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Into the matrix and beyond: seeking an understanding of problem priority-setting cases in the English courts

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ABSTRACT

Drawing upon and developing Chris Newdick's work on legal regulation of resource allocation in healthcare, this article analyses a series of problematic judicial review cases in the English courts in which judges appear to move away from scrutiny of procedure towards a form of review that is much more substantive in nature. The 'priority-setting rights matrix', which Newdick developed in later work, enables us to distinguish these cases from others, calling into question the claim that the jurisprudence in this field has evolved in a linear fashion. However, while the matrix has considerable value as a classificatory tool, it requires supplementation if we are to understand why judges respond differently in distinct scenarios. To this end, the article explores potential reasons for judicial preference for individual interests over collective priority-setting goals, which may explain the shift away from procedural review which characterises these cases.

Keywords: judicial review; priority-setting; procedural and substantive review; identifiability; rights.

INTRODUCTION

Chris Newdick's work on the legal regulation of healthcare resource allocation was truly pioneering. In *Who Should We Treat?*, first published in 1995,[1] he set out to explore an issue which had previously attracted virtually no attention from scholars working in the then still nascent field of medical law,[2] namely how the legal relationship between physician and patient was shaped and constrained by the organisational context in which healthcare was delivered, and particularly by the seemingly inevitable fact of scarcity of resources. The timing of the monograph was propitious, as this issue was just beginning to attract broader public attention.

1 C Newdick, *Who Should We Treat? Law, Patients and Resources in the NHS* (Clarendon Press 1995).

2 The work of Diane Longley affords a partial exception: see eg D Longley, *Public Law and Health Service Accountability* (Open University Press 1993).

This was so for two reasons. First, the creation of the so-called 'internal market' in the National Health Service (NHS) as an element of neoliberal policy during the early 1990s had visibly exposed limitations to the purportedly comprehensive coverage of the NHS, as purchasing health authorities sought, for reasons of cost, to restrict the 'menu' of services and treatments available to the population for whose health they were statutorily responsible.[3] This gave rise, in turn, to concerns as to geographical inequities in access ('postcode prescribing') which, later in the decade and under a different colour of government, prompted the establishment of the body which was originally styled the National Institute for Clinical Excellence (NICE). Secondly, the decision in *R v Cambridge Health Authority, ex parte B* – remarkable in itself for the fact that the first instance and appeal court had ruled on the same day[4] – demonstrated that courts were highly likely to become drawn into questions of allocation of scarce healthcare resources.[5] This was particularly the case as scientific advances raised the prospect of successful treatment in previously hopeless situations, but at significant cost to the public purse, necessitating some mechanism for resolution of competing individual and collective claims to limited resources.

In the almost three decades which have elapsed since then, the judicial review of allocative decisions has become a familiar, albeit still not commonplace, feature of regulation of the NHS. In turn, this has engendered a minor cottage industry of academic analysis, with scholars offering various readings of the evolving role for the courts in this field. This article contributes further to this debate by making use of a model developed in Newdick's later work, the 'priority-setting rights matrix',[6] to seek to explain certain more problematic English judicial review cases in which the courts have seemingly strained at the very limits of judicial competence. It will be argued that the matrix can be of considerable assistance in building understanding of *how* these cases can be differentiated from other decisions in this particular

3 See L Locock, 'The changing nature of rationing in the UK national health service' (2000) 78 Public Administration 91–109.

4 *R v Cambridge Health Authority, ex parte B* [1995] I FLR 1055 (QBD); [1995] EWCA Civ 49.

5 This was not the first such judicial consideration of resource allocation in the NHS; that had occurred in 1980 in *R v Secretary of State for Social Services, ex parte Hincks* (1992) 1 BMLR 93. However, the *Child B* case was the first to attract significant public and media attention: for discussion of which, see V Entwistle et al, 'Media coverage of the Child B case' (1996) 312 British Medical Journal 1587; and C Burgoyne, 'Distributive justice and rationing in the NHS: framing effects in press coverage of a controversial decision' (1997) 7 Journal of Community and Applied Social Psychology 119–136.

6 C Newdick, 'Can judges ration with compassion? A priority-setting rights matrix' (2018) 20 Health and Human Rights 107–120.

context; but also that it needs to be supplemented by further analysis in order to identify plausible reasons *why* the judicial approach taken in these cases may differ from that adopted elsewhere.

THE EVOLUTION OF JUDICIAL REVIEW OF HEALTHCARE RESOURCE ALLOCATION

During the decade which separates the two editions of *Who Should We Treat?*, there was a distinct alteration in the approach of the courts to allocative questions in healthcare, which is neatly encapsulated by the following extracts from the respective texts:

> Judges have been extremely reluctant to become involved in the assessment of priorities and the allocation of health service resources.[7]

> Today, however, there is much greater willingness to scrutinise resource allocation decisions and, if needs be, to overturn them and to refer them back for reconsideration.[8]

Newdick illustrates this 'dramatic increase in the willingness of the courts to scrutinise the reasonableness of rationing decisions' by particular reference to two cases in which allocative choices were deemed unlawful.[9] In *R v North Derbyshire Health Authority, ex parte Fisher*,[10] the health authority had failed to give effect to Department of Health guidance on the provision of beta interferon for the treatment of multiple sclerosis, offering no reasons for so doing. And in *R v North West Lancashire Health Authority, ex parte A, D and G*,[11] the Court of Appeal, while noting that the setting of priorities for allocation of scarce resources was in principle lawful, ruled against the health authority on the bases that its policy with regard to provision of gender reassignment surgery effectively amounted to a 'blanket ban' which did not admit of the possibility of the presentation of exceptional circumstances, and that it had failed to indicate 'in broad terms' why this form of treatment had been assigned a low priority.[12]

To the decisions analysed by Newdick might also be added the legal challenge to the decision of the then Secretary of State for Health, Frank Dobson, to exclude sildenafil (Viagra) from availability on the

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7 Newdick (n 1 above) 122.

8 C Newdick, *Who Should We Treat? Rights, Rationing and Resources in the NHS* 2nd edn (Oxford University Press 2005) 93.

9 Ibid 102.

10 *R v North Derbyshire Health Authority, ex parte Fisher* (1997) 8 Med LR 327.

11 *R v North West Lancashire Health Authority, ex parte A, D and G* [2000] 1 WLR 977.

12 Ibid 1000 (Buxton LJ).

NHS, save in exceptional circumstances.[13] Here, the primary issue was compliance with EU law, in the form of the so-called 'Transparency Directive' which required 'a statement of reasons based on objective and verifiable criteria' in any instance in which a medicinal product was excluded from coverage on a national health system.[14] The Government's failure to provide this was deemed unlawful by the High Court when the matter was first litigated;[15] however, a subsequent statement which it provided to the European Commission, referring to the cost of providing the drug on the NHS but not establishing its priority vis-à-vis treatments for other non-life-threatening conditions, was held by the Court of Appeal to suffice to meet the 'fairly modest' degree of explanation required by the Directive.[16]

What unites these decisions is a judicial commitment to fair process in decision-making on the allocation of healthcare resources, an approach the origins of which lie in the *dictum* of Laws J (as he then was) in the High Court in the *Cambridge Health Authority* case, that health bodies making allocative decisions must 'do more than toll the bell of tight resources. They must explain the priorities that have led them to decline to fund the treatment'.[17] Courts will require rationing choices to be transparent and properly reasoned on the basis of evidence (albeit stopping short of comprehensive justification), and open to challenge by those who can demonstrate that they fall into an exceptional category.[18] Various explanations have been proffered for what Newdick calls this 'striking' expansion in judicial scrutiny,[19] the principles of which were subsequently given statutory effect in secondary legislation,[20] as well as being enshrined (in England) in the *NHS Constitution*.[21]

Newdick himself looks to jurisprudential evolution in public law, viewing the stance of the courts in these cases as amounting to a species of 'hard look' scrutiny informed by a judicial trend towards requiring

13 Discussed in K Syrett, 'Impotence or importance? Judicial review in an era of explicit NHS rationing' (2004) 67 Modern Law Review 289–304.

14 Directive 89/105/EEC, art 7(3).

15 *R v Secretary of State for Health, ex parte Pfizer Ltd* [1999] Lloyd's Med Rep 289.

16 *R (on the application of Pfizer Ltd) v Secretary of State for Health* [2003] 1 CMLR 19, para 27 (Buxton LJ).

17 *Cambridge Health Authority* (n 4 above) at 1065.

18 Discussed further below: see nn 95–97 and accompanying text.

19 Newdick (n 8 above) 98.

20 The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, SI 2012/2996, regs 34(2)(b), 35.

21 Department of Health and Social Care, *The NHS Constitution for England* (last updated August 2023). For further discussion, see n 118 below and accompanying text.

the giving of reasons for administrative decisions, a move away from the extreme deference of the *Wednesbury* test towards a more searching standard of review in which courts scrutinise the internal logic of the choices made, and a shift towards proportionality stimulated by the enactment of the Human Rights Act 1998.[22] By contrast, Syrett, while not overlooking these normative developments,[23] has suggested that prominent drivers were the changing nature of allocative decision-making in the NHS, coupled with the rise of evidence-based medicine, particularly in the form of clinical guidelines.[24] This is to say that the courts responded to the move towards explicitness in rationing choices grounded upon scientific evidence by imposing explanatory obligations upon allocative decision-makers which were consonant with this altered environment.[25] Finally, something of a middle ground is taken by Wang, who notes that the changed approach to judicial review was 'concomitant to a move towards explicit rationing in the NHS',[26] but notes that 'correlation is not causation',[27] preferring the view that:

> that courts interacted within a 'soup of influences' that created a context that made rationing more explicit 'about what' and that, through their rulings, they established a continuous policy dialogue with decision-makers in the NHS that contributed to make rationing explicit 'about why and how'.[28]

These authors, however, are all united in agreement that this judicial development is consistent with the framework of procedural justice devised by Norman Daniels and James Sabin to address the so-called 'legitimacy problem' which arises when decision-makers make difficult choices about the allocation of scarce healthcare resources.[29] This 'accountability for reasonableness' model posits that compliance with certain procedural criteria – namely, publicity, relevance, challenge and revision, and regulation/enforcement – will reduce suspicion, distrust and resistance to rationing decisions, even in situations where an individual may personally lose out. Wang (whose discussion is

22 Newdick (n 8 above) 97–98, 121–125, 127–128.

23 See K Syrett, *Law, Legitimacy and the Rationing of Health Care: A Conceptual and Comparative Perspective* (Cambridge University Press 2007) especially ch 5.

24 For discussion of the latter, see K Syrett, 'Healthcare resource allocation in the courts: a systems theory perspective' (2019) 70 Northern Ireland Legal Quarterly 111–129.

25 See Syrett (n 13 above) 297.

26 D Wang, 'From *Wednesbury* unreasonableness to accountability for reasonableness' (2017) 76 Cambridge Law Journal 642–670, 644.

27 Ibid.

28 Ibid 658.

29 See N Daniels and J Sabin, *Setting Limits Fairly: Learning to Share Resources for Health* 2nd edn (Oxford University Press 2008).

chronologically the latest and who thus addresses the broadest range of cases) expresses matters thus:

> These changes in the administrative decision-making reflect the fact that the denial of funding for a health intervention will hardly ever be upheld by courts if the decision and the grounds for it are not made public ('publicity'), based on sound evidence and reasonable policy considerations ('relevance') and if the opportunity for adequately challenging the policy or presenting a case for an exception is not given ('challenge'). Accordingly, the courts are guaranteeing that health care rationing decisions in the NHS will comply with the first three conditions for 'accountability for reasonableness' and are thus materialising the last condition ('regulation/enforceability').[30]

Read in this manner, the evolution of judicial review of healthcare resource allocation described in this section is a development to be welcomed; the courts may be viewed as facilitating good administrative decision-making in this context by contributing to ensuring enhanced public legitimacy for the 'tragic choices' which arise as a consequence of inevitable scarcity in healthcare.[31]

SOME PROBLEM CASES

However, the trend outlined in the preceding section also carries with it an implicit constraint upon judicial activism. The courts may, and should, act as overseers of *procedural justice* in rationing cases, but should not be drawn into setting priorities themselves. Auld LJ expressed this limitation concisely in the *North West Lancashire Health Authority* case, stating that 'the precise allocation and weighting of priorities is clearly a matter of judgment for each Authority, keeping well in mind its statutory obligations to meet the reasonable requirements of all those within its area for which it is responsible'.[32]

Dovetailing with the traditionally constrained reach of judicial review in English administrative law in general – that is, that courts should refrain from involvement in the *substance* of administrative decisions, restricting their role to scrutiny of process and assurance that the decision-maker is acting within its constitutionally allotted powers – there are several well-rehearsed reasons for abstinence in

30 Wang (n 26 above) 668. See also Syrett (n 13 above) 297–298; Syrett (n 23 above), *passim* but especially ch 4; K Syrett, 'NICE and judicial review: enforcing "accountability for reasonableness" through the courts?' (2008) 16 Medical Law Review 127–140; Newdick (n 6 above) 111.

31 See, generally, G Calabresi and P Bobbitt, *Tragic Choices* (WW Norton & Co 1978); and, in the particular context of the judicial review cases discussed here, see R James and D Longley, 'Tragic choices: *ex parte B*' [1995] Public Law 367–373.

32 See *R v North West Lancashire Health Authority* (n 11 above) 991.

this particular context. These can be classified under the heads of (lack of) institutional and constitutional competence.

Within the first category lie concerns as to judicial inexpertise in matters of the clinical and cost-effectiveness of treatments which underpin contemporary allocative decision-making in healthcare;[33] and as to the polycentric nature of rationing choices – that is, that enabling a particular individual to access a treatment or service in situations of scarcity carries opportunity costs for multiple unidentified individuals whose interests cannot adequately be represented in the adversarial arena of judicial proceedings. As for the second category, it is argued that decisions on the allocation of resources are inherently political in nature and are therefore properly assigned, under the doctrine of the separation of powers, to officials who are accountable to the public (or, at least, to those who must themselves account to elected representatives), rather than to unelected judges.

However, it is possible to identify a number of cases – each of which was decided subsequent to the publication of the second edition of *Who Should We Treat?* – in which courts, pushing against the boundaries of this restricted role, have seemingly intruded upon aspects of the allocative choice which appear to lie beyond judicial reach. A brief account of these follows.

In the earliest case, *R (Otley) v Barking & Dagenham PCT*,[34] a patient with metastatic colorectal cancer sought access to the drug Avastin, which was not licensed for use on the NHS in England and Wales. The trust's 'Difficult Decisions Panel' determined that the patient did not meet the criteria for exceptional funding. Pronouncing himself 'unimpressed by arguments which go to procedure',[35] Mitting J concluded that the panel had acted unlawfully, in part because it had overlooked a passage in NICE guidance which indicated that, in a small number of cases, 'prescription of Avastin in combination with chemotherapy was capable of reducing secondary tumours in the liver to such an extent as to make them operable and so to give a patient a slim chance of long term survival'.[36] Given that no other treatments were, in practice, available for the patient (a factor also misunderstood by the panel), this oversight was deemed irrational.

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33 For criticisms of this claim, see K Syrett, 'Courts, expertise and resource allocation: is there a judicial "legitimacy problem"?' (2014) 7 Public Health Ethics 112–122; L Morales, 'Judicial interventions in health policy: epistemic competence and the courts' (2021) 35(8) Bioethics 760–766.

34 *R (Otley) v Barking & Dagenham PCT* [2007] EWHC 1927 (Admin).

35 Ibid [25].

36 Ibid [12].

In *R (Ross) v West Sussex PCT*,[37] another cancer patient sought access to the 'relatively new' drug lenalidomide, which had not yet been appraised by NICE, in combination with two other drugs. Again, the High Court ruled that a failure to provide access to the treatment was unlawful. Here, the unlawfulness arose from misapplication of a policy which, in effect, required evidence of 'uniqueness' rather than exceptionality;[38] but also because of the manner in which the panel which reviewed individual funding cases had interpreted the evidence of the clinical efficacy and cost-effectiveness of the drug. In respect of the former, Grenfell J held that there had been a mistake of fact in a failure to appreciate that the results of a randomised controlled trial demonstrated much stronger evidence of effectiveness than the panel had acknowledged.[39] In turn, this error made it impossible to correctly assess the cost-effectiveness of the treatment. Furthermore, this evaluation was also irrational as a consequence of a failure to comprehend that the treatment would probably not be continued beyond four cycles if the patient failed to respond, by 'double counting' of those with partial and full responses to the treatment, and by a failure to consider the savings made by discontinuing the previous treatment given to the patient.[40]

In *S v NHS England*, there was similarly 'an altogether too restrictive application of exceptionality',[41] in respect of the provision of sodium oxybate for narcolepsy and cataplexy. The patient's individual funding request (IFR)[42] was rejected on the basis that, although there was evidence of a deterioration in her condition, it could not be determined 'what absolute benefit she might expect to receive nor how absolute benefit would compare with other patients, some of whom might be experiencing a deterioration'.[43] The commissioning body, NHS England, also noted that there was a need to guard against 'patients, patient groups or services who lobby being given undue priority'.[44] For his part, Collins J considered this 'to be a very rare case in which the decision-making has gone wrong',[45] taking the view that progressive deterioration in the patient's physical and mental health meant that

37 *R (Ross) v West Sussex PCT* [2008] EWHC 2252 (Admin).
38 Ibid [78].
39 Ibid [83]. This arose because the randomised controlled trials had demonstrated that lenalidomide was so effective that it was offered to patients in the control group, thus skewing the statistical results in a manner which was misunderstood by the panel.
40 Ibid [88].
41 *S v NHS England* [2016] EWHC 1395 (Admin) [35].
42 For further discussion of this process, see n 96 below and accompanying text.
43 *S* (n 41 above) [26].
44 Ibid [28].
45 Ibid [37].

she would benefit from the drug to a greater extent than others who did not respond to usual forms of treatment for the condition and that, as a consequence, the treatment would be cost-effective since her needs for other forms of medical treatment would correspondingly be reduced.[46] Unusually, rather than merely quashing the decision, the judge issued an interim order requiring the drug to be provided to the patient for a three-month trial period on the basis that any further 'decision to refuse the treatment could not be supportable'.[47]

The same policy on IFRs was at issue in the final case to be outlined here, *R(SB) v NHS England*,[48] in which access was sought to the drug Kuvan, which was not routinely commissioned by NHS England. In this instance, although the patient was deemed to have made out exceptional circumstances, NHS England's IFR panel argued that there was insufficient evidence of the drug's clinical effectiveness. Andrews J deemed this decision to be irrational, in that it was 'informed by error upon error',[49] notably a confusion between clinical effectiveness and the issue of how long a drug might work for;[50] relatedly, a consideration of 'benefit' (eg upon nutritional status and cognitive development) as distinct from 'effectiveness' in the achievement of clinical outcomes;[51] and a failure properly to comprehend the clinical evidence which was being presented by the patient, which resulted in the panel asking itself the wrong questions when evaluating the application.[52]

This brief account of case law should make it apparent that courts do not always restrict themselves to a role of oversight of fair allocative decision-making procedure, as proponents of the conjunction between judicial review and accountability for reasonableness, including the present author, have tended to suggest. Rather, the intervention of the courts in these cases is premised upon a (mis)understanding and (mis)interpretation of the evidence which informs the allocative choice (this is particularly evident in the first two cases discussed here); and a failure upon the part of the decision-maker to ask itself the 'right' questions based upon the information with which it has been presented (especially pertinent to the latter two cases).

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46 Ibid [34].
47 Ibid [36].
48 *R(SB) v NHS England* [2017] EWHC 2000 (Admin).
49 Ibid [67].
50 Ibid [56]–[59].
51 In this instance, a reduction in the levels of the amino acid phenylalanine in the blood: ibid [62]–[64].
52 Ibid [67], [85].

WHAT IS THE PROBLEM?

For Wang, these cases are explicable as part of 'an almost linear narrative … about how the case law has evolved from a very self-restrained review of health care rationing decisions towards one in which courts have constantly added new boxes that authorities had to tick for a rationing decision to withstand judicial review'.[53] He appears content to fit the two of the four cases which he covers, *Otley* and *Ross*, within the 'accountability for reasonableness' framework while not specifying precisely how they can be accommodated: it would appear, however, that he considers that judicial scrutiny that the decision is based in 'sound evidence' amounts to enforcement of the 'relevance' condition.[54]

The doctrinal vehicle through which this task is accomplished is the judicial review ground of (ir)rationality. As Newdick argues, the scope of this ground has itself expanded such that, in addition to the egregious, barely comprehensible decision with which this head of review has traditionally been concerned, 'a decision which can be seen to have proceeded by flawed logic' may be deemed to be unlawful.[55] This development can readily be explained because, within the contemporary law of judicial review, the ground of irrationality is not interpreted in a 'monolithic' manner,[56] but rather admits of variable standards of review beneath its 'ample cloak'.[57]

What is clear, however, is that arguments of this type bring courts much closer to the evaluation and weighing of those factors which contribute to the eventual allocative choice, and to matters about which there is often scope for reasonable disagreement between experts. That is, to utilise Auld LJ's terminology, many of the issues raised in these cases would appear to be 'matters of judgment'.[58] The frequency with which judges in these cases seek to deny that they are engaged in impermissible merits review might, paradoxically, be seen as indicative of their awareness that a fine line is being trodden.[59]

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53 Wang (n 26 above) 651.

54 Ibid 668. See also A Ford, 'Accountability for reasonableness: the relevance, or not, of exceptionality in resource allocation' (2015) 15 Medicine, Health Care and Philosophy 217–227.

55 Newdick (n 8 above) 97, citing *R v North & East Devon Health Authority, ex parte Coughlan* [1999] EWCA Civ 1871, [65] (Lord Woolf MR).

56 See Sir John Laws, '*Wednesbury*' in I Hare and C Forsyth (eds), *The Golden Metwand and the Crooked Cord: Essays in Honour of Sir William Wade QC* (Oxford University Press 1998) 186–187.

57 J Jowell and A Lester, 'Beyond Wednesbury: substantive principles of administrative law' [1997] Public Law 368, 371.

58 See n 32 above and accompanying text.

59 See *Otley* (n 34 above) [26]; *Ross* (n 37 above) [35]; *S* (n 41 above) [33], [35]; *SB* (n 48 above) [29].

This may also be viewed as controversial given that 'accountability for reasonableness' is a 'classic appeal to procedural justice',[60] whose very existence is premised upon the assumption that agreement upon the substantive basis of priority-setting decisions is unattainable (at least, in the absence of broad public deliberation upon the need for difficult choices in healthcare). As discussed further below,[61] the 'relevance' condition fits somewhat awkwardly within this model, but it should be noted that, in its original articulation, it relates to factors that '"fair-minded" people can agree are relevant to pursuing appropriate patient care under necessary resource constraints'.[62] This elastic formulation seems to correlate more closely to the traditional *Wednesbury* standard than the modified version of irrationality noted by Newdick: that is, it admits of a wide variety of potentially relevant values or evidence which might legitimately inform priority-setting choices, only excluding those which would be rejected by the 'fair-minded', in similar fashion to the notorious 'red hair' example cited by Lord Greene MR in that case.[63] Conversely, it is not designed to be so fine-grained as to rule out certain outcomes because of conflicting interpretations of evidence, or differing understandings of the precise priority-setting question which is at play in light of the information available to the decision-maker.

Wang is therefore correct to identify that courts have moved beyond *Wednesbury* as the standard of review in allocative decision-making in healthcare; but, contrary to the analysis he presents, it would seem that, at least in the cases discussed in the preceding section, the courts have also ventured beyond mere enforcement of the conditions of a model of procedural justice.[64] Furthermore, his depiction of the 'linear narrative' of the case law may also be called into question.[65] The intense judicial scrutiny of the decision-making process and the interpretation of evidence which characterises these cases is not always replicated elsewhere. In order to demonstrate this, it will be helpful to consider a further decision concerning availability of the drug Kuvan, which was at issue in the *SB* case.

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60 N Daniels, *Just Health: Meeting Health Needs Fairly* (Cambridge University Press 2008) 109.

61 See n 123 below and accompanying text.

62 N Daniels and J Sabin, 'The ethics of accountability in managed care reform' (1998) 17 Health Affairs 50–64, 51.

63 *Associated Provincial Picture Houses Ltd v Wednesbury Corporation* [1948] 1 KB 223, 229.

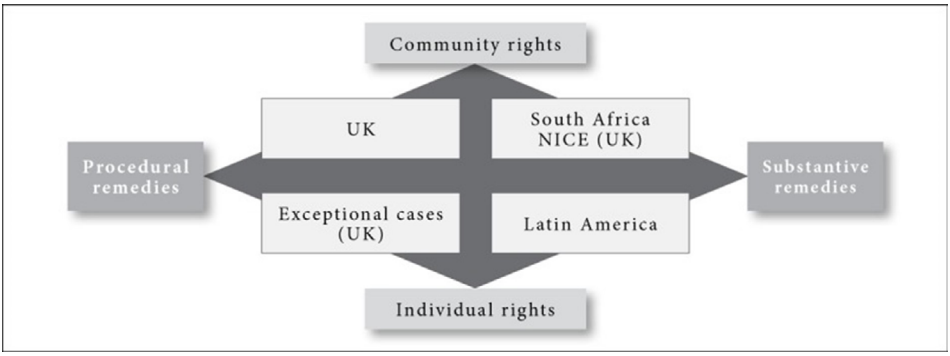
64 Wang (n 26 above) *passim*, but especially at 657–668.

65 Albeit that he qualifies this phrase with the word 'almost': Wang (n 26 above) and accompanying text.

In *R (Cotter) v NICE*,[66] the challenge consisted of an allegation that NICE had erred in law in choosing to evaluate Kuvan through its standard health technology appraisal process as distinct from the highly specialised technology process, the relevance of this being that the latter has a higher cost-effectiveness threshold of £100,000 per quality adjusted life year, meaning that a positive recommendation for use on the NHS is more likely to ensue. The claimant argued that NICE had misunderstood and misapplied criteria which determined which of its processes should be used – these relating to the size of the target patient group for the technology, the clinical distinctiveness of the group and whether the drug was expected to be used exclusively in the context of a highly specialised service – that is, that 'NICE did not ask itself the right questions'.[67] At first instance,[68] Cavanagh J observed that 'there is always a high threshold for irrationality cases'[69] and noted that 'those charged by NICE with taking this decision will generally be in a better position than a judge to make the evaluations that are inherent in the criteria'.[70] Accordingly, the court should show a degree of deference to the Institute's decision as to the process it chose to follow, since this 'require[d] the use of expert judgment, and the use of expert knowledge'.[71] On this basis, the judge held that the claim of irrationality had not been made out.

Aside from the obvious fact that access to the same drug was at issue in both of these cases,[72] there are clear similarities between *SB* and *Cotter*. In both cases, the defendant was a body operating at national level, which could be expected to draw upon a greater accumulation of expertise than is available to a more localised decision-maker such as clinical commissioning groups (or now, integrated care boards). Furthermore, the question of public law raised in each case was, in essence, identical: that is, whether the decision-maker had asked itself incorrect questions based upon its understanding of the evidence available, thus leading it to reach an 'invalid conclusion'.[73] However, the outcomes are strikingly different, with *Cotter* fitting more closely into what Wang labels 'the first stage' in the timeline of judicial review

66 *R (Cotter) v NICE* [2020] EWHC 435 (Admin).
67 Ibid [43].
68 The decision was upheld by the Court of Appeal: [2020] EWCA Civ 1037.
69 See *Cotter* (n 66 above) [70].
70 Ibid [65].
71 Ibid [63].
72 Albeit that, in *Cotter*, the pharmaceutical manufacturer had responded to NICE's decision by withdrawing Kuvan from the appraisal process, meaning that NICE had not yet been able to reach a decision upon whether to recommend it for use on the NHS: ibid [10], [12].
73 See *SB* (n 48 above) [29].



Source: C Newdick, 'Can judges ration with compassion? A priority-setting rights matrix' (2018) 20 Health and Human Rights 107–120, 110.

of healthcare allocation decisions, characterised by deference on the part of the courts.[74]

If this apparent anachronism is read alongside the seeming extension of judicial scrutiny in a more substantive direction, it would seem that the largely teleological analyses previously proffered by Wang and other authors, which connect the evolving case law with a growing judicial commitment to procedural justice consistent with the 'accountability for reasonableness' framework, warrant some reconsideration. In this regard, it is submitted that the 'Newdick matrix' can provide us with assistance in understanding developments.

INTO THE MATRIX

In one of his later works, the article 'Can judges ration with compassion?', Newdick seeks to 'assist clarity in the debate' on the appropriate role for judges in determining allocative questions in healthcare,[75] especially in light of concerns about the judicialisation of health which have particularly been expressed in relation to Latin America.[76] In order to do so, he devises a 'priority-setting rights matrix' by means of which differing ways in which the courts may supervise health service resource allocation can be visualised. The matrix is reproduced above:

In this matrix, the vertical axis differentiates between types of rights, with 'community rights' at the top, and individual rights at the bottom. The meaning of the latter term is relatively clear; by the former term,

74 Since this was not a direct challenge to an allocative recommendation by NICE (see n 72 above), the deferential stance adopted by the court is even more notable since the standard arguments for judicial reticence outlined in the previous section would seem to apply much less strongly.

75 Newdick (n 6 above) 108.

76 On this see O Ferraz, 'Health in the courts of Latin America' (2018) 20 Health and Human Rights 67–77.

Newdick is referring to collective interests of a solidaristic character which connect to notions of social citizenship,[77] including – but not necessarily restricted to – the familiar canon of social, economic and cultural rights. The horizontal axis denotes differing types of judicial remedy, procedural and substantive. Newdick writes that the former 'are more often appropriate to accommodate the politics inherent in promoting social welfare policy ... When others also have legitimate interests in the same resource, the courts must reflect our human interdependence by accommodating the competing rights and interests of other people.'[78]

As can be seen, this schematic enables Newdick to place certain jurisdictions within certain quadrants. He notes, however, that the United Kingdom (UK) system 'comfortably occup[ies] more than one compartment, depending on the circumstances of the individual case'.[79]

What can the matrix tell us about the 'problem cases' discussed herein and how these may be classified? A useful starting point is by means of the same comparison between the two cases concerning access to Kuvan which was drawn in the preceding section, although the absence of a finding of unlawfulness in *Cotter* makes this somewhat problematic, since no remedy was in fact awarded in that instance.

Nonetheless, it would appear that this case best fits within the top-left, collective-procedural quadrant. This is because it is to this category that Newdick assigns judicial review which 'acknowledges the constraints on the judiciary in terms of accountability and technical capacity'.[80] This clearly corresponds to Cavanagh J's expression of the need for deference given relative levels of institutional expertise.[81] In this context, the judicial approach taken is one which is consonant with 'accountability for reasonableness': 'the "right" is a guarantee of a fair and reasonable procedure ... Recognizing the opportunity costs inherent in public health promotion, the objective is to ensure that fair procedures have identified relevant matters and weighed and balanced them properly.'[82]

In contrast, Newdick himself assigns the *SB* case to the bottom-left, individual-procedural quadrant of the matrix.[83] He explains this category in the following terms:

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77 See C Newdick, 'The European Court of Justice, trans-national health care and social citizenship — accidental death of a concept?' (2009) 26 Wisconsin International Law Journal 844–867.

78 Newdick (n 6 above) 109.

79 Ibid 111.

80 Ibid 112.

81 See nn 70–71 above and accompanying text.

82 Newdick (n 6 above) 111.

83 Ibid 114.

> A comprehensive resource allocation system must also be capable of reassuring *individual* patients as to its competence and, essentially, its compassion and humanity … This is an *individual-procedural* right in the sense that it cannot guarantee access to treatment irrespective of cost. Yet it can reassure individuals that their individual circumstances have been considered properly in a way that is not possible when decisions are made at the community level.[84]

For Newdick, the remedy awarded in *SB* is 'strictly procedural' in that the court referred the decision back to NHS England for reconsideration, rather than granting access to the drug in question.[85]

This conclusion warrants some dissection for a number of reasons. First, the qualifying word 'strictly' hints at some hesitation as to the classification under the 'procedural' head. In part this is conceded by Newdick, who points out that the 'procedural' remedy in *SB* had a substantive *impact* in so far as the finding of unlawfulness prompted a reversal of the original decision to deny the claimant access to the treatment.[86] This taxonomical ambiguity is further compounded by the fact that Newdick places the case of *R (Rose) v Thanet Clinical Commissioning Group* within the 'community-substantive' quadrant notwithstanding that the remedy granted in that case was identical to that issued in *SB* (a quashing order, which necessitated reconsideration of the matter by the original decision-maker).[87]

Relatedly, and notwithstanding Newdick's reading of *Rose*, if we consider that reference back to the original decision-maker signals that a remedy is 'procedural' in character, it might be observed that this will generally be the case in the English law of judicial review given that courts are proscribed under the separation of powers doctrine from substituting their view for that initially reached.[88] It is different in a system in which some form of right to health receives constitutional protection, as Newdick acknowledges in reference to South Africa and Columbia, which he assigns to the substantive end of the axis.[89]

Hence, a classification according to *types of remedy* may not be sufficiently discriminating to distinguish between differing cases in this jurisdiction, although it should be noted that this is not Newdick's primary objective in his article. Arguably, the matrix needs to be three- or four-dimensional to capture the various nuances of the English

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84 Ibid emphases in original.

85 Ibid.

86 Ibid 114 and fn 44.

87 [2014] EWHC 1182 (Admin). See Newdick (n 6 above) 115.

88 In this regard the remedy awarded in *S* (n 41 above), which mandated that funding for the treatment be provided (albeit on an interim basis), appears problematic. See further n 127 below.

89 Newdick (n 6 above) 115–116.

case law since, in addition to the *impact* of the case, noted previously, the *standard of review* adopted by judges in allocative adjudication sometimes tends more towards the substantive than the procedural, as I have contended is the case in the instances discussed above.

Notwithstanding these concerns, the matrix can still function as a valuable analytical tool in respect of case law in the English courts. It serves to draw attention to the fact that, in certain cases, judges tend to construe the subject-matter of the claim as more collective or 'macro'-level in character; whereas in others they are much more attentive to the individual interests which are impacted by the particular allocative choice. Assignment to the former category (the top-left quadrant) tends to result in judicial deference, while adoption of a more individualistic focus (the bottom-left category) is more likely (although this is not inevitable) to result in judicial intervention in the allocative choice and accordingly carries with it the possibility that judges might stray towards impermissible merits review.

Application of the matrix thus permits for greater differentiation between allocative cases than the more linear, 'one size fits all' explanations that were discussed previously. This seems more congruent with the evolution of the jurisprudence itself.

However, there are important limitations to the utility of the matrix. In particular, while it is helpful in drawing distinctions between allocative cases, and can thus provide some insight into likely judicial responses, it does not enable us straightforwardly to comprehend *why* cases might be categorised in a particular manner. To return to the example discussed in this section, why is *SB* considered to be an 'individual-procedural' case, whereas *Cotter* seems more naturally to fall within the 'community-procedural' category? Both cases are brought to court by individuals whose important health interests have been adversely affected by the choice made by the decision-maker.[90] In both cases (as in every decision of this type, given the inevitability of scarcity of resources), there are collective consequences, in so far as any decision to allocate resources to the individual in question carries opportunity costs – that is, the 'alternative investments [that] could be made with the same healthcare resources'.[91] This therefore disrupts the collective activity of rational priority-setting for the benefit of the community as a whole, this being especially noticeable in instances such as these, where national-level bodies are involved. In sum, both cases necessitate the striking of a balance by the court between an

90 Cf *R v North West Lancashire, ex parte A, D and G* (n 11 above), per Buxton LJ at 997, describing 'a citizen's health' as an 'important interest'.

91 M Meltzer, 'Introduction to health economics for physicians' (2001) 358 The Lancet 993–998, 994.

individual claim and a wider collective interest. Yet, the two cases yield distinct outcomes.

It is, of course, plausible that these two cases are treated differently because the judges engage in backwards reasoning; that is, that the choice made in *Cotter* is upheld simply because it appears to be a more acceptable exercise of judgement on the part of the decision-maker than was the case in *SB*. It is certainly true, as Andrews J identified,[92] that there appeared to be multiple deficiencies in the decision-making of NHS England in the latter case, which would be likely to dispose the court to be much less sympathetic towards the position which it reached.

Nevertheless, the notion that cases can be 'retrofitted' into certain categories of the matrix depending upon the judge's preferred outcome feels unsatisfactory. Although such a conclusion does not divest the model of its value in demonstrating that all allocative cases should not be regarded as identical in character – and recalling that the matrix was not formulated primarily for the purpose of analysis of judicial review cases in England and Wales – the impact and quality of Newdick's scholarship is such that this author feels compelled to venture a further step. In the following section, I draw upon but develop the matrix, moving from the issue of classification of allocative cases and further exploring the complex question of why judges decide in particular ways.

A STEP BEYOND: SEEKING TO UNDERSTAND THE PROBLEM CASES

Importantly, the four problem cases outlined previously in this article share a common characteristic. In each case, the applicant had sought to argue that they amounted to an exceptional case, warranting a departure from the general policy not to fund the particular treatment which they had requested (with the support of their treating clinician). By contrast, in *Cotter*, no such argument was made: here, the claimant wished to gain access to the drug following her successful participation in a clinical trial.

The challenge from exceptionality, which is rooted in the hoary administrative law principle that there should be no fettering of discretion,[93] had its common law origins in the healthcare allocation context in the *North West Lancashire Health Authority* case, noted

92 See n 49 above and accompanying text.

93 See *R v Port of London, ex parte Kynoch Ltd* [1919] 1 KB 176; *British Oxygen Co Ltd v Minister of Technology* [1970] UKHL 4.

above,[94] and was given statutory effect in 2012.[95] In the NHS in England, it now takes the form of the IFR process, operated both by local decision-makers and, in relation to the specialised services which it nationally commissions (and which were at issue in both the *S* and *SB* cases), by NHS England.[96]

Of course, the activation of an IFR does not divest an allocative decision of its collective consequences; there remain significant opportunity costs in according resources to the applicant, as NHS England notes in respect of its commissioning responsibilities:

> Funding for additional treatments outside the prioritisation process can only be done by reducing the funding that is available for other established treatments. There is no allocated separate budget to meet the costs of providing treatments agreed through the IFR process. It is because of this that very careful consideration is required before the decision is taken to fund a treatment that is not usually available for an individual.[97]

In short, IFR cases still necessitate the striking of a balance between the individual claim and the broader collective interest. In each of these cases, the original allocative decision-maker has, in effect, opted for the latter over the former.[98]

Turning now to consider treatment of these cases in court, the matrix assists us in understanding the probable orientation of the judges. The IFR encourages a focus upon the circumstances presented by the individual. While the courts have been clear that it is not necessary for the applicant to demonstrate that they are in a unique position,[99] there must nonetheless be a departure from the norm which inevitably draws

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94 See n 11 above and accompanying text.

95 The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, SI 2012/2996, reg 34(2)(b), as amended by the Health and Care Act 2022 (Consequential and Related Amendments and Transitional Provisions) Regulations 2022, SI 2022/634.

96 For the latter, see *NHS England, Commissioning Policy: Individual Funding Requests*, PR2086 (8 February 2023). Responsibility for such commissioning will lie elsewhere once NHS England is abolished.

97 Ibid 3.

98 Note, however, that in *SB*, the patient's exceptionality claim was (eventually) accepted; but NHS England refused to provide funding given its doubts as to the clinical effectiveness of the treatment. This reflects the decision-maker's preference for the collective interest over the individual in that scarce resources would be better allocated to (likely successful) treatment of other, unspecified, conditions than to an identified individual who was unlikely to benefit.

99 See *Ross* (n 37 above) [77]; *S* (n 41 above) [12].

attention to the clinical particularities of the case.[100] For example, in the *S* case, Collins J noted that the patient was 'suffering from a particularly severe form of her condition. Her condition is rare, and her failure to respond to the usual treatment is also rare. But she is in a very rare situation in that she suffers from a particularly rare form of the condition.'[101] It thus seems appropriate, as already noted in respect of *SB*, to assign the four problem cases analysed in this article to the bottom-left quadrant of the matrix, Newdick's 'individual-procedural' category.

As discussed in the preceding section, judicial decisions in this category tend to be less deferential towards the allocative decision-maker. However, this still begs the question. Since *any* allocative case entails striking a balance between individual and collective, *why* is it that judges appear more likely to favour individuals in situations where the IFR process has been utilised? Addressing this point requires us to consider psychological and doctrinal factors that are not discussed by Newdick.

First, in so far as it effects a degree of individuation in the allocative decision, the IFR may reinforce particular psychological tendencies to which judges, as well as other decision-makers, may be prone. In this context, Hofmann has noted that rational priority-setting choices may be distorted by a number of 'biases' which may lead to 'perceptual distortion, inaccurate judgment, illogical interpretation'.[102] An important example which he cites is the 'identifiability and singularity effect', which he describes as occurring:

> when a single patient in front of the health care professional or on the front-page of the newspaper emotionally 'takes priority' over the many thousands that also may be in need … When the individual and proximate patient trumps all non-present and more remote patients general priority setting principles, such as justice and equity, are undermined … the singularity effect may trump priority setting principles, such as severity, effectiveness, and efficiency, and bypass established procedures and hence distort priority setting.[103]

This phenomenon has its roots in the:

> stronger emotional reactions elicited by an identified individual … empathic emotions, such as sympathy, compassion and distress at the plight of another are preconditioned on adopting the other person's

100 In *R (Condliff) v North Staffordshire PCT* [2011] EWHC 872 (Admin), it was determined that it was lawful to exclude social factors in a consideration of exceptionality.

101 See *S* (n 41 above) [34].

102 B Hofmann, 'Biases distorting priority setting' (2020) 124 Health Policy 52–60, 53.

103 Ibid.

> perspective and imagining how he or she feels. This is more likely to occur when an individual is identified rather than anonymous or statistical.[104]

In respect of allocation of healthcare resources, it connects to the 'rule of rescue', which may be defined as the 'obligation to help an individual whose life is imminently at risk, where the intervention is relatively costly and therefore does not maximise the expected benefit we can produce with the resources at our disposal'.[105] Identifiability has frequently been cited as a rationale for this potent psychological intuition,[106] although it is not clear that this should in fact amount to a morally relevant factor in allocative decision-making.[107]

As Sinclair points out, the IFR process fundamentally entails identifiability, which has the potential to lead to bias in the allocation of resources. Applying his analysis, the initial decisions reached in these four cases can be seen as normatively justified, because 'intuitively it would seem quite reasonable for the [IFR] panel to apply the same cost-effectiveness criteria as are applied in standard commissioning decisions applying to unidentified patients'; any other approach would be unfair to those who have not been identified.[108]

Conversely, the rulings of the courts in these four cases might be read as instances in which the singularity and identifiability effect has led the judges to a 'perceptual distortion' in favour of each claimant.[109] As Lewinsohn-Zamir and colleagues argue, there is no reason to presume that judges are immune from the emotive responses elicited by an identified individual.[110] Indeed, certain statements in these four cases, such as 'No one can completely put aside the human element of a case like this'[111] and 'I have, as anyone would, enormous sympathy for the claimant',[112] point towards exactly such a psychological reaction

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104 D Lewinsohn-Zamir, I Ritov and T Kogut, 'Law and identifiability' (2017) 92 Indiana Law Journal 505–555, 514.

105 S Sinclair, 'Explaining rule of rescue obligations in healthcare allocation: allowing the patient to tell the right kind of story about their life' (2022) 25 Medicine, Health Care and Philosophy 31–46, 31.

106 See eg D Hadorn, 'Setting health care priorities in Oregon: cost-effectiveness meets the rule of rescue' (1991) 265 Journal of the American Medical Association 2218–2225; R Cookson, C McCabe and A Tsuchiya, 'Public healthcare resource allocation and the rule of rescue' (2008) 34 Journal of Medical Ethics 540–544.

107 See Sinclair (n 105 above); J Mckie and J Richardson, 'The rule of rescue' (2003) 56 Social Science and Medicine 2407–2419.

108 Sinclair (n 105 above) 33. Given the outcome in *SB* (see n 48 above), clinical effectiveness is also relevant here.

109 Hofmann (n 102 above) 53.

110 Lewinsohn-Zamir et al (n 104 above) 533.

111 *Ross* (n 37 above) [4] (Grenfell J).

112 *S* (n 41 above) [33] (Collins J).

on the part of the judges, even if they are ostensibly balanced by claims of judicial objectivity.[113]

Moreover, the propensity of judges to succumb to the singularity and identifiability effect is exacerbated by the nature of adjudication as a form of law-making. Distinctly from the act of legislating, the identifiability effect is an inherent facet of the adjudicative process,[114] especially in systems where that process takes an adversarial form. Procedural requirements, such as standing, reinforce a judicial tendency to favour the identified litigant over alternative, unidentified, potential recipients of healthcare resources.[115]

Additionally, there is a significant development of a more doctrinal variety. In their survey of the evolution of the doctor–patient relationship in *Montgomery v Lanarkshire Health Board*, Lords Kerr and Reed observe that 'patients are now widely regarded as persons holding rights, rather than as the passive recipients of the care of the medical profession'.[116] In part, this development is reflected in the discourse of 'rights' which pervades the *NHS Constitution for England*.[117] The 'constitutional right' which is most pertinent to the present context is expressed as follows:

> You have the right to expect local decisions on funding of other drugs and treatments to be made rationally following a proper consideration of the evidence. If the local NHS decides not to fund a drug or treatment you and your doctor feel would be right for you, they will explain that decision to you.[118]

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113 In *Ross* (n 37 above), Grenfell J remarked of the 'human element' that 'it cannot be allowed to dictate the result. My approach has to be to decide whether or not the decision can be successfully challenged on clear and laid down principles' (n 111 above). Similarly, in *S* (n 41 above), Collins J said 'I am conscious that it is not for me to strike down the decision in this case because I believe that it was too harsh' (n 112 above).

114 Lewinsohn-Zamir et al (n 104 above) 507.

115 See I G Cohen, 'Identified versus statistical lives in US civil litigation: of standing, ripeness, and class actions' in I G Cohen, N Daniels and N Eyal (eds), *Identified Versus Statistical Lives: An Interdisciplinary Perspective* (Oxford University Press 2015). The relative elasticity of the 'sufficient interest' test in the law of judicial review in England and Wales (as compared with the approach adopted by US courts) has tended to render this factor somewhat less impactful, although a growing turn towards procedural rigour has been recently identified: see L Marsons, 'Crossing the t's and dotting the i's: The turn to procedural rigour in judicial review' [2023] Public Law 29–38.

116 *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 [75].

117 Department of Health and Social Care (n 21 above).

118 Ibid.

This 'right' is drawn from the common law cases discussed above,[119] and it appears compatible with Wang's reading of the evolution of the jurisprudence as reflective of 'accountability for reasonableness' in so far as it encompasses both the publicity and relevance conditions of the model.[120] On this analysis, the existence of such a right – which, it should be noted, was not explicitly articulated in any of the four problem cases analysed here – reinforces the classification in the bottom-left quadrant of the matrix. That is, this is an 'individual procedural' right and, as such, judicial intrusion into the merits of allocative decision-making need not follow.

Nonetheless, two factors might tend to push judges towards the right-hand portion of the Newdick matrix (the 'individual-substantive' quadrant). First, awareness of the requirement that local decisions should be made 'rationally' opens up the possibility of a judicial 'hard look' into the understanding, evaluation and application of evidence under the guise of a broader reading of the irrationality ground, as discussed above.[121] This does not appear to be consonant with Daniels and Sabin's original construction of the 'relevance' condition in accountability for reasonableness,[122] and would appear to support the view of certain authors that this condition is sufficiently imprecise and malleable that it can be interpreted and applied in a manner that is not proceduralist in orientation.[123]

Secondly, while as a matter of *legal* status, this and other 'rights' contained in the *NHS Constitution* are more closely akin to 'relevant considerations' for the purpose of judicial review,[124] there is profound *discursive* significance in the particular formulation which has been adopted. This is because, as Nedelsky reminds us, 'rights talk' connects at a fundamental level with a 'powerful legacy of liberal political thought in which rights are associated with a highly individualistic conception

119 See Department of Health and Social Care/Public Health England, Handbook to the NHS Constitution for England (updated 1 October 2023).

120 Wang (n 26 above) and accompanying text.

121 See nn 55–57 above and accompanying text.

122 See Daniels and Sabin (n 62 above) and accompanying text.

123 See eg A Friedman, 'Beyond accountability for reasonableness' (2008) 22 Bioethics 101–112, especially at 107–108; A Rid, 'Justice and procedure: how does "accountability for reasonableness" result in fair limit-setting decisions' (2009) 35 Journal of Medical Ethics 12–16, especially at 13; K Syrett, 'Health technology appraisal and the courts: accountability for reasonableness and the judicial model of procedural justice' (2011) 6 Health Economics, Policy and Law 469–488, especially at 481.

124 See Health Act 2009, s 2, which establishes a duty to have regard to the *NHS Constitution*. For a recent instance in which this duty was held to have been fulfilled, see *R (AA) v NHS Commissioning Board* [2023] EWHC 43 (Admin), [2023] EWCA Civ 902 (long wait times for treatment; Board was 'well aware' of the issue and was taking steps to address it).

of humanity ... indeed the "rights bearing individual" may be said to be the basic subject of liberal political thought'.[125] This serves further to reinforce the identifiability effect, focusing judicial attention on the 'wronged' individual. Moreover, it raises the possibility that, as a 'right', that individual's interest should be understood and enforced as a 'trump over some background justification for political decisions that states a goal for the community as a whole';[126] in this instance, the scarcity-driven need to set priorities for allocation of healthcare resources for the population. This, of course, is the problematic mode of judicial intervention which has been witnessed in jurisdictions in Latin America, as Newdick observes.[127]

To sum up, these problem cases may plausibly be understood as instances in which the judges, operating in a legal and health policy environment in which patients are now constructed as rights-holders, tend to favour an identified individual with particular circumstances articulated through the IFR process, whose plight arouses profound emotions of compassion and sympathy. This can lead them to stray from acceptable procedural review in the direction of more questionable substantive scrutiny, albeit that the inherent pliability of the irrationality ground of judicial review somewhat disguises that this step has been taken.

CONCLUSION

Both in the UK[128] and across the globe,[129] health systems continue to struggle to meet demand, even in 'normal', non-pandemic times. In these circumstances, it seems certain that there will be on-going resort to courts as disappointed patients attempt to secure access to healthcare services and treatments that have been denied or restricted on grounds of cost.

Future analysts of this phenomenon would do well to look to the groundbreaking work of Chris Newdick. As this article has sought to demonstrate, this continues to yield valuable insights which can assist

125 J Nedelsky, 'Reconceiving rights as relationship' (1993) 1 Review of Constitutional Studies 1–26, 12.

126 R Dworkin, 'Rights as trumps' in A Kavanagh and J Oberdiek (eds), *Arguing about Law* (Routledge 2009) 335.

127 Newdick (n 6 above) 116–117. This is not, of course, to suggest that the English courts have engaged in overreach on the scale seen in Latin America. Nonetheless, the drift towards the bottom-right quadrant of the matrix is demonstrated by the award of a substantive remedy in *S*, albeit only on an interim basis for three months: see n 47 above.

128 See eg Audit Scotland, *NHS in Scotland 2023*, AGS/2024/3 (2024).

129 See eg C Rauh, 'Why healthcare systems are in chaos everywhere' *The Economist* 21 January 2023.

greatly in the understanding of this contentious and often complex area of law and public policy. While – as here – there may on occasion be a need for some development and supplementation, the relevance and resonance of Newdick's scholarship is unquestionable and calls for enduring gratitude on the part of those working within this field.