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Brexit, Health and its potential impact on Article 2 of the Ireland/Northern Ireland Protocol

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Executive summary

Discerning the meaning and implications of Article 2 of the Protocol on Ireland/Northern Ireland (I/NI Protocol), annexed to the EU-UK Withdrawal Agreement (WA), is not straightforward. The UK's broader international legal obligations (binding, although not enforceable) assist in understanding Article 2 I/NI Protocol, which is enforceable.

If we accept this minimalist interpretative approach, we can read Article 2 through the prism of the 'right to health', a human right of fundamental importance in a democratic society, involving non-discriminatory access to at least a minimum core of healthcare provided by the state on the basis of medical need, and subject to a principle of non-retrogression. Such an inclusive approach to interpretation of Article 2 I/NI Protocol suggests that it encompasses the right to health – in the sense of 'rights, safeguards or equality of opportunity protections' in terms of access to healthcare for patients; provision of healthcare services; and supply of products to Health and Social Care services in Northern Ireland (HSC).

The loss of EU law underpinning access to healthcare is at least arguably a diminishment in itself, but this type of loss cannot be what is intended by the 'no diminution' obligation in Article 2 I/NI Protocol. In determining whether rights have been diminished, it must be the substance of the right to health, not the legal source of that right, that matters. Some fears that rights have been diminished in health contexts turn out, on closer inspection, to be unfounded. For many British and/or Irish people who reside and work in Northern Ireland, or reside and work in Ireland but access shared health facilities

located in Northern Ireland, the substance of their enjoyment of the right to health in the sense of access to healthcare services has not changed and will not change. Because access to healthcare is based on *residence*, rather than nationality, direct discrimination between Irish and British nationals who are residents of Northern Ireland is relatively unlikely in this context.

But analysis also shows some possible examples of 'diminution of rights'. For EU-26 frontier workers, and especially their family members, although the EU-UK Withdrawal Agreement obliges the UK to secure continued access to healthcare services in either Ireland or Northern Ireland, the way that the UK has hitherto implemented this obligation excludes family members who are not resident in Northern Ireland. NHS infrastructure (for example, concerning access to vaccination, and the paperwork showing vaccination status) is ill-adapted to the rights of frontier workers. These gaps constitute a potential breach of Article 2 I/NI Protocol. Where EU-26 nationals, or their 'third country' family members, who cannot rely on the 'common travel area' rules, are vulnerable to not securing settled status, they are also vulnerable to the loss of the right to access healthcare, as the HSC in Northern Ireland is

a residence-based system. Where trafficked children are present in Northern Ireland, but are not lawful residents, the enjoyment of their right to health may have been diminished if the rights conferred by the EU's Trafficking Directive are no longer directly effective law in Northern Ireland. As a minimum, given the non-retrogression principle, these situations constitute a potential diminution of the right to health, embodied in Article 2 I/Ni Protocol.

Workforce capacity affects enjoyment of the right to health, and the Northern Irish health and social care workforce has been negatively affected by the current EU-UK relationship. However, in this instance, it is difficult to demonstrate the necessary causality to establish a breach of Article 2 I/Ni Protocol. Similar considerations apply to supply of products to Health and Social Care Northern Ireland. But there is scope to explore whether failure to take decisions about security of NHS product supply which are unilaterally within the power of the UK Government and/or the Northern Ireland Executive could constitute a breach of Article 2 I/Ni Protocol, either by reference to non-retrogression, or non-discrimination, or both.

A key component of the right to health is that access to healthcare is based on transparent criteria. Several aspects of lack of legal clarity became apparent when conducting the research underpinning this report, a key finding of which is that the current difficulty of knowing and understanding the law could itself constitute a potential breach of Article 2 I/Ni Protocol.

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1. Introduction: background and context for the report

The Northern Ireland Human Rights Commission (NIHRC) reviews the adequacy and effectiveness of law and practice relating to the protection of human rights in Northern Ireland (NI), as required by section 69(1) of the Northern Ireland Act 1998.

Alongside the Equality Commission of Northern Ireland (ECNI), the NIHRC has a mandate under the EU (Withdrawal Agreement) Act 2020¹ to monitor the implementation of Article 2(1) of the Protocol on Ireland/Northern Ireland (I/NI Protocol) annexed to the UK EU Withdrawal Agreement². NIHRC and ECNI work separately or jointly as part of the ‘dedicated mechanism’ for oversight of the commitment, exercising advisory, reporting and awareness-raising functions. The Commissions may, to that end, bring judicial review proceedings for ‘breach (or potential future breach)’ of Article 2 (1) I/NI Protocol.³ NIHRC works with ECNI and the Irish Human Rights and Equality Commission (IHREC) to provide oversight of, and reporting

on, rights and equalities issues that have an island of Ireland dimension.

Article 2 I/NI Protocol provides:

- (1) The United Kingdom shall ensure that no diminution of rights, safeguards and equality of opportunity as set out in that part of the 1998 Agreement entitled Rights, Safeguards and Equality of Opportunity results from its withdrawal from the Union, including in the area of protection against discrimination as enshrined in the provisions of Union law listed in Annex 1 to this Protocol, and shall implement this paragraph through dedicated mechanisms.
- (2) The United Kingdom shall continue to facilitate the related work of the institutions and bodies set up pursuant to the 1998 Agreement, including the Northern Ireland Human Rights Commission, the Equality Commission for Northern Ireland and the Joint Committee of representatives of the Human Rights Commissions of Northern Ireland and Ireland, in upholding human rights and equality standards.

1 Northern Ireland Act 1998, sections 78A-78E, as amended by European Union (Withdrawal Agreement) Act 2020, schedule 3

2 Agreement on the withdrawal of the United Kingdom of Great Britain and Northern Ireland from the European Union and the European Atomic Energy Community [2019] OJ C1 384/1 (WA).

3 Northern Ireland Act 1998, section 78C, as amended by European Union (Withdrawal Agreement) Act 2020, schedule 3.

Healthcare has been consistently identified as a prevailing issue of concern in the UK's withdrawal from the EU.⁴ The specific arrangements pertaining on the island of Ireland make continued healthcare provision a particular challenge, given the changing formal and informal, legal, economic and political relationships between the EU, the UK and Ireland.⁵ Although the EU's competence in health is constrained,⁶ EU health policy is a cross-cutting matter and consequently EU law and policy has deeply imbricated the health policy domain across its Member States, and indeed beyond. The integrated nature of health provision on the island of Ireland, especially its geographically northern parts, mean that the UK's withdrawal from the EU affects Northern Ireland (and Ireland) in a way in which other parts of the UK (and other EU Member States⁷) are not affected. The emerging 'law and practice' on healthcare in Northern Ireland may

be understood as 'relating to the protection of human rights': the right to healthcare is recognised in European and international human rights instruments to which the United Kingdom is a party,⁸ and is implicitly embedded⁹ in the range of laws, policies, practices and guidelines which constitute the terms on which patients access the healthcare in each of the relevant devolved national health services within the United Kingdom. The part of the 1998 Agreement on Rights, Safeguards and Equality of Opportunity, on which the obligations in Article 2 I/NI Protocol rely, includes a broad range of human rights, in particular the right to 'equal opportunity in all social and economic activity'. Article 2 I/NI Protocol thus included human rights applicable in healthcare contexts. It is in this context that the NIHRC has commissioned this report on Brexit, Health and its potential impact on Article 2 I/NI Protocol.

4 See, for example, Health and Social Care Committee (2016) *Brexit and health and social care: people and process* (House of Commons HC Paper 640); Health and Social Care Committee (2017) *Brexit: medicines, medical devices and substances of human origin* (House of Commons HC Paper 392); Nick Fahy, Tamara Hervey, et al, 'How will Brexit affect health and health services in the UK? Evaluating three possible scenarios against the WHO health system building blocks' (2017) *The Lancet* 390(10107): 2110-8; Sylvia de Mars, Aoife O'Donoghue and Ben Warwick, Discussion Paper on Brexit (Joint Committee of the Irish Human Rights and Equality Commission and the Northern Ireland Human Rights Commission, 2018); European Union Committee, *Brexit: Reciprocal Healthcare* (House of Lords HL Paper 107, 2018); Nick Fahy, Tamara Hervey et al 'How will Brexit affect health and health services in the UK? An updated analysis' (2019) *The Lancet*; 393: 949-58; Nick Fahy, Tamara Hervey et al, 'Assessing the potential impact on health of the UK's future relationship agreement with the EU: analysis of the negotiating positions 16 *Health Economics Policy and Law* (2020) 290-307; Sylvia de Mars, Colin Murray, Aoife O'Donoghue and Ben Warwick, *Continuing EU Citizenship "Rights, Opportunities and Benefits" in Northern Ireland after Brexit* (Irish Human Rights and Equality Commission and Northern Ireland Human Rights Commission, March 2020); Jean McHale, Elizabeth Speakman, Tamara Hervey, Mark Flear, 'Health law and policy, devolution and Brexit', 55 *Regional Studies* (2020) 1561-70; HM Government, *Northern Ireland Protocol: The Way Forward*, 21 July 2021, CP 502, paras 20 and 61; Letter from Lord Frost to Lord Jay of Ewelme, Chair of the Protocol on Ireland/Northern Ireland Sub-Committee, House of Lords, 28 July 2021, <https://committees.parliament.uk/publications/7011/documents/72907/default/>; European Affairs Committee, "Report from the Sub-Committee on the Protocol on Ireland/Northern Ireland Introductory Report," 2nd Report of Session 2021-22, published 29 July 2021, esp para 96; Mark Dayan, Martha McCarey, Tamara Hervey, Nick Fahy, Scott Gree, Holly Jarman, Ellen Stewart and David Bristow (2021) *Going it alone: health and Brexit in the UK*. Research report, Nuffield Trust <https://www.nuffieldtrust.org.uk/research/going-it-alone-health-and-brexit-in-the-uk>.

5 When referring to the state, this report uses its formal name 'Ireland'. When referring to the geographical space, this report uses 'the island of Ireland'.

6 Article 168 Treaty on the Functioning of the European Union (TFEU).

7 Tamara Hervey, Ivanka Antova, et al, 'Health "Brexitualities": The Brexit effect on health and healthcare outside the EU' in Katherine Fierlbeck, ed, special issue on Health Care and the Fate of Social Europe 46 *Journal of Health Politics Policy and Law* (2021) 177-203.

8 European Social Charter, 1961, Article 11; Revised European Social Charter 1996, Article 11 (UK has signed, but not ratified); International Covenant on Economic, Social and Cultural Rights 1966, Article 12.

9 Whether the 'right to health' is part of UK law is contested. The NHS Constitution for England, for example, covers 'principles' and 'values', but also 'rights', for instance of patients to access healthcare free of charge, except as permitted by Parliament, and to authorised planned treatment in the EU under the EU-UK Trade and Cooperation Agreement. There is no equivalent document for Northern Ireland. The Northern Ireland Health and Social Care Service applies five standards for patient care, including respect, privacy and dignity, see nidirect.gov.uk/articles/patients-standards. Access to primary care is through a GP practice, and based on place of residence. It is unlawful for a GP Practice to refuse to accept a patient without reason, or on the basis of discrimination on grounds of race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition, see nidirect.gov.uk/articles/your-local-doctor-gp#toc-6.

Part of the broader legal context is the rights enshrined in the main body of the Withdrawal Agreement. For those people on the island of Ireland who fall within the scope of the Withdrawal Agreement (for example, EU citizens resident in Northern Ireland on 31 December 2020, frontier workers), the Withdrawal Agreement is the primary source of rights to healthcare. When assessing whether there has been any diminution of rights under Article 2 I/NI Protocol, it is necessary to consider not only domestic law, but also the law of the Withdrawal Agreement.

2. Research methods

The core method deployed in this report is that of ‘doctrinal’ legal analysis.

This approach is necessary in order to understand the fluid and emerging legal environment, and the rights and obligations of relevant actors within that environment. The position in Northern Ireland is encapsulated in a complex set of legal regimes, along with policy positions and ‘soft’ measures such as memoranda of understanding, which relate to one another in non-hierarchical and sometimes deliberately unspecified ways. The aim was to use standard doctrinal legal methods to discover and interpret the relevant legal rules, which range from very general intergovernmental agreements;¹⁰ specific intergovernmental measures;¹¹ (quasi) EU law;¹² to more specific national law;¹³ decisions of courts; to very detailed secondary/delegated

legislation (such as applicable to trade, immigration/employment rights, or access to healthcare). In addition, in some relevant contexts, legislation is supplemented by formally non-binding guidance or other ‘soft law’. Uncovering and explicating how these different legal rules interact, and explaining how each should be interpreted (especially new pieces of law), is a key element of the method intended to be applied in this report.

In fact, as will become clear, one of the key issues that emerges from the research is that the legal environment is so opaque that standard doctrinal legal methods are in some instances barely sufficient to uncover the relevant rights and obligations. It goes without saying that ‘ignorance of the law is no excuse’. But ignorance of a law that cannot be known is another matter entirely.

Whether the legal doctrine is knowable, it is not enough to understand only the written legal texts: ‘the law in the books’. It is also necessary to understand how this law applies in practice. For this aspect of the research, two interlocking and over-lapping methods were deployed. Both involve ‘co-production’, and the relevant co-producer stakeholders include the NIHRC and a range of actors in the healthcare domain in Northern Ireland, including regulatory bodies, industry and professional associations, and third sector entities acting for or advising health and social care staff and/or patients. First, standard social science qualitative methods – in particular

10 Such as the Trade and Cooperation Agreement between the European Union and the European Atomic Energy Community, of the one part, and the United Kingdom of Great Britain and Northern Ireland, of the other part [2021] OJ L 149/10 (TCA).

11 Such as the Memorandum of Understanding between the Government of the UK and the Government of Ireland concerning Common Travel Area Healthcare Arrangements (in recognition of residency-based health systems).

12 Such as the Agreement on the withdrawal of the United Kingdom of Great Britain and Northern Ireland from the European Union and the European Atomic Energy Community [2019] OJ C1 384/1 (WA), which itself refers to EU law, especially on coordination of social security regimes.

13 Such as Northern Ireland legislation.

semi-structured interviewing – were deployed. Nine interviews took place from August to October 2021. The interviews were designed to be discursive, based on open-ended questions, such as ‘what are the main effects of leaving the European Union on any matter related to health rights – broadly defined – that you see in your work today?’. Second, in addition, regular meetings took place with the NIHRC, to discuss the work as it unfolded and learn about relevant information from the Commission staff.¹⁴ The data from the interviews and meetings was used to inform the second method: scenario analysis. Where possible, the problems, concerns, challenges and opportunities that emerge from the interviews and meetings are encapsulated in stylised and anonymised scenarios. These are not necessarily statements of what any particular individual is experiencing, but they are intended to encapsulate real-life effects of particular phenomena.

The scenarios were then intended to form the basis of a subsequently written legal analysis, designed to answer the question ‘what is the legal position of a person in this scenario? What are their rights / obligations? How might any rights be enforced and against whom?’ In fact, what was discovered is that in some instances it is not possible to articulate with confidence what the legal position is, because the relevant legal texts are not currently ‘knowable’.

The overall aims of these interconnected methods are to undertake a ‘gap analysis’: to discover where the changing overall relationships between the EU and the UK mean that gaps have emerged in the enjoyment of human rights (in this instance, the ‘right to healthcare’) in Northern Ireland as a result of the UK leaving the EU. Part of the function of a gap analysis may be to provide reassurance, if it emerges through the analysis that there are not, in fact, gaps, but where there may be a perception that human rights (to healthcare) have been diminished.

Examples of these methods in action are available on the project website of the Health Governance after Brexit project,¹⁵ in the ‘Policy Analysis/Briefings’ section.

The question of emergent gaps in human rights, as opposed to legal or administrative entitlements, is the key focus of the gap analysis for this report. The conceptualisation of health as a human right is contested. A brief review of law and literature on health as a human right in national, European and international contexts forms the basis of this aspect of the report. Relations between health rights and justice,¹⁶ as well as human capacity or flourishing¹⁷ are an important facet of that literature, as is more technical or doctrinal legal work on the ‘right to health’ in both the Council of Europe¹⁸ and the European Union.¹⁹ The essence of the argument is that

14 The author wishes to acknowledge with gratitude the work of Emma Osborne in particular in this regard.

15 ESRC 2019 *Health Governance after Brexit: Law, Language and Legitimacy* <https://gtr.ukri.org/projects?ref=ES%2F500730X%2F1> and project website at <https://www.sheffield.ac.uk/law/news/health-governance-after-brexit-law-language-and-legitimacy>.

16 See, for example, Alicia Ely Yamin, ‘The right to health’ in Jackie Dugard, Bruce Porter, et al, eds, *Research Handbook on Economic, Social and Cultural Rights* (Edward Elgar, 2021); Alicia Ely Yamin, *When Misfortune becomes Injustice: Evolving Human Rights Struggles for Health and Social Equality* (Stanford University Press, 2020); Norman Daniels, *Just Health: Meeting Health Needs Fairly* (Cambridge University Press 2008).

17 See, for example, Amartya Sen ‘Why and How is Health a Human Right’ 372 *The Lancet* (2008)2010.

18 See, for example, Brigid Toebe, Mette Hartlev, et al, *Health and Human Rights in Europe* (Intersentia 2012).

19 See Tamara Hervey and Jean McHale, ‘Article 35’ in S Peers, T Hervey, J Kenner, A Ward, eds, *Commentary on the European Union Charter of Fundamental Rights* 951-68 (Hart Publishing 2021 and 2014).

the meaning of the obligations in Article 2 I/NI Protocol pertaining to human health may be understood by reference to the concept of the ‘right to health’ as found in international or European legal agreements to which the UK is a party.

Having identified the (potential) gaps, the report concludes with some recommendations which could avoid or otherwise alleviate potential diminution of the right to health consequent upon the UK’s withdrawal from the European Union, taking into account the special legal position of Northern Ireland in that process.

3. The meaning and significance of Article 2 I/NI Protocol in view of the right to health

All human rights norms are inherently contestable, in terms of the meanings and implications of legal textual embodiments of human rights principles, and especially their effects on the distribution of resources in society and on ethical implications, including dignity, equality of opportunity and justice.

The provision in Article 2 I/NI Protocol does not present as primarily a human rights norm per se. Nonetheless, as a legal text, its meaning and implications are open to contestation,

especially as, on its face, the text is open to different interpretations. The following section of the report explores possible interpretations of Article 2 I/NI Protocol, on the basis that the meaning of that provision should properly be understood by reference to (unenforceable, but binding) human rights norms and instruments, concerning health, applicable in Northern Ireland and/or recognised by the United Kingdom as part of its international human rights obligations.

3.1 The ‘but for’ test

The Northern Ireland Office is of the view²⁰ that a breach of Article 2 I/NI Protocol arises only in the following circumstance: a right, safeguard or equality of opportunity protection within the Belfast/Good Friday Agreement 1998²¹ has been diminished; the right, etc, was protected by law in Northern Ireland before the end of the transition period; and that the circumstance could not legally have occurred but for the UK’s withdrawal from the EU. As discussed further below, the Belfast/Good Friday Agreement covers not only civil and political rights, but also socio-economic rights, such as the right to health, and the equal opportunity to engage in social and economic opportunities.²² The ‘but for’ test must, I would argue, be understood as not only ‘but for’ the bare fact of the UK leaving the EU, but also as ‘but for’ the specific legal settlement that applies to that departure.²³

20 Northern Ireland Office, ‘Explainer: UK Government commitment to no diminution of rights, safeguards and equality of opportunity in Northern Ireland (NIO, 2020), para 10.

21 Note here that there is no accepted interpretation of the scope of those provisions in the Belfast/Good Friday Agreement 1998. This raises another point for contestation.

22 See, C Murray, A O’Donoghue and B Warwick, *Discussion Paper on Brexit (Irish Human Rights and Equality Commission and the Northern Ireland Human Rights Commission, 2018)*, p 7 <https://www.ihrec.ie/app/uploads/2018/03/Discussion-Paper-on-Brexit.pdf>; and EU Commission, ‘Guiding principles transmitted to EU27 for the Dialogue on Ireland/Northern Ireland’ (TF50 2017, 15) 3-4.

23 After all, if ‘but for’ were not understood this way, it would denude the obligation of all legal meaning, because, for example, if the UK had chosen to remain within the EEA, many of the problems concerning products moving in the island of Ireland would not have arisen.

It must mean ‘but for’ leaving the EU on the basis of the Withdrawal Agreement and the EU-UK Trade and Cooperation Agreement, not on some other basis, such as, for instance, membership of the European Economic Area. It also cannot mean ‘had we not exited the EU, the legal change would not have happened’: this would be contrary to the meaning and purpose of the Withdrawal Agreement as a whole.²⁴ Setting aside whether judicial authority would support this view, or a different view, the following analysis is based on that interpretation.

3.2 The ‘right to health’

The ‘right to health’ is found in the UN’s International Covenant of Economic Social and Cultural Rights (ICESCR) 1966, Article 12. The UN ICESCR has been binding on the UK since 1976, although it is not a source of justiciable rights in the UK.²⁵ According to the UN Committee on Economic, Social and Cultural Rights,²⁶ the ‘right to health’ includes the core components of availability, accessibility, acceptability and quality.

The right to health is also found in the Council of Europe’s human rights instruments. The Revised European Social Charter 1961 and Revised European Social Charter 1996 (ESC), Article 11 provide for the ‘right to protection of health’. The United Kingdom has been bound by the European Social Charter since

1965, although again provisions of the Charter are not justiciable rights in UK law. Some provisions of the European Convention on Human Rights and Fundamental Freedoms (ECHR) 1950, which takes effect in the UK through the Human Rights Act 1998, are also relevant in health contexts,²⁷ but the ECHR does not include the right to health per se.

The European Union’s Charter of Fundamental Rights and Freedoms, Article 35 includes the ‘right to health care’. It further provides that the EU must ensure a ‘high level of health protection’ in all its policies and activities. The EU’s competence in the health field is complex and transversal,²⁸ exercised through a range of EU powers and legal bases, many of which are not directly health-focused. For example, the EU exercises competence in health as part of its free movement law; coordination of social security; mutual recognition of qualifications; regulation of medicines, vaccines, medical devices, and substances of human origin; regulation of bio-medical research; environmental policy; and a range of other policies and activities.

This is not the place for a lengthy review of literature and jurisprudence on the right to health. Three key points will suffice. First, the right to health is not a superficial or secondary right. Second, respect for the right to health means non-discriminatory access to health services. Third, the right to health

24 See Christopher McCrudden, Evidence to the House of Commons European Scrutiny Committee: Parliamentary scrutiny of the Joint Committee and the application of the Northern Ireland Protocol’, 2 September 2020, para 51 <https://committees.parliament.uk/writtenevidence/10145/default/>.

25 This is a matter of concern for the UN Committee on Economic, Social and Cultural Rights, see, for example, UN Committee on Economic, Social and Cultural Rights, *Concluding observations on the sixth periodic report of the United Kingdom of Great Britain and Northern Ireland*, 2016, paras 5 and 6.

26 UN Committee on Economic, Social and Cultural Rights, General Comment No 14 (2000) <https://digitallibrary.un.org/record/425041>.

27 For example, the right to privacy and family life, Article 8 ECHR.

28 See further Tamara Hervey and Jean McHale, *European Health Law and Policy: Themes and Implications* (CUP, 2015); Tamara Hervey, ‘EU Health Law’ in Catherine Barnard and Steve Peers, eds, 3rd ed, *EU Law* (OUP, 2020).

obliges governments, irrespective of the level of development in their countries, or the consequent resources available to them, to continually improve the health rights of their populations. Each point is elaborated briefly below.

In common with other 'economic and social rights', the 'right to health' is concerned with the foundations of human well-being, with full participation in society, equality of opportunity and with social justice.²⁹ A right to health connects with human dignity, and with full participation in society, including exercise of democratic rights. This concept is sometimes known as the 'indivisibility' of human rights: the distinction between 'civil and political' and 'economic, social or cultural' rights is not a construct which implies that one type of human rights is more important than another. Although it is often characterised as a 'second generation' right, the right to health enjoys a pre-eminent status in human rights law: it is not a secondary right, but is of fundamental importance in a democratic society. The 1998 Belfast/Good Friday Agreement reflects this understanding of the indivisibility of rights, in its protection of the right to equal participation in society.

Although contested, the substantive content of a 'right to health' is typically understood as including both the social determinants of health, and the right to healthcare: to access at least a minimum core of healthcare services, and the medicines, medical devices, equipment, consumables, and human blood, organs, tissues or cells associated with the relevant medical treatment, provided by reference to patient safety and dignity.³⁰ Healthcare systems and services are themselves social determinants of health.³¹ But the right to health does not mean that a state has a duty to provide everyone with whatever health intervention they might need or desire: rather, it is more complex, related to the resources available to a state, and perhaps better expressed as a 'right to equitable access' to healthcare.³² As such, to secure the right to health, healthcare systems and services must be organised so that access to healthcare is available on a non-discriminatory basis, without differentiating on 'forbidden grounds', such as race, gender, sexuality, age or disability. Non-discriminatory provision of healthcare services is a fundamental aspect of the right to health. This is reflected, for

29 Mark Tushnet, 'Civil Rights and Social Rights: The Future of the Reconstruction Amendments' 25 *Loyola of Los Angeles Law Review* (1992) 1207; David Beetham, 'What Future for Economic and Social Rights?' in David Beetham, ed, *Politics and Human Rights* (Oxford: Blackwell, 1995); Keith Ewing, 'Social Rights and Constitutional Law' [1999] *Public Law* 105; Asbjørn Eide and Allan Rosas (2001), 'Economic, Social and Cultural Rights: A Universal Challenge' in Asbjørn Eide, Catarina Krause and Allan Rosas, eds, *Economic, Social and Cultural Rights* (Martinus Nijhoff, 2001); Tamara Hervey, 'The Right to Health in European Union Law' in Tamara Hervey and Jeff Kenner, *Economic and Social Rights under the EU Charter of Fundamental Rights* (Hart, 2003); Tamara Hervey, 'We don't see a connection: the "right to health" in the EU Charter and European Social Charter', in Grainne de Búrca and Bruno de Witte, eds, *Social Rights in Europe* (OUP, 2005) 305-335; Ellie Palmer, *Judicial Review, Socio-Economic Rights and the Human Rights Act* (Hart, 2007); Amartya Sen, 'Why and How is Health a Human Right' 372 *The Lancet* (2008)2010; Daniels, supra n 16; Danielle Borges, 'Making sense of human rights in the context of European Union health-care policy: Individualist and communitarian views' 7 *International Journal of Law in Context* (2011) 335; Paul O'Connell, *Vindicating Socio-Economic Rights: International Standards and Comparative Experiences* (Routledge, 2012); Yamin, 2020 supra n 16; Yamin, 2021, supra n 16; Octávio Luis Motta Ferraz, *Health as a Human Right: The politics and judicialisation of health in Brazil* (Cambridge University Press 2021).

30 See, seminally, on the 'minimum core' approach, from an international human rights perspective, Brigit Toebes, *The Right to Health as a Human Right in International Law* (Intersentia, 1999); and Brigit Toebes, (2001), 'The right to health' in Asbjørn Eide, Catarina Krause and Allan Rosas, eds, *Economic, Social and Cultural Rights* (Martinus Nijhoff, 2001).

31 World Health Organization Commission on Social Determinants of Health, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health* (WHO 2008), 26.

32 Ferraz, supra n 29, p 19, 143-146, 284.

instance, in the Council of Europe's ESC,³³ and the UN's ICESCR.³⁴

The right to health is a human right that must be progressively realised by governments.³⁵ It is recognised that different states have different capacities to protect the right to health among their populations. However, having insufficient resources, or indeed, at least arguably, reference to a range of other (non-economic) contextual factors,³⁶ is not a lawful justification for a government failing to take active steps towards respecting, protecting and fulfilling the right to health. The principle of progressive realisation is reflected, for instance, in the ESC³⁷ and the ICESCR.³⁸

An important aspect of progressive realisation is the concept of non-retrogression. Non-retrogression has been described as follows by the UN:³⁹

Non-retrogressive measures. States should not allow the existing protection of economic, social and cultural rights to deteriorate unless there are strong justifications for a retrogressive measure. For example, introducing school fees in secondary education which had formerly been free of charge would constitute a deliberate retrogressive measure. To justify it, a State would have to demonstrate that it adopted the measure only after carefully considering all the options, assessing the impact and fully using its maximum available resources.

A retrogressive measure, which results in a reduced or lower level of support for the right to health, must thus be justified as necessary. Different possible standards for necessity include reasonableness, proportionality, and 'least restrictive alternative' tests.⁴⁰ A necessity test might be satisfied, for example, where a change in policy puts

33 1961, Preamble, paragraph 4: 'Considering that the enjoyment of social rights should be secured without discrimination on grounds of race, colour, sex, religion, political opinion, national extraction or social origin'. See European Committee on Social Rights, Conclusions XVII-2 and 2005 Statement of Interpretation on Article 11, para 5.

34 1966, Article 2 (2) 'The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.'; Article 3 'The States Parties to the present Covenant undertake to ensure the equal right of men and women to the enjoyment of all economic, social and cultural rights set forth in the present Covenant.'

35 See, for example, CESCR General Comment No 3, *The Nature of States Parties Obligations* UN doc E/1991/23 (1990) para 9; Cass Sunstein, 'Social and Economic Rights: Lessons from South Africa' 11 *Forum Constitutionnel* (1999) 123; Lilian Chenwi, 'Unpacking "progressive realisation", its relation to resources, minimum core and reasonableness, and some methodological considerations for assessing compliance' 46 *De Jure* (2013) 742.

36 Eva Brems 'Human Rights: Minimum and Maximum Perspectives' 9 (3) *Human Rights Law Review* (2009) 349-372.

37 European Social Charter 1961, Preamble para 5: 'Being resolved to *make every effort* in common to *improve* the standard of living and to promote the social well being of both their urban and rural populations by means of appropriate institutions and action,'; European Social Charter 1966 Preamble, paragraph 4, 'Considering that in the European Social Charter opened for signature in Turin on 18 October 1961 and the Protocols thereto, the member States of the Council of Europe agreed to secure to their populations the social rights specified therein in order to *improve* their standard of living and their social well-being'. Italics added. See European Committee on Social Rights Conclusions 2005 Lithuania, pp 336-338.

38 Article 2 ICESCR '1. Each State Party to the present Covenant *undertakes to take steps*, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to *achieving progressively* the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.'; Article 12 '1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. 2. *The steps to be taken* by the States Parties to the present Covenant to achieve the full realization of this right shall include ...'; Article 16 '1. The States Parties to the present Covenant undertake to submit in conformity with this part of the Covenant reports on the measures which they have adopted *and the progress made* in achieving the observance of the rights recognized herein.' Italics added.

39 Office of the UN High Commissioner for Human Rights, *Frequently asked questions on economic, social and cultural rights*, Fact Sheet 33, undated, p 16 <https://www.ohchr.org/documents/publications/factsheet33en.pdf>. See also the Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights for the realisation of these human rights 1986; CESCR General Comment No 13 para 45; CESCR General Comment No 15 *The Right to Water* UN doc E/C12/2002/11 (2003) para 19; CESCR General Comment No 18 para 21.

40 Brems, *supra* n 36.

provision of healthcare on a better footing for the population as a whole, or achieves greater equity for vulnerable groups, or creation of the circumstances where social determinants of health are improved. Attention should be paid here to the effects of such apparently justified measures, especially on marginalised or vulnerable groups,⁴¹ as well as to comprehensive examination of alternatives, effective participation of the affected groups in decision-making, and the impacts on acquired rights.⁴²

The United Kingdom has been bound by international and European obligations to respect, protect and fulfil the ‘right to health’ for decades. The right to health must be realised progressively over time, using maximum available resources to respect, protect and fulfil the right. The introduction of retrogressive measures constitutes a breach of the United Kingdom’s obligations in international and European human rights law. Such a breach is not justiciable on the basis of the Treaty obligations in the UN ICESCR or the Council of Europe’s ESC. But the United Kingdom’s international obligations must be taken into account when interpreting provisions of domestic law, including those which are directly enforceable before the courts, especially where the language of that domestic law is ambiguous.⁴³ There is an interpretative presumption that UK domestic law is compatible with international obligations

that are binding on the United Kingdom.⁴⁴ The relationship between this general obligation of ‘non-retrogression’ and the ‘non-diminution’ rights of Article 2 I/NIP is as yet unclear, but I would argue that as a minimum, ‘non-diminution’ must include ‘non-retrogression’, and may go further.⁴⁵

3.3 Health in the Belfast/Good Friday Agreement 1998

Article 2 of the I/NI Protocol applies only to ‘rights, safeguards and equality of opportunity as set out in that part of the 1998 Agreement entitled Rights, Safeguards and Equality of Opportunity’. Health is not explicitly mentioned in the relevant part of the B-GFA on ‘Rights, Safeguards and Equality of Opportunity’. However para 1, entitled ‘Human Rights’ provides that ‘the parties affirm their commitment to the mutual respect, the civil rights and the religious liberties of everyone in the community. ... *in particular* (italics added) ... the right to equal opportunity in all social and economic activity, regardless of class, creed, disability, gender or ethnicity’.

The inclusion of the words ‘in particular’ suggest that this is not intended to be an exhaustive list of rights. On the one hand, the term ‘civil rights’ suggests that the rights intended to be covered are of the nature of civil and political rights. A right to healthcare or similarly formulated right would thus not be

41 See, eg, Sandra Liebenberg, *Socio-Economic Rights Adjudication under a Transformative Constitution* (Juta & Co 2010) p 190; Chenwi, *supra* n 33.

42 CESCR, General Comment No 19 para 42.

43 See, for example, *Belhaj v Straw* [2017] UKSC 3, para 252, *per* Lord Sumption; *Assange v The Swedish Prosecutor* 4 [2012] UKSC 22, para 122, *per* Lord Dyson at [122]; *R v Lyons* [2003] 1 AC 976, para 13 *per* Lord Bingham.

44 See further, Shaheed Fatima, ‘The Domestic Application of International Law in British Courts’, in Curtis A. Bradley, ed, *The Oxford Handbook of Comparative Foreign Relations Law*, 2019 DOI: 10.1093/oxfordhb/9780190653330.013.27.

45 For an argument to the effect that ‘non-diminution’ has a different meaning to ‘non-retrogression’, see C Murray, A O’Donoghue and B Warwick, *Discussion Paper on Brexit* (Irish Human Rights and Equality Commission and the Northern Ireland Human Rights Commission, 2018), p 12 <https://www.ihrec.ie/app/uploads/2018/03/Discussion-Paper-on-Brexit.pdf>.

included, as it is of the nature of economic and social rights. On the other hand, the heading ‘human rights’ suggests a more inclusive approach, covering all types of human rights. It is well established in international law and scholarly literature that the distinction between the different rights is far from bright-line or more meaningful than a product of history.⁴⁶ That suggests an inclusive approach to interpretation of the scope of the provision. The inclusive approach is also supported by the reference to ‘all social and economic activity’, a phrase which includes access to both the National Health System in Northern Ireland (and Ireland), and to privately provided healthcare services and social care services. I would argue that the integrated nature of health and social care in Northern Ireland means that the two are not distinguishable from each other in a bright-line way in this context.

Adopting such an inclusive approach to interpretation, ‘rights, safeguards or equality of opportunity protections’ in the domain of healthcare, understood through the interpretative lens of the ‘right to health’, could be engaged as falling within the Belfast/Good Friday Agreement 1998. These ‘rights, safeguards of equality of opportunity protections’ fall into three broad areas: access to healthcare for patients; provision of healthcare services; and supply of products to Health and Social Care Northern Ireland. In each of these areas, it is possible that diminution of rights has occurred or will occur,

taking into account the nature of the right to health, as discussed above. In particular, the obligation in Article 2 I/Ni Protocol, as a minimum consistently interpreted with the non-retrogression obligation in international law, could be breached if the protection of, respect for, or fulfilment of the right to health is lessened as a result of the current legal settlement flowing from the relationship between the UK and the EU (the ‘but for’ approach articulated by the Northern Ireland Office).

In addition, consideration should be given to the possibility that the ‘right to equal opportunity in all social and economic activity’ is breached in the domain of healthcare. Such breach might, for example, concern discriminatory effects of the UK leaving the EU on groups of patients based on their age, sex or disability. If a non-exhaustive approach to interpretation of the grounds listed in para 1 is adopted,⁴⁷ discrimination on grounds of nationality might also be covered, so long as the source of the right that is diminished does not expressly exclude nationality discrimination.⁴⁸ Consideration should be given not only to *direct* discrimination, but also the *indirectly* discriminatory effects of laws, policies, or administrative practices that have the effect of discriminating on the relevant forbidden grounds, because of the way in which they apply. In any event, the relevant part of the 1998 Agreement protects ‘everyone in the community’: it does not extend only to discrimination on the basis of political opinion;

46 See literature review above.

47 This interpretation would be on the basis that the wording in Article 2 (1) is not constrained by the scope of the provisions in Annex 1, to which Article 2 refers. Annex 1 includes the Council Directive 2000/43/EC of 29 June 2000 implementing the principle of equal treatment between persons irrespective of racial or ethnic origin OJ L 180/22, which explicitly excludes nationality discrimination from its scope, see Article 3 (2), Directive 2000/43.

48 For example, Council Directive 2000/43/EC of 29 June 2000 implementing the principle of equal treatment between persons irrespective of racial or ethnic origin OJ L 180, 19.7.2000, p. 22–26 does not cover nationality discrimination, see Preamble, Recital 13.

nor does it grant rights only to the contested but presumably narrower group of ‘the people of Northern Ireland’.⁴⁹ The distinction is important, especially when the position of frontier workers is considered (see further below).

4. The nature and enforceability of the obligations in Article 2 I/NI Protocol

The Protocol on Ireland/Northern Ireland is an integral part of the Withdrawal Agreement 2020,⁵⁰ which binds the EU and the UK in mutually agreed obligations concerning the process and consequences of the UK’s withdrawal from the EU.

In some circumstances, the Withdrawal Agreement also grants rights to individuals. Some provisions of the I/NI Protocol came into force when the Withdrawal Agreement entered into force, on 31 January 2020. The remaining provisions entered into force at the end of the transition period, on 1 January 2021.⁵¹

Fulfilment of the obligations in the Protocol must be assessed in a complex legal context. Relevant applicable provisions include domestic law of the UK, Northern Ireland and Ireland, including those conceptualised

as the ‘common travel area’; domestic law of the UK implementing the Withdrawal Agreement 2020 (for instance, the ‘frontier workers scheme’) and the EU-UK Trade and Cooperation Agreement 2021; and any applicable provisions of those two international agreements, and any future agreements between the EU and the UK, and measures implementing any of those agreements.

The Withdrawal Agreement is a hybrid creature: neither ordinary international law, nor fully EU law. However, the Withdrawal Agreement shares many of the qualities of EU law. As a matter of EU law, the Withdrawal Agreement has the qualities of ‘supremacy’⁵² and ‘direct effect’,⁵³ applying without the need for further action and constituting a source of enforceable rights for individuals, applicable in priority over contradictory measures of domestic law.⁵⁴ Treaties are not automatically self-executing in the UK’s constitution. The UK’s obligations under the Withdrawal Agreement, which include the obligation to secure supremacy of the Withdrawal Agreement,⁵⁵ are brought into national law by the European Union (Withdrawal Agreement) Act 2020. The EU (Withdrawal Agreement) Act 2020, section 5, which incorporates section 7A into the European Union (Withdrawal) Act 2018, mean that the Withdrawal Agreement enjoys the qualities of

49 For discussion of ‘the people of Northern Ireland’ and the contrast with ‘the community’ in this context, see, *inter alia* Sylvia de Mars, Colin Murray, Aoife O’Donoghue and Ben Warwick, *Continuing EU Citizenship “Rights, Opportunities and Benefits” in Northern Ireland after Brexit* (Irish Human Rights and Equality Commission and Northern Ireland Human Rights Commission, March 2020), p 15; 43-44; 46-52; C McCrudden, ‘Human Rights and Equality’ in C McCrudden, ed, *The Law and Practice of the Ireland/Northern Ireland Protocol* (CUP 2022), p 145, arguing that ‘the community’ in this context may mean ‘those on the island of Ireland’.

50 Article 182 WA.

51 Article 185 WA.

52 Article 4 (1) and (2) WA.

53 Article 4 (1) WA.

54 Section 7A European Union (Withdrawal) Act 2018.

55 Article 4 (2) WA: ‘... the required powers of its judicial and administrative authorities to disapply inconsistent or incompatible domestic provision ...’.

supremacy and direct effect as a matter of the UK law also.⁵⁶

Provisions enjoy the quality of direct effect (that is, are enforceable by individuals) only where they meet the pre-requisites for direct effect, that is that they constitute a complete legal obligation, being clear, precise and unconditional.⁵⁷ Article 2 (2), while binding on the UK, does not necessarily meet the criteria for direct effect, as it does not necessarily provide for a specific and complete legal obligation towards one or more individuals. The view that Article 2 (1), however, is directly effective is widely shared, as Article 2 (1) sets out rights ('no diminution of ...') specified by reference to part of the 1998 Belfast-Good Friday Agreement, and the provisions of Union law listed in Annex 1 I/NI Protocol.⁵⁸

The provisions of the I/NI Protocol also enjoy the quality known as 'indirect effect'.⁵⁹ National courts interpreting and applying the Protocol must interpret those provisions of the Protocol that refer to concepts or provisions of Union law 'in conformity with the relevant case law of the Court of Justice of the European Union'.⁶⁰

This obligation of consistent interpretation explicitly applies irrespective of the provisions in Articles 4 and 5 of the Withdrawal Agreement.

As an integral part of the Withdrawal Agreement, the provisions of Article 2 I/NI Protocol have the quality of supremacy: that is, judicial and administrative authorities are obliged to disapply contradictory provisions of domestic law. The relevant parts of the B-GFA, therefore, enjoy a constitutional status different from (and higher than) ordinary domestic law, via the I/NI Protocol.⁶¹

5. Substantive areas of possible diminution of rights

5.1 Access to healthcare services for people in Northern Ireland

It appears that there are currently few known examples of patients in Northern Ireland being unable to access healthcare in circumstances where they would have been able to access such care prior to the end of December 2020.

56 See, eg, Paul Craig and Grainne de Burca, *EU Law* (OUP, 2020), p 270; T Hervey, N Miernik and J Murphy, *EU Law Analysis 2020*, which discusses a different part of the Withdrawal Agreement but is applicable in principle to the I/NI Protocol also; see section 7A and 20 of the EU (Withdrawal) Act 2018, as amended by the EU (Withdrawal Agreement) Act 2020. See further, Northern Ireland Office, 'Explainer: UK Government commitment to no diminution of rights, safeguards and equality of opportunity in Northern Ireland (NIO, 2020), para 29; McCrudden, supra n 24, para 63.

57 Case 26/62 *Van Gend en Loos* ECLI:EU:C:1963:1; Case 6/64 *Costa v ENEL* ECLI:EU:C:1964:66.

58 This view is shared by Christopher McCrudden, at least in regard to the anti-discrimination clause in Article 2 (1), see McCrudden, supra n 24, paras 55-56; and by Colin Murray and Clare Rice, see 'Beyond Trade: Implementing the Ireland/Northern Ireland Protocol's Human Rights and Equalities Provisions' 72 *Northern Ireland Legal Quarterly* (2021) 1-28, at 21-23. The UK Government has expressed the view that the Protocol is 'binding on the UK Government and Parliament, the Northern Ireland Executive and Assembly as a matter of international law' and that the UK's international obligations 'became UK domestic law when Parliament passed the EU (Withdrawal Agreement) Act 2020', 'the UK Government will be legally obliged to ensure that holders of the relevant rights are able to bring challenges before the domestic courts and, should their challenges be upheld, that appropriate remedies are available', and 'Given that, under Article 4 of the Withdrawal Agreement, incorporated into domestic law through the EU (Withdrawal Agreement) Act 2020, all provisions in the Withdrawal Agreement and the provisions of Union law that it makes applicable in the UK have the same legal effect in the UK as in the EU and its Member States, individuals will also be able to bring challenges to the Article 2(1) commitment directly before the domestic courts', see UK Government, *Explainer: UK Government commitment to "no diminution of rights, safeguards and equality of opportunity" in Northern Ireland: What does it mean and how will it be implemented?*, 7 August 2020, paras 5, 6 and 29. The UK Government has also stated in a Written Answer in the House of Lords that it 'considers that article 2(1) of the Protocol is capable of direct effect and that individuals will therefore be able to rely directly on this article before the domestic courts', per Lord Duncan of Springbank, House of Lords Written Answer 404 (28 January 2020).

59 Case C-106/89 *Marleasing* ECLI: EU:C:1990:395.

60 Article 13 (2) I/NIP.

61 This view is shared by Christopher McCrudden, see McCrudden, supra n 24, para 51.

For the vast majority of people in Northern Ireland, the right to access healthcare remains intact.

The interviews suggested three main possible reasons for this. First, it may be that, because of the effect of the COVID-19 pandemic, there is less movement in general on the island of Ireland than before February/March 2020. Many people are still working from home, including some in the healthcare sector. Fewer people are moving around across the border on the island of Ireland for leisure or pleasure. Second, the effects of the various ‘grace periods’ surrounding product supply in Northern Ireland are masking the full effects of Brexit on supplying Health and Social Care Northern Ireland, with consequent effects on patient safety and access to essential medicines. Third, it may be that fear of jeopardising one’s immigration status by attracting the attention of ‘the authorities’ is leading people to avoid interacting with Health and Social Care NI. The Health and Social Care NI may (erroneously) be seen as somehow linked to entities that have the power to require people to leave the United Kingdom where their immigration status is not secure.

Every interviewee did however raise concerns about possible (though hypothetical, realistically possible) loss of rights to healthcare. Some of these concerns arose from the specific settlement for health on the island of Ireland following the implementation of the Belfast/Good Friday Agreement. Others focused more on the ways people live their lives on the island. Some felt that, especially

more recently, many non-Irish, non-UK nationals living near the border may effectively be almost oblivious to the presence of the border: without a lived experience of the longer history of the island, their experience is of the ‘de-bordered’ island with EU law on free movement (of goods, services, people) underpinning much of that de-bordering.⁶² Still others raised concerns springing from the relative size of the Northern Ireland population (1.8 million compared to England’s 60 million), given links with the English NHS, especially its reliance on MHRA and NICE. And finally, a few interviewees noted that increased anxiety associated with a profound constitutional change (the UK leaving the EU) is itself related to the right to health (mental health) and that lack of timely and detailed information about the legal and policy position (see further below) exacerbates this potential deterioration of people’s health in Northern Ireland.

5.1.1 Access to healthcare on the island of Ireland

One of the key potential sites for diminution of rights associated with a right to health in Northern Ireland after 31 December 2020 is in access to healthcare services within Northern Ireland, and to all-island services. The intention of the UK government, and also expressed in messaging from the Northern Ireland Department of Health, is that ‘nothing will change’ in terms of access to health services. On one level, this cannot be the case. The various parts of EU law on which access to healthcare across borders within the EU is

⁶² See also, Sylvia de Mars, Colin Murray, Aoife O’Donoghue and Ben Warwick, *Bordering Two Unions: Northern Ireland and Brexit* (Policy Press, 2018); Sylvia de Mars, et al 2020, supra n 4, point out that the increased number of frontier workers on the island of Ireland has arisen from the greater integration of the island economically consequent upon its debordering.

based⁶³ hardly constitute a simple or perfect system. Nonetheless, it was an understood system, with a logic and underpinning legal text, on which advocacy groups on the ground, and also health sector staff who are gatekeepers to health or social care, could rely, so as to understand the legal rights of people in complex situations. So the loss of EU law – even if there is a will to recreate the substance of the rights – is at least arguably a loss in itself.⁶⁴

However, it would seem that, for many people who access the health system through Health and Social Care NI (and the shared health services in Ireland), the substance of their rights to access healthcare has not changed and will not change. This is because the common travel area rules form the basis of access of resident British and Irish people to healthcare in Northern Ireland.

Healthcare professional, Irish citizen, resident in Ireland, who works in Ireland, was advised by his doctor that he needed an MRI scan. His doctor sent him to have the scan in Northern Ireland. He was able to access this healthcare without even showing his EHIC or GHIC.

Obviously, someone who is resident in Ireland is not eligible to apply for the UK ‘settled status’ scheme which is based on residence in the UK. So there was, according to one interview, some confusion initially about access of Irish residents in this situation to the Health and Social Care NI, including to the shared infrastructure such as the Altnagelvin Hospital or the children’s Autism Centre. It would appear that the common travel area rules provide protection for such Irish residents. Some aspects of those rules, such as the Northern Ireland Planned Healthcare Scheme, however, are not yet on a statutory basis, but are currently based only on administrative arrangements.⁶⁵

However, when it comes to frontier workers,⁶⁶ there is less clarity. As argued above, frontier workers are part of ‘the community’ protected by Article 2 (1) I/NI Protocol. The frontier workers scheme, which implements the UK’s obligations in the Withdrawal Agreement, should secure access to such healthcare. If it does, then there is no diminution of rights in this context. There is a lack of clarity, however, on the relationship between the frontier workers scheme and the common travel area rules.⁶⁷ The UK Government Guidance on the frontier workers scheme provides:

63 Regulation (EC) No 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems OJ L 166/1, Regulation (EC) No 987/2009 of the European Parliament and of the Council of 16 September 2009 laying down the procedure for implementing Regulation (EC) No 883/2004 on the coordination of social security systems OJ L 284/1; Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients’ rights in cross-border healthcare OJ L 88/45; Article 56 TFEU; and the associated case law.

64 As noted above, such a broad interpretation of the ‘no diminution’ obligation is inconsistent with the aim of the relevant legal text.

65 See Muiris O’Connor et al, Assistant Secretary General, R&D and Health Analytics Division, Department of Health, *Opening Statement to Seanad Special Select Committee on the Withdrawal of the UK from the EU*, 30 September 2021 https://data.oireachtas.ie/ie/oireachtas/committee/dail/33/seanad_special_committee_on_the_withdrawal_of_the_united_kingdom_from_the_european_union/submissions/2021/2021-10-19_opening-statement-muiris-o-connor-et-al-assistant-secretary-general-r-d-and-health-analytics-division-department-of-health_en.pdf. On the general legal status and ‘significant shortcomings’ (p 819) of common travel area ‘rights’, see Sylvia de Mars and Colin Murray, ‘With or Without EU? The Common Travel Area after Brexit’ 21 *German Law Journal* (2020) 815-837 and Grainne McKeever, ‘Brexit, the Irish Border and Social Security Rights’ 25 *Journal of Social Security Law* (2018) 34.

66 Defined in EU law as ‘any person pursuing an activity as an employed or self-employed person in a Member State and who resides in another Member State to which he/she returns as a rule daily or at least once a week’, Regulation 883/2004, Article 1 (f).

67 See Sylvia de Mars, Colin Murray, Aoife O’Donoghue and Ben Warwick, *Continuing EU Citizenship “Rights, Opportunities and Benefits” in Northern Ireland after Brexit* (Irish Human Rights and Equality Commission and Northern Ireland Human Rights Commission, March 2020), p 65-67.

“Irish citizens enjoy a right to work and reside in the UK which is not reliant on the UK’s membership of the EU. This means Irish citizens do not need to apply for a frontier worker permit and do not need to hold one in order to enter the UK to work. Nonetheless, Irish citizens can make an application under the frontier worker permit scheme, should they wish to do so.”⁶⁸

Irish citizens have a right to ‘work and reside’ in the UK which is separable from rights deriving from EU law.⁶⁹ Various specific rights flow from working or residing in Ireland/Northern Ireland and residing/working in Northern Ireland/Ireland. The detailed provisions on access of such frontier workers to healthcare is found in the ‘common travel area’ rules on access to healthcare for non-residents in Northern Ireland,⁷⁰ and the Irish rules on access to the Irish NHS, including access to the Irish medical card.⁷¹

Three questions then arise. First, whether reliance on common travel area rules *in itself* constitutes a diminution of rights in a I/NI Protocol sense. Some interviewees perceived that people – especially frontier workers – are

being ‘pushed towards’ common travel area entitlements,⁷² rather than being encouraged to claim rights under the Withdrawal Agreement. Common travel area entitlements are of course contingent on continued national legislation and/or guidance remaining in place. They lack the external quality of EU law/Withdrawal Agreement law, the administrative arrangements that underpin EU law,⁷³ and the consequences associated with non-compliance with EU law/Withdrawal Agreement law. But to argue that this in itself, without more, constitutes a diminution of rights in the sense of Article 2 (1) I/NI Protocol is, as already noted above, to adopt too broad an interpretation of the ‘no diminution’ obligation, which is inconsistent with the aim of the Protocol.

Second, then, is whether the *substantive content* of the relevant rights remains undiminished. For this, we need to consider the obligations in the Withdrawal Agreement to continue to provide access to cross border healthcare for frontier workers on the island of Ireland. The frontier worker rules in the Withdrawal Agreement are complex and in some instances opaque.

68 Home Office, *Frontier Worker Permit Scheme Guidance*, 1 April 2021 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/976162/frontier-workers-v2.0ext.pdf, p 9.

69 See Immigration Act 1971, as amended by Immigration and Social Security Co-ordination (EU Withdrawal) Act 2020, section 2 (2).

70 Provision of Health Services to Persons Not Ordinarily Resident Regulations (Northern Ireland) 2015, regulation 6.

71 <https://www.gov.uk/guidance/healthcare-in-ireland>.

72 The tendency of the UK government to make vague assurances based on the common travel area has been noted by Sylvia de Mars et al 2020, supra n 4, p 67.

73 The Electronic Exchange of Social Security Information (EESSI), provided for in Article 78, Regulation 883/2004, is an information technology system enabling the exchange of personal data across EU social security institutions. It is implemented by Article 3(3) Regulation 987/2009/EC, which states: ‘When collecting, transmitting or processing personal data pursuant to their legislation for the purposes of implementing the basic Regulation, Member States shall ensure that the persons concerned are able to exercise fully their rights regarding personal data protection, in accordance with Community provisions on the protection of individuals with regard to the processing of personal data and the free movement of such data’. It provides for an accurate, efficient and secure exchange of the necessary information for treating patients, routing all healthcare documents to the correct destination in another Member State. The EESSI also facilitates the payment of the treatment by the ‘competent state’ to the country which provides the benefit, that is, the needs-based or emergency healthcare or treatment. See European Commission, ‘Electronic Exchange Of Social Security Information’, <https://ec.europa.eu/social/main.jsp?catId=1544&langId=en>. The UK remains part of the EESSI under Article 34 WA.. However, the UK is no longer included among the Member States for which the European Commission provides information about social security entitlements for migrants.

People covered by Part Two of the Withdrawal Agreement, on Citizens' Rights, have life-long protection under the Withdrawal Agreement, so long as they continue to meet the conditions set out in either or both of Title II on rights and obligations (which includes residence rights; rights of workers and self-employed persons not to be discriminated against on grounds of nationality; recognition of professional qualifications) or Title III on coordination of social security systems. It is essential to determine whether someone falls within the scope of the Withdrawal Agreement in order to determine their rights under it. The scope rules of Title II and Title III are different. Someone may fall within the scope of Title III even if they do not fall within the scope of Title II. Furthermore, the scope rules as set out in Article 10 (Personal Scope) of the Withdrawal Agreement are explicitly 'without prejudice to Title III' which is the part on coordination of social security systems within which crossborder healthcare entitlements sit.

UK nationals who are frontier workers who exercised their right to reside or work in one or more Member States in accordance with EU law before the end of 2020 fall within the scope of Part Two of the Withdrawal Agreement. Frontier workers are explicitly mentioned in Articles 24-26 WA, in the definitions clause,⁷⁴ and in Article 10 WA on the scope of Part 2 of the Withdrawal Agreement.⁷⁵

The rules regarding coordination of social security are set out in Article 31 WA, which states that the rules in Regulation 883/2004⁷⁶ 'shall apply to the persons covered by this title.'⁷⁷

The relevant provisions on access to crossborder healthcare in Regulation 883/2004 are Articles 17 and 18. Article 17 provides that:

an insured person or members of his family who reside in a Member State other than the competent Member State shall receive in the Member State of residence benefits in kind provided, on behalf of the competent institution, by the institution of the place of residence, ... as though they were insured under the said legislation.⁷⁸

Article 18 covers frontier workers. A frontier worker in EU law is someone who works in a different state from the state in which they reside, and who returns home at least once a week.⁷⁹ Article 18 provides that:

1. Unless otherwise provided for by paragraph 2, the insured person and the members of his/her family referred to in Article 17 shall also be entitled to benefits in kind while staying in the competent Member State. The benefits in kind shall be provided by the competent institution and at its own expense, in

74 Article 9 (d), Withdrawal Agreement.

75 Article 10 (c) and (d) Withdrawal Agreement. These scope rules are 'without prejudice to Title III' (the Title on the coordination of social security).

76 Regulation (EC) No 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems OJ L 166/1.

77 Article 31 (1) WA.

78 Article 17, Regulation 883/2004.

79 Article 1 (f), Regulation 883/2004.

accordance with the provisions of the legislation it applies, as though the persons concerned resided in that Member State.

2. The members of the family of a frontier worker shall be entitled to benefits in kind during their stay in the competent Member State.⁸⁰

The concept of ‘stay’ in Article 18 does not seem to be formally defined in EU law, but in practice has been interpreted as physical presence in the relevant Member State, for whatever reason. It does not appear to require an overnight stay. The effect of these provisions is that UK nationals (and EU nationals) who are frontier workers under the Withdrawal Agreement, and members of their families, may access healthcare in both their place of residence and their place of work.⁸¹ This will be provided for on behalf of the competent institution, by the institution of the place of residence⁸² or the place of work,⁸³ in accordance with the legislation of the place in which the healthcare is provided, as though the frontier worker were a resident of that place.⁸⁴

Family members are defined in accordance with Regulation 883/2004/EC.⁸⁵ Article 1 (i) of that Regulation defines ‘member of the family’ as ‘any person defined or recognised as a member of the family or designated as a member of the household by the legislation

under which benefits are provided’; and, for healthcare, ‘any person defined or recognised as a member of the family or designated as a member of the household by the legislation of the Member State in which he resides’. So if the relevant Irish or Northern Irish legislation considers that individuals are members of a frontier worker’s family or household for the purposes of access to the healthcare system, according to the Withdrawal Agreement, they will be entitled to access healthcare in Ireland / Northern Ireland under the terms of that legislation. If the Withdrawal Agreement is correctly implemented, such frontier workers and their families continue to enjoy the same rights as before 31 December 2020. There would be no diminution of rights in an I/NI Protocol sense.

Third, then, is the question of whether the UK’s implementation of the Withdrawal Agreement in Northern Ireland is consistent with the Withdrawal Agreement obligations. If it is not, then the following steps should be considered in determining whether there is a diminution of rights in an I/NI Protocol sense. If it is accepted:

- (i). that ‘the right to health’, including access to healthcare, falls within the part of the B-GFA on ‘Rights, Safeguards and Equality of Opportunity’ (section 3.3 above); and

80 Article 18 goes on to provide an exception where indicated in Annex III of the Regulation. Neither Ireland nor the United Kingdom has entered such an exception.

81 Article 3 (1) (a), Regulation 883/2004; Articles 17 and 18 (1), Regulation 883/2004.

82 Article 17, Regulation 883/2004.

83 Articles 17 and 18, Regulation 883/2004.

84 Article 18 (1), Regulation 883/2004.

85 Article 31 (2) WA.

- (ii). that Article 2 (1) I/NI Protocol must be interpreted by reference to the UK's obligations to secure the right to health, including the non-retrogression principle (section 3.2 above),

it follows that a frontier worker was protected by law in Northern Ireland before the end of the transition period, and would have continued to be protected 'but for' (section 3.1 above) the inadequate implementation of the Withdrawal Agreement by the UK in Northern Ireland.

In this instance, it follows that there is a potential diminution of rights in the Article 2 (1) I/NI Protocol sense. This is the case even if a frontier worker does not reside in Northern Ireland, but seeks to access healthcare in Northern Ireland as the state in which she works, as a frontier worker. It would also be the case for a frontier worker who lives in Northern Ireland but works in Ireland, who seeks to access shared healthcare infrastructure in Northern Ireland, even if she normally accesses healthcare in Ireland.

Although the implementation of the Withdrawal Agreement seems adequate for frontier workers themselves, this does not seem to be the case for their family members. It seems that family members of frontier workers are not provided for under the UK's frontier workers' scheme,⁸⁶ which is supposed to implement the Withdrawal Agreement obligations, unless they are resident in the

'competent state'. So for a family member of a frontier worker who is resident in Ireland, and seeks access to the Northern Irish health system (perhaps because they are accessing education in Northern Ireland, or simply because it is easier for their parent to accompany them to a GP near their place of work, rather than their place of residence), the frontier workers scheme falls short of the Withdrawal Agreement's provisions.

Depending on whether the common travel area rules⁸⁷ nonetheless secure access to healthcare under those circumstances, this may be a breach of the Withdrawal Agreement. It would, in my view, also constitute a diminution of rights under Article 2 (1) I/NI Protocol, for the reasons outlined above. Family members of frontier workers used to be able to access healthcare in either Northern Ireland or Ireland before the UK left the EU and the transition period ended, and now the rules of the frontier workers scheme - at least as represented on the UK gov website - suggest that they can no longer do so. This is a retrogressive step, in terms of securing the right to health, for those family members of frontier workers.

There are also some questions about loss of rights arising from onward movement, for instance, if a non-Irish EU national works as a frontier worker in Northern Ireland/Ireland, and then retires to their home country in the EU. The Withdrawal Agreement does not, in general, grant such 'onward movement' rights.⁸⁸ It is difficult to see how such rights

86 See the UKG website, from which it seems family members are not provided for under the frontier workers scheme unless they are resident in the competent state: Frontier Worker permit - GOV.UK (www.gov.uk) "Family members are not covered by your Frontier Worker permit."

87 Which only apply to British/Irish nationals.

88 See Tamara Hervey et al, Withdrawal Agreement Scenario Analysis, for the Brexit Health Alliance, September 2020, available on file from author.

would meet the ‘but for’ test of diminution of rights under Article 2 (1) I/NI Protocol. These rights being lost are a consequence of leaving the EU in general.

An interviewee expressed the view that the frontier worker provisions of the Withdrawal Agreement are not fit for purpose for the Irish border. Further investigation would be necessary to explore this suggestion. It may be that the relevant infrastructure in health and social care in Northern Ireland and Ireland is insufficiently adapted to manage the position of frontier workers under the Withdrawal Agreement. This suggestion is illustrated by the following scenario.

Frontier workers who live in Ireland and work in Northern Ireland have entitlement under the Withdrawal Agreement to healthcare in either health system. So logically they were entitled to have their COVID-19 vaccinations in Northern Ireland (where the rollout was quicker than in Ireland). But what actually happened was that they were not called up for vaccination, because there was a perception that vaccination entitlement was residence-based. Subsequently, those who did access vaccination successfully (because they were entitled to it) were not able to register for the UK’s COVID vaccination ‘passport’, because again the digital infrastructure around the passport was all residence based.

EU-26 nationals resident in Northern Ireland may have difficulty accessing shared ‘all island’ healthcare facilities in Ireland, especially if they present to the health system administration as foreign non-residents. This is one of the

few concrete examples of an individual being reported as suffering a loss of rights that emerged from the interviews. Further investigation would be necessary to determine whether this is an isolated incident, or the product of the changed legal environment in terms on which EU-26 nationals resident in Northern Ireland access all-island healthcare services in Ireland.

A non-English speaking, BME, national of an EU-26 country gave birth to a premature baby in a hospital in Northern Ireland. The baby was critically ill, and was therefore transferred to the all-island children’s heart unit in Dublin. It was unclear whether the mother would be able to go with the baby (in terms of her immigration status), or access the healthcare that she needed if she did go. The hospitals concerned adopted a very cautious position: initially suggesting the mother would need to pay for non-emergency aspects of her healthcare. The situation was resolved by the intervention of a NGO, which was able to send staff to both the Belfast and Dublin hospitals to advocate for the mother and her child.

This example relates to the point that it may not be easy for EU-26 nationals to be aware of the border on the island of Ireland. Especially if they have arrived relatively recently, they may be accustomed to that border being invisible, and they may be used to behaving (including when accessing healthcare or buying healthcare products) as if it is not present. The re-bordering of Ireland (even if only very partial or only for some things) may thus affect them more profoundly than people who have been resident on the island

for longer and therefore are more aware of the need to question their continued entitlements to behave as if the border were not there.

The common travel area rules do not apply to these EU-26 frontier workers, as they grant rights only to UK and Irish citizens, so the points made above about the Withdrawal Agreement provisions apply to EU-26 frontier workers, and their families.

For EU-26 nationals, and their families, settled status is critical to residence, which is the basis of access to healthcare in Northern Ireland which is a residence-based system. At least one interviewee noted that Northern Ireland has done better than England in making sure that people have applied for settled and pre-settled status. As has been established by other research, anyone who is vulnerable to not having secured settled status (for example, children, women, people who are not IT literate, who do not read or write English etc⁸⁹) is also vulnerable to loss of healthcare rights, because of the way the settled status scheme has been implemented.

There is also the question of loss of rights suffered by other vulnerable people who are present in Northern Ireland, but who are not lawful residents. The key example here is child victims of human trafficking.

A child is brought unlawfully into Northern Ireland from Vietnam and forced to work producing cannabis. He is locked up and unable to leave the house. He suffers psychological trauma as a result of his treatment by his traffickers.

or

A child is brought unlawfully into Northern Ireland from Nigeria and forced into sex work. She becomes pregnant and seeks to access both physical and mental healthcare in Northern Ireland.

The EU Trafficking Directive⁹⁰ obliges Member States to make provision to protect victims of human trafficking. Such protection involves assisting victims before, during and for a sufficient period after criminal proceedings, to enable victims to exercise their rights conferred by the Directive.⁹¹ The protections include 'necessary medical care, including psychological assistance'.⁹² Member States are obliged to 'take due account of' specific needs of victims 'where those needs arise in particular from possible pregnancy, state of health, disability, mental or psychological disorders or serious forms of psychological violence, physical or sexual to which they have been subjected'.⁹³ This provision meets the qualities for 'direct effect', as it constitutes a complete legal obligation, is clear, precise and

89 See, for instance, Charlotte O'Brien, 'Between the devil and the deep blue sea: Vulnerable EU citizens cast adrift in the UK post-Brexit' 58(2) *Common Market Law Review* (2021) 431-470. Sylvia de Mars et al, 2020, *supra* n 4, p 66, point out that frontier workers on the island of Ireland come from all socio-economic classes.

90 Directive 2011/36/EU of the European Parliament and of the Council of 5 April 2011 on preventing and combating trafficking in human beings and protecting its victims, and replacing Council Framework Decision 2002/629/JHA OJ L 101/1-11, Article 11.

91 Directive 2011/36/EU, Article 11 (1).

92 Directive 2011/36/EU, Article 11 (5).

93 Directive 2011/36/EU, Article 11 (7).

unconditional.⁹⁴ The Directive thus would, if applicable, give rights to trafficked children (and adults) in the scenario outlined above.

The access of those trafficked children to healthcare in Northern Ireland is governed by the Human Trafficking and Exploitation (Criminal Justice and Support for Victims) Act (Northern Ireland) 2015.⁹⁵ Section 21 of the Act obliges the Regional Health and Social Care Board to appoint an ‘independent guardian’ to ‘assist, represent and support’ child victims of trafficking. The functions of the independent guardian include ‘making representations to, and liaising with, bodies or persons responsible for’ providing ‘health services’ to the child. But the obligation in section 21 does not extend to an obligation to provide those health services that are mandated for Member States of the EU under EU law. That obligation must be found elsewhere in the law of Northern Ireland, or through any retained EU law. Access of child victims of trafficking to healthcare was also governed by the Provision of Services to Persons Not Ordinarily Resident Regulations (Northern Ireland) 2015,⁹⁶ but these regulations were repealed in 2020.⁹⁷ They do not appear to have been replaced by any other regulations. Under the Provision of Services to Persons Not Ordinarily Resident Regulations, ‘family planning services’ and ‘accident and emergency services’ were exempt from charges.⁹⁸ So emergency care

is available to anyone present in Northern Ireland, irrespective of immigration status. But treatment for psychological trauma, unless in the context of an urgently presenting psychosis, did not fall under these exemptions. Neither did access to maternity care or abortion services. So before the UK left the EU, a trafficked child would have had to rely directly on the Directive to enforce those aspects of their right to health.

Regulation 7 of the (now repealed) Provision of Services to Persons Not Ordinarily Resident Regulations (Northern Ireland) 2015 provided that no charges may be made when healthcare is accessed in reliance on an enforceable EU law right, as defined by the European Communities Act 1972, section 2 (1). That provision has of course been amended by the European Union (Withdrawal) Act 2018 and the European Union (Withdrawal Agreement) Act 2020. The effect of those provisions is, in effect and to simplify, to remove the category of an ‘enforceable EU law right’ from UK law.

Are the protections in the Directive concerning the right to health (access to non-urgent treatment for psychological trauma, maternity care, abortion services) found elsewhere in the law in Northern Ireland? At the time that the UK opted in to that Directive, the European Commission took the view that amendments were needed to UK law to secure

94 Although neither the CJEU nor national courts in the UK have ruled on the direct effect of the provision in Article 11, UK domestic courts have found other provisions of the Directive to be directly effective, see *L, HVN, THN & T v R* [2013] EWCA Crim 991.

95 Section 18 of that Act provides an obligation to provide ‘assistance and support’, including ‘assistance in obtaining healthcare services’, for *adults*. That provision does not cover children. The Act is currently being amended by The Justice (Sexual Offences and Trafficking Victims) Bill. That Bill as it currently stands does not cover children’s access to healthcare either.

96 The Regulations provided for the appointment of an ‘independent guardian’ for a trafficked child, which is not directly relevant to access to healthcare, or to rights formerly arising from EU law.

97 See Provision of Health Services to Persons Not Ordinarily Resident (Amendment) (Revocation) Regulations (Northern Ireland) 2020. As outlined below, this is an example where the publicly available statement of the law is incomplete. It is necessary to have a ‘paid for’ legal research service, such as Westlaw or Lexis-Nexis, in order to discover the 2020 Regulations.

98 Provision of Services to Persons Not Ordinarily Resident Regulations (Northern Ireland) 2015, Regulation 4 (1).

compliance.⁹⁹ These included the Directive's provisions on assistance and support. No further amendments were made, as the UK government took the view that 'the new text ... does not contain any measures that would significantly change the way the UK fights trafficking'.¹⁰⁰ Removing the Directive from the law applicable in Northern Ireland therefore would mean that directly effective rights, including to access 'necessary medical care, including psychological assistance' free of charge are no longer available to child victims of human trafficking who are unlawfully present in Northern Ireland. Those rights may be available by virtue of the provisions of the European Union (Withdrawal) Act, section 4, which retains 'rights ... which, immediately before [31 December 2020] are recognised and available in domestic law by virtue of section 2(1) of the European Communities Act 1972, and are enforced, allowed and followed accordingly'. Are the amendments that were, in the view of the European Commission, necessary to ensure compliance, but in the view of the UK government were not necessary, within the meaning of rights covered by section 4? This is unclear.¹⁰¹

If they are not so covered, then the following steps should be considered in determining whether there is a diminution of rights in an I/NI Protocol sense. If it is accepted:

- (i). that 'the right to health', including access to non-emergency healthcare for trafficked children, falls within the part

of the B-GFA on 'Rights, Safeguards and Equality of Opportunity' (section 3.3 above); and

- (ii). that Article 2 (1) I/NI Protocol must be interpreted by reference to the UK's obligations to secure the right to health, including the non-retrogression principle (section 3.2 above),

it follows that a trafficked child was protected by directly effective EU law applicable in Northern Ireland before the end of the transition period, but is no longer so protected. That loss of protection could not have legally occurred 'but for' (section 3.1 above) the UK's departure from the EU, because the child would otherwise have had a remedy for the inadequate implementation of the Directive into domestic law by the UK in Northern Ireland, through the direct effect of the relevant Directive.

5.1.2 Access to healthcare services while a visitor in EEA countries or Switzerland

According to the interview data, a new system, involving a 'global health insurance card' (GHIC) and a new UK 'European Health Insurance Card' (EHIC), is expected to secure ongoing entitlements for people who are covered by the Northern Ireland health system to access necessary healthcare when visiting EU countries.

99 Immigration Law Practitioners' Association, 'ILPA Submission to the Joint Committee on Human Rights: Human Rights Implications of Brexit' 17 October 2016, paras 45-47.

100 Damian Green, MP, Hansard HC 12 March 2011: column 53WS.

101 The lack of clarity ('there is confusion which requires remedy', para 3.3) has been noted by the *Joint NIHRC / ECNI Briefing Paper on the Modern Slavery and Human Trafficking and Electronic Travel Authorisation provisions in the Nationality and Borders Bill, 27 January 2022*, <https://nihrc.org/publication/detail/joint-nihrc-ecni-briefing-paper-on-the-modern-slavery-and-human-trafficking-and-electronic-travel-authorisation-provisions-in-the-nationality-and-borders-bill>

Unlike the old EHIC, the GHIC does not entitle visitors to access necessary healthcare in Norway, Iceland, Liechtenstein, or Switzerland. The amended relevant Northern Ireland law removes the obligation to reimburse the costs of healthcare which becomes necessary during a visit to an EEA state.¹⁰² Although the new UK EHIC does include those four countries, UK citizens living in Northern Ireland are not ‘normally’¹⁰³ entitled to a new UK EHIC, even if they are also Irish citizens. This is an obvious reduction of rights. Whether it also constitutes a breach of the ‘no diminution’ obligation of Article 2 I/NI Protocol depends on at least two further considerations, assessed here on a minimalist interpretation of ‘no diminution’ as non-retrogression. First, as the negotiation of social security arrangements with other countries is not solely within the control of the UK government, the most that the non-retrogression principle could cover here is a ‘best endeavours’ obligation on the UK government. Second, we would consider whether the domestic law in each of those countries in fact grants the same entitlements, and that this is sufficient to constitute ‘no diminution’ in an Article 2 I/NI Protocol sense.¹⁰⁴

The UK government website¹⁰⁵ acknowledges that some people who are resident in Ireland ‘may’ be entitled to a new UK EHIC. The website says that UK state pensioners, or

recipients of other exportable benefits, resident in Ireland since before 1 January 2021; and ‘frontier workers’ who have been living in one country and working in another since before 1 January 2021, ‘may’ be entitled to a new UK EHIC. People in this category may not apply online or contact the relevant department through an online form in the same way as others who are entitled to a new UK EHIC or GHIC, but are advised to contact the NHS Overseas Healthcare Services by telephone or in writing. Not being able to access one’s rights as easily as before may potentially constitute a diminution of rights. Potentially more problematically, it has not been possible to find any relevant UK legislation applicable to UK nationals resident in Ireland in this category, so as to scrutinize whether the legal position (as opposed to what is on the website) is consistent with UK obligations under the Withdrawal Agreement and/or potentially constitutes a diminution of rights under Article 2 (1) I/NI Protocol. It may be that the only source of the obligations is the Withdrawal Agreement itself. As explained above, the Withdrawal Agreement gives rights to access healthcare for resident pensioners (including former frontier workers) through coordination of social security rules between the UK and the EU.¹⁰⁶ These provisions are discussed above, and entitle a UK national resident in Ireland (an EU Member State) before 1 January 2021 who is either a frontier

102 Previously, the Health and Personal Social Services (Northern Ireland) Order 1972, Article 14B; revoked by Health Services (Cross-Border Health Care and Miscellaneous Amendments) (Northern Ireland) (EU Exit) Regulations 2019 (SI 2019/784). SI 2019/784 also revokes the Health Services (Cross-Border Health Care) Regulations (Northern Ireland) 2013. Note that a proposal from the Irish Government in September 2019 would have provided an Irish equivalent of the EHIC to all residents of Northern Ireland, see Sylvia de Mars et al, 2020, *supra* n 4, p 53.

103 <https://www.nhs.uk/using-the-nhs/healthcare-abroad/apply-for-a-free-uk-global-health-insurance-card-ghic/>.

104 Determining that would be a comparative law exercise, involving scrutiny of the law in the relevant four states. All European countries do grant visitors free access to *emergency* healthcare. Whether emergency healthcare encompasses all of necessary healthcare as per Regulation 883/2004 would need to be carefully checked in the relevant legal system.

105 <https://www.nhs.uk/using-the-nhs/healthcare-abroad/apply-for-a-free-uk-global-health-insurance-card-ghic/>.

106 Article 31 (1) WA by reference to Regulation 883/2004, Arts 1 (q), 23-30.

worker, or a recipient of a pension, to access healthcare in the UK (here Northern Ireland) as though they were ‘insured by’ the UK (that is, as though they were covered by the HSC in Northern Ireland).¹⁰⁷

5.2 Provision of healthcare services

The right to healthcare encompasses the right to efficacious and safe healthcare. Safe and efficacious healthcare can only be provided by a properly staffed healthcare system, with safeguards to ensure that health professionals are appropriately qualified. Some interviewees expressed concerns about the ongoing understaffing of the HSC in Northern Ireland, pointing out that this has been exacerbated by the UK leaving the EU. Figures on workforce gaps in the integrated health and social care system in Northern Ireland are disputed or unclear. This is especially the case in the social care sector, where much provision is through private entities. Interviewees suggest that the lack of strategic plans to redress healthcare workforce gaps are leading to long wait-times for hospital care in particular. They also express concern about the loss of opportunities for migrants to the UK associated with the UK leaving the EU (for example, for family rights, onward migration, lack of mutual recognition of qualifications across the EU, to work with European networks) making it more difficult to attract young talent to the healthcare sector in Northern Ireland. At the same time, steps are

being taken to seek to redress these matters, especially in terms of training new healthcare staff.¹⁰⁸ Whether the workforce capacity issues are sufficiently severe to constitute a breach of the right to healthcare, or a breach of the ‘no diminution’ rule in Article 2 (1) I/NI Protocol would need to be carefully explored, taking into account the non-retrogression principle. That question is therefore outside the scope of this paper. It might be very difficult to show the relevant causality, given the many other intervening variables, including the effects of the COVID-19 pandemic on health sector staffing globally. The workforce gaps would have to be shown to have arisen *because* of the UK leaving the EU (the ‘but for’ test) and the reduced workforce would have to be shown to have caused worsening in safe and efficacious healthcare, to the extent that this constitutes a regression of the right to health, as defined through international law (see above).

Questions pertaining to mutual recognition of professional qualifications, including indemnity insurance, did not arise from the interviews undertaken in this research. It appears that the relevant professional associations are reaching agreements at sectoral level to take the place of relevant EU laws, and some Memoranda of Understanding are in place between Ireland and Northern Ireland which include mutual recognition of health professional qualifications and fitness to practise rules.¹⁰⁹ It is possible that these could be solidified into

107 Article 31 WA, by reference to Article 3 (1) (a), Regulation 883/2004; Articles 17 and 18 (1), Regulation 883/2004.

108 See, for example, Northern Ireland Department of Health, ‘Minister announces nursing and midwifery training places’ 21 April 2021 <https://www.health-ni.gov.uk/news/minister-announces-nursing-and-midwifery-training-places>; Northern Ireland Department of Health, ‘Funding secured for 300 additional nursing and midwifery undergraduate places’ 3 May 2020 <https://www.health-ni.gov.uk/news/funding-secured-300-additional-nursing-and-midwifery-undergraduate-places>.

109 See, for example, Steve Ford, ‘Unions sign unique deal designed to Brexit-proof midwives’ *Nursing Times* 22 January 2018; Department of Health, *Memorandum of Understanding: Covid-19 response: Public Health Cooperation* 7 April 2020 <https://www.health-ni.gov.uk/sites/default/files/publications/health/critical-care-north-south-mou.PDF>.

arrangements for recognition of professional qualifications under the EU-UK Trade and Cooperation Agreement.¹¹⁰

5.3 Supply of products to Health and Social Care Northern Ireland¹¹¹

Access to medicines, medical devices, equipment, consumables, and substances of human origin (blood, organs, tissue, cells) is a fundamental aspect of the human right to health.¹¹² In a well-functioning national health system, patients are entitled to be confident of secure, predictable, planned and sufficient product supply to ensure that the health professionals treating them are able to offer appropriate treatment, within the ‘basket of care’ offered by that particular NHS. Patients are entitled to be confident that these products are safe, and efficacious.

The process of legal separation between the UK and the EU has been and continues to be disjointed and drawn out, especially where it comes to trade in products.¹¹³ As things currently stand, in brief, some aspects of the full legal consequence of the UK becoming a ‘third country’ (non-EU Member State) apply already in Northern Ireland; the application of some has been delayed; and some aspects may never apply to Northern Ireland, or at least not for some considerable time. For example, as things currently stand, after the end of the ‘grace period’ for medicines, originally scheduled to end on 31 December 2021 but currently extended, medicines supplied from Great Britain to Northern Ireland will need to comply with all EU medicines regulations, including the Falsified Medicines Directive and importation requirements such as batch testing and Qualified Person

110 Article 158 TCA.

111 This section draws on Hafsa Yusufi, Tamara Hervey, et al ‘The NHS in Northern Ireland Post-Brexit: the Legal Position on Product Supply’ forthcoming *European Journal of Health Law* 2021.

112 See, for example, Paul Hunt and Rajat Khosla. ‘The human right to medicines’ 5 *Sur. International Journal on Human Rights* (2008): 100-121; the articles in the special issue of *Public Health Ethics* edited by Thomas Pogge, for the editorial, see, Thomas Pogge, Access to Medicines, 1 (2) *Public Health Ethics* (2008) 73-82. Much of the literature on this issue concerns access to medicines in the global south. But I would argue that the arguments for intervening with market forces to secure a right to health also apply to access to medicines for vulnerable populations in the global north.

113 On the temporal aspects of Brexit, see, seminally, Kenneth Armstrong *Brexit Time* (Cambridge University Press, 2017). The Northern Ireland Assembly has provided a useful timeline: <http://www.niassembly.gov.uk/assembly-business/brexit-and-beyond/timeline-and-key-documents/>. Key dates are 31 Jan 2020 when the UK formally left the EU; 1 February 2020 when the Withdrawal Agreement entered into force; 31 December 2020 when the transition period ended, at which point EU law ceased to be applicable in Great Britain (Article 126 WA), but in effect Northern Ireland remained within the EU’s single market, where products are concerned. But the transition period was not long enough to solve all legal matters of separation, some of which concern supply of products to the HSC Northern Ireland.

certifications. The current¹¹⁴ and ongoing¹¹⁵ legal complexity, and its contentious nature,¹¹⁶ demonstrate that the position of Northern Ireland, as partially 'within' the EU's legal regime for products, creates considerable uncertainty for the HSC in Northern Ireland, as the granularity of the legal regime becomes

understood, while at the same time that legal regime continues to be unusually unstable.

The interpretation and implementation of the Ireland/Northern Ireland Protocol, in conjunction with the existing Northern Irish, UK, and EU legislation, is a continuous and

114 Some of the principal changes which occurred in relation to medicines and medical devices on 1 January 2021 include the following. The EU ceased to recognise UK-established Notified Bodies. These are now known as 'Approved Bodies' within UK law. The regulatory standards applicable in Great Britain to medicines are contained in over 340 domestic regulations, consolidated as the Human Medicines Regulations 2012. The Medicines and Medical Devices Act 2021 gives broad executive powers to amend the relevant Regulations. These powers have been exercised by the MHRA, acting as the executive agency of the Department of Health and Social Care, see <https://www.gov.uk/guidance/regulating-medical-devices-in-the-uk>. Pharmacies in Great Britain disconnected from the National Medicines Verification System and are no longer required to conform to Falsified Medicines Directive processes, see Human Medicines (Amendment etc) (EU Exit) Regulations 2019, SI 2019/775 as amended by the Human Medicines (Amendment etc) (EU Exit) Regulations 2020, SI 2020/1488. A wholesale dealer in Great Britain can no longer import Qualified Person certified medicines from the EEA without certain checks being made by the Responsible Person (import), see The Human Medicines Regulations 2012, regulations 45(1) and (2). Establishments in Northern Ireland need an import licence from the Human Tissue Authority in order to receive human tissues and cells from Great Britain, see Human Tissue Authority, 2021, 'UK Transition licensing FAQs', 13 September, <https://www.hta.gov.uk/guidance-professionals/uk-transition-guidance/transition-faqs>.

115 Efforts by both the EU and the UK to avoid the disruption of medical supplies to Northern Ireland began in 2020, as both Northern Ireland and other small markets, especially Ireland, are historically dependent on Great Britain for their medicine supplies. An EU-UK Joint Committee (established by Article 164 WA) meeting resulted in unilateral declarations made by the EU and the UK detailing the EU's pharmaceutical *acquis* in regards to Northern Ireland, see HM Government, 2020, 'Unilateral declarations by the European Union and the United Kingdom of Great Britain and Northern Ireland in the Withdrawal Agreement Joint Committee on human and veterinary medicines', 17 December 2020, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/946659/Unilateral_declarations_by_the_European_Union_and_the_United_Kingdom_of_Great_Britain_and_Northern_Ireland_in_the_Withdrawal_Agreement_Joint_Committee_on_human_and_veterinary_medicines.pdf. The European Notice on this matter was later replaced by another on 25 January 2021: Commission Notice – Application of the Union's pharmaceutical *acquis* in markets historically dependent on medicines supply from or through Great Britain after the end of the transition period [2021] OJ C 27/11. A phased approach for implementing medicines regulations, agreed on 5 November 2020 by the Joint Committee, aimed to secure the 'undisrupted supply of medicines' to Northern Ireland, European Commission, 2020, 'Press statement following the fourth meeting of the Specialised Committee on Ireland and Northern Ireland Protocol', 5 September. Retrieved 16 September 2021, https://ec.europa.eu/info/publications/press-statement-following-fourth-meeting-specialised-committee-ireland-and-northern-ireland-protocol_en. Similar 'grace periods' have been negotiated, and also unilaterally extended, delaying implementation of various terms of the Withdrawal Agreement pertaining to an array of different issues, from medicines to chilled meats, see Peter Foster, 'UK extends Northern Ireland 'grace periods' for third time', 6 September 2021, <https://www.ft.com/content/Ofaeac83-dd07-48ca-baf5-67f36f6b7b59?accessToken=zwAAAXvzOMCgkc8PrqyD3QdlytO69Wfzb2t7WQ>. MEUCIQDhJg6aLMfnv8JqSAp-TBpggq_oI7ENFRIRsJchpE88AlgX-2jeHg8ynj52BzCvxUW43SRixrmLuurmM10Z3evzYM&sharetype=gift?token=caf8ff93-6090-48af-ac2e-41618b359826. For medical devices, equipment, and consumables, new regulations and legal requirements were and will be implemented in a staggered manner. For example, Class III and IIb implantable medical devices, active implantable medical devices and list A IVD products did not need to be registered with the MHRA until 1 May 2021. For Class IIb (non-implantable) and IIa medical devices, list B IVD products and self-testing IVDs, registration with the MHRA was not required until 1 September 2021, and Class I medical devices and generic IVDs do not need to be registered with the MHRA until 1 January 2022. Furthermore, the requirement for most products circulating in the GB market to have a UKCA marking will not come into force until 1 January 2023. From 30 June 2023, UKCA marks will be required for medical devices on the GB market, and only UK MDR compliance will be recognised in Great Britain, whereas the new EU(NI) mark will be needed for supply of products to Northern Ireland, see Medicines and Healthcare products Regulatory Agency, 'Regulating medical devices in the UK', 31 December 2020, <https://www.gov.uk/guidance/regulating-medical-devices-in-the-uk>.

116 The EU has challenged UK actions for breach of the Withdrawal Agreement, although EU action is currently suspended while talks are ongoing. In March 2021, the UK Government announced a delay to introduction of full import checks by an average of 6 months for British goods being imported into the EU, see Joe Marshall, 'Delaying Brexit border checks solves some problems but creates others', 12 March 2021, <https://www.instituteforgovernment.org.uk/blog/delaying-brexit-border-checks>. The EU response denounced the announcement as a breach of the I/Ni Protocol, and later issued a letter of formal notice to the UK for its breach (though the process was paused in July 2021), see European Commission, 'Statement by Vice-President Maroš Šefčovič following today's announcement by the UK government regarding the Protocol on Ireland / Northern Ireland', 3 March 2021 https://ec.europa.eu/commission/presscorner/detail/en/STATEMENT_21_1018; European Commission, 2021, 'Withdrawal Agreement: Commission sends letter of formal notice to the United Kingdom for breach of its obligations under the Protocol on Ireland and Northern Ireland', 15 March 2021, https://ec.europa.eu/commission/presscorner/api/files/document/print/en/ip_21_1132/IP_21_1132_EN.pdf; Hans von der Burchard, EU pauses both Brexit lawsuits against the UK, 28 July 2021, <https://www.politico.eu/article/eu-uk-legal-actions-paused/>. Similarly, attempts by the UK Government to call for a fundamental rethinking of the Northern Ireland Protocol on 21 July 2021 were rebuffed by the EU, see HM Government, *Northern Ireland Protocol: The Way Forward*, 21 July 2021, CP 502; European Commission, 2021, 'Statement by Vice-President Maroš Šefčovič following today's announcement by the UK government regarding the Protocol on Ireland / Northern Ireland', 21 July 2021, https://ec.europa.eu/commission/presscorner/detail/en/statement_21_3821. The European Commission issued a 'non-paper' on 13 October 2021, European Commission, 'Protocol on Ireland and Northern Ireland Non-Paper Medicines' 13 October 2021 https://ec.europa.eu/commission/presscorner/detail/en/ip_21_5215, proposing a permanent derogation from the application of EU law rules on pharmaceuticals marketing for medicines supplied to the Northern Ireland market. This was followed by a package of proposals on 17 December 2021, which seek to allow medicines supply for Northern Ireland to continue to be largely through GB by allowing regulatory functions for medicines supplied to Northern Ireland to be carried out by GB-based entities, applying EU rules, see https://ec.europa.eu/info/strategy/relations-non-eu-countries/relations-united-kingdom/publications-and-news_en.

live process, influenced by a variety of legal, practical and political factors. Even if the legal effects of the Ireland/Northern Ireland Protocol were to become better understood to some degree for the next three years, or subject to a new or qualified articulation, the requirement of approval of some parts of the Northern Ireland Protocol by the Northern Ireland Assembly on 31 December 2024¹¹⁷ holds the possibility of those parts of the Protocol being disapplied in the near future. At that point, further complexity to the existing status quo on the relationship between the EU, the UK and Northern Ireland would arise. This volatile legal environment is problematic for the HSC in Northern Ireland, which, like every other national health system, needs to be able to plan, well in advance, the procurement of products and substances of human origin necessary to treat its patients.

The HSC Northern Ireland is heavily reliant on supplies from Great Britain. If these supplies are disrupted, the quality of care offered to patients, and thus their human right to health, will diminish. This is especially so if the right to health is understood as including a non-regression obligation. Such diminution of rights would only occur after the ‘grace periods’, which are currently securing supply, cease to apply. Detailed legal analysis¹¹⁸ reveals significant costs and uncertainties associated with supply of products to the HSC in Northern Ireland. The direction of travel, unless something changes, is that new products will reach patients later than in Great Britain, and there is a real possibility

that some products become difficult or impossible for the HSC in Northern Ireland to source. Arguably this is not a matter that falls within the Article 2 I/NI Protocol obligation, because international cooperation is required to avoid the detrimental effects of the terms of the Withdrawal Agreement on the rights of patients in Northern Ireland. The operations of the Protocol rules on supply of goods to Northern Ireland are a consequence of the form of Brexit chosen. Of course, had the UK not exited the EU, the legal changes would not have happened, but this is not what the ‘but for’ test means (see above). But equally, it could also be argued that the UK government could take unilateral steps to avoid those effects, for example by offering significantly higher prices to firms supplying the HSC Northern Ireland, and by creating a more certain regulatory environment by compliance with those international agreements already reached, including the ‘dynamic alignment’ with EU law implicit in the I/NI Protocol.

Scenario: Patients in Northern Ireland access medicines later than in England, because the timeline for MHRA approval for a new indication for an existing drug is quicker than timeline to EMA approval.

Interviewees stressed that the supply of products is a major issue of patient safety. Prior to the end of 2020, patients in Northern Ireland enjoyed broad parity with England in terms of licensing (because they shared MHRA and EMA licensing processes) and also in terms of health technology assessment

117 Article 18 I/NI P.

118 See Tamara Hervey et al, Report for Brexit Health Alliance on Product Supply to the NHS in Northern Ireland (2021, on file with author); Hafsa Yusufi, Tamara Hervey, et al ‘The NHS in Northern Ireland Post-Brexit: the Legal Position on Product Supply’ forthcoming *European Journal of Health Law* 2021; Dayan et al, supra n 4.

(because Northern Ireland relies on the England-based NICE for decisions as to cost-effectiveness). Slower licensing decisions can be circumvented by 'off-label' prescribing by individual health professionals, but off-label decision-making can be controversial and potentially associated with increased risk to patients. There were some relatively minor differences in terms of specific commissioning decisions, but those were not disproportionate, and not dissimilar to the English NHS 'postcode lottery'. The HSC in Northern Ireland is almost totally reliant (98% of medicines) on a just-in-time UK-based supply chain, where products are moved from England to the HSC Northern Ireland. At least one interviewee felt that changing the supply chain routes to go through Ireland is not a solution, because the disparity in practice between the NHS in Ireland and the UK's national health systems is too wide.

Supply concerns affect all types of medicines: prescription-only, pharmacy, over-the-counter (for example, in supermarkets). Difficulties of supply in Northern Ireland are expected at the end of the various grace periods. The expectation from interviewees is that there will eventually be a reduced choice of products available on the NHS, and also pharmacy and over-the-counter products, for the Northern Irish population.

Whether disrupted or slower product supply; reduced availability of healthcare related products, especially medicines; or increased use of 'off-label' prescribing are not only a *patient safety concern*, but also constitute a *breach of the right to health* and/or consequently a breach of the Article 2 I/NI Protocol 'no diminution' obligation, would

need to be carefully explored, taking into account the principle of non-retrogression. Potentially this could be a 'diminution of rights' suffered by the whole population of Northern Ireland. As noted above, it is a matter over which the UK Government does have some unilateral room for manoeuvre, even though a decision to provide significantly higher funding for NHS supply to Northern Ireland might be politically unpalatable in England. It is very difficult at present to estimate the scale of the problem, as data is scarce and lacking public transparency.

Indirect nationality discrimination, as a component of the 'right to health' as embodying non-discriminatory access to healthcare on a range of 'forbidden grounds', might also be involved, as patients resident in Northern Ireland are more likely to be Irish than patients resident in England. Alongside a narrowing range of products, the costs to patients in Northern Ireland of pharmacy and over-the-counter products is also expected to increase. The burden of the increased expense will fall disproportionately on people on lower incomes and the elderly, as a greater proportion of their income will then be spent on medications. Whether this effect constitutes indirect discrimination on grounds of age or socio-economic class could also potentially be explored.

Finally, there is the question, raised by one interview, that the changes to arrangements for authorised healthcare product supply in Northern Ireland also constitute a loss of democratic rights and a reduction of democratic legitimacy. This arises because, under the I/NI Protocol, the European Medicines Agency is in effect the decision-

maker for medicines licensing in Northern Ireland, and the EU legislature is in effect responsible for changes in medicines regulation applicable in Northern Ireland, and also regulation of medical devices, equipment and substances of human origin. Yet, other than the committee structure set up under the Withdrawal Agreement, and its periodic consent procedure,¹¹⁹ the population of Northern Ireland does not have any access to the EU's democratic decision-making processes, except indirectly through third sector organisations.¹²⁰

6. Knowledge and understanding of health rights: need for clarification of applicable legal texts

According to the Helsinki Accords,¹²¹ a key aspect of human rights enjoyment is that individuals are entitled to 'know and act on their rights'.

To be real, human rights must not remain only in legal texts: they must infiltrate the lives of ordinary individuals.¹²² And for that, they must be known by, and knowable by, ordinary individuals. This is a fundamental aspect of the rule of law in a democratic society.

Need for clarification of applicable legal text

In the context of the right to health, access to healthcare services must be based on transparent criteria.¹²³ The usual pattern for a breach of the right to health is a situation where the legal texts entitle someone to health rights (to access essential healthcare, or essential medicines, for instance), but the practice on the ground is that their health rights are not protected.

A key theme in the interviews is that aspects of the relevant law applicable now in Northern Ireland are neither known, nor knowable, at present. This explains why practice on the ground – the behaviour of frontline health staff – at least when they interact with people who look and sound British and/or Irish, has not (yet) changed to reflect the legal changes that have taken place. The behaviour arises because frontline health and social care workers (GPs, chemists, hospital receptionists) lack access to clear information about the applicable law. The applicable legal text must be clarified, and effectively communicated, so that practice on the ground is based on the correct legal provisions. Furthermore, residents/patients must have easy access to clear information about their rights and what has changed since 1 January 2021, or on subsequent dates. Those patients, NGOs, and other third sector organisations working in

119 Articles 14, 15, 18 Ireland/Northern Ireland Protocol.

120 A point made by Sylvia de Mars et al, 2018, supra n 4; Sylvia de Mars et al, 2020, supra n 4; Colin Murray and Ben Warwick, 'The Strange Case of Northern Ireland's Disappearing Rights in the EU-UK Withdrawal Negotiations' in *European Yearbook on Human Rights* [2019] 35-62.

121 Conference on Security and Cooperation in Europe, *Final Act*, Helsinki 1975, VII <https://www.osce.org/files/f/documents/5/c/39501.pdf>. The UK is a signatory to the Helsinki Accords. The Accords do not have the binding status of a treaty in international law.

122 See, for example, Eleanor Roosevelt, 'In your hands: a Guide for Community Action for the Tenth Anniversary of the Universal Declaration of Human Rights' 27 March 1958, United Nations, New York.

123 European Committee on Social Rights, Conclusions XV-2, United Kingdom, p 599.

the field are finding it difficult or impossible to access the relevant formal legal texts. This is because they are not readily discoverable.

The lack of legal clarity is exacerbated by the ongoing process of Brexit and the regularly changing legal environment, and how it interfaces with political statements of intent (such as the ‘grace periods’ for matters related to product supply, some of which are embodied in legal texts and others of which are not).

The result is that, while there are few known examples of people being refused access to healthcare, people may not be able to access their right to health because of lack of knowledge of the rules that apply to accessing medical treatment under various circumstances. An example illustrates this phenomenon of ‘alegality’.¹²⁴

Example: access to healthcare in Ireland to clear the elective surgery backlog

(screenshots taken 3 September 2021 and checked 31 October 2021): The Department of Health announced on 16 June 2021 that the Health Minister ‘is to reinstate the cross-border healthcare directive to the Republic of Ireland’.¹²⁵ The ‘reinstatement’ took effect from 1 July 2021 and is to last for 12 months. The announcement promises ‘full detail and guidance’ will be made available on the Health and Social Care Website. The relevant hyperlink leads to a page entitled ‘Patients Travelling Outside Northern Ireland for Treatment’.¹²⁶



Further down this page, there is another hyperlink with ‘further information about the scheme’, and a download of ‘Guidance’.



Note: your Global Health Insurance Card (GHIC) is for emergency treatment that becomes necessary while you are outside the UK. It **does not** cover planned treatment – also known as elective treatment.

Download

Guidance on the Reimbursement of Expenses for Patients Travelling outside Northern Ireland for Treatment or Care

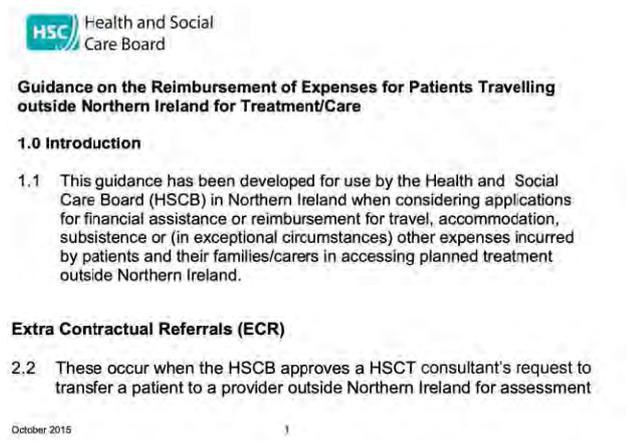
The Guidance (which is the closest there is to a formally applicable legal document available from this website) is dated October 2015. It runs to 17 pages, and gives significant detail in terms of entitlements. It refers to ‘Treatment utilising Directive 2011/24/EU on Cross Border Healthcare (Article 56): a provision of EU law that ceased to apply to the United Kingdom on 1 January 2021. Appendix 1 gives a user friendly

124 For further discussion of ‘alegality’ in the context of Brexit and health law, see, Tamara Hervey and Elizabeth Speakman, ‘The Immediate Futures of EU Health Law in the UK after Brexit: Law, ‘alegality’ and uncertainty’ 18 (2-3) *Medical Law International* (2018) 65-109.

125 (sic) <https://www.health-ni.gov.uk/news/cross-border-healthcare-directive-reinstated>.

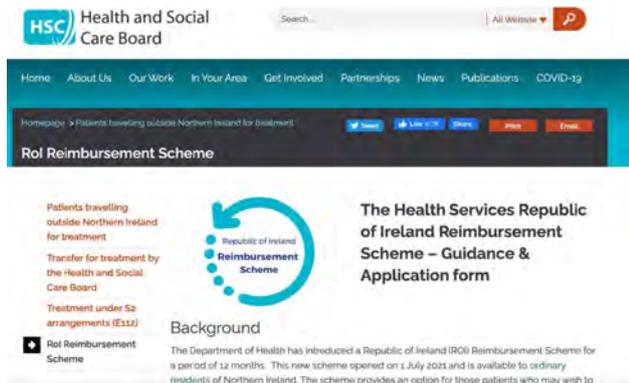
126 <http://www.hscboard.hscni.net/travelfortreatment/>.

summary of the complex rules on who initiates treatment, when authorisation from the Health and Social Care Board is required, and who bears the various associated costs.



Which Guidance is the proper source of patients' rights on 3 September 2021/31 October 2021/12 January 2022, when these screenshots were captured/checked? At the very least, the October 2015 Guidance should surely be updated to encompass the 2021 scheme, so that people affected can understand their rights.

But the 'Guidance and application form', available from the other hyperlink, refers to the new scheme which opened on 1 July 2021. It is considerably less detailed.



7. Recommendations

- Adjust NHS infrastructure so that frontier workers' rights to receive healthcare on either side of the border on the island of Ireland are underpinned by consistent administrative practice
- Ensure that settled status is secured by all residents of Northern Ireland who are entitled to it, especially those who are vulnerable
- Correctly implement the Withdrawal Agreement obligations to provide healthcare for frontier workers and their families
- Carefully check and clarify the entitlements of trafficked children to access healthcare in Northern Ireland and associated obligations
- Clarify the position of residents of Ireland for whom the UK is the 'competent state' and the Northern Irish health system is responsible for providing crossborder healthcare
- Use best-endeavours to extend the new EHIC entitlement to all residents of Northern Ireland, so that they enjoy access to healthcare when visiting Norway, Iceland, Liechtenstein and Switzerland
- Secure continuity of product and substances of human origin supply to the Northern Ireland NHS, either by negotiation with the EU, or by unilaterally offering incentives to continue to supply the Northern Ireland NHS
- Track effects of increased prices in medical products on costs to consumers, paying attention to protected groups, for example elderly people
- Clarify the official, publicly available legal texts, with inline consolidations being brought up to date as a matter of urgency
- Disseminate accurate information in plain language about relevant rights and obligations, with hyperlinks to formal legal texts



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