

# The right to health in the United Kingdom

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How far can a right to health be said to exist in the United Kingdom (UK)? The UK is a signatory to the International Covenant on Economic, Social and Cultural Rights and is a state party to the EU Social Charter, and to this extent there may be said to exist a commitment to the health-related rights expressed in those instruments. Furthermore, leading British scholars have emphasised the significance of rights (albeit not the right to health alone); the ‘fathers’ of medical law as an academic discipline in the UK argued that the field was a “subset of human rights law” ([1], 3), while a more recent analysis notes a “strong argument that the conceptual unity of medical law is human rights” ([2], 2).

Yet, when we turn from what many might see as statements of aspiration or ‘mere’ academic opinion to the practical reality of delivery of healthcare in the UK, the place of the right to health becomes much less distinct. This is perhaps unsurprising when one considers a broader historical and socio-political context in which the relationship between the individual and the British state was traditionally regulated not through positive rights but rather through negative ‘civil liberties’; freedom and autonomy were, in essence, residual. In the case of healthcare, this manifested itself through an *organisational* approach post-World War II; the state-individual nexus was understood not in terms of *rights of access* to treatments and services, but rather as a *duty* placed upon government

*to promote the establishment in England and Wales of a comprehensive health service designed to secure improvement in the physical and mental health of the people ... and the prevention, diagnosis and treatment of illness.*<sup>1</sup>

This was to be done by establishing institutions and processes within a National Health Service (NHS) underpinned by principles of comprehensiveness, universal access and free provision at the point of delivery. Hence, the creation of a sizable health infrastructure, an organisation which remains the third largest employer in the world, behind the Chinese Red Army and the Indian Railways.

Even the UK’s late (and still ambivalent) conversion to positive rights, which takes the form of ‘domestication’ of the European Convention on Human Rights via the Human Rights Act 1998, has had little direct impact upon this state of affairs. Perhaps fortified by the ab-

sence of a right to health within the Convention, courts have been generally dismissive of its relevance to litigation on access to services and treatments. Thus, in a case regarding access to gender reassignment surgery decided shortly before the 1998 Act came into force, the Court of Appeal described an argument deploying Article 3 as one which “strains language and common sense and even more seriously trivialises that Article in relation to the very important values that it in truth protects”.<sup>2</sup> More recently, a claim founded upon Article 8 relating to provision of gastric band surgery for a morbidly obese patient was dismissed by the same court, in this instance by reference to the Strasbourg jurisprudence which establishes that there is a wide margin of appreciation accorded to state authorities in realising any positive obligation in the area of provision of state benefits.<sup>3</sup>

However, beneath the surface, the picture is more complex and fluid. Rights have increasing purchase within the NHS, but in a somewhat distinct manner from that which may be familiar to those working in, or studying, other health systems. Two particular strands may be identified.

First, over some two decades, there has been a consistent governmental emphasis upon expansion of a patient’s ‘right to choose’ within a health system which otherwise appears somewhat centralised and ‘top-down’ in orientation. The most recent (and radical) reform of the NHS, undertaken by the Conservative-Liberal Democrat administration which was in office between 2010 and 2015, was in part underpinned by the slogan ‘No decision about me, without me’, capturing the idea of the patient as active participant (albeit, perhaps not an equal partner) in treatment decisions. The goal is ‘shared decision-making’, ranging from relatively straightforward exercises of individual autonomy – such as the right to choose the time and location of specialist secondary care – to more complex decisional processes, such as agreed plans of care for particular conditions informed by the use of patient decision aid tools [3]. One notable example of this form of right is the development of the personal health budget, whereby certain adults and children with long-term conditions receive an amount of money to manage their health and well-being needs, purchasing care directly themselves wherever this is feasible.

1 National Health Service Act 1946, section 1(1).

2 R v North West Lancashire Health Authority, ex parte A, D and G [1999] EWCA Civ 2022 (Buxton LJ).

3 R (on the application of Condliff) v North Staffordshire Primary Care Trust [2011] EWCA Civ 911.

A further development has been the emergence of rights connected to decision-making on funding of healthcare treatments and services. Prompted in part by judicial decisions in the field ([4], chapter 6), government has imposed legal obligations upon healthcare institutions to provide explanations for decisions to refuse particular forms of treatment to which a patient and their physician seek access. It has also mandated establishment of internal processes which enable patients to demonstrate that their individual circumstances warrant exceptional departure from an institution's policy not to fund a treatment or service for its local population. More generally, there is an expectation that decisions on what will be made available on the NHS – whether undertaken by national agencies such as the National Institute for Health and Care Excellence (NICE), or by local commissioners of health provision – will be rationally rooted in the best available evidence. These requirements are expressed not only in the traditional form of duties placed upon NHS institutions, but also as rights vested in patients, set out in an *NHS Constitution for England*. Something of a departure for a jurisdiction with no codified constitutional document delineating the structure and functions of its political institutions, the *Constitution* was created as a means of articulating the purpose, principles and values of the NHS with a view to preserving them for the future, to strengthen accountability by specifying expectations and lines of accountability, and to 'empower' patients (and NHS staff) by clarifying rights and responsibilities through codification ([5], chapter 7). There is a legal obligation placed upon a broad range of NHS institutions to 'have regard' to the *Constitution* when exercising functions relating to the commission, provision or regulation of health services, and courts have shown willingness to enforce this requirement.<sup>4</sup> Yet it should be noted that the *Constitution* is almost entirely declaratory in character – that is, it merely sets out existing rights and responsibilities derived from statute or common law rather than creating new ones – and the Government has conceded that "it is not yet having the effect originally intended", in large part because awareness of its existence remains low ([6], paragraph 140).

4 Health Act 2009, section 2; R (on the application of Booker) v NHS Oldham and Direct Line Insurance plc [2010] EWHC 2593 (Admin).

What, then, does this very brief snapshot tell us? Perhaps the best way to conceptualise the above developments is that they are reflective of the frequently incremental character of policy-making in Britain, both in healthcare and elsewhere [7, 8]. There has been no dramatic shift towards providing substantive rights of access to particular healthcare treatments and services, which might put significant financial pressure on an already cash-strapped Service, as well as placing its solidaristic principles under severe strain. But a gradual evolution of both procedural and 'market-oriented' rights to choose has subtly altered the position of the patient vis-à-vis those delivering healthcare, according more power to the former while not wholly undermining the traditional focus upon realisation of collective goals and values through organisational and institutional means. In sum, the NHS, "the closest thing the English have to a religion" ([9], 613), remains a fascinating, if sometimes frustratingly complex, subject of study for those who are interested in the changing patterns of relations between the individual and the state in a modern polity.

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