334.

Conway v Irish National Teachers Organisation [1991] 2 IR 305.

Cooke v Cronin [1999] IESC 54.

Cosma v Minister for Justice, Equality and Law Reform [2006] IEHC 36.

Cox v Ireland [1992] 2 IR 503.

Criminal Assets Bureau v Hunt [2003] 2 IR 168.

Croke v Smith (No 2) [1998] 1 IR 101.

Crotty v An Taoiseach [1987] IR 713.

Cunningham v Neary [2004] 2 ILRM 498.

Daniels v Heskin [1954] IR 73.

DB v Minister for Justice [1999] 1 IR 29.

DX v Buttimer [2012] IEHC 175.

Deaton v Attorney General [1963] IR 170.

de Búrca v Attorney General [1976] IR 38.

de Freitas v Permanent Secretary of Ministry of Agriculture, Fisheries, Lands and Housing [1999] 1 AC 69.

Delahunty v South Eastern Health Board [2003] 4 IR 361.

Dellway Investments Ltd & Ors v National Asset Management Agency [2011] IESC 14.

Desmond v Glackin (No. 1) [1993] 3 IR 1.

Desmond v Glackin (No.2) [1993] 3 IR 67.

Devlin v National Maternity Hospital [2008] 2 IR 222.

Devlin v Roche [2002] 2 IR 360.

DG v Eastern Health Board [1997] 3 IR 511.

District Judge McMenamin v Ireland [1996] 3 IR 100.

DK v Crowley [2002] 2 IR 744.

Doherty v Government of Ireland 2 IR [2011] 222.

Doherty & Doherty v South Dublin County Council 2 IR [2007] 696.

Doherty v Reynolds and St. James's Hospital [2004] 2 JIC 1301.

Doherty v Reynolds and St. James's Hospital [2004] 7 JIC 1505.

Dokie v Director of Public Prosecutions, Human Rights Commission, Ireland and the Attorney General Notice Parties [2011] 1 IR 805.

Donegan v Dublin City Council [2012] 2 ILRM 233.

Draper v Attorney General [1984] IR 277.

Dunne v Donohue [2002] 2 IR 533.

Dunne v Fitzpatrick [1958] IR 29.

Dunne v National Maternity Hospital [1989] IR 91.

East Donegal Co-operative Livestock Market Ltd v Attorney General [1970] IR 317.

Educational Co of Ireland v Fitzpatrick (No 1) [1961] IR 323.

Educational Co v Fitzpatrick (No 2) [1961] IR 345.

Edwards v Jenkins & Ors [1989] IEHC 36.

Efe & Ors v Minister for Justice, Equality and Law Reform (No 2) Unreported, 7 June 2011 (HC).

EH v St Vincent's Hospital and Ors [2009] IESC 46.

Eogan v University College Dublin [1996] 1 IR 390.

Fitzpatrick v Midland Health Board [1997] IEHC 76.

Fitzpatrick v National Maternity Hospital [2008] 3 JIC 0704.

Fitzpatrick v White [2008] 3 IR 551.

Fleming v Ireland, 10 January 2013, unreported (HC).

Flynn v Suleiman and Adavanced Cosmestic Surgery Limited [2006] 6 JIC 2101.

FN v Minister for Education [1995] 1 IR 409.

Foy v An t-Ard Chláraitheoir & Ors [2007] IEHC 470.

G v An Bord Uchtála [1980] IR 32.

Garvey v Ireland [1981] 1 IR 80.

GH v Health Service Executive [2011] 3 IR 315.

Geoghegan v Harris [2000] 3 IR 536.

Geoghegan v Institute of Chartered Accountants in Ireland [1995] 3 IR 86.

Glencar Explorations plc v Mayo County Council [2002] 1 ILRM 481.

Goodman International v Hamilton (No 1) [1992] 2 IR 542.

Gottstein v Maguire & anor [2004] IEHC 416.

Gough v Neary [2003] 3 IR 92.

Griffin v Patton & anor [2004] IESC 46.

Hanrahan v Merck Sharp and Dohme [1998] ILRM 629.

Health Service Executive v Commissioner of Valuation [2008] IEHC 178.

Heaney v Ireland [1994] 3 IR 593.

Heaney v Ireland [1996] 1 IR 580

Hegarty v O'Loughran [1990] ILRM 403.

Holland v Governor of Portlaoise Prison [2004] 2 IR 573.

In Re Article 26 The Employment Equality Bill, 1996 [1997] 2 IR 321.

In Re Article 26 and the Illegal Immigrants (Trafficking) Bill, 1999 [2000] 2 1R 360.

In Re Article 26 The Planning and Development Bill, 1999 [2000] 2 IR 321.

In Re Article 26 and the Regulation of Information (Services Outside the State for Termination of Pregnancy) Bill 1995 Judgment [1995] 1 IR 1.

In Re Article 26 The Employment Equality Bill, 1996 [1997] 2 IR 321.

In re Blake Deceased [1955] IR 89.

In Re Haughey [1971] IR 217.

In Re O Laighleis [1960] IR 93.

In the Matter of Article 26 of the Constitution & In the Matter of the Health (Amendment) (No. 2) Bill 2004 [2005] 1 IR 105.

Irish Times Ltd v Ireland [1998] 1 IR 359.

JD v The Residential Institutions Redress Review Committee [2008] IEHC 350.

JH v Russell (Mental Health) [2007] 4 IR 242.

Kavanagh v Governor of Mountjoy Prison [2002] IESC 13.

Kavanagh (A Minor) v Murphy & South Eastern Health Board [2003] IEHC.

Kavanagh (A Minor) v Murphy [2003] IEHC 105.

Kearney v McQuillan & North Eastern Health Board [2012] IEHC 127.

Kelly v Lenihan [2004] IESC 427.

Kelly v Board of Governors of St Laurence's Hospital [1988] IR 402.

Kennedy and Arnold v Ireland [1987] IR 587.

Kiely v Minister for Social Welfare [1977] IR 267.

King v Attorney General [1981] IR 223.

Kinsella v Governor of Mountjoy Prison [2012] 1 IR 467.

L and O v Justice, Equality & Law Reform [2003] 1 IR 1.

L v L [1992] 2 IR 77.

Law Society of Ireland v Competition Authority [1996] 2 IR 262.

Laurentiu v Minister for Justice [1999] 4 IR 26.

Lindsay v Mid-Western Health Board [1993] 2 IR 147.

Lindsay, Merriman v Greenhills Foods Ltd [1997] ILRM 46.

L O'K v LH and others [2006] IEHC.

Madigan v Attorney General [1986] ILRM 136.

Maguire v Ardagh [2002] 1 IR 419.

M v An Bord Uchtála [1977] 2 IR 286.

M v Drury & Ors [1994] 2 IR 8.

M v Medical Council [1984] IR 485.

MacAuley v Minister for Posts and Telegraphs [1966] IR 345.

MacMathúna v Attorney General [1995] 1 IR 484.

Maher v Attorney General [1973] IR 140.

Maher v Minister for Agriculture [2001] 2 IR 139.

Magee v Farrell [2009] 2 ILRM 453.

Makumbi v Minister for Justice [2005] IEHC 403.

] IEHC 276.

McD v PL and BM [2010] 2 IR 199.

McDonald v Bord na gCon [1965] IR 217.

McDonnell v Ireland [1998] 1 IR 134.

McGee v Attorney General [1974] IR 284.

McKenna v An Taoiseach (No 2) [1995] 2 IR 10.

McKinley v Minister for Defence [1992] 2 IR 333.

McMahon v Leahy [1984] IR 525.

MD (Minor) v Ireland, AG & DPP [2012] 2 ILRM 305.

M v Minister for Justice, Equality & Law Reform [2008] IEHC 390.

Meadows v Minister for Justice, Equality and Law Reform [2010] 2 IR 701

Meagher v Minister for Agriculture [1994] 1 IR 329.

MEO v Minister for Justice, Equality and Law Reform [2012] IEHC 394.

McCann v Judges of Monaghan District Court & Ors [2009Meskell v CIE [1973] IR 121.

Molyneux v Ireland [1997] 2 ILRM 1.

Mooney v Terrett [1939] Irish Jurist Reports 56.

Mordaunt v Gallaher & anor [1997] IEHC 123.

Morgan v Galway Board of Health [1943] IR 255.

Mulholland v An Bord Pleanála (No 2) [2006] 2 IR 453.

Murphy v Attorney General [1982] 1 IR 241.

Murphy v Corporation of Dublin [1972] IR 215.

Murphy v IRTC [1999] 1 IR 12.

Murphy v Turf Club [1989] IR 171.

Murtagh Properties v Attorney General [1972] IR 335.

MX v Health Service 23 November 2012, unreported (HC).

Myles v McQuillan & Ors [2007] IEHC 333.

Norris v Attorney General [1984] IR 36.

North Western Health Board v HW [2001] 3 IR 622.

Nwole v Minister for Justice, Equality and Law Reform [2003] 10 JIC 3103.

OAYA (A Minor suing by her Mother and Next Friend, MBO) [2011] IEHC 373.

O v Minister for Justice, Equality and Law Reform [2002] 2 IR 16.

O'B v S [1984] IR 316.

Ó Beoláin v Fahy [2001] 2 IR 279.

O'Brien v Mirror Group Newspapers Limited [2001] 1 IR 1.

O'Brien v Stoutt [1984] IR 316.

O'Brien v Wicklow UDC, unreported, 10 June 1994 (HC).

O'Connor & Tormey v Linehan [2005] IESC 176.

O'Donnell & Ors v South Dublin County Council & Ors [2008] IEHC 454.

O'Donnell v South Dublin County Council unreported, 22 May 2007 (HC).

O'Donoghue v Minister for Education [1996] 2 IR 20.

O'Donovan v Cork County Council [1967] IR 173.

O'Keefe v An Bord Pleanála & Others [1993] 1 IR 39.

O'Keefe v Hickey [2008] IESC 72.

O'Laoire v The Medical Council, unreported, 25th July 1997 (SC).

O'Leary v Attorney General [1993] 1 IR 102.

Olorunyomi v Minister for Justice, Equality and Law Reform [2004] IEHC 426.

O'Reilly v Limerick Corporation [1989] ILRM 181.

O'Shea v Tilman Anhold and Horse Holiday Farm Ltd, unreported, 23 October 1996 (HC).

O'T v B [1998] 2 IR 321.

People (Director of Public Prosecutions) v Quilligan (No.3) [1993] 2 IR 305.

PH v John Murphy & Sons Ltd [1987] IR 621.

Phillips v Medical Council Fitness to Practice Committee [1992] IRM 469.

Philp v Ryan [2004] 4 IR 241.

Pigs Marketing Board v Donnelly [1939] IR 413.

Prendiville v Medical Council [2008] 3 IR 122.

Pullen & Ors v Dublin City Council [2008] IEHC 379.

Pyne & Pyne v Western Health Board & Egan [2005] 4 JIC 1506.

Quinn v King's Inns [2004] 4 IR 344.

Quinn v Mid-Western Health Board [2005] 4 IR 1.

Quinn v South Eastern Health Board [2002] IEHC 43.

Quinn's Supermarket v Attorney General [1972] IR 1.

Rafferty v Bus Éireann [1997] 2 IR 479.

Rajah v Royal College of Surgeons of Ireland [1994] 1 IR 384.

Re a Ward of Court (withholding medical treatment) No. 2 [1996] 2 IR 79.

Reidy v The National Maternity Hospital [1997] IEHC 143.

Reilly v Moir [2009] IEHC 164

Re Phillip Clarke [1950] IR 235.

Re Tilson [1951] IR 1.

R v R [2006] IEHC 359.

Roche v Peilow [1985] IR 232.

Roche v Roche and others [2010] 2 IR 321.

Rock v Ireland [1997] 3 IR 484.

Rothwell v Motor Insurers Bureau of Ireland [2003] 1 IR 268.

Ryan v Attorney General [1965] IR 294.

Sheehan v Mid Western Health Board [2002] IEHC 93.

Shortt v Commissioner of An Garda Síochána, Ireland and Attorney General [2007] 4 IR 587.

Shuit v Mylotte & ors [2006] IEHC 89.

Sinnott v Minister for Education [2001] 2 IR 545.

Sinnott v Quinnsworth [1984] ILRM 523.

Somjee v Minister for Justice [1981] ILRM 324.

SS (a minor) v Health Service Executive [2008] 1 IR 594.

State (Colquhoun) v D'Arcy [1936] IR 641.

State (DPP) v Walsh [1981] IR 412.

State (Keegan & Lysaght) v Stardust Victims Compensation [1986] I IR 642.

Stevenson v Landy & Ors, unreported, 10 February 1993 (HC).

Sweeney v Duggan [1997] 2 ILRM 211.

TD v Minister for Education [2001] 4 IR 259.

The People (DPP) v JT (1988) 3 Frewen 141.

The People (Director of Public Prosecutions) v Quilligan [1986] IR 495.

The People v O'Shea [1982] IR 384.

The State (C) v Frawley [1976] IR 365.

The State (Healy) v Donoghue [1976] IR 325.

The State (M) v Attorney General [1979] IR 73.

The State (McDonagh) v Frawley [1978] IR 131.

The State (Nicoloau) v An Bord Uchtála [1966] IR 567.

The State (Richardson) v The Governor of Mountjoy Prison [1980] ILRM 82.

The State (Ryan) v Lennon [1935] IR 170.

Tierney v Amalgamated Society of Woodworkers [1959] IR 254.

Tormey v Ireland [1985] IR 289.

Tuohy v Courtney [1994] 3 IR 1.

University of Limerick v Ryan, unreported 21 February 1991 (HC).

W v Ireland (No. 1) [1997] 2 IR 132.

W v Ireland (No. 2) [1997] 2 IR 141.

W v W [1993] 2 IR 476.

Walsh v Family Planning Services Ltd [1992] 1 IR 496.

Walsh v Ireland, unreported, 30 November 1994 (SC).

Ward v McMaster [1988] IR 337.

White v Dublin City Council [2004] 1 IR 545.

Wolfe v St James' Hospital & ors [2002] 2 JIC 2003.

X v Attorney General [1992] 1 IR 1.

Equality Tribunal

A Patient v The Mater Misericordiae University Hospital, File No. ES/2006/0159, 25 August 2009.

A Patient v Health Service Provider and a Hospital, File reference: ES/2008/0222 and ES/2009/0005, 1 December 2010.

A Complainant (on behalf of her daughter, J) v Health Service Executive, File Reference: ES/2009/025, 14 December 2012.

Gerard Byrne v Health Service Executive, File Reference: ES/2011/001, 5 September 2012.

Michael Dowd v Dr Paula Gilvarry & HSE West, File Reference: ES/2008/107, 15 December 2011.

Fizel v Health Service Executive, Case ref: ES/2010/0080, Decision 6 January 2012.

Tadeusz Jedruch v The Adelaide and Meath Hospital, Case ref: ES/2010/0114, 7 December 2011.

Ms A (on behalf of her brother, Mr. B) v A General Hospital

Anthony Ronald Preston v H.S.E. Western Area Ambulance Service File Ref ES/2007/111, 9 July 2009.

England and Wales & Privy Council

A (A Child) v Ministry of Defence [2005] QB 183.

Arthur JS Hall & Co v Simons [2002] 1 AC 615.

Airedale NHS Trust v Bland [1993] AC 789.

Alcock v Chief Constable of South Yorkshire Police [1992] 1 AC 310.

Anderson v Milton Keynes General NHS Trust [2006] EWHC 2249.

Anns v Merton London Borough Council [1978] AC 728.

Associated Provincial Picture Houses Ltd v Wednesbury Corporation [1947] 1 KB 223.

Bailey v Ministry of Defence and Another [2008] EWCA Civ 883.

Barker v Corus [2006] 2 AC 572.

Barrett v Enfield LBC [2001] 2 AC 550.

Barnett v Chelsea & Kensington Hospital Management Committee [1969] 1 QB 428.

Bolam v Friern Hospital Management Committee [1957] 2 All ER 118.

Bolitho v City and Hackney Health Authority [1998] AC 232.

Bonnington Castings Ltd v Wardlaw [1956] AC 613.

Bull v Devon AHA [1989] EWCA Civ J0202-7.

Byrne v Boadle 2 H&C 722, 159 ER 299 (1863).

Caparo Industries plc v Dickman [1990] 2 AC 605.

Capital and Counties plc v Hampshire County Council [1997] QB 1004.

Cassidy v Minister for Health [1951] 2 KB 353.

Chaplin v Hicks [1911] 2 KB 786.

Chester v Afshar [2005] 1 AC 134.

Chief Constable of the North Wales Police v Evans [1982] 1 WLR 1155.

Coggs v Bernard (1703) 92 ER 107.

Colwill v Oxford Radcliffe Hospital NHS Trust [2007] EWHC 2881.

Council of Civil Service Unions v Minister for the Civil Service [1985] AC 374.

D v East Berkshire Community Health NHS Trust & others [2005] 2 AC 373.

Donoghue v Stevenson [1932] AC 562.

East Suffolk Rivers Catchment Board v Kent [1941] AC 74.

Evans v Amicus Healthcare Ltd and others [2004] 2 WLR 713.

Everard v Hopkins (1615) 80 ER.

Fairchild v Glenhaven Funeral Services Ltd [2002] 3 WLR 89.

Fletcher v Commissioners of Public Works in Ireland [2003] 1 IR 465.

Frenchay v Healthcare NHS Trust [1994] 2 All ER 403.

Ghaidan v Godin-Mendoza [2004] 2 AC 557.

Glasgow Corporation v Muir [1943] 2 All ER 448.

Gold v Essex County Council [1942] 2 KB 293.

Governors of Peabody Donation Fund v Sir Lindsay Parkinson & Co Ltd [1985] AC 210.

Gregg v Scott [2005] 4 All ER 812.

Hotson v East Berkshire Area Health Authority [1987] AC 750.

In Re A (Conjoined twins: medical treatment) [2000] EWCA Civ 254.

JD v East Berkshire Community NHS Trust [2005] 2 AC 373.

Jones v Manchester Corporation [1952] QB 852.

Jones v North West Strategic Health Authority [2010] EWHC 178.

Kent v Griffiths [2000] 2 WLR 1158.

Kuwait Airways Corporation v Iraqi Airways Co (Nos 4 and 5) [2002] 2 WLR 1353.

Lister v Hesley Hall Ltd [2002] 1 AC 215.

McFarlane v Tayside Health Board [2000] 2 AC 59.

McGhee v National Coal Board [1973] 1 WLR 1.

Murphy v Brentwood District Council [1991] 1 AC 398.

O'Reilly v Mackman [1983] 2 AC 237.

Oxford Radcliffe Hospital NHS Trust [2007] EWHC 2881.

Peabody Donation Fund v Sir Lindsay Parkinson & Co. Ltd [1985] AC 210.

Pearce v United Bristol Healthcare NHS Trust [1999] ECC 167.

Peskin v Anderson [2000] EWCA Civ 326.

Pfizer Corporation v Ministry of Health [1965] AC 512.

Ratcliffe v Plymouth and Torbay Health Authority [1998] Lloyd's LR Med. 162.

R v Bateman [1925] 94 LJKB 791.

R v East Berkshire Health Authority, e.p. Walsh [1985] QB 152.

R (Otley) v Barking and Dagenham Primary Care Trust [2007] CCL Rep 628.

Rabone and another (Appellants) v Pennine Care NHS Foundation Trust (Respondent), 8 February 2012 (SC) unreported.

R (on the application of Pretty) v DPP [2001] UKHL 61.

R (on the application Purdy) v DPP [2009] EWCA Civ 92.

R v Advertising Standards Authority e.p. The Insurance Service plc (1990) 2 Admin LR 77 (QB) 1041.

R v Cambridge Health Authority, ex parte B [1995] 2 All ER 129.

R v Criminal Injuries Compensation Tribunal e.p. Lain [1967] 2 QB 864.

R v Disciplinary Committee of the Jockey Club, ex parte Agha Khan [1993] 1 WLR 909.

R v Disciplinary Committee of the Jockey Club, ex parte Massingberd-Mundy [1993] 2 All ER 207.

R v Jockey Club, Ex parte RAM Racecourses Ltd [1990] Times Law Reports at 1.

R v Ministry of Defence ex p Smith [1996] QB 517.

R v North West Lancashire Health Authority ex parte A, D and G [2000] 1 WLR 977.

R (Ross) v West Sussex Primary Care Trust [2008] EWHC 2252.

R v Secretary of State for the Home Department ex parte Daly [2001] 1 PLR 332.

R v Take-over Panel, ex parte Datafin Plc. [1987] QB 815.

R (Mahmood) v Secretary of State for the Home Department [2001] 1 WLR 840.

R (Mullins) v Appeal Board of the Jockey Club [2005] EWHC 2197 Admin.

Robertson v Nottingham Health Authority [1997] 8 Med L R 1.

Roe v Minister for Health [1954] 2 QB 66.

Rogers v Swindon National Health Service PCT [2006] EWCA Civ 392.

Rothwell v Chemical & Insulating Co Ltd [2006] 4 All ER 1161.

Rowling v Takaro Properties Ltd [1988] AC 473.

Savage v South Essex Partnership NHS Trust [2009] 1 AC 681.

Scott v London & St. Katherine Docks Co (1865) 159 ER 665.

Sidaway v Governors of the Bethlem Royal Hospital [1985] AC 871.

Slater v Baker and Stapleton (1767) 95 ER 860.

Smith v Bush [1990] 1 AC 831.

Smith v Chief Constable of Sussex [2008] 3 All ER 977.

Stovin v Wise [1996] AC 923.

Thake v Maurice [1986] 1 All ER 497.

W v Commissioner of Police [2000] 1 WLR 1607

Wardlaw v Farrar [2003] EWCA Civ 1719 .

White v Chief Constable of South Yorkshire [1999] 2 AC 455.

Whitehouse v Jordan [1981] 1 All ER 267.

Wilsher v Essex Area Health Authority [1988] 1 AC 1074; 1 QB 730; All ER 871.

X (Minors) v Bedfordshire County Council [1995] 2 AC 633.

YL v Birmingham City Council & Ors [2008] 1 AC 95.

Yuen Kun-yeu v Attorney General of Hong Kong [1988] AC 175.

Scotland

Hunter v Hanley 1955 SC 2000.

Miller v Greater Glasgow NHS Board [2010] CSIH 40.

United States

Anderson v St Francis-St George Hospital Inc 77 Ohio St.3d 82 (1996).

Brown v Board of Education 347 US 483 (1954).

Burton v Wilmington Parking Authority 365 US 715 (1961).

Causey v St Francis Med Ctr., 719 So.2d 1072 (La.App. Cir.2 1998).

Conservatorship of Wendland 26 Cal 4th 519 (2001).

Cruzan v Director, MDH, 497 US 261 (1990).

Daubert v Merrell Dow Pharmaceutical Inc. 509 US 579 (1993).

Gilbert v Sycamore Municipal Hospital 622 N.E. 2d 788 (Ill. 1993)

Gilgunn v Massachusetts General Hospital No 922-4820 (1995).

Helling v Carey (1974) 83 Wash. 2d 514.

Hicks v United States 368 F.2d 626 (4th Cit. 1966).

Huffman v Lindquist 37 Cal.2d 465.

In re Quinlan 70 NJ 10, 355 A2d 647; 1976 NJ.

Johnson v Kokemoor 545 N.W.2d 495 (1996).

Jones v Young 607 N.E.2d 61 (Conn. 2003).

Maki v Murray Hospital, 91 Mont 251 7 P.2d 228 (1932).

Massachusetts Board of Retirement v Murgia 427 US 307 (1976).

Matsuyama v Birnbaum 890 N.E.2d 819 (Mass. 2008).

Moose Lodge v Irvis 407 US 163 (1972).

Palsgraf v Long Island Railroad 162 NE 99 (NY 128).

Paul v Davis 421 US 909 (1975).

Public Citizen Health Research Group v Department of Health, Education and Welfare US Court of Appeals, District of Columbia Circuit (1981) 668 F2d 537 215 US App. DC 191.

Roe v Wade 410 US 113 (1973).

Schloendorff v Society of New York Hospital, 211 N.Y. 125, 129-30, 105 N.E. 92 (1914).

Texas Boll Weevil Eradication Foundation Inc v Lewellen (1997) 952 SW2d 454, 469.

Truman v Thomas, 27 Cal 3d, 611 P.2d 902 (1980).

Washington v Glucksberg 521 U.S. 702.

Whiteside v Lukson 947 P.2d 1263 (1997).

Ybarra v Spangard 25 Cal.2d 486 (1944).

South Africa

Certification of the Constitution of the Republic of South Africa 1996 (CCT 23/96) [1996] ZACC 26; 1996 (4) SA 744 (CC); 1996 (10) BCLR 1253 (CC) (6 September 1996).

Du Plessis v De Klerk 1996 (3) SA 850 (CC); 1996 (5) BCLR 658 (CC).

Government of the Republic of South Africa v Grootboom and Others (CCT11/00) [2000] ZACC 19; 2001 (1) SA 46; 2000 (11) BCLR 1169 (4 October 2000).

Kern v Minister of Safety and Security Case CCT 52/04 (CC 13 June 2005).

Minister of Health v Treatment Action Campaign and Others (No 2) (CCT8/02) [2002] ZACC 15; 2002 (5) SA 721; 2002 (10) BCLR 1033 (5 July 2002).

Soobramoney v Minister for Health (Kwazulu-Natal) (CCT32/97) [1997] ZACC 17; 1998 (1) SA 765 (CC); 1997 (12) BCLR 1696 (27 November 1997).

India

Ashoka Kumar Thakur v Union of India (2008) 6 SCC 1.

Bandhua Mukti Morcha vs Union Of India & Others (1984) AIR SC 802.

In His Holiness Keesavananda Bharati Sripadagalvaru v State of Kerala 1973 (4) SCC 225.

Paschim Banga Khet Mazdoor Samity v State of West Bengal (1996) AIR SC 2426.

Samira Kohli v Dr Prabha Manchanda (2008) 2 SCC 1.

Shanbaug v Union of India Judgment of 11 March 2011, [2011] 2SC R8 69.

SR Bommai v Union of India 1994 (2) SCR 644.

Vinitha Ashok v Lakshmi Hospital 2001 (8) SCC 731.

Canada

Bazley v Curry [1999] 2 SCR 534.

Blue v Ontario (Health and Long Term Care) [2009] CanLII 18671 SC (Ont).

Chaulk v R [1990] 3 SCR 1303.

Cooper v Hobart [2001] 3 SCR 537.

Edgeworth Construction Ltd v Lea & Associates Ltd [1993] 3 SCR 206.

Fullowka v Pinkerton's of Canada Ltd [2010] 1 SCR 132.

Hill v Hamilton-Wentworth Regional Police Services Board [2007] 3 SCR 129.

Lawson v Lafferiére (1991) 78 DLR (4th) 609.

Re Manitoba Language Rights Case [1985] 1 SCR 721.

Pittman Estate v Bain (1994) 112 DLR (4th) 257.

R v Bain [1992] 1 SCR 91.

R v Kapp [2008] 2 SCR 483.

R v Oakes [1986] 1 SCR 103.

Re Reference by the Governor in Council concerning Certain Questions relating to the Secession of Quebec (1998) [1998] 2 SCR 217.

Schachter v Canada [1992] 2 SCR 679.

Syl Apps Secure Treatment Centre v BD [2007] 3 SCR 83.

Winnipeg Condominium Corp No. 36 v Bird Construction Co Ltd [1995] 1 SCR 85.

Vancouver General Hospital v McDaniel (1934) 152 LT 56.

Yepremian v Scarborough General Hospital (1980) 110 DLR (3d) 513.

Australia

Chappel v Hart [1992] HCA 55.

Ellis v Wallsend District Hospital (1989) 17 NSWLR 553.

Graham Barclay Oysters Pty Ltd v Ryan (2002) 211 CLR 540.

Jaensch v Coffey (1984) 155 CLR 549.

Lowns v Woods (1995) 36 NSWLR 344.

Naxasis v Western General Hospital [1998-89] Commonwealth Law Reports Vol 197 269.

Rosenberg v Percival (2001) 205 CLR 434.

Sullivan v Moody (2001) 207 CLR 562.

Sutherland Shire Council v Heyman (1985) 157 CLR 424.

Tabet v Gett [2010] HCA 12.

Singapore

Spandeck Engineering (S) Pte Ltd v Defence Science and Technology Agency [2007] 4 SLR(R) 100; [2007] SGCA 37.

New Zealand

Couch v Attorney General [2008] 3 NZLR 725.

European Court of Human Rights

A, B and C v Ireland, Application No. 25579/05, Judgment of 16 December 2010 (Hudoc 2010).

Abdulaziz, Cabales and Balkandali v The United Kingdom, Application Nos. 9214/80, 9473/81 and 9474/81) Judgment 28 May 1985 7 EHRR 471.

Assenov and Others v Bulgaria, Application No. 24760/94, Judgment 28 October 1998, 28 EHRR 652.

Atalay v Turkey, Application No. 1249/03 Judgment 18 September 2008 (Hudoc 2008).

Bensaid v United Kingdom, Application No. 44599/98, Judgment 6 February 2001 33 EHRR 10.

Botta v Italy, Application No. 21439/93, Judgment 24 February 1998, 26 EHRR 241.

Calvelli and Ciglio v Italy, Application No 32967/96, Judgment 17 January 2002, ECHR 2002-I.

CG and Others v Bulgaria, Application 1365/07, Judgment 24 April 2008, 47 EHRR 1117.

Cyprus v Turkey Application No. 225781/94, Judgment 19 May 2001, 35 EHRR 30.

D v United Kingdom, Application No. 30240/96, Judgment 2 May 1997, 24 EHRR 423.

Doran v Ireland, Judgment 31 July 2003 (Hudoc 2003).

Dudgeon v United Kingdom, Application No. 7525/76, Judgment 22 October 1981, 4 EHHR 149.

Evans v UK, Application No. 6339/05, Judgment 10 April 2007, 46 EHRR 728.

Gaygusuz v Austria, Application No. 17371/ 90, Judgment 16 September 1996, 23 EHRR 364.

Glor v Switzerland, Application No. 13444/04, Judgment 30 April 2009 (available in French only) (Hudoc 2009).

Haas v Switzerland, Application 31322/07, 20 January 2011 (Hudoc 2011).

Herczegfalvy v Austria, Application No. 10533/83, 24 September 1992, 15 EHRR 437.

Hoffman v Germany, unreported, Judgment 11 October 2001.

Hummatov v Azerbaijan, Application Nos. 9852/03 13413/04, Judgment 29 November 2007 (Hudoc 2007).

Hurtado v Switzerland, Application No. 17549/90, Judgment 26 January 1994 (Hudoc 1994).

IG v Slovakia, Application No. 15966/04, Judgment 13 November 2012 (Hudoc 2012).

Ireland v United Kingdom, Application No. 5310/71, Judgment of 18 January 1978, 2 EHRR 25

Jalloh v Germany, Application No. 54810/00, Judgment 11 July 2006, 44 EHRR 667.

Keenan v The United Kingdom, Application 27229/95, Judgment of 3 April 2001 33 EHRR 903.

Kiyutin v Russia, Application No. 2700/10 Judgment 10 March 2011 (Hudoc 2011).

Kudla v Poland, Application No. 30210/96, Judgment 26 October 2000, 2000-ECHR XI.

Klass and others v Germany, Series A No. 269, Judgment 6 September 1978) 2 EHRR 214.

Magee v Ireland Application No. 53743/09, Friendly Settlement December 2012.

McFarlane v Ireland, Application No. 31333/06, Judgment, 10 September 2010 (Hudoc 2010).

McKerr v United Kingdom, Application No. 28883/94, Judgment 4 May 2001 (2002) 34 EHRR 553.

MS v Sweden, Application No. 20837/92, Judgment 27 August 1997, 28 EHRR 313.

N v United Kingdom, Application No. 26565/ 05, Judgment of 27 May 2008, 47 EHRR 885.

NB v Slovakia, Application No. 29518/10, Judgment 12 June 2012 (Hudo 2012).

Nevmerzhitsky v Ukraine, Application No. 54825/00, Judgment 5 April 2005, ECHR 2005-II.

Norris v Ireland, Application 10581/83, 26 October 1988, 13 EHRR 186.

Paladi v Moldova, Application No. 39806/05, Judgment 10 March 2009 (Hudoc 2009).

Peck v The United Kingdom, Application No. 44647/98, Judgment 28 January 2003, 36 EHRR 719.

Pretty v United Kingdom, Application No. 2346/02, Judgment 29 April 2002, 35 EHRR 1.

Price v United Kingdom, Application No. 33394/96, Judgment 10 July 2001, 34 EHRR 1285.

RR v Poland, Application No. 27617/04, Judgment 26 May 2011 (Hudoc 2011).

Rasmussen v Denmark, Application No. 8777/79, Judgment 28 November 1984, 7 EHRR 372.

Reynolds v United Kingdom, Application No. 2694/08, Judgment 13 March 2012 (Hudoc 2012).

Salgueiro da Silva Mouta v Portugal, Application No. 33290/96, Judgment 21 December, 1999, 31 EHRR 1055.

Senturk v Turkey, Application No.13423/09, Judgment 9 April 2013 (Hudoc 2013).

Shanaghan, Jordan and Kelly and Others v United Kingdom, Application No. 37715/97, Judgment 4 May 2001, 34 EHRR 553.

Siemenska v Poland Application 37602/97, Admissibility Decision.

Silver and Others v The United Kingdom, Application No. 5947/72, Judgment 25 March 1983, 5 EHRR 347.

Smith and Grady v The United Kingdom, Application No. 33985/96 and 33986/96, Judgment of 27 September 1999, 29 EHRR 493.

Sunday Times v United Kingdom, Application No. 6538/94 Judgment 29 March 1979, 2 EHRR 245.

Thlimmenos v Greece, Application No. 34369/97, Judgment 6 April 2000, 31 EHRR 411.

Van Kück v Germany, Application 35968/97, Judgment 12 June 2003, 37 EHRR 51.

VC v Slovakia, Application No. 18968/07, Judgment 8 November 2011 (Hudoc 2011).

Vo v France, Application No. 53924/00, Judgment 8 July 2004, 40 EHRR 259.

European Committee of Social Rights

Autism-Europe v France, Complaint No. 13/2002, Decision on the merits of 4 November 2003.

Defence for Children International v The Netherlands, Complaint No. 47/2008, 20 October 2009.

European Roma Rights Centre (ERRC) v. Bulgaria, Complaint No. 46/2007, Decision on the Merits 3 December 2008.

European Roma Rights Centre (ERRC) v Bulgaria Complaint No.48/2008, Decision on the Merits 18 February 2009.

International Federation of Human Rights Leagues (FIDH) v France, Complaint No. 14/2003, Decision on the merits of 3 November 2004.

Court of Justice (EU)

Albany and Albany International BV v Stichting Bedrijfspensionefonds Textielindustrie, Cases C-67/96 and C-115/97 [1999] ECR 1-5751.

Angonese v Cassa di Risparmio di Bolzano SpA Case C-281/98 [2000] ECR 1-4139.

Bickel and Franz Joined Cases C-274/96 [1998] ECR I-7637.

Brasserie du Pécheur SA v Federation of Republic of Germany and R v Secretary of State for Transport, ex parte Factortame Ltd and others Joined Cases C-46/93 and 48/93 [1996] ECR 1-1029.

Brentjens Case C-219/97, Judgment 21 September 1999.

Bokken, Case C-180/98, Judgment 21 September 1999.

Commission v. Luxembourg Case C-111/91 [1997] ECR I-817.

DEB Deutsche Energiehandels - und Beratungsgesellschaft MbH v Bundesrepublik Deutschland Case C-279/09 [2010] All ER (D0 308 (DEC).

Defrenne v Sabena [1976] ECR 455.

Jasna Detiček v Maurizio Sgueglia Cases C-403/09 PPU, Judgment 23 December 2009.

Drijvende Bokken and Pavlov and others, Judgment 12 September 2000.

European Commission v Kingdom of Spain, Case C-211/08, Judgment 15 June 2010.

Federation francaise des societies d'assurance (FFSA), Case C-244/94, Judgment 16 November 1995 ECR 1-4013.

Francovich and Bonafaci v Italy Cases C-6 and 9/90 [1991] ECR 1-5357.

Germany v Commission Cases C-281, 283-285, 287/85 [1987] ECR 3202.

Hendrix Case C-287/05 [2007] ECR I-6904.

Internationale Handelsgesellschaft v Germany Case 11/70 [1970] ECR 1125.

CIlonka Sayn-Wittgenstein v Landeshauptmann von Wien Case C-208/09 [2010] All ER (D) 105.

Kohll v Union des Caisses en Maladie Case C-158/96 [1998] ECR 1-1931.

Meroni v High Authority of the European Coal and Steel Community 1961 CJ 0021 Joined Cases 21/61 to 26/61, Judgment 6 April 1962.

Nold v Commission Case 4/73 [1974] ECR 491.

Omega Spielhallen-und Automanatenaufstellungs v Oberbúrgermeistern der Bundesstadt Bonn Case C-36-02 [2004] ECR 1-9609.

Rutili v Ministre de l'Intérieur Case 36/75 [1975] ECR 1219.

Schempp Case C-403/03 [2005] ECR I-6421.

Schmidberger Case C-112/00 [2003] ECR I 5659.

Servet Kamberaj v Istituto per l'Edilizia sociale della Provincia autonoma di Bolzano (IPES) and Ors, Case C-571/10, Judgment 24 April 2012.

Schwarz and Gootjes Schwarz Case C-76/05 [2007] ECR I-6849.

Vanbraekeland Decker v Caisse de Maladie des Employes Prives Case C-120/95 [1998] ECR 1831.

Van Gend en Loos v Netherlandse Administratie der Belastingen Case 26/62 [1963] ECR 1.

Volker und Markus Schecke GbR and Hartmut Eifert v Land Hessen, Joined Cases C-92/09 and C-93/09 [2010] ECR 1-0000.

R v Bedford Primary Care Trust and the Secretary of State ex parte Watts, Case C-372/04 [2006] ECR 1-4325.

Zambrano v Office national de l'emploi (ONEM) Case C 34/09, Judgment 8 March 2011.

United Nations jurisprudence

Human Rights Committee

Foin v France, 3 November 1999, 55th Session of the Human Rights Committee, Suppl. No. 40 (A/55/40).

Gueye v France, 3 April 1989, 35th Session of the Human Rights Committee, Suppl. No. 40 (A/44/40).

Committee on the Elimination of Discrimination Against Women

Szijarto v Hungary Communication No. 4/2004, UN Doc CEDAW/C/36/D/4/2004 (29 August 2006).

VK v Bulgaria, Communication No. 20/2008, CEDAW/C/49/D/20/2008, Committee on the Elimination of Discrimination against Women, Forty-ninth session (27 September 2011).

Committee Against Torture

Elmi v Australia (2000) UN Committee Against Torture, 7 International Human Rights Reports.

International Court of Justice

Legality of the Threat of Nuclear Weapons, Advisory Opinion, 8 July 1996 (1996) ICJ Reps.

Constitutional provisions (Bunreacht na hÉireann)

Preamble

Article 5

Article 6

Article 8

Article 15

Article 28

Article 29

Article 34

Article 37

Article 38

Article 40

Article 41

Article 42

Article 43

Article 44

Article 45.

Statutes

Ireland

Adoption Act 1952.

Aliens Act 1935.

Chancery (Ireland) Act 1867.

Civil Law (Miscellaneous Provisions) Act 2011.

Civil Liability and Courts Act 2004.

Competition Act 1990.

Criminal Law Amendment Act 1885.

Criminal Law Amendment Act 1935.

Criminal Law (Suicide) Act 1993.

Defamation Act 2009.

Dentists Act 1985.

Disability Act 2005.

Domestic Violence Act 1996.

Employment Equality Acts 2000-2012.

Enforcement of Court Orders Act 1926

Enforcement of Court Orders Act 1940

Equal Status Acts 1998-2008.

European Communities Act 1972.

European Convention on Human Rights Act 2003.

Health Act 1947.

Health Act 1960.

Health Authorities Act 1960.

Health Act 1970.

Health Act 2004.

Health Act 2007.

Health Insurance Act 1994.

Health Insurance (Amendment) Act 2001.

Health Insurance (Amendment) Act 2003.

Health Insurance (Amendment) Act 2007.

Health Insurance (Miscellaneous Provisions) Act 2009.

Health Insurance (Miscellaneous Provisions) Act 2011.

Health Insurance (Amendment) Act 2012.

Health and Social Care Professionals Act 2005.

Health, Safety and Welfare at Work Act 2005.

Housing Act 1988.

Illegal Immigrants (Trafficking) Act 2000.

Irish Nationality and Citizenship Act 1956.

Mental Health Act 2001.

Medical Practitioners Act 1978.

Medical Practitioners Act 2007.

National Treasury Management Agency (Amendment) Act 2000.

Nurses Act 1985.

Occupiers Liability Act 2005.

Offences Against the Person Act 1861.

Ombudsman Act 1980.

Ombudsman for Children Act 2002.

Opticians Act 1956.

Personal Injuries Assessment Board Act 2003.

Pharmacy Act 2007.

Refugee Act 1996.

Statute of Limitations Act 1957.

Statute of Limitations (Amendment) Act 1991.

Succession Act 1965.

Supply of Goods and Services Act 1990.

United Kingdom

Damages Act 1996.

Deregulation and Contracting Out Act 1994.

Human Rights Act 1998.

National Health Insurance Act 1941.

National Health Service Act 2006.

National Health Service Reform and Health Care Professions Act 2002,

Social Security Administration Act 1992.

Supply of Goods and Services Act 1982.

United States

Federal Tort Claims Act 1946.

Medical Injury Compensation Reform Act 1975 (CA).

Patient Protection and Affordable Care Act 2011.

Netherlands

Health Insurance Act 2006.

France

Patients' Rights and Quality of the Health System Act 2002.

Denmark

Patient Insurance Act 1992.

Poland

2011 Revision of the Act on Patients' Rights and the Patients' Ombudsman.

New Zealand

Accident Compensation Act 1972.

Health and Disability Commissioner Act 1994.

Injury Prevention, Rehabilitation and Compensation Amendment Act (No. 3) 2005.

International instruments

United Nations Treaties

Charter of the United Nations (1945) June 26, 1945, 59 Stat. 1031, T.S. 993, 3 Bevans 1153, entered into force Oct. 24, 1945.

Constitution of the World Health Organization (1946) Official World Health Organization 2, 100.

International Convention on the Elimination of All Forms of Racial Discrimination (1965), United Nations, Treaty Series, Vol. 660, p. 195, entered into force on 4 January 1969.

International Covenant on Economic, Social and Cultural Rights (1966) G.A. res. 2200A (XXI), 21 U.N.GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, *entered into force* Jan. 3, 1976.

Optional Protocol to the International Covenant on Economic, Social and Cultural Rights (2008) G.A. res. 63/117 (2008).

International Covenant on Civil and Political Rights (1966) G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, entered into force Mar. 23, 1976.

Optional Protocol to the International Covenant on Civil and Political Rights (1966) G.A. res. 2200A (XXI), 21 U.N.GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, entered into force Mar. 23, 1976.

Vienna Convention on the Law of Treaties (1969) 1155 U.N.T.S. 331, 8 I.L.M. 679, entered into force Jan. 27, 1980.

Convention on the Elimination of All Forms of Discrimination against Women (1979) G.A. res. 34/180, 34 U.N. GAOR Supp. (No. 46) at 193, U.N. Doc. A/34/46, entered into force Sept. 3, 1981.

Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women (1999) G.A. res. 54/4, annex, 54 U.N. GAOR Supp. (No. 49) at 5, U.N. Doc. A/54/49 (Vol. I) (2000), entered into force Dec. 22, 2000.

Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984) G.A. res. 39/46, [annex, 39 U.N. GAOR Supp. (No. 51) at 197, U.N. Doc. A/39/51 (1984)], entered into force June 26, 1987.

Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, G.A. res. 39/46, [annex, 39 U.N. GAOR Supp. (No. 51) at 197, U.N. Doc. A/39/51 (1984)], entered into force June 26, 1987.

Convention on the Rights of the Child (1989) G.A. res. 44/25, annex, 44 U.N. GAOR Supp. (No. 49) at 167, U.N. Doc. A/44/49 (1989), entered into force Sept. 2 1990.

International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (1990) G.A. res. 45/158, annex, 45

U.N. GAOR Supp. (No. 49A) at 262, U.N. Doc. A/45/49 (1990), entered into force 1 July 2003.

Convention on the Rights of Persons with Disabilities (2006) G.A. Res. 61/106, U.N. GAOR, 61st Sess., U.N. Doc. A/RES/61/106 (2006), entered into force 3 May 2008.

International Declarations

Universal Declaration of Human Rights (1948) G.A. res. 217A (III), U.N. Doc A/810 at 71.

Declaration of Alma-Ata, International Conference on Primary Health Care (1978), Primary Health Care: report of the International Conference on Primary Health Care, Alma-Ata, U.S.S.R., 6-12 September, 1978. Geneva: W.H.O, 1978.

UN Millennium Declaration and Millennium Development Goals (1990), U.N.G.A. Resolution adopted by the General Assembly [without reference to a Main Committee (A/55/L.2)] 55/2. United Nations Millennium Declaration.

Vienna Declaration and Programme of Action adopted by the World Conference on Human Rights (1993), World Conference on Human Rights, Vienna, 14-25 June 1993, A/CONF.157/23.

Declaration of Commitment on HIV/AIDS (2001) U.N.G.A. Special Session on HIV/AIDS, 2 August 2001 A/RES/S-26/2.

Rio Political Declaration on Social Determinants of Health (2011), Rio de Janeiro, Brazil, 21 October 2011.

General Comments of Treaty bodies

Human Rights Committee General Comment No. 2 (1981) General Comments, 07/28/1981 CCPR General Comment No. 2. (General Comments) (Thirteenth session, 1981).

Human Rights Committee General Comment No. 18, (1999) Non-discrimination, 11/10/1989. CCPR General Comment No. 18. (General Comments) (Thirty-seventh session, 1989).

Human Rights Committee General Comment No. 31 Nature of the General Legal Obligation Imposed on States Parties to the Covenant, CCPR/C/21/Rev.1/Add. 13, 26 May 2004.

Committee on the Elimination of Discrimination against Women, General Recommendation N° 19 (1991) Violence against women (llth session, 1992).

Committee on Economic, Social and Cultural Rights, General Comment No. 3 (1990), The nature of State parties' obligations (Art. 2, par.1) 12/14/1990 CESCR General comment 3. (General Comments) Fifth session, 1990.

Committee on Economic, Social and Cultural Rights, General Comment No. 5 (1994) Persons with Disabilities, 12/09/1994, CESCR General comment 5. Eleventh session, 1994.

Committee on Economic, Social and Cultural Rights, General Comment No. 10, The role of national human rights institutions in the protection of economic, social and cultural rights, E/C.12/1998/25, adopted at the 51st meeting (nineteenth session), 1 December 1998.

Committee on Economic, Social and Cultural Rights, General Comment No. 12 (1999), The right to adequate food (art. 11) E/C.12/1999/5 (twentieth session), 12 May 1999.

Committee on Economic, Social and Cultural Rights, General Comment No. 13 (1999), The right to education (article 13 of the Covenant) E/C.12/1999/10 (Twenty-first session), 8 December 1999.

Committee on Economic, Social and Cultural Rights, General Comment No. 14 (2000), The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights) E/C.12/2000/4 (Twenty-second session) 11 August 2000.

Committee on Economic, Social and Cultural Rights, General Comment No. 16 (2005), The equal right of men and women to the enjoyment of all economic, social and cultural rights (art. 3 of the International Covenant on Economic, Social and Cultural Rights) E/C.12/2005/4 (Thirty-fourth session) 11 August 2005.

Committee on Economic, Social and Cultural Rights, General Comment No. 20 (2009), Non-discrimination in economic, social and cultural rights (art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights) E/C.12/GC/20 (Forty-second session) 2 July 2009.

Committee on the Rights of the Child, General comment No. 13 (2011), The right of the child to freedom from all forms of violence, C/GC/13, 18 April 2011.

Committee Against Torture, General Comment No. 2 (2008), Implementation of article 2 by States parties, CAT/C/GC/2, 24 January 2008.

Council of Europe

European Convention on Human Rights and Fundamental Freedoms (1950) (ETS 5), 213 U.N.T.S. 222 entered into force Sept. 3, 1953.

European Social Charter (1961), ETS 35 18 October 1961, entry into force: 26 February 1965.

Revised European Social Charter (1996), ETS 163 3 May 1996, entry into force: 1 July 1999.

Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (1997), CETS No.: 164 Oviedo 4/4/1997, entry into force: 1/12/1999.

European Union

Treaty Establishing the European Economic Community (EEC) (1957) ("Treaty of Rome"),

Treaty on European Union ("Maastricht Treaty") 1992 Official Journal C 191, 29 July 1992

Treaty of Amsterdam Amending The Treaty On European Union, The Treaties Establishing The European Communities And Related Acts (1997) Official Journal C 340, 10 November 1997.

Treaty Of Nice Amending The Treaty On European Union, The Treaties Establishing The European Communities And Certain Related Acts (2001) Official Journal C 80, 10 March 2001.

Consolidated Version of the Treaty on European Union, 9.5.2008 EN Official Journal of the European Union C 115/13.

Other Regional Instruments

African (Banjul) Charter on Human and Peoples' Rights, adopted June 27, 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982), entered into force Oct. 21, 1986.

American Convention on Human Rights, O.A.S.Treaty Series No. 36, 1144 U.N.T.S. 123, *entered into force* July 18, 1978, *reprinted in* Basic Documents Pertaining to Human Rights in the Inter-American System, OEA/Ser.L.V/II.82 doc.6 rev.1 at 25 (1992).

Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador) (1988), OAS, Treaty Series No. 69 entered into force 11/16/99.

Bilateral instruments

1998 Belfast Agreement between the United Kingdom and Republic of Ireland, Summary Record of Final Plenary Session - Friday 10 April 1998.

Bibliography

H Roscam Abbing, *Problem Doctors and Patients' Right to Good Quality Care in the European Union*, 16 European Journal of Health Law 301 (2009).

H Roscam Abbing, *Editorial: Health Law: Facing the European Challenges*, 17 European Journal of Health Law 7 (2010).

H Roscam Abbing, Editorial, *Social justice and Health care Systems in Europe*, 17 European Journal of Health Law 217 (2010).

F Abbott, T Cottier and F Gurry, *The International Intellectual Property System: Commentary adn Materials, Part Two*, Kluwer Law International The Hague, London, Boston (1999).

H I Abramson, *A Fifth Branch of Government, The Private Regulators and their Constitutionality*, 16 Hastings Constitutional Law Quarterly 165 (1988-89).

Ad hoc group for the development of implementing guidelines, *Ethical Considerations for Clinical Trials on Medicinal Products Conducted with the Paediatric Population, Recommendations of the ad hoc group for the development of implementing guidelines for Directive 2001/20/EC relating to the implementation of good clinical practice in the conduct of criminal trials on medicinal products for human use*, 15 European Journal of Health Law 223 (2008).

M Adams and H Weyers, *Supervision and Control in Euthanasia Law: Going Dutch?* 23 Kings Law Journal 121 (2012).

A C Aman Jnr, *Globalization, Democracy, and the Need for a New Administrative Law*; 49 UCLA Law Review 1687 (2002).

Agreement between the United Nations and the International Monetary Fund, April 15, 16 UNTS 328 (1948).

Agreement between the United Nations and the International Bank for Reconstruction and Development art.1, April 15, 16 UNTS 346 (1948).

C De Albuquerque, *Chronicle of an Announced Birth: The Coming into Life of the Optional Protocol to the International Covenant on Economic, Social and*

Cultural Rights- The Missing Piece of the international Bill of Rights, 32 Human Rights Quarterly 144 (2010).

T R S Allan, *Human Rights and Judicial Review: A Critique of Judicial Deference*, 65 Cambridge Law Journal 671 (2006).

T R S Allan, *Judicial Deference and Judicial Review: Legal Doctrine and Legal Theory*, 127 Law Quarterly Review 96 (2011).

M L Allen, *Crossing The Rubicon: The Netherlands' Steady March Towards Involuntary Euthanasia*, 31 Brooklyn Journal of International Law 535 (2005-2006).

P Allmark, M Cobb B J Liddle and A Todd, *Is the Doctrine of Double Effect irrelevant in end-of-life decision making?* Sheffield Hallam University (2010).

P Alston, *A Human Rights Perspective on the Millenium Development Goals; Paper prepared as a contribution to the work of the Millenium Project Task Force on Poverty and Economic Development* (2004).

P Alston, *The 'Not-a-Cat Syndome: Can the International Human Rights Regime Accommodate Non-State Actors*? in *Non-State Actors and Human Rights*, P Altson (ed.) Oxford University Press 1 (2005).

Y Arai-Takahashi, *The Right to Health in International Law - A Critical Appraisal*, in R Martyn, & L Johnson (Eds), *Law and the Public Dimension of Health* London Cavendish Publishing Limited (Chapter 5) (2001).

O Arnardottir, *Equality and Non-Discrimination under the European Convention on Human Rights*, Martinus Nijhoff Publishers (2004).

P Atiyah, *Personal Injuries in the Twenty-First Century: Thinking the Unthinkable*, in P Birks (ed) *Wrongs and Remedies in the Twenty-First Century* 1 (1996).

M Avbelj, *Supremacy or Primacy of EU Law - (Why) Does it Matter?* 17 European Law Journal 744 (2011).

I Bacik, *Future Directions for the Constitution, Governance and Values* in *The Irish Constitution, Governance and Values*, E Carolan & O Doyle (Eds) in *The Irish Constitution, Governance and Values*, Thomson Roundhall (2008).

L C Backer, *From Institutional Misalignments to Socially Sustainable Governance: The Guiding Principles for the Implementation of the United Nations' "Protect, Respect and Remedy" and the Construction of Inter-Systemic Global Governance*, 25 Pacific McGeorge Global Business & Development Law Journal (2012) 69.

E Bagińska, *The New Extra-Judicial Compensation System for Victims of Medical Malpractice and Accidents in Poland*, 3 Journal of European Tort Law 101 (2012).

T Baker, *Reconsidering the Harvard Medical Practice Study Conclusions about the Validity of Medical Malpratice Claims*; 33 Journal of Law, Medicine and Ethics 501 (2005).

I M Balfour-Lynn and R C Tasker, *At the coalface - medical ethics in practice Futility and death in paediatric medical intensive care,* Great Ormond Street Hospital for Children NHS Trust, London, 22 Journal of Medical Ethics 279 (1996).

K A Bamberger, *Regulation as Delegation: Private Firms, Decision Making and Accountability in the Administrative State*, 56 Duke Law Journal 377 (2006).

S Banda, *Taking Indirect Horizontality Seriously in Ireland: A Time to Magnify the Nuance* 31 Dublin University Law Journal 263 (2009).

A Bayefsky, *The Principle of Equality and Non-Discrimination in International Law* 11 Human Rights Law Journal 18 (1990).

A Beever, *Rediscovering the Law of Negligence*, Oxford: Hart Publishing (2007).

F Van den Berghe, *The EU And Issues of Human Rights Protection: Same Solutions to More Acute Problems?* 16 European Law Journal 112 (2011).

G Beihler, *International Law in Practice, an Irish Perspective*, Thomson Round Hall, Dublin (2005).

V Bilotkach, J A Clougherty, J Mueller and A Zhang, *Regulation, privatization, and airport charges: panel data evidence from European airports*, 42 Journal of Regulatory Economics (2012) 73.

W Binchy, *Constitutional Remedies and the Law of Torts*, in J O'Reilly (ed.), *Human Rights and Constitutional Law* RoundHall 201 (1992).

W Binchy, *Presentation to Forum on Fluoridation: The Legal Dimension*, Stationery Office, Government Publications, Dublin; Appendix 16 (2002).

W Binchy, *Recent Developments in the Law of Torts*, 4 Judicial Studies Institute Journal 1 (2004).

W Binchy, *Issues of Proof in Medical Negligence Litigation: New Questions Posed in the Irish Courts*, in *Medical Negligence Litigation: Emerging Issues*, (eds.) C Craven & W Binchy, First Law 56 (2008).

W Binchy, *Dignity as a Constitutional Concept*, in *The Irish Constitution, Governance and Values*, *Dignity as a Constitutional Concept*, E. Carolan & O Doyle (Eds) Thomson Roundhall (2008).

W Binchy, *Meskell, the Constitution and Tort Law* 18 Dublin University Law Journal 339 (2011).

M De Blacam, *Judicial Review* (Second Edition), Tottel Publishing (2009).

D Black, *The Behavior of Law*, New York Academic Press (1976).

D Black, *Toward a general theory of social control*, D Black (ed.) Volumes 1-2, Orlando, London Academic Press (1984).

D Black, *The Social Structure of Right and Wrong*, San Diego, London Academic Press, (1993).

J Black, "*Which Arrow?" Rule Type and Regulatory Policy* [1995] Public Law 94.

J Black, *Constitutionalising Self-Regulation*, 59 Modern Law Review 24 (1996).

J Black, *Managing Discretion: Penalties: Policy, Principles and Practice in Government Regulation,* ARLC Conference Papers, London School of Economics (2001).

O Black, *Conceptual Foundations of Antitrust*, Cambridge University Press (2005).

H Bok, *Baron de Montesquieu, Charles-Louis de Secondat*, The Stanford Encyclopedia of Philosophy (2003).

C Booth and D Squires, *The Negligence Liability of Public Authorities*, Oxford University Press (2006).

S Bonham, Department of Education/ ESRI 2006 *Report on Perinatal Statistics* for 2003 (2006), Department of Education.

J Bourke and S Roper, *In with the new: the determinants of prescribing innovation by general practitioners in Ireland,* 13 European Journal of Health Economics (2012) 393.

J R Bowblis and J A Lucas, *The Impact of state regulations on nursing home care practices*, 42 Journal of Regulatory Economics (2012) 42.

M Boylan, *Medical Negligence Litigation Challenges for the Plaintiff's Lawyers*, in *Medical Negligence Litigation: Emerging Issues*, (eds.) C Craven & W Binchy, First Law (2008).

C Bradley, *Judicial Review* RoundHall Limited (2000).

D D Bradlow, *The Reform of the Governance of the IFIs, A Critical Assessment*, in *International Financial Institutions and Global Legal Governance* (eds.) H Cisse, D D Bradlow B Kingsbury, The World Bank, Geneva (2012).

J Braithwaite and D Biles, *Empirical Verification and Black's The Behavior of Law*, 45 American Sociological Review 334 (1980).

M Brazier and J Miola *Bye bye Bolam, a Medical Litigation Revolution?* 8 Medical Law Review 85 (2000).

E Brody, *Institutional Dissonance in the Non-profit sector* 41 Villanova Law Review 433 (1996).

CV Browne, *Women, feminism, and aging*, New York, NY: Springer (1998).

S Buckler, *Medical Malpractice Law-Loss of Chance: Recovery for the Lost Opportunity of Survival - Matsuyama v Birnbaum 890 N.E.2d 819 (Mass. 2008)* 5 Journal of Health & Biomedical Law 117 (2009).

T Buergenthal, *The World Bank and Human Rights*, in E B Weiss, A R Sureda, and L Boisson de Chazournes (eds), *The World Bank, International Financial*

Institutions and the Development of International Law, Washington DC (1999).

R Byrne and W Binchy, *Annual Review of Irish Law* Roundhall Press (1995).

R Byrne and W Binchy, *Annual Review of Irish Law* Roundhall Press (1997).

R Byrne and W Binchy, *Annual Review of Irish Law* Roundhall Press (2007).

R Byrne and W Binchy, *Annual Review of Irish Law* Roundhall Press (2008).

R Byrne and W Binchy, *Annual Review of Irish Law* Roundhall Press (2009).

R Byrne and W Binchy, *Annual Review of Irish Law* Roundhall Press (2010).

P Cane (ed), Atiyah's *Accidents, Compensation and the Law*, London: Butterworths (6th Ed.) (1999).

V Carstairs and R Morris, *Deprivation and Health in Scotland,* Aberdeen University Press (1991).

J Casey, *Constitutional Law in Ireland* (3rd Ed.) RoundHall (2000).

G Casey, *Are There Unenumerated Rights In The Irish Constitution?* 23 Irish Law Times (2005).

E Carolan, *The Problems of Corporate Privacy*, 32 Dublin University Law Journal 51 (2010).

J L Cernic, *Two Steps Forward, One Step Back: The 2010 Report by the UN Special Representative on Business and Human Rights*, 11 German Law Journal 1264 (2010).

D Chalmers, A Tomkins, *European Union Public Law,* Cambridge University Press (2007).

D Chalmers, *European Union Public Law,* Cambridge University Press (2010).

A Chapman, *The Right to Health: Conceptualising a Minimum Core Content*, Working Paper for the Day of General Discussion on the Right to Health, CESCR, 9th session UN Doc E/C.12/1993/WP (1993).

A R Chapman, *A "violations approach" for monitoring the International Covenant on Economic, Social and Cultural Rights*, 18 Human Rights Quarterly 23 (1996).

M P Chitti, *The EC Notion of Public Administration: The Case of the Bodies Governed by Public Law*, 8 European Public Law 473 (2002).

W Chuan-feng, *Raising the Right to Health Concerns within the Framework of International Intellectual Property Law*, 5 Asian Journal, WTO & International Health Law & Policy 143 (2010).

A Clapham, *Non State Actors under International Law*, Oxford University Press (2008).

P A Clark and S B Gesell, *Using Patient Evaluations to Empirically Assess Medicaid Programs for Social Justice,* 25 Social Work in Public Health 486 (2010).

A Clarke, *The Sociology of Healthcare*, Longman (2010).

D M Clarke, *Interpreting the Constitution: Essentially Contested Concepts*; in *The Irish Constitution, Governance and Values*, E Carolan & O Doyle (Eds) in *The Irish Constitution, Governance and Values*, Thomson Roundhall (2008).

D Coffey, G Whyte *Natural Law and the Irish Constitution* 14 Irish Law Times 8 (1996).

D Coffey, *Article 28.3.3. The Natural Law and the Judiciary – Three Easy Pieces*, 20 Irish Law Times (2004).

G Coffey, *Administrative Law* (2nd Ed.) Round Hall, Dublin (2010).

E Collins & B Sheehan, *Access to Health Services for Transsexual People*, Nexus Research, Equality Authority (2004).

N Collins, *End of Life in ICU Care of the dying or Pulling the Plug*? 4 Irish Medical Journal 112 (2006).

J C Cooper, W E Kov, *Behavioral economics: implications for regulatory behavior*, 41 Journal of Regulatory Economics (2012) 41.

C Copeland and K Snyder, *Barriers to Mental Health Treatment Services for Low-Income African American Women Whose Children Receive Behavioral Health Services: An Ethnographic Investigation,* 26 Social Work in Public Health 78 (2011).

Commission on Social Determinants of Health, *Note by the Secretariat*, World Health Organization, Geneva (2005).

Commission on Social Determinants of Health, *Closing the gap in a generation, Health equity through action on the social determinants of health*, (Final Report) Geneva, World Health Organization (2008).

Commission on Patient Safety and Quality Assurance, *Building a Culture of Patient Safety*, Department of Health, Government Publications (2008).

Commission *Strategy for the effective implementation of the Charter of Fundamental Rights by the European Union,* COM (2010) 573 (2010).

Committee on Economic, Social and Cultural Rights, *Guidelines on Treaty-Specific Documents to be submitted by States Parties under Articles 16 and 17 of the International Covenant on Economic, Social and Cultural Rights*, Note by the Secretary-General, Committee on Economic, Social and Cultural Rights, E/C.12/2008/2 (2009).

P Connell, *Detaining Swine Flu Sufferers post S v Health Service Executive* 27 Irish Law Times 204 (2009).

N Connery and D Hodnett, *Regulatory Law in Ireland,* Tottel Publishing (2009).

C Copeland and K Snyder, *Barriers to Mental Health Treatment Services for Low-Income African American Women Whose Children Receive Behavioral Health Services: An Ethnographic Investigation,* 26 Social Work in Public Health 78 (2011).

D Costello, *Natural Law, the Constitution and the Courts*, in Lynch and Meenan eds, *Essays in Memory of Alexis Fitzgerald,* The Incorporated Law Society of Ireland 105 (1987).

Council of Europe, *Digest of the Case Law of the European Committee of Social Rights*, Strasbourg (2008).

Council of the World Federation of Societies of Intensive and Critical Care Medicine, *Ethical Guidelines, Declaration of the Council of the World Federation of Societies of Intensive and Critical Care Medicine* 2 Intensive and Critical Care Digest (1992).

P Countryman, *International Trade and World Health Policy: Helping People Reach Their Full Potential*, 21 Pace International Law Review 241 (2009).

N Cox, *Suing Hospitals and Health Boards*, in Medical Negligence Litigation: Emerging Issues, (eds.) C Craven & W Binchy, First Law 81 (2008).

C Craven, *Medical Negligence: The Dunne Principles and their Application*, in *Medical Negligence Litigation: Emerging Issues*, (eds.) C Craven & W Binchy, First Law (2008).

M Craven, The *International Covenant on Economic, Social and Cultural Rights, A Perspective on its Development*, Clarendon Press, Oxford (1995).

M Craven, *The Justiciability of Economic, Social and Cultural Rights*, in R Burchill, D J Harris and A Owers (eds.), *Economic, Social and Cultural Rights: Their implementation in United Kingdom Law*, Nottingham, University of Nottingham Human Rights Law Centre (1999).

P Craig, G De Búrca, *EU Law, Text, Cases and Materials*, (4th Ed.) Oxford University Press (2008).

P de Cruz, *Comparative Healthcare Law* Cavendish Publishing (2001).

C Curtis, *A Modern Supreme Court in a Modern World*, 4 Vanderbilt Law Review 427 (1951).

M Dabbah & P Lasok, *Merger Control Worldwide*, Cambridge University Press (Eds. Dabbah & Lasok) (2005).

E Daly, *Public philosophy and constitutional interpretation after natural law: republican horizons*, Conference on The Irish Constitution: Past, Present and Future, University College Dublin 1 (June 2012).

E Dannin, *Red Tape or Accountability: Privatization, Publicization, and Public Values*, 15 Cornell Journal of Law and Public Policy 111 (2005-2006).

P M Danzon, *The Swedish Patient Compensation System: Lessons for the United States*, 15 Journal of Legal Medicine 199 (1994).

G Davidson, B Kelly, G Macdonald, A Martin, M Rizzo, O Abogunrin and L Lombard, *Universal Health Insurance systems and the provision of health services for people with disabilities,* A National Disability Authority Working Paper, Dublin (2012).

R Davis, *Liability in Damages for a Breach of Community Law: Some Reflection on the Question of Who to Sue and the Concept of "the State"* 31 European Law Review 69 (2006).

C Davis, C*onjoined twins as persons that can be victims of homicide*, 19 Medical Law Review 430 (2011).

H Delany, *Judicial Review of Administrative Action* (2nd Ed.) Roundhall (2009).

Department of Health and Children, *Quality and Fairness: A Health System for You. Health Strategy*, Department of Health, Dublin, (2001).

Department of Health, *The Road to Enterprise Liability*, Department of Health, Dublin (2001).

Department of Health and Children, *Growing Up In Ireland, Review of the Literature Pertaining to the First Wave of Data Collection with the Child Cohort at 9 Years*; Office of the Minister for Children and Youth Affairs (2006).

Department of Health and Children's report *Resource Allocation, Financing and Sustainability in Health Care: Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector* (Volume II) (2010).

Department of Health, *Key Trends,* Department of Health, Dublin (2010).

Department of Health, *Health In Ireland, Key Trends*, Department of Health (2012).

D Dewes, D Duff, and M Trebilcock, *Exploring the Domain of Accident Law* Oxford University Press (1996).

M Devaney, *A Comparative Assessment of Personal Injuries Compensation Schemes: Lessons for Tort Reform* 13 Electronic Journal of Comparative Law (2009).

Albert V Dicey: *An Introduction to the Study of the Law of the Constitution* (1885).

J Dickson, *Directives in EU Legal Systems: Whose Norms Are They Anyway?* 17 European Law Journal 190 (2011).

P Didier, *WTO Trade Instruments in EU Law*, Cameron (1999).

B Dillon & P Butler *Facing the Challenge, The Impact of Recession and Unemployment on Men's Health in Ireland* (Eds. O Metcalfe & N Cotter), Institute of Public Health in Ireland (2011).

M Dixon and R McCorquodale, *Cases & Materials on International Law* (4th Ed.) Oxford University Press (2003).

C Donnelly, *Delegation of Governmental Power to Private Parties*, Oxford University Press (2007).

C Donnelly, *Remedies in Public Procurement in Ireland*, 18 Public Procurement Law Review 18 (2009).

C Donnelly, *Positive Obligations and Privatisation*, 61 Northern Ireland Legal Quarterly 209 (2010).

B Doolan, *Constitutional Law and Constitutional Rights in Ireland* (3rd ed.) (Gill & Macmillan, Dublin (1994).

P Doorley, *Health Status* in *A Healthier Future, Managing Health Care in Ireland* (eds.) E McAuliffe and L Joyce, Institute of Public Affairs (1998).

O Doyle, *Legal Validity: Reflections on the Irish Constitution* 25 Dublin University Law Journal 56 (2003).

O Doyle, *Constitutional Equality Law*, Round Hall, Dublin (2004).

O Doyle, *Constitutional law: Text, Cases and Materials* Dublin: Clarus Press (2008).

O Doyle, *Legal Positivism, Natural Law and the Constitution*, 31 Dublin University Law Journal 206 (2009).

R Dworkin, *Taking Rights Seriously*, Cambridge, MA: Harvard University Press, 1977, *The Philosophy of Law*, Oxford Readings in Philosophy, New York: Duckworth Oxford University Press (1977).

R Dworkin, *No Right Answer* in *Law, Morality and Society*, (eds.) P M S Hacker and J Raz, *Essays in Honour of H L A Hart* Clarendon Press 58 (1977).

R Dworkin, *A Matter of Principle* in *Legal principles and the Limits of Law, Dworkin and Contemporary Jurisprudence*, J Raz (ed.) Duckworth, Harvard Univ Press 73 (1985).

R Dworkin, *Law's Empire*. Cambridge, MA: Harvard University Press (1986).

R Dworkin, *Sovereign Virtue: The Theory and Practice of Equality*. Cambridge, MA: Harvard University Press (2000).

B Easton, *The Historical Context Of The Woodhouse Commission*, 34 Victoria University of Wellington Law Review 207 (2003).

J T Eberl, E D Kinney, M J Williams, *Foundation For A Natural Right To Health Care,* 36 Journal of Medicine and Philosophy 537 (2012).

L Edelstein, *The Hippocratic Oath: Text. Translation. and Interpretation*, Supplements to the Bulletin of the History of Medicine No. 1 Baltimore: Johns Hopkins University Press (1943).

Editorial, *Organ Transplantation and the Proposed Directive on Cross Border Care* 17 European Journal of Health Law 1 (2010).

D Ehlermann, '*The Contribution of EC Competition Policy to the Single Market* 29 Common Market Law Review 257 (1992).

C Eisgruber, *Constitutional Self-Government*, Cambridge, Harvard University Press, Chapter 1 (2001).

V S Elizabeth, *Distributive Justice-Poverty And Economic Development,* 28 Penn State International Law Review 463 (2009-2010).

C Elliott & F Quinn, *Tort Law* (8th Ed.), Longman (2011).

Equality Authority, *Annual Report* (2010).

S Esserman and R Howse, *The WTO on Trial,* Global Law, Global Politics, 82 Foreign Affair 130 (2003).

D C Esty and D Geradin, *Regulatory Co-opetition*, Journal of International Economic Law (2000) 235.

European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, *Report to the Government of Ireland on the visit to Ireland carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)* from 20 to 28 May 2002 CPT/Inf Strasbourg (2003).

European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, *Report to the Government of Ireland on the visit to Ireland carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)* from 2 to 13 October 2006 CPT/Inf Strasbourg (2007).

European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, *Report to the Government of Ireland on the visit to Ireland carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 25 January to 5 February 2010*, CPT/Inf Strasbourg (2011).

A den Exter, Health *System Reforms in The Netherlands: From Public to Private and its Effects on Equal Access to Health Care*, 17 European Journal of Health Law 233 (2010).

L Fallowfield and A Fleissig Cancer, *Communication With Patients In The Context Of Medical Error*, Research UK, Psychosocial Oncology Group Brighton & Sussex Medical School University of Sussex, National Patient Safety Agency (2003).

C Farrell, H McAvoy, J Wilde and Combat Poverty Agency, *Tackling Health Inequalities An All-Ireland Approach to Social Determinants* (2009).

M Farrell, *Recent Developments in Human Rights and Judicial Review, The Role of the European Convention on Human Rights Act, 2003*, Free Legal Advice Centres, Dublin (2009).

O Fauchald and J Stigen, *Corporate Responsiblity Before International Institutions*, 40 The George Washington International Law Review 1096 (2009).

D Feenan, *Death, Dying and the Law*, 14 Irish Law Times 90 (1996).

B Feldthusen, *Economic Negligence: The Recovery of Pure Economic Loss,* (5th ed.) Toronto: Thomson Carswell (2008).

Fifth (Shipman Inquiry) Report *Safeguarding Patients: Lessons from the Past - Proposals for the Future*, Command Paper Cm 6394 Crown Copyright (2004).

T Finegan, *Conceptual Foundations of the Universal Declaration of Human Rights: Human Rights, Human Dignity and* Personhood, 37 Australian Journal of Legal Philosophy 182 (2012).

T Finlay, *The Constitution of Ireland in a Changing Society*, in Curtin & O'Keefe (eds.), *Constitutional Adjudication in European Community and National Law: essays for the Hon. Mr. Justice T.F. O'Higgins*, Dublin: Butterworths (1992).

J M Finnis, *Bland: Crossing the Rubicon*, 109 Law Quarterly Review 329 (1993).

MP Fisher & C Elnitsky, *Health and Social Services Integration: A Review of Concepts and Models*, 27 Social Work in Public Health, 441 (2012).

G Fleming, *The Law of Torts* (9th ed.), The Law Book Company Ltd (1998).

C Flood, B Thomas, *Blurring of the Public/ Private Divide: The Canadian Chapter*, 17 European Journal of Health Law 257 (2010).

B Foley, *Concepts of the Judicial Power over the past 75 Years* Conference on "The Irish Constitution: Past, Present and Future", University College Dublin (June 2012).

M Forde, *Constitutional Law* (2nd Ed.) First Law (2004).

J Freeman, *The Contracting State*, 28 Florida State University Law Review 155 (2000-2001).

J Freeman *Annual Regulation of Business Focus: Privatization, Public Parties, Public Functions and the New Administrative Law*: 52 Administrative Law Review 813 (2000).

J Freeman, *Extending Public Law Norms Through Privatization*, 116 Harvard Law Review 1285 (2002-2003).

Fundamental Rights and Private Law in the European Union Vol, 1: A *Comparative Overview*, Eds G Bruggemeier, A C Ciacchi, G Comandé, Cambridge University Press (2010).

L Gable and L O Gostin, *Mental Health as a Human Right*, in Swiss Human Rights Book Vol. 3, Realizing *The Right To Health*, Andrew Clapham & Mary Robinson, Geneva (2009).

A Gannon, *Defence Strategies in Medical Negligence Litigation*, Medical Negligence Litigation Conference, Royal Marine Hotel, Dun Laoghaire, Dublin (September 2012).

W Gekiere, R Baeten and W Palm, *Free movement of services in the EU and health care,* in *Health Systems Governance in Europe, The Role of European*

Union Law and Policy (Eds E. Mossialos, G Permanand, R Beaten and T Hervey, Cambridge University Press (2010).

W Gellhorn, *Medical Malpractice Litigation (U.S.)- Medical Mishap Compensation (N.Z.)*, 73 Cornell Law Review 170 (1988).

W van Genugten, P Hunt & S Mathews *Tilburg Guiding Principles on World Bank, IMF and Human Rights*, in *World Bank, IMF and Human Rights*, Nijmegen: Wolf Legal Publishers 247 (2003).

B Ghazim, *The IMF, The World Bank Group And The Question Of Human Rights* (2005).

F Gianviti, *Economic, Social and Cultural Rights and the International Monetary Fund*, Paper presented to a meeting organized by the UN Committee on Economic Social and Cultural Rights (2001).

M Gibbons, M Manandhar, C Gleeson and J Mullan, *Recognising LGB Sexual Identities in Health Services, The Experiences of Lesbian, Gay and Bisexual People with Health Services in North West Ireland,* Equality Research Series, Equality Authority, Health Service Executive (2007).

D G Glance, *A systems approach to accepted standards of care: Shifting the blame*, 4 Australasian Medical Journal 490 (2011).

J Goldberg, A Sebok, B Zipursky, *Tort law: responsibilities and redress*, Austin : Wolters Kluwer Law & Business/Aspen Publishers (2008).

J Goldberg, B Zipursky, *Torts, the Oxford Introduction to US Law*, Oxford University Press (2010).

M-J Del Vecchio Good, *American Medicine, The Quest for Competence*, University of California Press (1988).

T Goodman, *Is there a Right to Health?* 30 Journal of Medicine and Philosophy 640 (2005).

F P Grad, *Medical Malpractice and the Crisis of Insurance Availability: The Waning Options*, 36 Case Western Reserve Law Review 1058 (1986).

O S Gray, Symposium - Future Prospects for Compensation Systems – Introduction, 52 Maryland Law Review 893 (1993).

S Green, *Coherence of Medical Negligence Cases A Game of Doctors and Purses*, 14 Medical Law Review 3 (2006).

Guidance on Contracting for Services in the Light of the Human Rights Act 1998, United Kingdom, Office of the Deputy Prime Minister (2005).

Guide to Professional Conduct and Ethics for Registered Medical Practitioners, Medical Council of Ireland (2009).

J Gumbis, V Bacianskaite, J Randakeviciute, *Human Rights Today*, Faculty of Law, Vilnius University, Mykolas Romeris University 131 (2010).

A Gutmann, *For and Against Equal Access to Health Care*, Millbank Memorial Fund Quarterly/ Health and Society 59(4) (1981) in Classical Works in Medical Ethics, Gregory Pence (Ed.) McGraw Hill: Boston 367 (1998).

D Guttman, *Public Purpose and Private Service: The Twentieth Century Culture of Contracting Out and the Evolving Law of Diffused Sovereignty*, 52 Administrative Law Review 859 (2000).

S Haack, *Proving Causation: The Holism of Warrant and the Atomism of Daubert* 4 Journal of Health & Biomedical Law 253 (2008).

S Halliday, *Legislating To Give Effect To Precedent Autonomy: Comparative Reflections on Legislative Incompetence*, 11 Medical Law International, 127 (2011).

F A Von Hayek, *The Road to Serfdom* 106 University of Chicago Press 2007 (1944) (1976 Ed.).

N A Hamid, L Daly, P Fitzpatrick, *All Ireland Traveller Health Study, Our Geels,* School of Public Health, Physiotherapy and Population Science, University College Dublin (ed.) C Kelleher, Department of Health (2010).

R Hanly, *Hospital-Acquired Infection: The Challenges for the Law of Negligence* 32 Dublin University Law Journal 69 (2010).

R Hanski and M Scheinin, *Leading Cases of the Human Rights Committee*, (2nd ed. revised) Institute for Human Rights, Åbo Akademi University (2007).

S H E Harmona, N Sethib, *Preserving Life and Facilitating Death: What Role for Government after Haas v. Switzerland?* 18 European Journal of Health Law 357 (2011).

D Harris, M Maclean, H Genn, *Compensation and Support for Illness and Injury*, Oxford: Clarendon Press (1984).

D Harris, *Cases and Materials on International Law* (7th Ed.), Sweet and Maxwell (2010).

D J Harris, M O'Boyle & C Warbrick, *Law of the European Convention on Human Rights* (2nd Edition) Oxford University Press (2009).

M Hartlev, *Diversity and Harmonisation, Trends and Challenges in European Health Law*, 17 European Journal of Health Law 46 (2010).

Harvard Medical Practice Study, *Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation and Patient Compensation in New York*, Harvard Medical Practice Study, Cambridge, MA (1990).

M Hassar, *Social Determinants of Institution Building*, International Association of National Public Health Institutions (2011).

V Hatzopoloulos, *Public Procurement and state aid in national health care systems,* in *Health Systems Governance in Europe, The Role of European Union Law and Policy* (eds.) E Mossialos, G Permanand, R Beaten and T Hervey, Cambridge University Press 379 (2010).

Health Insurance Authority, *Policy Paper Risk Equalisation in the Private Health Insurance Market in Ireland,* Health Insurance Authority (2002).

Health Insurance Authority, *Private Health Insurance, My Rights, My Choices*, Health Insurance Authority (2008).

Health Insurance Authority, *Updated Guide to the Risk Equalisation Scheme, 2003 as prescribed in Statutory Instruments No. 261 of 2003, No. 710 of 2003, No. 334 of 2005 and No. 220 of 2007,* Health Insurance Authority (2010).

Health Insurance Authority, *Report to the Minister for Health and Children on Risk Equalisation in the Irish Private Health Insurance Market*, Health Insurance Authority (2010).

Health Insurance Authority, *Annual Report and Accounts* (2011).

Health Insurance Authority, *Annual Report* (2012).

Health Service Executive, *National Shared Services Primary Care Reimbursement Scheme,* Health Service Executive (2006).

J Healy, *Medical Malpractice Law* Roundhall Press (2009).

L Heffernan, *Expert Evidence in Medical Negligence Litigation*" in Medical Negligence Litigation: Emerging Issues, (eds C Craven & W Binchy) First Law 102 (2008).

L Heffernan and M Coen, *The Reliability of Expert Evidence: Reflections on the Law Commission's Proposals for Reform*, 73 Journal of Criminal Law 488 (2009).

T Hervey, *We Don't See a Connection: The 'Right to Health' in the EU Charter and European Social Charter*, in *Social Rights in Europe*, G de Búrca, B de Witte (eds.), Oxford University Press 315 (2005).

T Hervey and B Vanhercke, *Health Care and the EU: the law and policy patchwork*, in *Health Systems Governance in Europe, The Role of the European Union Law and Policy*, (eds. E Mossialos, G Permanand, R Baeten and T Hervey) Cambridge University Press 89 (2010).

R F V Heuston, *Personal Rights under the Irish Constitution*, 11 Irish Jurist 205 (1976).

C Higgins, T Lavin, O Metcalfe, *Health Impacts of Education, a review*, Institute of Public Health in Ireland (2008).

G Hogan, *Unenumerated Personal Rights: Ryan's Case Re-evaluated*" 25-27 Irish Jurist 95 (1990-92).

G Hogan, *Directive Principles, Socio-Economic Rights and the Constitution*, 36 Irish Jurist 174 (2001).

G Hogan and D Morgan, *Administrative Law in Ireland* (4th Ed.) (2010).

J Holahan, *Health status and the cost of expanding insurance coverage*, 20 Health Affairs 279 (2001).

N Hoppe, *Editorial - On the Europeanization of Health Law*, 17 European Journal of Health Law 327 (2010).

A V Horwitz, *Toward a New Science of Sociology: A Retrospective Evaluation of The Behavior of Law*, 31 Contemporary Sociology 668 (2002).

E Howard, *EU Equality Law: Three Recent Developments,* 17 European Law Journal 787 (2011).

B Howell, *Medical Misadventure and Accident Compensation in New Zealand: An Incentives-Based Analysis* 35 Victoria University of Wellington Law Review 857 (2004).

R Humphreys, *Constitutional Interpretation* 15 Dublin University Law Journal 57 (1993).

R Humphreys, *Interpreting Natural Rights*, 28-30 Irish Jurist 221 (1993-1995).

P Hunt, & G MacNaughton, *Impact Assessments, Poverty and Human Rights: A Case Study Using the Right to the Highest Attainable Standard of Health,* UNESCO (2006).

P Hunt, *Mental Disability and the Right to Health*, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Geneva, Economic and Social Council, Commission on Human Rights (2005).

P Hunt, *A human rights-based approach to health indicators*, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Geneva, Economic and Social Council, Commission on Human Rights (2006).

P Hunt, *Report of the United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, Geneva, Economic and Social Council, Commission on Human Rights (2008).

P Hunt and G Backman *Health Systems and the Right to the Highest Attainable Standard of Health*, in Gostin in Swiss Human Rights Book Vol. 3, *Realizing The Right To Health*, Andrew Clapham & Mary Robinson, Geneva (2009).

Institute of Public Health in Ireland, *Briefing Paper on Health Inequalities for Elected Members of Local Government*, Dublin (2010).

International Commission of Jurists, *Report of the Expert Panel on Corporate Complicity in international Crimes* Geneva (2008).

International Federation of Health and Human Rights Organisations, *Our right to the highest attainable standard of health*, Human Rights Centre, University of Essex (2006).

International Labor Organization, *Tripartite Declaration of Principles Concerning Multinational Enterprises and Social Policy* (4th Ed.) (2006).

Irish Commission for Justice and Peace, *Re-righting the Constitution: The case for new social and economic rights: housing, health, nutrition, adequate standard of living* Genprint, Dublin (1998).

Irish Human Rights Commission, *Making Economic, Social and Cultural Rights Effective*" (2005).

Irish Human Rights Commission, *Report on the Human Rights Issues Arising from the Operation of a Residential and Day Care Centre for Persons with a Severe to Profound Intellectual Disability* (2010).

E Jackson, *Introduction to Bioethics* (Chapter 1), *Medical Law, Text, Cases and Materials* (2nd Ed.) Oxford University Press (2010).

N Jagers, *UN Guiding Principles On Business And Human Rights: Making Headway Towards Real Corporate Accountability?* 29 Netherlands Quarterly Human Rights 159 (2011).

C Jochnick, *Confronting the Impunity of Non-State Actors: New Fields for the Promotion of Human Rights*, 21 Human Rights Quarterly 56 (1999).

L Johnson, *Defining Public Health*, R Martyn, & L Johnson (Eds), *Law and the Public Dimension of Health*, London: Cavendish Publishing Limited (2001).

Joint Committee on Human Rights (UK), *The Meaning of Public Authority under the Human Rights Act Ninth Report of Session 2006-07*, Stationary Office, London (2007).

G Jones, *The Law of Restitution*, (5th Ed.) London: Sweet and Maxwell (1998).

M A Jones, *Informed consent and other fairy stories* 7 Medical Law Review 103 (1999).

M A Jones, *Medical Negligence* (2nd Ed.) Sweet & Maxwell (1996).

M A Jones, *Medical Negligence* (4th Ed.) Sweet & Maxwell (2008).

S Joseph, J Schultz & M Castan, *The International Covenant on Civil and Political Rights, Cases, Materials and Commentaries* (2nd Ed.) (2005).

C Kaczor, *The Tragic Case of Jodie and Mary: Questions about Separating Conjoined Twins*, Linacre Quarterly 159 (2003).

J Katz, *The Silent World of Doctor and Patient* New York, The John Hopkins University Press (1922) Foreword A M Capron (2002).

A Kavanagh, *Defending Deference in Public Law and Constitutional Theory*, 126 Law Quarterly Review 222 (2010).

J Kelly, *Fundamental Rights in Irish Law and Constitution* (2nd ed.), Dublin (1967).

J Kelly, *Fundamental Rights in Irish Law and Constitution* (4th ed.), Tottel Publishing (Hogan and Whyte) (2003).

E Keane, *Public Interest Litigation: Socio-Economic Rights And National Law*, 26 Irish Law Times 62 (2008).

P J Keenan, *The Future of the Guiding Principles*, in *Challenges for Corporate Lawyers Advising Clients on Human Rights,* ASIL Proceedings (2011).

I Kennedy, *Treat Me Right: Essays in Medical Law and Ethics*, Clarendon Press: Oxford, (1998).

J Kenny, *The Advantages of a Written Constitution Incorporating a Bill of Rights*, 30 Northern Ireland Legal Quarterly Autumn 189 (1979).

S Khilnani, *The Constitution and Individual Rights: A Comment on Dr Abhishek Singhvi's India's Constitution and Individual Rights: Diverse Perspectives*, 41 George Washington International Law Review 361 (2009).

U Kilkelly, *ECHR and Irish Law,* Jordan (2004).

J Kim, B Yang, T Lee & E Kang, *A Causality Between Health and Poverty: An Empirical Analysis and Policy Implications in the Korean Society*, 25 Social Work in Public Health, 210 (2010).

D Kinley and R Chambers, *The UN Human Rights Norms for Corporations: The Private Implications of Public International Law*, Human Rights Law Review, 6 447 (2006), in *Human Rights and Corporations*, The International Library of Essays on rights, D Kinley (Ed.) Ashgate Publishing (2009).

E D Kinney & B A Clark, *Provisions for Health and Health Care in the Constitutions of the Countries of the World*, 37 Cornell International Law Journal 285 (2004).

A Kirk, *Corporations and human rights: Two key developments*, 33 South African Yearbook of International Law (2008).

E Kirrane, *Human Rights And The Irish Constitution And In The European Convention On Human Rights – A Comparative Study*, 21 Irish Law Times 7 (2003).

R Klein, *Competence, professional self regulation, and the public interest*, 316 British Medical Journal 1740 (1998).

W A Kronmiller, *A Necessary Compromise: the Right to Forego Artificial Nutrition and Hydration Under Maryland's Life-sustaining Procedures Act*, 47 Maryland Law Review 1188 (2012).

A Kur and M Levin, *Intellectual Property Rights in a Fair World System, Proposals for Reform of TRIPS*, (Eds. Kur & Levin) Edward Elgar, Cheltenham UK, Nothmpton MA, USA (2011).

M Laffoy, *Human Rights Protection: The Role of the Irish Constitution* (2012) at 14, Paper at the 10th Annual Human Rights Conference of the Law Society of Ireland and the Irish Human Rights Commission, *Promoting and Protecting Human Rights in Ireland, The Role of the Irish Constitution and European Law*.

J T Lang in *Private Law Aspects of the Irish Constitution*, 6 Irish Jurist 237 (1971).

D Langwallner, *Separation of Powers, Judicial Deference and the Failure to Protect the Rights of the Individual*, in *The Irish Constitution, Governance and Values*, E Carolan & O Doyle (Eds) in *The Irish Constitution, Governance and Values*, Thompson Roundhall 258 (2008).

G Laurie and K Hunter, *Mapping, Assessing and Improving Legal Preparedness for Pandemic Flu in the United Kingdom,* 10 Medical Law International (2009).

Law Reform Commission, *Personal Injuries: Periodic Payments and Structures Settlements* (1996).

Law Reform Commission, *Bioethics: Advance Care Directives*, Law Reform Commission LRC 94 59 (2009).

Law Reform Commission of Victoria, New South Wales Law Reform Commission and Australian Law Reform Commission Joint report, *Informed Decisions About Medical Procedures,* Law Reform Commission of Victoria (Report 24); New South Wales Law Reform Commission (Report 62) and Australian Law Reform Commission (Report 50) (1989).

J Lear, E Mossialos and B Karl *EU Competition Law and Health Policy,* in *Health Systems Governance in Europe, The Role of European Union Law and Policy* (eds.) E Mossialos, G Permanand, R Beaten and T Hervey, Cambridge University Press 337 (2010).

T Leivo, *Against Whom May The Direct Effect of EC Directives Be Relied Upon*? 6 The Finnish Yearbook of International Law 564 (1995).

D Leon and G Walt, (Ed), *Poverty, Inequality and Health, an international perspective*, Oxford University Press, Chap 1 Poverty, Inequality and Health, an international perspective, a divided world? (2001).

D Lennon, *The introduction of Periodic Payment Orders in Ireland:What are the Implications,* Medical Negligence Litigation Conference, Royal Marine Hotel, Dun Laoghaire, Dublin (September 2012).

A Lester and S. Joseph, *Obligations of Non-Discrimination, in The International Covenant on Civil and Political Rights and United Kingdom Law*, (eds.) D Harris and S Joseph, Oxford (1995).

E Levinas, *Entre nous,* (2nd Ed. transl M B Smith and B Harshav) London Continuum (2006).

R Lewis, *Insurers and Personal Injury Litigation: Acknowledging the Elephant in the Living Room* Journal of Public Interest Litigation Issue 1 (2005).

J Locke, *Two Treatises of Government*, (Ed. P Laslett) Cambridge University Press (1988).

J M Luce, *Making Decisions About the Forgoing of Life-sustaining Therapy*, 156 American Journal of Respiratory and Critical Care Medicine 1715 (1997).

B Lucas and K O'Donnell *Conjoined Twins: the cutting edge*, [2002] 5 Web JCLI.

J T Macher and J W Mayo, *The World of Regulatory Influence*, 41 Journal of Regulatory Economics (2012) 59 .

C McCrudden and H Kountouros, *Human Rights and European Equality Law*, in *Equality Law in an Enlarged European Union, Understanding the Article 13 Directives*, H Meenan (ed), Cambridge University Press (2007).

M McKee, E Mossialos, P Belcher, *The influence of European law on national health policy*, in *Pluralism, Public Choice and the State in the Emerging Paradigm in Health Systems*, Dov Chernichovsky, Chapter 42 UK: Routledge, 308 (2005).

R Mares, *Defining The Limits Of Corporate Responsibilities Against the Concept of Legal Positive Obligations*, 40 George Washington International Law Review 1157 (2009).

A McBeth, *Breaching the Vacuum: A Consideration of the Role of International Human Rights Law in the Operations of the International Financial Institutions*, 10 International Journal of Human Rights 285 (2006).

A McBeth, *A Right By Any Other Name: The Evasive Engagement Of International Financial Institutions With Human Rights*, 40 George Washington International Law Review 656 (2009).

C McCrudden, *Human Dignity and Judicial Interpretation of Human Rights* 19 European Journal of International Law 655 (2008).

R McCorquodale, *Non-state actors and international human rights law*, in Research Handbook on International Human Rights Law, (eds.) S Joseph and A McBeth, E Elgar 107 (2010).

M Darrow, *Between Light And Shadow: The World Bank, The International Monetary Fund and International Human Rights Law,* Oxford: Hart Publishing (2003).

J McHale, *Fundamental rights and health care,* in *Health Systems Governance in Europe, The Role of European Union Law and Policy* (Eds E. Mossialos, G. Permanand, R. Beaten and T Hervey, Cambridge University Press 282 (2010).

D McCluskey (ed.), *Health Policy and Practice in Ireland,* University College Dublin Press (2006).

B M McCrystal, *The various human rights in healthcare*, 25 Marquette University Law School Human Rights, Issue 4 (1998).

P McLoone, *Carstairs Scores for Scottish Postcode Sectors from the 1991 Census,* Public Health Research Unit, University of Glasgow (2000).

SS Martin, J Trask, T Peterson, BC Martin, J Baldwin and M Knapp, *Influence of Culture and Discrimination on Care-Seeking Behavior of Elderly African Americans: A Qualitative Study,* 25 Social Work in Public Health 311 (2010).

T MacDonald, *Health, Human Rights and the United Nations, inconsistent aims and inherent contraditictions?* Radcliffe Publishing Oxford, New York (2008).

D McGoldrick, *The Human Rights Committee, Its Role in the Development of the International Covenant on Civil and Political Rights*, Clarendon Press Oxford (1994).

C McHugh *Socio-Economic Rights in Ireland: Lessons to be Learned from South Africa and India*, 3 Hibernian Law Journal 109 (2003).

AR Maclean, *From Sidaway to Pearce and Beyond: Is the legal regulation of consent any better following a quarter of a century of judicial scrutiny?* 20 Medical Law Review 108 (2012).

D Madden, *Medicine, Ethics and the Law* (2nd Ed.) (2009).

A Mahalatchimy, *Access to Advanced Therapy Medicinal Products in the EU: Where Do We Stand?* 18 European Journal of Health Law 305 (2011).

B McMahon and W Binchy, *Law of Torts* (3rd Ed.) Butterworths (2000).

L Malcolm and P Barnett, *Towards a More Open Culture of Safety in Managing Patient Complaints and Claims for Treatment Injury: Final Report to ACC*, Report prepared for ACC related to the reform of medical misadventure, Accident Compensation Corporation (2004).

R Mares, *Defining The Limits Of Corporate Responsibilities Against the Concept of Legal Positive Obligations*, 40 George Washington International Law Review 1157 (2009).

SS Martin, J Trask, T Peterson, BC Martin, J Baldwin and M Knapp, *Influence of Culture and Discrimination on Care-Seeking Behavior of Elderly African Americans: A Qualitative Study,* 25 Social Work in Public Health 311 (2010).

R Martyn, & L Johnson (eds.), *Law and the Public Dimension of Health* London: Cavendish Publishing Limited (2001).

C F Matherne 111, *Investigating the Relationship Between Affective Commitment and Unethical Pro-Organizational Behaviors: The Role of Moral Identity*, 9 Journal of Leadership, Accountability and Ethics (2012) at 35.

A Mehra, *Bridging Accountability Gaps – the Proliferation of Private Military and Security Companies and Ensuring Accountability for Human Rights Violations*, 22 Global Business & Development Law Journal (2010) 323.

B M Meier, *Global Health Governance and the Contentious Politics of Human Rights: Mainstreaming the Right to Health for Public Health Advancement*, 46 Stanford Journal of International Law 1 (2010).

B M Meier, *Advancing Health Rights in a Globalized World: Responding to Globalization through a Collective Human Right to Public Health*, 35 Global Health Law, Ethics, and Policy 545 (2007).

M Mello, D M Studdert, P Moran, E A Dauer, *Policy Experimentation With Administrative Compensation For Medical Injury: Issues Under State Constitutional Law*, 45 Harvard Journal on Legislation 59 (2008).

MM Mello, A Kachalia, and DM Studdert, *Administrative Compensation for Medical Injuries: Lessons from Three Foreign Systems*, Issues in International Health Policy, The Commonwealth Fund, London (2011).

S Michalowski, *Court-Authorised Caesarean Sections -The End of a Trend?* 62 Modern law Review 115 (1999).

R S Miller, *An Analysis and Critique of the 1992 Changes to New Zealand's Accident Compensation Scheme*, 52 Maryland Law Review 1070 (1993).

S Mills, *Informed Consent; Current law and outstanding issues*, Medical Negligence Litigation Conference, Royal Marine Hotel, Dun Laoghaire, Dublin (September 2012).

J Miola, *Medical Law And Medical Ethics – Complementary or Corrosive?* 6 Medical Law International 251 (2004).

P Moen, & K Chermack, *Gender disparities in health: Strategic selection, careers, and cycles of control* [Special issue II], 60 The Journal of Gerontology: Social Sciences 99 (2005).

S Moloney, *Dealing with Medical Negligence Claims: a review of options for reform*, 5 Medico-Legal Journal of Ireland, 79 (1999).

S Moloney, *Medical Misadventure: Compensation, Accountability and Regulating Standards of Practice,* 6 Medico-Legal Journal of Ireland 71 (2000).

G Moon and R Allen, *Dignity Discourse in Equality Law: A Better Route to Equality?* 6 European Human Rights Law Review 610 (2006).

S Morano-Foadi and S Andreadakis, *Reflections on the Architecture of the EU after the Treaty of Lisbon: The European Judicial Approach to Fundamental Rights*, 17 European Law Journal 595 (2011).

A Morgan, *The Belfast Agreement, a practical legal analysis*, The Belfast Press London (2000).

D G Morgan, *Constitutional Law in Ireland* (2nd Ed.) Roundhall Press (1990).

D G Morgan, *The Separation of Powers in the Irish Constitution* Sweet & Maxwell, Dublin (1997).

D G Morgan, *Administrative Law in Ireland* (3rd Ed.) (1988).

D G Morgan *A Judgement too far?: Judicial Activism and the Constitution*, Cork University Press (2001).

E H Morreim, *Cost Containment and the Standard of Medical Care* 75 California Law Review 1719 (1987).

F Morrissey, *Advance Directives in Mental Health Care: Hearing the Voice of the Mentally Ill*, 16 Medico-Legal Journal of Ireland 21 (2010).

E Mossialos and M McKee, *The Theoretical Basis and Historical Evolution of Health Policy in the European Union*, in *EU Law and the Social Character of Health Care*, P.I.E. Peter Lang (2004).

E Mossialos & M McKee, *EU Law and the Social Character of Health Care*, P.I.E. Peter Laing (2004).

E Mossialos and M McKee, *EU Competition Law and Health Care Systems*, in *EU Law and the Social Character of Health Care*, P.I.E. Peter Lang (2004).

E Mossialos and M McKee, *Voluntary Health Insurance*, in *EU Law and the Social Character of Health Care*, P.I.E. Peter Lang (2004).

E Mossialos, G Permanand, R Baeten and T Hervey, *Health Systems Governance in Europe, The Role of the European Union Law and Policy*, Cambridge University Press (2010).

B Mostaljelean, *Foreign Alternatives To The Alien Tort Claims Act: The Success (Or Is It Failure?) Of Bringing Civil Suits Against Multinational Corporations That Commit Human Rights Violations* 40 George Washington International Law Review 497 (2008).

W H A M van den Muijsenbergh and S Rezai, *Corporations and the European Convention on Human Rights* in *The Global Impact and Implementation of Human Rights Norm: Corporations and the European Convention on Human Rights*, Symposium, University of the Pacific, McGeorge School of Law, Pacific McGeorge Global Business & Development Law Journal (2012).

R Mulheron, *Principles of Medical Law* (3rd Ed.) Oxford University Press, (eds.) A Grubb, J Laing, J McHale (2010).

J Mullis, *Medical Malpractice, Social Structure, and Social Control*, 10 Sociological Forum 135 (1995).

T Murphy, *The Cat Amongst The Pigeons: Garrett Barden And Irish Natural Law Jurisprudence*, Chapter 6 in E Carolan & O Doyle (Eds) *The Irish Constitution, Governance and Values*, Thomson Roundhall (2008).

T Murphy & N Whitty, *Is Human Rights Prepared? Risk, Rights and Public Health Emergencies*, 17 Medical Law Review 210 (2009).

National Research Council, *Racial and ethnic differentials in health in late life*, Committee on Population, Division of Behavioral and Social Sciences and Education, Washington, DC: National Academies Press (2005).

LJ Nelson, *Rationing Health Care in Britain and the United States*, 7 Journal of Health & Biomedical Law 181 (2011).

P Newell, *Citizenship, accountability and community: the limits of the CSR agenda*, 81 International Affairs (2005) 541.

P Newell and J Wheeler, *Rights, resources and the politics of accountability: an introduction*, Chapter 1 (2006) Zed Books: London.

P Newell, *Taking accountability into account: the debate so far*, in Rights, Resources and the Politics of Accountability, *introduction*, Chapter 2 (2006) Zed Books: London.

P Nihoul and B D Trigg, *What is Meant by Regulation: The Roles Devoted to Markets and Authorities in Times of Crisis*, 25 Global Business & Development Law Journal 425.

M Nowak, *UN Covenant on Civil and Political Rights: CCPR Commentary,* Strasbourg: NP Engel (1993).

H Nygren-Krug *25 Questions and Answers on Health and Human Rights,* World Health Organization, Geneva, Health and Human Rights Series No. 1 15 (2002).

N Nguyen, *WTO Accession at any cost? Examining the use of WTO-Plus and WTO-Minus Obligations for Least-Developed Country Applicants*, 22 Temple International and Comparative Law Journal 243 (2008).

N O'Carroll Kelly, *General Legal risks of clinical practice and learning lessons from claims*, Medical Negligence Litigation Conference, Royal Marine Hotel, Dun Laoghaire, Dublin (September 2012).

C O'Cinneide, *Taking Horizontal Effects Seriously: Private Law, Constitutional Rights and the European Convention on Human Rights* 4 Hibernian Law Journal 77 (2003).

C O'Cinneide, *Irish Constitutional Law and Direct Horizontal Effect – A Successful Experiment?* 213, in D Oliver and J Fedke (Ed.s), *Human Rights in the Private Sphere, A Comparative Study,* Routledge-Cavendish 236 (2007).

C O'Cinneide, *The Uncertain Foundations of Contemporary Anti-Discrimination Law*, 11 International Journal of Discrimination and the Law 7 (2011).

D O'Connell, *The ECHR Act 2003: A Critical Perspective* in U Kilkelly *ECHR and Irish Law*, Jordan (2004).

R O'Connell, *Equality Before the Law to the Equal Benefit of the Law: Social and Economic Rights in the Irish Constitution*, in The Irish Constitution, Governance and Values, E Carolan & O Doyle (Eds) Thomson Roundhall 335 (2008).

Office of the UN High Commissioner for Human Rights and Joint United Nations Programme on HIV/AIDS, *International Guidelines on HIV/AIDS and Human Rights, 2006 Consolidated Version* Geneva UNAIDS and OHCHR (2006).

soiaOrganisation for Economic Co-operation and Development, *Guidelines for Multinational Enterprises,* OECD Publishing (1994).

E O'Dell and G Whyte, *Is This a Country for Old Men and Women? - In re Article 26 and the Health (Amendment) (No.2) Bill 2004*, 27 Dublin University Law Journal 368 (2005).

R O'Hanlon, *Natural Rights and the Irish Constitution* 11 Irish Law Times 8 (1993).

C Oldertz, *Security Insurance, Patient Insurance, and Pharmaceutical Insurance in Sweden*, 34 American Journal of Comparative Law 635 (1986).

S O'Leary, *Vindicating Citizens' Rights in the European Union,* IHRC & Law Society of Ireland 10th Annual Human Rights Conference, Promoting and Protecting Human Rights in Ireland, The Role of the Irish Constitution and European Law (draft paper) (October 2012).

K Oliphant, *Beyond Misadventure: Compensation for Medical Injuries in New Zealand*, 15 Medical Law Review 357 (2007).

K Oliphant, *Compensation, Ideology and Patient Safety in New Zealand's No Fault System*, 3 Opinio Juris in Comparatione 1 (2009).

C O'Mahony, *Societal Change and Constitutional Interpretation,* 1 Irish Journal of Legal Studies 71 (2010).

C O'Mahony, *Constitutional Amendment and Judicial Restraint: How Restrained should an Irish Court Be?* Conference on "The Irish Constitution: Past, Present and Future", University College Dublin (June 2012).

C O'Mahony, *Clinician's Perspective of the Medico-Legal Process*, Medical Negligence Litigation Conference, Royal Marine Hotel, Dun Laoghaire, Dublin (September 2012).

J O'Reilly, M Wiley, *The public/private mix in Irish acute public hospitals: Trends and implications,* Working Paper, The Economic and Social Research Institute, Dublin, No 218 (2007)

D Orentlicher, *Health Care Reform And The Patient-Physician Relationship* 5 Health Matrix 141 (1995).

D Orentlicher, *Health Care Law: A Field of Gaps* 19 Annals Health Law 1 (2009-2010).

M Otlowski, *Voluntary Euthanasia and the Common Law,* Oxford Univeristy Press (2000).

C Overall, *Conjonied Twins, Embodied personhood, and Surgical Separation*, in L Tessman, *Feminist Ethics and Social and Political Philosophy: Theorizing the Non-Ideal*, Springer, Dordrecht 69 (2009).

S Quinlivan and M Keys, *Official Indifference and Persistent Procrastination: An Analysis of Sinnott* 2 Judicial Studies Institute Journal 163 (2002).

P Quinn and P de Hert, *The Patients' Rights Directive (2011/24/EU) - Providing (some) rights to EU residents seeking healthcare in other Member States*, 27 Computer Law & Security Review 497 (2011).

W Palm, *The New Directive on the Application of Patients Rights in Cross-Border Care, Regional Conference on health insurance*, Sarajevo, European Observatory on Health Systems and Policies (2011).

D R Phelan, *The Concept of Social Rights* 16 Dublin University Law Journal 105 (1994).

E Palmer, *Judicial Review Socio-economic Rights and the Human Rights Act,* Hart Oxford (2007).

E Palmer, *The Liability of Functional Public Authorities for Breach of ECHR Rights: the House of Lords condones a palpable gap in human rights protection*, 18 Medical Law Review 141 (2008).

E Palmer, *Mechanisms Of Health Care Accountability, Marketisation And The Elusive State*, 11 Medical Law International 69 (2011).

G Palmer, *Compensation for Incapacity: a Study of Law and Social Change in New Zealand and Australia,* Oxford University Press 258 (1979).

G Palmer, *New Zealand's Accident Compensation Scheme: 20 Years on* 44 University Toronto Law Journal 223 (1994).

S Palmer, *Public, Private and the Human Rights Act 1998: An Ideological Divide* 66 Cambridge Law Journal 559 (2007).

JJ Paris, EH Cassem, G William, FE Reardon, *Use of a DNR Order Over Family Objections: The Case of Gilgunn v MGH* 14 Journal of Intensive Care Medicine 41 (1999).

C Paul, *Internal and external morality of medicine: lessons from New Zealand,* 38 British Medical Journal 320 (2000).

G Permanand and E Vos, *EU Regulatory Agencies and health protection*, in *Health Systems Governance in Europe, The Role of the European Union Law and Policy*, (eds. E Mossialos, G Permanand, R Baeten and T Hervey) Cambridge University Press 134 (2010).

J Phillips, A Firth, Introduction to Intellectual Property Law (4th Ed). Butterworths (2003).

N Pires de Carvalho, *The Trips Regime of Patent Rights*, (3rd Ed). Wolters Kluwer (2010).

T Prosser, *EU competition law and public services,* in *Health Systems Governance in Europe, The Role of European Union Law and Policy* (Eds E Mossialos, G Permanand, R Beaten and T Hervey, Cambridge University Press 315 (2010).

M Perry, *The Constitution in the Courts: Law or Politics?* Oxford University Press (1994).

D Phelan and B Kinirons, *Withdrawal of Futile Interventions in Intensive Care - an Everyday Ethical/Critical Care Issue*, 2 Medico-Legal Journal of Ireland 49 (1996).

R Plowden, *The Socioeconomic Burden of Hospital Acquired Infection* 5 Euro Surveillance 49 (2000).

S Plowden and H Volpe, *Fairchild and Barker in MRSA cases: Do Fairchild and Barker Provide an Argument for the Relaxation of Causation Principles in Claims for Hospital-Acquired MRSA*? 3 Journal of Personal Injury in Law 259 (2006).

S W Pottier, *Life insurer efficiency and State regulation: evidence of optimal firm behavior* 39 Journal of Regulatory Economics (2011) 169.

H Potts, *Accountability and the Right to the Highest Attainable Standard of Health*, Human Rights Centre, University of Essex (2008).

O Rabinovich-Einy, *See You Out of Court? The Role of ADR in Healthcare*, Foreward, Law and Contemporary Problems Summer, Duke University 1 (2011).

B Rajagopal, *Crossing the Rubicon; Synthesizing the Soft International Law of the IMF and Human Rights*, 11 Boston University International Law Journal 81 (1993).

S Rao, *India And Euthanasia: The Poignant Case Of Aruna Shanbaug*, 19 Medical Law Review 646 (2011).

S Rather, *Corporations and Human Rights: A Theory of Legal Responsibility*, Yale Law Journal Vol 111 at 443 in *Human Rights and Corporations*, The International Library of Essays on rights, D. Kinley (ed.) Ashgate Publishing 245 (2009).

J Raz, *The Authority of Law* (2nd Ed.) Oxford University Press (1990).

J Raz, *Authority, Law and Morality*, in J Raz, *Ethics in the Public Domain; Essays in the Morality of Law and Politic,* Oxford University Press 1010 (1994).

J Rehman, *International Human Rights Law* (2nd Ed.) Harlow: Pearson Education Limited (2010).

Report of the Constitutional Review Group, Dublin, Stationery Office (1996).

S Reid, *Product Liability & Medical Negligence*, Medical Negligence Litigation Conference, Royal Marine Hotel, Dun Laoghaire, Dublin, (September 2012).

Restatement (Second) of Torts No 302 (US) (1965).

E Riedel, *The Human Right to Health, Conceptual Foundations*, in Swiss Human Rights Book Vol. 3, *Realizing The Right To Health*, (eds.) A Clapham & M Robinson, Geneva 26 (2009).

P Roberts, *Policy to Protection: the Role of Human Nature and System Nature in Preventing Patient Injury* 35 Victoria University of Wellington Law Review 829 (2004).

A Robertson, *Constraints on Policy-Based Reasoning in Private Law* in Robertson and Tang (eds), *The Goals of Private Law* (2009).

W V H Rogers, *Winfield and Jolowicz on Tort* (17th ed.) Sweet & Maxwell (2006).

A Roos, F T Schut, *Spillover effects of supplementary on basic health insurance: evidence from the Netherlands*, 13 European Journal of Health Economist (2012) 51.

D Rowland, A Salganicoff & P Keenan, *The key to the door: Medicaid's role in improving health care for women and children*, 20 Annual Review of Public Health 403 (1999).

Royal Commission of Civil Liability and Compensation for Personal Injury (Pearson Commission) (1978).

Royal Commission of Inquiry into Compensation for Personal Injury, *Compensation for Personal Injury in New Zealand* (1967).

R Ryan & D Ryan, *A Lost Cause? Causation In Negligence Cases: Recent Irish Developments - Part 1* 24 Irish Law Times 91 (2006).

R Ryan and D Ryan, *Damage in negligence: getting the gist?* 1 Quarterly Review of Tort Law 20 (2006).

R Ryan and D Ryan, *Asbestos Litigation and the Requirements of the Negligence Action: New Developments in Irish and English Law* 2 Quarterly Review of Tort Law 10 (2007).

R Ryan and D Ryan, *Recent Judicial Approaches to "Loss of Chance"* in *Medical Negligence Cases*, in Medical Negligence Litigation: Emerging Issues, (eds C Craven & W Binchy) First Law 24 (2008).

R Ryan, *The future of medical negligence and claims management*, Medical Negligence Litigation Conference, Royal Marine Hotel, Dun Laoghaire, Dublin, (September 2012).

R M Sade, *Foundational Ethics of the Health Care System: The Moral and Practical Superiority of Free Market Reforms*, 33 Journal of Medicine and Philosophy 461 (2008).

D Sao, A Gupta, D Gantz, *Examining the risks affecting investors and consumers in health services abroad*, in *Healthcare Disputes Across National Boundaries: The Potential For Arbitration*, 42 George Washington International Law Review 475 (2010).

D E M Sappington and D L Weisman, *Regulating regulators in transitionally competitive markets*, 41 Journal of Regulatory Economics (2012) 19.

F Scharpf, *The European social model: coping with the challenges of diversity*, 40 Journal of Common Market Studies 645 (2002).

J H Scheid *Some Statutory Responses to the American Medical Malpractice Crisis*, in *Medical Negligence Litigation: Emerging Issues*, (eds C Craven & W Binchy) First Law (2008).

M Schmidt, *The Complementarity of the Covenant and the European Convention on Human Rights – Recent Developments, in The International Covenant on Civil and Political Rights and United Kingdom Law*, ed. by D Harris and S Joseph, Oxford, (1995).

M Schultz, *Questioning the Questionnaire: The Unheard Message from Scandinavian Tort Law* Stockholm Institute for Scandianvian Law 289 (2010).

O De Schutter, *The Accountability of Multinationals for Human Rights Violations in European Law*, in *Non-State Actors and Human Rights*, P Alston (Ed.), Oxford University Press 227 (2005).

C Scott, *The Interdependence and Permeability of Human Rights Norms: Towards a Partial Fusion of the International Covenants on Human Rights* 27 Osgoode Hall Law Journal 769 (1989).

C Scott, *Private Regulation of the Public Sector: A Neglected Facet of Contemporary Governance*, 29 Journal of Law and Society 56 (2002).

R Scott, *The Pregnant Woman and the Good Samaritan: Can a Woman have a Duty to Undergo a Caesarean Section?* 20 Oxford Journal of Legal Studies 407 (2000).

Secretariat of the European Social Charter, *The Right to Health and the European Social Charter, Information document prepared by the secretariat of the ESC,* Council of Europe (2009).

Selected Legislation and Jurisprudence, 18 European Journal of Health Law (2011).

D Shaw, *A Direct Advance on Advance Directives* 26 Bioethics 267 (2012).

S Sherwin *A Relational Approach to Autonomy in Healthcare* in Sherwin (ed.) *The Politics of Women's Health: Exploring Agency and Autonomy,* Temple UP: Philadelphia (1998).

N Sifuna, *Public Regulation of the use of Private Land: Opportunities and challenges in Kenya*, 5 Law, Environment and Development Journal (2008) 38.

A Simanowitz, *Accountability* in *Medical Accidents*: (eds.) Vincent, Ennis, Audley 209 Oxford University Press (1993).

D Singh, *Informed vs Valid Consent: Legislation and Responsibilities*, 5 Indian Journal of Neurotrauma 105 (2008).

A Singh-Manoux and M Marmot, *Role of socialization in explaining social inequalities in health,* 60 Social Science & Medicine 2129 (2005).

A Singhvi, *India's Constitution and Individual Rights: Diverse Perspectives,* 41 George Washington International Law Review 327 (2009).

B Sjafjell, *Internalizing Externalities In E.U Law: Why Neither Corporate Social Responsibility Provides The Answers* 40 The George Washington International Law Review 977 (2009).

S Skogly, *The Human Rights Obligations of the World Bank and the International Monetary Fund,* Cavendish Publishing Ltd London (2001).

F A Sloan and C R Hsieh, *Variability in medical malpractice payments: Is the compensation fair?* 24 Law and Society Review 997 (1990).

J V Smith II, *Defence Strategies in Medical Negligence* Litigation, *The New Approaches*, in *Medical Negligence Litigation: Emerging Issues*, (eds C Craven & W Binchy) First Law, 214 (2008).

R G Smith, *Medical Discipline,* Oxford: Clarendon Press (1994).

M Smith, *Developing Administrative Principles in the EU: A Foundational Model of Legitimacy?* 18 European Law Journal (2012).

S D Smith *Natural Law and Contemporary Moral Thought: A Guide from the Perplexed,* 42 American Journal of Jurisprudence 299 (1997).

L Snowden, *Bias in mental health assessment and intervention: Theory and evidence,* 93 American Journal of Public Health 239 (2003).

I Solanke, *Stop the ECJ'?: An Empirical Analysis of Activism at the Court,* 17 European Law Journal 764 (2011).

M Ssenyonjo, *Economic, Social and Cultural Rights in International Law*, Oxford and Portland Oregon: Hart Publishing (2009).

J Stapleton, *Duty of Care Factors: a Selection from the Judicial Menus* in P Cane and J Stapleton (eds.), *The Law of Obligations: Essays in Celebration of John Fleming,* Oxford: Clarendon Press (1998).

F van Steenbergen, O Bamaga and A Al-Weshali, *Groundwater Security in Yemen: Who is accountable to whom?* 7 Law, Environment and Development Journal (2011) 164.

H J Steiner, P Alston, R Goodman *International Human Rights in Context, Law Politics Morals* (3rd Ed.) Oxford University Press, 108 (2008).

R Stevens, *Torts and Rights*, Oxford University Press (2007).

L Snowden, *Bias in mental health assessment and intervention: Theory and evidence,* 93 American Journal of Public Health, 239 (2003).

M Stone, *On the Idea of Private Law*, in *Tort Law* (E J Weinrib Ed.), 2nd Series, The International Library of Essays in Law & Legal Theory, Ashgate Dartmouth 235 (2002).

R Strand, *Exploring the Role of Leadership in Corporate Social Responsibility: A Review*, 8 Journal of Leadership, Accountability and Ethics (2011) 85.

D M Studdert, E J Thomas, B I W Zbar, J P Newhouse, P C Weiler, J Bayuk and T A Brennan, *Can the United States Afford A "No-Fault" System of Compensation for Medical Injury?* 60 Law and Contemporary Problems 1 (1997).

S Subedi, *Protection of Human Rights through the Mechanism of UN Special Rapporteurs*, 33 Human Rights Quarterly 201 (2011).

H Sullivan, *Privatization of Public Services: A Growing Threat to Constitutional Rights*, 47 Public Administration Review 461 (1987).

K Sutherland S Leatherman, *Regulation and quality improvement: A review of the evidence,* The Health Foundation, London (2006).

K Syrett, *Mixing Private and Public Treatment in the UK's National Health Service: A Challenge to Core Constitutional Principles*? 17 European Journal of Health Law 235 (2010).

F Tang, JG Heo and M Weissman, *Racial Differences in Social Engagement and Health Status Among Older Women*, 26 Social Work in Public Health 110 (2011).

LD Tataw, S Bazargan-Hejazi, F W James, *Actualizing a Provider Alliance to Expand Health Services Access to a Low-Income Urban Community,* 26 Social Work in Public Health 651 (2008).

E Tarimo, *Towards a Healthy District. Organizing and Managing District Health Systems Based on Primary Health Care*, World Health Organization (1991).

M J Taylor, *Health Research, Data Protection, and the Public Interest in Notification*, 19 Medical Law Review 267 (2011).

S Taylor, *Clinical Negligence Reform: Lessons from France?* 52 The International and Comparative Law Quarterly 737 (2003).

R Thompson, A Ramasastry and M Taylor, *Translating UNOCAL: The Expanding Web Of Liability For Business Entities Implicated In International Crimes*, 40 The George Washington International Law Review 841 (2009).

S Thompson and E Mossialos, *Private health insurance and the internal market,* in *Health Systems Governance in Europe, The Role of European Union Law and Policy* (eds. E Mossialos, G Permanand, R Beaten and T Hervey), Cambridge University Press 419 (2010).

B Toebes, *BCA, The Right to Health as a Human Right in International Law*, Antwerp: Intersentia/ Hart (1999).

B Toebes, *The Right to Health, in Economic, Social and Cultural Rights, A Textbook* (2nd (Revised Ed.) Martinus Nijhoff Publishers (eds. A Eide, C Krause and A Rosas) (2001).

B Toebes, *The Impact of Acts of Corruption on the Enjoyment of the Right to Health*, Research Paper for the International Council on Human Rights Policy, Project: Corruption and Human Rights, Research consultant: Aberdeen, Scotland, UK (2007).

B Toebes and M San Giorgi, *Dutch realities: evaluating the Dutch health care reform from a human rights perspective* (draft chapter) in *The right to health: a multi-country study of law, policy and practice* (Eds B Toebes, R Ferguson, M Markovic and O Nnamuchi), TMC Asser Press/Springer (due 2014).

Transparency International, *2006 Corruption Perceptions Index.*

G Turner, *The Role of Tort Law in the Medical Context*, Institute of Comparative Law, McGill Univserity Montreal (1991).

G Turton, *A Case for Clarity in Causation? Bailey v Ministry of Defence and Another*, 17 Medical Law Review 142 (2009).

A Twomey, *The Death of Natural Law,* 13 Irish Law Times 270 (1995).

P Twoomey, *Human Rights Based Approaches to Development*, in B Mashood and R McCorquodale (eds.) *Economic Social and Cultural Rights in Action*, Oxford University Press (2007).

Y Tyagi, *The United Nations Human Rights Committee, Practice and Procedure*, Cambridge University Press (2011).

U.S. Congress, Office of Technical Assessment, *Defensive Medicine & Medical Malpractice,* Washington, DC, U.S. Government Printing Office (1994).

J Usman, *Non-Justiciable Directive Principles: A Constitutional Design Defect* 15 Michican State Journal of International Law 643 (2007).

B De Villiers, *Directive Principles of State Policy and Fundamental Rights: The Indian Experience,* 8 South African Journal on Human Rights 29 (1992).
J Waldron, *A Right-Based Critique of Constitutional Rights,* 13 Oxford Journal of Legal Studies 18 (1993).

J Waldron, *Kant's Legal Positivism*, 109 Harvard Law Review 1535 (1996).

B Walsh, *The Judicial Power, Justice and the Constitution of Ireland* in Curtin and O'Keefe eds, *Constitutional Adjudication in European Community and National Law: Essays for the Hon Mr Justice T F O'Higgins* Butterworths 145 (1992).

J Watson and P Ovseiko, *Health Care Systems, Major Themes in Health and Social Welfare* UK: Routledge, Introduction to Volume 1 (2005).

P C Weiler, *Medical Malpractice On Trial*, Harvard University Press (1991).

P C Weiler, *A Measure Of Malpractice*, 52 Maryland Law Review 908 (1993).

E J Weinrib, *Corrective Justice,* 77 Iowa Law Review 403 (1992).

E J Weinrib, *The Gains and Losses of Corrective Justice,* 44 Duke Law Journal 277 (1994).

E J Weinrib, *Correlativity, Personality, and the Emerging Consensus on Corrective Justice,* 2 Theoretical Inquiries in Law 107 (2001).

E J Weinrib, *Introduction* (E J Weinrib Ed.), 2nd Series, The International Library of Essays in Law & Legal Theory, Ashgate Dartmouth (2002).

R Weitz, *The Sociology of Health, Illness and Health Care, a Critical Approach* (3rd Ed.) Wadsworth (2004).

L Weiwei, *Equality and Non-Discrimination Under International Human Rights Law*, Norwegian Centre for Human Rights, Oslo (2004).

D H Wenkel, *Separation of Conjoined Twins and the Principle of Double Effect*, 12 Christian Bioethics 291 (2006).

P Whipple and P Havers on *Radcliffe and the res ipsa loquitur doctrine* in *Breach of Duty, Principles of Medical Law* (3rd Ed.) Oxford University Press, Eds. A Grubb, J Laing, J McHale, 249 (2010).

G Whyte, *Natural Law and the Constitution* 14 Irish Law Times 8 (1996).

G Whyte, *The Right to Die and the Irish Constitution*, 2 European Public Law 235 (1997).

G Whyte, *Social Inclusion and the Legal System: Public Interest Law in Ireland,* Institute of Public Administration (2002).

G Whyte, *Socio-Economic Rights in Ireland: Judicial and Non-Judicial Enforcement,* paper presented at the Irish Human Rights Commission Conference on Economic, Social and Cultural Rights (2005).

G Whyte, *Case Notes and Recent Developments – A Tale Of Two Cases – Divergent Approaches Of The Irish Supreme Court To Distributive Justice*, 32 Dublin University Law Journal 365 (2010).

H Wilberg, *Defensive Practice or Conflict of Duties? Policy Concerns in Public Authority Negligence Claims* 126 Law Quarterly Review 420 (2010).

R Wilkinson, *The impact of inequality: how to make sick societies healthier*, London Routledge (2005).

K Williams, *Medical Samaritans: Is There A Duty To Treat*? 21 Oxford Journal of Legal Studies 393 (2001).

Lord Woolf MR, *Access to Justice Final Report, Final Report to the Lord Chancellor on the civil justice system in England and Wales* (1996).

Lord Woolf *Are the courts excessively deferential to the Medical profession?* 9 Medical Law Review 1 (2001).

World Health Assembly, *Climate change and health,* Sixty First World Health Assembly meeting report WHO (2008).

World Health Assembly, *Climate change and health,* Report by the Secretariat, Sixty Second World Health Assembly (2008).

World Health Assembly, *Reducing health inequities through action on the social determinants*, Sixty-second World Health Assembly (2008).

World Health Organization, *Health Care Systems in Transition*, European Observatory on Health Care Systems, WHO Regional Office for Europe (2002).

World Health Organization and World Trade Organization, *Agreements and Public Health: A joint study by the WHO and the WTO Secretariat,* Geneva (2002).

World Health Organization, *Definitions and Debates for Health and Trade Policy Makers: A Glossary of 103 Health and Globalization Terms* (unpublished document, available on request from Globalization, Trade and Health (GTH/ETH/SDE), World Health Organization, 1211 Geneva, 27 (2002).

World Health Organization, *International Migration, Health & Human Rights*, Health and Human Rights Publication Series Issue No. 4, World Health Organization, Geneva (2003).

World Health Organization, *Consultation on Indicators for the Right to Health*, Château de Penthes, Health and Human Rights, Department of Ethics, Trade, Human Rights and Health Law, Sustainable Development and Healthy Environments, World Health Organization, Geneva (2004).

World Health Organization, *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes*, World Health Organization, Geneva (2007).

World Health Organization, *Women's health and human rights: Monitoring the implementation of CEDAW,* World Health Organization, Department of Reproductive Health and Research, Geneva (2007).

The World Health Organization, *The new Dutch health insurance scheme: challenges and opportunities for better performance in health financing*, Discussion Paper No 3, World Health Organization (2007).

World Health Organization, *Health in Asia and the Pacific*, Geneva, World Health Organization, Geneva (2008).

World Health Organization, Office of the High Commissioner for Human Rights, *The Right to Health,* Fact Sheet No 31 Geneva (2008).

World Health Organization, *World Health Report, Health Systems Financing, The path to universal coverage*, World Health Organization, Geneva (2010).

U Wynhoven, *The Protect-Respect-Remedy Framework and the United Nations Global Compact*, 9 Santa Clara Journal of International Law 81 (2011).

B Zipursky, *Civil Recourse, Not Corrective Justice*, 91 Georgetown Law Journal 695 (2003).