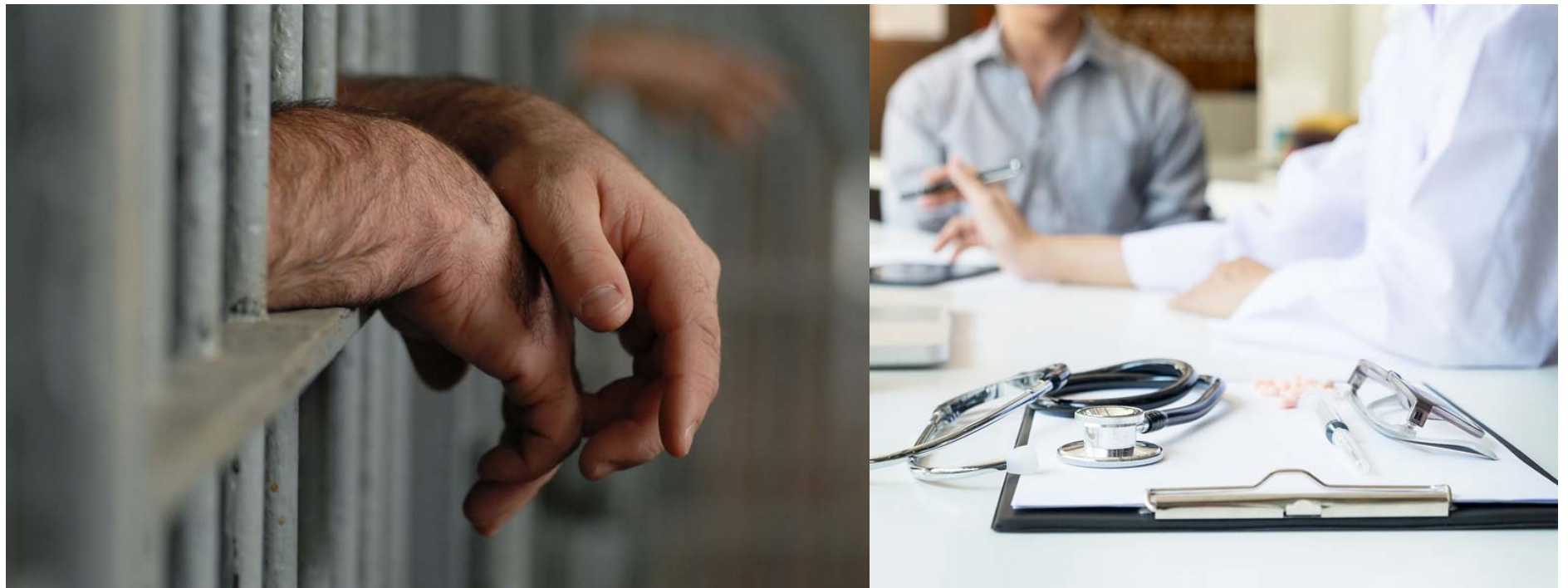


ORGANISATION OF HEALTH CARE IN BELGIAN PRISONS – LEGAL FRAMEWORK



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LIST OF ABBREVIATIONS

ABBREVIATION

CPT
ECHR
ECtHR

DEFINITION

European Committee for the Prevention of Torture
European Convention of Human Rights
European Court of Human Rights



■ SCIENTIFIC REPORT

1 INTRODUCTION

Providing adequate health care is particularly complex for healthcare professionals who treat patients in correctional settings. The prison population is particularly vulnerable, both as regards their physical as their mental wellbeing, amongst others due to their social background¹. Moreover, prison populations contain a high prevalence of persons with addiction problems, mental health issues and diseases^{2, 3}. Furthermore, ethical and legal issues such as confidentiality, informed consent of the patient and the perceived or real dual loyalty of health staff to patients and prison authorities⁴ play an important role in the organization of adequate health care in prisons.

This chapter gives an overview of the legal tensions and incompatibilities between prison legislation and legal provisions relating to qualitative health care in the general population. The latter will draw heavily on the rights of health care patients in a free society, as prison health care is governed by the principle of equivalence^{5a}, which should ensure that the type and quality of health care delivered to prisoners should be of the same standard as that available in free society. Attention will be paid to contradictions between prison law and the right to adequate health care, as well as contradictions between the organization of health care in prisons and in free society. The report has a rights-based approach, i.e. it offers an analysis of the legal rights prisoners may invoke while in detention to ascertain their right to qualitative health-care. This implies that the legal provisions discussed will mainly stem from laws such as the 2005 Basic Law on prisons. Circular letters, directed at the internal organization of prisons, do not enumerate new rights for prisoners, nor can prisoners use them to enforce the provisions contained therein. Moreover, as a rule, they are not made public. As such, they are discussed to clarify certain aspects rather than being discussed exhaustively.

The chapter starts off with an overview of the relevant legal instruments and then discusses each point of discussion.

^a Recommendation R (98) 7 concerning the ethical and organisational aspects of health care in prison, 1998; Recommendation Rec(2006)2 of the

Committee of Ministers to member states on the European Prison Rules, 11 January 2006; United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules), 2015.



2 RELEVANT LEGISLATION

2.1 International standards

Although the European Convention of Human Rights (ECHR) does not contain any provision dealing specifically with health care in prisons, the bindings standards included in the ECHR have been applied numerously on health care issues in prison settings. It may come as no surprise that the European Court of Human Rights has found many violations of the ECHR, mostly relating to the right to life (art. 2) and to the prohibition of torture or inhuman and degrading treatment (art. 3), due to inadequate health care in prisons^b (in Belgium)^c. International organizations, such as the Council of Europe, including the European Committee for the Prevention of Torture (CPT), and the United Nations, have equally published international non-binding standards directly dealing with the rights of prisoners and the organization of health care in prison. Despite their non-binding nature, they do reflect the general consensus of contemporary thought on what is generally accepted as being good principles and practice on the treatment of prisoners and prison management^d. Nevertheless, it should be stressed that non-compliance with these international non-binding standards is not without consequences: countries are increasingly being obliged to conform with said standards, be it because they are urged to do so by the CPT or because the European Court of Human Rights (ECtHR) is increasingly

referring to non-binding standards in its judgments^e. As such, France was convicted by the European Court of Human Rights in 2011 for a violation of art. 3 ECHR (the prohibition of torture and inhuman or degrading treatment or punishment) because medical examinations and treatment took place within hearing distance and within sight of prison staff, and because the examination took place while the prisoner was handcuffed and shackled^f. The violation was found, inter alia, on the basis of several recommendations made by the CPT to the French government which were not complied with^g.

The following instruments are particularly detailed and relevant, as they have been revised (very) recently (European Prison Rules and Mandela rules), because they have been written specifically with the topic of health care in prisons in mind (R (98) 7), or because they are based on situations and best practices observed by international monitoring bodies (the CPT-standards):

- The European Prison Rules^g;
- The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules)^h;

^b For an overview of the most important ECtHR case-law on prisoners' health-related rights, e.g. regarding medical assistance for prisoners with a physical illness, the treatment of disabled or elderly prisoners, the treatment of mentally-ill offenders or the treatment of prisoners with drug addiction, see: European Court of Human Rights, Factsheet – Prisoners' health-related rights, February 2016; European Court of Human Rights, Factsheet – Detention and mental health, February 2016.

^c See, amongst others: European Court of Human Rights 6 December 2011, 8595/06, *De Donder and De Clippel v. Belgium*; European Court of Human Rights 10 April 2013, 43418/09, *Claes v. Belgium*; European Court of Human Rights 22 October 2012, 22831/08, *L.B. v. Belgium*; European Court of Human Rights 10 January 2013, 43653/09, *Dufoort v. Belgium*; European Court of Human Rights 10 January 2013, 53448/10, *Swennen v. Belgium*.

^d Preamble United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules), 2015.

^e European Court of Human rights 26 May 2011, 19868/08, *Duval v. France*.

^f See also European Court of Human Rights 27 November 2003, 65436/01, *Hénaf v. France*; European Court of Human Rights 25 April 2013, 40119/09, *Canali v. France*.

^g Recommendation Rec(2006)2 of the Committee of Ministers to member states on the European Prison Rules, 11 January 2006.

^h United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules), 2015.



- Council of Europe Recommendation R (98) 7 concerning the ethical and organisational aspects of health care in prisonⁱ;
- The CPT-standards of the European Committee for the Prevention of Torture⁵.

2.2 National standards

Although the 'Basic law on prisons'^j aims at offering clarity and legal certainty, legal provisions regarding health care in Belgian prisons are still spread among multiple legal instruments. The reason for this, amongst others, is that the Basic law on prisons has only been partially implemented. Art. 180 of the Basic law on prisons stipulates that the legal provisions can only enter into force after a royal decree has been issued. Although most provisions have entered into force in 2011, 6 years after the publication of the Basic law on prisons, a royal decree on the implementation of the provisions relating to prison health care (art. 87-101) still hasn't been issued, except for art. 98^k. The latter foresees the creation of a Penitentiary Health Council. As long as the relevant provisions of the Basic law on prisons have not entered into force, binding legal provisions regarding prison health care can be found in the 1965 Royal Decree on the general rules on prisons^l.

Certain provisions of the 1965 Royal Decree relating to health care have been incorporated in the internal prison regulations ('huishoudelijk reglement'^m), such as the right to consult a prison doctor and the principle of equivalence of care⁷. The royal decree is issued by the government, and the lack of any involvement of parliament means the legality principle is not strictly complied with as long as the legal provisions of the Basic law on prisons have not entered into forceⁿ. Lastly, binding provisions may be found in the 1971 Ministerial Decree on the general instructions on prisons^o.

Regardless of specific prison regulations, health care rights can be found in legislation applying to the general population. Prisoners have not been expressly excluded from the scope of application of the legislations in question. This implies that, as long as there is no specific legislation in force regarding prisoners (*lex specialis*), there is no legal ground to apply rules to them that are different to the rules applicable to the general population. Since the general rules on prisons of 1965 (see above) have been set out in a royal decree and not in a law approved by Parliament, the 1965 general

ⁱ Recommendation R (98) 7 concerning the ethical and organisational aspects of health care in prison, 1998.

^j Basiswet van 15 januari 2005 betreffende het gevangeniswezen en de rechtspositie van de gedetineerden, BS 1 February 2005.

^k Koninklijk Besluit van 12 december 2005 tot bepaling van de datum van inwerkingtreding van artikel 98 van de basiswet van 12 januari 2005 betreffende het gevangeniswezen en de rechtspositie van gedetineerden en tot regeling van de samenstelling, de bevoegdheden en de werking van de Penitentiaire Gezondheidsraad, BS 29 December 2005.

^l Koninklijk Besluit van 21 mei 1965 houdende algemeen reglement van de strafinrichtingen, BS 25 May 1965.

^m E.g. Huishoudelijk reglement - Ministeriële omzendbrief nr. HR/1 - gevangenis van Sint-Gillis, 5 September 2011. All internal regulations are very much alike, safe for the inclusion of certain prison specific arrangements

concerning, for example, the daily contact hours of the general practitioner, the dentist or ophthalmologist.

ⁿ The legality principle dictates that the actions of the government are based on legislation which has received parliamentary approval. As such it limits the discretionary power of the state but guarantees citizens that the rule of law is abided. If government action is based on a royal decree, the law should expressly mention that the content of this action is further elaborated in a royal decree. In case of the 1965 Royal Decree, no law allows for the organisation of prisons by royal decree. As the Commission Dupont stated, the principle of legality is not respected when the legislator has only determined the length and nature of the punishment, but has failed to clarify the content and the implications of the deprivation of liberty. See Eindverslag van de commissie "basiswet gevangeniswezen en rechtspositie van gedetineerden", Parl.St. Kamer 2000-01, nr. 1076/001, 37.

^o Ministerieel Besluit van 12 juli 1971 houdende Algemene Instructie voor de Stafinrichtingen.



rules on prisons cannot be considered a *lex specialis*. As such, they cannot overrule the legal framework in place for the general population^p.

In particular, reference should be made to the 2002 Law on patient rights^q and the 2004 Law on experiments on human beings^r. The codification of patient rights was deemed necessary to affirm the autonomy of patients, their integration in society and their participation in health care policy, in hospitals and other institutions and to ensure a sound relation between patients and health care professionals. Several royal decrees related to the Law on patient rights have been issued in 2007, inter alia concerning the right to representation before the complaints committees.

When the 'Commission Dupont' finished the preparatory work on the Basic Law on Prisons in 2001^s, the law on patient rights did not yet exist. As such, legal provisions between both legal instruments might differ or even be contradictory. This is even truer for the 1965 Royal Decree on the general rules on prisons. The following section gives an overview of legal issues that have been identified, and provides an analysis of the applicable legal framework. The discussion starts with the overarching principles, after which more practical concerns are explained.

Although some mentally ill offenders are not held criminally liable for their acts, they can be detained in psychiatric annexes of prisons, under a regime called internment⁹. In anticipation of a separate legal framework concerning the treatment and internal legal status of interned mentally ill offenders, the Basic law on prisons equally applies to interned mentally ill offenders in prisons (art. 167 § 1). Until today however, parliament has not yet shown any intent to address this situation any day soon¹⁰. New legislation on the external legal status^t of the internment of mentally ill offenders^u, which will abolish the 1930 law^v, is currently being amended in parliament and will probably enter into force in October 2016. The law in question does not contain any provisions relating to the internal legal position of interned mentally ill offenders, except for the recognition of the right to (health) care¹¹. Interned mentally ill offenders will be allowed to be held in psychiatric annexes of prisons provisionally, while awaiting their placement in health care institutions.

^p The Federal Ombudsman even expressly states that all legal provisions from the Law on patient rights are equally applicable in prison as long as the legal derogations included in the Basic law of prisons have not entered into force. Federale Ombudsdienst "Rechten van de patiënt", Jaarverslag 2014, 2015, 52.

^q Wet van 22 augustus 2002 betreffende de rechten van de patiënt, BS 26 September 2002.

^r Voorstel van basiswet gevangeniswezen en rechtspositie van gedetineerden. Amendement, Parl.St. Kamer 2003-04, nr. 2031/2.

^s Koninklijk Besluit van 2 februari 2007 tot vaststelling van het maximumbedrag per gekopieerde pagina dat de patiënt mag worden gevraagd in het kader van de uitoefening van het recht op afschrift van het hem betreffende patiëntendossier, BS 7 March 2007; Koninklijk Besluit van 15 februari 2007 houdende vaststelling van afwijkende regels met betrekking tot de

vertegenwoordiging van de patiënt bij de uitoefening van het klachtrecht zoals bedoeld in artikel 11 van de wet van 22 augustus 2002 betreffende de rechten van de patiënt, BS 20 March 2007.

^t The external legal status refers to the legal status 'extra muros' of an interned mentally ill offender, e.g. under which circumstances one can be deprived of his freedom or the conditions of release.

^u Wet van 5 mei 2014 betreffende de internering van personen, BS 9 July 2014.

^v Wet van 9 april 1930 tot bescherming van de maatschappij tegen abnormalen, gewoontemisdadigers en plegers van bepaalde strafbare feiten, BS 11 May 1930. This law has been fully replaced by the Wet van 1 juli 1964 tot bescherming van de maatschappij tegen abnormalen en de gewoontemisdadigers BS 17 July 1964 and was modified by the law of 29 July 1990, 13 April 1995, 10 February 1998, 7 May 1999, 28 November 2000, 29 April 2001, 25 February 2003 and 27 December 2006.



3 LEGAL ISSUES

The 2002 Law on patient rights codifies seven distinct patient rights, namely a) the right to receive health care of a high quality; b) the right to choose a healthcare practitioner freely; c) the right to be informed; d) the right to avail oneself of carefully updated health records, and have the possibility to peruse them and obtain a copy; e) the right to consent freely to an intervention, with prior information; f) the right to be assured that one's privacy is protected; and g) the right to file a complaint with an ombudsman service. The rights enumerated in the law on patient rights will be discussed hereunder and will be contrasted with the rights of prisoners and the organization of health care in prison. Each discussion will start by listing the relevant legal sources and whether or not there is a contradiction.

3.1 The right to high quality health care

All patients, including prisoners, have the right to health care of high quality by health care professionals. Health care should be provided with respect to human dignity, the autonomy of the patient and without any discrimination on any ground. In other words, the patient and the health care professional should have a good quality relationship which is based on a commitment to high quality health care and due diligence. Nevertheless, the right to high quality health care relates to the needs of patients, not their aspirations.

The right to high quality health care is reflected in three important principles which govern the organization of health care in prisons: the 'principle of equivalence', the 'continuity of care' and the clinical independence of health care staff^w.

3.1.1 The principle of equivalence

Legal sources

- Law on patient rights, art. 5.
- Basic law on prisons, art. 88, 90 and 97.

The principle of equivalence is expressly mentioned in the Basic law on prisons. CPT reports ^{12, 13} on the Belgian situation, however, state that, at the time of their visit, there was insufficient medical staff to guarantee this principle.

Discussion

The 'principle of equivalence', implies that prisoners should enjoy the same high quality standards of health care that are available in free society, and should have access to the necessary health care services without discrimination on the grounds of their legal status. The mere fact that a person is detained, does not in any way justify an inferior treatment compared to persons who find themselves in free society. Furthermore, health care services should be adapted to the specific needs of the patient, i.e. the prison population. Taking into account the high prevalence of physical and mental health problems within the prison population, sufficient and specialized health care professionals should be available in each prison, including psychologists, psychiatrists and nurses who have enjoyed training in these fields ¹⁴. Belgium has been convicted several times by the ECtHR for a violation of art. 3 ECHR (the prohibition of torture and inhuman or degrading treatment) as it does not foresee adequate care for interned mentally ill offenders in prisons^x. Equally, the CPT has severely criticized the Belgian government for not ensuring sufficient medical staff in prisons. The criticism was not only directed at the shortage of psychiatrists and psychologists, but also at the shortage of general physicians, dentists and the absence of a permanent infirmary, even in large prisons of 700 detainees¹⁵.

^w Art. 24 United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules), 2015.

^x See among other things European Court of Human Rights 10 April 2013, 43418/09, *Claes v. Belgium*; European Court of Human Rights 9 January 2014, 22283/10, *Lanckester v. Belgium*.



The principle of equivalence thus relates to the quality of health care and the suitably qualified staff, a sufficient number of staff and adequate resources. The Basic law on prisons expressly refers to the principle of equivalence and the need to take into account the specific needs of the detained patient (art. 88). The law furthermore refers to the state's obligation to provide qualified health care staff (art. 90) and that, in case certain medical examinations or treatments cannot take place in prison, the detainee has the right to be treated in an external hospital or health care institution (art. 93). Art. 97 § 1 dictates that health care should be organized in such a way that it ensures high quality work, which should be further elaborated in a new royal decree (art. 97 § 2). However, contrary to the CPT's recommendations, a right to minimal service, including a permanent presence of health care staff, has not yet been foreseen. Although the principle of equivalence is generally respected in the Basic law on prisons, the legal provisions have not yet entered into force. The relevant provisions in the Royal Decree on the general rules on prisons, which is currently in effect, do not refer to the principle of equivalence.

Conclusion 1

The legal provisions of the Basic law on prisons should enter into force as soon as possible. The law could be amended with provisions on the minimal health care service expected in a prison, including health care permanence to ensure high quality health care in practice. Those provisions could equally be included in the Royal Decree foreseen by art. 97 § 2 of the Basic law on prisons, which should regulate the organisation of health care in prisons.

3.1.2 *Continuity of care*

Legal sources

- Law on patient rights, art. 5.
- Basic law on prisons, art. 89.
- The principle of continuity of care has been expressly incorporated in the Basic law on prison.

Discussion

Strongly linked with the principle of equivalence, the continuity of health care guarantees that prisoners should enjoy the same level of health care in prison as they enjoyed before incarceration. The imprisonment of a person is no reason to interrupt or phase out certain medical treatments (e.g. the treatment of drug addicts with substitutes such as methadone)¹⁶. Continuity of care is equally important after imprisonment¹⁷. Research has shown that proper health care after the prisoner has been released from prison is crucial to improve a prisoner's resocialization and decrease recidivism¹⁸.

The Basic law on prisons makes reference to the continuity of health care (art. 89). To this effect, the prisoner is referred to health care staff as soon as possible after entry, and in any case the day after their arrival in prison. However, again, the legal provision has not yet entered into force. The Royal Decree on the general rules on prisons, which is currently in effect, dictates that a prisoner should enjoy the necessary health care, but makes no reference to the continuity of the medical treatment (art. 96).

Conclusion 2

The legal provisions of the Basic law on prisons should enter into force as soon as possible.



3.1.3 Independence of health care staff

Legal sources:

- Law on patient rights, art. 5.
- Basic law on prisons, art. 96 and 144 §6 (and more generally: chapter VII v. chapter VIII).
- Circular letter n° 1800 regarding health care teams in psychiatric departments in prisons.
- Recommendation of the national council of the medical association of 28 June 2008 regarding health care in prisons.
- The independence of health care staff has been codified in the Basic law on prisons. However, issues still arise regarding their role in disciplinary procedures.

Discussion

High quality health care requires a relationship of trust between a patient and health care professionals. The professional independence of health care staff is the cornerstone of this trust. Health care staff in prisons cannot work as a medical expert^y on behalf of the prison administration and be expected to treat a patient. Medical activities should be in the interest of prisoners^z.

Professional independence of health care staff is provided for in the Basic law on prisons (art. 96). Moreover, the problem of dual loyalty is prevented by appointing both medical staff which acts as expert for the prison administration, thus responsible for providing medical expertise for the proper management of prisons, as well as health care staff which is solely concerned with providing medical assistance to prisoners in need (chapter VII v. chapter VIII of the Basic law on prisons). However, the relevant legal provisions have not yet entered into force and the issue of dual loyalty is not addressed in the Royal Decree on the general rules on prisons. Nevertheless, the national council of the Belgian medical association has recommended that there should be a clear distinction between medical expertise and health care^{aa}. Moreover, the central penitentiary administration has published the circular letter n° 1800^{bb} on the organization of health care and medical expertise regarding interned mentally ill offenders in prison. The circular letter details how health care staff and medical experts (psychosocial service in prison, psychiatric experts, etc.) should cooperate in accordance with the principle of independence. Such circular letter, however, does not provide rights for prisoners. It is an instrument of organizational nature that is addressed to those who work in the organization. Given this internal focus, circular letters are therefore not often made public.

^y This entails activities such as forensic assessments, disclosure of patient related medical data to others without consent of the patient, assisting in body searches or obtaining blood or urine for analyses for safety and security reasons and providing medical expertise for the application of disciplinary measures. European Committee for the Prevention of Torture, 3rd General Report on the CPT's activities covering the period 1 January to 31 December 1992, Strasbourg, 4 June 1993.

^z Art. 3 Resolution 37/194 of 18 December 1982 regarding principles of medical ethics relevant to the role of health personnel, particularly physicians, in the

protection of prisoners and detainees against torture and other cruel, inhuman or degrading treatment or punishment.

^{aa} Advies van de Nationale Raad van de Orde van Geneesheren van 28 juni 2008 betreffende de gezondheidszorg in penitentiaire inrichtingen.

^{bb} Omzendbrief nr. 1800 betreffende zorgequipes in psychiatrische afdelingen van de gevangenissen, in afdelingen en inrichtingen tot bescherming van de maatschappij: doelstelling, samenstelling, werking, 7 June 2007; Directoraat-generaal Penitentiaire Inrichtingen, Splitsing zorg/expertise. Interneringszorg en beroepsgeheim, Brussels, 11 April 2007; Bijlage bij circulaire 1800 van 7 juni 2006, June 2009.



Despite general compliance with the principle of functional independence of health care staff, an issue arises regarding the role of medical staff in disciplinary proceedings. As the Basic law on prisons was drafted before the 2006 European Prison rules, prison legislation (art. 144 § 6) foresees that medical experts have to certify to a prison director that a prisoner is fit to undergo solitary confinement as a disciplinary punishment. The CPT-standards and 2015 Mandela Rules clearly state that medical personnel should never participate in any part of the decision-making process resulting in any type of solitary confinement, except where the measure is applied for medical reasons^{cc}. Belgian legislation should be adapted in accordance with international standards by discarding the said provision and instead ensuring that medical experts visit the prisoner immediately after placement. In conformity with the European prison rules (art. 43.3), medical experts should then report to the prison director whenever a prisoner's health is being put seriously at risk by being held in solitary confinement.

Conclusion 3

The legal provisions of the Basic law on prisons should enter into force as soon as the provisions on the role of medical experts in the imposition of disciplinary punishments have been amended in line with international standards. As such, the incompatibility of health care and medical expertise would be expressly mentioned in penitentiary legislation, in accordance with international standards and the code of medical ethics^{dd} and recommendations^{ee} of the national council of the medical association.

^{cc} European Committee for the Prevention of Torture, 21st General Report of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) (1 August 2010-31 July 2011), CPT/Inf (2011) 28, Strasbourg, 2011, para. 62-63; Art. 46 United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules), 2015; World Health Organisation, Prisons and Health, 2014, 14.

^{dd} Nationale Raad van de Orde der Geneesheren, Code van geneeskundige Plichtenleer.

3.2 The right to choose a health care practitioner freely

Legal sources

- Law on patient rights, art. 6.
- Basic law on prisons, art. 91-93.

Discussion

The Law on patient rights (art. 6) states that patients, in general, have the right to choose a health care practitioner freely^{ff}. However, art. 6 equally permits a derogation of this right, as long as the limitation to the free choice of the practitioner is set by law. The preparatory works of the Law on patient rights explicitly refers to the organization of health care in prisons to motivate the need for legal derogations to the right to choose a health care professional freely. This is illustrated by referring to institutions that do not have more than one health care professional available, in which case a patient would not really have a choice.

The Basic law on prisons makes a distinction between the right to be visited and the right to be treated by a health care professional of choice. Art.91 §1 incorporates the right to be visited by a freely chosen health care practitioner. The latter should share his opinion and proposed treatment with the health care practitioner working in prison. Both practitioners should agree on the findings, otherwise a third practitioner should be appointed (with the consent of the prisoner). The treatment by a health care professional of choice can only take place with the authorization of the head

^{ee} See among others Advies van de Nationale Raad van de Orde van Geneesheren van 16 maart 2002 betreffende het afnemen van urinemonsters in het kader van het penitentiair drugsbeleid; Advies van de Nationale Raad van de Orde van Geneesheren van 28 juni 2008 betreffende de gezondheidszorg in penitentiaire inrichtingen, 2008.

^{ff} The law on patient rights mentions that the free choice of a health care practitioners is limited to the professions recognised as health care professionals in the 'Koninklijk besluit nr 78 van 10 november 1967 betreffende de uitoefening van de gezondheidszorgberoepen, BS 14 November 1967' (in accordance with art. 2, 3° of the Law on patient rights).



of service of the health department of the central penitentiary administration (art. 92 § 2). The request should be considered on the basis of reasonable grounds and cannot be arbitrarily refused. For example, a prisoner should be treated outside prison in case of a complex or specialized therapy which cannot be offered inside prison. The Basic law on prisons foresees that a royal decree will be issued as to detail further modalities regarding the reimbursement of the costs related to the advice or treatment by the external health care practitioner (art. 93 § 3).

The legal provisions in the Basic law on prisons conform to the Law on patient rights. As those provisions have not yet entered into force however, nor has there been a royal decree as foreseen by art 93 § 3, recourse has to be taken to the 1965 Royal Decree on the general rules on prisons. While the 1965 Royal Decree permits prisoners to receive visits from a freely chosen health care practitioner, it equally states that treatment by the latter is subject to approval by higher authorities. These provisions are stipulated in a royal decree. As the Law on patient rights permits derogations to the free choice of a health care practitioner by law (*'krachtens de wet'*), the current situation is in accordance with the Law on patient rights.

In theory, the costs relating to the visit and treatment of the health care practitioner are currently to be charged to the prisoner⁹⁹. In practice however, the treatment by a freely chosen health care professional which would be reimbursed by the health insurance in free society, is being paid by the Service for Prison Health Care². The national council of the medical association has previously insisted that rules should be put in place regarding the reimbursement of health care costs. Charging the costs of external practitioners to prisoners would be discriminatory for prisoners who do not have the necessary funds¹⁹.

The 'Commission Dupont' explicated that the right to a health care practitioner of one's choosing is not limited to general practitioners, but equally includes dentists, psychiatrists, etc. Furthermore, the number of health care practitioners working in prison should be sufficient as to

guarantee the right to free choice in practice. This would equally ensure that recourse should only seldom be taken to external practitioners⁸. The practical modalities are to be set out in a royal decree.

Conclusion 4

The legal provisions of the Basic law on prisons are in accordance with the Law on patient rights.

3.3 The right to be informed

The right to be informed comprises different aspects. It can refer to the right to be informed on one's state of health (art. 7 of the Law on patient rights), the right to be informed on a medical intervention (art. 8 of the Law on patient rights) as well as the right to be informed on one's health records (art. 9 § 2). Each aspect will be elaborated hereunder.

3.3.1 The right to be informed on one's state of health

Legal sources

- Law on patient rights, art. 7
- Basic law on prisons, art. 16 § 3, 19, 89, 92

Discussion

The right to be informed on one's state of health has a very broad scope: not only does it refer to the information on one's state of health as such, but it equally includes information on the probable evolution of one's state of health and 'every information necessary' to obtain information on one's state of health (art. 7 of the Law on patient rights). Hence, it includes information on how to avail oneself of appropriate health care.

The Basic law on prisons dictates that a prisoner, when arriving in prison, is informed on his rights and obligations, including the right to health care and

Nevertheless, said royal decree has been replaced with the 'Gecoördineerde wet betreffende de uitoefening van de gezondheidszorgberoepen, BS July 2015'. As such, health care practitioners equally include, among others, clinical psychologists, clinical orthopedagogues.

⁹⁹ Art. 96 Koninklijk Besluit van 21 mei 1965 houdende algemeen reglement van de strafinrichtingen, BS 25 May 1965; Advies 48.963/2 van 15 december 2010 van de Raad van State.



the existing facilities which he may rely on (art. 19). Furthermore, the prisoner should see the doctor within 24 hours of his arrival in prison^{hh}. Moreover, the internal regulations, which include provisions on health care, should be put at the disposal of prisoners (art 16 § 3). However, in practice, many internal regulations are outdated and poorly distributed amongst prisoners. Information regarding the rights of patients, including the existence of the Law on patient rights, should equally be disseminated. Currently, the law as well as the ombudsman service (see further) are very much unknown to prisoners¹⁸.

Apart from the right to see health care professionals at arrival, the Basic law on prisons foresees that a prisoner should be able to see a doctor whenever he so requests during his imprisonment (art. 89). As prison health care is, inter alia, aimed at the establishing the medical condition of a prisoner and improving his physical and mental health (art. 87), the right to be informed on one's state of health is sufficiently incorporated in prison legislation. The limitations to the right to be informed which have been included in the Law on patient rights, also apply in prison.

Furthermore, a patient has the right to be assisted by a confidential advisor, who equally has the right to be informed on the state of health of the patient (art. 7 § 2 of the Law on patient rights). Art. 92 § 1 of the Basic law on prisons has limited the designation of a confidential advisor for patients in prison. As such, only a doctor from outside prison, a lawyer or a chaplain may be appointed. The Law on patient rights does not define who can be designated as a confidential advisor. Nonetheless, the free choice of a confidential advisor in prison was not deemed to be a suitable solution, as a prisoner could be pressured to 'choose' a specific person as a confidential advisor (e.g. a fellow prisoner). Because parliament did not want prison staff or prisoners to act as a confidential advisor, it limited the choice to the 3 categories mentioned previously²¹. Nevertheless, this solution cannot be considered ideal as strongly restricting the persons who can act as a

confidential advisor goes exactly against the rationale of freely choosing someone whom can be trusted.

Conclusion 5

The legal provisions of the Basic law on prisons are in accordance with the Law on patient rights. However, there is room for improvement regarding the dissemination of information on health care services in prison and on patient rights, for example by ensuring a better distribution of the internal regulations, which include provisions on health care.

3.3.2 The right to be informed on a medical intervention

Legal sources

- Law on patient rights, art. 8

Discussion

The Law on patient rights (art. 8) clearly states that a patient should be informed on every proposed medical treatment, after which he may consent to the treatment (informed consent, see further). The information relates to the purpose, the nature, the urgency, the duration, the frequency, contra-indications, side effects, risks of the treatment, etc. This information can also be shared with the confidential advisor mentioned previously. Apart from the limitations regarding the confidential advisor, nothing in the Basic law on prisons interferes with the right to be informed on a medical intervention as written down in the Law on patient rights.

^{hh} This legal provision aims at ensuring the continuity of health care in practice. Incoming prisoners might suffer from certain diseases which require continuous care (diabetes, epilepsy, ...). In some cases, their arrest might have been violent, while others are mentally ill. Many incoming prisoners are under the influence of drugs or suffer from withdrawal symptoms. Moreover,

there's a risk that incoming prisoners might carry infectious diseases. As such, it is important that they are being seen by a health care professional as soon as possible. Voorstel van basiswet gevangeniswezen en rechtspositie van gedetineerden. Amendement, Parl.St. Kamer 2003-04, nr. 0231/2, 101-102. Art. 2 and 5²⁰



Conclusion 6

legal provisions of the Basic law on prisons are in accordance with the Law on patient rights.

3.4 The right to health records, including the possibility of perusal and obtaining a copy

Legal sources

- Law on patient rights, art. 9
- Basic law on prisons, art. 92 § 2

Discussion

Every patient has the right to carefully kept and up to date patient files and the right to inspect and to obtain a copy of those files (art. 9 of the Law on patient rights). The right to inspect and obtain a copy does not include personal notes of health care professionalsⁱⁱ nor information on third parties.

The Basic law on prisons contains a major exception to the provisions in the Law on patient rights: a prisoner has the right to inspect one's patient files, but cannot obtain a copy of the files in question. However, a prisoner can request that a copy be sent to the prisoner's confidential advisor (art. 92 § 2 of the Basic law on prisons). This limitation to the right to be informed on one's health records has been incorporated in the Basic law on prisons as a prison cell is not protected by the immunity of one's residence^{jj}. Hence, prison staff can search a prison cell without warrant, limiting the possibility for prisoners to keep personal information, such as medical files, in their cell². This arrangement conforms with international recommendations, such as the 2015 Mandela rules²². However, as long as the Basic law on prisons has not entered into force, the Law on patient rights applies fully and no derogation may be made to the right to obtain a copy of one's health records. For this reason, guidelines have been issued as to allow prisoners to obtain a copy of their files^{kk}. A prisoner is allowed to keep a copy in his cell, in a

closed envelope, which clearly states that the content is strictly personal and confidential.

A prisoner's health file is protected by the right to privacy and the duty of confidentiality. The information therein cannot be shared freely by the health care practitioner. This topic is discussed further (see 'the right to privacy').

Conclusion 7

The legal provisions of the Basic law on prisons limits the rights enumerated in Law on patient rights, with regard to the right to obtain a copy of one's health records. Nevertheless, this limitation is in line with international recommendations.

3.5 The right to consent freely to a medical intervention

Legal sources

- Law on patient rights, art. 8
- Basic law on prisons, art. 93 § 4 and 119-121

Discussion

The Law on patient rights foresees that a patient has the right to consent to or to refuse a medical intervention, after being informed on the medical treatment. The notion 'medical intervention' should be interpreted broadly. For example, it also includes halting a specific medical treatment²³. The free and informed consent of a prisoner is paramount in every medical decision and reflects the right to self-determination. Therefore, the right to informed consent conflicts with forced medication or forced medical treatments. The subject is particularly relevant with regard to interned mentally ill offenders or prisoners with a mental illness, who can be the subject of safety measures when they pose a threat to the safety of others and themselves. The World Psychiatric Association declared that "no treatment should be provided against the patient's will, unless withholding treatment would endanger the

ⁱⁱ The notion of 'health care professional' is defined by law, see footnote 49.

^{jj} Art. 15 Grondwet.

^{kk} Procedure n° G01 toegang tot het medisch dossier voor de gedetineerde.



life of the patient and/or those who surround him or her. Treatment must always be in the best interest of the patient"²⁴. The Belgian Bio-ethical Advisory Committee announced that "forced treatment should only be possible when a mental illness prevents a patient from being informed and from consenting with a treatment which is necessary in light of his condition"²⁵.

The national council of the medical association regrets that there is no specific legislation relating to forced medical treatments^{ll}.

Forced medical treatments can be accompanied by the use of instruments of restraint, such as shackles or handcuffs, for the purpose of preventing self-harm or harm to other prisoners and staff. Nevertheless, the European Court of Human Rights has stressed that instruments of restraint used as a security measure should always be proportionate, justified and motivated. As such, the ECtHR found a violation of art. 3 (the prohibition of torture or inhuman or degrading treatment) regarding a prisoner who was seriously ill but who was still handcuffed during a medical treatment in a regular hospital which took several weeks, while there was no reason to believe the person was dangerous, acted violently or attempted to escape^{mm}. Non-binding standards may also be found in the 2015 Mandela Rules, which only allow for the use of instruments of restraint when authorized by law in very specific situations, with respect to the proportionality principle (for the shortest time possible). Chains, irons or other instruments of restraint which are inherently degrading or painful shall be prohibited and no instrument of restraint should be used on women during labor, during childbirth and immediately after childbirthⁿⁿ. Moreover, the World Health Organization stresses that medical personnel should never carry out medical acts on prisoners who are under restraint (including handcuffs), except for patients suffering from an acute mental illness or delirium with potential for immediate serious risk for themselves or others³.

Art. 93 § 4 of the Basic law on prisons, which has not yet entered into force, stipulates that a royal decree should be issued which further regulates the surveillance of prisoners during their transportation to and residence in an external hospital or health care institution. The Basic law on prisons regulates the use of instruments of restraint in art. 119-121, in conformity with the principle of proportionality and the need for a legitimate goal (i.e. ensuring good order and security). Those legal provisions have entered into force in 2007^{oo}.

The right to informed consent equally raises questions regarding the application of particular medical rights which have not been incorporated into the Law on patient rights. The principle of equivalence and the free consent of a prisoner, should, in principle, enable the latter to enjoy the right to euthanasia, abortion, palliative care and the right to participate in medical trials under the same conditions as citizens outside prison¹⁸. Health care facilities in prison are, however, not adequately equipped as to guarantee the enforcement of those rights in practice. Hence, the organization of health care in prisons currently prevents prisoners from enjoying an equivalent health care and to enforce their health care rights. This is moreover contrary to international standards, which allow prisoners to participate, for example, in clinical trials and health research accessible in the community upon their free and informed consent and in accordance with applicable law if these are expected to produce a direct and significant benefit to their health, and to donate cells, body tissues or organs to a relative^{pp}. On the other hand, prisoners shall not be subjected to any experiments without their consent

ll ²⁴ See also ¹⁸

mm ECHR 14 March 2013, 28005/08, *Salakhov and Islyamova v. Ukraine*, para. 150-157.

nn Art. 47-49 ²²

oo Koninklijk Besluit van 28 december 2006 betreffende het gevangeniswezen en de rechtspositie van de gedetineerden, BS 4 January 2007.

pp Art. 32.2 ²² See also ²



and experiments involving prisoners that may result in physical injury, mental distress or other damage to health shall be prohibited^{qq}.

Conclusion 8

The legal provisions of the Basic law on prisons do not contradict the provisions of the Law on patient rights. However, there's a need to develop a legal framework on forced medical treatments (for every patient). Furthermore, the royal decree on the regulation of prisoners' surveillance during their transportation, which is to be issued in accordance with art. 93 § 4 of the Basic law on prisons, should take into account the jurisprudence of the European Court of Human Rights, and rules 47-49 of the 2015 Mandela Rules. Lastly, the enforcement of particular medical rights, such as the right to euthanasia and the right to palliative care, should be improved.

3.6 The right to the protection of one's privacy

Legal sources

- Law on patient rights, art. 9 and 10
- Basic law on prisons, art. 93, 94, 99 and 119-121

Discussion

The right to the protection of one's privacy, as it is recognized by the Law on patient rights (art. 10), entails two separate aspects. On the one hand it refers to the protection of information contained in the patient's medical file. On the other hand, it refers to the protection of the patient's intimacy during the medical consultation or treatment. The right to the protection of one's privacy is not absolute however: derogations are allowed by law, in as far as

the interference has a legitimate goal and is proportionate (art. 10 § 2). Both aspects relate to the involvement of third parties in the doctor-patient relationship, and will be discussed hereunder.

Confidentiality

The duty of professional confidentiality relates to the necessary independence of staff and the relationship of trust between patient and doctor. The basis for the confidentiality can be found in art. 458 of the Belgian Criminal Code, in the Privacy law^{rr} and is explicitly stated in the Belgian code of medical ethics (art. 55-70). More concretely, it refers to the prohibition of sharing information on the medical conditions of the patient to third parties. The CPT-standards mention that medical secrecy should be observed in prisons in the same way as in the community. Keeping patients' files should be the doctor's responsibility¹⁴.

Art. 10 of the Law on patient rights, as well as art. 55-70 of the Code of medical ethics, refer to the obligation of confidentiality.

The Basic law on prisons refers to the duty of professional confidentiality in art. 94: health care staff can inform a prison director of a prisoner's mental or physical problems only if the prisoner consents^{ss}. Moreover, art. 99 § 4 foresees that health care professionals should notify the prison director as soon as possible whenever he ascertains the existence of a contagious disease or the threat thereof. Two problems can be identified regarding art 99 § 4 of the Basic law on prisons as it does not comply with legal provisions in regional legislation. First, the Flemish Decree on preventive health care and the related execution decision state that the notification of a contagious disease (e.g., hepatitis A or B, tuberculosis, syphilis) or the threat thereof, should be done to a specially appointed health inspector and not to a prison

^{qq} Art. 48 Recommendation Rec(2006)2 of the Committee of Ministers to member states on the European Prison Rules, 11 January 2006.

^{rr} Wet van 8 december 1992 voor de bescherming van de persoonlijke levenssfeer ten opzichte van de verwerking van persoonsgegevens, BS 18 March 1993.

^{ss} The national council of the medical association points out that the free consent in closed settings (such as prisons) might be less free than would appear at first sight. For example, prisoners might easily be pressured to give their consent to due to the hierarchical relationship between prisoners and prison staff. See Advies van de Nationale Raad van de Orde van Geneesheren van 30 oktober 1999 betreffende het eindverslag van de werkzaamheden van de Commissie Internering.



director^{tt}. Both legal acts were published after the Basic law on prisons. The legal provisions in the latter were written on the basis of older legislation concerning the contagious diseases⁸. Second, the same decree states that reporting the existence of a contagious disease should happen anonymously (i.e. without the name of the patient). A derogation to this principle is only possible on the request of the specially appointed health inspector mentioned previously^{uu}.

The duty of professional confidentiality equally applies to a prisoner's medical files, as required by international standards^{vv}. However, until recently, the national council of the medical association disagreed with the legal provision in the Basic law on prisons on the access to medical files by members of the prison monitoring board ('*Commissie van Toezicht*'). The latter is an independent oversight body which, amongst others, monitors whether prisoners are treated humanely and in accordance with the law and mediates between prisoners and the prison director in case of complaints (art. 27 of the Basic law on prisons). Members of the prison monitoring boards, which mandatorily consists of a health care professional, have the right to access all necessary files to fulfil their mandate. Files containing personal information (thus including medical files) can only be consulted with the consent of a prisoner. As such, members of the prison monitoring board ought to have access to a patient's medical files if the prisoner consents. The national council of the medical association however took the view that members of the prison monitoring board did not have the right to access said information^{ww} as none of the members, including the health care professional, was a person involved in a prisoner's medical treatment, nor

could they be considered a confidential advisor. The Law on patient rights limits access to a patient's medical files to the patient and confidential advisors (art. 9 § 2), while the Basic law on prisons further limits the number of persons who can be appointed as confidential advisors (a health care professional from outside prison, a lawyer or a chaplain, art. 92, see before). The national council of the medical association thus concluded that the consent of a prisoner cannot oblige health care staff to share the information in a prisoner's medical file as the Law on patient rights did not expressly grant the right to access medical files to prison monitoring boards. Nonetheless, the prison monitoring board includes a health care professional, which could be considered as a health care professional from outside prison, as required by art. 92 of the Basic law on prisons. Furthermore, the refusal of access to a patient's medical files despite the latter's approval could be considered contrary to the patient's interest. Taking into account these concerns, the national council reconsidered its position in September 2014^{xx}. As such, sharing information contained in a prisoner's health files with the prison monitoring board is now allowed, provided that information is only be shared with the prison monitoring board's health care professional. On a last note, the circular letter n° 1800, which details how health care staff and medical experts (psychosocial service in prison, psychiatric experts, etc.) should cooperate (see previously), equally details which information from medical files can or can't be shared.

A specific aspect of the duty of professional confidentiality relates to the distribution of medication in prison. The Basic law on prisons (art. 99 § 1-2)

^{tt} The 'arts-gezondheidsinspecteur' of the 'Vlaams Agentschap Zorg en Gezondheid'. Art. 2 § 1²⁶, Art. 45 § 1²⁷ T.; Vansweevelt and F. Dewallens (eds.), *Handboek Gezondheidsrecht*, Volume II, Antwerpen, Intersentia, 2014.

^{uu} Art. 5²⁶ The rules were drafted on the basis of an opinion of the Belgian Commission for the protection of privacy.

^{vv} Art. 26 United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules), 2015

^{ww} Advies van de Nationale Raad van de Orde van Geneesheren van 22 september 2007 betreffende het beroepsgeheim van gevangenisartsen; Advies van de Nationale Raad van de Orde van Geneesheren van 20 september 2008 betreffende het beroepsgeheim van gevangenisartsen ten aanzien van de leden van de Commissies van Toezicht.

^{xx} Advies van de Nationale Raad van de Orde van Geneesheren van 20 september 2014 betreffende de toegang tot het medisch dossier van de gedetineerden door de Commissies van Toezicht van de gevangenen. On the situation before September 2014, see F. VAN MOL, *De gezondheidszorg in de Belgische gevangenen*, 2013, 39-40.



determines that professional health care staff is responsible for the distribution of medication. In its reports on health care in Belgian prisons, the CPT noticed that prison staff was responsible for distributing medication to prisoners. Other sources mention that interned mentally ill offenders, prisoners with psychiatric problems and prisoners with a drug addiction receive their medication from prison staff^{yy}. This practice is contrary to international standards and a breach of the duty of confidentiality as included in art. 10 § 1 of the Law on patient rights, as medical information is being shared with non-health care staff. The law on patient rights allows for a derogation of the need for confidentiality. As such, legally speaking, medication could be distributed by prison staff, only when a prisoner consents to this practice. However, international organizations insist on the fact that medication should only be given by health care staff as they have received appropriate training²⁸. Taking into account the due diligence principle, this is especially true for prisoners with mental illnesses or with intellectual disabilities^{16, 29}.

Conclusion 9

The legal provisions of the Basic law on prisons are in accordance with the Law on patient rights. However, contradictions exist between regional and national legislation on derogations to the duty of professional confidentiality whenever health care staff ascertains the existence of a contagious disease or the threat thereof. Moreover, the organization of the distribution of medication should be reassessed as to comply with international standards and the duty of confidentiality.

The presence of prison staff from a security perspective

The second aspect of the right to privacy is relevant when the presence of prison staff is deemed necessary during a medical examination or treatment. Except for when the patient agrees, no other persons may be present except for the staff necessary in the context of the medical services (art. 10 § 1 of

the Law on patient rights). Art. 10 § 2 allows for a derogation from this rule only if it is provided for by law and only to the extent necessary for the protection of public health or for the protection of the rights and freedoms of others. As such, this does not bar the presence of security staff on every occasion. Furthermore, the CPT-standards mention that all medical examinations of prisoners (whether on arrival or at a later stage) should be conducted out of the hearing and - unless the doctor concerned requests otherwise - out of the sight of prison officers. Further, prisoners should be examined on an individual basis, not in groups¹⁴. This confidentiality is equally stressed by the 2015 Mandela rules^{zz}. Hence, patient rights allow for the presence of prison staff during the medical intervention is only allowed when it is requested by the health care staff³⁰ or allowed by the prisoner. In practice, the CPT has criticized Belgium several times for the systematic presence of prison staff during medical consultations and treatments, contrary even to the applicable Belgian legislation^{28, 31aaa}.

Currently, the legal provisions in the Basic law on prisons relating to health care do not mention that health care staff may request the presence of prison staff for security reasons. Before the entry into force of the Basic law on prisons, a legislative amendment should be foreseen, as to comply with the need for a legal derogation as laid out in the Law on patient rights.

Conclusion 10

The legal provisions of the Basic law on prisons should be amended as to regulate the presence of security staff during medical examinations.

^{yy} Furthermore, research shows that training should be organized for all providers and all medical and non-medical staff involved in substitution medication, including prison staff, especially as insufficient knowledge can result in insufficient care¹⁸

^{zz} Art. 31²²

^{aaa} The European Committee for the prevention of torture refers to legislation as written down in a directive concerning the organization of health care in prison.



3.7 The right to file a complaint with an ombudsman service

Legal sources

- Law on patient rights, art. 11
- Basic law on prisons, art. 56-57

Discussion

The patient has the right to file a complaint relating to the application of the Law on patient rights. The task of the ombudsman service is preventive as well as complaints-based. The five main tasks of the ombudsman are the promotion of communication between patient and health care professional, the mediation in order to resolve a certain complaint; informing a patient on further possible steps to settle the dispute; making recommendations with a view to prevent complaints; and informing patients on the existence and functioning of an ombudsman (art. 11 § 2). In practice, prisoners make little use of the right to file a complaint. The Law on patient rights, as well as the ombudsman service, are poorly known and the ombudsman does not have the resources to carry out visits in prisons or conduct interviews³². The complaints which are received usually relate to forced medical treatments (e.g. injections and compulsory medication), the lack of access to one's medical files and the shortage of health care staff³⁰.

The Basic law on prison does refer to the ombudsman service in legal provisions regarding the confidentiality of correspondence. Letters coming from the ombudsman service are not subject to control (art. 57,18°). Letters from inmates to the ombudsman are not subject to control as long as there is no reasonable doubt that the content might pose a threat to good order or security (art. 56). The Basic law on prison furthermore creates a separate complaints mechanism within prison (art. 147-166). The complaints mechanism has a different scope than the ombudsman service created by

the Law on patient rights, as it deals only with complaints regarding decisions taken by the prison director⁷.

Conclusion 11

The legal provisions on the Basic law on prisons are in accordance with the Law on patient rights. Nevertheless, as long as the ombudsman is scarcely known within prison and does not have the necessary resources to visit prisoners to investigate the complaints made, the ombudsman remains a 'paper tiger'.

3.8 Social security rights for prisoners

An overarching issue, relating to the patient rights of prisoners and the principle of equivalence, is the fact that most prisoners lose the right to social security payments the moment they are detained. The right to unemployment benefits, social welfare and supplementary benefits for disabled persons is cancelled when incarcerated. Pensions are only paid the first 12 months. Detainees do maintain their right to benefits for occupational accidents and occupational diseases. Until December of 2015, benefits for sickness or disability were maintained for detainees with dependent family members and were reduced to 50 % for single households³³. Since the first of January 2016, benefits for sickness or disability are suspended for prisoners^{bbb}. The reason for the suspension of the social security is that medical care in prison is free of charge because it is paid for by the Federal Public Service Justice³⁴. The rationale behind the recent harmonization is that prisoners receiving sickness or disability benefits should not be favored over employed prisoners or prisoners receiving an unemployment benefit or a social welfare benefit.^{ccc} As a consequence, only a small number of detainees maintain their income from social security payments while detained. One can question whether the suspension of several social security benefits is in accordance with the Belgian basic law

^{bbb} Art. 233 § 1 Koninklijk besluit van 19 januari 2016 tot wijziging van het koninklijk besluit van 3 juli 1996 tot uitvoering van de wet betreffende de verplichte verzekering voor geneeskundige verzorging en uitkeringen, gecoördineerd op 14 juli 1994, BS 2 March 2016.

^{ccc} Vr. en Antw. Kamer comm. sociale zaken 2014-15, 27 mei 2015, CRIV 54 COM 180 (Vr. nr. 4488 N. Lanjri)



on prisons that prisoners should not be punished beyond the restriction of free movement. Fundamentally, we concur with the experts in the 2014 Memorandum that, in order to guarantee the rights of prisoners as patients that are equal to the rights of any patient, prisoners should have a full status within the Sickness and Disability Insurance. This would allow them to assert the same rights as the socially insured in the free society¹⁸. Indeed, in the policy note of the Minister of Justice, it is stated that 'in-depth consultation' is required to find out how the health care insurance of (interned) prisoners can become a part of the general health care insurance³⁴. Such a policy decision would bring prison health care policy closer to the general health services in a country, if not a part of it. This evolution would be in line with the recommendations of the World Health Organization, the Council of Europe, and many prison and public health reformers³.

4 CONCLUSION

The legal framework and organization of health care in prisons is characterized by a tension between two fundamental principles: providing the same (quality of) health care to prisoners as in free society (the principle of equivalence) and the maintenance of good order, safety and security in prison. While the rights of prisoners were traditionally severely restricted in prison, major advances have been made with the introduction of the 2005 Basic law on prisons which, however, has not yet entered into force with regard to the provisions on patient rights.

The maintenance of good order, safety and security in prison, is the major reason why the Law on patient rights cannot be implemented unequivocally in prison. This is not necessarily a legal problem: the law on patient rights allows for derogations, if these derogations are made by law (for example, relating to the free choice of a health care professional). Although derogations are included in the 1965 Royal decree on the general rules on prisons, the principle of legality requires that the legislator not only determines the length and nature of the punishment, but has also clarified the content and the implications of the deprivation of liberty. Therefore, derogations from the Law on patient rights should stem from the Basic law on prisons and the latter should enter into force sooner rather than later.

Furthermore, some comments can be made on the Basic law on prisons, in its current form, and how it relates to the legal rights of patients and the organization of prison health care. They have been enumerated hereunder.

- To ensure the principle of equivalence in practice, and to conform with the remarks of the European Committee for the Prevention of Torture, explicit provisions should be drafted on the minimal health care service expected in prison, including health care permanence. Those provisions could be included in the royal decree foreseen by art. 97 § 2 of the Basic law on prisons, which should regulate the organisation of health care in prisons, but which has not yet been issued.



- The legal provisions on the role of medical experts in the imposition of disciplinary punishments should be amended in line with international standards (i.e. medical experts should never have to certify beforehand to a prison director that a prisoner is fit to undergo solitary confinement, but should visit the prisoner immediately after placement).
- There is room for improvement regarding the dissemination of information on health care services in prison and on patient rights, for example by ensuring a better distribution of the internal regulations.
- Currently, there is no legal framework on forced medical treatments of patients, including prisoners.
- In theory, prisoners have the right to particular medical rights just as in free society, such as the right to euthanasia and the right to palliative care. In practice however, said rights cannot be enforced in prison as easily as outside prison.
- The royal decree on the regulation of prisoners' surveillance during their transportation, which is to be issued in accordance with art. 93 § 4 of the Basic law on prisons, should take into account the jurisprudence of the European Court of Human Rights, and rules 47-49 of the 2015 Mandela Rules.
- Contradictions exist between regional and national legislation on derogations to the duty of professional confidentiality whenever health care staff ascertains the existence of a contagious disease or the threat thereof.
- The organisation of the distribution of medication does not comply with international standards, nor with the duty of confidentiality.
- The legal provisions of the Basic law on prisons should be amended as to regulate the presence of security staff during medical examinations.
- The ombudsman service mentioned in the Law on patient rights is scarcely known within prison and does not have the necessary resources to visit prisoners to investigate the complaints made.

5 DISCUSSION

The Belgian penitentiary health care operates within a legal framework characterised by a tension between two fundamental principles: the principle of equivalence, on the one hand, and the maintenance of good order, safety and security in prison, on the other. The introduction of the 2005 Basic Law (the so-called Dupont Act) represented a major advance regarding the rights of prisoners – which were traditionally severely restricted in prison. The principle of normalisation – which is the thread running through the Act – specifies that life during incarceration must be as normal as possible. Regarding health care, with the Dupont Act a paradigm shift is made from a disease-oriented care to a care aiming to enhance the health of the inmate and sanitary protection on the one hand, and re-integration on the other.

This Act has however not yet entered into force with regard to the provisions on patient rights. The maintenance of good order, safety and security in prison, is the major reason why the Law on patient rights cannot be implemented unequivocally in prison. This is not necessarily a legal problem: the law on patient rights allows for derogations, if these derogations are made by law (for example relating to the free choice of a health care professional). 'Although derogations are included in the 1965 Royal decree on the general rules on prisons, the principle of legality requires that the legislator not only determines the length and nature of the punishment, but has also clarified the content and the implications of the deprivation of liberty. Therefore, derogations from the Law on patient rights should stem from the Basic law on prisons and the latter should enter into force sooner rather than later.



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