# Guidance Note for National Societies:

## Conducting a Survey of the Domestic Legal Framework for the Protection of Health Care

This Guidance is intended to support National Societies undertaking a review of their domestic health care frameworks based on the experience of Australian Red Cross (ARC). Further details can be obtained by contacting Yvette Zegenhagen yzegenhagen@redcross.org.au or Larry Maybee lmaybee@redcross.org.au.

## INTRODUCTION

### Background

The rationale for conducting a survey of the domestic legal framework for the protection of healthcare ("domestic law gap analysis") is found in the recommendations of the 2015 ICRC Report, Domestic Normative Framework for the Protection of Health Care which seeks to contribute to the implementation of those rules of international human rights law and international humanitarian law that protect the provision of health care during armed conflicts and other emergencies. The report recommends focusing the domestic law gap analysis to ensure coverage *inter alia* in the following areas: (1) improving legal protection for patients, healthcare workers healthcare facilities and medical transports; (2) ensuring proper use of the distinctive Red Cross/Red Crescent emblems; (3) providing legal protection for medical ethics and confidentiality; and (4) ensuring effective enforcement of the rules protecting the provision of health care. It is a good idea to review this report plus the guidance tool as your starting point.

**Objectives for a Domestic Law Gap Analysis**

- To champion the recommendations set out in the ICRC's Report on Healthcare in Danger (HCiD)
- To consider the extent to which the legal framework protects health care workers and those requiring health care in your country
- To identify any gaps in domestic legislation, regulations and procedures
- To create a report explaining the practical implications of the gaps
- To make recommendations in the report that suggest how your government can remedy these gaps

## METHODOLOGY

- **Process:** Establish an advisory group, jointly with government if practical. Consider utilising your National IHL Committee if you have one that functions well or partnering with a legal academic institution or organisation with relevant expertise, e.g. in law, human rights, health, etc.

  *Note: In the Australian case, the Australian Red Cross had the support of government; indeed, ARC was requested by government to undertake a review of the domestic legislation. This led to government being receptive to receiving our recommendations. Although a National Society might initiate a review on its own, or in collaboration with others, Australian Red Cross recommends at least exploring cooperation with government, if possible, to facilitate support for implementing the findings that are identified in the assessment and the recommendations you may make.*

- **Scope:** In defining the scope of the study examples of the relevant sources you will need to review as part of the domestic law gap analysis will include:
  - Legislation (national and state/local laws, where relevant)
  - Regulations, orders and instructions promulgated by government
  - Government policies
  - Legal decisions (depending on the jurisdiction)
  - Other relevant documents, including inter alia code of ethics for medical personnel, military doctrine, military disciplinary codes, procedures, regulations & instructions of regulatory bodies, organisations, etc.

  *Note: The focus of the domestic law gap analysis will be on those laws, regulations, instructions, etc. that apply in armed conflict, but noting that certain IHL obligations (e.g. those relating to the protection of the emblem, medical ethics and confidentiality) may be applicable in peacetime.*

- Maintain a research log and summary of relevant legislative provisions covered by the domestic law gap analysis.

  *Note: For the Australian Domestic Healthcare Law Survey, a detailed analysis was conducted into the relevant Commonwealth (national), State and Territory legislation. Annex 1 of the Australian Survey provides a research log with detailed information on the location of the legislation identified and analysed, the primary and secondary search terms used and relevant returns identified. Annex 2 of the Australian Survey records the identified Commonwealth, State and Territory laws in the Research Results Grid.*

- Relevant laws to consider will/may include:
  - Emergency Services and Emergency management laws
  - Laws implementing Geneva Conventions and/or Additional Protocols, and other IHL treaties
  - Laws relating to the protection of the Red Cross/Red Crescent emblems
  - Criminal laws/codes *(Note: In its assessment, the ARC limited its focus to laws only; it did not include criminal investigations or prosecutions)*
  - Human rights charters
  - Human rights legislation
  - Privacy legislation and data protection laws
  - Health laws (e.g. public health acts, health services acts, mental health act, etc.), including those relating to medical ethics and confidentiality
  - Ambulance Services laws
  - Civil liability laws (e.g. relating to good Samaritans, first responders, etc.)
  - Road Safety laws (e.g. obligations relating to ambulances)
  - RC/RC National Society law
  - Defence Forces Act & Code of Military Discipline *(Note: these may include disciplinary measures for certain behaviour in wartime as well as peacetime and may incorporate domestic civil and criminal laws & standards, creating military offences for violations)*

  *Note: For ease of reference, a summary of the domestic laws researched as part of the Australian Domestic Healthcare Law Survey are included in the table at Annex A to this Guidance Note.*

- Some additional considerations:
  - Is your legal system a dualist or monist legal system?
  - Common law or civil law, including method of implementation – annex conventions to laws or incorporate into provisions?
  - Are there constitutional provisions regarding international law?
  - Are your criminal, privacy, human right, medical & other laws national or state/province-based?
  - Will you review general laws, specific health care-related laws, or both? *(Note: In Australia, health care personnel are covered by general laws on murder, but the ARC study didn't go into all of these general laws, instead focusing on specific protections)*
  - Do the national/domestic laws distinguish between international armed conflicts and non-international armed conflicts in their application and enforcement?

## STRUCTURE AND LAYOUT

- Summarise international legal obligations, taking into account applicable treaty and customary IHL and obligations, and applicable international human rights law, relevant for the specific country. These may include inter alia:
  - Specific protection of the wounded and sick
  - Obligation to assist the wounded and sick
  - Obligation to search for, collect and evacuate the wounded and sick
  - Obligation to ensure access to medical facilities, good and services without discrimination
  - Right of the wounded and sick to receive medical care on a non-discriminatory basis
  - Protection of health care personnel (assault, attack, targeting)
  - Protection of health care personnel (access, obstruction, interference, ethics, confidentiality)
  - Specific protection of health care facilities (attack, targeting, misuse)
  - Protection of health care vehicles (attack, targeting, obstruction)
  - Specific protection of emergency workers during emergency (obstruction, interference)
  - Obstructing or impeding emergency vehicles
  - Protection of good Samaritans
  - Ensuring rapid and unimpeded delivery of impartial humanitarian relief and healthcare services
  - Protection of persons using distinctive emblems of the Red Cross/Red Crescent
  - Improper use of the distinctive emblems of the Red Cross/Red Crescent
  - Protection of emergency service emblems, signals and uniforms
  - Protection against being punished for performing medical duties that comply with medical ethics
  - Protection against being compelled to perform medical activities contrary to medical ethics
  - Duty of confidentiality (protection of information obtained by health care personnel)
  - Right to privacy (limitations & protection of information gathered for medical purposes)

*Note: A summary of the main international treaty and customary law obligations relevant to the protection of health care is included at Annex B to this Guidance Note. These obligations will, however, need to be tailored, depending on the international treaty obligations of the specific country concerned. Reference can also be made to Annex 3 of the Australian Domestic Healthcare Law Survey, which contains a detailed grid of IHL & IHRL provisions applicable to the Australian case.*

- Structure the domestic law gap analysis around thematic topics: identify domestic laws, regulations, instructions, etc.; analyse if these implement international obligations; summarise relevant laws & provisions under each chapter
- Include a summary of sanctions provided in domestic laws/provisions for violations of the above protections
- Summarise compliance and gaps: consider use of a table or charts
- Develop recommendations: these may relate to addressing gaps or other objectives e.g. training health care personnel on legal obligations, rights and protections

## FURTHER CONSIDERATIONS (SELECTED ISSUES)

- Consider counter terrorism laws and those applicable to civil unrest, riots, etc. that are relevant to the access, delivery and protection of health care, in addition to laws relating to armed conflict
- The assessment should identify and make recommendations (where applicable) for the implementation of IHL obligations into legislation and/or regulations, policy, military doctrine, etc.
- Consider the relevance of peacetime laws to the protection of healthcare, recognising that certain IHL obligations are applicable in peacetime (e.g. prevention and/or residual obligations post-conflict)
- Consider the issue of medical confidentiality and ethics, including the impact of national laws, particularly in situations of non-international armed conflict and in other emergencies below the threshold of armed conflict
- The right to health and health care under human rights law in the domestic framework should form part of the domestic law gap analysis

## FINALISATION AND PUBLICATION

- It is recommended that the domestic law gap analysis be shared with government for feedback and comment prior to finalisation *(Note: The Australian Government focal point was the Attorney-General's Department. This department also consulted with the Department of Defence and the Department of Foreign Affairs and Trade, as part of its review. In the ARC case, we did not engage directly with the Department of Health, although it will be among the recipients of the Report)*
- A strategy for the publication and distribution of the report should be developed by the National Society. For example, it should be considered whether the report will be published and distributed online and/or in hard copy
- A distribution list should be developed to share the report with relevant stakeholders (domestic and potentially international), such as medical peak bodies, health associations, humanitarian organisations, academic institutions, military and police forces, etc.
- An advocacy strategy may be developed to address any domestic law gaps identified, where appropriate
- The National Society may wish to develop a range of training tools for health care personnel and other stakeholders, such as police, security agencies, and military forces. Such training should include education on the rights, protections, duties and obligations of healthcare workers and the relevant national/state authorities in situations of armed conflict and other emergencies.

## Annex A – Laws consulted for the Survey of Australian Domestic Healthcare Legal Framework

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|---|---|
| **Commonwealth** | *Australian Citizenship Amendment (Allegiance to Australia) Act* 2015<br>*Citizenship Act* 2007<br>*Criminal Code* 1995<br>*Geneva Conventions Act* 1957<br>*Privacy Act* 1988 |
| **New South Wales** | *Crimes (Sentencing Procedure) Act* 1999<br>*Health Practitioner Regulation National Law* No 86a 2010<br>*State Emergency and Rescue Management Act 1989*<br>*Mental Health Act 2007*<br>*Public Health Act 2010*<br>*Health Services Act 1997*<br>*Civil Liabilities Act 2002*<br>*Road Rules 2014 – Enacted Pursuant to the Road Transport Act 2003*<br>*Health Records and Information Privacy Act 2002* |
| **Victoria** | *Ambulance Services Act* 1986 (currently under review)<br>*Crimes Act* 1958<br>*Sentencing Act* 1991<br>*Summary Offences Act* 1966<br>*Emergency Management Act* 1986<br>*State Emergency Services Act* 2005<br>*Fire and Emergency Services Act* 2005<br>*Health Services Act 1988*<br>*Public Health and Wellbeing Act 2008*<br>*Charter on Human Rights and Responsibilities Act* 2006<br>*Road Safety Road Rules* 2017<br>*Health Records Act* 2001<br>*Wrongs Act* 1958 |
| **Queensland** | *Ambulance Service Act* 1991<br>*Criminal Code* 1989<br>*Hospitals and Health Boards Act* 2011<br>*Law Reform Act* 1995<br>*Civil Liability Act* 2003<br>*Information Privacy Act* 2009 |
| **South Australia** | *Criminal Law Consolidation Act* 1935<br>*Essential Services Act* 1981<br>*Fire and Emergency Services Act* 2005<br>*Healthcare Act* 2008<br>*Civil Liability Act* 1936<br>*Australian Road Rules* 2009 - enacted pursuant to the *Road Traffic Act* 1969 |
| **Tasmania** | *Ambulance Service Act* 1982<br>*Police Offences Act* 1935<br>*Road Rules* 2009<br>*Civil Liability Act* 2002<br>*Personal Information and Protection Act* 2004 |
| **Western Australia** | *Criminal Code Compilation Act* 1913<br>*Health Services Act* 2016<br>*Mental Health Act* 2014<br>*Road Traffic Code* 2000<br>*Civil Liability Act* 2002 |
| **Northern Territory** | *Criminal Code Act* 1983<br>*Information Act* 2002<br>*Personal Injuries (Liabilities and Damages) Act* 2003 |
| **Australian Capital Territory** | *Civil Law (Wrongs) Act* 2002<br>*Crimes Act* 1990<br>*Human Rights Act* 2004<br>*Australian Road Rules* - enacted pursuant to the *Road Transport (Safety and Traffic Management) Act* 1999<br>*Health Records (Privacy and Access) Act* 1997 |

## Annex B – Relevant Treaty & Customary Obligations under International Law

### Relevant obligations under international law

Both treaty and customary international humanitarian law (IHL) and international human right law (IHRL) provide legal obligations and rights that are relevant to the protection of healthcare delivery in armed conflict and other emergencies. Australia's most significant IHL and IHRL obligations are identified below. A more extensive overview of the international legal protection afforded to healthcare is set out in Chapter 3 of the Brussels Report.[1]

### 1. International humanitarian law

IHL - the rules applicable during both international armed conflict (IAC) and non-international armed conflict (NIAC) - are found in treaty and customary law, including the four ***Geneva Conventions* of 1949**,[2] and their three ***Additional Protocols* of 1977 and 2005**.[3]

As a minimum, Common Article 3 of the four *Geneva Conventions* states that the wounded and sick shall be collected and given care during NIACs. This article is widely recognised as providing a minimum yardstick of protection applicable during both NIAC and IAC. In addition, each of the four *Geneva Conventions* contain multiple more specific articles protecting the wounded, sick and shipwrecked, as well as medical units, medical transports and medical personnel. The Additional Protocols extend this protection, especially in relation to civilian medical personnel, facilities and transports, as well as by setting out rules relating to the conduct of hostilities. Many of the rules in the Geneva Conventions and the Additional Protocols have attained the status of customary IHL ("CIHL") applicable in both IAC and NIAC.

The most significant treaty and customary IHL rules are summarised below:

whenever circumstances permit, and without delay, parties to armed conflict must take all possible measures to search for, collect and evacuate the wounded, sick and shipwrecked without adverse distinction;[4]

- the wounded and sick must receive, to the fullest extent practicable and with the least possible delay, the medical care and attention required by their condition on a non-discriminatory basis;[5]
- the wounded and sick must not be attacked, arbitrarily deprived of their lives or ill-treated;[6]
- medical personnel,[7] medical units[8] and medical transports[9] exclusively engaged in medical duties must be respected and protected;[10] they lose their protection if they commit, or are being used to commit, outside their humanitarian functions, acts harmful to the enemy[11];
- parties to armed conflict must, to the extent feasible, ensure that medical units are situated away from military objectives,[12] and remove the wounded/sick and medical personnel/units/transports from the vicinity of military objectives;[13]
- medical personnel, units and transports must not be unduly impeded or arbitrarily prevented from performing their work;[14]
- punishing a person for performing medical duties in conformity with medical ethics, or compelling a person engaged in medical activities to perform medical activities contrary to medical ethics is prohibited;[15]
- except if required to do so by law, persons engaged in medical activities must not be compelled to give information concerning the wounded and sick who are or have been under their care, either to their own party or to an adverse party if this information would prove harmful to the patients or their families;[16]
- the delivery of rapid and unimpeded impartial humanitarian relief (including medical assistance) must be allowed and facilitated;[17]
- improper use of the distinctive emblems of the Movement (Red Cross, Red Crescent and Red Crystal) is prohibited.[18] All necessary measures must be taken to prevent and repress misuse of the emblems,[19] including perfidy.[20]

### 2. International human rights law

Specific obligations protecting access to and provision of health care are also included in IHRL, including the ***International Covenant on Economic, Social and Cultural Rights*** (ICESCR) of 1966 and the ***International Covenant on Civil and Political Rights*** (ICCPR) of 1966. Unlike IHL, IHRL applies during both armed conflict and peacetime, and is subject to lawful reservations, limitations and derogations.[21] IHL however is the *lex specialis*, the body of law most narrowly tailored to situations of armed conflict and therefore takes precedence over the generally applicable IHRL standards.

Article 12 of the ICESCR requires States Parties to recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. This entails an obligation to respect, protect and fulfil the right.[22] Although Article 12 is non-derogable, the obligation of States Parties is dependent on the resources available.[23]

In interpreting this right, the **Committee on Economic, Social and Cultural Rights** (CESCR) has held that States have an obligation to ensure access to "health services, goods and services on a non-discriminatory basis," subject to the availability of resources.[24] Accordingly, States must provide access to healthcare for people who are unable to realise that right by the means at their disposal, for reasons beyond their control.[25]

Moreover, the CESCR has held that the obligation to respect the right to health requires States to refrain from interfering, directly or indirectly, with the enjoyment of that right.[26] They must not limit access to health services as a punitive measure, for example, in violation of IHL;[27] and they must take appropriate measures to prevent third persons from interfering with medical treatment to the wounded and sick.[28] Additionally, the right to the highest attainable standard of health entails a right to

be free from interference, including the right to be free from torture and non-consensual medical treatment and experimentation.[29]

Finally, the ICESCR requires States ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct.[30]

State Parties also have obligations under the ICCPR, which relate to the protection of healthcare during armed conflict and other emergencies. In particular, they are obliged to respect the right to life, including by refraining from deliberately withholding or delaying the provision of healthcare to individuals under their jurisdiction in life-threatening circumstances.[31] The right to life also requires that persons within the jurisdiction of the State – including the wounded, sick and healthcare personnel –not be subject to arbitrary deprivation of life.[32] Additionally, article 7 of the ICCPR prohibits torture, cruel, inhuman or degrading treatment or punishment, including when committed against medical personnel or patients.[33]

Finally, under article 17 of the ICCPR, all individuals in the jurisdiction of a State have the right to be free from arbitrary or unlawful interference with their privacy. The term unlawful means that no interference can take place except as authorised under domestic law. The use of the term arbitrary in the ICCPR means that any interferences with privacy must be in accordance with the provisions, aims and objectives of the ICCPR and should be reasonable in the particular circumstances. According to the Human Rights Committee, this right protects persons against undue disclosure of medical and other private data to persons outside the relationship between healthcare professionals and their patients.[34] Such disclosure is generally prohibited, except where explicitly based on national law.[35]

## Endnotes

1. Brussels Report, pp. 15-32.
2. Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field, Geneva, 1949 (GC I); Convention for the Amelioration of the Condition of Wounded, Sick and Shipwrecked of Armed Forces at Sea, 1949 (GC II); Convention Relative to the Treatment of Prisoners of War, Geneva, 1949 (GC III); Convention Relative to the Protection of Civilian Persons in Time of War, Geneva, 1949 (GC IV).
3. Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of International Armed Conflicts, Geneva, 1977 (AP I); Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of Non-International Armed Conflicts, Geneva 1977 (AP II).
4. Common Article 3(2), GI-IV; Art. 15(1), GC I; art. 18, GC II; art 8. AP II; Rule 109, J.M. Henckaerts and L. Doswald-Beck (eds), Customary International Humanitarian Law: Volume I, 2005, (Cambridge, Cambridge University Press) ("CIHL Study").
5. Common Article 3(2), GC I-IV; art. 12 GCI; art. 12, GC II; art. 30 GCIII; art. 91 GCIV; art 10(2), AP I; art. 7(2) AP II; Rule 110, CIHL Study.
6. Arts. 12, 15 and 46, GC I; art. 12 and 47, GC II; art. 16, GCIV; art. 10,41 and 75(2), AP I; arts. 4, 7 and 8, AP II. Wilful killing, wilfully causing serious injury, torture and inhuman treatment also constitute war crimes under IAC and NIAC. See Arts. 8(2)(a)(i), 8(2)(a)(ii), 8(2)(a)(iii), 8(2)(c)(i) and 8(2)(c)(ii), Rome Statute of the International Criminal Court, A/CONF.183/9, 17 July 1998 ("Rome Statute") and Rule 156, CIHL Study.
7. Art. 24, GCI; Arts. 36 and 37 GC II; art 20 GC IV; Art. 15(1), AP I; art. 9(1), AP II; Rule 25, CIHL Study. Under CIHL, making medical personnel the object of an attack is a war crime in both IAC and NIAC. See Rule 156, CIHL Study.
8. Art. 19 and 20, GC I; art 18, GC IV; art. 12, AP I; art. 11, AP II; Rule 28, CIHL Study. Under CIHL, making medical units the object of an attack is a war crime in both IAC and NIAC. See Rule 156, CIHL Study.
9. Art. 35 and 36, GC I; Arts. 22, 24, 25 and 39, GC II; Arts. 18, 21 and 22, GC IV; art. 21, 22, 23 and 24, AP I; art. 11, AP II; Rule 29, CIHL Study. Under CIHL, making medical transports the object of an attack is a war crime in both IAC and NIAC. See Rule 156, CIHL Study.
10. The Rome Statute criminalises the following acts against medical facilities in IAC and NIAC: intentionally directing an attack against hospitals and places where the wounded and sick are collected; and intentionally directing an attack against buildings, material, medical units and transport, and personnel using the distinctive emblems of the Geneva Conventions in conformity with international law. See arts 8(2)(b)(ix), 8(2)(b)(xxiv) and 8(2)(e)(ii), Rome Statute.
    Making medical personnel, medical units or medical transports the object of an attack is also a war crime under CIHL applicable in IAC; and making medical personnel the object of an attack is criminalised under CIHL applicable in NIAC. See Rule 156, *CIHL Study*.
11. Art. 21, GC I; art. 19, GC IV; art. 13, AP I; art. 11, AP II(2); Rules 25, 28 and 29, CIHL Study. This is considered to be particularly pertinent given the practice of certain terrorist groups to use ambulances as vehicle borne improvised explosive devices.
12. Art. 19(2), GC I; art. 18(4), GC IV; art. 12(4), API; Rule 24, CIHL Study.
13. Art. 58(a), AP I; Rule 24, CIHL Study.
14. Arts. 19, 24, 35 and 36, GC I; arts. 22, 25, 24, 36, 37 and 39, GC II; arts. 18, 20 and 21, GC IV; arts. 12(1), 15(1), 21, 23 and 29, AP I; Arts. 8, 9(1) and 11, AP II; Rule 25, CIHL Study; See also, Brussels Report, p. 20.
15. Art. 16, AP I; art. 10, AP II; Rule 26, CIHL Study.
16. Art. 16, AP I; art. 10, AP II.
17. Art. 70(2), AP I; Rule 55, CIHL Study.
18. Art. 44 and 53, GC I; art. 44, GC II; Arts. 12(4) and 38, AP I; art. 12, AP II; Rule 59, CIHL Study. Under the Rome Statute, it is a war crime in IAC to make improper use of the distinctive emblems, resulting in death or serious personal injury. See art 8(2)(b)(vii), Rome Statute.
19. Art. 54, GC I; art. 45, GC II; art. 6(1), AP III.
20. Perfidy means misuse of the emblem during an armed conflict to invite the confidence of an adversary and lead him or her to believe that one is protected in order to capture, injure or kill him or her. See art. 37(1), AP I. Wounding or killing an adversary by resorting to perfidy constitutes a war crime in both IAC and NIAC. See Art. 8(2)(b)(xi) and art. 8(2)(e)(ix), Rome Statute.
21. ICJ, Legal Consequences of the Construction of a Wall in Occupied Palestinian Territory, Advisory Opinion, 9 July 2004, ICJ Reports 2004, para 106. An analysis of the relationship between IHL and IHRL during armed conflict is beyond the scope of this Survey.
22. United Nations Committee on Economic, Social and Cultural Rights (CESCR), General Comment 14: The Right to the Highest Attainable Standard of Health (art 14), 11 August 2000, para 33.
23. Art 2(1), ICESCR, adopted on 16 December 1966, entered into force on 3 January 1976 (ICESCR); Brussels Report, pg. 18.
24. CESCR, General Comment 14, para 43. In General Comment 3, the CESCR also notes that States are obliged to ensure non-discriminatory provision of at least essential healthcare, including preventative, curative and rehabilitative services. See CESCR, General Comment 3: The Nature of States Parties' Obligations, 14 December 1990.
25. CESCR, General Comment 14, paras 12, 37 and 43, as cited in the Brussels Report, pg. 18.
26. CESCR, General Comment 14, para 33.
27. CESCR, General Comment 14, para 34.
28. CESCR, General Comment 14, para 33 and 37, as cited in the Brussels Report, pg. 21.
29. CESCR, General Comment 14, para 8.
30. CESCR, General Comment 14, para 35; art 12.
31. United Nations Human Rights Committee (HRC), General Comment No. 6: Article 6 (Right to Life), 30 April 1982.
32. Art. 6(1), ICCPR.
33. Art. 7, ICCPR.
34. HRC, General Comment 16, para 10, as cited in Brussels Report, pg. 24.
35. HRC, General Comment 16, para 3. Even if it is provided for under national law, the disclosure must be in conformity with the object and purpose of IHRL and reasonable in the circumstances of the case. See HRC, General Comment 16, paras 3 and 4, as cited in the Brussels Report, pg. 24.