

Irregular migrants and restrictions on access to state-funded
HIV/AIDS treatment in the United Kingdom: a critical evaluation
of the right to health care with particular focus on the
jurisprudence of the European Court of Human Rights.

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August 2013

Word count: 19,392

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Acknowledgements

The author extends heartfelt appreciation to the following individuals for their kind support: Dr. Kathleen Cavanaugh of the Irish Centre for Human Rights, NUI Galway, whose expertise and patient guidance were exceedingly beneficial while conducting the groundwork for this dissertation; Caroline Chappell, senior law lecturer at the University of Chester for an inspiring discussion on HIV/AIDS policy in the United Kingdom; Chantal Davies, senior law lecturer at the University of Chester for awakening my interest in HIV/AIDS and human rights while still an undergraduate student; and last but not least my partner Pamela Konso for her unfailing support in addition to keeping me consistently nourished over the past weeks. Thanks are due to all involved at the Irish Centre for Human Rights, NUI Galway for a most enriching year. A sincere debt of gratitude is owed to the numerous authors whose work enhanced my own understanding of the interplay between migration and HIV/AIDS in the United Kingdom and European human rights law. As always, it is a profitable indulgence to engage with the works of like-minded individuals, and to be challenged by dissenters. And lastly to the grace of God, through which success was assured from the very beginning, and by which all of the above was made possible, thank you.

I, David Hand, do hereby declare that this work that is submitted for assessment is my own and that due credit has been given to all sources of information contained therein according to the rules that govern the Irish Centre for Human Rights and the Faculty of Law. I acknowledge that I have read and understood the Code of Practise dealing with Plagiarism and the University Code of Conduct of the National University of Ireland, Galway and that I am bound by them.

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1. Background: the global AIDS epidemic

The most up-to-date figures indicate that an estimated 34 million people are living with the human immuno-deficiency virus (HIV) worldwide, with 2.5 million new infectees from 2010.¹ The virus, which if left untreated results in acquired immunodeficiency syndrome (AIDS), disproportionately affects certain regions of the world. Indeed the overwhelming majority of HIV/AIDS sufferers are found in sub-Saharan Africa which accounts for almost two thirds of all infectees.² Despite considerable progress in facilitating access to treatment from previous years, still only around 8 million sufferers worldwide have access to essential *antiretroviral therapy*³ required to curb the onset of AIDS in an infected individual.⁴

Over the years significant advancements in Western medicine have yielded an abundance of highly effective antiretroviral drugs minimising the threat of AIDS in economically developed regions where it is now considered a thoroughly manageable condition rather than a fatal disease. Conversely the majority of AIDS-related deaths in developing regions are linked to inadequate treatment facilities and a lack of affordable drugs.⁵ Internationally drugs are an increasingly commodified service with the result that intellectual property rights to pharmaceutical products are aggressively enforced by their manufacturers. While antiretroviral drugs are not prohibitively expensive to produce in themselves, their relatively high cost in developing countries is frequently cited as a barrier for ordinary people requiring treatment.⁶ This has largely been attributed to resistance on the part of industrialised nations and the global pharmaceutical industry to initiatives aimed at reducing the cost of drugs to suit emerging market economies.⁷

In some developing countries a reaction to the high cost of antiretroviral drugs has been concerted efforts aimed at reducing dependency on imported medication by producing generic versions of the

¹UNAIDS – The Joint United Nations Programme on HIV/AIDS, *Global Fact Sheet – World AIDS Day 2012*, p. 1.

²U. Schüklenk and S. Philpott, “AIDS – the time for changes in law and policy is now”, *International Journal of Law in Context*, 7(3) (2011), 305-315 (p. 305).

³Antiretroviral therapy typically involves the administration of at least three antiretroviral drugs for maximum suppression of HIV. Adherence to a consistent antiretroviral regime has been shown to reduce death and suffering rates particularly where prescribed in the early stages of the illness. World Health Organization website, *Antiretroviral Therapy* (paragraph 1), available online at <http://www.who.int/hiv/topics/treatment/art/en/index.html> [Accessed 10 August 2013].

⁴UNAIDS – The Joint United Nations Programme on HIV/AIDS, *Global Fact Sheet – World AIDS Day 2012*, p. 1.

⁵U. Schüklenk and S. Philpott, “AIDS – the time for changes in law and policy is now”, *International Journal of Law in Context*, 7(3) (2011), 305-315 (p. 305).

⁶E. Cameron, “The deafening silence of AIDS”, *Health and Human Rights*, 5(1) (2000), 7-24 (p. 11).

⁷E. 't Hoen, “TRIPS, pharmaceutical patents, and access to essential medicines: a long way from Seattle to Doha”, *Chicago Journal of International Law*, 3(27) (2002), 27-46 (p. 27)

drugs.⁸ However a combination of aggravating factors, including strained financial resources and deficiencies in national health systems, often undermines the effective distribution of antiretroviral drugs. As a result a significant proportion of people suffering from HIV/AIDS in the most affected regions are cut off from facilities dispensing antiretroviral drugs.⁹

Taking the enormity of the figures on HIV/AIDS prevalence and disparities in access to treatment worldwide (see paragraph one above) into account it is understandable why it has been posited that the increased commodification of medicine globally¹⁰ has only served to broaden the rift between the proverbial North and South.¹¹ The far-reaching effects of the AIDS epidemic in developing regions, including projected morbidity and mortality rates, numbers of orphaned children, costs borne by health care services, and the impact on national economies generate figures so vast as to elude human comprehension, not to speak of encouraging an altruistic response to the problem.¹² Its predominant confinement to the most impoverished zones of the world in turn evokes a pervading state of detachment from the severity of the HIV/AIDS epidemic among Western observers.

Regions of high HIV/AIDS prevalence are typically affected by endemic poverty, social inequality and turbulent political climates, all of which contribute to the spread of HIV infection and serve as an impetus for members of victimised communities to seek asylum in other countries from persecution and human rights abuses.¹³ For many in these affected regions the perceived favourable conditions of developed economies present an attractive alternative.¹⁴ As the global HIV/AIDS epidemic rages, numbers of asylum seekers who are infected with HIV are reportedly on the increase. Those who are aware of their HIV status are known to avail of the often superior health facilities in their host countries, the same facilities being unavailable, or only available at considerable expense, in their home countries. Given the costs and commitments in terms of medical resources popularly associated with accommodating non-national patients who are infected

⁸D. Patterson and L. London, "International law, human rights and HIV/AIDS", *Bulletin of the World Health Organization*, 80(12) (2002), 964-969 (p. 966).

⁹World Health Organization, *Progress on Global Access to HIV Antiretroviral Therapy: A Report by "3 by 5" and Beyond* (Geneva: World Health Organization, 2006), pp. 9, 11 and 72.

¹⁰J. Harrington, "Migration and access to health care in English medical law: a rhetorical critique", *International Journal of Law in Context* (2008), 315-335 (p. 315).

¹¹O. Aginam, "Global village, divided world: South-North gap and global health challenges at century's dawn", *Indiana Journal of Global Legal Studies*, 4(1) (2000) 603-628 (pp. 607-608).

¹²E. Cameron, "The deafening silence of AIDS", *Health and Human Rights*, 5(1) (2000), 7-24 (p. 10).

¹³L. Cherfas, "Negotiating access and culture: organizational responses to the healthcare needs of refugees and asylum seekers living with HIV in the United Kingdom", *University of Oxford Refugees Study Centre Working Paper No. 33*, October 2006, p. 4; Dr M. Haour-Knipe, *Migration and HIV: Improving Lives in Britain. An Inquiry into the Impact of the United Kingdom Nationality and Immigration System on People Living with HIV*, July 2003 (London: All-Party Parliamentary Group on AIDS, 2003).

¹⁴J. Harrington, "Migration and access to health care in English medical law: a rhetorical critique", *International Journal of Law in Context* (2008), 315-335 (p. 315).

with HIV, it is unsurprising that this trend has been met by considerable resistance on the part of law and policy makers in developed countries.¹⁵

¹⁵J. Harrington, "Migration and access to health care in English medical law: a rhetorical critique", *International Journal of Law in Context* (2008), 315-335 (p. 315).

2. The United Kingdom National Health Service and immigration: an ailing relationship

For the United Kingdom of Great Britain and Northern Ireland the 1980s onwards have witnessed a marked increase in asylum applications with the result that foreign nationals are subject to intense scrutiny by the government, the national media, and the public in general.¹⁶ Contributing to the *melée* has been the increased presence of irregular, or so-called “illegal”, migrants in European Union states from the early 2000s.¹⁷ This latter group includes clandestine visitors, individuals in possession of falsified documents, visa overstayers, those working without a permit or in violation of their conditions of residence, as well as refused asylum seekers.¹⁸

Negative stereotypes of foreign nationals abound in the public imagination, often propagated by inflammatory articles in popular tabloids¹⁹ as well as disparaging rhetoric employed by politicians.²⁰ The typical asylum seeker for example is often portrayed as an opportunist who gains access to the country by exploiting his host's legal obligation to provide him refuge. In doing so asylum seekers are allocated state resources ordinarily reserved for citizens. These perceptions are a source of frustration for some British people, many of whom consider themselves to possess a “legitimate sense of entitlement” to key services provided by the state.²¹ In extreme cases their rights as citizens are seen to be subverted in favour of those of non-nationals.²²

Since the post-war era the United Kingdom's National Health Service (NHS) has imparted health services free of charge at the point of delivery.²³ In the European context this formed part of the wider movement of promoting the universality of democracy through consolidation of key social rights such as the right to health.²⁴ Starting with the original National Health Service Act of 1946, successive amending legislation has repeatedly evoked the duty of the Secretary of State for Health

¹⁶D. Stevens, “Asylum seekers and the right to access health care”, *Northern Ireland Legal Quarterly*, 61(4) (2010), 363-390 (p. 363-364).

¹⁷R. Romero-Ortuño, “Access to health care for illegal immigrants in the EU: should we be concerned?” *European Journal of Health Law*, 11 (2004), 245-272 (p. 245).

¹⁸S. da Lomba, “Irregular migrants and the human right to health care: a case-study of health-care provision for irregular migrants in France and the United Kingdom”, *International Journal of Law in Context*, 7(3) (2011), 357-374 (p. 357).

¹⁹I. Hargreaves, “How the newspapers nourish racial intolerance”, *New Statesman*, 24 April 2000.

²⁰Consider a 2007 article written in *The Observer* by government minister Margaret Hodge which controversially suggested that the United Kingdom “prioritise[s] the needs of an individual migrant family over the entitlement others feel they have” in M. Hodge, “A message to my fellow immigrants”, *The Observer*, 20 May 2007.

²¹The phrase in inverted commas may also be attributed to Margaret Hodge MP in “A message to my fellow immigrants”, *The Observer*, 20 May 2007.

²²D. Stevens, “Asylum seekers and the right to access health care”, *Northern Ireland Legal Quarterly*, 61(4) (2010), 363-390 (p. 364).

²³National Health Service Act 1946, chapter 81.

²⁴R. Romero-Ortuño, “Access to health care for illegal immigrants in the EU: should we be concerned?” *European Journal of Health Law*, 11 (2004), 245-272 (p. 248).

to promote a “comprehensive health service”²⁵ available to all free of charge, albeit, with the exception where “the making and recovery of charges is expressly provided for”.²⁶ For the most part the NHS model in the United Kingdom has applied irrespective of the patient's residence status.²⁷ However due to the interest generated in immigration in recent decades, the latter proviso has permitted successive governments to implement financial barriers to health services for those classed as “overseas patients”.

At the policy making level, concerns over the cost of providing services to patients not normally resident in the United Kingdom have often served as a ground for restricting access to health care for certain groups of non-residents as well as British citizens living abroad.²⁸ Crucially, section 121 of the National Health Services Act 1977 empowered the Secretary of State for Health to make and recover charges from patients who were deemed not to be “ordinarily resident” in the United Kingdom.²⁹ Although the provision was not actively enforced for a number of years,³⁰ the facts pertaining to the 1982 case of *R v. Barnet London Borough Council, ex parte Shah (Nilish)*³¹ were such that the House of Lords was required to expand upon the definition of “ordinary residence” for clarity. The case concerned five overseas students with limited leave to remain in the United Kingdom for the purpose of undertaking undergraduate studies and who, upon completion of their degree programmes, were refused applications for grants for further study by their respective local authorities.

The House of Lords determined “ordinary residence” to refer to those living *lawfully* in the United Kingdom “voluntarily and for settled purposes as part of the regular order of their life”.³² The

²⁵For example the *Health and Social Care Act 2012*, section 1(1) of which stipulates that “[t]he Secretary of State must continue the promotion in England of a comprehensive health service designed to secure improvement (a) in the physical and mental health of the people of England, and (b) in the prevention, diagnosis and treatment of physical and mental illness.

²⁶See section 1(4) of the *Health and Social Care Act 2012*: “The services provided as part of the health service in England must be free of charge except in so far as the making and recovery of charges is expressly provided for by or under any enactment, whenever passed.”

²⁷D. Stevens, “Asylum seekers and the right to access health care”, *Northern Ireland Legal Quarterly*, 61(4) (2010), 363-390 (p. 364).

²⁸J. Pobjoy and S. Spencer, “Equality for all? The relationship between immigration status and the allocation of rights in the United Kingdom”, *European Human Rights Law Review*, 2 (2012), 160-175 (p. 168).

²⁹National Health Service Act 1977, section 121: “Regulations may provide for the making and recovery, in such manner as may be prescribed, of such charges as the Secretary of State may determine (a) in respect of such services provided under this Act as may be prescribed, being (b) services provided in respect of such persons not ordinarily resident in Great Britain as may be prescribed. Such regulations may provide that the charges are only to be made in such cases as may be determined in accordance with the regulations.”

³⁰D. Stevens, “Asylum seekers and the right to access health care”, *Northern Ireland Legal Quarterly*, 61(4) (2010), 363-390 (p. 365).

³¹16 December 1982; [1983] 2 Weekly Law Reports 16.

³²[1983] 2 Weekly Law Reports 16, p. 343, per Lord Scarman; Department of Health, *Review of access to the NHS by foreign nationals – Consultation on proposals*, February 2010, p. 6.

implication of the ruling was that irregular migrants, whose illegal presence in the United Kingdom excluded them from “ordinary resident” status, were eligible for recoverable charges under the 1977 Act;³³ although continuing changes made to the charging regulations generated confusion for migrants, such as asylum seekers, who were already considered to be ordinarily resident. From a legal standpoint, the burden of determining a patient's immigration status and, hence, establishing whether they are ordinarily resident in the United Kingdom rests with the NHS trust under the guidance of regulations drafted by the Department of Health.³⁴

Six years after the *Barnet* case secondary legislation was implemented in order to give effect to section 121 of the National Health Service Act 1977 Act by enshrining the House of Lords definition of “ordinary residence”.³⁵ In accordance with these developments, those who could not satisfy the criteria for ordinary residence were to be subject to recovery of statutory charges for “secondary care”,³⁶ or any treatment received in hospital;³⁷ although general practitioner services (primary care) remained free for all patients.³⁸ Non-residents who had already been present in the United Kingdom for 12 months prior to seeking treatment were exempt from charges,³⁹ and charges were not made recoverable for emergency treatment and compulsory detention under the Mental Health Act 1983.⁴⁰

The introduction of additional regulations in 2004 broadened the definition of overseas visitors with

³³S. da Lomba, “Irregular migrants and the human right to health care: a case-study of health-care provision for irregular migrants in France and the United Kingdom”, *International Journal of Law in Context*, 7(3) (2011), 357-374 (p. 365).

³⁴D. Stevens, “Asylum seekers and the right to access health care”, *Northern Ireland Legal Quarterly*, 61(4) (2010), 363-390 (p. 366).

³⁵National Health Service (Charges to Overseas Visitors) Regulations 1989, SI 1989/406

³⁶J. Pobjoy and S. Spencer, “Equality for all? The relationship between immigration status and the allocation of rights in the United Kingdom”, *European Human Rights Law Review*, 2 (2012), 160-175 (p. 168).

³⁷There are certain hospital services which are always exempt from charges regardless of the patient's circumstances, including treatment of infectious diseases (obviously with the notable exception of HIV/AIDS), compulsory psychiatric treatment, Accident and Emergency treatment and family planning services; S. da Lomba, “Irregular migrants and the human right to health care: a case-study of health-care provision for irregular migrants in France and the United Kingdom”, *International Journal of Law in Context*, 7(3) (2011), 357-374 (p. 365).

³⁸D. Stevens, “Asylum seekers and the right to access health care”, *Northern Ireland Legal Quarterly*, 61(4) (2010), 363-390 (p. 365).

³⁹National Health Service (Charges to Overseas Visitors) Regulations 1989, SI 1989/406, regulation 4: “No charge shall be made in respect of any services forming part of the health service provided for an overseas visitor . . . (b) who has resided in the United Kingdom for the period of not less than one year immediately preceding the time when the services are provided . . . or; (c) who has been accepted as a refugee in the United Kingdom, or who has made a formal application for leave to stay as a refugee in the United Kingdom . . .”.

⁴⁰National Health Service (Charges to Overseas Visitors) Regulations 1989, SI 1989/406, regulation 3: “No charge shall be made in respect of any services forming part of the health service provided for an overseas visitor – (a) at a hospital, accident and emergency department . . . unless and until he has been accepted as an in-patient at the hospital for treatment of the condition in respect of which such services are provided; or . . . (e) who is detained in a hospital, or received into guardianship, under the Mental Health Act 1983 or any other enactment authorising orders for admission to, and detention in, hospital by reason of mental disorder . . .”. See generally the Mental Health Act 1983, chapter 20.

the aim of excluding other groups of migrants, such as refused asylum seekers, from free secondary treatment.⁴¹ However the comparatively recent NHS (Charges to Overseas Visitors) Regulations 2011 clarified that statutory charges could not be recovered from those who had either been granted, or were awaiting a decision in respect of an application for temporary asylum.⁴² Nevertheless, as far as the treatment of HIV was concerned, the exemption from charges extended no further than the initial diagnostic procedure and counselling services associated with a positive test result.⁴³ Following these initial stages in HIV treatment overseas visitors were to be burdened with significant medical bills where they chose to embark on the typically prolonged course of highly active antiretroviral therapy (HAART) required to quell the effects of the virus and minimise health risks associated with the progression of the disease.⁴⁴ Arguably such measures were excessive and ultimately amounted to a “false economy” considering that costs incurred by the NHS in providing antiretroviral therapy for failed asylum seekers would be minimal when pitted against the eventual consequences of delayed action.⁴⁵

On the other hand the question of whether migrants should enjoy the same entitlements to crucial services, such as HIV treatment, as British residents is often a contentious one. Since 1989 the Department of Health has set its sights on whether asylum seekers awaiting a decision on their application, or those whose applications have already been refused, may access free health care through the NHS.⁴⁶ The issue has garnered close attention in recent years in relation to HIV treatment. In past years the British media has been notably critical of revelations that asylum seekers were undergoing expensive AIDS treatment under the sponsorship of certain NHS trusts,⁴⁷ and the ensuing controversy has called into question the entitlement of non-tax paying foreign nationals to benefit from a public funded health care system hampered by fiscal challenges in the

⁴¹National Health Service (Charges to Overseas Visitors) Charging (Amendment) Regulations 2004, SI 2004/614. These are revisited in more detail below.

⁴²The National Health Service (Charges to Overseas Visitors) Regulations 2011, SI 2011/1556, regulation 11: “No charge may be made or recovered in respect of any relevant services provided to an overseas visitor who – (a) has been granted temporary protection, asylum or humanitarian protection under the immigration rules . . . (b) has made an application, which has not yet been determined, to be granted temporary protection, asylum or humanitarian protection under those rules . . .

⁴³The National Health Service (Charges to Overseas Visitors) Regulations 2011, SI 2011/1556, regulation 6 (e): “. . . [B]ut in the case of services which relate to infection with Human Immunodeficiency Virus [no charge may be made or recovered] only to the extent that [treatment] consist of a diagnostic test for evidence of infection with the Virus and counselling associated with that test or its result” (parentheses inserted for clarity).

⁴⁴K. Taylor, “Asylum seekers, refugees, and the politics of access to health care: a United Kingdom perspective”, *British Journal of General Practice*, 59(1) (2009), 765-772 (p. 769).

⁴⁵A. Fowler, L. Collins, N. Larbalestier, R. Kulasegaram, A. de Ruiter and V. Micunovic, “HIV, HAART, and overseas visitors”, *Sexually Transmitted Infections*, 82(516) (2006) 516.

⁴⁶See The National Health Service (Charges to Overseas Visitors) Regulations 1989 SI 1989/306.

⁴⁷C. Sawyer, “Insufficiently inhuman: removal AIDS patients from the United Kingdom. N v. Secretary of State for the Home Department (Terence Higgins Trust intervening) [2003] EWCA Civ 1369”, *Journal of Social Welfare and Family Law*, 26(3) (2004), 281-288 (pp. 287-288).

present economic climate.⁴⁸ A sure catalyst to the debate has been the significant influx of foreign visitors to the United Kingdom that is characteristic of today's "global society" making it far removed from the largely homogenous Britain of 1948 when the NHS was first established.⁴⁹

⁴⁸See generally Department of Health, *Review of access to the NHS by foreign nationals – Consultation on proposals*, February 2010.

⁴⁹See the comments of Earl Howe in the House of Lords Hansard Debates, 5 March 2004, volume 658, column 958: "[W]hile the founding ideals of the NHS may not have changed since 1948, we cannot ignore the fact that the world around it has changed a very great deal. We live in a global society; and if an essential and very expensive service, which is entirely funded by the British taxpayer, is being offered and delivered to large numbers of people who do not live here, then we need to take a conscious decision: is this or is this not something we are prepared to live with?"

3. Is the NHS threatened by “health tourism”?

Continuing barriers to post-diagnostic HIV treatment for migrants exemplifies the United Kingdom government's approach to the issue of migrants and access to health care. The Department of Health's general policy on the subject is expounded in a 2010 consultation paper entitled *Review of Access to the NHS by Foreign Nationals*.⁵⁰ While the document acknowledges that situations do arise wherein foreign visitors require access to health services in the United Kingdom it retains a cautious stance on the matter. From initially recognising that the NHS holds a fundamental duty to visitors “whose life or long-term health is at immediate risk” the consultation paper goes on to assert a pressing need to protect the NHS from being treated as an “international health service”.⁵¹ Indeed it draws an explicit link between restrictions to public services and the government's wider policy on deterring irregular migration.⁵²

The consultation paper may be viewed against a backdrop of widespread concern over the prospect of free health care becoming a so-called “pull factor” enticing greater numbers of foreigners to seek asylum in the United Kingdom while depleting state health care resources in the process.⁵³ Such fears are fuelled by anecdotal reports of nationals from non-European Union states entering the United Kingdom for the sole purpose of obtaining free health care services before promptly returning to their home countries.⁵⁴ In 2004 when then Minister for Health John Hutton spoke out against the alleged practise, known as “health tourism”, he expressed “no doubt in my mind . . . that there is a significant amount of abuse going on”. When prompted to expand on the allegations Mr. Hutton admitted that it was not possible to offer figures pertaining to numbers of people coming to the United Kingdom to receive treatment through the NHS.⁵⁵

Similarly the Select Committee on Health has conceded a lack of evidence to suggest that health tourism poses a legitimate threat to the financial integrity of the NHS,⁵⁶ including where HIV/AIDS

⁵⁰J. Pobjoy and S. Spencer, “Equality for all? The relationship between immigration status and the allocation of rights in the United Kingdom”, *European Human Rights Law Review*, 2 (2012), 160-175 (p. 169).

⁵¹Department of Health, *Review of access to the NHS by foreign nationals – Consultation on proposals*, February 2010 (p. 1).

⁵²Department of Health, *Review of access to the NHS by foreign nationals – Consultation on proposals*, February 2010 (p. 3); J. Pobjoy and S. Spencer, “Equality for all? The relationship between immigration status and the allocation of rights in the United Kingdom”, *European Human Rights Law Review*, 2 (2012), 160-175 (p. 169).

⁵³D. Stevens, “Asylum seekers and the right to access health care”, *Northern Ireland Legal Quarterly*, 61(4) (2010), 363-390 (p. 369).

⁵⁴N. Kelley and J. Stevenson, *First do no harm: denying healthcare to people whose asylum claims have failed* (London: Refugee Council, 2006), p. 5.

⁵⁵BBC News, “Are health tourists draining the NHS?” 14 May 2004.

⁵⁶Secretary of State for Health, *Government response to the Health Select Committee's Third Report of Session 2004-2005 on New Developments in Sexual Health and HIV/AIDS Policy* (Norwich: Crown Copyright, 2005), p. 19.

treatment is concerned.⁵⁷ On the contrary existing data on migrants with HIV suggests that many do not attempt to seek treatment until physical symptoms are manifest, often many months after their arrival in the United Kingdom.⁵⁸ Arguably such behaviour casts doubt upon the presumption of their arriving as health tourists in the first place.⁵⁹ It is not unusual for new arrivals in the United Kingdom to be completely unaware of their HIV status, a fact born from the heavy stigma associated with the virus in some communities around the world which deters many from getting tested in the first place. In any case logic dictates that asylum seekers are far more likely to couch their applications in the intolerable circumstances that drove them to leave their home countries than in the urgent requirement of medical treatment.⁶⁰

In spite of the lack of evidence to support the perceived threat to the NHS from foreigners, the mere prospect of health tourism has sparked enough consternation in Parliament to warrant the continued tightening of restrictions for overseas visitors who require medical treatment in the United Kingdom. Addressing the House of Lords on the subject of the NHS and overseas visitors in 2004, Baroness Boothroyd tapped into the malaise shared by her peers when she remarked that “it would be a great pity if the goodwill of this nation were stretched to breaking point”.⁶¹ In essence the implementation of barriers to health services, particularly post-diagnostic HIV treatment, for prescribed categories of migrants appears firmly rooted in government apprehension towards the effects of uncontrolled immigration.

⁵⁷Health Select Committee, *Third Report of the Session 2004/5 on New Developments in Sexual Health and HIV/AIDS Policy*, at paragraph 107 states that “[d]espite John Hutton MP’s conviction that ‘there is a significant amount of abuse going on’, no evidence exists to objectively quantify the scale of abuse, either in relation to HIV or more generally”.

⁵⁸J. Erwin and B. Peters, “Treatment issues for HIV+ Africans in London”, *Social Science and Medicine*, 49(11) (1999), 1519-1528.

⁵⁹House of Commons Health Committee, *New Developments in HIV/AIDS and Sexual Health Policy – Third Report of Session 2004-05*, 8 March 2005 (Q211, p. 65).

⁶⁰V. Bettinson and A. Jones, “The future of claims to resist removal by non-nationals suffering from HIV/AIDS”, *Liverpool Law Review*, 28(2) (2007), 182-213 (pp. 184-185).

⁶¹House of Lords Hansard Debates, 5 March 2004, volume 658, column 950.

4. Immigration status and the right to the highest attainable standard of health

Having visited concerns expressed law and policy makers in the United Kingdom over the threat of “health tourism” it is fitting to explore the opposite end of the spectrum wherein lies the argument that the human right to health care is a tenet of civilised society and should apply to everyone irrespective of their residence status.⁶² From this perspective a public funded health service is crucial to the realisation of the right to health care.⁶³ Doctors traditionally take pride in the NHS and its core principles, the most fundamental of which is its endorsement of health care as a basic human right available to all patients based on clinical need rather than ability to pay for services provided.⁶⁴

That medical practitioners are expected to comply with legislation promoted as a means of discouraging certain patients from seeking treatment otherwise available to the public at large appears counterintuitive, even hinting at unethical.⁶⁵ Moreover, while equality of access to health care lies primarily in the realm of medical ethics, it has for decades resonated in international law starting with the 1948 Universal Declaration of Human Rights.⁶⁶ International human rights law recognises access to health care as an important component of the right to the *highest attainable standard of health* provided under Article 12(1) of the International Covenant on Economic, Social and Cultural Rights (ICESCR).⁶⁷

The Covenant was ratified by the United Kingdom in 1976 and, while it has not been incorporated into domestic legislation, remains a binding instrument in that jurisdiction.⁶⁸ All signatory states are

⁶²D. Stevens, “Asylum seekers and the right to access health care”, *Northern Ireland Legal Quarterly*, 61(4) (2010), 363-390 (p. 364).

⁶³S. da Lomba, “Irregular migrants and the human right to health care: a case-study of health-care provision for irregular migrants in France and the United Kingdom”, *International Journal of Law in Context*, 7(3) (2011), 357-374 (p. 357).

⁶⁴P. Hall, “Failed asylum seekers and health care: current regulations flout international law”, *British Medical Journal*, 333 (2006) 109-110 (p. 109).

⁶⁵P. Hall, “Failed asylum seekers and health care: current regulations flout international law”, *British Medical Journal*, 333 (2006) 109-110 (p. 110).

⁶⁶*The Universal Declaration of Human Rights* (Paris: 1948). Article 25(1) articulates a preliminary framework for the right to health: “Everyone has a right to a standard of living adequate for the health and well-being of himself and of his family, including . . . medical care and necessary social services . . .”

⁶⁷*International Covenant on Economic, Social and Cultural Rights* (New York: 1966), Article 12(1): “The State 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 State 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.”

⁶⁸P. Hall, “Failed asylum seekers and health care: current regulations flout international law”, *British Medical Journal*,

required to adopt “appropriate measures” (legislative, administrative and judicial) in order to fully realise the right to health.⁶⁹ Importantly the right engenders the *prevention, treatment and control of epidemic and endemic diseases* such as AIDS,⁷⁰ and has been observed by the guiding Committee on Economic, Social and Cultural Rights (CESCR) as requiring an “inclusive” interpretation.⁷¹ Thus it is expected that health facilities be made accessible to everyone without discrimination.⁷² The CESCR has addressed myriad factors which affect accessibility to health care in contracting states emphasising the importance of affordability (“economic accessibility”) where the right to health is concerned. Accordingly it is expected that state parties ensure that health services are affordable to everyone, including “socially disadvantaged groups”.⁷³

Social scientific studies have made it abundantly clear that asylum seekers and irregular migrants together make up a highly vulnerable group in society.⁷⁴ Many arrive in the United Kingdom in varying states of mental and physical health, often having departed their home countries in traumatic circumstances. Even after they have been granted leave to enter the United Kingdom many are confronted by additional challenges in the form of extreme poverty, substandard housing, social isolation and austere state support.⁷⁵ For the typical asylum seeker these circumstances are compounded by the fact that they are prohibited from seeking employment or earning a living of any kind while their application is reviewed by the Home Office.⁷⁶ Cumulatively these factors can prove detrimental to the overall physical and mental wellbeing of asylum seekers and irregular migrants. For those who are not infected with HIV their vulnerability places them at an increased risk of contracting the virus. Robust correlations have been shown between high prevalence of HIV/AIDS and social factors such as poverty and inequality. As such it disproportionately affects some of the most marginalised groups in society.⁷⁷

333 (2006) 109-110 (p. 109).

⁶⁹Committee on Economic, Social and Cultural Rights, General Comment No. 14: The Rights to the Highest Attainable Standard of Health (Art. 12) (Document E/C.12/2000/4), 11 August 2000, at paragraph 33.

⁷⁰*International Covenant on Economic, Social and Cultural Rights* (New York: 1966) (Article 12.2 c)

⁷¹Committee on Economic, Social and Cultural Rights, General Comment No. 14: The Rights to the Highest Attainable Standard of Health (Art. 12) (Document E/C.12/2000/4), 11 August 2000, at paragraph 11.

⁷²*International Covenant on Economic, Social and Cultural Rights* (New York: 1966) (Article 2.2)

⁷³Committee on Economic, Social and Cultural Rights, General Comment No. 14: The Rights to the Highest Attainable Standard of Health (Art. 12) (Document E/C.12/2000/4), 11 August 2000, at paragraph 12 (b).

⁷⁴K. Taylor, “Asylum seekers, refugees, and the politics of access to health care: a United Kingdom perspective”, *British Journal of General Practice*, 59(1) (2009), 765-772 (p. 765).

⁷⁵J. Connelly and M. Schweiger, “The health risks of the United Kingdom's new asylum act: the health of asylum seekers must be closely monitored by service providers”, *British Medical Journal*, 321(7252) (2000), 5-6 (p. 5).

⁷⁶The Asylum and Immigration Act 1996, section 8(1): “. . . [I]f any person (“the employer”) employs a person subject to immigration control (“the employee”) who has attained the age of 16, the employer shall be guilty of an offence if – (a) the employee has not been granted leave to enter or remain in the United Kingdom; or (b) the employee's leave is not valid and subsisting, or is subject to a condition precluding him from taking up the employment, and (in either case) the employee does not satisfy such conditions as may be specified in an order made by the Secretary of State.”

⁷⁷L. Cherfas, “Negotiating access and culture: organizational responses to the healthcare needs of refugees and asylum seekers living with HIV in the United Kingdom”, *University of Oxford Refugees Study Centre Working Paper No.*

For those whose applications for asylum have not been successful and all subsequent appeals exhausted (“refused” or so-called “failed asylum seekers”) the status quo is a great deal more precarious. Refused asylum seekers are often incapable of leaving the country due to statelessness, being refused appropriate travel documents from their governments, or being too sick to travel.⁷⁸ Again, allusions to health tourism and its intimations of fraud appear disingenuous in this context since that behaviour implies ability on the part of the refused asylum seeker to return to their country of origin with relative ease upon receipt of treatment.⁷⁹ Nevertheless trends in health care policy suggest that the right to health is one which is increasingly dependent upon one's legal right to remain in the country.⁸⁰

Their physical presence in the United Kingdom notwithstanding, refused asylum seekers, along with other irregular migrants, by virtue of being in disaccord with immigration laws, are identified as not belonging to the national community and are systematically cut off from the rights typically engendered by community membership.⁸¹ This rationale is heavily reflected in the approach of health care legislation towards refused asylum seekers. Given the widespread apprehension over health tourism at the time it is unsurprising that in 2004 the scope of charging regulations for overseas patients was extended to include refused asylum seekers.⁸² It is telling that the NHS (Charges to Overseas Visitors) (Amendment) Regulations 2004 were enacted as a means “to protect finite NHS resources by closing up loopholes where it has been identified that certain regulations may be open to abuse”.⁸³

It may be recalled that under the former charging system laid down in the NHS (Charging for Overseas Visitors) Regulations 1989 (as amended), foreign nationals who had been present in the United Kingdom for 12 months had been exempt from recoverable charges for secondary treatment

33, October 2006, p. 4.

⁷⁸Still Human Still Here – The campaign to end destitution of refused asylum seekers, *Information for the Committee on Economic, Social and Cultural Rights' (CESCR) review of the United Kingdom, 42nd session, 4-22 May 2009*, at paragraph 2.

⁷⁹N. Kelley and J. Stevenson, *First do no Harm: Denying Healthcare to People whose Asylum Claims have Failed* (London: Refugee Council, 2006), p. 6.

⁸⁰S. da Lomba, “Irregular migrants and the human right to health care: a case-study of health-care provision for irregular migrants in France and the United Kingdom”, *International Journal of Law in Context*, 7(3) (2011), 357-374 (p. 357).

⁸¹S. da Lomba, “Irregular migrants and the human right to health care: a case-study of health-care provision for irregular migrants in France and the United Kingdom”, *International Journal of Law in Context*, 7(3) (2011), 357-374 (pp. 357-358).

⁸²N. Kelley and J. Stevenson, *First do no Harm: Denying Healthcare to People whose Asylum Claims have Failed* (London: Refugee Council, 2006), p. 5.

⁸³Proposed Amendments to National Health Service (Charges to Overseas Visitors) Regulations 1989: A Consultation, 28 July 2003, paragraph 1 cited in N. Kelley and J. Stevenson, *First do no harm: denying healthcare to people whose asylum claims have failed* (London: Refugee Council, 2006), p. 5.

(see above).⁸⁴ Cherfas attributes the exception to a logic which, hostile as it might have been towards foreign nationals, recognised a measurable timeframe after which outsiders were deemed to “belong” in the United Kingdom. Essentially their perceived belonging formed the basis of overseas visitors' right to access free health services.⁸⁵ Nevertheless the 2004 rules shifted the focus towards an individual's *legal* right to remain in the United Kingdom as prescribed by the asylum laws.⁸⁶ As a result of these measures refused asylum seekers, a considerable proportion of whom would have already been present in the United Kingdom for more than 12 months while awaiting a decision on their applications, became ineligible for essential treatment once available to them.

As immigration policy became further embedded in health care guidelines, commentators called into question⁸⁷ the integrity of principles such as the *universality of health care* endorsed by the NHS Constitution, paragraph one of which reads:⁸⁸

The NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status. . . *It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health care and life expectancy are not keeping pace with the rest of the population* [emphasis added].

Additionally the CESCR has noted in the past that it has not identified any factors that could prevent the United Kingdom from fully implementing the provisions contained in the ICESCR.⁸⁹ While the United Kingdom for the most part enjoys a commendable reputation for its commitment to the human rights regime, it is suggested that the active enforcement of restrictions to secondary care, including drug therapy for HIV patients, for overseas patients prevents the United Kingdom from giving full effect to the right to the highest attainable standard of health.⁹⁰ Arguably the

⁸⁴National Health Service (Charges to Overseas Visitors) Regulations 1989, SI 1989/406, regulation 4 (1) (b) and (c).

⁸⁵L. Cherfas, “Negotiating access and culture: organizational responses to the healthcare needs of refugees and asylum seekers living with HIV in the United Kingdom”, *University of Oxford Refugees Study Centre Working Paper No. 33*, October 2006, p. 27.

⁸⁶NHS Wales, *Implementing the Overseas Visitors Hospital Charging Regulations – Guidance for NHS Trust Hospitals in Wales*, 31 May 2004 (Cardiff: Welsh Assembly Government, 2004), p. 25.

⁸⁷L. Cherfas, “Negotiating access and culture: organizational responses to the healthcare needs of refugees and asylum seekers living with HIV in the United Kingdom”, *University of Oxford Refugees Study Centre Working Paper No. 33*, October 2006, p. 27.

⁸⁸*The NHS Constitution – the NHS belongs to us all*, 26 March 2013 (London: Department of Health, 2013), paragraph 1, p. 3.

⁸⁹United Nations, *Concluding Observations of the Committee on Economic, Social and Cultural Rights: United Kingdom of Great Britain and Northern Ireland, United Kingdom of Great Britain and Northern Ireland – Dependant Territories*. 05/06/2002. E/C.12/1/Add.79. (Geneva: UN, 2002), at paragraph 10.

⁹⁰S. da Lomba, “Irregular migrants and the human right to health care: a case-study of health-care provision for irregular

absence of a comprehensive health care model applying indiscriminately to overseas visitors, including undocumented migrants, and the “official” population means that the United Kingdom cannot fully satisfy its obligations under Article 12 of the ICESCR.⁹¹

migrants in France and the United Kingdom”, *International Journal of Law in Context*, 7(3) (2011), 357-374 (p. 368).

⁹¹R. Romero-Ortuño, “Access to health care for illegal immigrants in the EU: should we be concerned?” *European Journal of Health Law*, 11 (2004), 245-272 (p. 266).

5. European human rights law and the right to health

It has been illustrated in the previous chapter that health care legislation in the United Kingdom, driven by the perceived threat of health tourism, has sought to restrict access to HIV treatment for those deemed “not belonging” in the country. This trend has lead commentators to conclude that the right to health care in the United Kingdom is contingent one's legal right to reside there as determined by immigration law. While this is arguably problematic insofar as the United Kingdom's commitment to observing the right to the highest attainable standard of health under Article 12 of the ICESCR is concerned, it will be shown in the present chapter that, with one notable exception, European supra-national legal mechanisms grant their supervisees a wide margin of discretion in the enforcement of domestic immigration policy and the provision of HIV/AIDS treatment to irregular migrants.

In terms of European human rights guidance the right to “equitable access to health care” is enshrined in Article 3 of the European Convention on Human Rights and Biomedicine drafted by the Council of Europe.⁹² The provision refers to health care “of an appropriate quality” where medical need has been taken into account. On the other hand the extent of the application of Article 3 is explicitly outlined as being contingent to availability of state resources.⁹³ Moreover supplementary European guidelines do not exist to delimit the scope of the right as it applies to migrants who have no legal right to remain in a Council of Europe member state. It is therefore a matter for member states and domestic laws to determine whether refused asylum seekers and other irregular migrants are entitled to access the same medical treatment as ordinary residents, as well as which types of treatment are deemed “medically necessary” for those groups. In a similar vein, there is little by way of human rights instruments to prevent a member state from expelling a HIV-positive migrant even where by doing so they are deprived of treatment completely in their home country.⁹⁴

While the European Convention on Human Rights⁹⁵ does not explicitly refer to a right to health, since coming into effect in 1953 it has been single-handedly responsible for the creation of a

⁹²*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: 1997) (Article 3). This is not to be confused with Article 3 of the *Convention for the Protection of Human Rights and Fundamental Freedoms* discussed in considerably greater detail in the subsequent paragraphs.

⁹³“Parties, taking into account health needs *and available resources*, shall take appropriate measures with a view to providing, within their jurisdiction, equitable access to health care of appropriate quality [emphasis added].”

⁹⁴V. Derckx, “Expulsion of illegal residents (aliens) with medical problems and Article 3 of the European Convention on Human Rights”, *European Journal of Health Law*, 13(4) (2006), 313-319 (p. 313).

⁹⁵*Convention for the Protection of Human Rights and Fundamental Freedoms* (Strasbourg, 1949).

remarkably elaborate jurisprudence, and several of its provisions have been used to advocate access to health care on human rights grounds, the most relevant of these being Articles 2,⁹⁶ 3,⁹⁷ 8⁹⁸ and 14.⁹⁹ Typically these provisions have been invoked in order to resist the expulsion of irregular migrants where it is anticipated that their health will deteriorate, whether as a result of the abrupt withdrawal of treatment, or due to treatment of a similar quality being unavailable or prohibitively expensive in the expellee's home country.¹⁰⁰ These are particularly relevant factors in the context of HIV/AIDS sufferers for whom cessation of antiretroviral treatment invariably leads to significant impairment of the immune system increasing the likelihood of death by opportunistic infections. Due to the inherent loss of dignity this entails for suffering individual, Article 3 has proved particularly popular as an instrument for individuals resisting removal.

The European Court of Human Rights has emphasised in past judgements that as a matter of international law, including the European Convention on Human Rights, contracting states have a prerogative to control the entry, movement and removal of aliens who are present on their territory.¹⁰¹ Moreover there is no principle under European human rights law entitling aliens who are pending removal from a contracting state to remain “in order to continue to benefit from medical, social or other forms of assistance provided by the expelling state.”¹⁰² Nevertheless the Court's jurisprudence recognises that Article 3 of the European Convention on Human Rights may apply in exceptional cases where the circumstances stemming from the unavailability of medical treatment in the applicant's home country are so extreme as to amount to *inhuman and degrading treatment*;¹⁰³ this is considered in detail in the following chapters.

⁹⁶“Everyone's right to life shall be protected by law. No one shall be deprived of his life unintentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.”

⁹⁷“No one shall be subjected to torture or to inhuman or degrading treatment or punishment.”

⁹⁸“Everyone has the right to respect for his private and family life, his home and his correspondence.”

⁹⁹“The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.”

¹⁰⁰D. Stevens, “Asylum seekers and the right to access health care”, *Northern Ireland Legal Quarterly*, 61(4) (2010), 363-390 (p. 371); V. Derckx, “Expulsion of illegal residents (aliens) with medical problems and Article 3 of the European Convention on Human Rights”, *European Journal of Health Law*, 13(4) (2006), 313-319 (p. 314).

¹⁰¹See *Chahal v. United Kingdom* (Application No. 22414/93, [1997] 23 European Human Rights Law Review 423, at [46]); *Bensaid v. United Kingdom* (Application No. 44599/98 [2001] 33 European Human Rights Law Review 10, at [32]); *Saadi v. Italy* (Application No. 37201/06 [2009] 49 European Human Rights Law Review 30, at paragraph 124).

¹⁰²*D v. United Kingdom* (Application No. 30240/96) (1997) 24 European Human Rights Law Review 423, at [54]. The case is discussed in detail below.

¹⁰³It is well-known among scholars of the European Convention on Human Rights that owing to the ruling in *Soering v. United Kingdom* (Application No. 14038/88, [1989] 11 European Human Rights Law Review 439) state responsibility under Article 3 may be incurred extraterritorially where there is a real risk of torture, inhuman or degrading treatment or punishment following an individual's removal from the territory a contracting state (paragraph 96). The right to freedom from torture, inhuman and degrading treatment or punishment is absolute (see *Ireland v. United Kingdom*, at paragraph 163) and, once engaged, applies irrespective of the applicant's conduct no matter how reprehensible (see *Chahal v. United Kingdom*, at paragraph 79).

6. The case of *D v. United Kingdom*: an exceptional obligation to provide medical care

While it has been mentioned that Article 3 of the European Convention on Human Rights may intervene to prevent the return of a patient who cannot access treatment in their home country, to date only *D v. United Kingdom*,¹⁰⁴ a case founded upon an exceptional right of access to medical treatment, has been observed to meet the threshold for inhuman and degrading set by the Court¹⁰⁵ in the context of medical *refoulement*.¹⁰⁶ It is useful to the present discussion that the applicant, an irregular migrant who was an AIDS patient, petitioned against a decision by the United Kingdom to deport him. The case of *D v. United Kingdom* concerned a national of St Kitts, D, who upon arrival at Gatwick Airport in 1993 was arrested for being found in possession of a substantial quantity of cocaine. He was denied leave to enter the United Kingdom on the grounds that his exclusion was conducive to the public good and was subsequently convicted of drug-trafficking offences. D received a six year prison sentence at H.M. Prison Wayland during which he was diagnosed with AIDS. By the time of his release on licence in 1996 he was in the advanced stages of the illness¹⁰⁷ and dependant on a charitable organisation for free accommodation and food. In addition D was undergoing counselling therapy by a trained volunteer who prepared him emotionally for death and with whom he had developed a strong rapport.¹⁰⁸

Immediately before his release on licence the immigration authorities directed that D be removed to St Kitts. His request to the Chief Immigration Officer for leave to remain in the United Kingdom on compassionate grounds was refused as was his application to the High Court for judicial review of the Home Office's decision.¹⁰⁹ A letter provided by a consultant doctor noted that D's prognosis if returned to St Kitts was "extremely poor" without access to appropriate treatment to mitigate the

¹⁰⁴(Application No. 30240/96) (1997) 24 *European Human Rights Law Review* 423.

¹⁰⁵Although the case of *BB v. France* (Application No. 30930/96, 7 September 1998), in which the applicant pending deportation was suffering from AIDS, was found by the European Commission on Human Rights to engage Article 3 of the Convention, it was resolved by friendly settlement before it could be examined by the Court.

¹⁰⁶See Article 3 of the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (New York: 1987). *Refoulement* refers to the act of "expel[ling], return[ing] . . . or extradit[ing] a person to another State where there are substantial grounds for believing that he would be in danger of being subjected to torture." The internationally recognised prohibition of *refoulement* has been incorporated into the broader wording of Article 3 of the European Convention on Human Rights (see *Soering v. United Kingdom*).

¹⁰⁷*D v. United Kingdom*, at paragraphs 7-8.

¹⁰⁸*D v. United Kingdom*, at paragraph 19.

¹⁰⁹*D v. United Kingdom* at paragraphs 11-12. Under section 4(1) of the Immigration Act 1971 the power to grant or refuse leave to enter the United Kingdom is exercised by immigration officers, whereas the Secretary of State is empowered to grant leave to remain. In *R v. Secretary of State for the Home Department, ex parte D* (15 February 1996) the Court of Appeal found that the Secretary of State had not acted unreasonably or irrationally in refusing D's application for leave to remain since an individual in D's case who had been refused leave to enter but was still physically present in the United Kingdom pending removal could not be treated as applying for leave to remain (At paragraphs 24-25).

damaging effects of opportunistic infections.¹¹⁰ A professor of immunology at a London hospital stated that the damage to D's immune system was irreparable and that the drug therapy he was receiving was now approaching the limits of its effectiveness. D's prognosis was estimated at little more than eight to twelve months on the therapy he was receiving and less than half of this if the treatment were withdrawn;¹¹¹ in essence his condition had reached a terminal stage.

In response to a request for information by the managing medical officer at H.M. Prison Wayland in 1995, the High Commission for the Eastern Caribbean States affirmed that the island of St. Kitts did not have the facilities to provide D with the medical treatment he required, said treatment being widely available in the United Kingdom.¹¹² This information was relayed to the government whose own investigation concluded that there were two hospitals in the federation of St Kitts and Nevis catering for AIDS patients until well enough to be discharged, and that AIDS sufferers on the island nation were increasingly likely to live with relatives for care.¹¹³ Nevertheless D did not have any close family in St Kitts. His mother lived in the United States and, owing to health and financial difficulties would not have been able to return to St Kitts to care for her son if he were deported. It was understood that D had no other relatives in St Kitts who would have been able to care for him.¹¹⁴

In August 1996 the Immigration and Nationality Department of the Home Office imparted policy guidelines explaining that an applicant's HIV/AIDS status could not serve as grounds for refusing leave to enter or leave to remain in the United Kingdom. On the other hand, neither could HIV/AIDS status justify clemency on the part of the Secretary of State for the Home Department where the applicant had failed to abide by the Immigration Rules.¹¹⁵ The guidelines sought to elucidate that an application for leave to enter the United Kingdom would be processed in strict accordance with the Immigration Rules irrespective of the fact that the applicant was suffering from AIDS.¹¹⁶ However paragraph 5.4 of the document conceded "strong compassionate circumstances" in which discretion outside the Immigration Rules was possible where apparent that the applicant's home country did not have available treatment facilities and that the absence of these facilities would, on evidence, lead to a significant shortening of their life expectancy.¹¹⁷

¹¹⁰*D v. United Kingdom*, at paragraph 14.

¹¹¹*D v. United Kingdom*, at paragraph 15.

¹¹²*D v. United Kingdom*, at paragraph 16.

¹¹³*D v. United Kingdom*, at paragraph 17.

¹¹⁴*D v. United Kingdom*, at paragraph 18.

¹¹⁵*D v. United Kingdom*, at paragraph 26. The "Immigration Rules" were the procedural rules laid down by the Secretary of State to give effect to the Immigration Act 1971.

¹¹⁶*D v. United Kingdom*, at paragraph 27.

¹¹⁷*D v. United Kingdom*, at paragraph 28.

In June 1996 D's application to the now-defunct European Commission on Human Rights was declared admissible. His proposed removal to St Kitts, it was claimed, would breach Articles 2, 3 and 8 of the European Convention on Human Rights, while it was further alleged that he had been denied an effective remedy in the United Kingdom to challenge his removal contrary to Article 13 of the Convention.¹¹⁸ The Commission's report, while indicating that it had found no cause to examine D's application in light of Articles 2, 8 and 13, expressed concern by a majority over a real risk of circumstances amounting to inhuman and degrading treatment in breach of Article 3.¹¹⁹ D maintained that his removal to St Kitts would confine him to living out his last remaining months in extreme poverty, isolation and squalid conditions, crippled with untreatable pain and having no access to financial or social support. His health would be significantly compromised due to unsanitary conditions on the island and local hospitals would be ill-equipped to thwart the onset of infections induced by the harsh living conditions. The combination of these factors was argued to constitute inhuman and degrading treatment within the meaning of Article 3.¹²⁰

The United Kingdom government couched a response firmly in the fact that the applicant's circumstances which allegedly gave rise to the potential violation of Article 3 would stem entirely from the nature of his illness in conjunction with deficiencies in the health care system of St Kitts and Nevis, making his plight no different from any other AIDS sufferer on the island. Furthermore, had the applicant not chosen to attempt entry to the United Kingdom in breach of drug-trafficking laws in the first place he would have been returned to St Kitts long before his health had degenerated.¹²¹ The Grand Chamber, although sympathetic to the respondent state's right to control the entry and expulsion of aliens in addition to the challenges born from restricting the passage of controlled substances through its borders, were mindful that Article 3 "enshrines one of the fundamental values of democratic societies" and thus applies irrespective of the reprehensible conduct of the applicant.¹²²

Regardless of whether the applicant had entered the United Kingdom in the legal sense as stipulated by the Immigration Act 1971, he was still physically present in the country and hence within that

¹¹⁸Article 13 states that "[e]veryone whose rights and freedoms as set forth in this Convention are violated shall have an effective remedy before a national authority notwithstanding that the violation has been committed by persons acting in an official capacity."

¹¹⁹*D v. United Kingdom*, at paragraph 37.

¹²⁰*D v. United Kingdom*, at paragraph 40.

¹²¹*D v. United Kingdom*, at paragraph 42.

¹²²*D v. United Kingdom*, at paragraphs 46-47. The Court alluded to the recent judgements of *Ahmed v. Austria*, 17 December 1996 (paragraph 38) and *Chahal v. United Kingdom*, 15 November 1996 (at paragraphs 73-74).

jurisdiction for the purpose of Article 1 of the Convention.¹²³ He was therefore assured the protection of Article 3,¹²⁴ a provision that owing to its fundamental character demanded “sufficient flexibility” to operate in situations where anticipatory inhuman or degrading treatment emanated from the effects of a naturally occurring illness as opposed to the intentional acts of state or non-state actors.¹²⁵ Thus taking into account the enriching combination of sophisticated drugs and palliative care that sustained what remained of D's life in the United Kingdom, in contrast with what awaited him in St Kitts, the Court famously concluded that the applicant, if returned, would be forced to endure “acute mental and physical suffering”.¹²⁶ The accumulation of “exceptional circumstances” unique to the applicant's dilemma, in conjunction with the critical stage in his “fatal illness” would therefore have amounted to inhuman treatment as understood by Article 3.¹²⁷

The Court added as a final caveat that aliens who are subject to expulsion cannot in principle use the European Convention on Human Rights as a vehicle through which to assert entitlement to medical assistance provided by a contracting state. Essentially the decision to uphold D's application hinged upon what the Court described in the final paragraph of its judgement on the alleged violation of Article 3 as “very exceptional circumstances” and “compelling humanitarian considerations”.¹²⁸ The urgency of these criteria suggests that the Court had little intention of again enforcing an Article 3 obligation in order to appease a medical *refoulement* claim.

¹²³“The High Contracting Parties shall ensure to *everyone within their jurisdiction* the rights and freedoms defined in Section I of this Convention” [Emphasis added].

¹²⁴*D v. United Kingdom*, at paragraph 48.

¹²⁵*D v. United Kingdom*, at paragraph 49.

¹²⁶*D v. United Kingdom*, at paragraphs 51-52.

¹²⁷*D v. United Kingdom*, at paragraph 53.

¹²⁸*D v. United Kingdom*, at paragraph 54.

7. The “N Cases”: *N v. Secretary of State for the Home Department*

While ostensibly similar to the landmark *D v. United Kingdom*, the 2005 case of *N v. Secretary of State for the Home Department*¹²⁹ can be distinguished from the former for its starkly contrasting outcome and thorough judgements delivered at first by the Court of Appeal,¹³⁰ the House of Lords and, later, by the European Court of Human Rights.¹³¹ The appellant N arrived in the United Kingdom from Uganda in March 1998¹³² under a false passport.¹³³ She applied for asylum on the grounds that she had been held captive and subjected to ill-treatment, including rape, by “rogue elements” of the National Resistance Movement in Uganda.¹³⁴ It was evident that her health was poor and within hours of her arrival N was admitted to Guy's Hospital in London where she was diagnosed HIV-positive with disseminated tuberculosis.¹³⁵ Her CD4 cell count had dwindled to a critical level of 10 (the CD4 cell count of a healthy individual is over 500) and she subsequently developed *Kaposi's sarcoma*, an aggressive form of cancer typically associated with the advanced stages of AIDS. Following a prolonged course of chemotherapy and ARV treatment N's condition stabilised so that by 2002 her CD4 count had risen to 414 and her health had improved.¹³⁶

In 1998 asylum applications were typically prolonged affairs so that it was not until April 2001 that N's claim was ultimately refused.¹³⁷ The Secretary of State for the Home Department, unconvinced by the credibility of her claim or the existence of a threat from the Ugandan authorities, directed her expulsion from the United Kingdom.¹³⁸ N unsuccessfully appealed to the Immigration Appeal Tribunal (IAT) to overturn the decision of the Secretary of State, though the adjudicator did allow her to appeal due to “overwhelming” evidence¹³⁹ that her return to Uganda would violate Article 3 of the European Convention on Human Rights as set out in Schedule 1 of the Human Rights Act

¹²⁹[2005] United Kingdom House of Lords 31.

¹³⁰*N v. Secretary of State for the Home Department (Terence Higgins Trust Intervening)* [2003] England and Wales Court of Appeal Civil Division 1369.

¹³¹*N v. United Kingdom* (Application No. 26565/05) (2008) 47 European Human Rights Law Review 39. The case is visited below.

¹³²*N v. Secretary of State for the Home Department*, at paragraph 1.

¹³³*N v. Secretary of State for the Home Department*, at paragraph 97.

¹³⁴*N v. Secretary of State for the Home Department*, at paragraph 57. The National Resistance Movement form part of Uganda's security forces.

¹³⁵*N v. Secretary of State for the Home Department*, at paragraph 73.

¹³⁶*N v. Secretary of State for the Home Department*, at paragraph 2.

¹³⁷C. Sawyer, “Insufficiently inhuman: removing AIDS patients from the UK. *N v. Secretary of State for the Home Department (Terence Higgins Trust Intervening)* [2003] EWCA Civ 1369”, *Journal of Social Welfare and Family Law*, 26(3) (2004), 281-288 (pp. 281-282).

¹³⁸D. Stevens, “Asylum seekers and the right to access health care”, *Northern Ireland Legal Quarterly*, 61(4) (2010), 363-390 (p. 372).

¹³⁹As mandated by the *Asylum Directorate Instructions*: “Where is credible medical evidence that return, due to the medical facilities in the country concerned, would reduce the applicant's life expectancy and subject him to acute physical and mental suffering, in circumstances where the UK can be regarded as having assumed responsibility for his care,” [cited in *N v. United Kingdom* (Application No. 26565/05) (2008), p. 888 at paragraph 14].

1998.¹⁴⁰

An evidential medical report described N's present condition as "stable" and indicated that she was "likely to remain well for decades" if permitted to stay in the United Kingdom. On the other hand it warned that N "would not have the full treatment she required [in Uganda] and would suffer ill-health, pain, discomfort and an early death as a result."¹⁴¹ It would appear that the treatment N required was only available at considerable expense in Uganda and would have been in limited supply in her home town. Moreover while she still had relatives there, it seemed that none of them would have been willing and able to provide her with accommodation and care.¹⁴² A supplementary report compiled by a consultant physician opined that she would live, at most, for another two years if returned to Uganda.¹⁴³

In February 2003 the IAT allowed an appeal by the Secretary of State¹⁴⁴ and N proceeded to the Court of Appeal¹⁴⁵ whose assessment concluded by majority that the evidence pertaining to her circumstances fell short of the "extreme" class of cases reserved by the European Court of Human Rights for Article 3 intervention.¹⁴⁶ Indeed her predicament was "similar to that of many who suffer from HIV/AIDS" in the United Kingdom for whom the cessation of medical treatment inevitably leads to a substantial reduction in life expectancy.¹⁴⁷ Lord Justice Carnwath, dissenting, found the decision rested with the fact-finding tribunal to determine whether N's unique circumstances, which differed from those in *D v. United Kingdom*, were "sufficiently serious" to fall under Article 3.¹⁴⁸ Ultimately the Court of Appeal were to conclude that, in the absence of a "special feature" giving rise to compelling humanitarian considerations, it would be inappropriate to open the "Article 3 door" to cases involving irregular migrants hitherto in receipt of medical treatment.¹⁴⁹

The House of Lords pursued much the same line of reasoning in *N v. Secretary of State for the*

¹⁴⁰*N v. Secretary of State for the Home Department*, at paragraph 5; the *N* appeals, unlike *D v. United Kingdom*, took place after the Human Rights Act 1998 was enacted as a vehicle through which to enforce the European Convention on Human Rights domestically.

¹⁴¹*N v. Secretary of State for the Home Department*, at paragraph 73.

¹⁴²*N v. Secretary of State for the Home Department*, at paragraph 51.

¹⁴³*N v. Secretary of State for the Home Department*, at paragraph 73.

¹⁴⁴[2002] United Kingdom Immigration Appeal Tribunal 06707 – HX05310-02.

¹⁴⁵*N v. Secretary of State for the Home Department (Terence Higgins Trust Intervening)* [2003] England and Wales Court of Appeal Civil Division 1369.

¹⁴⁶[2004] 1 Weekly Law Reports 1182 at paragraph 43, per Lord Justice Laws. In accordance with section 2(1) of the Human Rights Act 1998 "A court or tribunal determining a question which has arisen in connection with a Convention right must take into account any (a) judgment, decision, declaration or advisory opinion of the European Court of Human Rights . . . whenever made or given, so far as, in the opinion of the court or tribunal, it is relevant to the proceedings in which that question has arisen."

¹⁴⁷[2004] 1 Weekly Law Reports 1182 at paragraph 49, per Lord Justice Dyson.

¹⁴⁸[2004] 1 Weekly Law Reports 1182 at paragraph 54, per Lord Justice Carnwath.

¹⁴⁹[2004] 1 Weekly Law Reports 1182 at paragraph 49, per Lord Justice Dyson.

Home Department,¹⁵⁰ albeit rejecting the humanitarian approach assumed by the Court of Appeal in favour of a more clinical assessment of the scope of Article 3.¹⁵¹ Lord Hope of Craighead found that N's appeal did not entail circumstances of a sufficiently exceptional nature, and that a contrary finding would unduly extend the "exceptional category of case" exemplified by *D v. United Kingdom*.¹⁵² In the substantive body of Lord Hope's judgement it was conspicuously remarked that such an extension of the scope of Article 3:

[W]ould risk drawing into the United Kingdom large numbers of people already suffering from HIV in the hope that they too could remain here indefinitely so that they could take the benefit of the medical resources that are available in this country.¹⁵³

The fallout of a ruling in favour of the appellant would therefore have been "a very great and no doubt unquantifiable commitment of resources" such that the signatories of the European Convention on Human Rights would never have intended.¹⁵⁴ While the Convention, as a "living instrument" grounded in humanitarian principles, allows room for expansion beyond the scope of its express terms, such an expansion would have applied for *all of the contracting states* and not merely the United Kingdom. The question therefore, as Lord Hope emphasised from the beginning, was whether such an enlargement of Article 3 was one by which the contracting parties would have agreed to be bound.¹⁵⁵

Baroness Hale of Richmond acknowledged that N had arrived in the country not to obtain medical treatment but to escape harassment and ill-treatment. Certainly it was not disputed that she had not been aware of her HIV status prior to admittance to Guy's Hospital.¹⁵⁶ For guidance both Her Ladyship and Lord Hope invoked the concurring opinion of Judge Pettiti in *D v. United Kingdom* in which he had emphasised that the European Court of Human Rights was not concerned with the inequality of medical treatment between member states of the United Nations and, by extension, the question of whether an obligation existed to provide treatment for aliens where it was unobtainable

¹⁵⁰*N v. Secretary of State for the Home Department* [2005] United Kingdom House of Lords 31.

¹⁵¹V. Bettinson and A. Jones, "Is inadequate medical care insufficient to resist removal? The return of foreign nationals with HIV/AIDS and article 3 ECHR", *Journal of Social Welfare and Family Law*, 28(1) (2006), 70-80 (p. 70).

¹⁵²*N v. Secretary of State for the Home Department*, at paragraphs 51-52.

¹⁵³*N v. Secretary of State for the Home Department*, at paragraph 53.

¹⁵⁴*N v. Secretary of State for the Home Department*, at paragraph 53.

¹⁵⁵*N v. Secretary of State for the Home Department*, at paragraph 21. Lord Hope quoted Lord Bingham of Cornhill in *Brown v. Stott* ([2003] 1 Appeals Cases 681), who, in turn, had invoked Lord Chancellor Sankey's old admonition that the Convention be seen "as a living tree capable of growth and expansion within its natural limits". Thus, according to Lord Bingham, though "the language of the Convention is for the most part so general that some implication of terms is necessary . . . the process of implication is one to be carried out with caution, if the risk is to be averted that the contracting parties may, by judicial interpretation, become bound by obligations which they did not expressly accept and might not have been willing to accept."

¹⁵⁶*N v. Secretary of State for the Home Department*, at paragraph 57.

in their home countries. Rather the Court had been drawn to the very exceptional circumstances of D's case; the humanitarian considerations connected to the removal of an individual whose life was drawing to a close from a fatal illness.¹⁵⁷ The presence of humanitarian considerations merely served as a qualification to the general rule that aliens subject to expulsion could not “in principle claim any entitlement to remain in the territory of a contracting state in order to continue to benefit from medical, social or other forms of assistance provided by the expelling state.”¹⁵⁸

The implication of *D v. United Kingdom* was, as Lord Hope determined, that the appellant's present medical condition was a crucial factor when examining whether their claim gave rise to an obligation under Article 3.¹⁵⁹ Unlike the applicant D, N had not reached a critical stage in her illness. The appellant's drug regime, as was noted by Lord Nicholls of Birkenhead, promised decades of good health. Her immune system was heavily supplemented by medication, the effects of which mitigated her susceptibility to opportunistic infections without actually restoring her to her former natural state of health.¹⁶⁰ Lord Hope admitted that the stability of N's present condition depended entirely on the advanced course of antiretroviral therapy she received in the United Kingdom. In this respect the treatment was akin to a life support machine; he even conceded it “somewhat disingenuous” to concentrate on an individual's present state of health where it was indisputably linked to the very treatment at stake if she were expelled.¹⁶¹

Nevertheless the consequences of dismissing N's appeal could not be “sensibly detached” from the implications of a decision in her favour.¹⁶² Lord Hope's analysis of past jurisprudence of the European Court of Human Rights demonstrated how all HIV/AIDS expulsion cases after *D v. United Kingdom* had closely examined the applicants' present state of health against their Article 3 claim,¹⁶³ apparently impassive to significant advancements in medical treatment since the *D* ruling in 1997.¹⁶⁴ These cases indicated that the *D* case represented the paradigm for “very exceptional circumstances.” Since N's medically enhanced state of health did not reflect the compelling

¹⁵⁷Judge Pettiti in *D v. United Kingdom*, cited in *N v. Secretary of State for the Home Department* by Lord Hope at paragraphs 34-35, and by Baroness Hale at paragraph 68.

¹⁵⁸*D v. United Kingdom* (Application No. 30240/96) (1997) 24 European Human Rights Law Review 423, at [54]. The principle was invoked verbatim by Lord Hope in *N v. Secretary of State for the Home Department* at paragraph 35.

¹⁵⁹*N v. Secretary of State for the Home Department*, at paragraphs 36 and 43.

¹⁶⁰*N v. Secretary of State for the Home Department*, at paragraph 3.

¹⁶¹*N v. Secretary of State for the Home Department*, at paragraph 49.

¹⁶²*N v. Secretary of State for the Home Department*, at paragraph 21 [See the above quote from Lord Hope].

¹⁶³*BB v. France* (9 March 1998, RJD 1998-VI), cited in *N v. Secretary of State for the Home Department* at paragraph 38; *Karara v. Finland* (Application No. 40900/98, 29 May 1998), cited in same case at paragraph 39; *SCC v. Sweden* (Application No. 46553/99, 15 February 2000), cited at paragraph 41; *Henao v. The Netherlands* (Application No. 13669/03, 24 June 2003), cited at paragraph 45; *Ndangoya v. Sweden* (Application No. 17868/03, 22 June 2004), cited as paragraph 46; *Amegnigan v. The Netherlands* (Application 25629/04, 25 November 2004), cited at paragraph 47.

¹⁶⁴*N v. Secretary of State for the Home Department*, at paragraph 50.

humanitarian considerations in *D v. United Kingdom*, her appeal could not succeed without the House of Lords expanding that category of exceptional cases, something the European Court of Human Rights had been at pains to avoid in the *D* ruling;¹⁶⁵ the appeal was unanimously dismissed.

¹⁶⁵*N v. Secretary of State for the Home Department*, at paragraph 48.

8. The “N Cases”: N v. United Kingdom

having unsuccessfully sought to resist removal to Uganda through the domestic system, N, a HIV-positive refused asylum seeker petitioned the Grand Chamber of the European Court of Human Rights,¹⁶⁶ the majority of whom held that her removal to Uganda would not breach Article 3, and that it was unnecessary to examine her additional complaint under Article 8. In its core judgement the Court drew attention to the “minimum level of severity” threshold that must be satisfied in order for ill-treatment to fall within the scope of Article 3. The threshold, it stressed, is *relative* in nature and contingent to “all of the circumstances of the case” including the nature and duration of the anticipated ill-treatment, its mental and physical effects, and sometimes the age, sex and health of the victim.¹⁶⁷ While maintaining that suffering which emanated from the effects of a naturally occurring illness, as distinct from intentional acts or omissions committed by state and non-state actors, could fall within the scope of Article 3 protection, it was deemed appropriate to observe the high threshold for inhuman and degrading treatment set in *D v. United Kingdom* and adhered to in subsequent cases.¹⁶⁸

Again, the high threshold owed itself to the now familiar maxim that aliens who are subject to expulsion cannot claim entitlement to remain in a contracting state in order to continue to benefit from medical and social assistance provided by the expelling state. Abiding by this rationale the Court found that the applicant's circumstances, including the fact that her life expectancy would be significantly reduced following her removal from the United Kingdom, were not sufficient in themselves to engage Article 3 responsibility by the United Kingdom.¹⁶⁹

Moreover the Court saw fit to call attention to the fact that while the rights contained in the Convention have “implications of a social or economic nature”, they were drafted primarily with the protection of *civil and political rights* in mind.¹⁷⁰ That Article 3's absolute character demands sufficient flexibility to intervene in expulsion cases underpinned by exceptional circumstances does not mean that contracting states are under an obligation to alleviate inevitable socio-economic disparities that exist between countries. It stressed that inherent to the whole of the Convention is “*a search for a fair balance*” between the general interests of the community and the protection of an

¹⁶⁶*N v. United Kingdom* (Application No. 26565/05) (2008) 47 European Human Rights Law Review 39.

¹⁶⁷*N v. United Kingdom*, at paragraph 29 (pp. 895-896). The principle originates in the case of *Ireland v. United Kingdom* (Series A, No. 25) (1979-80) 2 European Human Rights Law Review 25, at paragraph 162.

¹⁶⁸*N v. United Kingdom*, at paragraph 43 (p. 900).

¹⁶⁹*N v. United Kingdom*, at paragraph 42 (p. 900).

¹⁷⁰*N v. United Kingdom*, at paragraph 44 (p. 900). See *Airey v. Ireland* (1979-80) 2 European Human Rights Law Review 305, at [26].

individual's fundamental rights. Medical advancement in the developed world notwithstanding, the finding of an obligation to provide free and unlimited health care to all aliens who do not have a right to remain in a state's jurisdiction would have exerted too great a burden on the contracting states.¹⁷¹

Judges Tulkens, Bonello and Spielmann dissented from the main judgement citing “substantial grounds” to support the claim that N's case was one of “exceptional gravity”.¹⁷² Turning to the Court's past evaluation of *degrading treatment* as laid out in Article 3 of the European Convention on Human Rights the joint dissenting opinion recalled that treatment could be said to fall under that category where it:

[H]umiliates 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.¹⁷³

The dissenting view invoked the “Pretty threshold”, according to which “intense physical or mental suffering” which “flows from naturally occurring illnesses, physical or mental, may be covered by Article 3.”¹⁷⁴ This rationale was bolstered by the Court's recognition in *D v. United Kingdom* that state responsibility could be engaged amidst the risk of a serious illness being exacerbated by treatment arising from the conditions of expulsion. Provided the minimum level of severity was attained, the dissenting three saw fit to apply the Court's definition of degrading treatment equally to situations where suffering resulted from the lack of facilities required to treat a naturally occurring illness in a receiving state.¹⁷⁵

¹⁷¹*N v. United Kingdom*, at paragraph 44 (p. 901).

¹⁷²*N v. United Kingdom*, at O-I3 (p. 893).

¹⁷³*Pretty v. United Kingdom* (Application No. 2346.02) (2002) 35 European Human Rights Law Review 1, cited by Judges Tulkens, Bonello and Spielmann in *N v. United Kingdom*, at O-I5 (p. 903).

¹⁷⁴*Pretty v. United Kingdom*, at paragraph 52. In this case the applicant, who suffered from motor neurone disease, claimed that the refusal of the Director of Public Prosecutions to grant the applicant's husband immunity from prosecution if he assisted her in committing suicide would violate Articles 2, 3, 8, 9 and 14 of the Convention.

¹⁷⁵*N v. United Kingdom*, at O-I5 (p. 904).

9. Is the European Convention on Human Rights primarily concerned with *civil and political rights* as opposed to *social and economic rights*?

The joint dissenting opinion in *N v. United Kingdom* rebuked the majority consensus that the Convention is essentially an instrument geared towards the safeguarding of civil and political rights (see the previous chapter), an “incomplete” pronouncement that in the opinion of the three judges alluded to policy considerations.¹⁷⁶ They referred to the judgement in *Airey v. Ireland*,¹⁷⁷ which submitted that the Convention “must be interpreted in the light of present-day conditions” in order to “safeguard the individual in a real and practical way as regards those areas with which it deals.”¹⁷⁸ The cited case concerned a woman of humble means who, owing to the unavailability of free legal aid in Ireland had been prevented from petitioning for a judicial separation in the Irish High Court. The European Court of Human Rights observing that “there is no watertight division” separating socio-economic rights from those covered by the Convention had been willing to find a breach of Articles 6¹⁷⁹ and 8.¹⁸⁰

It was lamented that the majority of the Grand Chamber in *N v. United Kingdom* had deviated from the “integrated approach” advocated in *Airey*,¹⁸¹ central to which was the recognition that *social and economic* interests could, where necessary, fall under the protection of rights that are inherently *civil and political* in nature.¹⁸² The *substantive integrated approach* identifies both of these facets as intrinsically linked, since civil and political rights have social and economic implications, and enjoyment of the former is frequently redundant without the inclusion of the latter.¹⁸³ To illustrate this point, Mantouvalou invoked the *travaux préparatoires* of the European Convention on Human Rights, plainly envisaging the interdependence of civil-political and socio-economic rights with the adage: “What indeed does freedom mean, what does the inviolability of the home mean for a man who has got no home?”¹⁸⁴

¹⁷⁶*N v. United Kingdom*, at O-I6 (p. 904).

¹⁷⁷(1979-80) 2 European Human Right Law Review 305, cited in *N v. United Kingdom* at O-I6 (p. 904).

¹⁷⁸*Airey v. Ireland*, at paragraph 26.

¹⁷⁹“In the determination of his civil rights and obligations or of any criminal charge against him, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law. . .”

¹⁸⁰*Airey v. Ireland*, at paragraph 26.

¹⁸¹*N v. United Kingdom*, at O-I6 (p. 904).

¹⁸²V. Bettinson and A. Jones, “The integration or exclusion of welfare rights in the European Convention on Human Rights: the removal of foreign nationals with HIV after *N v UK* (Application No. 26565/05; decision of the Grand Chamber of the European Court of Human Rights, 27 May 2008)”, *Journal of Social Welfare and Family Law*, 31(1) (2009), 83-94 (p. 83).

¹⁸³V. Mantouvalou, “Work and private life: *Sidabras and Dziautas v Lithuania*”, *European Law Review*, 30(4) (2005), 573-585 (p. 575).

¹⁸⁴Council of Europe, *Collected Edition of the Travaux Préparatoires of the European Convention on Human Rights*, cited by V. Mantouvalou in “Work and private life: *Sidabras and Dziautas v Lithuania*”, *European Law Review*, 30(4) (2005), 573-585 (p. 574).

For the courts an integrated approach entails a holistic examination of the boundaries of Convention rights guided by the circumstances of the applicant, taking socio-economic implications into account, rather than adhering to an unqualified rule that Convention rights are purely civil-political in nature and do not extend to social and economic interests.¹⁸⁵ Thus in *Sidabras v. Lithuania*¹⁸⁶ the Court, citing with approval the principle adopted in *Airey*,¹⁸⁷ held that the consequences of a statutory ban preventing two former KBG officers from finding employment in the private sector affected their right to a “private life” within the meaning of Article 8 of the European Convention on Human Rights.¹⁸⁸ The House of Lords even demonstrated willingness to accommodate welfare rights under Article 3 of the European Convention on Human Rights in the case of *R (on the application of Adam, Limbuela and Tesema) v. Secretary of State for the Home Department*,¹⁸⁹ an undertaking that required their Lordships to examine the Article 3 compatibility of immigration legislation providing for the withdrawal of state support from delayed asylum applicants.¹⁹⁰ The appellants, who would already have been prohibited from working,¹⁹¹ were forced into destitution giving rise to a violation of Article 3.¹⁹²

In light of the above it is curious that the majority of the Grand Chamber in *N v. United Kingdom* abstained in robust terms from recognising welfare rights pertaining to N's Article 3 claim.¹⁹³ Applying what may be termed the “exclusion approach”,¹⁹⁴ the antithesis of the integration approach, the Court rejected outright an argument that Article 3 of the European Convention on Human Rights could be used to enforce a socio-economic right to medical treatment. Its rationale was austere: “Although many of the rights it contains have implications of a social or economic nature, the Convention is essentially directed at the protection of civil and political rights”. Since

¹⁸⁵V. Bettinson and A. Jones, “The integration or exclusion of welfare rights in the European Convention on Human Rights: the removal of foreign nationals with HIV after *N v UK* (Application No. 26565/05; decision of the Grand Chamber of the European Court of Human Rights, 27 May 2008)”, *Journal of Social Welfare and Family Law*, 31(1) (2009), 83-94 (p. 84).

¹⁸⁶(Application Nos. 55480/00; 59330/00) (2006) 42 European Human Rights Law Review 6.

¹⁸⁷*Airey v. Ireland*, at paragraph 47.

¹⁸⁸*Airey v. Ireland*, at paragraph 50.

¹⁸⁹[2005] United Kingdom House of Lords 56, 1 Appeals Cases 396.

¹⁹⁰Nationality, Immigration and Asylum Act 2002, section 55(1): “The Secretary of State may not provide or arrange for the provision of social support to a person . . . if (a) the person makes a claim for asylum which is recorded by the Secretary of State, and (b) the Secretary of State is not satisfied that the claim was made as soon as reasonably practicable after the person's arrival in the United Kingdom,”

¹⁹¹Asylum and Immigration Act 1996, section 8(1).

¹⁹²V. Mantouvalou, “*N v. UK*: no duty to rescue the nearby needy?” *Modern Law Review*, 72(5) (2009), 815-828 (p. 822).

¹⁹³*N v. United Kingdom*, at paragraph 24 (p. 913).

¹⁹⁴V. Bettinson and A. Jones, “The integration or exclusion of welfare rights in the European Convention on Human Rights: the removal of foreign nationals with HIV after *N v UK* (Application No. 26565/05; decision of the Grand Chamber of the European Court of Human Rights, 27 May 2008)”, *Journal of Social Welfare and Family Law*, 31(1) (2009), 83-94 (p. 84).

prevailing socio-economic conditions mean that the standard of medical care between countries is subject to considerable variance, it was found that Article 3 “does not place an obligation on the contracting state to alleviate such disparities through the provision of free and unlimited health care to all aliens without a right to stay within its jurisdiction.”¹⁹⁵

While Article 3 can in principle intervene in situations giving rise to *refoulement*,¹⁹⁶ the Court did not treat N's petition as an attempt to resist removal to Uganda. Rather it was viewed as a refused asylum seeker's bid to continue to benefit from an expensive course of treatment that she could not easily access in her home country; a devious attempt at “smuggling” social and economic rights into Article 3 jurisprudence.¹⁹⁷ The House of Lords had assumed a similar stance in *N v. Secretary of State for the Home Department* with Lord Brown discerning that N's appeal was couched in a *positive obligation* for the United Kingdom to refrain from expelling her so that her treatment could continue. With this being the case, an “unbreakable link”¹⁹⁸ was held to exist between the purported obligation not to return and the consequential obligation to provide medical treatment since “[t]here would simply be no point in not deporting her unless her treatment [in the United Kingdom] were to continue.”¹⁹⁹

Thus the position adopted by the House of Lords and the European Court of Human Rights was that the circumstances surrounding the *N* cases were distinguishable from those in *D v. United Kingdom* in that the earlier case had concerned a negative obligation not to deport an individual who would have been forced to endure a highly undignified end.²⁰⁰ Conversely N claimed a right to remain in the United Kingdom indefinitely, supported by a sophisticated drug regimen which, for all intents and purposes, had not existed in 1997 when the judgement in *D v. United Kingdom* was delivered. Accordingly, whereas D had asserted what essentially amounted to a right to remain in the United Kingdom to die, N, by invoking the same principle, claimed a right to remain there in order to enjoy a vastly enriched quality of life.²⁰¹ Improved medical treatment for AIDS sufferers between 1997 and the 2005 judgement in *N v. Secretary of State for the Home Department* would have necessarily

¹⁹⁵*N v. United Kingdom*, at paragraph 44 (p. 901).

¹⁹⁶*Soering v. United Kingdom* (Application No. 14038/88) (1989) 11 European Human Rights Law Review 439.

¹⁹⁷V. Bettinson and A. Jones, “The integration or exclusion of welfare rights in the European Convention on Human Rights: the removal of foreign nationals with HIV after *N v UK* (Application No. 26565/05; decision of the Grand Chamber of the European Court of Human Rights, 27 May 2008)”, *Journal of Social Welfare and Family Law*, 31(1) (2009), 83-94 (pp. 83-84).

¹⁹⁸V. Bettinson and A. Jones, “Is inadequate medical care insufficient to resist removal? The return of foreign nationals with HIV/AIDS and article 3 ECHR”, *Journal of Social Welfare and Family Law*, 28(1) (2006), 70-80 (p. 73).

¹⁹⁹*N v. Secretary of State for the Home Department*, at paragraph 88, per Lord Brown.

²⁰⁰*N v. Secretary of State for the Home Department*, at paragraph 93, per Lord Brown.

²⁰¹V. Mantouvalou, “*N v. UK*: no duty to rescue the nearby needy?” *Modern Law Review*, 72(5) (2009), 815-828 (p. 819).

entailed increased costs to the state were a violation of Article 3 to be found.²⁰²

It is not disputed that the House of Lords and the European Court of Human Rights were presented with a taxing moral dilemma. The humanitarian implications of forcibly separating an AIDS patient from life-altering treatment were glaringly obvious throughout the extended proceedings. Lord Nicholls conceded in *N v. Secretary of State for the Home Department* that the appellant's plight, like that of so many other overseas AIDS sufferers, evoked "a lasting sense of deep sadness".²⁰³ Nevertheless the task, as both courts perceived it, lay in delimiting the contracting states' obligation under Article 3 where suffering stemmed from a naturally occurring illness. To find a potential violation of Article 3 in either *N* case would have extended the category of "exceptional circumstances" ordinarily reserved for cases mirroring *D v. United Kingdom* in severity.

Baroness Hale, referring to *D v. United Kingdom*, had noted that the Article 3 "test" lay in determining whether the illness had "reached such a critical stage (i.e. he was dying) that it would be inhuman to deprive him of the care which he is currently receiving".²⁰⁴ Given that the *D* case was itself an extension of Article 3 of the European Convention on Human Rights, to find in favour of *N*, whose illness was under control and therefore had not reached a critical stage, would have imposed a particularly onerous positive obligation on United Kingdom to provide treatment to foreign nationals in the regrettably all-too-common situation in which *N* found herself.²⁰⁵ It will be recalled that a similar logic was applied by the Grand Chamber who argued that "too great a burden" on the contracting states would have resulted from such an obligation.²⁰⁶

To invoke Lord Hope in the aforementioned *Limbuela* case, *proportionality* remains a relevant consideration where a Convention right implies an obligation to do something.²⁰⁷ Accordingly, one of the challenges faced by the courts when confronted by *refoulement* claims falling under Article 3 jurisprudence is determining whether it is reasonable for the contracting-state to incur a corresponding obligation to mitigate suffering which stems from the conditions of expulsion.

²⁰²V. Bettinson and A. Jones, "The integration or exclusion of welfare rights in the European Convention on Human Rights: the removal of foreign nationals with HIV after *N v UK* (Application No. 26565/05; decision of the Grand Chamber of the European Court of Human Rights, 27 May 2008)", *Journal of Social Welfare and Family Law*, 31(1) (2009), 83-94 (p. 86).

²⁰³*N v. Secretary of State for the Home Department*, at paragraph 10, per Lord Nicholls.

²⁰⁴*N v. Secretary of State for the Home Department*, at paragraph 69, per Baroness Hale.

²⁰⁵V. Bettinson and A. Jones, "Is inadequate medical care insufficient to resist removal? The return of foreign nationals with HIV/AIDS and article 3 ECHR", *Journal of Social Welfare and Family Law*, 28(1) (2006), 70-80 (p. 70).

²⁰⁶*N v. United Kingdom*, at paragraph 44 (pp. 900-901).

²⁰⁷*R (on the application of Adam, Limbuela and Tesema) v. Secretary of State for the Home Department*, at paragraph 55.

10. The search for a “fair balance” between individual rights and community interests in the European Convention on Human Rights

The dissenting judges in *N v. United Kingdom* were perturbed by the consensus expressed by the majority that the rights contained in the Convention as a whole are grounded in the search for a *fair balance* between individual rights and community interests.²⁰⁸ They countered that the recent important judgement delivered in *Saadi v. Italy*²⁰⁹ had emphatically rejected a proposed balancing exercise in the context of Article 3, whose absolute nature took precedence over countervailing state interests.²¹⁰ In *Saadi* it was held that the deportation of a Tunisian national suspected of involvement in international terrorism would subject him to a “real risk” of torture at the hands of the Tunisian authorities,²¹¹ giving rise to a violation of Article 3.

Intervening as a third party in *Saadi*, the United Kingdom government argued, without success, that the duty not to deport an individual in order to protect them from ill-treatment inflicted by the authorities in a receiving state *implied a positive obligation* on the contracting state under Article 3. In keeping with the Court's guidelines on implied positive obligations, it would therefore be appropriate in the opinion of the intervening government, to weigh the risk of the Article 3 rights of the applicant being violated against the interests of the community as a whole.²¹²

Naturally one might raise the counter-argument that the facts of *N v. United Kingdom* differ from other *refoulement* cases which engage Article 3 of the European Convention on Human Rights, notably *Saadi v. Italy* and the similar *Chahal v. United Kingdom*.²¹³ As Lord Justice Carnwath commented during N's proceedings before the Court of Appeal “the natural subject matter of the Article is *state oppression*”.²¹⁴ The facts of *Saadi* and *Chahal* slot neatly into the traditional category of Article 3 cases that follow the principle in *Soering v. United Kingdom*.²¹⁵ The issue

²⁰⁸*N v. United Kingdom*, at O-I7 (p. 904).

²⁰⁹(Application No. 37201/06) (2009) 49 European Human Rights Law Review 30.

²¹⁰*Saadi v. Italy*, at paragraph 138.

²¹¹*Saadi v. Italy*, at paragraph 146.

²¹²*Saadi v. Italy*, at paragraph 120.

²¹³Application No. 22414/93 (1997) 23 European Human Rights Law Review 413; a case concerning the proposed removal of a prominent Sikh separatist believed to pose a threat to national security in the United Kingdom. It was held that his removal would expose him to a real risk of torture by the authorities in India due to his past activism there.

²¹⁴[2004] 1 Weekly Law Reports 1182 at paragraph 51, per Lord Justice Carnwath [emphasis added].

²¹⁵(Application No. 14038/88) (1989) 11 European Human Rights Law Review 439; concerning the proposed extradition of a German national to the United States where, having stood trial for murder, he would likely be sentenced to death and be subjected to the “death row phenomenon”. Recall that this was the first case to articulate a link between Article 3 of the European Convention on Human Rights and the international legal principle of *non-*

central to both had been whether competing factors such as national security could serve as legitimate grounds for exempting a state from their *non-refoulement* obligations under Article 3 of the European Convention on Human Rights. *N v. United Kingdom*, on the other hand, invited the Court to determine whether Article 3 had been applicable in the first place. As Bettinson and Jones have pointed out, the case prompted close examination of the *scope* of Article 3 as opposed to its *absolute character*; it may be posited that both are distinct tenets, capable of being dissected independently of each other as required.²¹⁶

refoulement.

²¹⁶V. Bettinson and A. Jones, “The integration or exclusion of welfare rights in the European Convention on Human Rights: the removal of foreign nationals with HIV after *N v UK* (Application No. 26565/05; decision of the Grand Chamber of the European Court of Human Rights, 27 May 2008)”, *Journal of Social Welfare and Family Law*, 31(1) (2009), 83-94 (p. 87).

11. Would “the floodgates have been opened” if the United Kingdom were required to provide N with the treatment she needed?

Although it was not articulated in explicit terms in the main judgement of *N v. United Kingdom*, Judges Tulkens, Bonello and Spielmann suspected that the true reason behind the decision to reject N's petition lay in the belief that the United Kingdom's resources would have been stretched to capacity if placed under an obligation to provide medical treatment to overseas patients suffering from serious illnesses.²¹⁷ It will no doubt be familiar by now that the resounding conclusion shared by fourteen of the judges in the Grand Chamber was that no obligation existed under Article 3 to provide “free and unlimited health care” to aliens who do not have a right to stay within the jurisdictions of contracting states who would, otherwise, be entrusted with “too great a burden”.²¹⁸ This was strikingly reminiscent of Lord Hope's comment regarding the “very great and no doubt unquantifiable commitment of resources” that would have emanated from the creation of such an obligation by the House of Lords.²¹⁹

Arguably both conclusions were couched in a thinly-veiled “floodgate argument”,²²⁰ essentially an implicit fear of subjecting signatories of the European Convention on Human Rights to being overwhelmed by aliens with serious illnesses, each asserting an irrevocable right to benefit from expensive medical treatment free of charge. If Lord Brown of Eaton-under-Heywood was to be believed, the expected annual cost to the state for providing N with antiretroviral therapy was GBP7, 000, a conservative figure given the likely addition of social welfare and immigration control costs if, as it was suggested, more AIDS sufferers were to be drawn to the United Kingdom in the hope of qualifying for the same treatment.²²¹ However the joint dissenting opinion in *N v. United Kingdom* dismissed the floodgate argument as “misconceived”, citing Rule 39 statistics which illustrated the total number of petitions received from the United Kingdom each year compared with the relatively paltry number of those which were HIV cases heard by the Court.²²² The dissenting three were not alone in their doubts.

Certainly some commentators have been reluctant to accept the floodgates argument undigested. Bettinson and Jones argue that repercussions would have been minimal had the two-stage test

²¹⁷*N v. United Kingdom*, at O-18 (p. 905). V. Mantouvalou, “*N v. UK: no duty to rescue the nearby needy?*” *Modern Law Review*, 72(5) (2009), 815-828 (p. 825).

²¹⁸*N v. United Kingdom*, at paragraph 44 (p. 901).

²¹⁹*N v. Secretary of State for the Home Department*, at paragraph 53.

²²⁰V. Mantouvalou, “*N v. UK: no duty to rescue the nearby needy?*” *Modern Law Review*, 72(5) (2009), 815-828 (pp. 815-816).

²²¹*N v. Secretary of State for the Home Department*, at paragraph 92.

²²²*N v. United Kingdom*, at O-18 (p. 905-906)

established in *D v. United Kingdom* been applied successfully in *N v. United Kingdom*, i.e., “has the applicant's illness attained an advanced or terminal stage?”²²³ and if so, would their return render him bereft of medical treatment and family support subjecting him to “acute mental and physical suffering?”²²⁴ Indeed, not since *D v. United Kingdom* has the Court observed that the removal of an alien suffering from a serious illness would give rise to a violation of Article 3, arguably rendering moot the concerns expressed in the *N* cases over an unacceptable number of claims from aliens suffering from serious illnesses arising if *N* were permitted to stay in the United Kingdom. In any case it has been mentioned above that, owing to concerns about stigma, many HIV-positive migrants are unaware of their condition to begin with when they first arrive in the United Kingdom, as was the case with *N* herself.²²⁵ It would certainly appear to be a logical leap to presume that this trend would be liable to sudden change if *N v. United Kingdom* were to have yielded a positive outcome for the applicant.

Mantouvalou was similarly critical of the floodgates argument alluded to in the *N* cases, citing “great scepticism” from other jurisdictions on the matter.²²⁶ In *Chan v. Canada (Minister of Employment and Immigration)*²²⁷ where the appellant, who came from China, claimed asylum under the Canadian Immigration Act 1985²²⁸ amidst a fear of being forcibly sterilised on return for having violated China's one-child birth control laws, the Supreme Court of Canada, while “mindful that the possibility of a flood of refugees may be a legitimate political concern” conceded it not to be “an appropriate legal consideration.” To accommodate concerns of such a nature in its decision making process, it reasoned, would be to “unduly distort the judicial-political relationship” and debase an area of the law primarily concerned with the safeguarding of basic human rights.²²⁹

In much a similar vein the joint dissenting opinion in *N v. United Kingdom* considered it inappropriate to subject the scope of Article 3 of the European Convention on Human Rights to

²²³See *Arcila Henao v. The Netherlands* (Application No. 13669/03), 24 June 2003. The case also concerned the return of a HIV-positive alien.

²²⁴*D v. United Kingdom*, at paragraph 52.

²²⁵V. Bettinson and A. Jones, “The integration or exclusion of welfare rights in the European Convention on Human Rights: the removal of foreign nationals with HIV after *N v UK* (Application No. 26565/05; decision of the Grand Chamber of the European Court of Human Rights, 27 May 2008)”, *Journal of Social Welfare and Family Law*, 31(1) (2009), 83-94 (p. 87).

²²⁶V. Mantouvalou, “*N v. UK*: no duty to rescue the nearby needy?” *Modern Law Review*, 72(5) (2009), 815-828 (p. 826).

²²⁷[1995] 3 Supreme Court Reports 593.

²²⁸Immigration Act, Rules of the Supreme Court, 1985, Chapters 1-2. The appellant sought “Convention refugee” status defined under section 2(1) of the act as “any person who (a) by reason of a well-founded fear of persecution for reasons of race, religion, nationality, membership in a particular social group or political opinion (i) is outside the country of the person's nationality and is unable or, by reason of that fear, is unwilling to avail himself of the protection of that country . . .

²²⁹*Chan v. Canada (Minister of Employment and Immigration)*, at paragraph 151, per Mahoney J.A.

scrutiny against such a background. Judges Tulkens, Bonello and Spielmann submitted that policy considerations such as budgetary constraints undermined the absolute character of Article 3 and indeed the integrity of all of the rights guaranteed by the European Convention on Human Rights.²³⁰ The Convention rights could not, they argued, be divorced from “prevailing practical realities”,²³¹ indeed Lord Hope had acknowledged in *N v. Secretary of State for the Home Department* that any decision undertaken by those tasked with implementing those rights assured “profound consequences” for the applicant.²³²

The *N* cases are indicative of an underlying tension between the preservation of state resources and the obligation to comply with human rights law, notably the right to health care for HIV/AIDS sufferers. This strained relationship often evokes complex moral and legal questions that are not easily resolved. It is accepted, for example, that the protection of human rights exerts a toll on state resources, but at what point can it be reasonably found that the foreseeable consequences of enforcing an individual's fundamental rights are so profound as to release a state from an inherent obligation?²³³ The conundrum was brought to the forefront in *N v. United Kingdom*, the joint dissenting opinion of which endorsed a radically different, albeit minority, interpretation of Article 3 as it ought to apply in circumstances underpinned by a lack of medical care.²³⁴ Certainly the issue is all the more complex, perhaps more emotive, in the context of AIDS, a disease which at present has no cure, is often poorly managed in developing regions, and whose strong ties with poverty and marginalisation intensify perceived worldwide socio-economic inequality. The joint dissenting opinion in *N v. United Kingdom* exemplified the controversy that is inherent to the sadly necessary act of applying limits to the United Kingdom's human rights obligations towards AIDS sufferers from overseas.

On the other hand Mantouvalou has pointed out that scarcity of resources has not deterred the European Court of Human Rights from finding that a Convention right has been infringed upon in the past.²³⁵ In the case of *Gaygusuz v. Austria*²³⁶ for instance the Court held that Article 14 in conjunction with Article 1, Protocol 1²³⁷ had been breached where a Turkish national was denied an

²³⁰*N v. United Kingdom*, at O-I8 (p. 905-906)

²³¹*N v. United Kingdom*, at O-I10 (p. 907).

²³²*N v. Secretary of State for the Home Department*, at paragraph 20, per Lord Hope.

²³³V. Mantouvalou, “*N v. UK: no duty to rescue the nearby needy?*” *Modern Law Review*, 72(5) (2009), 815-828 (p. 826).

²³⁴*N v. United Kingdom*, Joint Dissenting Opinion of Judges Tulkens, Bonello and Spielmann (p. 893).

²³⁵V. Mantouvalou, “*N v. UK: no duty to rescue the nearby needy?*” *Modern Law Review*, 72(5) (2009), 815-828 (p. 825).

²³⁶(Application No. 17371/90) (1997) 23 European Human Rights Law Review 364.

²³⁷“Every natural or legal person is entitled to the enjoyment of his possessions. No one shall be deprived of his possessions except in the public interest and subject to the conditions provided for by law and by the general

advance on his pension in the form of emergency assistance because he did not have Austrian nationality. Accordingly the Austrian government's submission that the benefit be limited to Austrian citizens out of necessity due to the “difficult financial situation” was not acceptable.²³⁸ The same Convention rights were found to have been impeached in *Koua Poirrez v. France*²³⁹ where the respondent government had refused to pay an adult disability allowance to non-French national. Again, the Court rejected the respondent government's justification that the drawing of a distinction between nationals and non-nationals for purposes of awarding disability allowance was in pursuit a legitimate aim, this being the balancing of state welfare income and expenditure.²⁴⁰

As far as Article 3 is concerned, the Court has even staunchly opposed the idea that financial constraints may relieve a state party of its obligations. In *Aliev v. Ukraine*,²⁴¹ one of a few cases addressing substandard conditions in Ukraine's prisons, it remarked that a “lack of resources cannot in principle justify prison conditions which are so poor as to reach the threshold of treatment contrary to Article 3 of the Convention.”²⁴² The principle which may be drawn from these examples is that the Court has generally been prepared to enforce certain obligations stemming from Convention rights regardless of financial commitment on the part of the contracting state. The implication in *N v. United Kingdom* is that were Court to find that an obligation existed under Article 3 to allow the N to remain in the United Kingdom and continue with her treatment, the respondent state could have been relieved of that obligation if evidence were to support the concern that aliens would be inspired to seek asylum in the United Kingdom in their droves claiming a right to state-funded antiretroviral therapy.²⁴³

Nevertheless, it will be recalled that among the main objections raised in the joint dissenting opinion in *N v. United Kingdom* was the *implicit* use of a floodgates argument in the Grand Chamber's main judgement. In other words, if the majority truly were swayed by fear over the Council of Europe member states being pushed into the untenable position of becoming the “sick-bay of the world” as a result of N's application succeeding, then their concerns were not articulated in explicit terms in the main text of the judgement.²⁴⁴ One might well raise the argument that such a

principles of international law . . .”

²³⁸*Gaygusuz v. Austria*, at paragraph 46.

²³⁹(Application No. 40892/98) (2005) 40 European Human Rights Law Review 2.

²⁴⁰*Koua Poirrez v. France*, at paragraph 43

²⁴¹(Application No. 41220/97), 29 April 2003. Cited by V. Mantouvalou in “*N v. UK: no duty to rescue the nearby needy?*” *Modern Law Review*, 72(5) (2009), 815-828 (pp. 825-826).

²⁴²*Aliev v. Ukraine*, at paragraph 151. Cited by V. Mantouvalou in “*N v. UK: no duty to rescue the nearby needy?*” *Modern Law Review*, 72(5) (2009), 815-828 (p. 826).

²⁴³V. Mantouvalou, “*N v. UK: no duty to rescue the nearby needy?*” *Modern Law Review*, 72(5) (2009), 815-828 (p. 826).

²⁴⁴*N v. United Kingdom*, at O-18 (p. 905).

portentous claim ought to be substantiated with concrete evidence, particularly if it formed the basis for rejecting the claim that the United Kingdom owed N a duty not to return her.²⁴⁵ Indeed, as this dissertation has previously highlighted, the evidence simply does not suggest that most asylum seekers are drawn to the United Kingdom for medical care, and certainly not those who are HIV-positive.²⁴⁶

Moreover, as Sawyer has argued, if it is to be taken on principle that aliens who are subject to expulsion do not necessarily incur protection from a contracting state then it cannot be true that Convention rights apply universally within the jurisdiction of contracting states,²⁴⁷ but ultimately fall secondary to immigration status. At the very least, this would appear to run counter to the understanding that the human rights regime is grounded in notions of fair treatment.²⁴⁸

²⁴⁵V. Mantouvalou, “N v. UK: no duty to rescue the nearby needy?” *Modern Law Review*, 72(5) (2009), 815-828 (p. 826).

²⁴⁶J. Erwin and B. Peters, “Treatment issues for HIV+ Africans in London”, *Social Science and Medicine*, 49(11) (1999), 1519-1528; House of Commons Health Committee, *New Developments in HIV/AIDS and Sexual Health Policy – Third Report of Session 2004-05*, 8 March 2005 (Q211, p. 65); Secretary of State for Health, *Government response to the Health Select Committee's Third Report of Session 2004-2005 on New Developments in Sexual Health and HIV/AIDS Policy* (Norwich: Crown Copyright, 2005), p. 19.

²⁴⁷Article 1 of the European Convention on Human Rights.

²⁴⁸C. Sawyer, “Insufficiently inhuman: removing AIDS patients from the UK. N v. Secretary of State for the Home and Department (Terence Higgins Trust Intervening) [2003] EWCA Civ 1369”, *Journal of Social Welfare and Family Law*, 26(3) (2004), 281-288 (p. 282).

12. Conclusion

The *N* cases shed important light on the current position of AIDS sufferers who do not have the right to remain in the United Kingdom. It has been shown how domestic health care legislation has progressively tightened executive control over access to medical treatment for irregular migrants. A dominant theme in policy discussions of the allocation of state-funded treatment has been a sense of urgency to discourage undesirable overseas patients from taking advantage of the NHS, particularly where it comes to antiretroviral therapy which is prohibitively expensive in other jurisdictions. Arguably in its great hurry to implement barriers to HIV/AIDS treatment, the United Kingdom places itself at increased risk of neglecting its obligation to respect the right of socially disadvantaged groups to the highest attainable standard of health as dictated by Article 12 of the ICESCR.

On the other hand European human rights law places considerable discretion in state hands to determine the entry, movement and expulsion of aliens and the right to equitable access to health care is strictly subject to the availability of resources. Moreover the jurisprudence of the European Court of Human Rights has resoundingly observed no duty under Article 3 of the European Convention on Human Rights to alleviate social and economic disparity through the provision of medical treatment to HIV/AIDS sufferers.

While sympathetic to the need to demarcate boundaries in respect of the United Kingdom's obligations under Article 3, an absolute right of profound importance, the author is in agreement with the joint dissenting opinion in *N v. United Kingdom* that a latent “floodgates argument” permeated the main judgement in that case. Given the lack of evidence to support such an argument, it is regrettable that such preoccupations were manifest in both the House of Lords and the European Court of Human Rights reasoning. In any case the author concurs with the dictum of Mahoney J.A. in *Chan v. Canada (Minister of Employment and Immigration)* that concerns over increased immigration belong in the political realm and only serve as a distraction from “practical realities” unpinned by human suffering in the judicial sphere.

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