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IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

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KING'S BENCH DIVISION
(JUDICIAL REVIEW)

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IN THE MATTER OF AN APPLICATION BY EILEEN WILSON FOR JUDICIAL REVIEW

AND IN THE MATTER OF AN APPLICATION BY MAY KITCHEN FOR JUDICIAL REVIEW

Between:

EILEEN WILSON

Applicant

and

(1) DEPARTMENT OF HEALTH FOR NORTHERN IRELAND
(2) SOUTH EASTERN HEALTH AND SOCIAL CARE TRUST
(3) THE HEALTH AND SOCIAL CARE BOARD

Respondents

and

THE COMMISSIONER FOR OLDER PEOPLE FOR NORTHERN IRELAND

Intervenor

Between:

MAY KITCHEN

Applicant

and

(1) DEPARTMENT OF HEALTH FOR NORTHERN IRELAND
(2) BELFAST HEALTH AND SOCIAL CARE TRUST
(3) THE HEALTH AND SOCIAL CARE BOARD

Respondents

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Mr Ronan Lavery KC with Mr Conan Fegan BL (instructed by McIvor Farrell Solicitors) for both Applicants
Mr Ian Skelt KC with Ms Laura McMahon BL (instructed by Departmental Solicitor's Office) for the Department of Health for Northern Ireland
Dr Tony McGleenan KC with Mr Gordon Anthony BL (instructed by the Directorate of Legal Services) for both Trusts
Ms Bobbie-Leigh Herdman BL made written submissions on behalf of the Commissioner for Older People for Northern Ireland

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COLTON J

Introduction

[1] When the National Health Service was founded in 1948 by Aneurin Bevin, it had three core principles at its heart; that it would meet the needs of everyone, that it would be free at the point of delivery, and that it would be based on clinical need, not ability to pay. Whilst the health service in this jurisdiction is not technically part of the NHS, it too, subscribes to these principles.

[2] These applications bring into focus what is widely regarded as a crisis facing the health service in this jurisdiction, namely the length of time patients are waiting for treatment. It does not need recourse to law to establish that such a crisis exists.

[3] Both applicants in this case demonstrate the problem with such waiting lists in this jurisdiction.

[4] The applicant, Eileen Wilson, is a 47-year old lady who lives alone. She was referred to the South Eastern Health and Social Care Trust's ("the Trust") neurology service in June 2017 by her general practitioner because of suspected multiple sclerosis. The initial referral for assessment was classified as "urgent." She was initially advised that the current waiting list for neurology appointments is 163 weeks. Her case was later assessed by the attending consultant to be "routine." She was placed on a waiting list and has been advised to contact her GP in the event of any deterioration in her condition. She was due to have an appointment on 16 March 2020 but this was cancelled due to restrictions arising from the Covid-19 pandemic. A consultant neurologist conducted a virtual appointment with her on 11 March 2022. MRI scans were conducted on the applicant on 11 May 2022. She has not been diagnosed with having multiple sclerosis as a result of that scan and it is suggested that her symptoms should continue to be treated as fibromyalgia.

[5] The applicant, May Kitchen, is a 75-year lady who also lives alone. She was diagnosed with cataracts approximately five years ago. She was referred to the Belfast Health and Social Care Trust's ("the Belfast Trust") ophthalmology service on 7 July 2019 by her general practitioner and optician. She was advised that the necessary operation for treatment of her cataracts would not take place for three to four years due to the length of waiting lists. After the pre-action protocol letter was

issued on her behalf on 13 December 2019 although the waiting list for a routine out-patient appointment was 42 months she was provided with an appointment by the Belfast Trust for examination and testing of her eyes on 5 February 2020.

[6] Although she was offered this out-patient appointment she was advised that the current waiting time for surgery was likely to be 15-17 months. Despite attending the out-patient's appointment she did not receive a date for surgery. She was fearful of losing her sight completely and therefore felt compelled to pay for private surgery through Benenden Health Care. Following an appointment on 14 September 2020, she was offered an appointment for private surgery within approximately six weeks.

[7] Although the factual matrix for each applicant is different, involving different medical conditions, different Trusts and different medical requirements, they both raise similar legal issues. For this reason, it has been agreed that both applications be heard together and that the court considers the legal issues that arise in respect of both applicants.

[8] The court is obliged to all counsel in this case for their helpful written and oral submissions. The court acknowledges the work of their respective solicitors in preparing the trial bundles. The court also acknowledges the written submissions from Ms Herdman BL on behalf of the Commissioner for Older People for Northern Ireland.

The applicants' case

[9] The applicants' cases are based on alleged:

(a) Breach of statutory duty; and

(b) An unjustifiable interference with their Article 8 rights.

Breach of statutory duty

[10] Each of the applicants allege a failure on behalf of the respondents to provide or secure the provision of primary medical services within Northern Ireland and/or the jurisdiction of the relevant Trusts.

[11] The general statutory duties of the Department in relation to the provision of healthcare are set out in section 2 of the Health and Social Care (Reform) Act (Northern Ireland) 2009 ("the 2009 Act"). Section 2 provides as follows:

> "**Department's general duty**
>
> 2-(1) The Department shall promote in Northern Ireland an integrated system of—

(a) health care designed to secure improvement—

(i) in the physical and mental health of people in Northern Ireland, and

(ii) in the prevention, diagnosis and treatment of illness; and

(b) social care designed to secure improvement in the social well-being of people in Northern Ireland.

(2) For the purposes of subsection (1) the Department shall provide, or secure the provision of, health and social care in accordance with this Act and any other statutory provision, whenever passed or made, which relates to health and social care.

(3) In particular, the Department must –

(a) develop policies to secure the improvement of the health and social well-being of, and to reduce health inequalities between, people in Northern Ireland;

(b) determine priorities and objectives in accordance with section 4;

(c) allocate financial resources available for health and social care, having regard to the need to use such resources in the most economic, efficient and effective way;

(d) set standards for the provision of health and social care;

(e) prepare a framework document in accordance with section 5;

(f) formulate the general policy and principles by reference to which particular functions are to be exercised;

(g) secure the commissioning and development of programmes and initiatives conducive to the improvement of the health and social well-being

of, and the reduction of health inequalities between, people in Northern Ireland;

(h) monitor and hold to account [...] the Regional Agency, RBSO and HSC trusts in the discharge of their functions;

(i) make and maintain effective arrangements to secure the monitoring and holding to account of the other health and social care bodies in the discharge of their functions;

(j) facilitate the discharge by bodies to which Article 67 of the Order of 1972 applies of the duty to co-operate with one another for the purposes mentioned in that Article.

(4) The Department shall discharge its duty under this section so as to secure the effective co-ordination of health and social care."

[12] The predecessor to the section 2 general obligation was Article 4 of the Health and Personal Social Services (Northern Ireland) Order 1972 ("the 1972 Order") which is relevant for the court's analysis. It provided:

"**General duty of Ministry**

4. It shall be the duty of the Ministry –

(a) to provide or secure the provision of integrated health services in Northern Ireland designed to promote the physical and mental health of the people of Northern Ireland through the prevention, diagnosis and treatment of illness;

(b) to provide or secure the provision of personal social services in Northern Ireland designed to promote the social welfare of the people of Northern Ireland and the Ministry shall so discharge its duty as to secure the effective co-ordination of health and personal social services."

[13] Further to Article 4, Article 6 of the 1972 Order provides:

"**Provision of general health care**

6.—(1) The Ministry shall secure the provision of primary medical services, of general dental and ophthalmic services and of pharmaceutical services in accordance with Part VI."

[14] The general duties set out in section 2 and Article 6 above are supplemented by Articles 5 and 15 of the 1972 Order which provide the more detailed outworkings of the general, unparticularised duties enshrined in section 2 and Article 6. They provide as follows:

"**Provision of accommodation and medical services, etc**

5.—(1) The Ministry shall provide throughout Northern Ireland, to such extent as it considers necessary, accommodation and services of the following descriptions—

(a) hospital accommodation, including accommodation within the meaning of Article 110 of the Mental Health Order;

(b) premises, other than hospitals, at which facilities are available for all or any of the services provided under this Order or the 2009 Act;

(c) medical, nursing and other services whether in such accommodation or premises, in the home of the patient or elsewhere.

(2) In addition to its functions under paragraph (1), the Ministry may provide such other accommodation and services not otherwise specifically provided for by this Order or the 2009 Act as it considers conducive to efficient and sympathetic working of any hospital or service under its control, and, in relation to any person and notwithstanding anything contained in section 2(1)(a) of the 2009 Act, to provide or arrange for the provision of such accommodation or services, and in connection therewith, to incur such expenditure as is necessary or expedient on medical grounds.

(3) Where accommodation or premises provided under this Article afford facilities for the provision of primary medical services, of general dental or ophthalmic services or of pharmaceutical services, they

shall be made available for those services on such terms and conditions as the Ministry may determine.

(4) The Ministry may permit any person to whom this paragraph applies to use for the purpose of private practice, on such terms and conditions as the Ministry may determine, the facilities available at accommodation or premises provided under this Article.

(5) The persons to whom paragraph (4) applies, being persons who provide services under this Order or the 2009 Act, are as follows:—

(a) medical practitioners;

(aa) persons providing primary medical services under a general medical services contract or in accordance with Article 15B arrangements;

(b) dental practitioners;

(c) ophthalmic ... opticians;

(d) pharmacists; and

(e) such other persons as the Ministry may determine."

[15] Article 15(1) of the 1972 Order (as amended) which is to be considered in conjunction with section 2(1)(b) of the 2009 Act (social care), provides:

"In the exercise of its functions under section 2(1)(b) of the 2009 Act the [Department] shall make available advice, guidance and assistance, to such extent as it considers necessary and for that purpose shall make such arrangements and provide or secure the provision of such facilities (including the provision or arranging for the provision of residential or other accommodation, home help and laundry facilities) as it considers suitable and adequate."

[16] Article 15B provides as follows:

"Primary medical services or personal dental services

15B.—(1) A Health and Social Services Board may make one or more agreements with respect to its area, in accordance with the provisions of regulations under Article 15D, under which—

(a) primary medical services are provided (otherwise than by the Department); or

(b) personal dental services are provided (otherwise than by the Department).

(2) An agreement made under this Article—

(a) may not combine arrangements for the provision of primary medical services with arrangements for the provision of personal dental services; but

(b) may include arrangements for the provision of health care -

(i) which are not primary medical services or personal dental services; but

(ii) which may be provided under this Part."

[17] In respect of statutory duties imposed on the Trust and the Health and Social Services Board Article 56(1) of the 1972 Order provides:

"**Primary medical services**

56.—(1) Each Health and Social Services Board shall, to the extent that it considers necessary to meet all reasonable requirements, exercise it powers so as to provide primary medical services or secure their provision.

(2) The Health and Social Services Board may (in addition to any other power conferred on it)—

(a) provide primary medical services itself;

(b) make such arrangements for their provision as it thinks fit, and may in particular make contractual arrangements with any person.

(3) Each Health and Social Services Board shall publish information about such matters as may be prescribed in relation to the primary medical services provided under this Part."

Summary of the evidence

[18] Having set out the relevant statutory provisions relied upon by the applicants I return to the evidence available to the court. In this regard the court has been provided with a vast amount of material which illustrates the extent to which the issue of waiting lists has been considered by an array of interested parties and the associated extensive public coverage.

[19] The applicants have set out the factual context of their experience with waiting lists and they bring these cases both on their behalf and "on behalf of the general public."

[20] The applicants rely, in particular, upon a report prepared by Professor Deirdre Heenan in support of these applications. Professor Heenan is a leading academic who has written and been published extensively on issues affecting the health service in Northern Ireland. In 2010 she was appointed by the then Northern Ireland Health Minister to a five-person advisory panel to oversee a review of health and social care in Northern Ireland. That panel produced its report "Transforming your Care in Northern Ireland" in 2011. It made 99 proposals for change across the range of health and social care services.

[21] In her report in this case she focuses specifically on the issue of waiting lists.

[22] Mr Lavery highlights the following aspects of her report:

"Page 1 – Here she sets out the context and scale of the problems with waiting lists:

- In 2019 the number of people on a waiting list in NI was 105,486 (population 1.9m) compared to 1,089 in England (population 56m).

- Recent statistics for NI (DoH, September 2021) show approximately one in four people (in a population of 1.9m) are waiting either to see a consultant for the first time or to receive treatment. That figure has

increased by almost 3% since June 2021, and by nearly 10% since September 2020.

- Despite official targets stating that no patient should wait longer than 52 weeks for a first appointment, over half of patients have been on a waiting list for more than a year. None of the waiting list targets are being met. There are people waiting up to five years for routine orthopaedic treatment, four years for ear, nose and throat procedures and up to seven years for a neurology appointment (BBC News, NI Report 10 June 2021). Even the most urgent of cases, red flag cancer patients, are having their operations cancelled."

[23] In page 2 she rejects the suggestion that the problems arise from a lack of funding:

> "The DoH have repeatedly stated that the issue is largely financial, and more money was required to address the issue (Connolly, 2019). NI spends more per head of population on health care than any other UK region, with by far the worst outcome."

[24] She refers to a series of reviews of the system dating from 2001 culminating in the Bengoa Report published in 2016 which called for the development of an accountable care system that aimed to manage people's health and keep them well. It concluded the system had the capability to deliver on key objectives but stressed that this would be a long term 10-year plan. She analyses what she considers to be the causes for lengthy waiting lists.

[25] She is critical of the failure of the Department to produce a detailed, comprehensive strategy to deal with the waiting list issue. She refers to the fact that in 2019 the Department announced that £1bn additional money (Connolly, 2019) would be required to address waiting lists in NI.

[26] She refers to the Rebuilding Health and Social Care Services Strategic Framework which was published by the DoH in June 2021. This document sets out how the health service has been impacted by the pandemic and reiterates longstanding issues around waiting lists and elective care. It sets out details of a new management structure to oversee the rebuilding of the health and social care system. She is critical of the elective care framework as being a rehearsal of points that have already been suggested and "is aspirational and very light in detail of how rebuilding will be achieved." She concludes:

- "There is a lack of urgency to tackle the crisis by the Department.

- Targets are routinely missed and simply replaced with new ones.

- The "catastrophic", "appalling performance" and "functional collapse" of the health system in NI cannot be explained by just lack of money or annual budgets, in particular, because of the higher per capita spend.

- There is no detailed strategy to maximise the delivery of services, stabilise and ultimately reduce the waiting lists. There is an accountability vacuum in the system that facilitates its deterioration.

- In NI we have enough money to build a world class health system, but we do not have the money to run the one we have."

[27] In terms of evidence from the respondents the court has an affidavit from Mr Andrew Kerr which provides specific detail about neurology services at the Ulster Hospital and explains the history of delay in relation to the applicant, Eileen Wilson.

[28] The court received an affidavit from Mary Hanrahan on behalf of the Belfast Trust. It provides detail about the provision of the Trust's ophthalmology service. She avers that cataract surgery is one of the most common elective surgical procedures, and it accounts for approximately one third of ophthalmology procedures in Northern Ireland. In particular, she refers to the integrated elective access protocol which provides regional guidance on the management of waiting lists. It sets out as a general principle that patients with the same clinical need be treated on clinical priority and then in chronological order. She confirms that the Trust sought to assess Mrs Kitchen's case in accordance with the principles set out in the protocol but that its attempts to do so were affected by resource pressures.

[29] The court received an affidavit from Mr Paul Cavanagh on behalf of the respondent Board. This is historic in nature and related to the role of the Board in commissioning services on behalf of the Department. As subsequently explained by Mr Wilson on behalf of the Department, the Health and Social Care Board closed on 31 March 2022. The Health and Social Care (Northern Ireland) Act 2022 provided for the transfer of liabilities of the HSCB and the novation of contracts entered into by HSCB as at that date, to become liabilities and contracts of the Department from 1 April 2022. The decision to close the Board arose from a review of commissioning arrangements within the system. The closure of the HSCB is the first step in a wider

transformation which will consider how future HSC services will be planned and managed differently. As a consequence, the Board is no longer a respondent to these proceedings.

[30] The key evidence from the Department is found in the three affidavits sworn by Mr Ryan Wilson, who is the Director of Secondary Care in the Northern Ireland Department of Health, an Assistant Secretary and the Department's Senior Adviser to the Minister of Health and Secondary Health Care Policy and delivery of services.

[31] In his comprehensive affidavits Mr Wilson sets out the processes for the delivery of health care in Northern Ireland.

[32] There is a particular focus in his affidavits on the question of funding for the health service in NI. He indicates that:

> "A significant increase in recurrent funding will be required to … return waiting lists to acceptable levels. This sets out the difficult and frustrating process from the Department's perspective in relation to funding with budgets determined on a year to year basis."

He avers that:

> "A multi-year budget approach is needed to secure a recurrent funding source to increase the capacity of our elective care system."

He indicates that:

> "What is needed at a minimum is a recurrent source of ear marked funding, agreed in advance, to close the capacity gap and address the patient backlog. Longer term surety of funding at a significant scale will enable innovations both inhouse and with independent sector providers."

[33] He then refers to the elective care plan published in 2017 which set out the approach to addressing the waiting list crisis through major reform and transformation to sustainably improve elective care services and build capacity in the HSC.

[34] He explains that the collapse of the Northern Ireland Executive in 2017 was a significant contributory factor to the inability to implement the plan. Whilst transformation funding was made available, this was only for a two year period, which did not allow for long term, or even medium term planning.

[35] He acknowledges that since then the number of patients waiting has increased as the health service deficit has increased and that waiting lists are now at a level where they will take years to stabilise and even longer to return to their pre-2015 levels.

[36] He then refers to the Elective Care Framework Restart, Recovery and Redesign document of 15 June 2021 of which Professor Heenan was highly critical. The framework proposes a £700m investment over five years. It sets out in his words:

> "Firm, time bound proposals for how the Department intends to systematically tackle the backlog of patients waiting longer than ministerial standards, and how we will invest in and transform services to allow us to meet the population's demands in future. It describes both the investment and reform that are required in terms of targeted investment to get many more people treated as quickly as possible; and reform to ensure the long term problems of capacity and productivity are properly addressed."

[37] He, in effect, agrees with many critics of the health service when he avers at para 59 of his affidavit:

> "The way in which services are organised in Northern Ireland has also contributed to issues with efficiency of the service. Maintaining 24/7 emergency surgery at multi-acute hospital sites has led to a service that is overly reliant on locum doctors and agency nurses in order to fill rotas. This situation also makes it more difficult to separate elective and unscheduled service, which ultimately leads to the loss of one or more of the components required to deliver planned elective work."

He continues at para 60:

> "It is clear that reform is necessary but, above all, there needs to be a commitment to significant and sustained investment both in the HSC and in the independent sector. Increasing capacity essentially means increasing the workforce. This is true for capacity within the independent sector and the HSC. Short term funding does not provide the stability necessary to attract and retain staff, or to plan services efficiently."

He concludes that:

> "The Department has clearly set out the actions and funding required to bring waiting times into balance over the next five years. Delivery of the action set out in the elective care framework will require the commitment of NI Executive Ministers and will be dependent upon additional, sustained, recurrent funding."

Have the applicants established a breach of statutory duty?

[38] In this regard the common position of the respondents in these applications is that the claims are neither justiciable nor reviewable by the court.

Case Law

[39] In essence, the legal issue in these cases resolves to the issue as to whether the alleged breaches of duty of the respondents are sufficient to crystalise into an enforceable statutory duty owed to the applicants.

Justiciability/reviewability

[40] The respondents contend that the issues raised by the applicants are "non-justiciable." They say that the matters raised are questions of macro-political policy to be determined by the legislature and not the courts. In such circumstances it is argued that the court is constitutionally precluded from engaging in a consideration of such matters.

[41] There is a distinction between justiciability and reviewability. Examples of matters that have been considered "non-justiciable" are to be found in *R(A, J, K, B and F) v Secretary of State for the Home Department* [2022] EWHC 360 which dealt with a challenge to a ministerial decision to lay draft legislation before Parliament. In a similar vein, in *Re Burns* [2022] NICA 20 the Court of Appeal endorsed the decision of this court that a Command Paper setting out government proposals ws non-justiciable.

[42] The distinction between reviewability and justiciability was acknowledge by Kerr LCJ in *Re Shuker's Application* [2004] NIQB 20 at para [7]:

> "It is possible (at least at a theoretical level) to distinguish the question of justiciability (which might be defined for present purposes as 'whether the decision of the Attorney General is subject to the jurisdiction of the court') from the notion of reviewability (i.e. whether the specific type of challenge made can, in the particular circumstances of the case, be permitted) although the application of the correct principles from either concept may provide the

> same answer, and in any event, the concepts tend to blend into one another."

[43] In the context of these cases the court prefers to analyse the matter through the prism of reviewability. If the court were to determine that the matter was non-justiciable this would have the effect of closing the door on any consideration by the court of the important issues raised in the applications.

[44] In terms of reviewability the court considers that the duties imposed on the respondents under consideration in this case fall within the macro-economic/macro-political field. This conclusion is reached both from the wording of the relevant legislation and consideration of the relevant case law. It is well established at the highest judicial level that where decisions lie in that field the court's supervision will be less intrusive or "soft edged."

[45] Consideration of several seminal cases makes this point. The leading authority and starting point on this issue remains *R v Cambridge Area Health Authority, ex parte Child B* [1995] 1 WLR 898. The issue in that case was whether the respondent authority had acted unlawfully when refusing to administer a form of cancer treatment to a 10-year-old child. Holding that the authority had not acted unlawfully, Sir Thomas Bingham, giving the lead judgment of the court, said:

> "I have no doubt that in a perfect world any treatment which a patient, or a patient's family, sought would be provided if doctors were willing to give it, no matter how much it costs, particularly when a life was potentially at stake. It would however, in my view, be shutting one's eyes to the real world if the court were to proceed on the basis that we do live in such a world. It is common knowledge that health authorities of all kinds are constantly pressed to make ends meet. They cannot pay their nurses as much as they would like; they cannot provide all the treatments they would like; they cannot purchase all the extremely expensive medical equipment they would like; they cannot carry out all the research they would like; they cannot build all the hospitals and specialist units they would like. Difficult and agonising judgments have to be made as to how a limited budget is best allocated to the maximum advantage of the maximum number of patients. That is not a judgment which the court can make. In my judgment, it is not something that a health authority such as this authority can be fairly criticised for not advancing before the court.
>
> Mr McIntyre went so far as to say that if the Authority has money in the bank which it has not spent, then they

> would be acting in plain breach of their statutory duty if they did not procure this treatment. I am bound to say that I regard that submission as manifestly incorrect. Unless the Health Authority had sufficient money to purchase everything which in the interests of patients it would wish to do, then that situation would never ever be reached. I venture to say that no real evidence is needed to satisfy the court that no Health Authority is in that position.
>
> I furthermore think, differing I regret from the judge, that it would be totally unrealistic to require the Authority to come to the court with its accounts and seek to demonstrate that if this treatment were provided for B then there would be a patient, C, who would have to go without treatment. No major Authority could run its financial affairs in a way which would permit such a demonstration."

[46] In *R(G) v Barnett LBC* [2004] AC 208 the House of Lords was examining whether the council was obliged to provide accommodation for the claimants and their children. In that case the court determined that the relevant legislation was concerned with general principles and not designed to confer absolute rights on individuals. The duties appeared to have been carefully framed to confer a discretion on the local social services authority as to how it should meet the needs of each individual child in need.

[47] In a different context the Court of Appeal recognised that decisions about resources are polycentric in nature and taken in the "real world." In *Department of Justice v Bell* [2017] NICA 69, which involved a case about delay in an investigation by the Police Ombudsman for Northern Ireland, Gillen LJ said at para [38]:

> "[28] Whilst the effective operation of the police complaints system to ensure investigations occur within a reasonable time is an extremely important aspect of the Department's duties, nonetheless it cannot be overlooked that the Department is not the source of budgetary restraints—that being the responsibility of the Executive or of the Treasury or of the Secretary of State for Northern Ireland who provide a block grant to the Executive ... The Department has financial responsibilities for and duties owed to bodies as disparate as the PONI, the PSNI, the prison service, youth justice, family justice etc. Presumably if it provided all the money required by the PONI that would entail taking funds away from some other body or bodies for which it has responsibility. It

> would be to shut one's eyes to the real world if it was to be asserted that in a period of unprecedented economic difficulties the Department was not to be permitted to play its part in the belt tightening exercises throughout government. It would of course be laudable if all the needs of the Departmental responsibilities could be met but such hopes are simply not realistic."

[48] Having set out the general principles in play, I now turn to two important decisions in this jurisdiction which analyse some of the duties relied upon in this case, although there are significant contextual differences to which I will return.

[49] In *Re LW's Application for Judicial Review* [2010] NIQB 62, McCloskey J was examining the applicant's challenge contending that the relevant health trust (as agent of the Department of Health) had failed to discharge the duty which it owed to the applicant under section 2 of the Chronically Sick and Disabled Persons (Northern Ireland) Act 1978 ("the 1978 Act"). As a secondary ground of challenge, the applicant also relied on an alleged breach of Article 15 of the 1972 Order, as amended which is relied upon by the applicant in this case.

[50] In *LW* it is important to understand that the court was dealing with an applicant who had assessed needs under the 1978 Act which, in McCloskey J's words, provided advantages to that discrete group over other members of the population which included the existence of an unequivocal duty on the part of the Department. That does not apply in this case.

[51] However, McCloskey J did analyse the provisions of Article 15 of the 1972 Order, in the context of a disabled applicant. He says:

> "**Article 15 of the 1972 Order**
>
> [42] However, the conclusion set out immediately above does not preclude the court from holding that the Trust may be obliged to provide this discrete service/facility to the applicant under Article 15 of the 1972 Order, rather than Section 2 of the 1978 Act. This is the next question which must, logically, be addressed. I consider, bearing in mind the language of Article 15, as amended, that this question can be formulated in the following abstract terms: where a Trust determines what social care arrangements and facilities are considered by it to be necessary and/or suitable and adequate for a given member of the population, does a consequential duty of provision, in tandem with a corresponding right, crystallize? And if `yes', what are the contours of the duty?

[43] In *Re Hanna's Application* [2003] NIQB 79, Coghlin J considered the question of the proper construction of Article 15 of the 1972 Order. On this occasion, in contrast with *Judge*, Article 15 arose for consideration in isolation, on its own merits. Coghlin J concluded:

> '… I do not think that it is appropriate to conceive of Article 15 placing the Department or, in this case, its agent the Respondent Trust under a mandatory duty to fulfil any specific need once that need has been assessed. In my view, in the context of this application, the duty imposed upon the Department and its agencies by Article 15, is to provide such facilities by way of residential nursing accommodation as it considers suitable and adequate to meet the needs of the applicant, consistent with its overall duty to promote the physical and mental health and social welfare of all of the people of Northern Ireland, including those whose needs may, depending on the circumstances, be more urgent and pressing than those of the applicant. In achieving this goal, it seems to be inevitable that it will be necessary to take into account available resources and, in my view, this has been practically achieved in a reasonable manner by the scheme administered by the defendant Trust. It is important to bear in mind that the respondent Trust has not refused to meet the applicant's assessed needs, it has recognised those needs but has been compelled by the resources available to it to adopt a system which seeks to balance the fulfilment of those needs with the needs of others.'

Thus, for Coghlin J, the hallmark of Article 15 of the 1972 Order is discretion, rather than duty. Amongst the decided cases, the decision in *Hanna* approximates most closely to the present case. However, it is important to recognise that in *Hanna* there was no refusal by the authority to meet the applicant's assessed need. Rather, the impugned determination was to the effect that the applicant would have to await the availability of the relevant facility, which would be provided to her as soon

as it became available. Thus, the precise terms of the impugned determination must be carefully recognised. Moreover, the central argument advanced, unsuccessfully, attempted to equate Article 15 of the 1972 Order with certain English statutory provisions. Finally, the arguments canvassed by the parties did not entail consideration and determination of the abstract question posed in paragraph [42], supra. Thus, the factual and legal matrix in *Hanna* does not equate precisely with that of the present case."

[52] The key passages of the judgment in *LW* are at para [45] as follows:

> "[45] In my opinion, Article 15 of the 1972 Order is to be analysed in the following way:
>
> (a) It constitutes the more detailed outworkings of the general, unparticularised duty enshrined in Section 2(b) of the 2009 Act (formerly Article 4(b) of the 1972 Order), which is to be construed as a 'macro' or 'target' duty, akin to a general principle (per Lord Hope in *Barnett LBC*, supra.
>
> (b) It is for the authority concerned to make available advice, guidance and assistance to such extent as it considers necessary. This plainly invests the authority with a discretion, to be exercised in accordance with well-established principles.
>
> (c) For the purpose of making available advice, guidance and assistance to such extent as it considers necessary, the authority shall make such arrangements and provide or secure the provision of such facilities as it considers suitable and adequate. This language also clearly confers a discretion on the authority.
>
> (d) Bearing in mind the present context, it is expressly provided that such 'facilities' may include the provision or arranging for the provision of residential or other accommodation.
>
> (e) Once a decision on what the authority considers 'necessary' and/or 'suitable and adequate' has been made, the discretion in play is exhausted. The

> assessment having been made, a duty of provision arises.
>
> This analysis accommodates the proposition that, in making the assessment in each individual case, the authority can properly take into account factors such as available resources, the demands on its budget, the particular circumstances of the individual concerned and their family, including their resources, the availability of facilities and its responsibilities to other members of the population. The ingredients of this proposition are a process of reasoning by analogy with the decision in *Barry* and the well-established principles of public law summarised in *Administrative Law* pp 321-322. Thus, factors of this kind can properly influence the assessment to be made in an individual case. However, when the assessment has been made, I consider that discretion is supplanted by duty. This, in my view, is the effect of the presumptively mandatory 'shall', which contra indicates any suggestion that discretion should prevail from beginning to end. Had the latter been the legislative intention, one would expect to find its expression in the discretionary 'may.'"

[53] It is on this analysis that Mr Lavery rests his case for the applicants. He compares the decisions that the applicants require certain medical treatment as the "assessment stage" which subsequently creates a mandatory duty on the respondents to provide the treatment – the duty of "provision."

[54] Before analysing this argument, I turn to the case of *JR47* [2013] NIQB 7 where McCloskey J, again, was dealing with the responsibilities of the Department and a Trust in relation to resettlement in the community.

[55] In that case the court was again dealing with an alleged breach of Article 15 of the 1972 Order. At para [33] of the judgment McCloskey J says as follows:

> "[33] Moreover, I consider that assessments conducted under Article 15 entail the exercise of a clear measure of discretion and do not occur in a policy vacuum. Statutory provisions such as Article 15 require the adoption of related policies and criteria. This was explicitly recognised by the House of Lords in *R v Gloucester CC, ex parte Barry* [1997] AC 584. See also the recent decision of this court in *Re McClean's Application* [2011] NIQB 19 (Chapter III in particular). Properly analysed, I consider Mr Potter's submission to resolve to the contention that

> irrespective of whether Mr E was assessed at any material time, he has acquired a right to be discharged into a residential setting in the community acceptable to him with minimum delay. In my view, absent a concrete assessment of this kind, no crystallised duty and corresponding right under Article 15 of the 1972 Order arise."

[56] He then goes on to consider the applicants' claim under section 2 of the 2009 Act and at para [34] observes:

> "My first conclusion is that Section 2(3)(c) is couched in heavily qualified terms and confers on the Department a discretion of manifest breadth."

[57] His conclusions on the duties allegedly owed by the Department and Trust in that case are set out in paras [35] and [36] as follows:

> "[35] The specific question is whether Mr E can establish a rights/duties axis on the facts of his case. Where statutory provisions of this kind are concerned, the debate which is frequently stimulated focuses on whether these are so-called 'target' duties. This nomenclature and that of target setting legislation … have become established features of the legal lexicon during recent years. In *R (G) v Barnett LBC* [2004] 2 AC 208, the statutory provision under consideration was Section 17 of the Children Act 1989. Lord Hope observed that one of the central features of target duties is that they are '… concerned with general principles and not designed to confer absolute rights on individuals.'
>
> [36] The three statutory provisions under scrutiny here are couched in manifestly broad, elastic and non-prescriptive terms. I consider that they confer a significant measure of discretion on the Department. In my view, the general principle in play is that statutory provisions of this kind do not create enforceable duties on the part of the public authority concerned. This accommodates the proposition that, <u>in a certain factual matrix</u>, an enforceable statutory duty owed to an individual could conceivably crystallise – an issue which I do not determine here."

Applying the law

[58] In summary, the applicants' case against the Department is as follows. By reason of the delay in providing treatment to each of the applicants it is in breach of its statutory duties under section 2 of the 2009 Act and Article 6 of the 1972 Order as read with Articles 5 and 15B of the 1972 Order. They rely on the authority in the case of *Family Planning Association of Northern Ireland v Minister for Health, Social Services and Public Safety, (SPUCNI) and others intervening* [2015] NI 188 as an authority for the proposition that the relevant statutory duties are reviewable and can be enforced by individuals with a sufficient interest. Relying on the authorities of *Re LW* and *JR47* they say that:

(i) Once an assessment of need has been made, a duty of provision arises;

(ii) That the post assessment duty is to provide the assessed benefit within a reasonable time; and

(iii) That the availability of resources is not a permissible consideration.

[59] In relation to the breaches of duty against the trusts they submit that there has been a breach of Articles 56(1) and 98 of the 1972 Order. In this regard reliance is, again, placed on *Re LW* and *JR47*. Although not expressly raised during the hearing it could be argued that the Trusts are acting as agents for the Department in respect of the Department's obligations under the legislation referred in the paragraphs above. However, it is not necessary to determine this issue for the reasons set out below.

[60] It is beyond doubt that the statutory duties set out in section 2 of the 2009 Act are general duties or, using the language of the authorities, "target duties" in the "macro-economic political field." This is apparent from the drafting of the legislation itself. Section 2 is headed "The Department's general duty." Section 2 is replete with directory language imbuing a high degree of latitude/discretion to the Department. Thus, the Department shall "promote" an integrated system of health care.

[61] It shall "develop policies", "determine priorities and objectives", "allocate financial resources available for health and social care", "formulate the general policy."

[62] Section 2 should also be read with the following sections which are drafted in a similar vein. Thus, under section 3 "the Department may" - … provide health and social care … "as it considers appropriate for the purpose of discharging its duty under section 2" and do anything else "which is calculated to facilitate or is conducive or incidental to the discharge of that duty." Section 4 provides that: "the Department shall determine and may from time to time revise its priorities and

objectives." Under section 4 it must consult such bodies or persons "as it thinks appropriate."

[63] Section 4 also includes phrases such as "where the Department is of the opinion" and "as it thinks appropriate."

[64] In the court's view Article 6 should equally be considered as a general/target duty. Article 6 needs to be read with Article 5 of the 1972 Order which is also drafted in similar terms. Thus, Article 5(1) provides that the ministry shall provide throughout Northern Ireland "to such extents as it considers necessary." The remainder of Article 5 uses language such as "as it considers conducive"; "on such terms and conditions as the ministry may determine"; "may permit"; "on such terms and conditions as the ministry may determine."

[65] In *JR47* [2013] NIQB 7 McCloskey J analyses the nature of the duties created by section 2. (See above.) At para [31] he says:

> "[31] Furthermore, the subject matter of this challenge belongs par excellence to the so-called "macro-economic/macro-political" field. The notorious fact of progressively diminishing state resources surfaces and resurfaces repeatedly in the publications under scrutiny. These disclose that delicate and difficult decisions about the determination of priorities in the allocation of finite resources have had to be made. The merits of Mr E and the other members of his group are undoubtedly strong. The court genuinely sympathises with them. However, regrettably, there exists within society a multiplicity of meritorious individuals and classes – the infirm, the elderly, neglected children and the unemployed, to name but a few. Properly analysed, I consider that the present challenge resolves to a complaint – a genuine one – about how Government has chosen to allocate its limited budget. The difficulties inherent in challenging resource allocation decisions are graphically illustrated in *R v Cambridge Health Authority, ex parte B* [1995] 1 WLR 898, which involved an unsuccessful challenge to a health authority's decision that it would not provide expensive and speculative medical treatment to a girl aged eleven years suffering from acute leukaemia. Sir Thomas Bingham MR stated:
>
> > 'Difficult and agonising judgments have to be made as to how a limited budget is best allocated to the maximum advantage of the maximum number of patients …

> It would be totally unrealistic to require the authority to come to the court with its accounts and seek to demonstrate that if this treatment were provided for B there would be a patient C who would have to go without treatment.'

In Administrative Law (Wade and Forsyth, 10th Edition), the authors observe (p.327):

> 'In these discretionary situations it is more likely to be unlawful to disregard financial considerations than to take account of them.'

> While a complaint of this kind does not per se lie beyond the purview of this court's supervisory jurisdiction, bearing in mind the doctrines and principles in play its nature makes judicial intervention inherently improbable. Given my primary findings and conclusions, no issue of public interest justification arises. However, if it did, I would have concluded that ample public interest justification has been demonstrated. Unfairness amounting to an abuse of power – the applicable legal touchstone – would not have been established."

[66] This analysis amply demonstrates the high threshold faced by any applicant seeking to rely on a breach of section 2 of the 2009 Act in establishing an enforceable statutory duty actionable by an individual. To quote McCloskey J:

> "Bearing in mind the doctrines and principles in play its nature makes judicial intervention inherently improbable."

[67] Recognising this principle, I now turn to the two cases on which the applicants rely to say that this is one of those exceptional cases where an enforceable statutory duty has crystalised. The first is the *Family Planning Association* case. In that case the court was considering an application by an association which provided a service for women faced with unwanted pregnancies. The association applied for judicial review seeking a declaration that the respondent had acted unlawfully in failing to issue advice and/or guidance to women of childbearing age and to clinicians on the availability and provision of termination of pregnancy services.

[68] There the court was dealing with Article 4(a) of the 1972 Order which has since been replaced by section 2 of the 2009 Act.

[69] The court accepted that the duty involved was a "target duty" because it was a general duty expressed in broad terms "leaving the respondent and his Department with a wide measure of latitude over the steps to be taken to perform the duty owed to the relevant section of the public."

[70] At para [40] the court said:

> "Even though a 'target duty' does not give rise to an individual right correlative with the duty, it may be enforced by an applicant with a sufficient interest by way of judicial review."

At para [41] the court observed:

> "[41] I accept the submission on behalf of the respondent that 'target duties' have a degree of elasticity and allow a considerable degree of tolerance to the public authority concerned in determining how the appropriate provisions should be effected, that they are broadly aspirational in their effect and do not easily lend themselves to mandatory enforcement. They require the public authority to aim to make provision but do not regard failure to achieve it without more as a breach and do not confer rights on individuals. The court should be slow to intervene in relation to the adequacy or otherwise of these services."

Following on from this:

> "[42] I accept the respondent's argument that the appellants cannot require the court to compel the respondent to issue guidance under Art 4 but reject it insofar as it may seek, implicitly, to deter the court from making a declaration."

The court concluded:

> "[44] I accept the view that in many cases the appropriate remedy for breach of a target duty may be to indicate to the public body that they should consider what steps they should take to fulfil their target duty, rather than order them to perform a specific act."

[71] Having determined that the relevant association had a "sufficient interest" this is precisely what the court went on to do. Thus, at para [92] the court said:

> "[92] Whilst Art 4 imposes a 'target duty' on the respondent and his Department, this does not mean that there can be no breach of that duty. To take an extreme example, if the respondent does not provide any abortion services it will be in breach of Art 4. To take a very much less extreme example, I have concluded that, for the reasons I have given, the respondent and his Department are in breach of Art 4 by failing to provide their employees, to provide those services with adequate guidance as to the law in Northern Ireland relating to abortion. By this failure they leave them open to prosecution for unlawfully carrying out abortions, although I am mindful that there have been no prosecutions since the passing of the legislation, a point not made by any party to the appeal."

[72] Later in the judgment the court expresses a more diluted version of its conclusion. Thus, at para [115] the court said:

> "… I am not saying that guidelines should be issued. I am saying that the Department ought to investigate whether guidelines should be issued, by consulting the RCOG and the Royal College of Psychiatrists and the medical practitioners, including GPs in Northern Ireland. If it transpires that the latter would not benefit from having them, then there would be no point in issuing them."

[73] One can see that the decision here was based on the specific factual matrix (an important factor identified by McCloskey J in *JR47*).

[74] If one applies the ratio of that decision to the facts here the differences are apparent. This is not a case where either of the respondents is refusing to provide health care. In this case what would be the benefit of a declaration to the effect that the Department or the Trust should "consider what steps they should take to fulfil the target duties under section 2 and the related legislation?" It is abundantly clear that this is exactly what the respondents are doing. From the evidence there have been repeated steps taken in an attempt to fulfil the duty in question. It is clear from that evidence, including the evidence submitted by the respondent and, in particular, the expert report from Professor Heenan that there have been a series of efforts to provide solutions to the issue of waiting lists in this jurisdiction. The question of waiting times has been identified as a major priority by various Ministers for Health and by the Department itself. What is involved in resolving the problem is a matter of contention. It clearly involves high level political decisions in relation to resources and also in relation to structural reform of the health service. Manifestly, that is not a matter for the courts. The court is not dealing here with a

situation as was the case in the *Family Planning Association* where there was a complete absence of the guidance which was at the heart of the challenge. Professor Heenan may properly, along with other commentators and politicians, criticise the efforts to reform the system. She may well be correct in her assessment that this issue is not solely about the allocation of resources, but it seems to me that these are not matters in which the court can productively intervene. Whether the problems that arise in relation to waiting lists in the health service are caused by resource issues or strategic issues, or a combination of both is not something which can be measured by any legal standard. This is not a judgment which the court can make.

[75] The *Family Planning Association* case does support the submission that in certain circumstances a court can intervene when considering target duties. The ability of the courts to do so is reinforced by the decision of McCloskey J in *LW* (see above). Again, the factual context is important. As already set out in *LW* the court was dealing with social care and not health care in the context of a chronically sick and disabled person with an assessed need. That factual difference is significant.

[76] Mr Lavery argues that when the applicants in this case were diagnosed as requiring further treatment (in one case an operation for cataracts and in the other a consultation with a neurologist) applying the analogy in *LW* the "provision" stage is reached and there is an enforceable obligation on the respondents to provide the relevant treatment. In this regard, Mr Lavery argues that resources (as relied upon by the respondents in this case) are not a relevant factor.

[77] It is important to recognise that in both *LW* and *JR47* McCloskey J was dealing with the provision of social care and in the context of a disabled person. There is an important distinction between social care and health care. Thus, if one returns to Article 4 of the 1972 Order it will be seen that the duties imposed on the Department/Trust are separated with (a) dealing with health care and (b) dealing with social care.

[78] Section 2 of the 2009 Act which refers to the Department's "general duty" refers in 2(1)(a) to health care and in (b) to social care.

[79] Thus, when one turns to the amended version of Article 15 of the 1972 Order it will be seen that it only relates to the functions under section 2(1)(b) of the 2009 Act, namely social care. Thus, the target duties in relation to health care which are at issue in this case under 2(1)(a) of the 2009 Act do not have the supplementary or buttressing provisions of Article 15. The provisions of Article 15B of the 1972 Order relate to external contracting. They enable the Board (now the Trusts) to make arrangements rather than imposing duties or obligations.

[80] An analysis of the reasoning in the *LW* case does not support a read across to the circumstances in these cases. In coming to his conclusion that resources could not be taken into account when a duty of provision arises, McCloskey J was able to do so because:

> "This analysis accommodates the proposition that, in making the assessment in each individual case, the authority can properly take into account factors such as available resources, the demands on its budget, the particular circumstances of the individual concerned and their family, including their resources, the availability of facilities and its responsibilities to other members of the population. The ingredients of this proposition are a process of reasoning by analogy with the decision in *Barry* and the well-established principles of public law summarised in Administrative Law pp 321-322."

[81] This cannot be said of the applicants in this case. In *LW* carrying out the assessment of the applicant's need the authority was able to take into account the various factors referred to in the passage above. What the authority was doing was determining what social care arrangements and facilities it considered were necessary and/or suitable and adequate for an individual disabled patient.

[82] That cannot be said of the "assessments" in these applications. The question of when the relevant treatment is to be provided manifestly involves considerations of resources, the demand on its budget, and responsibilities to other members of the population. Those assessments cannot be made when the applicants were first assessed by their general practitioners or when, and if, they are subsequently assessed for further medical treatment. As per *Hanna*:

> "It is important to bear in mind that the respondent Trust has not refused to meet the applicant's assessed needs, it has recognised those needs but has been compelled by the resources available to it to adopt a system which seeks to balance the fulfilment of those needs with the needs of others."

[83] Therefore, it seems to me that the circumstances of this case are well outside the particular factual context in *LW.* It cannot be established that this is an appropriate example of the extreme circumstances when a court can intervene in dealing with the duties under consideration here.

[84] The applicants' case resolve to the issue as to whether there is an absolute/enforceable duty owed to each of them in this case to provide medical treatment within a reasonable time. What is meant by a "reasonable time?" Plainly, the reasonable time will be dependent on resources and other issues. By what measure can the court identify what is meant by a reasonable time? In this regard, the court takes into account the able submissions from Ms Herdman on behalf of the Commissioner for Older People for Northern Ireland to the effect that "a point must come when the provision of medical treatment on the facts of a particular case is so

delayed as to make it ineffective to the point that its provision is in breach of the statutory duties under consideration in this case". Mr Lavery also focuses on the obligations under the statute to provide "effective healthcare."

[85] How can the court determine whether adequate resources or whether a restructuring or reorganisation of the health service is necessary to deal with the unsatisfactory situation regarding waiting lists? Assuming Professor Heenan is correct that what is required to remedy the admitted problem with waiting lists is urgent structural reform and transformation, by what legal measure can this court determine whether the strategies outlined by the respondents meet that requirement? Any interference in this sphere would plainly be impermissible.

[86] The applicants are undoubtedly motivated by, not only their own position, but the general position in relation to waiting lists in this jurisdiction. That is clearly a matter of manifest public concern. A resolution to the issue would be welcomed by all citizens, but particularly those directly involved in the health service including patients and staff alike. It is a matter that needs to be addressed by political leadership and decision making. It will also require, undoubtedly, leadership within the relevant department and Trusts. They are the people to make the necessary decisions, not the courts.

[87] If the court, for example, were either to make a declaration, or award damages as requested by the applicants in this case then that could well lead to multiple similar applications. On what basis could the court distinguish these applicants from other members of the public who are currently on waiting lists for treatment by the health service? To do so would, in my view, not be in the public interest. The finite resources available to the respondents should be devoted to taking the necessary steps to deal with the problem of waiting lists rather than defending expensive litigation in the public law sphere in which the courts are unsuited to make the necessary decisions.

[88] In relation to the Trusts the applicants additionally allege a breach of Article 56(1) of the 1972 Order and in respect of Mrs Kitchen a breach of Article 98 of the 1972 Order.

[89] Dealing briefly with Article 56(1) from its language it is plainly in the form of a target duty. It provides:

> "56.—(1) A Trust shall, <u>to the extent that it considers necessary to meet all reasonable requirements, exercise it powers</u> so as to provide primary medical services, or secure their provision."

[90] Consistent with the analysis in relation to the Department's obligations under section 2 of the 2009 Act and Article 6 as read with Articles 5 and 15 of the 1972

Order it cannot be said that an absolute duty has crystalised in favour of the applicants under this provision.

[91] In relation to Article 98 this is pleaded in relation to the applicant, Mrs Kitchen. Article 98 provides:

> "**Services free of charge**
>
> 98.—(1) The services provided under this Order or the 1991 Order or the Health Services (Primary Care) (Northern Ireland) Order 1997 or the 2009 Act shall be free of charge, except where any provision contained in or made under this Order or the Health Services (Primary Care) (Northern Ireland) Order 1997 or the 2009 Act expressly provides for the making and recovery of charges."

[92] The applicant contends that because of the delay in providing her with an appointment for cataract surgery she was required to pay for private treatment and, thus, the Trust has failed to provide/secure the provision of free medical services, contrary to Article 98 of the 1972 Order. In my view, there is no basis upon which to establish such a breach. Article 98 simply provides that services provided under various legislation shall be free of charge. The fact remains that the cataract operation which was the subject of the waiting list was to be provided free of charge. The applicant's complaint relates to delay and in light of the court's analysis the applicant has failed to establish that an absolute duty on behalf of the Trust or the department has crystalised in her favour.

Article 8 of the ECHR

[93] The applicants contend that the scope of Article 8 ECHR covers the physical and psychological integrity of a person, including aspects of an individual's physical identity, protects the right to personal development and the notion of personal autonomy. Under Article 8(2) any interference with the exercise of this right must be in accordance with the law and be necessary in a democratic society. It is argued that excessive delay in providing medical care may provide grounds for an infringement of Article 8 ECHR. In this regard the applicants rely on the European Commission's opinion in the case of *Passannante v Italy* [1998] 26 EHRR CD 153. That case concerned an applicant who suffered from migraines and had a five-month delay for a neurological appointment in the state system. The Commission held that Article 8 may include positive obligations to ensure effective respect for private life, as well as the negative obligation on the state to refrain from interference. It was the Commission's opinion that where the state has an obligation to provide medical care, an excessive delay of the public health service in providing a medical service to which the patient is entitled and the fact that such delay has, or

is likely to have, a serious impact on the patient's health could raise an issue under Article 8(1).

[94] As a general principle the ECHR case law is consistent with domestic law in that the allocation of resources in this field is generally not justiciable or reviewable.

[95] Thus, in *Lopez de Sousa Fernandes v Portugal* 56080/13 the court held:

> "175. In this connection the Court reiterates that issues such as the allocation of public funds in the area of health care are not a matter on which the Court should take a stand and that it is for the competent authorities of the Contracting States to consider and decide how their limited resources should be allocated, as those authorities are better placed than the Court to evaluate the relevant demands in view of the scarce resources and to take responsibility for the difficult choices which have to be made between worthy needs."

[96] I cannot see that the ECtHR would take a different approach than that of the domestic authorities in this jurisdiction.

[97] It seems to me that the authority of *Passannante* is of limited value.

[98] At its height the Commission held that an excessive delay that causes or is likely to have a serious impact on the patient's health could raise an issue under article 8(1). This was identified as an arguable issue only. The application was deemed inadmissible in that case on the basis that the duty allegedly owed to the applicant was not subject to any time limits and that the applicant could not show that the delay had a serious impact on her physical or psychological conditions.

[99] In respect of the individual applicants there is no evidence before the court in the case of Mrs Kitchen that any alleged delay has had a significant impact on her health.

[100] In the case of Ms Wilson, at its height, a report served on her behalf from Dr Paul, Consultant Psychiatrist, suggests that the applicant's mental health issues are not primarily caused by her waiting on neurological referral. He suggests that any delay is a contributor of less than 25%. He is of the opinion that "it is likely to continue to be a component of stress or worry for her whilst the delay is ongoing." As matters have transpired the neurological assessment at the heart of her application has been provided and the issue has been resolved.

[101] I am not persuaded that article 8 adds anything of substance to the court's analysis of the State's obligation to each of the applicants, or indeed, to the public at large. The State provides a system of health care for the benefit of the public and

devotes significant resources on an ongoing basis to fund that system. It is the subject of a statutory scheme, political scrutiny and oversight. In exceptional circumstances it may be subject to review by the courts.

[102] Any decision that recognised a duty under article 8 ECHR to provide health care within a particular timescale would be a very substantial departure from established authority and not in accordance with the court's analysis of the State's obligations under domestic law.

Conclusion

[103] For these reasons the applications for judicial review are dismissed.