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**THE IMPACT OF DISABILITY: A COMPARATIVE APPROACH TO
MEDICAL RESOURCE ALLOCATION IN PUBLIC HEALTH
EMERGENCIES**

KATIE HANSCHKE,* LESLIE E. WOLF** & WENDY F. HENSEL***

I. INTRODUCTION

It is a matter of time before the next widespread pandemic or natural disaster hits the U.S.¹ The Ebola epidemic in Africa has captured the public's attention and fanned fears of contagion as infected patients are flown to America and placed in U.S. hospitals for treatment.² The Centers for Disease Control and Prevention's (CDC) mishandling of dangerous pathogens in its labs and the infection of two nurses working with an Ebola patient in a Dallas hospital have both highlighted the ongoing risk of infectious disease in the U.S. and diminished confidence in the government's ability to protect the public from such threats.³ At the same time, news reports continue to track

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1. As the World Health Organization itself has concluded, “[i]nfluenza pandemics will continue to occur,” and there is no way to predict “exactly when, where, and how severe the next pandemic will be.” WORLD HEALTH ORG., IMPLEMENTATION OF THE INTERNATIONAL HEALTH REGULATIONS (2005): REPORT OF THE REVIEW COMMITTEE ON THE FUNCTIONING OF THE INTERNATIONAL HEALTH REGULATIONS (2005) IN RELATING TO PANDEMIC (H1N1) 2009, at 10 (2011) [hereinafter WHO REPORT]. See also Joseph Bresee & Frederick G. Hayden, *Epidemic Influenza – Responding to the Expected by Unpredictable*, 368 NEW ENGL. J. MED. 589, 592 (2013).

2. See Adam Nossiter, *Fears of Ebola Breeds a Terror of Physicians*, N.Y. TIMES (July 27, 2014), <http://www.nytimes.com/2014/07/28/world/africa/ebola-epidemic-west-africa-guinea.html>; see also Adam Nossiter & Alan Cowell, *Sierra Leone Declares Public Health Emergency over Ebola Outbreak*, N.Y. TIMES (July 31, 2014); see also Adam Nossiter & Alan Cowell, *Ebola Virus is Outpacing Efforts to Control It, World Health Body Warns*, N.Y. TIMES (Aug. 1, 2014), <http://www.nytimes.com/2014/08/02/world/africa/african-leaders-and-who-intensify-effort-to-combat-ebola-virus.html>. See generally Misty Williams & Ariel Hart, *Ebola Patients Stir Worry in Atlanta*, ATLANTA J. CONST., Aug. 2, 2014, at A1.

3. Donald G. McNeil, *C.D.C. Closes Anthrax and Flu Labs After Accidents*, N.Y. TIMES (July 11, 2014), <http://www.nytimes.com/2014/07/12/science/cdc-closes-anthrax-and-flu-labs-after-accidents.html>; Denise Grady, *Pathogen Mishaps Rise as Regulators Stay Clear*, N.Y.

instances of people contracting and dying from avian influenza in Asia,⁴ and concerns remain that the Middle East Respiratory Virus (MERS), first identified in 2012,⁵ will spread beyond the Arabian Peninsula.⁶ All of this is coupled with the significant rise in the last decade of earthquakes, hurricanes, and other natural disasters that have widespread catastrophic consequences for the populations involved.

Despite the certainty of similar future events, the World Health Organization (WHO) has acknowledged that “[t]he world is ill-prepared to respond to . . . any similarly global, sustained and threatening public-health emergency.”⁷ The international response to the 2009 influenza A (H1N1) virus stands as a cautionary tale in this regard. Although the pandemic fortunately proved to be less severe than initially anticipated, it nevertheless resulted in shortages of medical equipment, overburdened hospitals, and preventable patient deaths, particularly among young people.⁸ The “fundamental gap between global need and global capacity” in health care has led to “the unavoidable reality . . . that tens of millions of people w[ill] be at risk of dying” once a severe pandemic hits.⁹

TIMES (July 19, 2014), <http://www.nytimes.com/2014/07/20/science/pathogen-mishaps-rise-as-labs-proliferate-with-scant-regulation.html>.

4. See, e.g., Faine Greenwood, *Cambodia Bird Flu Outbreak Continues with 14th Case*, GLOBAL POST (July 16, 2013), <http://www.globalpost.com/dispatch/news/regions/asia-pacific/cambodia/130716/cambodia-bird-flu-outbreak-continues-14th-case>; see also Donald G. McNeil Jr., *New Tools to Hunt Viruses*, N.Y. TIMES (May 27, 2013), <http://www.nytimes.com/2013/05/28/health/new-tools-to-hunt-new-viruses.html?pagewanted=all> (describing the 36 deaths from H7N9 in China and 22 deaths from a virus related to SARS in the Arabian Peninsula). See also *Avian Influenza A Virus Infections in Humans*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/flu/avianflu/avian-in-humans.htm> (last updated Jan. 8, 2014).

5. *Middle East Respiratory Syndrome (MERS)*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/coronavirus/mers/> (last updated Jan. 26, 2014).

6. Donald G. McNeil Jr., *MERS Virus Not Global Emergency, Health Officials Say*, N.Y. TIMES (July 17, 2013), <http://www.nytimes.com/2013/07/18/health/mers-virus-not-global-emergency-health-officials-say.html>; Donald G. McNeil Jr., *Second U.S. Case of MERS Virus is Confirmed*, N.Y. TIMES (May 12, 2014), <http://www.nytimes.com/2014/05/13/health/second-case-of-mers-virus-is-announced.html>; Ben Hubbard & Donald G. McNeil Jr., *Flawed Saudi Response is Cited in the Outbreak of the Middle East Virus, MERS*, N.Y. TIMES (June 29, 2014), http://www.nytimes.com/2014/06/30/world/middleeast/flawed-saudi-response-fueled-outbreak-of-mers-middle-east-virus.html?_r=0; *MERS is Unlikely to Spread in Asia: WHO Expert*, YAHOO HEALTH (July 10, 2014), <http://news.yahoo.com/mers-unlikely-spread-asia-expert-072617603.html>.

7. WHO REPORT, *supra* note 1, at 12.

8. *Interim Guidance on Infection Control Measures for 2009 H1N1 Influenza in Healthcare Settings, Including Protection of Healthcare Personnel*, CTRS. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/h1n1flu/guidelines_infection_control.htm (last updated July 15, 2010); WHO REPORT, *supra* note 1, at 17.

9. WHO REPORT, *supra* note 1, at 20.

The reality of scarcity will inevitably lead to difficult decisions about the allocation of medical resources, such as who will have priority access to ventilators and critical care beds when demand exceeds supply. In the U.S., there has been little guidance from the federal and state governments on how to prioritize distribution between individuals, in part because these issues are highly politicized and implicate the fundamental question of who will live and die in the event of a public health emergency. “To fill this gap, some public health and medical organizations have promulgated protocols” to guide allocation decisions in some circumstances.¹⁰ “Although these efforts at advance planning are to be lauded, they raise a number of troubling civil rights issues,” particularly for people with disabilities.¹¹ Several of the protocols exclude some people with disabilities from receiving care altogether, even when their disabilities do not affect the likely success of the medical interventions at issue.¹² Still others preclude some individuals with disabilities from receiving care because of a need for prolonged use of resources, poor “quality of life,” or limited long-term prognosis.¹³

Two of us previously evaluated the legality and ethics of these allocation protocols, concluding many of their directives violated U.S. law and were highly problematic in other respects.¹⁴ We found that even when purportedly “objective” criteria are used to allocate care, subjective notions about the desirability of life with disabilities can play a determinative role in allocation decisions.¹⁵ Because there will be little or no time in a public health emergency for thoughtful reflection on these fundamental questions, we argued that “[i]t is critical to evaluate in advance the legal [and ethical] parameters within which medical professionals and public health officials must operate when setting treatment agendas,” and involve people with disabilities directly in these discussions.¹⁶

10. Wendy F. Hensel & Leslie E. Wolf, *Playing God: The Legality of Plans Restricting People with Disabilities from Scarce Resources in Public Health Emergencies*, 63 FLA. L. REV. 719, 719 (2011) [hereinafter *Playing God*].

11. *Id.*

12. *Id.*; see also Leslie E. Wolf & Wendy F. Hensel, *Valuing Lives: Allocating Scarce Medical Resources During a Public Health Emergency and the Americans with Disabilities Act (Perspective)*, PLOS CURRENTS: DISASTERS, 2011, at 1, 1 [hereinafter *Valuing Lives*].

13. *Playing God*, *supra* note 10, at 719.

14. See *Valuing Lives*, *supra* note 12.

15. *Playing God*, *supra* note 10, at 752.

16. *Id.* at 723-724, 769-770. Our analysis focused on the allocation of critical care medicine during a public health emergency. Although the issue of whether excluding people with disabilities from access to critical care medicine during a public health emergency has not been litigated, two courts have considered the application of antidiscrimination laws to emergency plans. See, e.g., *Cmtys. Actively Living Indep. & Free v. City of Los Angeles*, No. CV 09-0287 CBM, 2011 WL 4595993 (C.D. Ca. Feb. 10, 2011) and *Brooklyn Ctr. for Independence of the Disabled v. Bloomberg*, 980 F. Supp. 2d 588 (S.D.N.Y. Nov. 7, 2013). Both involved plans for

To date, few, if any, U.S. scholars engaged in this debate have drawn on the myriad approaches taken by the international community when facing these same issues. Because the legal and social status of people with disabilities is tied to underlying societal attitudes toward impairments,¹⁷ cultural differences between populations may lead to significantly different distributive outcomes. Examining other countries' approaches to the allocation problem in public health emergencies is important not only its own right, but also because we may gain insight into how to develop more equitable policies to guide allocation decisions during a public health emergency in the U.S.

Part II of this paper details the methodology we employed in selecting countries for discussion herein and the materials that we reviewed. Part III briefly discusses the United Nations Convention on the Rights of Persons with Disabilities (Convention), which many international governments have ratified and thus, overlays much of the international discussion on treatment protocols. Part IV then systematically explores the antidiscrimination protection found in

responding to physical emergencies (e.g., after a hurricane, earthquake, flooding, terrorist attack, etc.), including evacuation, shelter, and related plans. In both cases, there was evidence that the cities involved had failed to take into account the special needs of people with disabilities and concluded that, as a result, the emergency plans violated federal antidiscrimination laws. The California U.S. District Court concluded that "[b]ecause individuals with disabilities requires special needs, the City disproportionately burdens them through its facially neutral practice of administering its program in a manner that fails to address such needs." *Cmtys. Actively Living Indep. & Free*, 2011 WL 4595993, at *14. The Court disputed the City's claim that it could make reasonable accommodations as needed during an emergency, noting:

[t]he purpose of the City's emergency preparedness program is to anticipate the needs of its resident in the event of an emergency and to minimize the very type of last-minute individualized requests for assistance described by the City, particularly when the City's infrastructure is substantially compromised or strained by an imminent or ongoing emergency or disaster.

Id. The New York U.S. District Court similarly found that the City's plans violated federal and state antidiscrimination laws in a number of ways, although not in all the ways that the plaintiffs alleged. *Brooklyn Ctr. For Independence*, 980 F. Supp. 2d at 658-59. Importantly, the Court noted:

[t]he question in this case, however, is not whether the City, or individual first responders, have done an admirable job in planning for, or responding to, disasters generally. They plainly have. Instead, the question is whether the City has done enough to provide people with disabilities meaningful access to its emergency preparedness program given the broad remedial purposes of the ADA, the Rehabilitation Act, and the [state antidiscrimination law].

Id. at 659. Similarly, in the context of allocation protocols for critical care, we have applauded the efforts of those who have developed those protocols and have suggested that more may need to be done to ensure people with disabilities are provided meaningful access to critical care during an emergency.

17. Wendy F. Hensel, *Interacting with Others: A Major Life Activity Under the Americans with Disabilities Act?* 2002 WISC. L. REV. 1140, 1145 (2002) (describing the social model of disability).

each country and the existing emergency protocols in effect during a potential epidemic. Part V concludes with an analysis of the public policy implications of these disparate approaches and the feasibility and desirability of adopting them within the U.S.

II. METHODOLOGY

The following analysis explores the approaches taken in Mexico, Brazil, South Africa, Singapore, Cambodia, Australia, New Zealand, and the United Kingdom (U.K.). We purposefully selected a diverse group of countries in terms of geography, culture, economic status, and governmental structure.¹⁸ Some we included because of their proximity to prior or existing pandemics,¹⁹ and others we included in an attempt to reflect divergent cultures across continents. We also necessarily took into account pragmatic considerations, such as the availability of materials in an accessible language.²⁰

Conducting international research presents unique challenges. Our efforts were informed by a variety of resources, including *Foreign Law Guide* and *Globallex*, which outline the various concerns associated with conducting research within each foreign jurisdiction. We relied on *World Constitutions Illustrated* for locating countries' constitutions, as it is considered reliable, particularly for constitutions in translation. We also relied on government websites for legislation, regulations, and guidance documents. Because the documents are provided through government websites that change often and do not necessarily provide information on said changes, many of the web sources provided for said documents required archived versions of the government websites. This is to assure access to the exact language used to interpret each country's guidance.

18. Our selection was also informed by preliminary research conducted to understand the local context as we presented our previous paper, *Playing God*, at international conferences, including conferences in the United Kingdom, Tel Aviv, and New Zealand.

19. For example, we included Mexico given its involvement in the 2009 H1N1 influenza pandemic, and Oceania both for its proximity to Asia (where avian flu has been prevalent) and its similar common law tradition to the United States.

20. Both Mexico's and Brazil's disability discrimination prevention legislation were only available in the countries' native tongues, Spanish and Portuguese respectively. However, by reviewing an unofficial translation, one can still develop a sense of the protections in place and what each of the countries value regarding prevention of disability discrimination. We used Google Translate™ to facilitate translation of these materials, with one of us (LEW) reviewing the original material as a check (albeit limited) on the translation.

III. CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES

Unlike the U.S.,²¹ many countries have signed or ratified the Convention, a treaty that may have significant implications for the treatment of individuals with disabilities in public health emergencies going forward. The Convention recognizes the equality of all persons under the law and prohibits discrimination on the basis of disability,²² defined as “any distinction, exclusion or restriction . . . which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms[.]”²³ The Convention also requires “reasonable accommodation” to allow people with disabilities to participate fully in public life.²⁴

The Convention specifically requires states to take “all necessary measures to ensure the protection and safety of people with disabilities in situations of risk, including situations of armed conflict, humanitarian emergencies, and the occurrence of natural disasters.”²⁵ Signatories must “prevent discriminatory denial of health care or health services or food and fluids on the basis of disability.”²⁶ Finally, the Convention assures the right to life, including requiring a country to “take all necessary measures to ensure its effective enjoyment by persons with disabilities on an equal basis with others.”²⁷

The language of the Convention may provide significant protection for people with disabilities during public health emergencies. Its preclusion of disability as a factor in withholding health care arguably would extend to situations of scarcity, mandating that individuals with disabilities receive

21. HUMAN RIGHTS WATCH, UNITED STATES RATIFICATION OF INTERNATIONAL HUMAN RIGHTS TREATIES 14 (2009), available at http://www.hrw.org/sites/default/files/related_material/Treaty%20Ratification%20Advocacy%20document%20-%20final%20-%20Aug%202009.pdf.

22. See generally Convention on the Rights of Persons with Disabilities, Dec. 13, 2006, 2515 U.S.T. No. 44910-44917 [hereinafter Convention]. The Convention was adopted on December 13, 2006 and opened for signature on March 30, 2007. *U.N. Convention on the Rights of Persons with Disabilities*, DEPT. OF PUBLIC INFO., UNITED NATIONS, <http://www.un.org/disabilities/convention/signature.shtml> (last accessed Feb. 28, 2015).

23. Convention, *supra* note 22, art. 1, 2.

24. A “reasonable accommodation” is defined as any “necessary or appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case to ensure to persons with disabilities the enjoyment or exercise on an equal basis with other of all human rights and fundamental freedoms.” Convention, *supra* note 22, art. 2.

25. Convention, *supra* note 22, art. 11. As this section describes, this responsibility is “in accordance with [the state’s] obligations under international law, including international humanitarian law and international human rights law.” *Id.*

26. Convention, *supra* note 22, art. 25. The U.N. Convention also requires that signatories “provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes.” *Id.*

27. Convention, *supra* note 22, art. 10.

comparable treatment to those who are not disabled. The extent of protection, however, depends on the degree and manner to which it is implemented in individual countries.²⁸ Accordingly, the specific impact of the Convention in each country is discussed, where applicable, in Part IV below.

IV. INTERNATIONAL PROTECTION OF DISABILITY AND ACCESS TO HEALTH CARE

In light of the high stakes involved in public health emergencies, it is no surprise that each of the countries identified has outlined at least basic principals and protocols to guide government decision-making in such circumstances.²⁹ However, the degree to which these protocols specifically contemplate and protect people with disabilities from discrimination varies considerably.

A. Mexico

1. General Protection for People with Disabilities

Mexico gives broad legal protection to its citizens with disabilities. It was an early supporter of the Convention and one of the first to ratify its

28. As described in the individual country sections below, the process and the importance of ratification varies from country to country. *See infra* Part IV.

29. International organizations, like the World Health Organization (WHO) and the World Bank have facilitated countries efforts to adopt plans to address public health emergencies. *See Influenza Pandemic Preparedness*, WORLD HEALTH ORG., <http://www.who.int/influenza/preparedness/pandemic/en/> (last visited Feb. 6, 2015). As stated on the WHO website and in many of the documents available there, “Influenza pandemics are unpredictable but recurring events that can cause severe social, economic, and political stress. Advanced planning and preparedness are critical in helping to mitigate the impact of influenza epidemic or pandemics.” *Id.* The WHO has developed a framework, checklist, and guidance for influenza pandemic preparedness planning. *See* WORLD HEALTH ORG., PANDEMIC INFLUENZA PREPAREDNESS FRAMEWORK (2011) [framework]; *see also* WORLD HEALTH ORG., WHO CHECKLIST FOR INFLUENZA PANDEMIC PREPAREDNESS PLANNING (2005 [checklist]; *see also* WORLD HEALTH ORG., PANDEMIC INFLUENZA PREPAREDNESS AND RESPONSE (2009) [guidance]. While considered in its other work, WHO has also specifically focused on preparedness planning for low-resource countries. *See, e.g.*, WORLD HEALTH ORG., INFORMAL CONSULTATION ON INFLUENZA PANDEMIC PREPAREDNESS IN COUNTRIES WITH LIMITED RESOURCES (2004). The World Bank has partnered with WHO’s efforts to support countries preparedness efforts, particularly with respect to capacity building. *Pandemics Overview*, WORLD BANK, <http://www.worldbank.org/en/topic/pandemics/overview> (last updated Sept. 30, 2014). In addition to providing financial support, the World Bank has engaged in information sharing. *Id.* At least two of the countries we studied here (Mexico and Cambodia) benefited from assistance. *See Mexico—All Projects*, THE WORLD BANK http://www.worldbank.org/en/country/mexico/projects/all?qterm=pandemic&lang_exact=English (last visited Feb. 6, 2015); *Cambodia—All Projects*, THE WORLD BANK http://www.worldbank.org/en/country/cambodia/projects/all?qterm=pandemic&lang_exact=English (last visited Feb. 6, 2015).

provisions.³⁰ Its own Constitution provides that all citizens have the right to health care³¹ and specifically precludes “discrimination motivated by . . . disabilities . . . conditions of health . . . or any other [basis] that infringes human dignity . . . or . . . diminish[es] the rights and freedoms of persons[.]”³² It further mandates that the norms of human rights for its citizens be interpreted “at all times” to favor individuals with “the greatest possible protection.”³³

Mexico reiterated these principals in its passage of the groundbreaking General Law for the Inclusion of Persons with Disabilities (GLIPD) in 2011. GLIPD mandates the full inclusion of people with disabilities inside “a framework of respect, equality and equal opportunities”³⁴ and broadly covers all individuals with impairments that pose barriers to the equal inclusion in society. Article Three of the GLIPD explicitly states the law is applicable to various federal, state, and municipal government entities, as well as private entities that provide services to people with disabilities.³⁵ The Law authorizes affirmative “antidiscrimination” measures.³⁶ Article Seven provides that the Ministry of Health is responsible for assuring the highest attainable standard of health for persons with disabilities.³⁷ This will be done through programs and services that were provided and designed based on quality, expertise, gender, and free or affordable price.³⁸

Mexico’s General Health Law articulates the various aspects of the right of all citizens to health services as provided by the Mexican Constitution³⁹ and specifically recognizes the importance of providing care to vulnerable groups

30. Mexico signed on as soon as the Convention was open for signature and ratified it (and the optional protocol) on December 17, 2007. *Convention and Optional Protocol Signatures and Ratifications*, UN ENABLE, <http://www.un.org/disabilities/countries.asp?navid=17&pid=166>, (last accessed January 5, 2015) [hereinafter *U.N. Convention Signatures*].

31. Political Constitution of the United Mexican States, *as amended*, art. 4, Diario Oficial de la Federación [DO], February 5, 1917. (Mex.).

32. *Id.* art. 1.

33. *Id.*

34. General Law for the Inclusion of People with Disabilities, art. 1, Diario Oficial de la Federación [D.O.], May 30, 2011 (Mex.). [hereinafter Mexico Disability Act].

35. *Id.* art. 3.

36. “Anti-discrimination measures include the prohibition of conduct that target or consequence violating the dignity of a person, create an intimidating, hostile, degrading or offensive environment due to the disability that it possesses.” *Id.*

37. *Id.* art. 7.

38. *Id.*

39. General Health Law, art. 6, Diario Oficial de la Federación [DO], February 7, 1984 (Mex.).

in society.⁴⁰ Mexico provides universal access to health care through the System of Social Protection in Health.⁴¹

2. Specific Protection Relating to Pandemics

Mexico's General Civil Protection Act outlines several important parameters for the Mexican government in the case of a natural disaster or emergency, which includes pandemics.⁴² The principles meant to guide government actions⁴³ during such a pandemic center around "protection of life, health and integrity," "fairness . . . in the delivery of aid and . . . in an emergency or disaster," and "respect for human rights."⁴⁴ Throughout the risk management process, the Act requires both that priority be given to vulnerable social groups⁴⁵ and that, when implementing this law, government entities comply with the Constitution.⁴⁶ Thus, the Act explicitly reinforces the continued effect of constitutional protections against discrimination based on disability.⁴⁷

Mexico's *National Preparedness Plan and Response to an Influenza Pandemic (Preparedness Plan and Response)*⁴⁸ more specifically addresses the

40. *See id.* art. 3.

41. *Id.* art. 77. *See also* Felicia Marie Knaul et al., *The Question for Universal Health Coverage: Achieving Social Protection for All in Mexico*, 380 LANCET 1259, 1259 (2012).

42. General Law of Civil Protection, *as amended*, art. 2, Diario Oficial de la Federación [DO], June 6, 2012 (Mex.).

43. "The private and social sectors will participate in the achievement of the objectives of this law, in the terms and conditions that it sets." *Id.* art. 1. Further, in order to receive support from the central government, state governments must demonstrate that they have complied with the principles of impartiality. *Id.* art. 18.

44. *Id.* art. 5.

45. *Id.* art. 21. The Constitution identifies the following factors as potentially creating social vulnerability: ethnic or national origin, gender, age, disabilities, social status, conditions of health, religion, opinions, preferences, and civil estate. Political Constitution of the United Mexican States, *as amended*, art. 1, Diario Oficial de la Federación [DO], February 5, 1917. (Mex.).

46. Mexico General Civil Protection Act art. 6.

47. *See* Political Constitution of the United Mexican States, Diario Oficial de la Federación [DO], February 5, 1917. (Mex.).

48. One of these is the chapter on medical care and hospitals, in which Mexico has outlined a method of triage meant to evaluate the needs of citizens based on different medical conditions, consistent with the World Health Organization guidelines. SECRETARÍA DE SALUD, PLAN NACIONAL DE PREPARACIÓN Y RESPUESTA ANTE UNA PANDEMIA DE INFLUENZA [NATIONAL PREPAREDNESS PLAN AND RESPONSE TO AN INFLUENZA PANDEMIC], ch. 5, 3-5 (2006) [hereinafter INFLUENZA PREPAREDNESS PLAN]. This plan generally addresses how to expand and coordinate assessment of flu cases and what care (e.g., inpatient vs. outpatient care; prevention measures vs. antiretrovirals), as well as priorities for vaccination. *See id.* ch. 5. However, the priority setting for vaccination is typically quite different than for critical care. As is common, Mexico preferences health care workers and certain government officials (necessary for function during the emergency) and patients at risk of complications from illness. *Id.* at 27-28. In contrast, when priorities are specified for critical care medicine, sicker patients are often excluded. *Playing*

application of the Constitution of Mexico, the Law of General Civil Protection, and the General Health Law during a pandemic.⁴⁹ It reiterates the principles of respect for the dignity of the human being and non-infringement of fundamental rights,⁵⁰ but does not specifically address the allocation of critical care.⁵¹ Although the *Preparedness Plan and Response* acknowledges that during a state of emergency, fundamental rights, including health, may be diminished temporarily,⁵² citizens who believe they have had their rights infringed are permitted to file a complaint with the National Human Rights Commission for investigation.⁵³ Taken together, these measures suggest that exclusion of persons with disabilities from care could potentially be punishable under Mexican law.⁵⁴ Moreover, this position is consistent with the Mexican constitutional provisions on public health emergencies. While the President may, with agreement of various government officials, restrict or suspend “the rights and guarantees which could be an obstacle to [a] rapid and effective response to the situation,”⁵⁵ such restrictions may last only a short period of time⁵⁶ and may not limit “the exercise of the rights to non-discrimination and [the right] to life.”⁵⁷

Overall, Mexico has a consistent, comprehensive approach to the protection of people with disabilities and equal access to health care. Mexico embraces the principles of equal protection and antidiscrimination in its constitutional provisions⁵⁸ and ratification of the Convention. It translates these principles into specific rights through its GLIPD and its guarantee of universal health care.⁵⁹ In its General Civil Protection Act, Mexico is explicit that those civil rights remain in effect in a public health emergency.⁶⁰ Entities not only are prohibited from discriminating against vulnerable populations in the distribution of care, but also, arguably must give priority to these individuals in

God, supra note 10, at 728. The protocol does not address allocation of critical care medicine, such as respirators, during a pandemic.

49. INFLUENZA PREPAREDNESS PLAN, *supra* note 48, ch. 10, 5-8.

50. *Id.* at 4.

51. *Id.* at 8.

52. *Id.* at 7.

53. *Id.*

54. Of course, this right may be illusory should critical care medicine be inappropriately withheld during a public health emergency.

55. Political Constitution of the United Mexican States, art. 29, Diario Oficial de la Federación [DO], February 5, 1917. (Mex.).

56. *Id.*

57. *Id.*

58. *See id.* arts. 1, 4.

59. *See* General Health Law, arts. 3, 77, Diario Oficial de la Federación [DO], February 7, 1984 (Mex.).

60. *See* General Law of Civil Protection, arts. 1, 5, 18, 21, Diario Oficial de la Federación [DO], June 6, 2012 (Mex.).

times of crisis. Nevertheless, it acknowledges in its *Preparedness Plan and Response* that fundamental rights might be diminished in a state of emergency.⁶¹ While it provides a mechanism for redressing any such infringement, in the case of critical care resources during a public health emergency, such redress may come too late.

B. Brazil

1. General Protection for People with Disabilities

Brazil has afforded significant protection to people with disabilities. The country not only has adopted the Convention and its optional protocol,⁶² but it has specifically recognized that these protections rise to the level of constitutional rights.⁶³ Notably, this is the only treaty to garner such distinction from the Brazilian government.⁶⁴

Brazil's Constitution specifically provides that "everyone is equal before the law"⁶⁵ and states that one of the fundamental objectives of the Federative Republic of Brazil is "to promote the well-being of all, without prejudice as to origin, race, sex, color, age and any other forms of discrimination."⁶⁶ Although protection of disability is not specifically articulated in this list, the Constitution states that health is a social right and provides robust protection for individuals' access to health care.⁶⁷ It articulates that this is "the duty of the National Government and shall be guaranteed by social and economic policies aimed at reducing the risk of illness and other maladies and by universal and equal access to all activities and services for its promotion, protection and recovery."⁶⁸ The Constitution goes further to enforce this provision by providing in Article Eighty-Five that acts by the President of Brazil against the exercise of a social right, which includes access to health care, is an impeachable offense.⁶⁹

Brazil⁷⁰ also has legislation outlining the governmental protections for individuals with disabilities and access to health care.⁷¹ Article Two of Law

61. See INFLUENZA PREPAREDNESS PLAN, *supra* note 48, chs. 5, 10.

62. See *U.N. Convention Signatures*, *supra* note 30.

63. Decreto no. 6.949, de 3 de Agosto de 2009, DIÁRIO OFICIAL DO RIO DE JANEIRO [D.O.E.R.J.] (Braz.).

64. *Id.*

65. CONSTITUIÇÃO FEDERAL [C.F.] [CONSTITUTION] art. 3 (Braz.).

66. *Id.* art. 3.

67. *Id.* art. 6.

68. *Id.* art. 196.

69. *Id.* art. 85.

70. According to Foreign Law Guide, a new civil code was enacted beginning in 2002. The current civil code consolidated all aspects of corporate law and governance. Current legislation in Brazil is extremely difficult to follow. National legislation is generally accomplished now

No. 7853 ensures that individuals with disabilities have access to public and private health establishments⁷² and requires adequate treatment based on “appropriate” standards,⁷³ although it does not define either “adequate” or “appropriate.” Additionally under the Law, refusing, delaying, or hindering admission for medical or hospital care “where possible” is a crime, punishable by incarceration for one to four years and includes a fine.⁷⁴ However, the Law fails to specify what the qualifier “where possible” means.⁷⁵ Thus, it is not clear under what circumstances, if any, care for a person with disabilities may be refused, delayed, or hindered. The accompanying regulations define disability as any loss of psychological, physiological or anatomical structure or function, causing the inability to perform activities within the standard considered normal for humans.⁷⁶ The regulations also include a section focused on equalization of opportunities for people with disabilities, which specifically provides for services to support “comprehensive rehabilitation.”⁷⁷ In addition, the regulations describe a comprehensive list of health services necessary both to prevent disability and to support those with disabilities.⁷⁸ This includes “the development of health programs for the disabled, developed with the participation of society . . . [motivating] social inclusion.”⁷⁹ Ordinance No. 793, moreover, establishes a Network of Care of People with Disabilities,⁸⁰ which is tasked with ensuring access to care and quality of services for this group.⁸¹

Brazil’s Law No. 8080 of September 1990 also governs its Unified Health System. This law regulates both private and public legal entities and

through separate administrative organs. Foreign Law Guide recommends looking to commercially published guides on legislation in Brazil, so the research utilized below will offer more of a guide in the right direction rather than a completely reliable source of what laws are in effect. *See generally* MARCI HOFFMAN, FOREIGN LAW GUIDE, BRAZIL –LEGISLATION AND THE JUDICIAL SYSTEM (2013), available at http://referenceworks.brillonline.com/entries/foreign-law-guide/brazil-legislation-and-the-judicial-system-COM_037302.

71. Lei No. 7.853, de 24 de Outubro de 1989, art. 2, DIÁRIO OFICIAL DA UNIÃO [D.O.U.] de 25.10.89 (Braz.).

72. *Id.* art. 2(II)(d).

73. *Id.*

74. *Id.* art. 8.

75. *Id.*

76. Decreto No. 3.298, de 20 de Dezembro de 1999, art. (3)(I), DIÁRIO OFICIAL DA UNIÃO [D.O.U.] de 21.11.1999 (Braz.).

77. *Id.* art. 15.

78. *Id.* art. 16-23.

79. *Id.* art. 16(VI).

80. Portaria No. 793, de 24 de Abril de 2012, art. 1, DIÁRIO OFICIAL DA UNIÃO [D.O.U.] (Braz.) [hereinafter Ordinance No. 793].

81. *Id.* art. 2(IV).

individuals.⁸² The Law both establishes health as a fundamental right, in which the State must create an environment conducive to its full realization,⁸³ and it requires that the State establish conditions to ensure equal access to actions and services meant to promote, protect, and aid in recovery.⁸⁴ Further, the principles meant to guide the Unified Health System center around universal access to care, equality of health care, the absence of prejudice, and use of epidemiology for establishing priorities, allocating resources, and program orientation.⁸⁵ While this Law discusses coordination by the Unified Health System to assure goods and services are provided during an outbreak of epidemic,⁸⁶ it does not specify how these resources will be allocated during an epidemic.

2. Specific Protection Relating to Pandemics

Brazil offers several Agency documents to guide the government in an epidemic,⁸⁷ including a *Protocol for Combating Influenza Pandemic (2009): Shares of Primary Health Care*⁸⁸ and the *Contingency Plan to Confront an Influenza Pandemic*,⁸⁹ which is in draft form. Although these documents provide some insight into Brazil's approaches to allocation during a pandemic, they focus on prevention and treatment with vaccinations and antivirals rather than allocation of critical care medicine during a public health emergency.⁹⁰ Although both documents preference vulnerable populations for vaccination and treatment, application to distribution questions involving critical care

82. Lei No. 8080, de 19 de Setembro de 1990, art. 4, DIÁRIO OFICIAL DA UNIÃO [D.O.U.] de 20.9.1990 (Braz.).

83. *Id.* art. 2.

84. *Id.*

85. *Id.* art. 7.

86. *Id.* art. 15(XIII).

87. Brazil provides a Vaccination Manual that outlines how vaccinations should be distributed; however, the manual does not have to be strictly abided by during the course of an epidemic. See MINISTÉRIO DA SAÚDE, MANUAL DE NORMAS DE VACINAÇÃO [MANUAL STANDARDS VACCINATION] 17 (3rd ed. 2001) [hereinafter VACCINATION MANUAL].

88. MINISTÉRIO DA SAÚDE, PROTOCOLO PARA O ENFRENTAMENTO À PANDEMIA DE INFLUENZA PANDÊMICA (H1N1) 2009: AÇÕES DA ATENÇÃO PRIMÁRIA À SAÚDE [PROTOCOL FOR FACING THE PANDEMIC OF INFLUENZA PANDEMIC (H1N1) 2009: THE ACTIONS PRIMARY HEALTH CARE] 1-3 (1st ed. 2010) [hereinafter INFLUENZA PANDEMIC PROTOCOL].

89. HEALTH MINISTRY, BRAZIL CONTINGENCY PLAN TO CONFRONT AN INFLUENZA PANDEMIC 1 (2005). Much of the document is still in development; however, it does offer preliminary insight into the Brazilian government decision-making involving allocation of resources during such an event. *Id.* at 10-11.

90. See generally *id.* (focusing on prevention & treatment with vaccinations and antivirals); see also INFLUENZA PANDEMIC PROTOCOL, *supra* note 88.

medicine is limited.⁹¹ Moreover, it is not clear whether these have any binding effect.

Taken together, Brazil's constitutional provisions⁹² and legislation⁹³ demonstrate a strong commitment to equity in treatment. While disability is not explicitly identified as a target of protection in the Constitution, Brazil has recognized the rights afforded under the Convention as constitutional rights.⁹⁴ Moreover, it has adopted legislation designed to provide equitable access to health care for people with disabilities. Nevertheless, the provisions suggesting that these protections may be lifted in undefined circumstances⁹⁵ render it unclear how these rights would be applied with respect to people with disabilities in allocating care in times of emergency.

C. South Africa

1. General Protection for People with Disabilities

South Africa has a number of constitutional provisions and legislative acts that protect the rights of people with disabilities. Additionally, the country has both signed and ratified the Convention.⁹⁶ South Africa's Constitution, moreover, provides both that all citizens are "equally entitled to the rights, privileges and benefits of citizenship" and that "[e]veryone has inherent dignity and the right to have their dignity respected and protected."⁹⁷ It states that "[e]quality includes the full and equal enjoyment of all rights and freedoms,"⁹⁸ and specifically provides that "the state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including . . . disability."⁹⁹

91. As we have discussed elsewhere, the allocation of vaccines may be guided by different allocation principles than for critical care. For example, health care personnel may be prioritized for vaccination because they provide essential services when responding to an epidemic and caring for patients. On the other hand, a person requiring a ventilator is unlikely to recover quickly enough to return to the workforce and assist with the public health emergency. Thus, the same principles may not apply. *Playing God*, *supra* note 10, at 732-733.

92. *See, e.g.*, CONSTITUIÇÃO FEDERAL [C.F.] [CONSTITUTION] arts. 3, 6, 85, 196 (Braz.).

93. *See, e.g.*, Lei No. 7.853, de 24 de Outubro de 1989, arts. 2, 8 DIÁRIO OFICIAL DA UNIÃO [D.O.U.] de 25.10.89 (Braz.); *see also* Decreto No. 3.298, de 20 de Dezembro de 1999, arts. 3, 15, 16, 23, DIÁRIO OFICIAL DA UNIÃO [D.O.U.] de 21.11.1999 (Braz.).

94. *See* Decreto No. 6.949, de 25 de Agosto de 2009, art. 28, DIÁRIO OFICIAL DA UNIÃO [D.O.U.] de 25.8.2009 (Braz.) (providing Presidential declaration of Brazil's adoption of the UN Convention); *see also* Convention, *supra* note 22.

95. *See* Lei No. 7.853, de 24 de Outubro de 1989, art 8, DIÁRIO OFICIAL DA UNIÃO [D.O.U.] de 25.10.89 (Braz.).

96. *U.N. Convention Signatures*, *supra* note 30.

97. S. Afr. Const., 1996, arts. 3(2)(a), 10.

98. *Id.* art. 9(2).

99. *Id.* art. 9(3).

There are limits to this protection that may be significant in the context of pandemics. First, not all discrimination is precluded; instead, only that which is considered “unfair.”¹⁰⁰ Of particular concern, the South African Constitution lists rights that are non-derogable during declared “states of emergency,” such as the right to life and the right to human dignity.¹⁰¹ Notably, discrimination based on disability is not included in this list¹⁰² and thus presumably may be set-aside during a “state of emergency”. Potentially, this could lead to a complete nullification of all constitutional protections against disability discrimination in the context of a public health emergency.

Nevertheless, the Constitution specifically grants the right to health care¹⁰³ and requires that “the state . . . take reasonable legislative and other measures, within its available resources” to achieve this mandate.¹⁰⁴ Although this is favorable to people with disabilities, the limitation to “available resources” could, once again, potentially restrict access to health care in times of scarcity. Notably, however, the next section provides that “[n]o one may be refused emergency medical treatment”¹⁰⁵ and arguably is not subject to the “available resources” limitation.

The *Policy on Quality in Health Care for South Africa (Policy on Quality)*, moreover, provides a broader health care policy overview.¹⁰⁶ Although not focused on an epidemic-specific situation, this document provides insight into South Africa’s commitments in its health care system.¹⁰⁷ As in other documents, it stresses the importance of equity in rendering health care to vulnerable populations, where “equity means ensuring that the whole population has access to quality health care.”¹⁰⁸ Importantly for our purposes, it addresses the need to focus on historically disadvantaged groups, including

100. *Id.* art. 9(5).

101. S. Afr. Const., 1996, art. 37(5)(c).

102. *See id.* The other grounds that are included as non-derogable rights against unfair discrimination are race, color, ethnic or social origin, sex, religion or language. *Id.* art. 9(3).

103. *Id.* art. 27(1)(a).

104. *Id.* art. 27(2).

105. *Id.* art. 27(3).

106. *See generally* NAT’L DEPT. OF HEALTH, A POLICY ON QUALITY IN HEALTH CARE FOR SOUTH AFRICA 2 (2007) [hereinafter POLICY ON QUALITY]. South Africa has also compiled a Patient’s Rights Charter that, although not directly related to pandemics, does provide for the right to “access to health care” and the right to have treatment uninterrupted. HEALTH PROFESSIONALS COUNCIL OF SOUTH AFRICA, NATIONAL PATIENTS’ RIGHTS CHARTER 1.2, 2.11 (2008). However, this charter “is subject to any laws operating within the Republic of South Africa” and “the financial means of the country.” *Patients’ Rights Charter*, NAT’L DEPT. OF HEALTH (2007), available at <http://www.justice.gov.za/VC/docs/policy/Patient%20Rights%20Charter.pdf>.

107. *See* POLICY ON QUALITY, *supra* note 106.

108. *Id.* at 10.

people with disabilities.¹⁰⁹ The *Policy on Quality* also provides specific examples of what equity requires, including “[r]edistributing health expenditure to achieve equity—those with equal need should receive the same level of funding; [r]edistributing health resources, in particular doctors and nurses; [s]etting national norms and standards to judge that all people receive an acceptable quality of care; and [m]onitoring progress.”¹¹⁰ While the South African Constitution may allow lifting of antidiscrimination protections for people with disabilities during an emergency,¹¹¹ these documents suggest a stronger commitment to alleviating disparities in health care that may nevertheless influence decision-making during a public health emergency.

South Africa’s Promotion of Equality and Prevention of Unfair Discrimination Act (Unfair Discrimination Act) also contains several important provisions. The Act defines discrimination as “any act or omission, including a policy, law, rule, practice, condition or situation which directly or indirectly—(a) imposes burdens, obligations or disadvantages on; or (b) withholds benefits, opportunities or advantages from, any person on one or more of the prohibited grounds.”¹¹² Such prohibited grounds include disability, and the Act specifically bars “denying or removing from any person who has a disability, any supporting or enabling facility necessary for their functioning in society.”¹¹³

The Act explains the concept of “unfair discrimination,” evaluating context based on a list of factors¹¹⁴ and whether the complained of behavior “reasonably and justifiably differentiates between persons according to objectively determinable criteria, intrinsic to the activity concerned.”¹¹⁵ The

109. *Id.*

110. *Id.*

111. *See* S. Afr. Const., 1996, art. 37(5)(c).

112. Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 § 1(1)(viii) (S. Afr.).

113. *Id.* § 9(a).

114. *Id.* § 14(3). The factors are:

[w]hether the discrimination impairs or is likely to impair human dignity; [] the impact or likely impact of the discrimination on the complainant; [] the position of the complainant in society and whether he or she suffers from patterns of disadvantage or belongs to a group that suffers from such patterns of disadvantage; [] the nature and extent of the discrimination; [] whether the discrimination is systemic in nature; [] whether the discrimination has a legitimate purpose; [] whether and to what extent the discrimination achieves its purpose; [] whether there are less restrictive and less disadvantageous means to achieve the purpose; [and] [] whether [and] to what extent the respondent has taken such steps as being reasonable in the circumstances to— [] address the disadvantage which arises from or is related to one or more of the prohibited grounds; or [] accommodate diversity.

Id.

115. *Id.* § 14(2)(c).

favorable treatment of people with disabilities is permissible and not considered “unfair discrimination.”¹¹⁶ The Act also imposes a positive duty on public institutions to eliminate discrimination and promote equality.¹¹⁷

Of particular significance, South Africa’s Unfair Discrimination Act specifically identifies unfair practices in the provision of health care services, and states that a person cannot be “unfairly den[ied] or refus[ed] . . . access to health care facilities.”¹¹⁸ Moreover, emergency medical treatment cannot be denied “to persons or particular groups identified by one or more of the prohibited grounds,”¹¹⁹ including disability.¹²⁰ As discussed earlier, however, such protection is not absolute and may be reduced during a state of emergency such that it does not apply during public health emergencies.¹²¹

South Africa’s National Health Act 2003 also reiterates the right of access to medical services,¹²² and identifies the protection, respect, promotion, and fulfillment of the rights of persons with disabilities as one of its objectives.¹²³ Like other legislation, this Act also acknowledges that the ability of the state to meet these goals is constrained by available resources.¹²⁴ The Act prohibits the refusal of a health care provider, worker, or establishment to provide emergency medical treatment.¹²⁵ The Act further reinforces the obligations of equal access to health care through its licensing requirements.¹²⁶ However, because the constitutional protections for individuals with disability are derogable, it is unclear whether these requirements will continue within a declared state of emergency.

116. Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 § 14(1).

117. *Id.* § 24.

118. *Id.* Schedule, § 29(3)(b).

119. *Id.* § 29(3)(c).

120. *Id.* ch. 1, § 1(xxii) (defining “prohibited grounds” as “race, gender, sex. . . disability”).

121. S. Afr. Const., 1996, art. 37.

122. *See* National Health Act 61 of 2003 § 1 (S. Afr.).

123. *Id.* § 2(c)(iv).

124. *Id.* § 2(a)(ii). The Minister of Health is required to “within the limits of available resources . . . equitably prioritiz[e] the health services that the State can provide.” *Id.* § 3(1)(e).

125. *Id.* § 5. The requirement that services are distributed equitably is extended to municipalities as well *See* National Health Act 61 of 2003 § 3(2).

126. The Act requires a “certificate of need” to:

establish, construct, modify, or acquire a health establishment or health agency; [] increase the number of beds in or acquire prescribed health technology at, a health establishment or health agency; [] provide prescribed health services; or [] continue to operate a health establishment or health agency after the expiration of 24 months from the date this Act took effect, without being in possession of certificate of need.

Id. § 36(1). In issuing a certificate of need, the Director-General must take into account specific issues, which include equitable distribution and access to care. *Id.* § 36(3).

2. Specific Protection Relating to Pandemics

South Africa has both a Disaster Management Act and a Policy Framework for the Disaster Management Act. The Act establishes what constitutes a disaster and what should apply to public health emergencies like epidemics.¹²⁷ The Act itself refers to occurrences that cause disease in the definition of a disaster,¹²⁸ and the Policy Framework¹²⁹ explicitly classifies biological agents as natural hazards.¹³⁰ Although no section specifically references the rights of individuals with disabilities, the Policy Framework stresses the need to consider individuals with special needs¹³¹ and at-risk groups throughout, including specific instruction to place priority on “those areas, communities and households that . . . have the least capacity to resist and recover from resulting impacts [of the threat].”¹³² This would seem to place individuals with disabilities potentially at the front of the line in receiving medical interventions in times of scarcity.

South Africa also has a final draft of an *Influenza Pandemic Preparedness Plan (Pandemic Preparedness Plan)*. Although it is not clear whether this draft has been formally promulgated, it provides insights into the country’s approach to a pandemic.¹³³ If a pandemic occurs, the *Pandemic Preparedness Plan’s* protocol requires that, if clinical guidelines are not readily available, WHO-guidelines should be adopted with respect to treating patients.¹³⁴ Like Mexico, South Africa’s plan focuses primarily on vaccination and administration of antivirals, rather than on allocation of critical care among flu patients.¹³⁵ The

127. See generally Disaster Management Act 57 of 2002 § 1 (S. Afr.).

128. *Id.* § 1. Disaster is defined as:

a progressive or sudden, widespread or locali[z]ed, natural or human-caused occurrence which [] causes or threatens to cause [] death, injury or disease; [] damage to property, infrastructure or the environment; or [] disruption of the life of the community; and [] is of a magnitude that exceeds the ability of those affected by the disaster to cope with its effects using only their own resources.

Id.

129. In the event that resource allocation would be required, one can presume for the purposes of this paper that the magnitude of the disaster would reach the levels required above in order to fall within the umbrella of the protections afforded under both the Disaster Management Act and the National Disaster Management Framework.

130. General Notice 654 of 2005 § 2.1.7 (S. Afr.) (including “epidemic diseases affecting people or livestock” as an example of a hazard).

131. *Id.* § 2.1.4.

132. *Id.* § 3.2.3.

133. S. AFR. NAT’L DEPT. HEALTH, INFLUENZA PANDEMIC PREPAREDNESS PLAN, FINAL DRAFT 6-9 (2006) [hereinafter SOUTH AFRICA’S PREPAREDNESS PLAN].

134. *Id.* at 13.

135. *Id.* at 13-14. For example, it outlines that the Outbreak Response Team should monitor resource utilization and instructs the directorate of the Pharmaceutical Policy and Planning team to develop a plan for stockpiling vaccines and antivirals and to “ensure the provision of medical

Pandemic Preparedness Plan separates a pandemic threat into several phases, outlining the objectives and activities within each phase.¹³⁶ Phase Six addresses the actual pandemic period, in which the government should consider applying emergency powers.¹³⁷ The health system has the responsibility of “provid[ing] guidance on ways to optimi[z]e patient care with limited resources.”¹³⁸

On the whole, South Africa seemingly provides significant protections to persons with disabilities through its ratification of the Convention and its express constitutional protections.¹³⁹ However, its constitutional provision that allows waiver of those protections in times of emergency¹⁴⁰ is troublesome and creates the potential for discrimination in the distribution of resources in times of scarcity. Although disability protection is bolstered in legislation as well,¹⁴¹ unlimited emergency medical treatment is unlikely to be feasible in a pandemic, and allocation decisions must be made on some basis. The country’s refusal to recognize disability rights as non-derogable may place people with disabilities at the bottom of a distribution hierarchy given that other rights remain in force during a pandemic.

D. Singapore

1. General Protection for People with Disabilities

Singapore has little protection for individuals with disabilities within its borders. The country has signed the Convention, but, to date, has not ratified it.¹⁴² Until this document is ratified, the Convention’s protections remain merely symbolic for Singapore’s citizens.

Singapore’s Constitution does provide that “all persons are equal before the law and entitled to the equal protection of the law.”¹⁴³ Although it broadly prohibits “discrimination against citizens of Singapore on the ground only of religion, race, descent or place of birth,” it does not include disability in the list of protected traits.¹⁴⁴ Moreover, even these protections may be abrogated in

supplies before and during outbreaks.” *Id.* at 18. The Department of Social Development is responsible for ensuring “the availability of basic social needs during outbreaks.” *Id.* at 19.

136. SOUTH AFRICA’S PREPAREDNESS PLAN, *supra* note 133, at 23-36 (Annex A).

137. *Id.* at 36.

138. *Id.* at 37 (“Fully implement[ing] pandemic plans for health systems and essential services, adjust triage, deploy workforce and provide social/psychological support.”).

139. *See, e.g.*, S. Afr. Const., 1996, arts. 3, 9, 27 and 37.

140. *Id.* art. 37(5)(c).

141. *See, e.g.*, Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 §§ 1, 2, 14, 24, 129 (S. Afr.); National Health Act 61 of 2003 §§ 1, 2, 3, 5, 36 (S. Afr.).

142. *U.N. Convention Signatures*, *supra* note 30.

143. CONST. OF THE REPUBLIC OF SINGAPORE, 1963, art. 12(1) (Sing.).

144. *Id.* art. 12(2).

times of crisis, as Parliament has the constitutional authority “to make laws with respect to any matter, if it appears to Parliament that the law is required by reason of emergency.”¹⁴⁵ Although Singapore has legislation specifically addressing disability discrimination with respect to the accessibility of physical spaces,¹⁴⁶ no legislation relates to the resource allocation issues at question here.¹⁴⁷

2. Specific Protection Relating to Pandemics

Singapore has adopted both a general *Guide to Infectious Diseases of Public Health Importance in Singapore*¹⁴⁸ and a more specific *Influenza Pandemic Plan*.¹⁴⁹ As in other countries, these documents address allocation of antiretroviral treatment vaccination with respect to influenza,¹⁵⁰ rather than the allocation of critical care medicine. The lack of specific guidance in this area coupled with the lack of general antidiscrimination laws relating to disability suggest strongly that allocation decisions will be made at the bedside entirely at the discretion of medical personnel.

As is apparent, there are very few legal protections for people with disabilities in Singapore. Thus, there seems to be little protection against exclusion from treatment based on disability during a public health emergency.

E. Cambodia

1. General Protection for People with Disabilities

In 2012, Cambodia ratified the Convention.¹⁵¹ Because the country regards treaties and conventions as superior to everything but its Constitution,¹⁵² the protections offered by the treaty may ensure some fairness in the allocation of scarce resources during a public health emergency for this population.

Cambodia’s Constitution also provides some protection from discrimination for people with disabilities. It provides that “the State shall help

145. *Id.* art. 150(4).

146. *See* Building Control Act, (Act No. 8/ 1989) § 22D (Sing.); SING. BLDG. & CONSTR. AUTH., CODE ON ACCESSIBILITY IN THE BUILT ENVIRONMENT 8, 12, 17 (2007) [hereinafter ACCESSIBILITY CODE].

147. These discrimination protection Acts deal with accessibility and building codes. *See* Building Control Act § 22D; ACCESSIBILITY CODE, *supra* note 146.

148. *See* MINISTRY OF HEALTH, A GUIDE TO INFECTIOUS DISEASES OF PUBLIC HEALTH IMPORTANCE IN SINGAPORE (Adrian Ong & Goh Kee Tai, eds., 7th ed. 2011) [hereinafter GUIDE TO INFECTIOUS DISEASES].

149. *See* MINISTRY OF HEALTH, INFLUENZA PANDEMIC READINESS AND RESPONSE PLAN (2005).

150. *See id.* 10-16; *see also* GUIDE TO INFECTIOUS DISEASES, *supra* note 148, at 54.

151. *U.N. Convention Signatures*, *supra* note 30.

152. CONST. OF THE KINGDOM OF CAMBODIA, 1993, art. 55 (Cambodia).

support the disabled and the families of combatants who sacrificed their lives for the nation.”¹⁵³ However, the type of support is not defined, and the inclusion of “families of combatants” suggests the provision could be limited to those whose disabilities arose from warfare in some respect. Although it also provides that all citizens are “equal before the law, enjoying the same rights and freedom and obligations regardless of race, color, sex . . . or other status”¹⁵⁴ it does not define the meaning of “other status.”

Cambodia’s Constitution does provide that “the health of the people shall be guaranteed.”¹⁵⁵ It also states that the nation “shall pay attention to disease prevention and medical treatment,”¹⁵⁶ suggesting that access to health care, at a minimum, is an important commitment of the government. Nevertheless, Cambodia’s economic situation limits its ability to fulfill these commitments.¹⁵⁷ While the country has made significant improvements in health status in recent years, health inequities persist among different segments of the population, and the government plays a limited role in providing health care.¹⁵⁸

In contrast, the Law on the Protection and Promotion of the Rights of Persons with Disabilities specifically provides that it is intended to “protect and promote the rights of persons with disabilities within the Kingdom of Cambodia.”¹⁵⁹ Coverage includes “any persons who lack, lose, or damage any physical or mental functions, which result in a disturbance to their daily life or activities, such as physical, visual, hearing, intellectual impairments, mental disorders and any other types of disabilities toward the insurmountable end of the scale.”¹⁶⁰ As a whole, however, the law is relatively vague. Although it states that the country “shall give due attention, as appropriate, to promoting livelihoods for persons with disabilities in conformity with the national economic situation,”¹⁶¹ it provides few specific protections against disability

153. *Id.* art. 74 (this is the English translation provided in the tri-lingual text 2008 version of the Constitution).

154. *Id.* art. 31.

155. *Id.* art. 72.

156. *Id.* art. 72.

157. *See* THE WORLD BANK, TECHNICAL ANNEX ON A PROPOSED GRANT IN THE AMOUNT OF SDR 3.8 MILLION TO THE ROYAL KINGDOM OF CAMBODIA FOR AN AVIAN AND HUMAN INFLUENZA CONTROL AND PREPAREDNESS EMERGENCY PROJECT UNDER THE GLOBAL PROGRAM FOR AVIAN INFLUENZA AND HUMAN PANDEMIC PREPAREDNESS AND RESPONSE FOR ELIGIBLE COUNTRIES UNDER THE HORIZONTAL APL 2 (2008) [hereinafter WORLD BANK CONTROL AND PREPAREDNESS PROGRAM].

158. WORLD HEALTH ORG., COUNTRY COOPERATION SURVEY AT A GLANCE: CAMBODIA 1 (2014).

159. Law on the Protection and the Promotion of the Rights of Persons with Disabilities, art. 1 (Cambodia).

160. *Id.* art. 4.

161. *Id.* art. 10.

discrimination, particularly in the health care context.¹⁶² Nevertheless, because the law provides that international treaties govern its application,¹⁶³ Cambodia's ratification of the Convention in 2012 should reaffirm its commitment to the prevention of disability discrimination.¹⁶⁴

2. Specific Protection Relating to Pandemics

Although the government of Cambodia does not provide readily accessible information on its plans for an epidemic, it is currently working with the World Bank and the WHO on emergency preparedness in the face of an influenza epidemic.¹⁶⁵ From this collaboration, several documents have developed that delve into the details of Cambodia's pandemic plans, although they focus more on increasing capacity to respond to an epidemic, rather than on resource allocation.¹⁶⁶ Nevertheless, the Cambodian government has developed an *Avian and Human Influenza Project Code of Conduct (Code of Conduct)*.¹⁶⁷ Relevant to our purposes, this document requires that all caregivers "discharge [their] duties in accordance with the Law and relevant decrees and regulations,"¹⁶⁸ "respect religious freedom, promote equity . . . and not discriminate on the basis of any other person's race, colo[r], religion, gender, marital and parental status, handicap, age, or national origin."¹⁶⁹ Because there are no specific directives on how the government should implement these principles in times of a pandemic, it is impossible to predict the protection they would provide to people with disabilities.

162. The only provisions about specific discrimination include that qualified individuals with disabilities have a "right to be employed without discrimination." *Id.* art. 33. Additionally, "stigmatization and discrimination against [electoral] candidates with disabilities shall be prohibited." *Id.* art. 45.

163. Law on the Protection and the Promotion of the Rights of Persons with Disabilities, art. 49 (Cambodia).

164. See *U.N. Convention Signatures*, *supra* note 30.

165. See WORLD BANK CONTROL AND PREPAREDNESS PROGRAM, *supra* note 157, at 3. Mexico coordinated with the World Bank on a similar project in November 2009 in order to "improv[e] its National Epidemiological Surveillance System (SINAVE) including the upgrading of the Borrower's national reference laboratory for epidemiological surveillance, strength[en] the infrastructure to effectively distribute medicines, vaccines and medical supplies and replenish[] and expand[] the country's strategic reserves thereof." *Influenza Prevention and Control*, THE WORLD BANK, <http://www.worldbank.org/projects/P116965/influenza-prevention-control?lang=en&tab=overview> (last visited Feb. 28, 2015).

166. WORLD BANK CONTROL AND PREPAREDNESS PROGRAM, *supra* note 157, at 8.

167. See ROYAL GOVERNMENT OF CAMBODIA NATIONAL COMMITTEE FOR DISASTER MANAGEMENT, AVIAN AND HUMAN INFLUENZA CONTROL AND PREPAREDNESS EMERGENCY PROJECT IDA GRANT NO. H361-KH CODE OF ETHICAL CONDUCT FOR STAFF (2010) [hereinafter CODE OF ETHICAL CONDUCT].

168. *Id.* at 1.

169. *Id.*

Overall, while Cambodia's laws offer limited protection for people with disabilities, it does have some laws that offer explicit protection.¹⁷⁰ Its ratification of the Convention, given the strong authority it grants such international agreements,¹⁷¹ may be the strongest protection in Cambodia. It has confirmed this commitment to equitable treatment in its *Code of Conduct*, which specifically applies to pandemics.¹⁷² However, Cambodia provides an example of how practical realities may suggest these dictates are merely aspirations. Given its inability to realize its commitment to guarantee the health of its citizens,¹⁷³ it may not be in a position to fulfill its commitment to equal access to care for people with disabilities in the event of a public health emergency.

F. Australia

1. General Protection for People with Disabilities

Australia ratified the Convention¹⁷⁴ and because the Convention did not create new rights or entitlements, but rather, expressed existing rights found in the country's Human Rights and Equal Opportunity Commission Act of 1986 (Human Rights Act),¹⁷⁵ the Convention came into force in Australia.¹⁷⁶ The Human Rights Act specifies the right to file a complaint with the Commission established by the Act, as well as with the Australian courts.¹⁷⁷

170. See, e.g., Law on the Protection and the Promotion of the Rights of Persons with Disabilities (Cambodia).

171. See *id.* art. 49.

172. CODE OF ETHICAL CONDUCT, *supra* note 167, at 1.

173. See WORLD BANK CONTROL AND PREPAREDNESS PROGRAM, *supra* note 157, at 2.

174. U.N. Convention Signatures, *supra* note 30.

175. ATTORNEY GEN. OF AUSTRALIA, EXPLANATORY STATEMENT: HUMAN RIGHTS AND EQUAL OPPORTUNITY COMMISSION ACT 1986 CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES DECLARATION 2009 at 1 (2009) [hereinafter ATTORNEY GENERAL EXPLANATORY STATEMENT].

176. *Id.* Although Australia typically requires implementing legislation in order for a treaty to be binding law, it does not require that specific implementing legislation be enacted. Should the Australian government find that prior enacted legislation is either adequate "to implement the provisions of the convention" or that the treaty obligations "can be implemented progressively and without radical change to existing laws," it would not require passing new legislation specifically to implement a convention. *Treaty Making Process*, AUSTL. DEP'T OF FOREIGN AFFAIRS & TRADE, <http://www.dfat.gov.au/treaties/making/#constitution> (last visited Feb. 28, 2015). With respect to the Convention, the Attorney General determined that the Convention was consistent with the provisions of the Human Rights and Equal Opportunity Commission Act 1986. ATTORNEY GENERAL EXPLANATORY STATEMENT, *supra* note 175.

177. *Australian Human Rights Act 1986* pt. IIB 46P(1) (Austl.).

Australia's Constitution refers to disability only in the context of requiring states to treat residents of other states equally.¹⁷⁸ Thus, antidiscrimination provisions primarily are defined by Australian legislation.

Australia's Disability Discrimination Act of 1992 prohibits both direct and indirect disability discrimination,¹⁷⁹ which is defined as treating, or proposing to treat, a person with disabilities less favorably than others without the disability "in circumstances that are not materially different."¹⁸⁰ The Act applies to the provision of "goods and services," employment, and access to premises, whether public or private.¹⁸¹ Of potentially particular significance, the legislation precludes discrimination in the administration of Commonwealth laws and programs.¹⁸² Because Australia has a universal health care system that is administered by the government,¹⁸³ health care access would fall within this mandate.¹⁸⁴

These antidiscrimination provisions can be overcome by a showing of an unjustifiable hardship on the person providing the services, which is determined by reference to five factors:

- (1) the nature of the benefit or detriment likely to accrue to, or to be suffered by, any person concerned;
- (2) the effect of the disability of any person concerned;
- (3) the financial circumstances, and the estimated amount of the expenditure required to be made, by the first person;
- (4) the availability of financial and other assistance to the first person; and
- (5) any relevant action plans given to the Commission under section 64.¹⁸⁵

In addition, the Act requires that those subject to its provisions make reasonable adjustments for people with disabilities that would allow them to meet any requirements or conditions deemed necessary.¹⁸⁶ If a failure to make

178. AUSTRALIAN CONSTITUTION ch. 12., art. 177. The section provides: "A subject of the Queen, resident in any state, shall not be subject in any other State to any disability or discrimination which would be equally applicable to him if he were a subject of the Queen resident of such other state." *Id.* art. 102.

179. *Disability Discrimination Act 1992* art. 5 & 6 (Austl.).

180. *Id.* art. 5(1).

181. *Id.* art. 21, 23, & 24.

182. *Id.* art. 29.

183. *Australia's Health System*, AUSTRALIAN INST. OF HEALTH & WELFARE, <http://www.aihw.gov.au/australias-health/2014/health-system/> (last visited Feb. 28, 2015). While Australia does have some private health care, the majority of care, particularly the hospital-based care relevant to this discussion, is publicly funded. *See id.* Table 2.1.

184. "The aim of the Australian health system is to give universal access to health care under what is known as 'Medicare', while allowing choice for individuals through substantial private sector involvement in delivery and financing." WORLD HEALTH ORG., COUNTRY HEALTH INFORMATION PROFILES: AUSTRALIA 16 (2011).

185. *Disability Discrimination Act 1992* art.11 (Austl.).

186. *Id.* art. 5(2).

such adjustments “has, or is likely to have, the effect of disadvantaging persons with the disability,” the failure would constitute discrimination.¹⁸⁷

2. Specific Protection Relating to Pandemics

The Australian government has compiled several documents meant to guide decision-making in the event of a pandemic. One example is the *Australian Health Management Plan for Pandemic Influenza (Health Management Plan)*, which takes into consideration the lessons learned from the H1N1 pandemic in 2009.¹⁸⁸ Importantly, this document provides an ethical framework to guide how decisions should be made, including the determination of how to allocate scarce resources.¹⁸⁹ Two major principles include protecting the entire population and providing care in an equitable manner.¹⁹⁰ At the same time, the *Health Management Plan* affords some flexibility by endorsing “the use of policy that can respond to the . . . resources we have available.”¹⁹¹ The document expands on these resources, discussing personnel, as well as facilities and equipment. The discussion of facilities and equipment includes the use of personal protective equipment and vaccines to prevent infection to health individuals, and antivirals to treat sick individuals.¹⁹² These discussions assume scarcity may occur and allocation may need to be managed at the national level. While there is discussion that health care workers and other essential personnel may receive priority for prevention measures, there is no discussion of how allocation decisions would be made for treating sick people.¹⁹³

In addition to the *Health Management Plan*, the *Information Kit and Workplan for General Practice*, focusing specifically on pandemic influenza, provides some insight into the allocation of scarce resources, as it concerns hospital beds.¹⁹⁴ The document states that as hospitals become overwhelmed,

187. *Id.* art. 6(1)(c).

188. DEP’T OF HEALTH & AGING, AUSTRALIAN HEALTH MANAGEMENT PLAN FOR PANDEMIC INFLUENZA: IMPORTANT INFORMATION FOR ALL AUSTRALIANS 7 (2009) (Austl.) [hereinafter AUSTRALIA’S MANAGEMENT PLAN]. Other documents include the Interim National Pandemic Influenza Clinical Guidelines, which is intended primarily for health professionals to use when dealing with avian and pandemic influenza patients, including discussion of prioritization of both vaccines and antivirals that will be necessary at some point during the pandemic. *See* AUSTL. DEP’T OF HEALTH & AGING, INTERIM NATIONAL PANDEMIC INFLUENZA CLINICAL GUIDELINES (2009).

189. AUSTRALIA’S MANAGEMENT PLAN, *supra* note 188, at 33.

190. *Id.*

191. *Id.* at 35.

192. *Id.* at 38.

193. *Id.* Appendix F (p. 99-100).

194. *See* AUSTL. DEP’T OF HUMAN SERVS., PREPARING FOR AN INFLUENZA PANDEMIC: AN INFORMATION KIT AND WORKPLAN FOR GENERAL PRACTICE 13 (2006) [hereinafter WORKPLAN FOR GENERAL PRACTICE].

admission should only continue for patients “who may benefit from hospital care,”¹⁹⁵ necessitating home care for the mildly sick and palliative care for terminally ill patients.¹⁹⁶ It does not explain how medical providers would make the determination of who receives assistance under this standard.

Finally, *Exercise Sustain 08: Overview (Exercise Sustain)* is a report based on a series of pandemic exercises to deal with potential policy issues identified in the *National Action Plan for Human Influenza Pandemic*, which discusses government coordination for pandemic response.¹⁹⁷ *Exercise Sustain* identifies the prioritization of vulnerable groups for care as a policy issue that needs attention. The exercises resulted in inconsistent conclusions in this regard. While one exercise led to the conclusion that national guidelines prioritizing services and care for vulnerable groups should be established,¹⁹⁸ others concluded that national guidelines would be “too prescriptive, given that many of the decisions relating to the prioritization of vulnerable groups would need to be made at a local level.”¹⁹⁹ These responses illustrate the general problem of allocation protocols. Although most recognize that guidelines for critical periods may provide needed protection and consistency for vulnerable populations, there is reluctance to restrict the discretion of local (often medical) decision-makers. As such, *Exercise Sustain* provides perhaps the most realistic insight into how Australia would actually respond in a public health emergency, despite legislation requiring equitable treatment of people with disabilities.

In summary, Australia does not provide constitutional protection to people with disabilities, but does provide protections through multiple pieces of legislation²⁰⁰ and its ratification of the Convention. This includes provisions precluding discrimination based on disability in government programs, which is significant in a country in which most care—particularly hospital care—is government-funded. These commitments are reinforced in its plan for pandemic influenza.²⁰¹ However, as noted above, documents describing pandemic preparedness efforts²⁰² suggest a desire for flexibility in decision-

195. *Id.* at 13.

196. *Id.*

197. COUNCIL OF AUSTRALIAN GOV'TS, HUMAN INFLUENZA PANDEMIC EXERCISE PROGRAM: EXERCISE SUSTAIN 08 OVERVIEW 3 (2009) [hereinafter EXERCISE SUSTAIN 08]; *see also* AUSTRALIAN DEP'T OF HUMAN SERVS., NATIONAL ACTION PLAN FOR HUMAN INFLUENZA PANDEMIC (2009).

198. EXERCISE SUSTAIN 08, *supra* note 197, at 30.

199. *Id.*

200. *See, e.g., Australian Human Rights Act 1986* (Austl.); *Disability Discrimination Act 1992*, arts. 5, 6, 21, 23, 24, 29 (Austl).

201. *See* AUSTRALIA'S MANAGEMENT PLAN, *supra* note 188.

202. *See* EXERCISE SUSTAIN 08, *supra* note 197.

making that if provided, could undermine the legal protections afforded to people with disabilities.

G. *New Zealand*

1. General Protection for People with Disabilities

New Zealand has enacted comprehensive protection for people with disabilities at all levels of government. In 2008, the country ratified the Convention,²⁰³ which is binding in New Zealand.²⁰⁴ Likewise, the country has passed legislation to align existing laws with the Convention's requirements.

Although there is no constitutional protection of disability in New Zealand, the nation has extremely robust legislative enactments in this area. In particular, the Human Rights Act of 1993 provides extensive protections against disability discrimination under the umbrella of a general antidiscrimination law.²⁰⁵ The Act categorizes disability as a prohibited ground for discrimination²⁰⁶ and gives examples of what qualifies as a disability,²⁰⁷ including "physical illness" and "the presence in the body of organisms capable of causing illness."²⁰⁸ As is apparent, this definition would include individuals sickened in a pandemic.

The refusal or failure "to provide [an individual with disabilities] with . . . goods, facilities, or services"²⁰⁹ on the basis of disability, or treating individuals with disabilities less favorably with respect to their provision of care,²¹⁰ is prohibited discrimination unless the provider can show the services

203. *U.N. Convention Signatures*, *supra* note 30.

204. *Convention on the Rights of Persons with Disabilities*, Ministry of Foreign, NEW ZEALAND TREATIES ONLINE <http://www.treaties.mfat.govt.nz/search/details/t/3620> (last visited Feb. 28, 2015). New Zealand Treaties Online is the official record of binding international law in New Zealand. NEW ZEALAND TREATIES ONLINE <http://www.treaties.mfat.govt.nz/> (last visited Feb. 28, 2015). *See also The Treating Making Process in New Zealand*, MINISTRY OF FOREIGN AFFAIRS & TRADE <http://mfat.govt.nz/Treaties-and-International-Law/03-Treaty-making-process/index.php> (last updated Jan. 12, 2015).

205. *See* New Zealand Human Rights Act 1993 (N.Z.).

206. *Id.* pt. 2, § 21(h).

207. *See id.*

208. *Id.* The complete list is as follows:

- (i) physical disability or impairment; (ii) physical illness; (iii) psychiatric illness; (iv) intellectual or psychological disability or impairment; (v) any other loss or abnormality or psychological, physiological, or anatomical structure or function; (vi) reliance on a guide dog, wheelchair, or other remedial means; (vii) the presence in the body of organisms capable of causing illness.

Id.

209. New Zealand Human Rights Act 1993, § 44(1).

210. *Id.* § 44(1).

would have to be provisioned in a “special manner.”²¹¹ If this exception is met, the provider, where reasonable, can impose more onerous terms for individuals with disabilities,²¹² or refuse to provide the services altogether.²¹³ Nevertheless, even “conduct, practice[s], condition[s], or requirement[s]” that appear to comply with the Act can be unlawful if they have the effect of discriminating against individuals with disabilities in the absence of a “good reason for it.”²¹⁴

The New Zealand Bill of Rights Act of 1990 also reaffirms that “everyone has the right to freedom from discrimination on the grounds of discrimination,”²¹⁵ specified in the 1993 Human Rights Act.²¹⁶ The Act applies to direct actions performed by either the executive, legislative, or judicial branch, or any person performing a “public function, power, or duty conferred or imposed on that person or body by or pursuant to law.”²¹⁷ The Act prohibits the deprivation of life unless the grounds are both established by law and “consistent with the principles of fundamental justice.”²¹⁸ Nevertheless, it allows for “limitations” on the rights and freedoms outlined in the Act, but only those that “can be reasonably justified in a free and democratic society.”²¹⁹ Given the 1993 Human Rights Act and the 2000 Public Health and Disability Act²²⁰ described below, it does not appear that disability discrimination could be “reasonably justified.” This conclusion is further supported by the *New Zealand Influenza Pandemic Plan: A Framework for Action (Framework for Action)*, which lists the New Zealand statutes that

211. *Id.* § 52(a) (“the person who supplies the facilities or services cannot reasonably be expected to provide them in that special manner.”) The statute does not define nor give examples of what is meant by a “special manner.”

212. *Id.* § 52(b).

213. *Id.*

214. New Zealand Human Rights Act 1993, § 65.

Where any conduct, practice, requirement, or condition that is not apparently in contravention of any provision of this Part has the effect of treating a person or group of persons differently on 1 of the prohibited grounds of discrimination in a situation where such treatment would be unlawful under any provision of this Part other than this section, that conduct, practice, condition, or requirement shall be unlawful under that provision unless the person whose conduct or practice is in issue, or who imposes the condition or requirement, establishes good reason for it.

Id.

215. New Zealand Bill of Rights Act 1990, pt. 2, § 19(1).

216. *See* New Zealand Human Rights Act 1993 pts. 1A, 2.

217. New Zealand Bill of Rights Act 1990, pt. 1, § 3.

218. *Id.* pt. 2, § 8.

219. *Id.* pt. 1, § 5.

220. *See generally* New Zealand Public Health and Disability Act 2000.

cannot be modified during a public health emergency.²²¹ These include the New Zealand Bill of Rights Act 1990.²²²

Notably for our purposes, New Zealand's Public Health and Disability Act of 2000 identifies the elimination of health disparities among vulnerable populations as a national goal.²²³ The Act establishes District Health Boards, charged with "developing and implementing, in consultation with the groups concerned, services and program[s] designed to raise their health outcomes to those of other New Zealanders."²²⁴ It is not clear how or if these provisions would apply in an epidemic.

2. Specific Protection Relating to Pandemics

The government of New Zealand has outlined the nation's strategy for handling an influenza pandemic in several thoughtful documents. This includes both epidemic legislation and guidance documents developed by relevant Agencies.

New Zealand's Epidemic Preparedness Act of 2006 was promulgated "to enable the relaxation of some statutory requirements that might not be capable of being complied with, or complied with fully, during an epidemic."²²⁵ This broad power, however, does have some limitations. The Act does not authorize modification of:

[1] a requirement [] to release a person from custody or detention; or [] to have any person's detention reviewed . . . or [2] . . . a restriction on keeping a person in custody or detention; or [3] . . . a requirement or restriction imposed by the Bill of Rights 1688, the Constitution Act 1986, the Electoral Act 1993, the Judicature Amendment Act 1972, or the New Zealand Bill of Rights Act 1990 . . . or by [the Epidemic Preparedness] Act.²²⁶

This suggests some protections of people with disabilities could fall victim to exigencies of an epidemic. The Director-General of Health is authorized to make decisions about prioritization of disbursement of medicine during an epidemic, and "every person administering, dispensing, prescribing, or supplying medicines that are under the control of the Crown or a Crown entity" must conform to these provisions.²²⁷ The legislation gives no indication, however, of the method through which prioritization decisions should occur.

221. MINISTRY OF HEALTH, NEW ZEALAND INFLUENZA PANDEMIC PLAN: A FRAMEWORK FOR ACTION 121 (2010) [hereinafter FRAMEWORK FOR ACTION].

222. *Id.* Other statutes that cannot be modified include the Bill of Rights 1688, Constitution Act 1986, Electoral Act 1993, Judicature Amendment Act 1972, and the Epidemic Preparedness Act 2006. *Id.*

223. New Zealand Public Health and Disability Act 2000, pt. 1, § 3(1)(b).

224. *Id.* pt. 3, § 22(1)(f).

225. Epidemic Preparedness Act 2006, § 3(2)(b) (N.Z.).

226. *Id.* § 12(3).

227. Health Amendment Act 2006, § 74(C)(2) (N.Z.).

The 2008 *National Health Emergency Plan (Emergency Plan)* provides broad guidance with respect to health emergencies, including infectious disease pandemics.²²⁸ According to the document, the plan provides “overarching direction to the health and disability sector and all of government,”²²⁹ and would become active when “usual resources are overwhelmed or have the potential to be overwhelmed.”²³⁰ It outlines various legislative documents as part of the plan,²³¹ which suggests that it would work in conjunction with said legislation. Although its main focus is on the specific needs of indigenous populations, the *Emergency Plan* requires the government to maintain an effective dialogue with other vulnerable communities, especially those at risk in a pandemic.²³² It sets forth principles for managing health emergencies, which include providing:

an emergency management structure that supports, to the greatest extent possible, the protection of all . . . health and disability service consumers . . . [and] support for services that are best able to meet the needs of patients/clients and their communities during and after an emergency event, even when resources are limited, and ensure that special provisions are made for hard-to-reach, vulnerable communities so that emergency responses do not create or exacerbate inequalities.²³³

This specific language would seem to provide individuals with disabilities, tangible protection when seeking access to resources in public health emergencies.²³⁴

228. MINISTRY OF HEALTH, NATIONAL HEALTH EMERGENCY PLAN 6 (2008) [hereinafter EMERGENCY PLAN].

229. *Id.* at IV.

Specifically the NHEP: outlines the structure of emergency management in New Zealand and how the health and disability sector fits within it, and provides a high-level description of responsibilities held by local and regional groupings compared to those held at the national level by the Ministry; provides the health and disability sector with guidance and strategic direction on its approach to planning for and responding to health emergencies in New Zealand; provides other organi[z]ations and government agencies with contextual information on emergency management in the health sector and the structure the health and disability sector uses in response to an emergency.

Id.

230. *Id.*

231. *Id.*

232. EMERGENCY PLAN, *supra* note 228, at 18.

233. *Id.*

234. Further guidance is provided in the National Reserve Supplies Management Usage Policies, which discusses management and use of national reserve supplies, along with any guiding principles that should be utilized in determining allocation. However, this document is more relevant to antiretroviral and vaccine allocation, rather than allocation of critical care. *See* MINISTRY OF HEALTH, NATIONAL HEALTH EMERGENCY PLAN: NATIONAL RESERVE SUPPLIES MGMT. & USAGE POLICIES 1, 7 (3rd ed. 2013).

The 2010 *Framework for Action* restates the central government's role in planning and responding to an influenza pandemic,²³⁵ and "sets out all-of-government measures to be taken to prepare for and respond to an influenza pandemic."²³⁶ The *Framework for Action* does not specifically address the allocation of critical care during a pandemic, but reaffirms the government's intent to "minimi[z]e the impact of the disease, and to mitigate its effects on the people of New Zealand without increasing health inequalities."²³⁷ It specifically provides that individuals requiring assistance, including individuals with chronic disability, should be "as a matter of priority . . . targeted to provide support."²³⁸

Of particular significance, New Zealand devised an ethical framework, the 2007 *Getting Through Together: Ethical Values for a Pandemic (Getting Through Together)*, to "help health professionals [] make the best and fairest use of resources in situations of overwhelming demand,"²³⁹ when planning for or responding to an epidemic.²⁴⁰ The framework identifies the values that should inform how decisions are made, such as inclusiveness, reasonableness, and responsibility. Inclusiveness is defined as including people from all cultures and communities who will be affected by the decision.²⁴¹

235. FRAMEWORK FOR ACTION, *supra* note 221, at 10-11. This document includes a nice summary of applicable legislation, including those provisions that cannot be modified even under emergency powers. *Id.* at 117-125.

236. *Id.* at 1. According to the plan, the Ministry of Health, which promulgated the document, is responsible for leading the government's response to any pandemic. This means that any Agencies' actions would be based on the direction from the Ministry of Health. *Id.* at iii. Notably, these measures are largely directed towards central government planning. It is not meant to prescribe local plans. *Id.* at 1.

237. FRAMEWORK FOR ACTION, *supra* note 221, at 9, Figure 1. According to the plan, the health sector operates, among other strategies, under the New Zealand Disability Strategy. *Id.* at 14. The Disability Strategy's objectives include ensuring the rights for disabled people. MINISTRY OF HEALTH, THE NEW ZEALAND DISABILITY STRATEGY, 15 (2001). It also encourages government actions that ensure that all government Agencies treat disabled people with dignity and respect. *Id.* at 20. Finally, through its objective of creating long-term support systems centered on the individual, it promotes the action of ensuring that overarching processes, eligibility criteria and allocation of resources are nationally consistent, but that individual needs are treated flexibly. *Id.* at 21. This objective also encourages "equity funding and service provision for people with similar needs, regardless of the cause of their impairment. *Id.*

238. FRAMEWORK FOR ACTION, *supra* note 221, at 20.

239. NAT'L ETHICS ADVISORY COMM., GETTING THROUGH TOGETHER: ETHICAL VALUES FOR A PANDEMIC at iv (2007) [hereinafter GETTING THROUGH TOGETHER]. Getting Through Together was compiled by the National Ethics Advisory Committee (NEAC). The NEAC is an independent advisor to the Ministry of Health. *Id.* It "works within the context of the New Zealand Public Health and Disability Act 2000 and the key strategy statements for the health sector." *Id.* The plan provided is meant to offer guidance for healthcare providers during a pandemic. *Id.*

240. *Id.* at 22.

241. GETTING THROUGH TOGETHER, *supra* note 239, at 24.

Reasonableness means “using a fair process to make decisions,”²⁴² and responsibility is “acting on our responsibility to others for our decisions and actions.”²⁴³ The document makes clear that “those involved in pandemic-planning should understand, respect and make due allowance for the diversity of affected populations.”²⁴⁴

Getting Through Together also emphasizes the importance of minimizing harm, as well as the importance of respect and fairness in allocating resources in pandemics.²⁴⁵ Minimizing harm means both “protecting one another from harm”²⁴⁶ and “not harming others.”²⁴⁷ The framework encourages consideration of a pandemic’s potentially exacerbated impact on vulnerable communities.²⁴⁸ Respect is defined as the recognition that “every person matters and treating people accordingly,”²⁴⁹ which encompasses protecting people with impaired or diminished autonomy and vulnerable populations that may be incapable of protecting their own interests.²⁵⁰ Finally, fairness means “ensuring that everyone gets a fair go,” “prioritizing fairly when there are not enough resources for all to get the services they need,” and “minimizing inequalities.”²⁵¹ Efforts should be taken to ensure prioritization does not further disadvantage already disadvantaged populations that already face health inequalities.²⁵²

The framework of *Getting Through Together* also provides an example of how to make allocation and prioritization decisions in an epidemic, by identifying a series of questions to be used to determine whether a patient does or does not receive intensive care unit (ICU) treatment.²⁵³ These questions provide direct insight into how New Zealand would allocate its resources in an epidemic. Question six, the most pertinent to our inquiry, asks, “can this patient be ranked highly enough based on benefit from ICU treatment?”²⁵⁴ Net benefit is determined by “considering the benefit of ICU treatment, the harm of missing out, and the potential to mitigate the harm should the patient miss

242. *Id.* at 26.

243. *Id.* at 27.

244. *Id.* at 25.

245. *Id.* at 28.

246. GETTING THROUGH TOGETHER, *supra* note 239, at 28.

247. *Id.*

248. *Id.* at 36.

249. *Id.* at 5.

250. *Id.* at 30.

251. GETTING THROUGH TOGETHER, *supra* note 239, at 37.

252. *Id.* at 38.

253. In this example, a patient has severe breathing problems for which access to ventilation might help. Unfortunately, other patients need access to the same care and there are not enough ICU beds. *Id.* at 7-22.

254. *Id.* at 22.

out[.]”²⁵⁵ Taking everything into consideration, the document advocates that those with a higher net benefit score “should access the resource before those whose ‘net benefit’ ranks lower.”²⁵⁶ At the same time, the document makes clear that gender, ethnicity, and disability are not acceptable criteria for prioritization.²⁵⁷

Getting Through Together exemplifies the robustness of New Zealand’s pandemic strategy and is consistent with the country’s more general statements about the allocation of scarce resources in pandemics and its antidiscrimination statutes.²⁵⁸ Nevertheless, the focus on medical benefit can be problematic. As discussed elsewhere,²⁵⁹ if the determination of medical benefit is based on objective medical information, this document may provide significant protection for people with disabilities in pandemics. If, however, the assessment of “benefit” focuses on more subjective issues of quality of life, or the fact that an individual with disabilities remains disabled after the intervention in question, people with disabilities may be disadvantaged in allocation decisions despite the nondiscrimination principles articulated throughout New Zealand’s laws and policies for preparedness planning.²⁶⁰

H. United Kingdom

1. General Protection for People with Disabilities

The U.K. has ratified and implemented the Convention.²⁶¹ The country has indicated that the Convention is meant to set obligations “to promote, protect,

255. *Id.* at 20.

256. GETTING THROUGH TOGETHER, *supra* note 239, at 20.

257. *Id.* at 21.

258. *See, e.g.*, New Zealand Human Rights Act 1993, pt. 2, §§ 21, 44, 52, 65; *see also* New Zealand Bill of Rights Act 1990, pt. 1, §§ 5, 19, pt. 2, § 8; *see also* New Zealand Public Health and Disability Act 2000.

259. *See Playing God*, *supra* note 10, at 763-67.

260. *Id.* at 766. For example, New Zealand’s Code of Health and Disability Consumers Rights firmly establishes that “every consumer has the right to be free from discrimination, coercion, harassment, and sexual, financial, or other exploitation.” HEALTH & DISABILITY COMM.: CODE OF HEALTH AND DISABILITY SERVS. CONSUMERS’ RIGHTS REGULATION 1996 (2009). In addition, The Medical Council of New Zealand, a professional organization rather than a government Agency, issued its Statement on safe practice in an environment of resource limitation which emphasizes that, in establishing prioritization systems, doctors should be “fair, systematic, consistent, evidence-based and transparent.” MEDICAL COUNCIL OF N.Z., STATEMENT ON SAFE PRACTICE IN AN ENVIRONMENT OF RESOURCE LIMITATION § 18 (2008).

261. *U.N. Convention Signatures*, *supra* note 30. The Kingdom’s Order 2009, No. 1181 establishes that the Convention is a community treaty under the Communities Act 1972, which means that the treaty does not require additional implementing legislation. The European Communities (Definition of Treaties) (United Nations Convention on the Rights of Persons with Disabilities) Order 2009, §1(2) (2009) (U.K.) [hereinafter Definition of Treaties]. As such, the U.K. establishes:

and ensure the human rights of disabled people, so that they are treated on an equal basis with other people.”²⁶²

The U.K. also has comprehensive legislative protection for people with disabilities. The 2010 Equality Act²⁶³ covers individuals who currently have a disability and those who have had a disability.²⁶⁴ It prohibits both direct, purposeful discrimination and indirect discrimination, while permitting the favorable treatment of people with disabilities.²⁶⁵ The Act applies to public entities, with the exception of Parliament,²⁶⁶ and those “concerned with the provision of services to the public or a section of the public (for payment or not).”²⁶⁷ Covered entities are required to make reasonable adjustments, which include reasonable steps to eliminate provisions, criteria, or policies or physical features that put persons with disabilities at substantial disadvantage compared to those without disabilities, or to provide auxiliary aids that, without which, would create a substantial disadvantage compared to those without disabilities.²⁶⁸

The Civil Contingencies Act recognizes the need for flexibility in times of emergency, which includes events that threaten “human welfare” and provides that “the person making the regulations” in such circumstances has the authority to “make any provision which is . . . appropriate for the purpose of protecting human life, health or safety.”²⁶⁹ While the Act includes the limitation that such regulations may not amend the Human Rights Act of 1998,²⁷⁰ which implements the European Convention on Human Rights

all such rights, powers, liabilities, obligations and restrictions from time to time created or arising by or under the Treaties, and all such remedies and procedures from time to time provided for by or under the Treaties, as in accordance with the Treaties are without further enactment to be given legal effect or used in the United Kingdom shall be recognized and available in law, and be enforced, allowed and followed accordingly.

European Communities Act, (1972), §2(1) (U.K.).

262. Definition of Treaties, *supra* note 261, at Explanatory Note.

263. Equality Act, (2010), ch. 15 (U.K.). The United Kingdom’s Disability Discrimination Act of 2005 was superseded largely by the Equality Act. The remaining sections simply require that public authorities carry out functions that “have due regard” to various needs, including the need to eliminate unlawful discrimination. *Id.* at Part 11, ch. 1, § 149(1); *see also* Disability Discrimination Act, (2005) ch. 13, pt. 5(A), § 49 (U.K.). This Act also has regulations associated with it; however, the most recent version available is 2010. Because only the original version is available, it is unclear whether the regulations provided online are the most current. There is no record of an update online. In any event, these regulations deal with topics that are irrelevant to resource allocation.

264. Equality Act, (2010), pt. 2, ch. 1, § 4 (U.K.).

265. *Id.* ch. 2, §§ 13, 19.

266. *Id.* at Schedule 3.

267. *Id.* pt. 3, § 29(1).

268. *Id.* pt. 2, ch. 2, § 20.

269. Civil Contingencies Act, (2004), pt. 1, §§ 1(a), 5, 22(a) (U.K.).

270. *Id.* § 20(5)(iv).

(European Convention),²⁷¹ this restriction is not relevant to our inquiry. Although the European Convention prohibits discrimination, it does not list disability among its protected interests.²⁷² Moreover, the European Convention allows changes under public emergency situations.²⁷³

2. Specific Protection Relating to Pandemics

The U.K. government has issued several documents dealing with pandemic preparedness. The 2012 *Health and Social Care Influenza Pandemic Preparedness and Response Plan (Preparedness Plan)* identifies ethical principles to be utilized when responding to an epidemic, to minimize its harm,²⁷⁴ and requires consideration of how to provide continuous services to vulnerable groups.²⁷⁵ It should be read in conjunction with the U.K.'s *Pandemic Influenza Preparedness Strategy 2011 (Preparedness Strategy)*²⁷⁶ and offers guidance on operational aspects of pandemic response in the health and social care sectors.²⁷⁷ Because this document merely offers guidance, its enforceability is unclear. Although it primarily references the provision of treatment or vaccination,²⁷⁸ the *Preparedness Plan* does encourage the use of pandemic-specific clinical assessment tools for making decisions about who to convey to emergency departments—"only patients with severe illness and a probability of responding to treatment"²⁷⁹—and for providing interim care for patients who are "less-likely to benefit from critical care, or who have received critical care but now require a lower level of care."²⁸⁰ Unfortunately, the Plan offers little additional detail on how these decisions should be made.

271. Human Rights Act, (1998), ch. 42, § 3(1) (U.K.).

272. See EUROPEAN COURT OF HUMAN RIGHTS, THE EUROPEAN CONVENTION ON HUMAN RIGHTS art. 12 (2015), available at <http://human-rights-convention.org/thetexts/evolution-of-the-convention/?lang=en>. The European Convention on Human Rights, Article 14 provides: "The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colo[r], language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status." *Id.* art. 14.

273. *Id.* ("Derogation in time of emergency").

274. UK DEP'T OF HEALTH, NAT'L HEALTH SYS., HEALTH & SOCIAL CARE INFLUENZA PANDEMIC PREPAREDNESS & RESPONSE 17 (2012), [hereinafter U.K.'S PREPAREDNESS PLAN].

275. *Id.* at 20.

276. *Id.* at 6; see also UK DEP'T OF HEALTH, SOC. SERV., & PUB. SAFETY, DEP'T OF HEALTH, UK INFLUENZA PANDEMIC PREPAREDNESS STRATEGY 2011 (2011) [hereinafter U.K.'S PREPAREDNESS STRATEGY].

277. U.K.'S PREPAREDNESS PLAN, *supra* note 274, at 6.

278. *Id.* at 8.

279. *Id.* at 32.

280. *Id.* at 43.

The U.K. formulated the *Preparedness Strategy* in response to the 2009 influenza epidemic.²⁸¹ The document outlines the government's strategic plan for addressing an influenza pandemic.²⁸² Like the *Preparedness Plan*, it merely offers guidance to the public and private sector.²⁸³ The *Preparedness Strategy* is meant to account for varying levels of pandemics that require varying levels of resources.²⁸⁴ It indicates that any pandemic preparedness and response will be "based on ethical principles"²⁸⁵ and endorses a framework, *Responding to Pandemic Influenza: The Ethical Framework for Policy and Planning (Ethical Framework)*, developed by the Department of Health.²⁸⁶ The *Ethical Framework* maintains several principles including respect, minimizing harm, fairness, working together, reciprocity, keeping things in proportion, flexibility, and good decision-making.²⁸⁷ However, the *Ethical Framework* has been archived by the U.K., so while the principles may be valid, the document itself is no longer recognized by the U.K. as a tool meant to guide decision-making during a pandemic.

Once again, however, neither the *Preparedness Plan*, nor the *Preparedness Strategy*, discuss in detail how any allocation decisions might be made, including prioritization for critical care.²⁸⁸ More specific suggestions on allocation decisions are provided in the 2013 *Preparing for Pandemic Influenza: Guidance for Local Planners (Guidance)*, which was published in

281. U.K.'S PREPAREDNESS STRATEGY, *supra* note 276, at 2. The Influenza Strategy explicitly supersedes the 2007 *national ethical framework for responding to an influenza pandemic* (and the Scottish equivalent), although it indicates that there are not substantial changes in approach. *Id.* at 7. See also UK DEP'T OF HEALTH, RESPONDING TO PANDEMIC INFLUENZA: THE ETHICAL FRAMEWORK FOR POLICY & PLANNING 2 (2007), [hereinafter FRAMEWORK FOR RESPONDING].

282. U.K.'S PREPAREDNESS STRATEGY, *supra* note 276, at 2.

283. *Id.*

284. *Id.* at 8.

285. *Id.* at 20.

During a pandemic, the Government will need to make final decisions and issue advice on the application of specific measures in the light of emerging scientific evidence and data.

In doing so, the ethical framework and in particular the principles of precaution (which assists in ensuring that harm is minimized), proportionality and flexibility will apply throughout.

Id. at 34.

286. This ethical framework comes from a previously archived influenza pandemic protocol compiled by the UK Department of Health. See FRAMEWORK FOR RESPONDING, *supra* note 281.

287. *Id.* at 6-9.

288. The Strategy does reference provision of antivirals to only members of "risk groups" if "the pandemic proves to be mild in nature or if the antiviral medicine supplies are being depleted too rapidly." U.K.'S PREPAREDNESS STRATEGY, *supra* note 276, at 14. Further, in more severe influenza pandemics, the Strategy does recognize that non-urgent activity might need to be reduced or ceased entirely. *Id.* at 52.

conjunction with the *Preparedness Strategy*.²⁸⁹ In an annex, the *Guidance* defines vulnerable people as “those that are less able to help themselves in the circumstances of an emergency.”²⁹⁰ The document recommends that local pandemic plans “include an estimate of the number of and type of potentially vulnerable people for a locality and their needs during a pandemic”²⁹¹ and “set out the how the needs of these vulnerable groups will be met and how any potential barriers (e.g., culture and transport) will be addressed.”²⁹²

Also in response to the 2009 pandemic, the U.K. asked the Department of Health’s Critical Care Clinical Group to analyze future surge capacity planning based on their very real concern that triage decisions in future pandemics would be “left in some cases to individual clinicians, on duty at the time, to bear the responsibility for stopping activity.”²⁹³ The Group encouraged the National Health Service to “further develop their local approaches to triage”²⁹⁴ and offer a set of principles to support triage.²⁹⁵

The Group’s report recognizes the problematic lack of consensus among clinicians on the effectiveness of various scoring systems, such as the Sequential Organ Failure Assessment (SOFA).²⁹⁶ The report “emphasi[z]e[s] the need for multi-specialty team decision-making arrangements to be set up and that . . . a local decision-making process . . . [be] clearly documented,”²⁹⁷ but acknowledges that the decision to admit an individual to critical care is ultimately a clinical determination based on the likelihood of benefit.²⁹⁸ As indicated previously, leaving decisions about benefit in clinicians’ hands, without other guidance, is problematic and may result in people with disabilities being disadvantaged in critical care allocation decisions.

289. Similar to many other documents provided throughout this section, this document is meant to serve as guidance for local Agencies in the event of an influenza pandemic. U.K. CABINET OFFICE, PREPARING FOR PANDEMIC INFLUENZA: GUIDANCE FOR LOCAL PLANNERS 5 (2013).

290. *Id.* at 27. Those individuals include children, older people, mobility impaired, mental/cognitive function repaired, sensory impaired, individuals supported within the community, immune-compromised children and adults, those with underlying health conditions, individuals cared for by relatives, homeless, pregnant women, and those in need of bereavement support. *Id.*

291. *Id.*

292. *Id.*

293. U.K. DEP’T OF HEALTH, REPORT OF THE SWINE FLU CRITICAL CARE CLINICAL GROUP & KEY LEARNING POINTS FOR FUTURE SURGE PLANNING 15 (2010) [hereinafter FUTURE SURGE PLANNING].

294. *Id.* at 11.

295. *Id.* at 28-31.

296. *Id.* at 18.

297. *Id.*

298. FUTURE SURGE PLANNING, *supra* note 293, at 30.

The problem of relying on clinician decision-making is further highlighted by a document produced in 2009, *The Pandemic Flu: Managing Demand and Capacity in Healthcare Organizations (Managing Demand and Capacity)*.²⁹⁹ Although this document has been replaced by newer plans,³⁰⁰ it nevertheless provides insight into the U.K.'s current policies. More to the point, it presents specific recommendations for the allocation of critical care.

Managing Demand and Capacity expresses a commitment to ensuring that “the needs of any patient or client populations, which may be disproportionately affected during a pandemic, [] [are] specifically considered.”³⁰¹ With respect to a critical care setting, it recommends SOFA for decision-making.³⁰² Despite reference to ethical principles that include concepts of equity and equal access to care,³⁰³ the guidance strongly suggests that most decision-making will rest on doctors’ discretionary power. For example, it recommends, “critical care [be] preferentially provided for individuals who are most likely to benefit, so as to minimize the number of avoidable deaths.”³⁰⁴ *Managing Demand and Capacity* also identifies a variety of “exclusion criteria,” including “severe and irreversible neurological event or condition” and “known, advanced and irreversible immunocompromise,” among others.³⁰⁵ Taken together, these provisions suggest that the identification of who is most likely to “benefit” may be based on subjective assumptions about quality of life, unrelated to pandemic treatment, rather than specific medical criteria. The guidance also relies on prioritization literature from the U.S. and Canada³⁰⁶ that has been identified as having problematic features for people with disabilities.³⁰⁷

299. U.K. DEP’T OF HEALTH, PANDEMIC FLU: MANAGING DEMAND & CAPACITY IN HEALTHCARE ORGANIZATIONS (SURGE) 2, 12 (2009), [hereinafter MANAGING DEMAND & CAPACITY].

300. The Managing Demand Capacity document emphasized the need for consistent planning in accordance with the U.K.’s national *Framework for Responding*. *Id.* at 5. However, the *Framework for Responding* was superseded by the U.K. Pandemic Preparedness Strategy. *See supra* note 283 and accompanying text. *See also* U.K.’S PREPAREDNESS STRATEGY, *supra* note 276.

301. MANAGING DEMAND & CAPACITY, *supra* note 299, at 37.

302. *Id.* at 54.

303. Ethical principles are listed as:

(1) Everyone matters; (2) Everyone matters equally—but this does not mean that everyone is treated the same; (3) The interests of each person are the concern of all of us, and of society; and (4) The harm that might be suffered by every person matters, and so minimizing the harm that a pandemic might cause is a central concern.

Id. at 51.

304. *Id.* at 53.

305. *Id.* at 108.

306. MANAGING DEMAND & CAPACITY, *supra* note 299, at 53.

307. *See Playing God*, *supra* note 10.

On the whole, the U.K. provides protection for people with disabilities through its ratification of the Convention and through its legislation.³⁰⁸ However, the Civil Contingencies Act permits alteration of legal requirements as needed during an emergency.³⁰⁹ Moreover, although the U.K. has engaged in preparedness planning and proposed frameworks for decision-making during a pandemic,³¹⁰ these documents ultimately conclude that such decisions are clinical. Thus, its legislative commitments to equality of treatment of persons with disabilities seem at risk both from legislative enactments and from practices in the exigencies of a pandemic.

V. CONCLUSION

We undertook this comparative investigation, in part, to determine whether different countries' cultures and commitments would result in different responses to allocation of scarce resources during public health emergencies. The U.S. is often criticized for overemphasizing respect for individual autonomy, a moral commitment that is reflected in our Constitution and other laws. Accordingly, we wondered, for example, whether countries like the U.K., with strong communitarian commitments, would adopt different laws that would result in different approaches to developing allocation protocols.

Overall, we found an impressive commitment internationally to the rights of people with disabilities. All of the countries we studied, with the exception of Singapore, had ratified the Convention and recognized its provisions, in some way, in their own laws. Mexico and South Africa have constitutional provisions explicitly prohibiting discrimination against people with disabilities, and Mexico, Brazil, and South Africa guarantee health in their constitutions. All of the countries except Cambodia and Singapore have legislation affording protection to people with disabilities. This adoption of laws at a variety of levels—treaties, constitutions, and legislations—represents an important step forward in advancing the civil rights of people with disabilities over the last thirty years. Given the politics of the U.S. and the challenges of amending the Constitution, it seems unlikely that we will follow these countries' approaches and thus, must rely on the statutory protections contained in the Americans With Disabilities Act (ADA). Other laws suggest a federal commitment to the

308. *See, e.g.*, Equality Act, (2010) ch. 15 (U.K.); Disability Discrimination Act, (2005) ch. 13, pt. 5(A), § 49 (U.K.); Human Rights Act, (1998) ch. 42, § 3(1) (U.K.).

309. Civil Contingencies Act, (2004) pt. 1, §§ 15-16 (U.K.).

310. *See, e.g.*, U.K.'S PREPAREDNESS PLAN, *supra* note 274; *see also* U.K.'S PREPAREDNESS STRATEGY, *supra* note 276; *see also* FRAMEWORK FOR RESPONDING, *supra* note 281; *see also* FUTURE SURGE PLANNING, *supra* note 293; *see also* MANAGING DEMAND & CAPACITY, *supra* note 299.

antidiscrimination principles contained in the ADA, although a more explicit statement would be beneficial.³¹¹

However, as we previously found in the U.S., while legal protections are crucial, they are unlikely to be sufficient to protect the civil rights of people with disabilities during a public health emergency. While a few of the countries affirm that the antidiscrimination statutes remain in effect during a public health emergency, several permit those protections to be suspended during an emergency. Moreover, behavior does not always match legal statements. As described above, Cambodia has committed to guaranteeing health to its citizens through its laws, but does not have the resources to do so. Similarly, South Africa's Constitution guarantees access to health care, but simultaneously recognizes that resource constraints may impact its provision. Like Cambodia, there are health disparities among its various populations.

The example of New Zealand is particularly instructive here. Although it does not have a constitution, it has adopted the provisions of the Convention, has its own antidiscrimination laws, and has engaged in substantial public discussion about emergency preparedness. It has a more communitarian ethos, reflected in the title of one of its preparedness documents, *Getting Through Together*. It explicitly endorses inclusiveness and fairness as core values, and discusses people with disabilities, along with other vulnerable populations in its considerations. However, despite these moral commitments, it ends up relying on medical decision-making and interpretation of net benefit as an allocating principle, without limiting it to avoid inappropriate quality of life determinations.

As recent events in the U.S. reflect, even when the government is committed to enforcing its laws, individual decisions could result in violations. The 2014 Ebola epidemic in West Africa provided numerous examples of the limits of U.S. antidiscrimination laws in times of crises. Although the ADA and the decisions of two Supreme Court cases make clear that the ADA's protections apply to those who have or are suspected of having infectious disease,³¹² state and local governments isolated health care workers without court orders, businesses told employees not to report to work, and children whose parents had been in West Africa were excluded from school.³¹³ Public fears dominated responses without regard to the legal protections in place. In most of these cases, those discriminated against had time to pursue legal remedies—they typically were not infected, just regarded as at risk of

311. See *Playing God*, *supra* note 10, at 741-46.

312. *School Board of Nassau County v. Airline*, 480 U.S. 273, 279 (1987); *Bragdon v. Abbot*, 524 U.S. 622, 639 (1998).

313. Wendy F. Hensel, *Civil Rights Have a Place in Conversation*, ATLANTA JOURNAL-CONST., Nov. 21, 2014, at 16A.

infection.³¹⁴ But when the question is about whether one receives critical care or not, the victim of the violation may not have an opportunity to seek enforcement of the law.

Thus, it appears that while legal protections are important, they cannot be considered the final step. Education and public engagement is essential to move the moral commitments reflected in antidiscrimination laws into reality. Again, the New Zealand example is instructive. The number of preparedness documents reflects active engagement on the issue and an effort to consider the effect of these policies on vulnerable populations, including its indigenous peoples. Nevertheless, there are questions about who participates in the development of such documents. It is not clear that people with disabilities have had a significant role in discussions of these plans; indeed, our experience suggests that even typically active disability advocacy groups are largely unfamiliar with the allocation protocols and preparedness plans. This may explain the default to medical decision-making and the potentially problematic reliance on quality of life assessments. Greater inclusion of diverse populations, specifically including people with disabilities, would go a long way toward fairer policies.

314. *See id.*

