



LEGAL RIGHTS TO HEALTHCARE

13 November 2007

Nigel Giffin QC
11KBW

BACKGROUND NOTES

Nigel Giffin QC practises in a range of public law areas at 11 King's Bench Walk Chambers in the Temple (11KBW). These include health and social care. He has recently acted for the National Institute for Clinical Excellence in the challenge to its guidance on drugs for the treatment of Alzheimer's Disease. He was appointed Queen's Counsel in 2003. He is also a Bencher of the Inner Temple, and a qualified mediator. In 2004-5 he acted as senior counsel to the public inquiry into the death of Zahid Mubarek.

A LEGAL RIGHT TO MEDICAL TREATMENT?

Section 1 of the National Health Service Act 2006 provides as follows:

“The Secretary of State must continue the promotion in England of a comprehensive health service designed to secure improvement –

in the physical and mental health of the people of those countries, and

in the prevention, diagnosis and treatment of illness.

The Secretary of State must for that purpose provide or secure the provision of services in accordance with this Act.”

Section 3(1) of the 2006 Act provides that:

“The Secretary of State must provide throughout England, to such extent as he considers necessary to meet all reasonable requirements –

hospital accommodation;

other accommodation for the purpose of any service provided under this Act;

medical, dental, ophthalmic, nursing and ambulance services;

such other facilities for the care of pregnant women, women who are breastfeeding and young children as he considers are appropriate as part of the health service;

such other services or facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as he considers are appropriate as part of the health service;

such other services as are required for the diagnosis and treatment of illness.”

But these duties are not, in legal terms, absolute ones.

The courts have held that it is legitimate for the Secretary of State to limit NHS resources in the light of government economic policy, and that the NHS has to do the best it can within its allocation of resources: *R v Secretary of State for Social Services ex p. Hincks* (1980) 1 BMLR 93.

The courts will not normally interfere in a decision to allocate scarce resources to one form of treatment or one patient rather than another: *R v Cambridge Health Authority ex p. B* [1995] 1 WLR 898.

That meant, for example, that it was lawful to ration IVF treatment by not offering it to women aged over 35: *R v Sheffield Health Authority ex p. Seale* (1994) 25 BMLR 1.

Contrary to what may sometimes be the public perception, cases in which the courts have overturned refusals to provide treatment are almost never examples of judges saying that the NHS body was not entitled to come to a particular conclusion about resource allocation. They are virtually all cases in which something else has gone wrong with the decision. Thus -

- *R v North West Lancashire Health Authority ex p. A, D and G* [2000] 1 WLR 977 - The health authority's approach to gender reassignment surgery was unlawful because in setting its policy it had failed properly to address the evidence of when such surgery could be of clinical benefit, and because it had applied its policy in a way which did not in truth pay regard to the particular circumstances of individual cases.
- *R v North Derbyshire Health Authority ex p. Fisher* (1998) 1 CCLR 150 - The health authority's policy on the funding of Beta-Interferon

treatment was struck down because, although purporting to follow guidance given by the Secretary of State, which aimed at targeted use of the drug, the reality was that it had imposed a *de facto* bar on such treatment.

- *R (Rogers) v Swindon NHS PCT* [2006] EWCA Civ 392 – The PCT’s policy on the use of Herceptin was irrational, because it purported to reserve it for exceptional cases when there was no sensible reason why one case should be more exceptional than another. Importantly, the PCT in this case disavowed any reliance on financial considerations.
- *R (Otley) v Barking & Dagenham NHS PCT* [2007] EWHC 1927 (Admin) – The refusal of Avastin was struck down on the basis that the relevant panel’s reasoning was flawed.

So the law does not confer a right to any particular form of medical treatment, at least not as such. It does confer a right to have decisions about whether or not to provide treatment taken rationally and by reference to properly relevant considerations.

The Human Rights Act 1998 does not fundamentally change the position. In the *North West Lancashire* case, above, the Court of Appeal was highly dismissive of the idea that either Article 3 (right not to be subjected to inhuman or degrading treatment) or Article 8 (right to respect for private life) of the European Convention on Human Rights could be relied upon to establish a positive right to treatment. A similar argument also received short shrift from Munby J at first instance in *R (Watts) v Bedford Primary Care Trust* [2003] EWHC 2228 (Admin), a case where the elderly claimant was required to wait 7 or 8 months for urgently needed hip replacements.

The caselaw of the European Court of Human Rights in Strasbourg is more willing to countenance the idea that there might in some circumstances be a positive obligation to provide treatment under Article 3 or Article 8 (or, presumably, Article 2 – the right to life): at any rate, the Court has been unwilling to exclude the possibility. But in practice all such complaints have failed, sometimes in cases of little merit, but also in cases in which the complainant could be seen to have endured real suffering. The Court has stressed the wide discretion allowed to national authorities in the allocation of scarce resources. Examples of such cases include *Passannante v Italy* (1998) 26 EHRR CD153, *Scialacqua v Italy* (1998) 26 EHRR CD164, *Nitecki v Poland* (applicn. no. 65653/01, 21 March 2002), *Sentges v Netherlands* (applicn. no. 27677/02, 8 July 2003) and *Pentiacova v Moldova* (2005) 40 EHRR SE23. Note that in *Sentges*, a case about a robotic arm for an electric wheelchair rather than medical treatment as such, an interference with the right to private life was said to be established, but the state's entitlement to set priorities for the allocation of scarce resources nonetheless constituted justification for that interference.

If it can at least be said that the provision or non-provision of medical treatment falls within the scope of one or more Convention rights, then even if it may be very hard to establish a breach of that substantive right, Article 14 of the Convention will be engaged, so that discrimination in relation to such provision “on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status” will be unlawful unless justified.

However, it should be borne in mind that:

- In the recent case of *R (Eisai Ltd.) v NICE* [2007] EWHC 1941 (Admin), Dobbs J was doubtful that the issue of treatment of

Alzheimer's Disease with AChEIs was one that even fell within the scope of Article 8.

- The relatively limited interpretation given to the concept of “status” in recent caselaw indicates that many of the grounds upon which treatment might possibly be withheld could not be brought within the ambit of Article 14. Being a smoker, for example, is almost certainly not a “status”. (Being a disabled person may be another matter, and in such a case the Disability Discrimination Act 1995 will also be in play.)
- The margin of discretion enjoyed by the state in deciding whether a particular form of differential treatment is justified is in any case likely to be considerable.

Note too that the European Court of Human Rights has held that the fact that, in a system of devolved decision-making about the use of resources, a particular benefit may be available to those resident in one locality but not in another, does not amount to discrimination contrary to Article 14: see *Application 10476/83 v Sweden* (1985) 9 EHRR 247.

What is said above about the absence of a legal right to any particular form of treatment must be qualified by reference to the existence of NICE and the directions given by the Secretary of State to PCTs, requiring them so to allocate their budgets as to make funds available to enable technologies approved by NICE to be provided where they are recommended by clinicians as appropriate: see the *Directions to Primary Care Trusts and NHS trusts in England concerning arrangements for the funding of technology appraisal guidance from the National Institute for Clinical Excellence* (July 2003, as amended).

Strictly speaking, these Directions do not confer upon any individual patient a right to the treatment in question. But their effect in substance is that, where a particular treatment falls within NICE guidelines and is clinically recommended in a particular case, it will not be open to the PCT to refuse to fund the treatment on the basis that it does not, as a matter of policy, choose to allocate its resources in that way.

Finally, it should be noted that European Community law may have some impact on entitlement to treatment. It is highly unlikely that there is any EC law right to a particular form of treatment which the NHS chooses not to provide (see the *North West Lancashire*, rejecting discrimination arguments based on Council Directive 79/7/EEC on social security - the Treaty left the provision of public health services to member states). However, under article 22 of Council Regulation 1408/71 a person entitled to health benefits in his home state may be entitled to receive such benefits in another EU state, at the expense of the home state, if the competent home authority authorises him to go there for the purpose. Importantly, article 22(2) provides that in certain limited circumstances such authorisation may not be withheld. This was the main subject-matter of the *Watts* litigation, in which the European Court of Justice gave its decision on 16 May 2006 (case C-372/04). It said that:

“where the treatment in question is among the benefits provided for by the legislation of the [home state] and where he cannot be given such treatment within the time normally necessary for obtaining the treatment in question in the [home state] taking account of his state of health and the probable course of the disease.”

PLACE OF RESIDENCE AND NHS CARE

Commissioning services for the relevant population is generally the responsibility of the PCT in England, and of the NHS Board in Scotland, although some specialist services are centrally commissioned.

If different commissioning bodies may adopt different policies about the allocation of resources to particular treatments, it becomes important to know what governs the identification of the responsible commissioning body for a particular patient.

In England, the key determinant is GP registration, although entitlement to such registration is a function of residence. In Scotland, the key determinant is residence.

The position as it is seen by the Department of Health and by the Scottish Executive is set out in, respectively, *Establishing the Responsible Commissioner* (April 2006 guidance) and NHS HDL(2004)15 *NHS Scotland: Guidance on Establishing the Responsible Commissioner*.

The following summarises in broad terms the effect of the legislation. The legislation also contains a variety of detailed exceptions and qualifications.

In England, relevant functions are conferred on PCTs by r.3 of the *National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) (England) Regulations 2002*.

By r.3(7)(a) PCTs are required to exercise the functions of providing or securing the provision of services to patients for the benefit of:

- The practice patients of persons providing primary medical services in respect of whom they are the relevant PCT;
- Persons who are not, on that basis, the responsibility of another PCT and who are *either* usually resident in its area *or* resident outside the UK but present in its area.

By r.3(7)(b) PCTs are required to provide some services for the benefit of all persons present in their areas – accident and emergency services, walk-in centre services, and certain others.

By r.2(1) a practice patient is a person who is on the list maintained by the PCT of the patients of a person providing primary medical services under Part 1 of the National Health Service Act 1977 (now consolidated into the National Health Service Act 2006), other than an individual who is resident in Scotland.

Lists of practice patients are maintained pursuant to the *National Health Service (General Medical Services Contracts) Regulations 2004*.

The patients to be included on the list are those who have been accepted by the contractor for inclusion in its list of patients under Schedule 6 para 15 to the Regulations, or who have been assigned to the contractor by the PCT: Schedule 6 para 14.

If the contractor's list is open, it may accept an application for inclusion by *any* person, whether or not resident in its practice area: Schedule 6 para 15(1). The practice area is the area specified in the contract as that as respects

which persons who are resident in that area will be entitled to register with the contractor or seek acceptance by the contractor as a temporary resident.

The contractor may only refuse an application for inclusion in its list if it has reasonable grounds for doing so (which may not relate to, amongst other matters, the patient's medical condition): Schedule 6 para 17(1). But the fact that the applicant does not live in the practice area is a reasonable ground for refusal: para 17(2).

Conversely, if the PCT is satisfied that a person on a contractor's list of patients no longer resides in its practice area, it must inform the patient and the contractor that the contractor is no longer obliged to visit and treat the person, and it will remove the patient from the list unless notified that the contractor's agreement to their continued inclusion has been obtained: Schedule 6 para 23.

Schedule 6 para 16 recognises a distinct category of persons accepted by a contractor as temporary residents – that is, people who are temporarily resident away from their normal place of residence and who arrive at the place of temporary residence intending to stay there for more than 24 hours but not more than 3 months. They will be entitled to essential services from the contractor, but will not be on its list of patients with the consequent responsibilities for the PCT which that entails.

So an individual can become the responsibility of a particular PCT by:

- Persuading a GP practice in the PCT's area to accept him onto its list, regardless of whether he lives in its area;

- Living in the practice area of such a practice, when there will normally be an entitlement to be accepted onto its list (if the list is open);
- Being usually resident in the PCT's area.
- Being resident outside the UK but present in the PCT's area.

In Scotland, the *Functions of Health Boards (Scotland) Order 1991* ("the Order") confers on an NHS Board the function of providing for the health care of:

- Persons who reside ordinarily in its area.
- Persons who reside ordinarily outside the UK who are in its area.

Again, accident and emergency and certain other services are to be provided for all persons in the NHS Board's area.

Because ordinary residence is the test of responsibility, the Scottish provisions on choice of GP are of less significance for present purposes. They are contained in the *National Health Service (Choice of Medical Practitioner) (Scotland) Regulations 1998*.

So the key factor in entitlement to medical care in Scotland is ordinary residence. The Order and the guidance treat ordinary residence and usual residence as synonymous.

The Order provides (a.2(2)(a)) that, subject to directions given by the Secretary of State (now the Scottish Executive), if it is unclear where a person ordinarily

resides, he shall be treated as ordinarily residing at the address which he gives to the NHS Board as being that at which he ordinarily resides.

(Note that ordinary residence, in this case ordinary residence in the UK, is also the touchstone of whether a person is entitled to NHS treatment without charge under the *National Health Service (Charges to Overseas Visitors) Regulations 1989* and the *National Health Service (Charges to Overseas Visitors) Regulations 1989*.)

What does ordinary residence mean? There is a good deal of caselaw, from a variety of contexts, concerning terms such as “ordinary residence”, “habitual residence”, “usual residence” and “normal residence”. Generally speaking these different phrases appear to signify much the same thing, but the courts have allowed for the possibility that there may be some nuances of meaning between them (although “ordinary” and “usual” residence do appear to be synonymous). The courts also indicate that the precise meaning borne by such a concept must take its colour from the particular legislative context in which it is used. Nonetheless, the prevailing tenor of the authorities is to suggest that, certainly in relation to “ordinary residence”, the term is taken to have a well-established meaning which does not change greatly according to the specific statute in which it is used.

Lord Scarman in *R v Barnet LBC ex p. Shah* [1983] 2 AC 309 said this:

“ ‘Ordinary residence’ refers to a man’s abode in a particular place or country which he has adopted voluntarily and for settled purposes as part of the regular order of his life for the time being, whether of short or of long duration.”

Note that in *Shah*:

- (i) It was expressly recognised that it is possible to be ordinarily resident in two countries at the same time;
- (ii) The claimants were entitled to say (under the legislation on mandatory student awards as it then stood) that they had 3 years' ordinary residence in the UK for the purposes of qualifying for such awards, even though it was only for the purpose of pursuing their studies that they had entered the UK, and their leave to remain was limited accordingly;
- (iii) Lord Scarman explained that the "settled purpose" to which he referred might be either general or specific, and could be for a limited period. It just needed to have a sufficient degree of continuity for it to be properly described as settled. He gave a number of what he described as common reasons for such a settled choice of residence, which included not only education, employment, family and love of the place concerned, but also health.

Ordinary residence can in principle be changed in a day, if the person concerned intends to make his home in the new place for an indefinite period: *Nessa v Chief Adjudication Officer* [1999] 1 WLR 1937. But in that case it was held that before a person could become habitually resident in a place, at least for the purposes of the income support legislation, it was necessary for him to have taken up residence in the place in question and lived there for an appreciable, albeit possibly brief period – a sufficient period to demonstrate that the residence had become and was likely to continue to be habitual. How long that might be would depend on factors such as whether the individual arrived along with possessions, whether he had taken steps to establish residence before arriving, whether he had a legal right of abode, and whether

he was to be joined by his family or could show other durable ties with the place.

In *Mohammed v Hammersmith & Fulham LBC* [2002] 1 AC 547 the House of Lords accepted that the location of a person's interim accommodation under the homelessness could be his normal residence. Although the precise context might matter, the *prima facie* meaning of normal residence was the place where at the relevant time the person in fact resided, in the sense of being the place where he voluntarily ate and slept.

It seems likely that the *Shah* approach should be applied to the Scottish legislation governing the responsibility of NHS Boards. If that is right, it follows that:

- An individual who chose to move house permanently could certainly effect a change of ordinary residence to Scotland with immediate or almost immediate effect.
- An individual could establish ordinary residence in Scotland even if he or only intended to remain there for a limited period, provided that he had a settled purpose in doing so.
- An individual who has the resources genuinely to maintain two homes may even be able to acquire ordinary residence in Scotland without ceasing to be ordinarily resident in England. Interestingly, the legislation then appears to work in such a way as to make him the responsibility of the Scottish commissioning body.

The fact that both the English and Scottish legislation treats an intended period of 3 months' residence as the litmus test of temporary residence may

indicate that a sojourn intended to last no more than that should not rank as ordinary residence in this particular context. But even if that is right, it does not follow that, where there is an intention to remain for a longer period than that, it takes 3 months to become ordinarily resident. Even if the *Nessa* requirement of an appreciable period is applicable, that could be much less than 3 months, especially if the badges of permanence are there from the outset.

An interesting question is whether an individual could be said to be ordinarily resident in Scotland if there solely for the purpose of receiving a course of medical treatment which he would not receive in England, and therefore with the avowed intention of leaving Scotland at the conclusion of the treatment. On the logic of Lord Scarman in *Shah*, it is difficult to see why not, provided his presence was reasonably continuous and the duration of the treatment likely to be appreciable. However, a similar argument in the context of charges to overseas visitors was rejected in a somewhat thinly reasoned judgment in *R v Hammersmith Hospitals NHS Trust ex p. Raffell* [2000] EWHC Admin 363.