DOI:10.47152/PrisonLIFE.D4.5.13
Review Paper

Right to Access Health Care in Prisons: International Standards and Practice[1]

Anđela Đukanović[2]

All rights are maintained by individuals deprived of their liberty unless they are legally revoked by the verdict that sentences them or orders their detention. Nevertheless, the provision of health care in prisons is not feasible in the same way, due to the prevalence of certain health issues in prisons and specific inherent constraints. Even though international documents governing the treatment of prisoners declare equivalence of health care, which implies that prisoners must have access to the same levels of health care as the general population and must receive the same level of care as the community, the health of prisoners is often inferior to that of the general population. In the context of international bodies that make decisions on individual complaints, access to health care is achieved through civil and political rights, rather than economic and social rights. Regarding the right of prisoners to access health care, the European Court of Human Rights maintains the most comprehensive practice, and human rights violations are addressed in accordance with the unique circumstances of each case, in addition to a few general principles. However, the European Court of Human Rights allows states to exercise some discretion concerning the principle of equivalence of health care. The World Health Organization's efforts to collect data on critical health indicators in prisons and develop evidence-based health care policies could lead to improved prisoner health.

Keywords: *Health care, Prison, right to health, European Court of Human Rights*

[1] This work is the result of the engagement of the author in accordance with the Plan and program of work of the Institute for Criminological and Sociological Research based on contract no. 451-03-66/2024-03/200039 with the Ministry of Science, Technological Development and Innovation of the Republic of Serbia.
[2] Research Fellow, Institute for Criminological and Sociological Research, *E-mail*: andjelastoja@gmail.com. https://orcid.org/0000-0002-2053-9324

Introduction

The issue of health care access is primarily concerned with the rights of marginalized groups, including migrants, asylum seekers, national minorities, individuals with mental health issues, and those who are incarcerated. Regrettably, it is a common occurrence that imprisoned individuals lack sufficient access to health care. Individuals deprived of their liberty maintain all their rights unless they are legally taken away by the verdict that sentences them or orders their detention (Council of Europe Committee of Ministers, 2006, par. 2). However, health care in correctional facilities is not attainable in the same manner, owing to specific inherent constraints, and due to the prevalence of certain health issues in prisons. The principle of equality when accessing health services is the least controversial element of the right to health care, and it can be viewed as a fundamental dimension of the right to access health care in general. In addition to safeguarding the individual human rights and interests of prisoners, the provision of appropriate health care also serves a more general purpose: to facilitate their re-socialization and increase their likelihood of reintegrating into society as active members (Ilijić, & Batrićević, 2015, p. 448).

The treatment of prisoners is significantly influenced by the United Nations Standard Minimum Rules for the Treatment of Prisoners (hereinafter: Mandela Rules) at the universal level and the European Prison Rules (hereinafter: EPR) at the European level, which are dedicated to the preservation of prisoner rights. The health care equivalence principle is declared in both documents. Nevertheless, there are unresolved issues regarding the delivery of health care in prison, since the health data available on prisoners suggests that the quality of health care and health outcomes are suboptimal and do not align with the health care provided to the general population (Jotterand & Wangmo, 2014, p. 10). The European Court of Human Rights (hereinafter: ECtHR) also observed that "medical assistance available in prison hospitals may not always be at the same level as in the best medical institutions for the general public". However, the State is obligated to ensure that the health and well-being of detainees are adequately protected, and it bears a special responsibility for this matter, as the deprivation of liberty places prisoners in a dependent position, with limited options compared to the general public.

World Health Organization (hereinafter: WHO) prioritizes the investment in health records by prison health systems to facilitate the implementation of evidence-based policies. Status report on prison health in the WHO European Region 2022, shows inequalities still exist across Europe

concerning equitable access to health care as incarcerated people continue to have a higher prevalence of disease and worse outcomes when compared to the general population. It acknowledges the deficiencies in the ratio between the size of the prison health workforce and the number of prisoners, particularly psychiatrists. It emphasizes the need for appropriate treatment of mental health disorders, more effective suicide prevention practices, and a comprehensive package of prevention measures, particularly for common disorders that affect the prison population. Additionally, it recognizes that immunization for vaccine-preventable diseases should be offered, HIV PEP should be included in the response to HIV in prisons, tuberculosis continues to be a health concern in prisons, and also screening and referral for breast, cervical, and colorectal cancer should be offered. Finally, it emphasizes the importance of health ministries' involvement in the delivery of health care in prisons (WHO Regional office for Europe, 2023, p. 67-70). Health policy in prisons should be integrated into, and comparable with national health policy, and must encompass the health-related particularities of prisons (Abbing, 2013, p. 18).

Research conducted in the English prison estate indicates some of the challenges related to accessing secondary care, and prisoners experience security concerns that override their health care requirements and challenges associated with the prison officer's role in accompanying them to medical consultations. The prison regime and transport requirements have delayed access, particularly the limited number of prison officers available to act as escorts. In addition, patient autonomy is restricted since they cannot book their appointments, or choose the hospital where they will receive treatment or transport themselves, and the right to information is lacking (Edge et al., 2020, pp. 3-6).

Relevant international instruments

Discussions on health and human rights often refer to a differentiation between 'civil and political rights' that are considered to have greater legal significance and can be protected from state interference, and 'economic and social rights' that are seen as aspirations that require the state to provide protection and assistance, and which may involve the allocation of resources (Hervey & McHale, 2015, p. 158). Nevertheless, the justiciability of economic and social rights is no longer significantly contested, and there is a growing recognition of the necessity for judges to give full meaning to the realization of these rights (Yusuf, 2012, p. 754). It is important to consider that the right to access health care is related to several civil and

political rights, including the right to life, the prohibition of torture and inhumane or degrading treatment or punishment, the right to personal integrity, the right to privacy, and the prohibition of discrimination. The fulfillment of the right to access health care is also realized, to a certain degree, through these well-established and detailed rights and practices.

The right to health encompasses multiple rights, and the concept of health is undoubtedly broader than the concept of health care. Two fundamental components of the right to health are the right to health care and the underlying determinants of health. Health care refers to the provision of services that encompass diagnostic, preventative, therapeutic, and rehabilitative interventions. These services are aimed at either maintaining or enhancing an individual's overall health or alleviating their suffering. Also, health care must adhere to an appropriate level of quality following advancements in science and undergo continuous quality assessment.[3] Underlying determinants of health encompass a broad range of factors that foster the conditions necessary for individuals to lead a healthy life, including safe food, nutrition, and housing, as well as potable water, a healthy environment, adequate sanitation, health-related education, and information (*Ssenyonjo, 2009, p. 324-328)*. It could be argued that the right to health care is more appropriately categorized, while these determinants should be placed within the right to an adequate standard of living, since "it does not take very much to bring any aspect of social life into connection to right to health" (De Groot, 2005, p. 55). The type of health care that individuals should have access to and the extent to which they should have access is impossible to determine at a very detailed level, and the scope of realization of this right is contingent upon the specific circumstances and health requirements of a given state, as well as its financial resources (San Giorgi, 2012, p. 20).

The Universal Declaration of Human Rights (UDHR) in Article 25 (1) protects the right of everyone to an adequate standard of living, including medical care. Article 12 (1) of the International *Covenant* on *Economic*, *Social, and Cultural Rights* (ICESCR) entitles every individual to the enjoyment of the highest attainable standard of physical and mental health. General Comment No. 14 of the UN Committee on Economic, Social, and Cultural Rights (CESCR) provides an additional explanation of the principles outlined in Article 12 of the ICESCR. The right to health consists of four key, interconnected components: availability, accessibility, acceptability, and

[3] Explanatory Report to the Convention for the protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine, par. 24.

quality. According to the CESCR, accessibility essentially means that health facilities, goods, and services must be available to all individuals without discrimination, especially the most vulnerable or marginalized sections of the population (CESCR, 2000, par. 12). Hence, it is imperative that access to health care remains unobstructed by incarceration, and it essentially entails the absence of equality when seeking access. In most cases, other relevant universal documents protect the right to the highest possible standard of health.[4]

At the European level, a more reserved approach is implemented. Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (hereinafter: Biomedicine Convention) protects equitable access to health care (Article 3) "Parties, taking into account health needs and available resources, shall take appropriate measures with a view to providing, within their jurisdiction, equitable access to health care of appropriate quality".[5] "Equitable" is defined as the absence of unjustified discrimination, as stated in the Explanatory Report to the Biomedicine Convention. While not identical to absolute equality, equitable access implies the effective acquisition of a satisfactory level of care. Parties to the Convention must take appropriate steps to attain this aim within the limits of available resources. Also, this provision aims to encourage the State to prioritize fair access to health care as part of its social policy, rather than creating an individual right that can be used in legal proceedings against the State.[6] The basis for this interpretation stems from the above mentioned position that social rights, unlike civil and political rights, and are ineligible

[4] When it comes to universal instruments for the protection of human rights, a completely unified approach to the protection of the right to health has not been adopted. Some protect the right to healthcare (Convention on the Elimination of All Forms of Discrimination Against Women Article 12 (1)) while the majority protects the right to the highest possible standard of health (Convention on the Rights of the Child, Article 24 (1); Convention on the Rights of Persons with Disabilities, Article 25 (d); Convention on the Rights of Persons with Disabilities, Article 25 (d) Universal Declaration on Bioethics and Human Rights, Article 14), or in one case the right to public health, medical care, social security, and social services (International Convention on the Elimination of All Forms of Racial Discrimination, Article 5 (d)).

[5] Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine, Article 3.

[6] Explanatory Report to the Convention for the protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine, par. 25-26.

for court proceedings since they are still undeveloped and vague (Alston, 1999, p. 679). European Social Charter (revised), in Article 11 protects "The right to protection of health"[7]. At the EU level, Article 35 of the EU Charter of Fundamental Rights recognizes the right to health care rather than the right to health. Namely, "everyone has the right to access preventive health care and the right to treatment under the conditions established by domestic laws and practice"[8].

Although not legally binding, the Mandela Rules at the universal level and the EPR at the European level have a substantial impact on the treatment of prisoners. Mandela's rules declare equivalence of health care, which implies that prisoners must enjoy the same levels of health care that are provided in the community, as well as access to necessary health care services (UN General Assembly, 2016, Rule 24). EPR states that: *"Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation*" (Council of Europe Committee of Ministers, 2006, par. 40.3). European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment Standards (hereinafter: CPT) also declares equivalence of health care (CPT, 2002, par. 38). However, it is important to note that the level of health care provided in prisons should not just be the same as in the community, but should meet even higher standards. Prisons are widely recognized as having a greater propensity for transmitting infectious diseases. Also, there is a heightened prevalence of individuals belonging to underprivileged groups that suffer from inadequate health, particularly unaddressed chronic conditions. In addition, there is a larger population of individuals with mental health issues, whose condition frequently worsens due to being deprived of their freedom (WHO Regional Office for Europe, 2014, p. 8). Consequently, it is imperative to transcend the notion of comparable standards for health care and instead advocate for standards that fulfill equivalent objectives (Lines, 2006, p. 269-280). The health care system in numerous countries is often hampered by a variety of issues that affect the general population. However, persons deprived of liberty are in a dependent position, which is why states have a special responsibility to provide health care to prisoners.

[7] This right includes the Parties obligation to remove as far as possible the causes of ill-health; to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health and to prevent as far as possible epidemic, endemic and other diseases, as well as accidents Council of Europe,

[8] Charter of Fundamental Rights of the European Union, Article 35.

The World Health Organization (WHO) is also committed to improving the health of imprisoned individuals by issuing guidelines that are derived from an evaluation of the quality and effectiveness of prison health services that are provided on a global scale (WHO, Europe). The WHO Regional Office for Europe also recently established the Health in Prisons European Database (HIPED) which collects data on critical health indicators in prisons in Europe.

Basic rules governing access to health care in prisons

Attainment of health care in penitentiary institutions is not always feasible in the same fashion as in the general public, due to certain distinct limitations. For example, in the community, a patient's appointment with a doctor indicates consent for diagnosis and treatment. Implied consent cannot be presumed in a prison setting since prisoners typically cannot choose their doctor, and the medical examination upon admission is mandated by the prison authorities rather than requested by the patient; hence, implied consent can be assumed only if it has been made clear to the patient that the physician is obliged to offer the admission examination (Pont & Harding, 2019, p. 19). When it is impossible to avoid deviating from the principle of equivalence of care, due to limitations related to restrictions of liberty, the inclination should consistently exceed the standards of the community rather than failing to meet them (Niveau, 2007, p. 612). Also, health care personnel frequently exhibit dual loyalty in prisons, as they are often loyal to the prison administration or the state authority in addition to their patients. Health care personnel employed by the prison administration may be susceptible to pressures to prioritize security over patient care, and in order to prevent the emergence of dual loyalty, the prison administration ought to delegate responsibility for the provision of health care to the public health authorities (Pont et al., 2018, p. 472-476).

The Mandela Rules and the EPR place a significant emphasis on the provision of health care in prisons. They regulate the organization of prison health care, as well as the qualifications and responsibilities of medical and health care personnel. The provision of health care services in prison is addressed in Mandela Rules articles 24-35, 46, and 109-110, and it is also addressed in EPR paragraphs 12 (1-2) and 39-48. Aside from the previously mentioned principle of equivalence of health care, it is stated that all necessary medical, surgical, and psychiatric services, including those available in the community, must be provided to the prisoner for that purpose, and prisoners who require specialized treatment or surgery must be transferred to specialized institutions or civil hospitals (Rule 27 of the

Mandela Rules, Paragraph 46.1 of EPR). EPR in paragraph 41 specifically states that every prison must have the services of at least one qualified general medical practitioner, that a qualified medical practitioner is always available and without delay in cases of emergency, and that if a prison does not have a full-time medical practitioner, a part-time medical practitioner must visit regularly. Furthermore, every prison must have personnel adequately trained in health care, and every prisoner must have access to certified dentists and opticians. Mandela rules (Rule 25) generally state that every prison must have in place a health care service tasked with evaluating, promoting, protecting, and improving the physical and mental health of prisoners, paying particular attention to prisoners with special health care needs and that the health care service consists of an interdisciplinary team with sufficient qualified personnel acting in full clinical independence and sufficient expertise in psychology and psychiatry. In addition, the services of a qualified dentist shall be available to every prisoner. Both documents emphasize that the organization of medical services in prison should be closely coordinated with the general health care administration of the community or nation. (Rule 24 (2) of the Mandela Rules, Paragraph 40.1 of EPR). They stress the necessity and significance of conducting the initial medical examination of each prisoner by a physician or other qualified health care professional as soon as feasible after admission. (Rule 30 of the Mandela Rules, Paragraph 42.1 of EPR). The majority of prisoners agree to undergo an initial medical assessment upon admission. However, there is a challenging balance to be struck between respecting the patient's ethical considerations by accepting their refusal to undergo the assessment, and the public health concern of conducting the assessment without the detainee's informed consent, particularly in cases involving contagious diseases (Convention Against Torture Initiative, 2021, p. 8).

Certain problems are emphasized as crucial when a prisoner is examined by a medical practitioner or other health care expert. These issues indicate the need to achieve equivalent objectives rather than just providing equivalent health care. Specifically, it is emphasized as essential to adhere to the standard rules of medical confidentiality, diagnose physical or mental illness and implement all necessary measures for its treatment and the continuation of existing medical treatment, record and report indications of violent treatment of prisoners, manage drug, medication, or alcohol-related withdrawal symptoms, identify psychological stress resulting from deprivation of liberty, isolate prisoners suspected of infectious diseases for the duration of the infection and provide them with appropriate treatment, prevent the isolation of prisoners carrying the HIV, and make

arrangements for the continuation of any necessary treatment after release with the consent of the prisoner. (Paragraph 42.3 of EPR, Rules 30, 32, and 34 of the Mandela Rules). EPR (Paragraph 43.1) also explicitly states that the medical practitioner shall see, under the conditions and with a frequency consistent with health care standards in the community, all sick prisoners, all who report illness or injury, and any prisoner to whom attention is specially directed.

Mandela's rules state that prisoners must have access to necessary health care services free of charge (Rule 24). In the WHO Declaration on Prison Health as a part of Public Health, member governments are recommended to ensure that all necessary health care for those deprived of their liberty is provided to everyone free of charge (WHO Regional Office for Europe, 2003).

An essential factor concerning access to health care in prisons is timely delivery, particularly in medical emergencies, as well as in all other situations, to prevent worsening results or unnecessary suffering. Mandela Rules state that "all prisons shall ensure prompt access to medical attention in urgent cases" (Rule 27), and EPR "*arrangements shall be made to ensure at all times that a qualified medical practitioner is available without delay in cases of urgency" (EPR paragraph 41.2).* In non-emergency situations, medical practitioners are required to adhere to the frequency of medical care that is considered standard in the community. The pace of the medical care offered is contingent upon the state of the individual, as certain conditions necessitate a more expeditious reaction from the medical personnel. The fundamental professional standards and obligations in health care are crucial in determining the appropriate conduct of medical staff in specific situations. The practice of international bodies overseeing the application of human rights reveals that the timely provision of medical care is a particularly challenging issue in prisons.

The EPR and Mandela Rules both emphasize the importance of preventative measures that are designed to address the most prevalent risks in prisons. Consequently, the authorities are explicitly obligated to prevent suicides and self-injury among detainees under the Mandela rules and EPR. Regarding infectious diseases, if a person is suspected to have an infectious health issue, it is necessary to isolate the patient and provide proper treatment until the contagious phase of the disease is over (Mandela Rules, Rule 30, EPR 42.3 (e,f)). Specific funds must be allocated to prevent violations of the right to health care concerning preventive measures, and states are permitted to determine which specific measures are necessary or

sufficient. Nevertheless, the answer to this issue is not always easy to identify in practice.[9]

International bodies practice

Although the UN Committee on Economic, Social and Cultural Rights (CESCR) has been empowered to accept and consider individual complaints since the Optional Protocol to CESCR entered into force in 2013, there has been no significant practice relating to the right to health.
European Committee of Social Rights under the Collective Complaints procedure did consider the right to protection of health (Article 11). However, the decisions on the merits mostly concern groups such as migrants, Roma, those living in poverty, children, and those facing poor working conditions.
Specific aspects of health care in prison, such as emergency medical aid or essential medical services that have a significant impact on people's health, must be provided. These fundamental necessities are included in basic civil and political rights, and international courts and bodies that monitor and interpret these rights have extensive practice in this field. Consequently, the refusal to provide medical assistance can result in severe human rights violations. The ECtHR stated that the right to life is violated when the authorities put the lives of individuals at risk by refusing to provide health care. Additionally, the right to life necessitates that the authorities take adequate steps to protect the lives of those under their jurisdiction.[10] It frequently involves violations of the prohibition of torture and other forms of inhuman or degrading treatment or punishment. Article 10(1) of the ICCPR, which broadly addresses the humane and dignified treatment of persons deprived of their liberty, may also be relevant. This obligation complements the prohibition of torture, inhuman or degrading treatment or punishment, as well as the prohibition of subjecting to a medical or scientific experiment without free consent, contained in Article 7 of the PGPP (Đukanović, 2016, p. 50). Thus, for instance, the UN Human Rights Committee determined that the absence of medical treatment was a violation of Articles 7 and 10 (1) of the ICCPR in a case involving a prisoner who was left without medical assistance after being beaten by security.[11] It can also involve a violation of the right to private life.[12] In

[9] *Shelly v. United Kingdom*.
[10] *Güzelyurtlu and Others v. Cyprus and Turkey* [GC], par. 219.
[11] Michael Bailey v. Jamaica**,** par. 9. 3.
[12] *Dickson v. United Kingdom,* par. 85.

addition, the detention of an individual with serious mental health issues can be considered "lawful" under the right to liberty and security if it is conducted in an adequate institution.

The UN Committee against Torture frequently provides states with recommendations on how to prevent torture if there is a lack of essential health care components, as a result of state reports and visits and individual complaint mechanisms. Also, the CPT is of particular significance at the European level. The ECtHR consults the standards and reports of the CPT, and the health of individuals deprived of their liberty is a primary concern during prison visits. The CPT has a substantial impact on penal practice in European countries.

Medical assistance must be provided in a timely manner to protect the individual's health. In one case for example, the UN Human Rights Committee determined that there was a breach of Article 10, paragraph 1 of the ICCPR, as the prisoner did not receive necessary medical aid when it was required[13]. In a case before the Inter-American Court of Human Rights, a prisoner was offered a medical procedure five years prior to it being performed. However, this delay resulted in a decline in his health, even though he had been receiving some medical care from a doctor during that time, the medical assistance provided was insufficient for his condition. The court found the violation of his physical, mental, and moral integrity, as well as inhuman and degrading treatment, and concluded that medical treatment has been insufficient and his health conditions have worsened.[14] The prohibition of torture or the right to life can be infringed if a significant period of time, such as 36 hours, or less, has not elapsed in cases of medical emergencies[15]. Consequently, it is a matter that is undoubtedly related to the individual's condition and recognized professional standards.

The ECtHR developed the most comprehensive practice regarding the right to health care of prisoners. Inadequate medical treatment in prison may also be the consequence of prisoners' irregular or absent appointments to the doctor[16]. The ECtHR has observed that it is inaccurate to claim that an individual who was not examined by a doctor for approximately one and a half years received reasonable and adequate medical assistance after the hunger strike[17].

---

[13] *Kalenga v. Zambia*, par. 6.5.

[14] *Caesar v. Trinidad and Tobago*.

[15] *İlhan v. Turkey* [GC], paras. 87-88.

[16] *P*aul Lallion v. Grenada**,** par. 88.

[17] *Nevmerzhitsky v. Ukraine*, par. 105.

A refusal to transfer a prisoner to a civilian hospital for treatment, without a valid reason, when the necessary specialists and equipment are not available in prison, might potentially violate Article 3 of the ECHR[18]. In certain instances, it may be necessary for the authorities and the domestic courts to seek additional advice from a specialized medical expert in order to fulfill their positive obligation under Article 3 of the ECHR. For instance, if a single physician made the decision to deny surgery without conducting a comprehensive pre-surgical examination and a multidisciplinary assessment that involved multiple medical specialists[19].
Health services, despite their organization, might not be physically accessible to the sentenced individual depending on his condition. In one instance, the applicant was wheelchair-bound and suffered from a variety of health issues. His confinement was situated on the fourth floor of a building that lacked an elevator. He was anticipated to frequently use the stairs to receive hemodialysis and other essential medical services, as there was no elevator. The court determined a violation of Article 3 of the ECHR on account of the medical care provided since domestic authorities neglected to provide the applicant with safe and appropriate treatment, particularly concerning his disability, which resulted in his inability to access medical facilities[20].
Considering the conventional comprehension of health care, a convicted individual needs to have access to diagnostic procedures, in addition to therapeutic treatments. While therapeutic procedures are typically given more emphasis, it is important to acknowledge that health care encompasses both aspects. For instance, it may be necessary to provide specialized medical supervision in order to promptly diagnose and treat any potential recurrence of cancer, taking into account individual health state[21]. Preventive health care is also a critical component of prison health care. It is recognized that the risk of infectious disease transmission is elevated in prisons. Consequently, the state must make a greater effort to prevent the spread of these diseases. Several human rights can be violated due to the threat to the health and lives of detainees from the spread of infectious diseases and inadequate care. In this regard, the state is obligated to guarantee the prevention of the disease's transmission and the provision of suitable medical care to the ill, and a breach of this obligation may result in a violation of the right to life (HRC, 2002, p. 77). In situation where the

[18] *Mozer v. the Republic of Moldova and Russia* [GC], par. 179.
[19] *Budanov v. Russia,* par .73.
[20] *Arutyunyan v. Russia,* par. 81.
[21] *Popov v. Russia,* par. 211.

CPT had already determined that the state had not made sufficient efforts to prevent tuberculosis in prisons, this was one of the factors that was used to establish a violation of Article 3 of the ECHR[22]. The ECtHR also suggested that the prison administration's decision not to implement a program designed to reduce needle-borne infections could result in a violation of the right to private life. Nevertheless, the ECtHR also noted that the authorities are not obligated to implement any specific preventive health policy measure to combat infections in institutions for the execution of prison sentences. The ECtHR referenced the principle of the State's margin of appreciation, which allows states to select appropriate measures based on the available resources. In the aforementioned case, some preventive measures were implemented[23]. Concerning COVID-19, the ECtHR has declared that it is the responsibility of prison authorities to ensure the physical health and safety of prisoners. This includes the implementation of specific measures aimed at preventing infection, controlling the spread of the virus within the prison, and providing adequate medical care in case of contamination. Preventive actions should be proportional to the level of risk, but they should not excessively burden the authorities[24].

The extent of services that individuals must have access to is one of the most complex issues. The ECtHR noted that the adequacy of provided medical assistance is the most challenging aspect of evaluation[25]. In this context, the absence of equality concerning services that are offered to the general public is one of the fundamental parameters used to determine a violation of one of the human rights, with some distinctions that could be exclusively tied to deprivation of liberty (for example right to choose medical practitioner). States frequently cite a lack of funding as an excuse for not providing the right to access health care. ECtHR has stated that detention conditions that are so severe as to meet the requirements outlined in Article 3 of the ECHR cannot be justified by a lack of funding[26]. However, the ECtHR implemented an approach that does not align with the principle of equivalent health care. Namely, "medical treatment provided within prison facilities must be *appropriate*, that is, at a level *comparable* to that which the State authorities have committed themselves to provide to the population as a whole. Nevertheless, this does not mean

[22] *Staykov v. Bulgaria*, paras 81-81.
[23] *Shelly v. United Kingdom*.
[24] *Fenech v. Malta*, par. 129.
[25] *Aleksanyan v. Russia,* par. 139.
[26] Iovchev v. Bulgaria, par. 136.

that every detainee must be guaranteed the *same level* of medical treatment that is available in the best health establishments outside prison facilities."[27] The ECHR employs a flexible approach to establishing the necessary standard of health care, determining it on a case-by-case basis. The standard should be "consistent with the human dignity" of a detainee, while also considering "the practical requirements of imprisonment"[28].

In a case involving an HIV-positive prisoner, the ECtHR determined that the authorities were not obligated to provide specific high-cost anti-retroviral therapy. The ECtHR did not identify a violation of Article 3 of the ECHR in this context[29]. Nevertheless, it was observed that the prison medical personnel lacked sufficient experience in administering anti-retroviral therapy, resulting in a violation of Article 3 of the ECHR, due to the absence of specialized medical assistance for an HIV-positive prisoner[30].

For example, the ECtHR determined that the authorities had violated Article 3 of the ECHR by refusing to provide orthopedic footwear to a convicted individual who had had a foot amputated. This was due to the fact that the management of a medical institution declared that the individual required such footwear, although the relevant regulations on the supply of convicted persons did not mandate that the state provide such footwear. The ECtHR determined that the individual in question was subjected to challenges that exceeded the inevitable level of suffering for a six-year period, namely that the health and well-being of the convicted person were not adequately protected.[31] Also, a violation of Article 3 of the ECHR was determined as a result of the absence of dental care, which also had an impact on a person's overall health. The applicant was not provided with a dental prosthesis, since the current regulations required him to pay the costs in full. He was unable to do so even later, although a new law had been passed that would have allowed individuals in his situation to receive dentures free of charge[32]. Similarly, the applicant claimed that his eyesight had deteriorated as a result of a period of several months without glasses which were confiscated shortly after his arrest. The ECtHR determined that, despite the absence of evidence indicating that his vision has

[27] *Blokhin v. Russia* [GC], par. 137
[28] *Fenech v. Malta*, par. 128
[29] *Aleksanyan v. Russia,* par. 148-149.
[30] *Aleksanyan v. Russia,* par. 150-158.
[31] *Vladimir Vasilyev v. Russia,* paras. 67-70.
[32] *V.D. v. Romania, paras 94-100.*

permanently deteriorated, it created numerous challenges in his daily life. Consequently, it found a violation of Article 3 of the ECHR[33].

In various decisions, the European Court of Human Rights emphasized the significance of mental health protection in prisons. For example, the ECtHR held that: "Undeniably, detained persons who suffer from a mental disorder are more susceptible to the feeling of inferiority and powerlessness. Because of that an increased vigilance is called for in reviewing whether the Convention has been complied with"[34].

Drug, medication, or alcohol-related addiction and withdrawal symptoms are also among the most prevalent concerns in prison environments. According to the ECtHR, it is necessary to offer the prisoner the treatment corresponding to the disease the prisoner was diagnosed with. Drug addiction treatments remain controversial. As long as they comply with the prison medical care standards, states can choose between abstinence-oriented drug therapy and drug substitution therapy and set a general policy in this area.[35] However, if the circumstances of the case indicate that authorities did not thoroughly investigate and consult a specialized medical professional over a change in drug addiction treatment, this might potentially lead to a breach of Article 3 of the ECHR.[36] Regarding drug availability in prisons, the Court emphasized that authorities have a responsibility to implement measures to combat drug trafficking to safeguard the health and lives of citizens. Nevertheless, it is not possible to ensure the complete eradication of drugs, and authorities have broad discretion in determining the methods to be employed[37].

Concerning force-feeding during a hunger strike in prison, the ECtHR emphasized that a medical intervention that is deemed necessary based on established medical principles cannot be considered inherently inhuman or degrading. This principle also applies to cases where force-feeding is employed to save the life of a detainee who is consciously refusing to eat[38].

The ECtHR also identified a violation of Article 8 of the ECHR in a case involving the denial of access to assisted reproduction to a prisoner. The ECtHR determined that the absence of an evaluation of the rationale behind the restriction of the right to access the assisted reproduction procedure, which is of paramount importance to the applicants, and public interests

[33] *Slyusarev v. Russia*, paras 34-44.
[34] *Sławomir Musiał v. Poland,* par. 96.
[35] *Wenner v. Germany*, par. 61.
[36] *Wenner v. Germany*, par. 80.
[37] *Marro and Others v. Italy*, par. 45.
[38] *Ciorap v. Moldova*, par. 77.

"must be seen as falling outside any acceptable margin of appreciation so that a fair balance was not struck between the competing public and private interests involved".[39] Although the government justified its approach with the issue of the inevitable absence of one parent, which would have had negative consequences for the child and society as a whole, there were no security or other physical or financial barriers (applicants would have paid any expenses).

Access to health care also necessitates the continuity of treatment, which means that the treatment of a variety of physical or psychological conditions and disorders must be consistent. In some cases, this support may be required after the individual has been released. If the treatment was initiated at the prison hospital and subsequently discontinued without medically justifiable reason, adequate medical assistance was not provided[40].

The prohibition of subjecting to a medical or scientific experiment without free consent is encompassed within the prohibition of torture (explicitly in ICCPR). In one case before the Human Rights Committee, a violation of Article 7 of the PGPP was identified in this context. Specifically, the applicant was the subject of a psychiatric experiment while in prison, as he was administered sedatives every two weeks against his will.[41] The issue of prisoner participation in medical experiments is contentious due to potential abuse, and the difficulty of ensuring the confidentiality and free and informed consent of the participants. In contrast, there is a prospective foundation for the right to access medical research and experimental medicines (Đukanović, 2016a, pp. 283-286). While imprisonment should not stand in the way of potential benefits from scientific developments, the difficulties inherent to the prison environment must be considered.

Conclusion

Although there is no significant practice directly related to the right to access health care or the right to health of prisoners, the bodies that monitor the implementation of civil and political rights, particularly the ECtHR, have developed standards directly relevant to the issue. They are primarily consistent with the EPR and Mandela Rules. However, the ECtHR reserves flexibility for the states regarding healthcare equivalence. This can be attributed to the acknowledgment of physical, economic, and organizational constraints associated with prison environments, and the fact that prison

[39] *Dickson v. United Kingdom*, par. 85.
[40] *Paladi v. Moldova*, par. 85.
[41] *Viana Acosta v. Uruguay*.

health care is still regarded as substandard to some extent, despite the equivalence of health care declared in Mandela Rules and EPR. The civil and political rights practice is not associated with the prohibition of discrimination, as it is not linked to internationally prohibited grounds of discrimination. Nevertheless, it typically entails some form of evaluation of disparities in treatment between individuals with comparable medical needs and equal treatment in general on this matter. The ECtHR is satisfied with appropriate health care at a comparable level, which does not necessarily have to be the same as for the general population, as long as it is consistent with human dignity while bearing in mind the practical requirements of imprisonment. However, prisons are acknowledged to be at a higher risk of developing specific health issues and necessitate not only equivalence of care but equivalent objectives, as previously mentioned. Authorities have a special obligation to safeguard the health of prisoners since they are in a dependent position with limited options compared to the general public. The specific health care services that individuals have access to remain one of the most complex issues related to access to health care in prisons, as well as in the general population. The ECtHR, which has the most advanced practice, addresses issues following the unique circumstances of each case, in addition to a few general principles.

Mandela and EPR provide some of the essential requirements for the provision of health care in prisons, with a particular emphasis on the medical examination carried out upon admission. Some of the identified prison-specific issues must be the focus of the therapeutic, diagnostic, and preventative measures. The specific measures that must be taken are usually not elaborated upon, as they are closely related to the overall health policy and expenses, as well as specific circumstances.

One of the strategic objectives of the WHO is to reach health care standards equivalent to those in the wider community. The WHO Office for Europe had a substantial role in enhancing the accessibility and quality of health care in prisons. Collecting reliable data on vital health indicators in European prisons could aid in identifying key issues and developing guidelines to address these difficulties. However, additional states must participate in providing data, as the Health in Prisons European Database (HIPED) received data from 36 of the 53 member states in 2020. Since the practice also demonstrates challenges in ensuring timely access to health care, there should be a greater emphasis placed on this issue, particularly in medical emergencies, as well as the provision of secondary health care, although gathering data on this matter is challenging. WHO however addresses some of the issues that should elevate timely access. These issues include security concerns and dual loyalty of health care professionals,

expense concerns, inadequately trained personnel, and physical and other organizational obstacles in prisons.

References

Abbing, H. R. (2013). Prisoners Right to Healthcare, a European Perspective. *European Journal of Health Law,* 20, 5-19. https://doi.org/10.1163/15718093-12341251

Alston P. (1987). Out *of* the Abyss: The *Challenges Confronting* the *New U.N. Committee* on Economic, Social and Cultural Rights. *Human Rights Quarterly, 9*(3), 332-381.

De Groot, R. (2005). Right to Health Care and Scarcity of Resources. In J. K. M Gevers., E. H. Hondius, J. H. Hubben (Eds.), *Health Law, Human Rights And the Biomedicine Convention: Essays in Honour of Henriette Roscam Abbing* (pp. 49-59). Brill Academic Publishers.

Đukanović, A. (2016a). *Evropski standardi u oblasti biomedicine – pravo* na *integritet ličnosti*. [Doctoral dissertation, Belgrade University]

Đukanović, A. (2016). Zaštita ljudskih prava i nove tehnologije. In S. Jellisavac (ed.), *Savremeni međunarodni ekonomski i pravni poredak* (pp. 279-304). Institut za međunarodnu politiku i privredu.

Edge, C., Stockley, R., Swabey, L., King, E., Decodts, F., Hard, J., & Black, G. (2020). Secondary care clinicians and staff have a key role in delivering equivalence of care for prisoners: A qualitative study of prisoners' experiences. *EClinical Medicine*, 24, 1-9. https://doi.org/10.1016/j.eclinm.2020.100416

Hervey, T., & McHale, J. (2015). *European Union Health Law: Themes and Implications,* Cambridge University Press.

Ilijić, Lj., & Batrićević, A. (2014). Health Care of Prisoners as a Crime Prevention Factor: General Standards and Conditions in Serbia. In Thematic Conference Proceedings of International Significance. Vol. 1 / International Scientific Conference "Archibald Reiss Days", Belgrade.

Jotterand, F., & Wangmo, T. (2014). The Principle of Equivalence Reconsidered: Assessing the Relevance of the Principle of Equivalence in Prison Medicine. *The American Journal of Bioethics*, *14*(7), 4-12. http://dx.doi.org/10.1080/15265161.2014.919365

Lines, R. (2006). From Equivalence of Standards to Equivalence of Objectives: The Entitlement of Prisoners to Health Care Standards Higher than Those Outside Prisons. *International Journal of Prisoner Health, 2*(4), 269-280.

Niveau, G. (2007). Relevance and limits of the principle of "equivalence of care" in prison medicine. *Journal of Medical Ethics*, *33*(10), 610–613. https://doi.org/10.1136/jme.2006.018077

Pont, J., Enggist, S., Stöver, H., Williams, B., Greifinger G., & Wolff, H. (2018). Prison Health Care Governance: Guaranteeing Clinical Independence. *American Journal of Public Health*, *108*(4), 472-476. https://doi.org/10.2105/AJPH.2017.304248

Pont, J., & Harding, W. (2019). *Organisation and Management Of Health Care in Prison –Guidelines.* Council of Europe.

San Giorgi, M. (2012). *The Human Right to Equal Access to Health Care*. School of Human Rights Research Series, 53.

Ssenyonjo, M. (2009). Economic, Social and Cultural Rights in International Law. Hart Publishing.

Toebes, B. (1999). Towards an Improved Understanding of the International Human Right to Health. *Human Rights Quarterly, 21*(3), 661-679.

Yusuf, S. (2012). The Rise of Judicially Enforced Economic, Social, and Cultural Rights-Refocusing Perspectives. *Seattle Journal for Social Justice*, *10*(2), 752-791.

International documents and reports

CESCR. (2000). General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), E/C.12/ 2000/4, UN Committee on Economic, Social and Cultural Rights.

Charter of Fundamental Rights of the European Union 2012/C 326/02, *Official Journal of the European Union*, 26.10.2012.

Convention Against Torture Initiative. (2021). The Initial Medical Assessment of Detainees upon Admission. https://cti2024.org/wp-content/uploads/2021/12/CTI-Tool-10-Medical-Assessment-2021-ENG-FINAL-fixed.pdf

Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine, Oviedo, 4.IV.1997, Council of Europe, ETS No. 164.

Council of Europe Committee of Ministers (2006), Recommendation Rec(2006)2-rev of the Committee of Ministers to Member States on the European Prison Rules (Adopted by the Committee of Ministers on 11 January 2006, at the 952nd meeting of the Ministers' Deputies and revised and amended by the Committee of Ministers on 1 July 2020 at the 1380th meeting of the Ministers' Deputies)

CPT (2002). The CPT standards, CPT/Inf/E (2002) 1 - Rev. 2010, 8 March 2011, https://www.refworld.org/reference/themreport/coecpt/2011/en/78171
European Social Charter (Revised), ETS 163, 3 May 1996, https://www.refworld.org/legal/agreements/coe/1996/en/40138
Explanatory Report to the Convention for the protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine, Oviedo, 4.IV.1997, European Treaty Series - No. 164, Council of Europe.
HRC (2002). Report of the Human Rights Committee,UN General Assembly, 2002, A/57/40 (Vol. I).
International Covenant on Economic, Social and Cultural Rights, United Nations, UN General Assembly, 16 December 1966, Treaty Series, vol. 993.
UN General Assembly (2016). United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), Resolution / adopted by the General Assembly, A/RES/70/175.
WHO Regional Office for Europe (2014). *Prisons and Health*, https://www.who.int/europe/publications/i/item/9789289050593
WHO Regional Office for Europe. (2023). *Status report on prison health in the WHO European Region 2022*. https://www.who.int/europe/publications/i/item/9789289058674
WHO Regional Office for Europe (2003). Declaration on prison health as part of public health: adopted in Moscow on 24 October 2003.
WHO, Europe. https://www.who.int/europe/health-topics/prisons-and-health

Case law

Aleksanyan v. Russia, ECtHR App. No. 46468/06, Judgement of 22 December 2008.
Arutyunyan v. Russia, ECtHR App. No. 48977/09, Judgement of 10 January 2012.
Blokhin v. Russia [GC], ECtHR App. No. 47152/06, Judgment of 23 March 2016.
Budanov v. Russia, ECtHR App. No. 66583/11, Judgement of 9 January 2014.
Caesar v. Trinidad and Tobago, Inter-Am. C.H.R., Judgement of 11 March 2005, paras 49 (19), 50 (p).
Ciorap v. Moldova, ECtHR App. No. 12066/02, Decision of 29 May 2007.
Dickson v. United Kingdom, ECtHR App. No. 44362/04, Judgement of 4 December 2007.
Fenech v. Malta, ECtHR App. No. 19090/20, Judgment of 1 March 2022.

Güzelyurtlu and Others v. Cyprus and Turkey [GC], App. No. 36925/07, Judgement of 4 April 2017.
İlhan v. Turkey [GC], ECtHR App. No. 22277/93, Judgement of 27 June 2000.
Iovchev v. Bulgaria, ECtHR App. No. 41211/98, Judgement of 2 February 2006.
Kalenga v. Zambia (27 July 1993), App. No. 326/1988, UN Doc CCPR /C/48/D/326/1988.
Marro and Others v. Italy, ECtHR App. No. 29100/07, Decision 8 April 2014.
Mozer v. the Republic of Moldova and Russia [GC], ECtHR App. No. 11138/10, Judgement of 23 February 2016.
Michael Bailey v. Jamaica, Communication No. 334/1988, U.N. Doc. CCPR /C/47/D/334/1988 (1993), UN Human Rights Committee, 12 May 1993.
Nevmerzhitsky v. Ukraine, ECtHR App. No. 54825/00, Judgement of 5 April 2005.
Paladi v. Moldova, ECtHR App. No. 39806/05, Judgement of 10 July 2007.
*P*aul Lallion v. Grenada, Case 11.765, Report No. 55/02, Inter-Am. C.H. R., Doc. 5 rev. 1 at 551 (2002).
Popov v. Russia, ECtHR App. No. 26853/04, Judgement of 13. July 2006.
Shelly v. United Kingdom, ECtHR App. No. 23800/06, Decision of 4. January 2008.
Sławomir Musiał v. Poland, ECtHR App. No. 28300/06, Judgement of 20 January 2009.
Slyusarev v. Russia, ECtHR App. No. 60333/00, Judgement of 20 April 2010.
Staykov v. Bulgaria, ECtHR App. No. 49438/99, Judgement of 12 January 2007.
V.D. v. Romania, ECtHR App. No. *7081/02,* Judgement of *16 February 2010.*
Viana Acosta v. Uruguay, Communication No. 110/1981, U.N. Doc. Supp. No. 40 (A/39/40) at 169 (1984), UN Human Rights Committee, 31 March 1983.
Vladimir Vasilyev v. Russia, ECtHR App. No. 28370/05, Judgement of 10. January 2012. godine.
Wenner v. Germany, ECtHR App. No. 62303/13, Judgement of 1 September 2016.