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Why are we waiting? Judicial scrutiny of delays in access to healthcare in Northern Ireland

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INTRODUCTION

The waiting list is a familiar and long-standing feature of the delivery of publicly funded healthcare in the UK, but in the wake of the Covid pandemic it has become especially prevalent. A record 7.8 million people were awaiting hospital treatment in England in September 2023,[1] with the 18-week target for treatment established in the National Health Service (NHS) Constitution for England not having been met since 2016.[2]

The problem is especially acute in Northern Ireland, which has the longest waiting times of any nation in the UK. The equivalent of more than one quarter (26.3 per cent) of the population was on a waiting list for treatment and care as of March 2023, as distinct from 12.4 per cent in England and 24 per cent in Wales.[3] Waiting time targets for elective care have not been met since 2013–2014.[4] The Department of Health has estimated that an additional £707.5 million would be required to meet modest waiting time targets set in 2021 of 52 weeks for a first outpatient appointment/inpatient treatment and 26 weeks for a diagnostic test by 2026,[5] but has already conceded that these cannot be achieved.[6]

The waiting list can be a positive experience for the patient, since it offers 'hope and a plan for treatment',[7] hence 'to be on a waiting

1 C Baker, *NHS Key Statistics: England, November 2022*, HC Lib 07281 (17 November 2022) 4.

2 Ibid. See Department of Health and Social Care, *Handbook to the NHS Constitution for England* (updated 1 October 2023).

3 Northern Ireland Audit Office, *Tackling Waiting Lists: Report from the Comptroller and Auditor General* (NIAO 2023) 8.

4 Ibid. The targets are set out at [1.2].

5 Ibid [5.5].

6 Ibid [5.12].

7 R Tudor Edwards and J Davies, 'My planned care, your planned care and our planned care in the NHS' (Centre for Health Economics and Medicines Evaluation, Bangor University 10 May 2022).

list is to be betwixt and between; to be accepted as a suitable case for treatment, even if the prospect of that treatment being delivered may be distant or absent'.[8] But, of course, lengthy wait times for treatment are not acceptable to all. They can have a negative impact upon the health gain which may be derived from the treatment,[9] a deleterious effect on mental health,[10] and reduce levels of patient satisfaction with health services.[11] Furthermore, they may have an impact on the collective activity of allocating scarce resources efficiently to publicly funded care. As the Northern Ireland Audit Office (NIAO) has observed, long waits mean that 'significantly increasing numbers of patients risk developing serious conditions and illnesses which damage their daily lives, and which ultimately become much more complex and expensive to treat, [and this] represents extremely poor value for money'.[12]

Waiting times thus represent a 'divisive and contentious' issue in the contemporary welfare state[13] and would seem to be an obvious target for challenge by those who are adversely affected by them. Judicial review represents a potential mechanism by means of which controversies of this type may be addressed and might be thought to be of particular value where political avenues for complaint are less accessible, as has recently been the case in Northern Ireland during the suspension of the Stormont Assembly.

This commentary considers a recent legal challenge in the High Court and Court of Appeal in Northern Ireland to lengthy waiting times in the Northern Irish health service. It will analyse the judicial response to this familiar but persistent problem of public policy and will seek to locate this within the broader, but arguably distinct, context of an evolving jurisprudence on denial of access to healthcare treatments and services.

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8 S Frankel and R West, 'What is to be done?' in S Frankel and R West (eds), *Rationing and Rationality in the National Health Service: The Persistence of Waiting Lists* (Macmillan 1993) 115, 125.

9 See S Nikolova, M Harrison and M Sutton, 'The impact of waiting time on health gains from surgery: evidence from a national patient-reported outcome dataset' (2016) 25 Health Economics 955–968.

10 See A Gagliardi et al, 'The psychological burden of waiting for procedures and patient-centred strategies that could support the mental health of wait-listed patients and caregivers during the COVID-19 pandemic: a scoping review' (2021) 24 Health Expectations 978–990, especially at 981–982.

11 See C Bleustein, 'Wait times, patient satisfaction scores, and the perception of care' (2014) 20 American Journal of Managed Care 393–400.

12 NIAO (n 3 above) 18.

13 *Wilson and Kitchen v Department of Health for Northern Ireland and Others* [2023] NICA 54, [79] (McCloskey LJ).

THE FACTS

The first applicant, Eileen Wilson, was referred to a neurology service in June 2017 by her general practitioner because of suspected multiple sclerosis, her case therefore being classified as urgent. This was later modified to 'routine' by the attending consultant. Having been advised that the waiting list for neurology appointments was 163 weeks, an appointment was scheduled for March 2020, but this was cancelled due to the pandemic. A virtual appointment took place in March 2022 and MRI scans were undertaken in May of that year, but these showed nothing out of the ordinary, and her symptoms were managed as those of fibromyalgia. The Court of Appeal noted that 'no detriment to this appellant's health in consequence of the timeline under consideration has been established'.[14]

The second applicant, Eileen May Kitchen, had been diagnosed with cataracts, and referred to an ophthalmology service for an operation in July 2019. She was told that this would not take place for three to four years. In the event, she was offered an outpatient appointment within the 42-month waiting period for such appointments, but was informed that there was still a further wait time of between 15 and 17 months for an operation. Concerned that she might lose her sight altogether, she sought private care and was offered an appointment within six weeks.

THE HIGH COURT DECISION[15]

At first instance, the cases rested upon claims of breach of statutory duty and interference with rights under article 8 of the European Convention on Human Rights. The latter argument was readily dismissed, Colton J noting that the Strasbourg organs regarded matters relating to the allocation of resources as 'generally not justiciable or reviewable',[16] hence judicial recognition of a duty triggered by article 8 to provide healthcare within a particular timeframe 'would be a very substantial departure from established authority'.[17]

The court engaged in much more comprehensive analysis of the claim that there had been a breach of the general duties of the Department of Health in relation to the provision of healthcare imposed by section 2 of the Health and Social Care (Reform) Act (Northern Ireland) 2009, and the predecessor provisions contained in the Health and Personal Social Services (Northern Ireland) Order 1972.[18] These duties are

14 Ibid [57].

15 *Wilson's and Another's Application* [2023] NIKB 2.

16 Ibid [94].

17 Ibid [102].

18 Health and Personal Social Services (Northern Ireland) Order 1972 No 1265 (NI 14).

phrased in very broad terms, such as the obligation to 'promote … an integrated system of healthcare',[19] and they admit of significant discretion, as manifested in wording such as 'to such extent as it considers necessary',[20] and 'on such terms and conditions as the ministry may determine'.[21] Nonetheless, it was contended on behalf of the applicants that, once they had been assessed as having a clinical need, a duty to provide them with healthcare within a reasonable time crystallised, and that this was not subject to the availability of resources.

This argument was rejected by the court. Construing the statutory provisions as amounting to 'target duties' of a macro-economic or macro-political nature,[22] Colton J endorsed the view of McCloskey J in *JR47* – which was also concerned with section 2 of the 2009 Act – that judicial intervention was 'inherently improbable' in a case of this type.[23] Of course, this admitted of the *possibility* that review could succeed, and the applicants pointed to two cases, *Family Planning Association of Northern Ireland v Minister for Health, Social Services and Public Safety*[24] and *Re LW's Application for Judicial Review*,[25] in support of the argument that an enforceable duty existed.

However, these cases were distinguished. In the first, there had been a complete failure to comply with the duty at all, whereas in this instance there had 'been repeated steps taken in an attempt to fulfil the duty in question'.[26] The second case related to social care provision: in this context it was accepted that availability of resources could be considered in the initial assessment of individual need, but once that need had been established, an enforceable duty of provision arose which was not resource-dependent.[27] By contrast, in the healthcare setting, a body's decision of when to treat 'manifestly involve[d] considerations of resources, the demand on its budget, and responsibilities to other members of the population' which could not be fully assessed when the clinical need was first identified by (for example) a general practitioner.[28]

19 Health and Social Care (Reform) Act (Northern Ireland) 2009, s 2(1)(a).
20 Health and Personal Social Services (NI) Order 1972 (n 18 above) art 5(1).
21 Ibid art 5(3).
22 *Wilson's and Another's Application* (n 15 above) [60], [64].
23 *JR47* [2013] NIQB 7, [31].
24 [2015] NI 188.
25 [2010] NIQB 62.
26 *Wilson's and Another's Application* (n 15 above) [74].
27 *Cf R v Gloucester CC, ex parte Barry* [1997] AC 584.
28 *Wilson's and Another's Application* (n 15 above) [82].

On this basis, there had been no breach of duty by the Department, and a similar argument advanced in relation to the exercise of powers by the respective Trusts was also rejected.

THE COURT OF APPEAL DECISION[29]

The 'centre piece of the appeals' was article 5(1)(c) of the 1972 Order,[30] the question being whether government had failed to comply with an enforceable duty to 'provide throughout Northern Ireland, to such extent as it considers necessary ... medical, nursing and other services'. The argument was quite briskly dismissed. The court held that any obligation which existed by virtue of article 5(1)(c) should be discharged within a reasonable time,[31] but did not consider that the facts in either case established a breach of any such duty. Moreover, McCloskey LJ, on behalf of the court, noted that the article related to 'the exercise of discretionary powers couched in manifestly elastic terms'.[32] Reiterating the stance of the 'inherent improbability' of judicial intervention which he had articulated in *JR47*,[33] the judge sought to 'highlight ... the limitations on the competence of a court seized of isolated legal challenges of this kind'.[34]

Other arguments advanced by the appellants,[35] relating to the possibility of granting declaratory relief even in situations where duties were of a 'target' nature; that (in the case of Mrs Kitchen, who had received private treatment) services were not provided free of charge; and that there was a violation of article 8 of the European Convention on Human Rights due to the impact that the delays had on health, were accorded little weight by the court.

WAITING LISTS AS A DIMENSION OF RATIONING HEALTHCARE

It is important to comprehend that the waiting list fulfils a function as a means of rationing of scarce healthcare resources. In the useful typology adopted by Klein and Maybin, this is 'rationing by delay: the traditional form of rationing in the NHS, designed to control access to

29 See *Wilson and Kitchen* (n 13 above).
30 Ibid [13].
31 Ibid [54].
32 Ibid [64].
33 See *JR47* (n 23 above).
34 See *Wilson and Kitchen* (n 13 above) [75].
35 Ibid [65]–[74].

the system and match demand to supply by making patients wait'.[36] The mechanism is explained in more detail by Siciliani:

> A major difference between a national health service and a more conventional market is that demand is not price rationed: when health care is free of charge and supply is constrained, part of the demand remains untreated and the formation of a waiting list occurs. A different rationing system arises and waiting times deter patients from seeking treatment in the public sector. The longer the waiting time, the more patients will seek treatment in the private sector or will seek no treatment. The value of the treatment may reduce with time because of the foregone expected benefit, temporary discomfort and pain, and, for some pathologies, the higher risk of a permanent reduction in health status.[37]

Yet, while 'the phenomenon of the waiting list is one of the most visible symptoms of scarcity of resources in healthcare',[38] it has not been the primary focus of litigation on allocative questions in the UK. Although there are exceptions,[39] the majority of judicial review cases have concerned 'rationing by denial', that is situations where 'specific forms of intervention are excluded from the NHS services on offer, on the grounds of lack of effectiveness, high cost or a combination of the two'.[40]

However, when wait times are excessive, the distinction between delay and denial of access to care becomes blurred. As ten Have explains, what might otherwise seem ethically acceptable as a rational and equitable instrument for the selection of patients and the distribution of scarce resources basis suffers from 'breakdown' once the wait becomes too lengthy:

> Waiting lists have a critical length. If patients have to wait too long, they feel that they can no longer expect to be treated within a reasonable

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36 R Klein and J Maybin, *Thinking About Rationing* (King's Fund 2012) 4. The umbrella term 'NHS' is used here to refer to publicly funded health services in the UK, including those falling under Health and Social Care in Northern Ireland. In the High Court (n 15 above) [1], Colton J observes that the health service in Northern Ireland is 'not technically part of the NHS', but that it nonetheless subscribes to the same three core principles of universality, being free at the point of use, and based on clinical need rather than ability to pay.

37 L Siciliani, 'Does more choice reduce waiting times?' (2005) 14 Health Economics 17, 17.

38 H ten Have, 'Choices in health care: waiting list, rationing and priorities' in H ten Have and B Gordijn (eds), *Bioethics in a European Perspective* (Springer 2001) 219.

39 See eg *R v Central Birmingham Health Authority, ex parte Collier* [1988] WLUK 690: repeated delays to cardiac surgery on a child; *R (Watts) v Bedford Primary Care Trust* [2003] EWHC 2228 (Admin): reimbursement for cost of a hip operation carried out in EU because of long waiting lists on the NHS.

40 Klein and Maybin (n 36 above) 4.

> period of time. In these circumstances waiting is equivalent to endless postponement of treatment or admission to a healthcare institution. Waiting is without perspective of help. The very harm that is planned to be prevented or eliminated in the foreseeable future because of appropriate treatment or care within an institution, will probably occur during a long waiting period…When the waiting time for a healthcare facility exceeds a critical limit, it cannot be argued any more that the waiting list helps to distribute fairly the scarce resources available. In fact, we have a situation where care and treatment are irresponsibly delayed or not provided at all to particular categories of patients… Waiting for many people has become equivalent to not being treated or cared for; waiting implies that some patients have to live with significant disability and suffering without reasonable prospect of relief. Waiting in fact implies that the healthcare system has become inaccessible.[41]

In circumstances such as this, a 'legitimacy problem' arises which is comparable in nature to the more frequently litigated cases of rationing by denial.[42] This transpires as those who are unable to access the treatment for which they have a clinical need manifest 'suspicion, distrust and even resistance' towards the authority of the allocative decision-maker.[43] As argued elsewhere,[44] the courts are both an obvious vehicle for articulation of such grievances and appear, at least in principle, to possess the capacity to assist in redressing this problem. They can do so by ensuring that allocative decision-makers comply with tenets of procedural justice which can serve to enhance public understanding and acceptance of the inevitably difficult choices inherent in the allocation of scarce healthcare resources, even in situations where the patient ultimately loses out. Much of the English and Welsh jurisprudence subsequent to the *Child B* decision in 1995 can be understood in this light.[45]

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41 ten Have (n 38 above) 225–226.

42 For discussion, see K Syrett, 'NICE work? Rationing, review and the "legitimacy problem" in the new NHS' (2002) 10 Medical Law Review 1; K Syrett, *Law, Legitimacy and the Rationing of Healthcare: A Contextual and Comparative Perspective* (Cambridge University Press 2007). The concept is originally drawn from N Daniels and J Sabin, 'Limits to healthcare: fair procedures, democratic deliberation and the legitimacy problem for insurers' (1997) 26 Philosophy and Public Affairs 303.

43 N Daniels, 'Accountability for reasonableness in private and public health insurance' in A Coulter and C Ham (eds), *The Global Challenge of Health Care Rationing* (Open University Press 2000) 89, 90.

44 Syrett (2007) (n 42 above).

45 *R v Cambridge Health Authority, ex parte B* [1995] 1 WLR 898. For discussion, see D Wang, 'From *Wednesbury* unreasonableness to accountability for reasonableness' (2017) 76 Cambridge Law Journal 642.

A RESTRAINED JUDICIAL APPROACH

The *Wilson and Kitchen* case demonstrates a quite different judicial approach to situations in which patients have been unable to access treatments for which they have a clinical need. The focus of both courts was upon the question of whether the delays *per se* were lawful. There was accordingly the potential for the judges to be drawn much closer into an analysis of whether decisions to prioritise certain patients over others were permissible.

Review of this type is inherently more problematic than review of procedure given its potential to second-guess the decision-maker and thus to interfere with the separation of powers. Courts therefore rightly show a degree of reticence in such cases. However, as Newdick has observed,[46] judges in England and Wales have nonetheless shown increasing willingness to undertake 'hard look' scrutiny in certain instances of allocative decision-making, for example in cases in which they have identified misunderstandings or mistakes of fact in relation to the interpretation of the evidence of clinical efficacy or cost-effectiveness upon which decisions on access to particular treatments are premised.[47] While acknowledging that such precedent is not binding in Northern Ireland, it is not, therefore, inevitable that there will be a refusal to intervene in cases of this type.

However, this case is characterised by a highly restrained stance on the part of the judiciary that is more reminiscent of the pre-*Child B* period of 'judicial passivity' than the subsequent 'hard look' mode of scrutiny.[48] Designation of the relevant statutory duties as 'target duties' affords justification for judicial reticence to intervene, since such duties are 'aspirational in nature' and 'the standards to be achieved by the public authority and the manner in which it achieves them are essentially matters for each public authority's discretion'.[49]

This application of legal principle to the facts is reinforced by expression of lack of judicial competence to adjudicate upon delays in offering treatment, a matter which is stated to be subject to 'less intrusive or "soft edged"' supervision.[50] In the High Court, Colton J pointed out that, while the delays inevitably had impacts upon particular individuals, their causes, and the means to remedy them, were situated elsewhere:

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46 C Newdick, *Who Should We Treat? Rights, Resources and Rationing in the NHS* 2nd edn (Oxford University Press 2005) 100–107.

47 See eg *R (Ross) v West Sussex Primary Care Trust* [2008] EWHC 2252 (Admin); *Servier Laboratories Ltd v NICE* [2010] EWCA Civ 346; *R(SB) v NHS England* [2017] EWHC 2000 (Admin).

48 See Newdick (n 46 above) 98–100.

49 C Callaghan, 'What is a "target duty"?' (2000) 5 Judicial Review 184, 184, 185.

50 *Wilson's and Another's Application* (n 15 above) [44].

> What is involved in resolving the problem [of long waiting lists] 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 ... 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.[51]

> 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[52] 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.[53]

A similar view was taken in the Court of Appeal. McCloskey LJ opined that:

> The forum for debate, inquiry, investigation and proposals for improvement and resolution of the issues raised in these proceedings – fundamentally, the single issue of hospital waiting lists in Northern Ireland and its offshoots – belongs to government Ministers, politicians, economists, sociologists, doctors, academics and doubtless other experts and many interested persons and agencies. The subject is one of much controversy and obviously broad and substantial dimensions. It is manifestly inappropriate for judicial intervention.[54]

ARE WAITING LISTS DIFFERENT?

The adoption of a highly deferential judicial stance at both levels in this case raises the question of whether a distinction can be drawn between challenges based upon delays in accessing treatment, and those in which treatment is denied: in which, as indicated previously, judges have shown increasing willingness to intervene, albeit largely on procedural grounds.

The most obvious response to this is to observe that delay and denial are distinctive phenomena: the latter is a definitive decision (albeit, not necessarily irreversible), whereas in the former case, there remains a possibility that discretion will (eventually) be exercised in

51 Ibid [74].

52 Professor of Social Policy, Ulster University and author of a report dated 3 January 2022 which was relied upon in evidence by the applicants.

53 *Wilson's and Another's Application* (n 15 above) [85].

54 *Wilson and Kitchen* (n 13 above) [78].

favour of the aggrieved individual. The differentiation is reflected in the fact that delay is not a free-standing ground on which relief in judicial review proceedings can be awarded, albeit that it may amount to breach of a statutory duty.[55] In these circumstances, a court is likely to be extremely reticent to intrude upon a situation which, ostensibly, remains ongoing. However, this may well not reflect the patient's perception of the situation, As noted by ten Have,[56] delay eventually becomes so excessive that it equates, for practical purposes, to non-accessibility.

Relatedly, it is plausible that the judges in this case did not (or chose not to) construe lengthy waiting times as instances of rationing at all. Instead, they may simply have been viewed as an inevitable concomitant of publicly funded healthcare.[57] As New and LeGrand observe, 'after all, queuing is something we do when we wait for a bus, or when we wait at a supermarket checkout, and so would not suggest that there was any fundamental mismatch between demand and supply'.[58] This connects to a deeper understanding of the nature of the health system and the values that underpin it. As a form of queuing, the waiting list can be seen as an inherently communal phenomenon: 'it is a site where people who are total strangers follow an unspoken script for collective behaviour that respects priority and produces an orderly outcome'.[59] As such, it may be seen as a reflection of the solidaristic nature of publicly funded health services in the UK. Judicial intervention which, in effect, permitted individual patients to 'jump the queue' would therefore strike at the heart of the founding principles of the NHS. Even more broadly, it would represent a challenge to a fundamental aspect of collective identity given the centrality of the NHS to the political psyche, coupled with the fact that 'norms against line jumping are so strongly felt that people frequently regard no cutting as a point of national pride'.[60]

The construction of waiting lists as an innate feature of a publicly funded health system points also towards the inherently political

55 See S Lambert and A Strugo, 'Delay as a ground of review' (2005) 10 Judicial Review 253. For discussion of a possible duty relating to wait times in the NHS in England, see *R (AA and Others) v NHS Commissioning Board* [2023] EWHC 43 (Admin), [2023] EWCA Civ 902.

56 ten Have (n 38 above) and accompanying text.

57 Especially as they have existed since the inception of the NHS: around 460,000 people were on the waiting list as inpatients on 5 July 1948: see A Harrison and J Appleby, *The War on Waiting for Hospital Treatment* (King's Fund 2005) 1.

58 B New and J LeGrand, *Rationing in the NHS: Principles and Pragmatism* (King's Fund 1996) 23.

59 D Fagundes, 'The social norms of waiting in line' (2017) 42 Law and Social Inquiry 1179, 1194–1195.

60 Ibid 1182.

character of this form of rationing of healthcare, which is stressed by both judges.[61] Further, as they note, there are multiple drivers of lengthy delays in health systems. In the Northern Ireland context these range from patient non-attendance and cancellations, to the redirection of staff and other resources to manage the pressures arising from the pandemic, to reductions in non-recurrent funding to address waiting lists through provision of extra capacity or use of the independent sector.[62] The 'multifaceted and polycentric nature of the issues at play'[63] in respect of lengthy wait times render these matters which 'fall within the macro-economic/macro-political field',[64] and are thus 'par excellence, unsuitable for assessment in a judicial forum'.[65] This stands in contradistinction to 'micro-level' instances of denial of care,[66] which, while impacted by the scarcity of resources, generally turn on considerations of clinical efficacy and cost-effectiveness in relation to the particular circumstances of an individual patient, upon which judges consider themselves more competent to adjudicate.[67]

TOWARDS A LIMITED JUDICIAL ROLE IN CASES OF DELAY?

If, as this case suggests, challenges to delays in treatment afford an exception to the general trend of greater judicial reviewability of allocative decision-making in healthcare which has evolved over the past three decades or so, the matter is of some practical importance to aggrieved patients. Since 'waiting lists are the predominant rationing mechanism for the allocation of non-urgent health care services under the ... NHS',[68] and in light of the continuing pressure on services following the pandemic, delays are matters of ongoing and significant public controversy. This is especially the case in Northern Ireland,

61 See nn 51 and 54 above and accompanying text.

62 See NIAO (n 3 above).

63 See *Wilson and Kitchen* (n 13 above) [77].

64 See *Wilson's and Another's Application* (n 15 above) [44].

65 See *Wilson and Kitchen* (n 13 above) [79].

66 For discussion of the various 'levels' at which rationing takes place, see K Syrett, 'Fairness, accountability and legitimacy: law's role in micro-level rationing' in M Danis et al (eds), *Fair Resource Allocation and Rationing at the Bedside* (Oxford University Press 2014).

67 Although note that judicial intervention in cases of this type may also be controversial. For discussion, see K Syrett, 'Into the matrix and beyond: seeking an understanding of problem priority-setting cases in English courts' (2024) 75 Northern Ireland Legal Quarterly (forthcoming).

68 R Tudor Edwards and J Barlow, 'Rationing health care by waiting list: an extra-welfarist perspective' (Centre for Health Economics, University of York, Discussion Paper 114 1994) 1.

not only because wait times are lengthier than elsewhere in the UK, but also because the periodical suspension of devolved government renders the prospect of addressing this policy problem through the political process – as the judges here suggest – more remote.[69]

However, it is not simply the length of waits which is problematic. A recent report from the Northern Ireland Public Services Ombudsman (NIPSO) concludes that there is systematic maladministration in relation to the communications provided to patients and/or their carers following placement on a waiting list.[70] The report notes that 'the focus of waiting list processes has moved away from being patient centred. Instead, patients are too often provided with little to no communication on the progress of a fundamental aspect of their lives, leaving them to feel forgotten.'[71]

Although the recommendations contained in the report may, if implemented, result in improvements in time,[72] pressure through the judicial review process might have provided an additional impetus for definitive action to be taken, and sooner, on this failing within the Northern Irish health system. This need not entail the type of overreach of which the judges in this case appear fearful since, as noted above, procedural review is now an accepted dimension of litigation on healthcare resource allocation in England and Wales. A key element of this form of review (albeit, as previously discussed, not articulated mainly in the context of waiting times) has been judicial enforcement of 'duties of transparency' on the part of allocative decision-makers.[73] This would assist in addressing the problem of the lack of openness in waiting list communications identified by the Ombudsman.[74]

Wilson and Kitchen was not directly concerned with the issue of communication regarding wait times. Nonetheless, the highly deferential judicial stance adopted here, which echoes the 'passive'

69 The solicitor to the two applicants was quoted as saying 'Even if we had a functioning Executive, the issue of our growing hospital waiting lists has been prevalent for almost two decades. Citizens have no option but to turn to our courts when the other limbs of our government have failed.' See A Erwin, 'Two Belfast women appeal verdict in legal challenge over NI's "catastrophic" hospital waiting lists' *Belfast Telegraph* (Belfast 12 September 2023).

70 Northern Ireland Public Services Ombudsman, *Forgotten* (NIPSO 2023).

71 Ibid 5.

72 These include use of text messages and standard acknowledgment templates, updating after six months' wait, provision of additional information to general practitioners, updating of websites and provision of information on fundamental issues with services: see ibid, passim.

73 Wang (n 45 above) 667.

74 NIPSO (n 70 above) 9.

early English case law,[75] gives little cause for optimism that Northern Irish judges might be prepared to engage even in a limited procedural form of scrutiny of delays in access to healthcare. In view of the capacity of courts to enhance understanding and acceptance of decisions to restrict access to healthcare resources through their enforcement of fair process,[76] this is regrettable. Rather, it would appear that the wait for amelioration, let alone resolution, of this thorny policy problem in Northern Ireland is set to continue.

75 Newdick (n 46 above). An example is *Collier* (n 39 above), in which Ralph Gibson LJ observed that 'If I were the father of this child, I think that I would want to be given answers about the supply to, and use of, funds by this health authority', but nonetheless held that 'The court by this application is being asked to conduct an investigation which it has no power to conduct.'

76 See further Syrett (2007) (n 42 above), Wang (n 45 above).