

From Navas to Kaltoft: The European Court of Justice's evolving definition of disability and the implications for HIV positive individuals

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Abstract

This article will examine the definition of disability developed by the European Court of Justice for the purposes of the Employment Equality Directive and examine whether it is sufficient for the purpose of bringing People Living with HIV/AIDS within its scope. The article will argue that in order to adequately protect People Living with HIV/AIDS within the EU from discrimination, the European Court of Justice needs to ensure that a coherent EU wide definition of disability, based fully upon the social model of disability, is adopted. This is necessary in order to ensure adequate protection not only for People Living with HIV/AIDS but for all individuals with disabilities from discrimination throughout the EU. In addition to this central argument, this paper will argue that the lack of a

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coherent definition of disability grounded in the social model fragments
protection for People Living with HIV/AIDS across the EU leading to a
number of possible unintended consequences.

Keywords

Discrimination, EU law, equality, stigma, disability, HIV, AIDS

Introduction

Despite the fact that there are approximately 80 million individuals with disabilities within the European Union (“EU”), there is no coherent definition of disability (European Commission, 2010). There is also no clear consensus amongst Member States as to the question of whether People Living with HIV/AIDS (“PLHA”) should be defined as “disabled” and thus acquire the various legal protections associated with such a designation. This article will examine the definition of disability developed by recent decisions of the European Court of Justice for the purposes of the Employment Equality Directive (Council Directive 2000/78/EC) and examine whether it is sufficient for the purpose of bringing PLHA within its scope. This paper will argue that in order to adequately protect PLHA within the EU, the European Court of Justice (“CJEU”) needs to ensure that a coherent EU wide definition of disability, based upon the social model of disability, is adopted. Such a definition is necessary in order to ensure adequate protection not only for PLHA but for all individuals from disability discrimination throughout the EU. Finally it should be noted that, for the purposes of brevity, the increasingly relevant provisions of the

European Convention on Human Rights will not be discussed by this article.

In some ways, PLHA represent the “front line” in the ideological battle concerning the definition of disability at an EU level and the question concerning the relationship between sickness and disability as will be seen by the Advocate General’s opinion in the recent *HK Danmark (Ring and Skouboe Werge)*¹ case concerning unlawful discrimination within employment.

HIV represents a major public health problem for Europe. It has been estimated that there are approximately 2.2 million people living with the virus in the WHO European Region; approaching 1 million in the European Union (UNAIDS, 2010) and 1.4 million in Eastern Europe and central Asia (Hamers & Phillips, 2008). However, due to the fact that HIV does not generally produce symptoms which lead to diagnosis around the time of infection, these figures are mere estimates. There are many PLHA who are unaware of their HIV and who have not been diagnosed.

According to Hamers & Philips (2008) it is estimated that as many as one-third of PLHA in the EU are unaware of their HIV status and in some eastern European countries up to 60% of PLHA are undiagnosed. This is borne out by the figures which show that although an estimated 107,800 people were living with HIV in the UK in 2013, approximately one quarter of these were undiagnosed and unaware of their infection (Public Health England, 2014). In terms of composition in the UK, HIV is largely concentrated amongst already marginalised groups namely gay, bisexual men and other men who have sex with men and black-African heterosexual men and women. By way of example, of the estimated 107,800 people were living with HIV in the UK in 2013, 43,500 were men who have sex with men and 38,700 were black-African (Public Health England, 2014).

HIV damages the immune system, leaving the infected person vulnerable to a variety of infections (called "opportunistic" infections to indicate that they arise in the setting of immune impairment). However having HIV does not mean that an individual has AIDS and, with early

HIV diagnosis and access to effective treatment most PLHA will never progress to a diagnosis of AIDS. Indeed evidence now indicates that due to improved treatment options PLHA can be expected to live into their early seventies, a life expectancy approaching that of the general population (Samji et al., 2013, Sterne, 2005).

The marginalised nature of the vast majority of PLHA, for example their status as men who have sex with men, and the need to protect such individuals from discrimination has led to a plethora of legislation. This emanates from a variety of sources: international, European and domestic. Whilst each has at its heart the objective of protecting PLHA from discrimination the collective result is a multifaceted collection of various pieces of legislation, often overlapping and sometimes contradictory. From a specifically legal perspective, HIV and AIDS have provoked a range of interventions. In some countries, PLHA benefit from general anti-discrimination legislation. By way of example, in the Netherlands and Latvia, PLHA benefit from the general constitutional prohibition of discrimination. In others anti-discrimination provisions expressly refer to

HIV/AIDS as a separate protected status or are included in special laws dealing with the prevention and control of HIV. In others still, PLHA are protected under disability laws which either expressly include HIV in the definition of a disability or have been interpreted to that effect. By way of example, in the United Kingdom paragraph 6 to Schedule 1 of the Equality Act 2010 states that HIV is deemed to be a disability.

As such the EU, its institutions and Member States are faced with a quandary as to the exact definition, description and classification of HIV. This paper will now identify and analyse the overlapping legal frameworks and definitions facing the CJEU when asked to decide cases involving unlawful discrimination directed towards individuals with disabilities and, in particular, PLHA. It will then proceed to examine the emerging jurisprudence of the CJEU in this area before examining the possible implications of recent decision for PLHA.

Primary and secondary legislation of the European Union

The starting point in relation to a consideration of the legal framework prohibiting discrimination within the European Union is Article 19 of the Consolidated Version of the Treaty on the functioning of the European Union (“TFEU”). This provides:

“Without prejudice to the other provisions of the Treaties and within the limits of the powers conferred by them upon the Union, the Council, acting unanimously in accordance with a special legislative procedure and after obtaining the consent of the European Parliament, may take appropriate action to combat discrimination based on sex, racial or ethnic origin, religion or belief, disability, age or sexual orientation.”

There is no explicit mention of an individual’s HIV status in Article 19 TFEU nor any opportunity to expand the closed list of prohibited grounds. Yet despite this the European Union has committed itself to combating discrimination against PLHA. In February 2004 representatives of governments from Europe and central Asia met at a

conference in Dublin and outlined their commitments to combatting HIV in a set of 33 objectives. The resulting document known as the Dublin Declaration commits Member States to:

“combat stigma and discrimination of people living with HIV/AIDS in Europe and Central Asia, including through a critical review and monitoring of existing legislation, policies and practices with the objective of promoting the effective enjoyment of all rights for people living with HIV/AIDS and members of affected communities.” (at para. 20)

This is reaffirmed in the European Union’s Vilnius Declaration of 2004 where there is a commitment on the part of Member States to “continue to develop and implement relevant legislation, in particular with a view to prohibiting discrimination, inter alia in employment, on the grounds of HIV status”. Despite these commitments, discrimination provisions in EU law fail to explicitly include HIV status. The consequence of this is that Member States are free to choose either to

protect or not to protect PLHA from discrimination, and that PLHA must therefore seek protection from discrimination on the grounds that their condition constitutes a disability.

Due to the scope of Directives adopted in order to combat discrimination within the EU, protection from discrimination on the grounds of disability is less far reaching than protection from discrimination in relation to other grounds. By way of example, the Racial Equality Directive 2000/43/EC (2000) protects individuals from discrimination upon the ground of racial and ethnic origin in a number of fields including employment, social protection, social advantages, education and access to and supply of goods and services. In addition, the Gender Goods and Services Directive 2004/113/EC (2004) was introduced in order to expand the scope of equality on the grounds of gender to goods and services. However protection from discrimination on the grounds of disability is more restricted in scope due to the fact that the relevant Directive, the Employment Equality Directive 2000/78/EC (2000) (“the

Framework Directive”), only provides protection against discrimination in the fields of employment, occupation and vocational training.

Article 2(1) of the Framework Directive provides:

“For the purposes of this Directive, the principle of equal treatment shall mean that there shall be no direct or indirect discrimination whatsoever on any of the grounds referred to in Article 1.”

The grounds referred to in Article 1 are religion or belief, disability, age and sexual orientation. Rather unsatisfactorily, the Framework Directive provides no definition of disability. This has the potential to permit multiple varying definitions of disability to be adopted across the EU and for different domestic courts to adopt differing approaches as to whether a particular impairment constitutes a “disability”. For example, in relation to PLHA, there is no guarantee that they will be afforded uniform protection across the EU.

The European Court of Justice’s emerging jurisprudence

In the seminal case of *Chacon Navas v Eurest Colectividades SA*² the CJEU offered guidance on the issue of how to define “disability” for the purposes of the Framework Directive stating at para 43 that:

“[The Framework Directive] aims to combat certain types of discrimination as regards employment and occupation. In that context, the concept of ‘disability’ must be understood as referring to a limitation which results in particular from physical, mental or psychological impairments and which hinders the participation of the person concerned in professional life.”

Importantly in *Chacón Navas*, the CJEU held that workers do not fall within the scope of the protection afforded by the Framework Directive as soon as they develop any type of sickness and so made an important distinction between sickness and disability. In addition, it was

strongly stated that sickness cannot be regarded as a separate prohibited ground of discrimination for the purposes of the Framework Directive.

It was against this backdrop that the judgment in the case of *HK Danmark (Ring and Skouboe Werge)*³ was delivered by the CJEU. In *HK Danmark (Ring and Skouboe Werge)*, Danish legislation permitted businesses to dismiss those who had been off ill for a certain number of days with only one month's notice, shorter than the notice normally required under Danish employment law. The case was brought by two applicants one of whom, Ms. Ring, had developed back pain. The second applicant, Ms. Werge, had whiplash following a road accident. Crucially, both applicants were still able to work but were unable to work on a full-time basis.

The applicants argued that they had a disability, and that this reduced notice period was unlawful disability discrimination, in breach of the EU Framework Directive. A question of fundamental importance was whether or not they fell within the definition of disability as expounded by the *Chacon Navas*⁴ case. The employers disputed that the applicants' state

of health was covered by the concept of “disability” within the meaning of the Framework Directive, since the only incapacity that affected them was that they were now not able to work full-time. As such it was argued by the employers that as they could work part-time they were not excluded completely from participating in professional life and so fell outside the *Chacon Navas* definition. The employer’s central argument was that disability, as constructed by the decision in *Chacon Navas*, implies a complete exclusion from work or professional life as opposed to the partial exclusion here.

The CJEU disagreed and placed strong emphasis on the United Nations Convention on the Rights of Persons with Disabilities (“the UN Convention”). The UN Convention was adopted by the UN General Assembly in December 2006, following prolonged lobbying by disability rights activists. It entered into force in May 2008 and was ratified by the European Union in 2010. The ratification of the UN Convention by the European Union thus followed the *Chacon Navas* decision and accordingly it clearly follows from Article 216(2) TFEU that international

agreements concluded by the European Union are binding upon the institutions of the European Union and on its Member States. Thus, the concept of disability within the meaning of the Framework Directive should not fall short of the scope of the protection afforded by the UN Convention.

The UN Convention itself does not include a definition of "disability" or "persons with disabilities". However the Convention's preamble recognizes that "disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others".

Article 1 of the UN Convention further states: "Persons with disabilities include those who have long term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others."

Models of disability

At this point, in order to adequately understand the social construction of the relevant legal framework, it is important to consider how disability itself has been socially constructed. It is generally accepted that there are two dominant models of disability, namely the medical model of disability and the social model of disability.

This medical model locates disability within the individual. Disability is a medical condition and consequently, like all other conditions it can be treated by doctors to ensure that its symptoms are, ultimately, alleviated or eradicated. According to Parsons (1958) the nature of the model is that, from a social perspective, the disabled individual is placed in the sick role. Drimmer (1992) asserts that this role contains four key elements. Firstly, the sick person is not held responsible for their illness – it is due to biological factors over which they have no control. Following on from this primary tenet, it is advanced that (2) the

sick person is exempted from normal social obligations and (3) is in a socially legitimate position if (4) they co-operate with medical professionals in order to work towards recovery.

One of the leading academic commentators on disability, Michael Oliver, has been highly critical of this model of disability. He contends that there are two fundamental aspects to the medical model of disability. Firstly, it locates the “problem” of disability within the individual and secondly, it sees the causes of this problem as stemming from the functional limitations or psychological losses which are assumed to arise from disability (Oliver, 1996). Furthermore, the medical model has been subjected to substantial criticism by disabled individuals themselves. They contend that it is, in fact, society which disables physically impaired people as “[d]isability is something imposed on top of our impairments by the way which we are unnecessarily isolated and excluded from full participation in society” (UPIAS, 1976). Further criticism derives from that fact that a cure for many disabilities may never be found; and in any event, persons with disabilities are quite capable of participating in society

and the practices of confinement that accompany the sick role are unacceptable (Kaplan, 1999). To combat these inadequacies, the use of a social model of disability has been advocated by many commentators.

According to the social model, disability is any societal factor which imposes restrictions on disabled people. These can range from individual prejudice to institutional discrimination and from inaccessible public buildings to inaccessible transport systems (Oliver, 1996). As Wendell (1996: 46) notes:

“The cultural habit of regarding the condition of the person, not the built environment or the social organization of activities, as the source of the problem, runs deep. For example, it took me several years of struggling with the heavy door to my building, sometimes having to wait until a person came along, to realize that the door was an accessibility problem, not only for me, but for others as well. And I did not notice, until one of my students pointed it out, that the lack of signs that could be read from a distance at my

university forced people with mobility impairments to expend a lot of energy unnecessarily, searching for rooms and offices. I interpreted it, automatically, as a problem arising from my illness (as I did with the door), rather than as a problem arising from the built environment that has been created for too narrow a range of people and situations.”

HIV clearly fits more comfortably within the social model due to high levels of stigma faced by PLHA. At its most basic stigma can be characterized as the negative perceptions of so-called normal people to all individuals who are different from themselves (English, 1977). However academic and policy discussions of stigma, particularly in relation to HIV and AIDS, concentrate on Goffman’s work (Goffman, 1963). Goffman’s research draws upon the experience of people suffering from mental illness, possessing physical deformities, or practicing what were perceived to be socially deviant behaviours such as homosexuality or criminal behaviour and defines stigma as “an attribute that is significantly discrediting” and which serves to reduce social standing of the person

who possesses it. He identifies three bases of stigma. First, abominations of the body. Second, blemishes of individual character and third tribal stigma, due to an individual's membership of a despised group in society. Watt (1996) advances that stigmatization of individuals with HIV rests upon all three of Goffman's bases and consequently stigma is more pronounced. Building on this theory Conyers, Boomer and McMahon (2005) assert that two main theories assist us in explaining the unique level of discrimination and stigma directed at PLHA. The first centres upon the characteristics of the virus itself, with significant focus placed upon the fact that it is currently a potentially fatal infectious disease with no cure. The second relates to the marginalized nature of the vast majority of PLHA, e.g. their status as intravenous drug users, men who have sex with men or members of ethnic minorities. Thus commentators like Watt (1996) advance that discrimination against PLHA is often related to pre-existing stigma which makes PLHA particularly vulnerable to discrimination. The virus is thus socially disabling and the fear of stigma often prevents PLHA from accessing full legal protection by, for example, failing to disclose their condition to their employer.

Returning to the UN Convention, by the language employed in both the preamble and Article 1, it is clear that it adopts the social model. This use of the social model of disability, which shall be discussed later, is ground-breaking and has the potential to empower individuals with disabilities and PLHA on a global basis. Indeed it clearly influenced the thinking and decision of the CJEU in the *HK Danmark (Ring and Skouboe Werge)*⁵ case. Referring explicitly to the UN Convention, the CJEU felt that:

“the concept of ‘disability’ must be understood as referring to a limitation which results in particular from physical, mental or psychological impairments which in interaction with various barriers may hinder the full and effective participation of the person concerned in professional life on an equal basis with other workers.” (at para 38).

The impairment does not have to completely hinder, or exclude, an individual from participation in professional life but rather be one which *may* hinder full and effective participation in professional life.

Even though *HK Danmark (Ring and Skouboe Werge)* appears to lower the bar, it nevertheless remains high for PLHA. Thus, due to the progressive nature of the disease it is questionable whether PLHA will fulfil the CJEU's conceptual requirement of "disability" at the point of their diagnosis. If a purely functional approach to the question of "participation in professional life" is taken then the majority of PLHA face no functional or imitational barriers to participation in professional life. They can, to the naked eye, participate on exactly the same terms and meet the same functional requirements as fellow professionals without HIV. Unlike wheelchair users they are not disabled by any physical features of their employer's premises, for example steps or heavy doors. However, at the point of diagnosis, stigma and the fear of discrimination combine to significantly hinder the full and effective participation of PLHA in professional life on an equal basis with their fellow workers. This is

evidenced by research carried out by Fesko (2001). Fesko reviewed the workplace experiences and disclosure decisions of eighteen PLHA in depth and discovered that six of the participants were completely open about their HIV status within the workplace. Seven individuals had revealed their status to selected people in the workplace and, at the point of doing so, requested that the information be kept confidential. Finally, five individuals reported that they did not tell anyone in their workplace. Individuals identified the stigma associated with HIV as being a factor in their decision to disclose and some felt that they might disclose in future if the stigma associated with the disease were reduced. In addition, participants also described multiple levels of stigma associated with homosexual orientation or membership of an ethnic minority group. By way of example, one African-American woman described her work environment in the following terms:

“With my boss, he was a joker – jokes around and stuff like that – but they had a lot of semi-gay bashing and they raised some very nasty little jokes that I didn’t care for, and people were joking

around and by me being black and it was an all-white company I was working for, I decided not to tell.” (Fesko, 2001: 239)

This fear of stigma and the potential inability to disclose means that, across the EU, numerous PLHA are unable to request that reasonable accommodations be made to their working environment because of the fact they have not disclosed their status to their employer. Such a fact could have detrimental effects on a PLHA’s health and their participation in professional life should they become ill. By way of example, in the absence of disclosure and reasonable accommodations being made PLHA may miss hospital appointments if such appointments fall during working hours or opt to not take doses of medication whilst at work for fear of possible awkward questioning by fellow workers.

HIV was mentioned by Advocate General Kokott in her opinion in *HK Danmark (Ring and Skouboe Werge)* when referring to the express distinction between sickness and disability that the CJEU had earlier drawn in *Chacon Navas*, she stated:

“33. A distinction must therefore be drawn between sickness as the possible cause of the impairment and the impairment resulting from sickness. A permanent limitation resulting from sickness which hinders participation in professional life is also covered by the protection of the directive.

...

35. There is nothing in the wording of Directive 2000/78 to indicate that its scope of application is limited to a certain degree of severity of disability. Since, however, this issue has been neither raised by the referring court nor discussed by the parties to the proceedings, it does not need to be definitively resolved here.”

The problem HIV presents is that it is not a static condition but one that evolves with time. In the early stages of infection, it is stigma associated with the virus that is disabling rather than the virus itself.

Indeed at the point of diagnosis many PLHA are fit and healthy and, with access to appropriate treatment, will remain so for a number of years. However if the virus progresses it becomes functionally disabling in addition to socially disabling. The virus has the potential to manifest itself via AIDS defining illnesses and thus render the individual disabled from both a medical and social perspective. It is only at this point that the virus becomes disabling from the perspective of the medical model.

A retreat from the social model?

As previously noted, the issue of whether HIV could amount to a disability and whether a minimum level of severity is required before an impairment can be considered a disability was touched upon by the Advocate General in *HK Danmark (Ring and Skouboe Werge)*. Advocate General Kokott stated at paragraph 34 that, “*The distinction between sickness and disability is therefore easier to draw in these cases than in the case on which the Supreme Court of the United States of America had to rule, where it held that even an asymptomatic HIV infection may*

constitute a disability within the meaning of the ADA 1990." The United States' Supreme Court decision referred to is that of *Bragdon v Abbott*⁶. In this case the claimant, Abbott, disclosed to her dentist that she was HIV positive prior to requiring treatment in order to fill a cavity. Abbott's dentist refused to treat her in his office and instead offered to treat her at a hospital where she would be responsible for the increased costs associated with the use of hospital treatment. Abbott argued that this treatment contravened the Americans with Disabilities Act 1990 ("ADA") and the key legal issue for the Supreme Court was whether PLHA fell within the definition of disability under the ADA. The ADA defines disability at s1202 as:

"(A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual;

"(B) a record of such an impairment; or

"(C) being regarded as having such an impairment."

The Supreme Court decided that PLHA did fall within the definition of disability for the purposes of the ADA as the virus substantially limited one of Bragdon's major life activities. The Americans with Disabilities Act 1990 contains no definition of what constitutes a "major life activity" but after referring to medical evidence, the Court concluded that HIV substantially limited Bragdon's ability to reproduce which they considered a major life activity. Chief Justice Rehnquist, Justice Scalia and Justice Thomas dissented with the majority of the court on this point, considering reproduction not to be a major life activity. In the Supreme Court's opinion although conception and childbirth are not impossible for PLHA, the court considered them to be "dangerous to the public health" and so amount to a substantial limitation for the purposes of the ADA.

With these facts in mind, it must be questioned whether PLHA will be able to fall within the definition of "disability" advanced by the CJEU in for the purposes of the Framework Directive in *HK Danmark (Ring and Skouboe Werge)*. Bragdon was able to persuade the Supreme Court that she should fall within the remit of the ADA as HIV substantially limited

one of her major life activities, her ability to reproduce. Yet clearly a restriction on one's ability to reproduce does not hinder the participation of an individual in professional life as required by the CJEU's functional conception of "disability". This is where the concept of "disability" advanced by the CJEU differs markedly from that employed by the ADA as evidenced by the CJEU's decision in *Z. v A Government department and The Board of management of a community school*⁷. In this case Ms Z, who was employed as a school teacher, had a rare condition which meant that she had healthy ovaries but no uterus and so was unable to support a pregnancy. In order to become pregnant Ms Z entered into a surrogacy arrangement via a Californian agency and a child was born to the surrogate on 28 April 2010. Biologically, the child was the genetic child of Ms Z and her husband, having been created from their gametes however since Z had not been pregnant and could not give birth to a child, she was unable to satisfy the requirements under Ireland's Maternity Protection Act 1994 for taking paid maternity leave. She did also not qualify for paid adoptive leave, as provided by Ireland's Adoptive Leave Act 1995, since she was not adopting a child born through surrogacy. Ms Z argued before the

CJEU that this refusal to allow her to access paid leave amounted to discrimination upon, amongst other grounds, disability. Her claim failed as the CJEU decided that she did not fall within the definition of disability for the purposes of the Framework Directive. The court stated that “the inability to have a child by conventional means does not in itself, in principle, prevent the commissioning mother from having access to, participating in or advancing in employment. In the present case, it is not apparent from the order for reference that Ms Z.’s condition by itself made it impossible for her to carry out her work or constituted a hindrance to the exercise of her professional activity. In those circumstances, it must be held that Ms Z.’s condition does not constitute a ‘disability’” (at paras 81 & 82). The case of *Z* thus illustrates the potential difficulties that PLHA may have in persuading the CJEU that they are disabled for the purposes of the Framework Directive. In common with Ms Z, PLHA will not be able to demonstrate that a restriction upon their ability to have children by conventional means hinders their participation in professional life. Indeed provided they are in good health and their medical condition is stable, they will face an uphill battle in persuading the CJEU that their condition

imposes any hindrance whatsoever upon their participation in professional life. This somewhat restrictive construction of the concept of disability has been echoed in the later CJEU decision of *Fag og Arbejde v Municipality of Billund*⁸ where it was stated that “an illness requiring particular attention, continuous medication and control may be a physiological or psychological burden to the person concerned, but not render impossible the full and effective carrying out of work, or hinder participation on an equal basis in professional life in general” (at para. 38).

This developing construction of the concept of disability is unfortunate as in order to fully embrace the social model future decisions of the CJEU need to recognize that the stigma faced by PLHA is disabling as it is a factor imposed on top of PLHA’s impairment that serves to unnecessarily isolate and exclude them from full participation in society. It is hoped that in future the CJEU broaden the concept of disability for the purposes of the Framework Directive to encompass individuals who are prevented from participating fully and effectively in society and not just,

as the law currently stands, professional life. The case of *Bragdon*⁹ illustrates that whilst a condition like HIV may not hinder an individual's functional participation in professional life it certainly is able to limit an individual's full and effective functional participation in society. Indeed, the fact that it does hinder functional participation in society only serves to exacerbate stigma against PLHA who may be perceived as "other" or "different" from the able bodied majority due to their inability to fully participate in some aspects of society. This stigma knows no boundaries; it exists within the place of work of PLHA and outside of it. The CJEU ought to recognize that for the purposes of the Framework Directive individuals who are prevented from participating fully and effectively in any aspect of society due to stigma, and not just as currently enunciated employment, are "disabled" and should fall within the remit of the Framework Directive.

In addition, it may be perceived as somewhat troubling as to why Advocate General Kokott in the *HK Danmark (Ring and Skouboe Werge)*¹⁰ case questioned whether a certain degree of severity of disability

is required for the purposes of the Framework Directive. By referring to HIV and questioning whether a minimum level of severity is required, some might interpret Advocate General Kokott's comments as failing to take into account the fact that PLHA, in common with many other individuals with disabilities, face discrimination within employment not solely because of functional limitations due to the severity of their condition but often because of the substantial stigma associated with their condition. Indeed, due to recent medical advances in the treatment of HIV, PLHA within employment are now arguably more likely to be discriminated against because of the stigma associated with their condition as opposed to any functional limitations. By questioning whether a certain degree of severity is required and using HIV as an example, it would appear that Advocate General Kokott moves the concept of disability away from the social model of disability. It is respectfully submitted that the focus appears to be solely upon a particular condition's degree of impact upon an individual's functional ability. If the CJEU is to fully embrace the social model of disability, such considerations should not come into play. Under the social model, disability is any societal factor which imposes

restrictions on disabled people. Thus the correct focus of any future CJEU decision concerning the definition of disability for the purposes of the Framework Directive should be to examine what factors limit the individual in question from participating fully and effectively in society. Focusing on the restricting factors of an individual's impairment and examining degrees of severity, as was suggested in the *HK Danmark (Ring and Skouboe Werge)* case, merely undermines any attempt at effectively implementing the social model of disability into EU law.

At some point in the future the question as to whether a minimum level of severity is required for the purposes of the Framework Directive will be addressed by the CJEU. The hope then must be that the CJEU recognize that PLHA, in common with other individuals with disabilities, are precluded from full and effective participation in professional life by not merely environmental or physical barriers but also by attitudinal and psychological ones. As such, a definition of disability which is firmly grounded in the social model needs to be adopted. Such a definition would recognize that an individual could be classified as "disabled" for the

purposes of the Framework Directive notwithstanding the fact that their condition does not functionally limit them in any way. The definition would also recognize the fact that individuals with disabilities are prevented from participating fully and effectively not just in professional life, but in all aspects of society.

Conclusion

To say that the law relating to HIV discrimination within the EU is complex would be an understatement. In an attempt to protect PLHA from discrimination, various pieces of legislation have been enacted. Whilst each has at its heart the objective of protecting PLHA from discrimination, the collective result is a multifaceted plethora of legislation often overlapping and sometimes contradictory. In order to decipher the possible legal protection afforded to PLHA, regard must be had to the UN Convention, European Union law, any applicable law of the individual member state and depending on the facts of the case, regard might also be had to the European Convention on Human Rights. The net result is that

many lawyers now struggle to comprehend the law as it relates to discrimination. That laws should be open, clear and accessible is a fundamental requirement of any legal system and one advocated by many leading jurists, for example Fuller (1969), Raz (1979) and Bingham (2011). This is especially important in an area such as discrimination in which the law should be accessible and interpretable to, often marginalized, lay people in order that they may utilize its protection. The current situation fails entirely in this regard. The EU has committed itself to combatting HIV. In order to do this, a clear and consistent legal framework in relation to, not only HIV, but disability as a whole needs to be implemented. The adoption of a coherent definition of disability grounded in the social model would ensure that PLHA are adequately protected from discrimination across the EU. In addition, it would constitute a significant step in tackling the high levels of stigma directed towards PLHA.

The decision of the CJEU in *HK Danmark (Ring and Skouboe Werge)* represented the CJEU's first opportunity to revisit the concept of

“disability” employed by the Framework Directive since the ratification of the UN Convention by the European Union in 2010. In this case, the CJEU conceptualized disability as being an impairment which, in interaction with various barriers, hinders the full and effective participation of an individual in professional life. The decision represents a welcome step in the direction of the social model but it also illustrates that the CJEU still has some way to go until a definition of disability primarily based upon the social model of disability is fully adopted. Future decisions of the CJEU need to build upon the decision in *HK Danmark (Ring and Skouboe Werge)* but also acknowledge that the question of disability is not solely concerned with an individual’s functional limitations. Some conditions, of which HIV is an example, impose limited functional limitations upon an individual. Certainly if the concept of disability is solely concerned with functional limitations which restrict an individual’s ability to fully participate in professional life, then it is questionable whether PLHA will gain the protection of the Framework Directive. This would be an unfortunate outcome, given the marginalized nature of large numbers of PLHA within the European Union. Thus, it is hoped that in future the

CJEU broaden the concept of disability for the purposes of the Framework Directive to encompass individuals who are prevented from participating fully and effectively in society and not just professional life.

It must also be hoped that the CJEU does not impose a requirement for an impairment to have a minimum degree of severity before it can be classified as a “disability”. The CJEU must recognize that the barriers which hinder the full and effective participation of disabled people in professional life go beyond just the environmental or physical but include attitudinal and psychological barriers. As such, a definition of disability which is firmly grounded in the social model needs to be adopted. Such amendments to the concept of disability would have far reaching beneficial consequences for not just PLHA but all individuals with disabilities across the European Union.

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² *Chacon Navas v Eurest Colectividades SA*, Case C-13/05 [2006] ECR I-6467.

³ *HK Danmark, acting on behalf of Jette Ring v Dansk Almenyttigt Boligselskab DAB and HK Danmark, acting on behalf of Lone Skoube Werge v Pro Display A/S in liquidation*, Joined Cases C-335/11 and C-337/11, [2013] 3 CMLR 21.

⁴ *Chacon Navas v Eurest Colectividades SA*, Case C-13/05 [2006] ECR I-6467.

⁵ *HK Danmark, acting on behalf of Jette Ring v Dansk Almenyttigt Boligselskab DAB and HK Danmark, acting on behalf of Lone Skoube Werge v Pro Display A/S in liquidation*, Joined Cases C-335/11 and C-337/11, [2013] 3 CMLR 21.

⁶ *Bragdon v Abbott* 524 U.S. 624 (1998).

⁷ *Z v A Government Department and the Board of Management of a Community School* [2013] EUECJ C-363/12 (26 September 2013).

⁸ *Fag og Arbejde (FOA), acting on behalf of Karsten Kaltoft, v Kommunernes Landsforening (KL), acting on behalf of the Municipality of Billund*, [2014] EUECJ C-354/13.

⁹ *Bragdon v Abbott* 524 U.S. 624 (1998).

¹⁰ *HK Danmark, acting on behalf of Jette Ring v Dansk Almenyttigt Boligselskab DAB and HK Danmark, acting on behalf of Lone Skoube Werge v Pro Display A/S in liquidation*, Joined Cases C-335/11 and C-337/11, [2013] 3 CMLR 21.