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Equality, discrimination and exceptionality in access to healthcare

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ABSTRACT

Where healthcare commissioners decide, as an overall policy, that they will not generally fund a particular medical treatment or intervention (or will restrict its availability to those meeting certain criteria), individual patients denied under the policy can ask for an exception to be made. This is usually done by means of an individual funding request (IFR) whereby the patient, typically with the support of their medical team, can make a case for individual funding on the basis that there are significant and relevant differences between their circumstances and those of other patients who might need or want the treatment in question. The approach of healthcare commissioners to deciding on IFRs is normally to take into account clinical factors only – policies tend to make clear that they will not take into account 'social factors', including personal characteristics such as race, sex, age, religion, disability and sexual orientation, in deciding whether or not to make an exception – because of a desire to avoid discrimination and to treat patients fairly. This article explores the way equality law might bear on decisions to make exceptions to funding policies. It identifies, as far as is possible, the circumstances under which equality law will permit or will require the personal characteristics of patients to be taken into account in order to avoid discrimination and to treat patients fairly. It also highlights a number of challenges the equality law framework presents for commissioners in making decisions about how to allocate scarce resources.

Keywords: equality discrimination; health; healthcare; human rights.

INTRODUCTION

> [I]t is an unhappy but unavoidable feature of state funded healthcare that … health authorities have to establish certain priorities in funding different treatments from their finite resources.[1]

So noted Auld LJ in *R v North West Lancashire*, a case concerning a decision by a health authority to not fund gender reassignment surgery. Following the most recent reorganisation of the National Health Service (NHS), this difficult task currently falls largely to integrated care boards (ICBs) alongside NHS England and a number of other authorities, often acting with reference to the guidance of the National Institute for Health and Care Excellence (NICE).[2] These commissioning bodies will make the policy decisions that determine, for example, whether or not to fund (and for whom) *in vitro* fertilisation (IVF), cosmetic surgery and new drugs for cancer or for dementia, for the relevant populations. In doing so, they are under a statutory obligation to break even in each financial year.[3]

Where healthcare commissioners decide, as a general policy, that they will not generally fund a particular medical treatment or intervention (or will restrict its availability to those meeting certain criteria), individual patients denied under the policy can ask for an exception to be made. This is usually done by means of an individual funding request (IFR) whereby the patient, typically with the support of their medical team, can make a case for individual funding on the basis that there are significant and relevant differences between their circumstances and those of other patients who might need or want the treatment in question. The openness of public decision-makers to making exceptions to a general policy is a central requirement of public law – decision-makers must not fetter their own discretion by applying policies rigidly and must be willing to consider whether to depart from the policy in an individual case.[4]

The approach of healthcare commissioners to deciding on IFRs is normally to take into account clinical factors only. The key question is whether the individual patient – clinically speaking – is likely to

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[1] *R v North West Lancashire Health Authority ex parte A* [2000] 1WLR 977, para 991.

[2] On 13 March 2025 the Government announced its intention to abolish NHS England and to bring its functions within the Department of Health and Social Care. In previous reorganisations of the NHS primary responsibility for commissioning lay with Primary Care Trusts (PCTs) or Clinical Commissioning Groups (CCGs). Much of the case law discussed in this article makes reference to these organisations.

[3] National Health Service Act 2006, s 223GC.

[4] *R (A) v Secretary of State for the Home Office* [2021] UKSC 37.

benefit significantly more from the treatment in question, or to suffer considerably more if denied, than other patients in their cohort.[5] This is often no easy task for a patient to demonstrate. According to NHS England:

> Very few patients have clinical circumstances which are genuinely exceptional. To justify funding for treatment for a patient which is not available to other patients, and is not part of the established care pathway, the IFR Panel needs to be satisfied that the clinician has demonstrated that this patient's individual clinical circumstances are clearly different to those of other patients, and that because of this difference, the general policies should not be applied. Simply put, the consideration is whether it is fair to fund this patient's treatment when the treatment is not available to others.[6]

IFR policies tend to make clear that they will not take into account 'social factors' in deciding whether or not to make an exception. Social factors include the role of the patient as an employee or parent or carer; whether or not the patient has a criminal conviction; and the responsibility of the patient for behaviours which have contributed to their need for treatment. They may also include personal characteristics such as sex, age, religion and others protected by the Equality Act 2010 (Equality Act), or by article 14 of the European Convention on Human Rights (ECHR), in part through concern that to do otherwise would amount to unfair and potentially unlawful discrimination.

This article explores the way equality law might bear on decisions to make exceptions to funding policies. It will aim to identify, as far as possible, the circumstances under which equality law will permit or require the personal characteristics of patients be taken into account in determining whether an exception should be made. It will also highlight a number of challenges the equality law framework presents for commissioners in making decisions about how to allocate resources. It is divided into two sections. The first section outlines the approaches taken to making exceptions in the context of IFRs, the reasons behind these and the approach the courts have taken to decisions to exclude social factors from consideration. The second section then briefly outlines the equality law framework – both the Equality Act and article 14 of the ECHR – before looking in more detail at three sets of circumstances in which commissioners may be permitted, or required, to take personal characteristics into account when deciding on an approach to exceptions: positive action, reasonable adjustments and indirect discrimination.

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[5] For a more detailed discussion of this process, see Hart et al in this issue.

[6] NHS England, *Commissioning Policy: Individual Funding Requests* version 3 (NHS England February 2023) 8.

INDIVIDUAL FUNDING REQUESTS

Individual funding request policies

Generally, policies on IFRs make clear that when making decisions about whether to make an exception for an individual patient, it is only their clinical circumstances which will be taken into account. Non-clinical or social factors will not be considered. Where social factors are defined in policies, they tend to embrace two different categories. First are value judgements about the usefulness of factors related to the role of the individual in society – whether the patient is an employee or parent or carer – and value judgements about the deservingness of the patient – for example the lifestyle of the patient and the extent to which they may bear some responsibility for bringing about their need for medical treatment. The second category – and that of interest in this article – includes the personal characteristics of the patient: sex, age, disability and so on. For example, one current IFR policy states that '[n]on-clinical social factors (for example, but not limited to, age, gender, ethnicity, employment status, parental status, marital status, carer status, religious/cultural factors) will not be taken into account in determining whether exceptionality has been established';[7] another that 'IFRs should not be made on the basis of non-clinical social factors, personal or protected characteristics'.[8]

The position is complicated by the fact that some personal characteristics, including age, sex and disability, may sometimes be highly relevant to the clinical benefit an intervention is likely to produce. Accordingly, some IFR policies may make clear that where personal characteristics are relevant to the clinical effectiveness of a treatment then they may be taken into account as part of this assessment.[9] The scope of this is not clear, however, and, in relation to co-morbidities (concurrent health conditions, some of which may amount to disabilities and therefore be protected characteristics under the Equality Act), NHS England suggests that:

> If the usual treatment cannot be given because of a pre-existing comorbidity which is unrelated to the condition for which the treatment is being sought under the IFR or is not unusual in the relevant patient group or generally, the fact that the co-morbidity is present in this

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[7] NHS Staffordshire and Stoke-on-Trent Integrated Care Board, *Individual Funding Request Policy* (8 July 2022) para 4.2.5.

[8] NHS Cornwall and Isles of Scilly, *Individual Funding Requests Policy and Procedures* (December 2022) 5.

[9] Nottingham and Nottinghamshire Integrated Care Board, *Individual Funding Requests (IFR) Commissioning Policy* (June 2024–June 2027) para 7.5.

> patient and its impact on treatment options for this patient is unlikely to make the patient clinically exceptional.[10]

Finally, some IFR policies make express reference to the need to improve health inequalities and the need to sometimes give priority to health services which target population groups who tend to have poorer than average health outcomes or who are disadvantaged in some way in relation to access to healthcare.[11] It is not obvious how this is envisaged working in the context of considering IFRs (rather than, say, in the context of an overall strategic approach to priority-setting where resources may be targeted to disadvantaged groups from the outset). It is not clear, for example, whether patients from groups with poorer health outcomes generally are more likely to be given individual funding, and, if so, whether this would be the case for those with poorer outcomes related to the specific conditions for which treatment is sought or for those with poorer outcomes more generally.

At best, therefore, there is lack of clarity as to the way personal characteristics will, if ever, be relevant to determining when to make an exception to a funding policy and the criteria for determining whether and when it will. The focus on clinical reasons for exceptionality, and the broad rejection of the relevance of social factors, including personal characteristics, appears to stem from a number of related concerns. First, it is clear that there is some worry that treating social factors as relevant to decisions about individual funding risks discrimination. The decision to treat social utility, personal responsibility or personal characteristics as irrelevant stems, at least in part, from concern to ensure that the health of one individual is not valued any more or less highly than that of another. Thus, for example, one ICB states that '[t]he ICB considers all lives of all patients to be of equal value and in making decisions about funding treatments will seek not to discriminate on the grounds of age, sex, sexuality, race, religion' and so on;[12] and NHS England notes that '[as] a central principle, the NHS does not make judgements about the worth of different individuals and seeks to treat everyone fairly and equitably. Consideration of these non-clinical factors would introduce this concept of "worth" into clinical decision making.'[13] There is also a more practical problem. Commissioners will usually lack the data and expertise to evaluate non-clinical evidence and to compare this across individuals and populations.[14] While initial cost-effectiveness reviews of the relevant treatment or drug, based on

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[10] NHS England (n 6 above).

[11] For an example, see NHS Kent and Medway Integrated Care Board, *Principles and Guidance for Dealing with Individual Funding Requests* (August 2022) 22.

[12] Nottingham and Nottinghamshire Integrated Care Board (n 9 above) para 6.5.

[13] NHS England (n 6 above) 11.

[14] NHS Staffordshire and Stoke-on-Trent Integrated Care Board (n 7 above) 22.

published trial data, for example, will have given a good idea of the average and typical range of clinical responses, allowing exceptions to be identified with more confidence, the same is not true of social factors.

Underlying these concerns is a desire to treat patients fairly. This includes both fairness as between those who are denied under an IFR and those who are successful; and fairness to those patients from whose treatment the money spent on making an exception in a particular case might be divested. While those deciding on IFR requests (and indeed the courts adjudicating claims made by individual patients refused under an IFR) are able to know the circumstances of the individual asking for an exception to be made, they will not be similarly aware of the needs and circumstances of those whose heath care may be compromised by the consequent reduction in budget. The difficulty with this – often apparently blanket – approach to the (ir)relevance of personal characteristics, however, is that it ignores the disadvantage that can be caused to (or reinforced in) members of protected groups by adopting 'characteristic blind' decision-making criteria. Sole focus on clinical response, while apparently fair, may ignore both underlying differences in ability to access treatment and underlying disadvantage, which may itself result from other forms of discrimination and will be compounded by lack of access to treatment. The following sections now turn to consider the circumstances under which the legal framework may in fact require, or permit, departure from an equal treatment or characteristic blind model so that personal characteristics are taken into account in commissioning decisions in order to avoid or reduce substantive inequalities.

Individual funding requests in public law

In common with all public bodies, healthcare commissioners are under a public law duty to not fetter their own discretion. In deciding which medical interventions to fund, and the access criteria for these, they must therefore remain open to the possibility of making exceptions to a general policy in response to individual patient circumstances. This duty was explained in *R v North West Lancashire*, a case concerning the refusal of gender reassignment surgery, where Auld LJ held that 'it is proper for an authority to adopt a general policy for the exercise of such an administrative discretion, to allow for exceptions from it in "exceptional circumstances" and to leave those circumstances undefined'.[15]

Case law subsequent to *Lancashire* has addressed questions about the scope of this duty but has failed to produce clear guidance.

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[15] *R v North West Lancashire Health Authority* (n 1 above) para 991.

Commissioners must make decisions about whether individual patients are 'exceptional' in accordance with the general principles of public law – and, in particular, in this context, in accordance with the principle of rationality – but what rationality requires has proved difficult to pin down. As a result, the criteria for determining the circumstances under which an exception should be made – and the factors relevant to making these decisions – remain fraught with uncertainty. In particular, it remains unclear how 'unusual' a patient has to be, and in what respects. Indeed, the lack of clear guidance from the courts or elsewhere on this issue has resulted in what has been described as a 'legal farce', creating uncertainty for patients, clinicians and commissioners.[16]

One aspect of exceptionality on which the courts have sent a much clearer message, however, is in relation to the exclusion of social factors from decision-making on IFRs. The courts have sanctioned the approach to exceptionality which treats non-clinical factors as irrelevant. The leading case is *Condliff*, a case which did not itself involve any claims of discrimination.[17] Mr Condliff was morbidly obese and wanted laparoscopic gastric by-pass surgery. The policy of North Staffordshire Primary Care Trust (PCT) was then to fund this surgery only for those patients whose body mass index (BMI) exceeded 50, and Mr Condliff was not eligible because his BMI was below this threshold. He therefore made an IFR, supported by his general practitioner and by a number of other specialists, which noted the serious impact of his condition on his mental and physical well-being, and on his lifestyle, but his request was turned down by the PCT, whose IFR policy stated that social factors (including personal characteristics such as age, gender and ethnicity as well as employment, parental and marital status and religious or cultural factors) would not be taken into account in deciding whether or not a patient was exceptional.

Mr Condliff challenged the social factors exclusion arguing, among other things, that it was in breach of article 8 of the ECHR because it failed to take into account all factors relevant to his article 8 right to a private life.

Neither the High Court nor the Court of Appeal found any breach of article 8. In the first place, it was doubted that article 8 founded any positive right to treatment in the circumstances; even it if did, it was held that the approach of the PCT would amount to a justified interference with Mr Condliff's article 8 rights because it had struck a fair balance between the rights of individual patients and the needs of the community. The Court of Appeal noted that:

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[16] A Ford, 'The concept of exceptionality: a legal farce?' (2012) Medical Law Review 20(3): 304–336.

[17] *R (on the application of Condliff) v North Staffordshire Primary Care Trust* [2011] EWHC 872 (Admin); [2011] EWCA Civ 910.

> The policy of allocating scarce medical resources on a basis of the comparative assessment of clinical needs is intentionally non-discriminatory. The statutory function of the PCT is to use the limited resources provided to it for the purposes of the provision of healthcare … To perform that function by allocating those resources strictly according to the PCT's assessment of medical need … is to do no more than to apply the resources for the purpose for which they are provided without giving preferential treatment to one patient over another on non-medical grounds.[18]

A similar approach was taken in *Longstaff*: a case concerning a patient who wanted access to artificial blood products which were not routinely funded.[19] His reason for rejecting human blood was a phobia developed as a result of his brother's death from contaminated blood products. The court suggested that there is a difference in kind between a refusal of treatment for clinical reasons and a refusal based on other factors including phobia or religious belief.[20] While neither of these cases involved claims of discrimination, the remainder of this article now turns to consider what equality law might require of commissioners in determining their approach to these kind of decisions where personal characteristics are involved. Under what circumstances may, or must, personal characteristics be taken into account when deciding whether or not to make an exception from a general rule or policy to not fund a particular medical intervention?

EQUALITY LAW

Introduction

Public bodies exercising public functions and providing services – as will be the case for commissioning bodies in the UK including ICBs, NHS England and NICE – have obligations under both the Equality Act and the Human Rights Act 1998 (HRA).

The Equality Act prohibits discrimination in a number of different contexts – including service provision and exercise of public functions – where this involves one or more of the characteristics protected by

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[18] Ibid para 36. At first instance, Waksman LJ suggested that some social factors were directly relevant to clinical outcomes – but that these would then constitute clinical factors themselves and so not be caught by the policy. On the facts, Mr Condliff's circumstances did not fall into this category: ibid para 23.

[19] *R (on the application of Longstaff) v Newcastle NHS Primary Care Trust* [2003] EWHC 3252 (Admin)

[20] Ibid para 56.

the Act.[21] There are several forms of prohibited discrimination. Direct discrimination – 'less favourable treatment because of a protected characteristic' – captures the principle that likes should be treated alike. Where there are no other relevant differences between two individuals, it is not lawful to treat one less favourably than the other because of a protected characteristic, and it is not (with some exceptions) generally possible to legally justify treatment that amounts to direct discrimination.[22] This seems to be the type of discrimination which underlies concerns, in IFR policies, about treating personal factors as relevant to the decision to make an exception. In many ways direct discrimination is also something that will often fall foul of 'rationality' already required by judicial review, which will require decision-makers to treat likes alike and to not take irrelevant considerations into account.[23]

The prohibition on direct discrimination is only part of the story, however. Anti-discrimination has long reflected a recognition of the limits of equal treatment as a means to achieve substantive equality. The Equality Act therefore also includes a number of prohibitions and obligations which reflect the fact that disadvantage can also be created or become entrenched where the differences between groups sharing particular characteristics are not recognised and accommodated. Among these are three sets of obligations which will be explored in more detail below. These are positive action, as a form of exception to the prohibition on direct discrimination; the duty to make reasonable adjustments in the case of disability; and indirect discrimination which arises where an apparently neutral policy or practice serves to disadvantage those sharing a protected characteristic and cannot be justified.

It is important to note here that the Equality Act also imposes an obligation on commissioners, in common with all public sector bodies, in the form of the public sector equality duty (PSED). This requires public bodies to have 'due regard' to the need to eliminate discrimination and to advance equality of opportunity when formulating policy. In order to satisfy these obligations, public bodies need to consider, proactively, at policy stage, what disparate impacts, relevant to characteristics

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[21] In relation to services and public functions these are age, disability, gender reassignment, race, religion or belief, sex and sexual orientation – Equality Act 2010, ss 4 and 28.

[22] The exception is less favourable treatment because of age (Equality Act 2010, s 13). There are also a number of exceptions in the Act; and, in relation to disability, pregnancy and gender reassignment, only those with the characteristic are protected under the Act – there is no prohibition on treating someone less favourably because they do *not* have one of these characteristics.

[23] See, for example, *Matadeen v Pointu* [1999] 1 AC 98, 109.

protected under the Act, the policy may have and whether or not the policy should be amended as a result. The courts have made clear that the duty imposes an obligation on authorities to engage meaningfully with the duty as something 'of very great substantial, and not merely technical importance'[24] and as of fundamental importance in meeting the aims of anti-discrimination and making equality issues an essential part of public decision-making.[25] The relevance of the duty to the question of exceptionality is considered further below.

The HRA imposes obligations on public authorities to act in a way that is compatible with the ECHR.[26] Article 14 of the ECHR provides that:

> the enjoyment of the rights and freedoms set forth in [the] Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status

Article 14 is not a freestanding right – claimants are required to demonstrate that the facts in issue fall within the 'ambit' of one of the other Convention rights (although they are not required to demonstrate a breach of one of the other rights). In relation to access to healthcare, the article most likely to be relevant in the current context is article 8 (although articles 2, 3 and 9 may also be relevant) Both the European Court of Human Rights (ECtHR) and the domestic courts have been reluctant to find that article 8 grounds a positive right to healthcare, the ECtHR noting that member states are to be afforded a wide margin of appreciation in this respect.[27] However, this does not mean that article 14 will not be relevant, particularly in circumstances where healthcare is provided but in a way that is discriminatory. Indeed, in *R (AC) v Berkshire*, a case considered in more detail below, the Court of Appeal did not dismiss the relevance of article 14 to a claim of discrimination resulting from a policy not to treat trans and non-trans women differently in access to breast enlargement surgery.[28]

What follows will now focus on three contexts in which commissioners may be permitted, or required, to treat individuals or groups of patients differently because of their protected characteristics: positive action, the duty to make reasonable adjustments and avoiding indirect discrimination.

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[24] *R (C) v Secretary of State for Justice* [2008] EWCA Civ 882.

[25] *Bracking v Secretary of State for Work and Pensions* [2013] EWCA Civ 1345.

[26] HRA 1998, s 6.

[27] *Sentges v Netherlands* [2004] 7 CCL Rep 400; *Pentiacova v Moldova* [2005] 40 EHRR SE23.

[28] *R (AC) v Berkshire West Primary Care Trust* [2010] EWHC 1162 (Admin); *R (AC) v Berkshire West Primary Care Trust* [2011] EWCA Civ 247.

Positive action

Positive action under the Equality Act

The Equality Act provides that positive action is permitted in certain circumstances. Positive action involves the use of steps to help those facing particular disadvantages connected to a protected characteristic to overcome them.[29] It is normally distinguished from positive or 'reverse' discrimination, which is generally unlawful in the UK, and is normally characterised as preferential treatment of an individual because of a protected characteristic – although the division between these two concepts is not always clear. Positive action in any form is controversial because it can involve the perception that it creates unfair advantage for some groups at the expense of others; the boundary between redressing disadvantage and creating unfair advantage is sometimes hard to draw. On the other hand, it is widely acknowledged that some form of positive action is often necessary to achieve substantive equality and to ensure that society is sufficiently responsive to the different needs and experiences of different groups.[30]

Section 158 of the Equality Act provides that positive action will be lawful where service providers, or those carrying out public functions, reasonably think that individuals who share a particular protected characteristic are at a disadvantage connected to the characteristic, or have needs that are different from those who do not have the characteristic; when this is the case, it is then lawful for service providers to take *proportionate* steps to help them to overcome the disadvantage or to meet those needs.

There are, as yet, no cases considering the application of section 158 in relation to healthcare resources, but a first judgment on the scope of these provisions by the Supreme Court in 2020 in *R(Z) v Hackney*, in the context of social housing, gives a useful example of how the provision may operate in the context of public services.[31] A portion of the social housing stock in Hackney was owned by the Agudas Israel Housing Association (AIHA), whose policy was to prioritise its housing stock for members of the Orthodox Jewish Community. The claimant, who had young children, including two with autism, was considered by Hackney Council to be among the group with the highest need for housing but was not nominated by the council for a series of suitable properties owned by AIHA because of its priority policy. She claimed

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[29] For a helpful categorisation of different forms of positive action, see C McCrudden, 'Rethinking positive action' (1986) 15(4) Industrial Law Journal 219–243.

[30] For a useful summary of the debate on positive action, see S Fredman, *Discrimination Law* 3rd edn (Oxford University Press 2022) ch 7.

[31] *R (Z) v Hackney London Borough Council and another* [2020] UKSC 40.

that she had suffered direct discrimination on grounds of religion and race under the Equality Act as she had been treated less favourably because she was not Jewish. The Supreme Court found that there had been no discrimination because (among other things) the council and the AIHA were able to rely on the positive action provisions in section 158. There was undisputed evidence that the Orthodox Jewish Community faced 'real and substantial disadvantage' connected with their religion in relation to housing, as well as having different needs to those who were not members of the community. The court held that the correct approach to determining the proportionality of a positive measure was to weigh the disadvantage to the group in question – here the Orthodox Jewish Community – against the disadvantage other groups would face in consequence of the disputed measure.[32] On the facts, although the individual claimant in this case was significantly disadvantaged by the measure because of her particular circumstances, the evidence suggested that the wider group of those in need of social housing were not because the housing stock of the AIHA formed such a small proportion of the overall housing stock available to the council. The measure was therefore proportionate.

In the context of commissioning healthcare, the positive action provisions should therefore allow an approach to considering IFRs which takes into account the protected characteristics of patients in some circumstances. Where it is recognised that a decision not to fund a particular treatment is likely to disadvantage members of a particular group, commissioners are unlikely to be acting unlawfully if they allow for exceptions to be made for those within that group, provided that this is proportionate. Arguably, this could be achieved *either* by carving out an exception as part of the funding policy itself – for example by generally funding a drug or intervention *only* for members of the relevant group – *or*, alternatively, by having an IFR policy which makes clear that protected characteristics may be relevant to individual decisions where the positive action provisions of the Act apply. There are good reasons to take the first approach wherever possible, not least because, as argued by Hart et al in this journal, identifying exceptional groups at the policy stage is likely to prove fairer, more effective and more transparent. The exercise of the PSED should equip commissioners to consider needs and disadvantage at an early stage of policy-making. On the other hand, there may be situations where it is

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[32] Ibid para 79. This accords with the guidance in the EHRC, *Equality Act 2010 Statutory Code of Practice: Services, Public Functions and Associations* (EHRC January 2011) which notes at para 10.22 that '[t]he seriousness of the relevant disadvantage, the degree to which the need is different … need to be balanced against the impact of the action on other protected groups, and the relative disadvantage, [or] need … of these groups'.

more challenging to identify in advance the groups whose needs may be different to others affected by the policy or who may be particularly disadvantaged in relation to it for reasons connected to a protected characteristic. In these circumstances, allowing the disadvantage to be overcome or needs met through the mechanism of the IFR process may be another way of utilising the positive action provisions for commissioners wishing to do so.

Therefore, while positive action is possible, commissioners may nonetheless have understandable reservations about taking such action when they are not required to. This has certainly proved true in other contexts. In relation to employment, for example, research suggests that 'organizations prefer to steer clear of this opportunity to address disadvantage suffered by protected groups'[33] and that a lack of clarity as to the boundaries of permissible public action, and resulting lack of confidence, may be to blame.[34] It would be unsurprising if this was also true of policy-makers in the NHS.

Clarity and confidence aside, a second challenge for policy-makers is to determine an approach for voluntary positive action that accords with their broader ethical framework (as well as the legal one) and is compatible with the principles that underscore their approach to resource allocation. In line with the legal framework, this exercise will involve at least two elements. The first is identifying the respects in which a group should be disadvantaged (or have different needs) in order to trigger the use of permissible positive action in the first place. The Equality Act appears to allow a broad definition of relevant disadvantage in this context which could potentially include both disadvantage related to a particular policy or funding decision and disadvantage in relation to access to healthcare or healthcare outcomes more generally, although the boundaries remain unclear. The answer to this question will be highly significant to deciding whether and when positive action in access to healthcare may be used as a mechanism to address health inequalities more broadly. A second step comes in relation to deciding whether making a group exception to a particular funding decision is a proportionate response. Following the Supreme Court's guidance in *Re Z*, it is clear that this will involve a weighing of the disadvantage to the protected group which has triggered the need for positive action in the first place (here, Orthodox Jews in need of housing) against any disadvantage caused *by* the positive action to those not in the protected group. In *Re Z*, the group disadvantaged by the

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[33] C M Davies and M Robison, 'Bridging the gap: an exploration of the use and impact of positive action in the United Kingdom' (2016) 16(2–3) International Journal of Discrimination and the Law 83–101.

[34] C Davies, *Exploring Positive Action as a Tool to Address Under-representation in Apprenticeships* (EHRC Research Report 123 2019).

positive action were those, like the claimant, also seeking housing in the borough and were therefore relatively easy to identify. When it comes to healthcare commissioning, this weighing exercise is potentially much more challenging. Money spent on funding exceptions may need to be divested from healthcare provision which may be entirely separate from the treatment and cohort being considered, and as a result it is likely to be much more difficult for commissioners to identify who is likely to be impacted. If I need access to more expensive drug B because my religion prevents me from using the cheaper and generally available drug A, the money spent on eliminating my disadvantage (and that of others in my position) in relation to that treatment may be taken from others who are disadvantaged, in different ways (and indeed in relation to other protected characteristics) in relation to health outcomes and access to healthcare. Arguably at least, this will therefore require a different and potentially more complicated weighing exercise than required of Hackney Council in *R(Z),* and a clear and transparent process will be needed.

Positive action under the HRA

Under the HRA, positive action is not only permitted but may sometimes be required. The ECtHR made clear in *Thlimmenos v Greece* that it is possible for a breach of article 14 to arise because of a failure to treat individuals differently, without justification, where there are relevant differences between them.[35] Mr Thlimmenos had been refused appointment as a chartered accountant because of a criminal conviction for refusing to wear a military uniform because of his religious beliefs. In finding that this failure to make an exception for individuals in the position of Mr Thlimmenos was a violation of article 14, in conjunction with article 9, the court held that:

> [t]he right not to be discriminated against in the enjoyment of the rights guaranteed under the Convention is also violated when States without an objective and reasonable justification fail to treat differently persons whose situations are significantly different.[36]

In common with all claims under article 14, when determining whether a failure to treat people differently in this way amounts to unjustified discrimination, the domestic courts engage in varying intensity of review which will determine the approach taken to proportionality and the extent to which the assertions of policy-makers will be accepted by the courts without the need for close scrutiny. The approach to be taken in any particular case depends on a complex matrix of factors including the ground of discrimination (with some grounds calling for

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[35] *Thlimmenos v Greece* App no 34369/97 (ECtHR, 6 April 2000).

[36] Ibid para 44.

a more intense review than others), the seriousness of the disadvantage created by the contested policy or treatment and whether or not the relevant policy involves questions of socio-economic policy and the allocation of resources.[37] In cases involving difficult decisions about the allocation of resources – as will normally be the case in relation to healthcare commissioning – the courts tend to take a deferential approach, although this is not automatic and stricter scrutiny may still be called for in some circumstances.[38]

Deference was very much in evidence in a rare case involving claims of '*Thlimmenos*' discrimination in the context of healthcare commissioning. In *R (AC) v Berkshire*, the claimant, a male to female transexual, sought judicial review of a decision by Berkshire West PCT to refuse her breast augmentation surgery.[39] It was the policy of the PCT to treat breast augmentation surgery as low priority, and it was only funded for those who could demonstrate exceptional clinical need or benefit. The claimant had made a number of requests for funding which had been rejected. Her claim included an argument that by failing to make an exception for her, by agreeing to her IFR, the PCT was in breach of article 14, together with article 8 of the ECHR.[40] The claimant argued that there were relevant differences between her need for surgery and those of a natal woman because, as the Equality and Human Rights Commission (EHRC) (intervening) put it in its submission 'only a transgender woman needs breasts to address the very condition from which she suffers, and only transsexuals suffer, of living in a body which is not the gender which they feel themselves to be'.[41] In rejecting her claim, however, the Court of Appeal effectively delegated the decision on the question of which differences between individuals are relevant to the PCT.[42] As the PCT had decided it was not relevant that 'one of the women seeking treatment was born a

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[37] *R (SC) v Secretary of State for Work and Pensions* [2021] UKSC 26.

[38] Ibid.

[39] *R (AC) v Berkshire West Primary Care Trust* (2010) (n 28 above); *R (AC) v Berkshire West Primary Care Trust* (2011) (n 28 above).

[40] At the time the claim arose, there was no legal protection from indirect discrimination on grounds of gender reassignment under the Equality Act – a claim which may be now advanced on the same facts.

[41] *R (AC) v Berkshire West Primary Care Trust* (2011) (n 28 above) 41.

[42] While a deferential approach is not surprising here, given the context of resource allocation, it is arguable that the appropriate sphere of deference should have arisen in relation to the question of whether a decision to not treat the claimant differently was justified here, rather than the question of whether or not there was potential discrimination requiring justification in the first place. See, for example, *Burnip v Birmingham City Council* [2012] EWCA Civ 629.

woman whereas the other has become a woman or seeks to become a woman', that was the end of the matter.[43]

Using article 14 to argue successfully that exceptions should be made may therefore prove a difficult task for patients. More recently, however, a less deferential approach to the scope of *Thlimmenos* discrimination was taken by the court in *R (Adath Yisroel Burial Society) v HM Senior Coroner for North London*,[44] which involved religious belief and therefore concerned article 9 (freedom of religion) as well as article 14. The case offers some useful insights as to how obligations to make exceptions might arise. It concerned a policy of the Senior Coroner not to prioritise deaths because of the religious belief of the deceased or their families – where, for example, their religion required that burial take place as soon as possible after death. Instead, deaths would be dealt with in the order in which they were referred – described by the defendant as the 'cab rank rule'. The only basis on which prioritisation was permitted was for homicide and organ donation. Prioritisation for religious – or any other reason – had been described by the defendant as 'queue jumping', and she had expressed concern about the impact of prioritising one group on the families of others who were therefore pushed further back in the queue.[45] It was also suggested in argument that, among other things, one of the reasons for the coroner's refusal to prioritise deaths on religious grounds was a fear of discriminating under the Equality Act,[46] concerns which echo those seen in IFR policies.

The claimants successfully challenged the policy on a number of grounds, including that it was a breach of the claimant's article 9 and article 14 rights. In relation to article 9, the court held the policy constituted a *prima facie* interference with the right to freedom of religion which could not be justified. In particular, it noted that it was relevant to justification that prioritisation on grounds of religious belief is not unlawful under the Equality Act because it is consistent with the positive action provisions of section 158, discussed above. The coroner's concerns about giving priority to one person over another on religious grounds were therefore 'misguided'.[47] In relation to article 14, the court, having established that this was a *prima facie* case of *Thlimmenos* discrimination – because there were significant relevant differences between those requiring expedited burial for religious reasons and others using the services of the coroner – considered whether there

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[43] *R (AC) v Berkshire West Primary Care Trust* (2011) (n 28 above) 54.

[44] *R (Adath Yisroel Burial Society) v HM Senior Coroner for North London* [2018] EWHC 969.

[45] Ibid para 50.

[46] Ibid para 108.

[47] Ibid para 112.

could be any 'objective and reasonable' justification for the coroner's policy of not allowing exceptions to be made on religious grounds. On the facts, there was not. The coroner had advanced two justifications – the first that a 'bright line rule' was easier to understand and to administer; the second that the resources of the coroner's office were limited. The court dismissed both. The fact that the coroner allowed for exceptions in other circumstances undermined the argument about administrative workability.[48] In relation to concerns about managing finite resources – perhaps of particular resonance in the context of thinking about the approach to commissioning healthcare – the court noted that:

> Limits on resources may explain why it is not possible to help a particular family to achieve expedition (whatever the reason for their request for expedition, whether or not it is based on a religious belief) but they cannot justify discrimination of this kind, which means that certain reasons for a request for expedition (religious ones) are excluded from consideration altogether.[49]

Given a diversity in judicial approach in considering article 14, the scope of the obligation on public bodies therefore remains unclear. It is certainly plausible, however, that commissioners might be required *at least* to be open to the possibility of making exceptions for patients whose religious beliefs or other characteristics underlie their need to access generally unfunded treatment options. While concerns about the impact on funding for others may justify a particular decision not to make a policy exception for those from a particular group – or refuse an exception for a particular individual – these wider impacts would be factors to be weighed in the balance when considering the question of justification. IFRs which rule out the relevance of personal characteristics may fall foul of article 14.

The duty to make reasonable adjustments

Sometimes a patient may be unable to access available treatment for their condition because of an unrelated health condition or 'comorbidity' – because, for example, that treatment may exacerbate their comorbidity or interact badly with medication taken for it or because the available treatment is in some other way inaccessible. If alternative treatments, which would be accessible, are not normally funded, then the patient may need to make an IFR to ask that the unfunded treatment be made available to them instead. Commissioners may agree to IFR where, because of comorbidity, you can demonstrate you are able to derive significantly more clinical benefit from the unfunded treatment and

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[48] Ibid para 123.

[49] Ibid para 124.

are therefore clinically exceptional. However, NHS England policy suggests that it will not usually be enough simply to demonstrate that you are unable to access a treatment because of a comorbidity, particularly where the condition is a common one because ‘a patient cannot be exceptional by virtue of also having a comorbidity which is common in the general population’.[50]

The court considered what common law rationality requires of decisions in this type of situation in *R (SB) v NHS England*.[51] Here, the claimant was a severely autistic child who also had a rare condition called phenylketonuria (PKU) which inhibits the ability to ingest protein and can cause serious disabilities if not treated. The usual treatment for PKU is dietary management – involving a very restrictive diet. Because of his severe autism, the claimant was unable to cope with the required dietary restrictions and so – supported by his doctors – had requested to be treated with the drug Kuvan. This request had been rejected by NHS England (the relevant commissioning body). The court held that its rejection was irrational for a number of reasons. In particular, the court noted that, given the rarity of the combination of conditions, their severity and the evidence that Kuvan would prove a clinically effective option:

> it is difficult to see how the Panel could reach any other rational conclusion than that he was likely to gain significantly more clinical benefit from taking Kuvan than other children with PKU whose condition could be managed by the conventional treatment alone ...[52]

The combination of severe autism and PKU in this case was very rare indeed – only one or two individuals in the whole of the UK, including the claimant, were both affected by the two conditions and responsive to Kuvan.[53] It remains unclear how rare a case – and how significant the clinical benefit – would have to be before a refusal to treat as exceptional is irrational.

However, where – as will sometimes be the case – the comorbidity in question amounts to a disability within the meaning of the Equality Act,[54] additional legal obligations will arise which do not depend on how common or rare that condition is in the population. Separate from the positive action provisions, the Equality Act includes an obligation on service providers and those charged with public functions to treat

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[50] NHS England (n 6 above) 9.

[51] *R (on the application of SB) (by his father and litigation friend PB) v NHS England* [2017] EWHC 2000 (Admin).

[52] Ibid para 49.

[53] Ibid para 43

[54] An individual is disabled under the Equality Act if they have a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities (s 6(1)).

individuals with disabilities differently in some circumstances by making reasonable adjustments. Section 20 of the Act provides that, where there is a policy, criterion or practice which puts disabled persons at a substantial disadvantage in comparison with persons who are not disabled, service providers are obliged to take such steps as are reasonable to avoid the disadvantage. Failure to do so amounts to unlawful discrimination.[55] The purpose of reasonable adjustments is to eliminate, as far as possible, the disadvantage attaching to that disability in order to improve equality of access and opportunity, and the duty is generally seen as a transformative legal tool which has significant potential to improve inclusion across the areas in which it applies.[56] There have been instances – mainly in an employment context where most of the case law still is – where courts have taken a very expansive approach to interpretation of the duty.[57] Importantly, unlike with rationality at common law, the existence of the obligation to make reasonable adjustments to policy will apply irrespective of how rare or common the relevant disability is.

An adjustment will only be required if it is reasonable. Reasonableness is left undefined by statute. The EHRC Code of Practice provides some guidance, suggesting that of particular relevance will be the extent to which a proposed adjustment would overcome the disadvantage and the practicability and cost of the adjustment.[58] Of especial concern in this particular context will, of course, be the extent to which budgetary considerations are relevant to the question of reasonableness: will it be reasonable to make an exception irrespective of the implications of diverting resources away from other patients? The *Code of Practice* notes that '[t]he resources available to the service provider as a whole are likely to be taken into account as well as other demands on those resources'.[59]

There is little case law to assist in assessing reasonableness in the context of public services. In an employment context it is clear that, while cost alone is unlikely to disqualify a potential adjustment from being reasonable, the relative cost of the adjustment might be. Laws LJ, in *Sanders v Newham Sixth Form College*[60] (another employment case), made clear that it was not possible to assess the reasonableness of an adjustment separately from the question of how significant the disadvantage caused by the policy is. The more significant the

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[55] Equality Act 2010, s 29(7).

[56] For a comprehensive account of the duty, see A Lawson, *Disability and Equality Law in Britain: The Role of Reasonable Adjustment* (Hart 2008.)

[57] See, for example, *Archibald v Fife Council* [2004] IRLR 651.

[58] EHRC (n 32 above) paras 7.29–7.30.

[59] Ibid para 7.32.

[60] *Sanders v Newham Sixth Form College* [2014] EWCA Civ 734.

disadvantage, the greater the resources that are required to be spent before the cost prevents the adjustment from being a reasonable one. In *Cordell v Foreign and Commonwealth Office* (FCO) (Employment Appeal Tribunal (EAT), the (very high) cost of the adjustment in question – the provision of a lip-reading service in Kazakhstan – was considered relative to the overall budget available for reasonable adjustments. The FCO had a budget set aside for reasonable adjustments, and the impact on that budget was to be taken into account according to its own policy. The EAT decided that, while the size of this budget could not be decisive (as the size of the budget was itself a decision of the employer and an employer cannot be permitted to avoid its legal obligations simply by selecting a smaller budget for adjustments), it was nonetheless a relevant factor. It was also held that the general resources of the employer were relevant to the question of reasonableness as 'no-one's resources, not even the government's, are infinite'.[61]

In relation to commissioning healthcare, the cost of making an adjustment and the impact of doing so on the overall commissioning budget will therefore be factors likely to be relevant to the question of reasonableness – but only when considered in relation to the nature of the disadvantage faced of the individual patient whose disability means they cannot access a funded course of treatment in the same way as can other patients. For this reason, where a disability is – in the words of NHS England – 'common in the general population', this *may* have a bearing on whether or not commissioners are obliged to make adjustments or exceptions for this group. But the prevalence of that disability will have no bearing on whether or not the duty to make reasonable adjustments arises in the first place.

In contrast to employment, the duty is an anticipatory one.[62] Commissioners (and other service providers) cannot wait for individuals with disabilities to present themselves but must consider in advance what adjustments to policies and practices might be reasonable in relation to disabled services users generally. While it may be easiest to do so by identifying in advance a set of alternative arrangements for the relevant group at the stage of determining funding policy, it is arguable that this duty could also be met by ensuring that there is a route to access alternatives by means of an IFR. In any case, in addition to the anticipatory duty, it is likely that the duty to make reasonable adjustments will also apply in a reactive way – as it does in other contexts such as employment and education – in response to specific difficulties faced by specific individuals which become known

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[61] *Cordell v Foreign and Commonwealth Office* [2012] ICR 280 (2011), paras 32 and 33.

[62] Equality Act 2010, sch 2, 2(2), stipulates that the duty arises in respect of 'disabled persons generally'.

to commissioners.[63] In these circumstances, making an exception to the original funding policy may well amount to a reasonable adjustment and IFR policies should reflect this.[64]

Indirect discrimination

In determining the approach to take to dealing with requests for individual funding, commissioners should also be mindful that their approach to dealing with IFRs may also be relevant to whether or not the *original* funding policy from which an exception is sought – such as a decision not to fund a particular drug – is itself discriminatory. Most funding policies do not directly discriminate although some do – the use of age limits for access to IVF would be an example of potential direct age discrimination, for example, although it will be remembered that, unlike for other characteristics, direct age discrimination can be justified under the Equality Act. Funding policies are more likely to be susceptible to charges of indirect discrimination – prohibited both under section 19 of the Equality Act and article 14 of the ECHR. A policy will be *potentially* indirectly discriminatory where it is apparently neutral, and applies equally to those with and without the relevant protected characteristic, but in fact serves to disadvantage those sharing a characteristic more than it does those without it. For example, a policy which determines that artificial blood products will not generally be funded applies equally to all but may disadvantage those who are unable to be treated with human blood because of their religious beliefs; and a policy which determines that only one hearing aid, rather than two, will generally be funded will disadvantage older age groups because they are more likely to benefit from having access to two hearing aids. Importantly, the impact, or disadvantage which is relevant to identifying indirect discrimination will be broader than one relating solely to clinical considerations. Nor will the size of the group affected be relevant here. There is no need to show that the impact on the individual is unusual or exceptional. Indeed, part of the point of indirect discrimination is to understand the disadvantage faced by an individual in the context of the disadvantage faced by a much wider group with a shared protected characteristic.

Where policies have disparate impact, they can be justified where the policy-makers can show that the policy is a proportionate means of achieving a legitimate aim. Behind many or most decisions to restrict access to health interventions is, of course, the need to ration limited resources and to target those limited resources towards interventions which commissioners believe will be most cost-effective

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[63] Recently confirmed, in the context of higher education, in *The University of Bristol v Dr Robert Abrahart* [2024] EWHC 299 (KB).

[64] EHRC (n 32 above) paras 7.7 and 7.8.

or otherwise beneficial. It is important to note in this particular context that, while discrimination cannot be justified simply because it is cheaper, courts have recognised that the imperative of meeting wider budgetary constraints is likely to amount to a legitimate aim.[65] However, commissioners will still be obliged to demonstrate that the policy choices made to achieve that aim are proportionate because while 'saving cost is a legitimate objective of public policy … if a benefit is to be limited to save costs it must be limited in a non-discriminatory way'.[66]

It is in relation to proportionality that the role of exceptions is likely to be relevant. The case law on proportionality is complex and often inconsistent and, for reasons of space, there is not scope to consider the test in detail here. However, most approaches to proportionality require *either* an assessment of whether *or* not the measure is necessary to achieve the aim (or whether a less discriminatory alternative route is available) or a balancing between the aim of a measure and its impact on those disadvantaged by it. Often both are required because 'there are some situations in which the ends, however meritorious, cannot justify the only means which is capable of achieving them'.[67]

To what extent is a willingness to make exceptions capable of 'saving' the original policy from being indirectly discriminatory? Given that the possibility of making exceptions to a general rule means that the harmful impacts of the rule may be reduced and, further, that a willingness to make exceptions will sometimes amount to a less discriminatory way of achieving the overall aim, it seems plausible that it should be a relevant factor. Identifying and considering disparate impact on protected groups is of course required of commissioners to ensure they comply with the PSED to have 'due regard' to the need to avoid discrimination and promote equality. Indeed, Fredman has argued that, where disparate impact has been identified as part of the exercise of the PSED, pre-emptive action may be required in order to correct any practices identified as potentially discriminatory, amounting to a form of mandatory positive action.[68] In relation to reasonable adjustments, the EHRC *Code of Practice* makes clear that it will be difficult to establish proportionality, and therefore justification, where there has been a failure to make reasonable adjustments to the policy or practice in question.[69]

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[65] *R (Coll) v Secretary of State for Justice* [2017] UKSC 40.

[66] Ibid para 40.

[67] *Akerman-Livingstone v Aster Communities Ltd* [2015] UKSC 15, at 28.

[68] S Fredman, 'Addressing disparate impact: indirect discrimination and the public sector equality duty' (2014) 43(3) Industrial Law Journal 349–363, 354; and see discussion in Davies and Robison (n 33 above).

[69] EHRC (n 32 above) para 5.34.

There is case law to suggest that a willingness to make exceptions will be relevant to whether or not a policy is indirectly discriminatory. In *Watkins-Singh*, a uniform policy at the school which prohibited the wearing of jewellery was indirectly discriminatory on grounds of race and religion *because* the school had refused to make an exception to the policy in the case of a Sikh pupil who needed to wear jewellery for religious reasons.[70] Similar considerations were also evident, in the context of article 14 of the ECHR. In *AL (Serbia)*, for example, it was one of the features that led the court to conclude that the government policy of using family status to determine eligibility for indefinite leave to remain was justified. The measure was proportionate because, among other things, 'it permitted compelling claims by those falling outside the policy to be recognised and accommodated'.[71]

On the other hand, it is unlikely that a mere willingness to make exceptions in principle will always be enough to prevent a funding policy amounting to indirect discrimination. In *Eisai v NICE*, there was a challenge to NICE guidance which had recommended that Aricept, a drug manufactured by Eisai to alleviate symptoms in those with mild to moderate Alzheimer's disease, should only be funded for patients whose scores fell within a certain range on a cognitive test. Eisai argued, among other things, that the guidance was indirectly discriminatory on grounds of race and disability because the test disadvantaged those with learning difficulties and those for whom English was not a first language. NICE accepted this but argued that there was unlikely to be discriminatory impact in practice because the guidance made clear it was not to be followed slavishly – clinicians were able to identify these anomalies and funding policies and decisions could reflect this accordingly. NICE argued that this flexibility should be enough to defeat any charge of discrimination. Dobbs J in the High Court disagreed. He found that the issue of atypical groups had been dealt with in an unsatisfactory way in the guidance because:

> instead of looking at how NICE as a public body could itself promote equal opportunity, having accepted that the Guidance could have a discriminatory effect if applied slavishly, the approach taken was to leave it to others to sort out in the hope and expectation that they would.[72]

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[70] *R (on the application of Watkins-Singh) v Governing Body of Abderdare Girls' High School* [2008] EWHC 1865.

[71] *AL (Serbia) v Secretary of State for the Home Department* [2008] UKHL 42 at 3.

[72] *Eisai Limited v The National Institute for Health and Clinical Excellence (NICE)* [2007] EWHC 1941 (Admin) at 83.

This failure to deal adequately with disadvantaged groups in the guidance meant that the guidance did amount to indirect discrimination.

Making exceptions for a group – or being open to making exceptions for individuals – on the basis of personal characteristics may also undermine the aim of the original funding policy decision in some circumstances. This is most obviously the case where the original policy relates to a treatment which would be wholly or mainly likely to benefit a protected group if it were available, but where a decision has been made that the resources to fund that treatment would be better spent elsewhere. In these circumstances, the onus will be on commissioners to justify the original policy as proportionate in the context of wider funding priorities. Even where this is not the case, the likely size of the group for which exceptions are potentially appropriate should – arguably at least – have a bearing on whether or not they need to be made in order to justify the original funding policy. The likely cost of making exceptions will have a direct bearing on the reduction in resources available for other patients and should therefore be relevant to any proportionality assessment which involves the weighing of disadvantage to those who will be impacted by the measure.

CONCLUSION

Equality law has long recognised that the requirement to treat likes alike can only go so far in eliminating unfair discrimination and promoting equality. Being blind to personal characteristics will often create or entrench disadvantage where those characteristics inhibit access to available services or are otherwise relevant to the impact a policy will have on those to whom it applies. In the ways described above, therefore, the law sometimes permits, and sometimes requires, service providers and others subject to equality law to make exceptions to general rules so as to eliminate disadvantage experienced by particular groups in access to healthcare. Using, or complying, with these provisions presents a number of challenges for policy-makers, however.

It will have become apparent in the discussion above that there is still some uncertainty over the boundaries of permissible positive action and the question of what will amount to a reasonable adjustment. One thing does seem clear, however: an IFR policy, or an approach to identifying exceptions to a funding policy which excludes altogether the relevance of protected characteristics from considerations of exceptionality is likely to be legally problematic. As well as identifying the likely disparate impact of funding policies on protected groups as part of the exercise of the PSED, commissioners should consider whether exceptions can or should be made for protected groups. Exceptionality policies should make clear that exceptions will be made for individuals disadvantaged by protected characteristics where required by law. Consideration should also be given to the circumstances under which use will be made of the optional positive action provisions to redress disadvantage or meet needs.

As Chris Newdick has long argued, there is a need to balance the compelling cases of individuals against the healthcare needs and outcomes of the wider population, and as a result the legal framework needs to permit commissioners to find an appropriate compromise between realising individual rights and addressing communitarian concerns. This was recognised by the High Court in *Condliff* where it was held that:

> it is impossible to see how the Social Factors Exclusion, as part of the PCT policy of medical resource allocation, does not amount to a fair balance between the individuals seeking treatment under the IFRs and the medical requirements of the community as a whole.[73]

One of the challenges posed by the equality law framework, and in particular the provisions discussed above, however, is that it requires commissioners to also consider a third dimension in arriving at this balance: that of groups whose shared characteristics disadvantage them, or give rise to particular needs, in relation to individual treatments or interventions or more generally in relation to access to healthcare or health outcomes. This is not to suggest that groups disadvantaged by protected characteristics need be prioritised or treated more favourably than those disadvantaged in other ways. As was seen above, there is scope to consider the impact of making exceptions for protected groups and individuals on other patients in the context of determining proportionality (for positive action and indirect discrimination) or reasonableness (for reasonable adjustments), but consideration of the needs of these groups must be part of the balancing act.

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[73] Waksman LJ in *R (on the application of Condliff)* (n 17 above) 67.