Prisoners Right to Healthcare, a European Perspective

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Abstract
The right to healthcare applies regardless of a person's legal status. Prisoners have a right to a healthcare equivalent to the one in the community at large: access to medical care and preventive measures of good quality and costs covered. States have a positive duty to provide for appropriate healthcare in prison, including harm reduction policies (for instance health screening, vaccination and needle exchange). Denial of access to appropriate health facilities to prisoners and other detainees is likely to result in bodily harm, unnecessary morbidity and avoidable death. Essential elements of the social right to care for the health of prisoners are protected through the positive obligations individual human rights impose on States (e.g., the right to life, the prohibition of torture, degrading treatment and punishment, the right to liberty and the right to private life). Health related human rights standards for prison healthcare have been formulated worldwide and in Europe. The Council of Europe's Committee of Prevention of Torture monitors the situation of prisoners in Member States. Still, healthcare for prisoners falls short of what is required. Prison healthcare is an essential part of public health. A major involvement of the Minister of Health is indispensable.

Keywords
prisoners' health; social right to healthcare; principle of equivalence; right to life; prohibition against torture; degrading treatment and punishment; right to private life; public health; European standards

Prisoners should have access to the health services available in the country without discrimination on the grounds of their legal situation.2

Introduction
Over two million people across the European Region of the World Health Organisation are in prison. Prisoners3 bring a range of health problems with them when entering the prison. They are also at risk of a range of health problems when in prison. The prevalence of communicable diseases (HIV, tuberculosis), mental

1) This article is based on the author's presentation at the joint EAHL-EJHL workshop held during the 19th World Congress on Medical Law, Maceió, Brazil, 7-10 August 2012.
2) UN Basic principles for the treatment of prisoners, 1977.
3) In the context of this article prisoner (or detainee) includes persons held in police custody, in pre-trial detention and in prison.
health problems and substance abuse is higher in prison than in the open community. In certain prison systems in Europe, transmissible diseases have emerged as a dramatic problem. The final report (2008) on prevention, treatment and harm-reduction services in prison, showed an overall lack of systematic monitoring and research on drugs, infectious diseases and risk behaviours in the prison population in Europe. Prison-based substitution treatment, though being as effective in reducing mortality and hepatitis C Virus as in the community at large, are not equally well accepted and realised in prison care. Material conditions under which prisoners are held often favour the spread of diseases in prison rather than containing them. Substandard prison conditions and health services have cumulative negative effects, adding an increased risk for suicide as well. Studies show that women have substantial more health problems than men while in prison. The prison environment does not always take into account their specific needs. This applies also to older prisoners and juveniles.

When States deprive people from their liberty, they have the responsibility to look after their health, and to create conditions that promote the well being of both prisoners and staff. Conditions in prison should not be the cause of death of a prisoner. As indicated by the UN Human Rights Committee in its decision on a complaint concerning the death of a prisoner, it is incumbent on the State to ensure the right of life of detainees. It is not incumbent on the detainee to request protection. Even when medical help has not been requested in time

the essential fact remains that a State party by arresting and detaining individuals takes the responsibility to care for their life. It is up to the State Party by organizing its detention facilities to know about the state of health of the detainees as far as may be reasonably expected. Lack of financial means cannot reduce this responsibility.

1. Prisoners’ Right to Care for Health and its Enforceability

The social right to care for health is recognized in several human rights instruments. It applies regardless of a person’s legal status. In relation to health,

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5) CPT Standards, European Committee for the Prevention of Torture and Inhuman and Degrading Treatment or Punishment (CPT), CPT/ Inf/E 2002/ 1, Rev 2011, para. 31.
8) Other terminology in use: right to health (= the right to the highest attainable standard of health according to the WHO), right to healthcare.
States have to abstain from enforcing discriminatory practices as a State policy. It follows that they ought to refrain from denying or limiting equal access to healthcare for prisoners.

The social right to care for health applies to prison healthcare in all its dimensions: health promotion and protection, prevention of ill health, treatment and care. An act of depriving a person of his liberty always entails a duty of care. The State is responsible for adequately securing a prisoner’s health by providing the requisite medical assistance to the detainee. Prisoners should not leave prison in a worse health condition than when they entered.

At European level, compliance with the right to care for health under the European Social Charter is monitored through a reporting procedure (the European Social Committee) and a collective complaint mechanism. The European Social Charter does not provide for an individual complaint procedure. States Parties to the UN Convention against Torture (OPCAT) who have ratified the 2006 Optional Protocol are obliged to have national preventive mechanisms to carry out the monitoring of prisons. Yet, effective systems of prison inspection, oversight by an independent body and a confidential complaint system are often lacking.

Denial of access to appropriate health facilities to prisoners and other detainees is likely to result in bodily harm, unnecessary morbidity and avoidable death. Failing the proper functioning of prison health services, the right to respect for the physical and mental integrity of the person are at stake. Prisoners retain their individual rights when in prison. Care for health being a prerequisite for the preservation of human dignity, there is an obvious link between the social right to care for health and (social elements of) individual human rights:

Human dignity is the fundamental value and indeed the core of positive European human rights law, whether under the European Social Charter or under the European Convention on Human Rights… and healthcare is a prerequisite for the preservation of human dignity.

For that reason, essential elements of the social right to care for health of prisoners are protected through the positive obligations individual human rights impose on States. This pertains particularly to the right to life and the prohibition of

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10) UN General Comment no. 14, 2000, CH. II, para 34.
13) UNODC/WHO Europe, Women’s health in prison, correcting gender inequity in prison health, 2009 (Kiyv Declaration on Women’s Health in Prison, p. 4).
torture, inhuman or degrading treatment or punishment. Depending on the circumstances, also the right to liberty and security (Art. 5 ECHR), as well as the right to respect for private and family life (Art. 8 ECHR) can be relevant. In the case of an alleged violation of one of the rights under the European Convention on Human rights (ECHR), the prisoner can file a complaint with the European Court of Human Rights (EcrtHR). It is also possible to file a complaint with the UN Human Rights Committee established under the International Covenant on Civil and Political Rights.

2. European Standards for Prison Healthcare

A State party to the International Covenant on Economic, Social and Cultural rights cannot justify its non-compliance with the core obligations to ensure the right of access to health facilities, goods and services on a non-discriminatory basis, and to ensure equitable distribution of all health facilities, goods and services. In Europe, important principles for healthcare in prison can be derived from the case law of the EcrtHR. Specific standards are developed by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT). By visiting all places of detention in the Member States, the CPT, functions as a non-judicial preventive mechanism. The findings address situations that may lead to torture, inhuman or degrading treatment or punishment. The CPT standards have had a significant impact on the jurisprudence of the European Court of Human Rights (EcrtHR). As underlined by Marochini, the main positive developments in the protection of prisoners result from the cumulative work of the EcrtHR and the CPT. But also from the European Prison Rules and other more elaborated health specific recommendations.

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17) On the basis of the first Optional Protocol to the Covenant.
18) Complaints filed with the ECHR or with the UN Human Rights Committee are admissible only after all domestic remedies have been exhausted.
19) United Nations, Economic and Social Council, The right to the highest attainable standard of health, General Comment no. 14, 2000, paras. 43 and 47.
20) ‘The CPT is founded under the Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (in force since 1989).
21) The findings and recommendations of the unannounced visits are sent to the resp. governments for their comment and only published on the request of the government. The publication is rarely refused. In the case of clear evidence of a practice of torture, the CPT may make a unilateral “public statement”.
24) The European prison rules include a Chapter (III) on healthcare.
adopted by the Council of Europe Committee of Ministers. There is a clear interconnection between the work of the three organs in the field of prison healthcare.

### 3. Applicability of Art. 3 ECHR

Originally, the approach by the Court towards the applicability of article 3 of the ECHR in prison related complaints was concentrated upon violence and maltreatment of the prisoner, rather than being focused upon the prison conditions as such and on the level of medical services available. Gradually, the Court broadened the application of Article 3 to include also detention conditions and their effect on the health of prisoners, as well as the prison healthcare itself. The Court gives a dynamic interpretation of the ECHR, in the light of “present days’ conditions” or “present days’ circumstances”. The conditions of detention must be compatible with human dignity in terms of current expectations. Thus, the threshold of minimum seriousness for Article 3 to be applicable has been gradually lowered; in other words, the standards have been heightened.

The ECHR has repeatedly emphasized that a detained person does not by the mere fact of incarceration, lose the protection of his rights guaranteed by the Convention. On the contrary, the people in custody are in a vulnerable position and the authorities are under the duty to protect them. The lack of appropriate medical care and detention of a sick person in inadequate conditions may in principle be contrary to article 3, irrespective of the circumstances of the case and the victim’s behaviour. The State has to ensure that the manner of detention does not subject a prisoner to hardship of an intensity exceeding the unavoidable level of suffering inherent in detention, and that his health and wellbeing are adequately secured by providing him with the requisite medical assistance. The mere fact that a prisoner's health deteriorates while in prison, is not in itself sufficient for the finding of a violation under the ECHR if the authorities have promptly done everything they could to treat the prisoner.

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26) See also the UN minimum standard rules for the treatment of prisoners, 1977 and the UN basic principles for the treatment of prisoners, 1995.


28) Labita v. Italy, no. 26772/95, 6 April 2000.


30) Goginashvili v. Georgia, no. 47729/08, 4 October 2011.
...authorities must ensure that the diagnosis and care are prompt and accurate, and that where necessitated by the nature of the medical condition supervision is regular and systematic and involves a comprehensive therapeutic strategy aimed at curing the detainee’s health problems or preventing their aggravation.31

With regard to vulnerable prisoners, the EcrtHR has specified that the national authorities have an obligation to take all steps reasonably expected to prevent real and immediate risks to the prisoner’s physical integrity, of which the authorities has or ought to have had knowledge.32

The main criteria developed by the Court on the application of article 3 ECHR in relation to healthcare in prison as reiterated in a number of its judgments33 are:

- Art. 3 prohibits in absolute terms torture or inhuman or degrading treatment or punishment, irrespective of the circumstances of the case and the victim’s behaviour.
- Ill treatment must attain a minimum level of severity if it is to fall within the scope of Art. 3.
- The assessment of the minimum is relative; it depends on all the circumstances of the case, such as the duration of the treatment, its physical and mental effects and in some cases, the sex, age and state of health of the victim.
- The suffering must in any event go beyond that inevitable element of suffering or humiliation concerned with the detention.
- In exceptional circumstances, Art. 3 may go as far as requiring the conditional liberation of a prisoner who is seriously ill or disabled.
- Even if Art. 3 does not entitle a detainee to be released on compassionate grounds it always requires that the health and well-being of detainees are adequately secured by among other things, providing them with the requisite medical assistance.

With regard to the minimum severity of treatment required to make the authorities responsible for protection of the prisoner, the Court’s approach has evolved. Initially, the Court held that the mere feeling of stress of a detained person and the mere fear of reprisals from the cell-mates were not by themselves sufficient to bring the situation under the scope of article 3. Later on, the Court considered that the cumulative effect of overcrowding and the intentional placement of a person in a cell with persons who may present a danger to him may in principle also raise an issue under article 3. The Court has gone a step further in holding that “the hardship the applicants have endured, in particular the constant mental

31) Pakhomov v. Russia, no. 44917/08 (first section), 30 September 2010.
anxiety caused by the threat of physical violence and the anticipation of such... must have exceeded the unavoidable level inherent in detention”. The Court noted also that the obligation to protect vulnerable prisoners should not be interpreted in such a way as to impose an impossible or excessive burden on the authorities.  

In deciding whether or not the detention of a seriously ill person raises an issue under Article 3, the Court takes into account various factors, such as the medical condition of the prisoner, the adequacy of the medical assistance and care provided in detention and the advisability of maintaining the detention measure in view of the state of health of the applicant (taking into account the dynamics of the applicants' health condition, the possibility of conditional release or parole for a seriously ill detainee if his health deteriorates and the applicant’s own attitude vis-à-vis medical assistance). In Mouisel v. France, the Court found that although the prisoner's condition had become increasingly incompatible with his continued detention as his illness progressed, the prison authorities had failed to take any special measures. Next to the violation of Article 3, the treatment of the prisoner further fell afoul of the recommendations of the CPT regarding conditions in which prisoners are transferred and medically examined.  

The Court reserves sufficient flexibility in defining the required standard of healthcare, deciding it on a case-by-case basis. The standard of care should be “compatible with the human dignity” of a detainee, but account should be taken also of the practical demands of imprisonment. For instance, in the case of Aleksanyan v. Russia the applicant’s poor eyesight as such was not considered incompatible with his detention from the standpoint of Art. 3 of the Convention.  

For being applicable, Article 3 of the ECHR does not require a positive intention to humiliate or debase a detainee (degrading treatment). Also the cumulative effect of overcrowding, poor regime activities and inadequate access to toilet/washing facilities can prove extremely detrimental to prisoners.  

When there is a recurrence of violations of Art. 3 ECHR resulting from sub-standard conditions of detention that are likely to persist for several years, the EcrtHR identifies the specific problems and gives the Government concerned clear indications of the type of remedial measures needed to solve the problems (a so called pilot judgment procedure, based on article 46 of the ECHR). For
instance in its judgment in the case of *Ananyev and others v. Russia*, the Court concluded that the conditions of detention which the applicant had to endure, in particular the severely overcrowded and unsanitary environment and its detrimental effect on the applicants’ health and well being, combined with the length of the period involved, amounted to degrading treatment.40

The systematic problems of ill-treatment in police custody in Ukraine are at the basis of the Court’s insistence that Ukraine urgently put specific reforms into place in its legal system to ensure that the practice of ill treatment in police custody is eradicated, that effective investigations are carried out into every single case where there was an arguable complaint of ill treatment and that any shortcomings in such investigations should be effectively remedied at domestic level.41 Immediate cause for this message of the Court was the complaint by *Kaverzin v. Ukraine*.42 The applicant in this case was tortured in police custody, with as a consequence an eye injury. Inadequate medical care for the eye injury in the first nine month of his subsequent detention caused him eventually to go blind.

4. Principle of Equivalence of Prison Healthcare

As was indicated before, the principle of equivalence of care and treatment of prisoners with that in the outside community is the standard for prisoners’ right to healthcare.43 This standard brings to expression both the principle of human dignity and the non-discrimination requirement. According to para. 31 of the CPT standards, “prisoners are entitled to the same level of medical care as persons living in the community at large. This general principle is inherent in the fundamental rights of the individual.” The principle is further elaborated in the CPT standards, notably in para. 38: “A prison healthcare service should be able to provide medical treatment and nursing care — in conditions comparable to those enjoyed by patients in the outside community”. Conditions of detention must also be consistent with the specific needs arising out of the prisoners disabilities.44

In the case of disabilities, the prison authorities have a reasonable accommodation obligation.45

government clear indications of the type of remedial measures needed to solve it. Factsheet Pilot Judgments, July 2012.

40) *Ananyev and others v. Russia*, no. 42525/07, 10 January 2012. The Court had found over 80 judgments involving Russia since *Kalashnikov v. Russia* (no. 47095/99, 15 July 2002). A further 250 cases were pending.

41) On the basis of Article 46 ECHR, binding force and execution of judgements.


44) ‘Farboby v. Latvia’, no. 4672/02. See also *Flaminzeanu v. Romania*, 56664/08, 12 April 2011, section III.

Obviously, the objective of the principle of equivalence as the basis for prisoners’ healthcare is to implement principle 11 of the European Social Charter: “Everyone has the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable”. This objective should be achieved by guaranteeing prisoners equitable access to healthcare of appropriate quality, taking into account health needs and available resources as stipulated in Article 3 of the Convention on Human rights and Biomedicine. For instance when necessary medicines are unavailable, the overall quality of medical assistance is called into question.46

Prisoners retain their individual rights in prison, unless there is a justification for a restriction in an individual case. Absent such a justification, the principle of equivalence also applies to for instance the right to respect for decisions to become genetic parents, article 8 ECHR. This includes facilities for artificial insemination that fall under the scope of article 8 of the ECHR, unless there is a justified exception (the case Dickson v. U.K.).47 Acceptable could be a restriction as a necessary and inevitable consequence of the imprisonment, or a restriction that follows from an adequate link between the restriction and the circumstances for the prisoner in question. But according to the EcrtHR, it is unacceptable to base a justification solely on what would offend public opinion. Although in the case Dickson v. U.K. matter at hand countries still have a large margin of appreciation, in the present case, the State’s policy was such that it excluded any real weighing of the competing individual and public interests and prevented the required assessment of proportionality of a restriction in any individual case. Therefore, the Court concluded that the absence of such an assessment, given the importance of such a weighing for the applicants in the case, falls outside the margin of appreciation. The refusal to allow the prisoner to have facilities for artificial insemination violated Article 8 of the Convention.

As I see it, the principle of equivalence implies generally speaking that prisoners have the same entitlements to medical treatment and care as those available in the outside community, provided the treatment is medically necessary, is adequate for the medical problem, and in accordance with medical professional standards. The quality of care should be appropriate.48 As underlined by the EcrtHR “the State has to ensure that the health and wellbeing of detainees are adequately ensured by providing them with the requisite medical assistance.”49

According to the EcrtHR, the adequacy of medical assistance remains the most difficult element to determine.50 The Court defines the required standard of care

47) Dickson v. U.K. no. 44362/04, 4 December 2007. In this case, the welfare of the child was not into question.
48) Article 3 Oviedo Convention.
49) Khudobin v. Russia, no. 59096/00, 26 October 2010.
50) Aleksanyan v. Russia, no. 46468/06 of 22 December 2008, para. 139.
for prisoners on a case-by-case basis, with as points of departure that it should be compatible with the human dignity of the detainee, but it should also take into account the practical demands of imprisonment. In accepting “that the medical assistance available in prison hospital might not always be at the same level as in the best medical institutions for the general public”, the EcrtHR has refined the equivalence principle without detracting from it. Also in the community at large there are differences in quality of health services that are as such acceptable. Likewise, there are variations in medical professional practices.

The same applies in case disparities in the delivery of healthcare between the community at large and the prison are due to limited resources in prison when compared to the outside community. The Court is “prepared to accept that in principle resources of medical facilities within the penitentiary system are limited compared to those of civil(ian) clinics.” However, disparities may not be so significant that it adversely affects the state of health of a prisoner or is the cause of suffering. In the Grishin v. Russia judgment, the absence of anti-viral drugs in prison was not as such considered contrary to Art. 3 because the applicant did not depend on the pharmacy’s stock as he could receive necessary medication from his relatives.51 But contracting States are bound “to provide all medical care their resources might permit”.52 Economic considerations cannot go as far as reducing the protection of the rights of prisoners to (preventive) healthcare as recognized by the European Social Charter.53 The respect for human dignity and the non-discrimination requirement as brought to expression in individual human rights obviously put limits to the possible deviations from the standard of care. According to para. 4 of the Council of Europe Prison Rules, lack of resources cannot justify prison conditions that infringe prisoners’ human rights. In the case of Pnaitescu v. Romania where the prisoner who was entitled under the relevant law to receive free of charge medication and medical assistance and who died as a consequence of not having received the necessary medication, the EcrtHR considered that a State cannot cite the lack of funds as an excuse for not protecting practically and effectively peoples life.54

It goes without saying that the equivalence principle also applies to patients’ rights, such as informed consent and the protection of confidentiality. For being able to deliver adequate care and treatment, the authorities of a penitentiary institution should keep a record of the prisoner’s state of health and the treatment

51) Grishin v. Russia, no. 30983/02 o.c. para. 77. See also Aleksanyan v. Russia, o.c., para. 149.
54) Pnaitescu v. Romania, no. 30909/06, 19 April 2012.
given while in detention. Moreover, in prison, the professional independence must be guaranteed.

5. Prison and Mental Health

A failure to comply with the mental health screening process of a new arrival in prison in order to identify effectively those prisoners who require for their own welfare or the welfare of other prisoners to be placed under medical supervision, with as a consequence death of another detainee in a shared cell, is a breach of the State’s obligation to protect the life of a prisoner. Mental illnesses are a serious problem in prisons. People with mental health problems are particularly vulnerable when they are detained by the State. Mental disorders exist when entering prison, but they also develop during imprisonment as a consequence of prevailing conditions. Torture or other human rights violation are among the possible causes of mental disorders. The prison conditions often have a negative effect on mental health and create an increased risk of suicide. Prolonged detention of a prisoner in a state of great vulnerability, if not accompanied by adequate treatment, diminishes human dignity also when the neglect is not intentional. A failure to comply with the Council of Europe’s recommendations dealing with prisoners with mental illnesses may amount to a violation of article 3ECHR.

A 2007 research project showed that at the time of the research, some countries relied entirely on an internal concept of mental health that foresees the provision of care exclusively on the prison premises by prison staff, others favoured an entirely external system, while a large group of countries only included general mental health services in the system of prison mental health. The research findings also showed that regular mental health screening at admittance that fulfil quality criteria were found to be rare across Europe.

Prisoners known to be suffering from serious mental disturbances and to pose a suicide risk require special measures geared to their condition. Prisoners who apparently suffer from psychological disorders must be examined by a psychiatrist as soon as possible in order to determine whether the psychological condition is compatible with detention and what therapeutic measures should be taken.

55) CPT Standards (2002)1, rev. 2011, para. 39. See also Alektyan v. Russia, e.g. para. 147.
56) Paul and Audrey Edwards v. the United Kingdom, no. 46647/99 (third Section), 14 March 2002.
58) M.S. v. the United Kingdom, no. 24527/08, 3 May 2012. In this case the neglect was a consequence of a lack of coordination between the relevant authorities.
61) Rupa v. Romania, no. 56664/08, 2 October 2012.
The equivalence principle brings with it that prisoners with serious mental disorders must have the possibility of being admitted to, and treated in hospital.

In principle, the detention of a person suffering from mental health problems can only be regarded as “lawful” for the purposes of Art. 5 ECHR if it takes place in an appropriate institution.62 There has to be a connection between the ground that is supposed to justify the deprivation of liberty and the place and conditions of detention. In the case of incompatibility of the mental disposition with detention, prisoners should be transferred to hospitals with appropriate treatment for the mentally ill. Continued detention of a mentally ill if the living conditions in (the psychiatric wing of) a prison have serious negative impact on the prisoner’s health, may engage Articles 3 and 5 of the ECHR. Maintaining a prisoner in a psychiatric wing is supposed to be temporary, while the authorities are looking for an institution that is better adapted to the applicant’s condition and re-adaptation.

Solitary confinement is an extreme hazard to those suffering from, or prone to serious mental illnesses and is a major factor for (attempts of) suicide.

It should only be imposed in exceptional circumstances, as a last resort and for the shortest possible time. Prisoners should have the possibility of appeal against the decision and review of the confinement.63

6. Prison Healthcare and Public Health

In prison, the health problems and health needs are intensive and complex, more than is common in the population outside prison. Prison conditions can be such that they negatively affect prisoners’ health.

Different groups of the population have different health demands. This also holds for the prison population. Penitentiary health policies should take these differences into account. Health systems for instance should include penitentiary health policies that integrate women’s health needs in all phases of planning and implementation.64 Equivalence of care requires that a woman’s right to bodily integrity should be respected in places of detention as in the outside community. As a consequence, the so-called “morning after” pill and/or other forms of abortion at later stages of a pregnancy that are available to women who are at liberty, should be available under the same conditions to women deprived of their liberty.65 The provision of health education relevant to young persons in prison must be considered as an important element of a preventive prison healthcare

63) CPT Standards (2002)1, rev. 2011, para. 64.
64) Supra note 13, p. v.
program. For this group in particular, information about risks of drug abuse and transmittable disease is important.\textsuperscript{66} As indicated by the CPT, “the task of prison healthcare services should not be limited to treating sick patients. They should also be entrusted with responsibility for social and preventive medicine”.\textsuperscript{67} Also in economic difficulties times, States have a duty of care which calls for effective methods of prevention, screening and treatment.\textsuperscript{68} Prevention falls under the duty to protect the physical integrity of people deprived of their liberty as much as the obligation to provide them with healthcare. Regular medical screening for instance is necessary in order to prevent prisoners’ exposure to communicable diseases. Failure to take adequate steps to prevent the spread of such diseases may by itself amount to a violation of Article 3. It can also be a contributing factor to that fact that overall conditions of imprisonment are degrading.\textsuperscript{69} The latter was the case in \textit{Kalashnikov v. Russia},\textsuperscript{70} where the Court found the conditions of detention (particularly the severe overcrowding and unsanitary environment) and its detrimental effect on the applicant’s health (who suffered from skin diseases and fungal infections contracted during detention) combined with the length of imprisonment, amounted to degrading treatment.

As for preventive health, the EchrHR noted in its \textit{Shelley v. the United Kingdom} judgment that so far there is no authority that places any obligation under article 8 on a Contracting State to pursue any particular policy (in this case: needle exchange programmes). But the Court did not exclude that a positive obligation might arise to eradicate or prevent the spread of a particular disease or infection under Arts. 2 or 3 of the Convention: “Matters of healthcare policy, in particular as regards preventive measures, are in principle within the margin of appreciation of the domestic authorities who are best placed to assess priorities, use of resources and social needs.”\textsuperscript{71} Nowadays, there is ample evidence of the usefulness of needle exchange programmes to prevent blood-borne viral infections among injecting drug-users in prison as a consequence of a high prevalence of syringe exchange. Making available sterile injecting equipment in prison following the example of community needle and syringe programmes in the open community is therefore indicated.\textsuperscript{72}

\begin{thebibliography}{99}
\bibitem{66} Ibid., para 41.
\bibitem{67} Ibid., para. 52.
\bibitem{68} Ibid., p. 26.
\bibitem{70} No. 47095/99, 15 July 2002, section III.
\bibitem{71} Shelley v. United Kingdom, no. 23800, 4 January 2008. In this case, the authorities had taken some preventive steps, while monitoring at the same time developments in needle exchange elsewhere.
\end{thebibliography}
As I see it, effective and pro-active medical services for prisoners, pleaded for by Rick Lines,\textsuperscript{73} are inherent to the principle of equivalence. Like the health services in the community at large, health services in prison should be based on an integrated approach, reflecting public health aims as well, not only of prison care as such, but also of prison care as part of healthcare in general. As stated in the Council of Europe Recommendation concerning the ethical and organisational aspects of health care in prison, “health policy in custody should be integrated into, and comparable with national health policy.”\textsuperscript{74} After all, prison healthcare is part of the health system of a country. The national health system ought to take into account the health related particularities of prison as much as this is the case with other categorical sectors of the health system: different situations should be treated differently.

### Conclusions

Despite the progress made, it follows from the European jurisprudence and the recommendations made by the CPT after a country visit,\textsuperscript{75} that prisoners’ right to care for health continues to fall short, sometimes seriously, of what is required. Concerns about the lack of quality of healthcare for, and the delays in treatment of prisoners remain.

The health situation of the prisoner will improve only when the prison health services are adequate. Only with adequate entrance and regular subsequent screening, the influence of unfavourable prison conditions on the mental health of the prisoner can be timely detected and prevented. In the absence of a mental health assessment prior to release, appropriate psychiatric after-care is hindered.\textsuperscript{76}

For prison healthcare to be addressed properly, it should be considered as a part of the overall health policy. This will raise the awareness of the specific health needs of (groups of) prisoners so that prison health systems will have an equal share of resources available for healthcare in such a manner that the specific health demands in prisons are taken into account. To achieve equivalence between healthcare in the open society and in the prison-setting from the perspective of the social right to care for health, it does not suffice to gear the treatment facilities

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\textsuperscript{73} Rick Lines, ‘From equivalence of standards to equivalence of objectives: the entitlement of prisoners to healthcare standards higher than those outside prisons,’ *International Journal of Prisoners Health* (December 2006) 269-280.

\textsuperscript{74} Council of Europe Recommendation 1998/7, para. 10.

\textsuperscript{75} The CPT has access to all places of detention. The visits are unannounced. After each visit a report about the findings and recommendations is drawn up. In 2006, this European model was adapted and generalized by the United Nations through an optional protocol to the UN Convention against Torture.

towards the specific demands of prisoners. Also the preventive health measures must be geared towards the specific circumstances in prison.

As in the community at large, prison health services should be evidence based.\(^77\) Special training and post graduate courses, as well as visitations by professionals must ensure quality of prison healthcare.

Prison healthcare cannot be isolated from broader public health issues. For prisoners with mental health problems, drug-addicts and prisoners suffering from contagious diseases continuity of care is essential. This is another reason why prison healthcare should be part of the overall (public) health policies of a country. In this way, specific health problems related to prison can be taken into account in the overall (public) health policy from the medical screening at admission to the discharge and the overtaking by healthcare services in society at large. From the perspective of the right to care for health of the prisoner, continuity of care between prison and community at large is imperative.

Moreover, an integrated approach of prison healthcare will prevent reduction of medical services because of financial constraints to below the level of what is usual in the community at large. It will put a halt to doctors’ refraining from referring prisoners for treatment to outside medical facilities, as is often the reality of prison healthcare.\(^78\) Prison health services are a public service that requires a strong role of the minister of health, in line with Recommendation no. R 98/7 of the Committee of Ministers.\(^79\) This role also includes monitoring and supervision by the National Health Inspectorate (or an equivalent institution).

Prisoners do not lose their basic human rights when they are committed to prison, and the State has an obligation to ensure that these rights are protected through the provision of effective and independent complaint procedures and investigative mechanisms.


\(^79\) Council of Europe Recommendation 1998/7, para. 12. Paul Hayton, Alex Gatherer and Andrew Fraser, ‘Patient or Prisoner: does it matter which government ministry is responsible for the health of prisoners?’ A briefing paper for networking meeting, WHO, Copenhagen, October 2010.