2005 Journal for Juridical Science 30(2): 1-29

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Revisiting the judicial role in the allocation of healthcare resources: on deference, democratic dialogue and deliberation

Summary

The objective of this paper is to engage in critical reconsideration of the nature and value of the judicial role in situations where courts adjudicate upon questions connected to the allocation of scarce healthcare resources via the processes of public law. The argument posited is that the predominantly negative perspective which is adopted towards judicial involvement in issues of this type, although to some extent explicable, fails to capture the potential for public law adjudication to function as a deliberative mechanism. This is important because the dominant strand in contemporary health policy theory identifies proceduralisation through deliberative arrangements as a response to the problems, notably those of legitimacy, which have been generated by the evolution and development of explicit strategies of priority-setting or the 'rationing' of access to health-care resources. In order to assess the prospects of the courts fulfilling a deliberative role of this type, a comparative survey of three jurisdictions in which such issues have come before the courts — England, Canada and South Africa — will be conducted.

Herbeskouing van die geregtelike rol in die toewysing van gesondheidsorghulpbronne: oor ontsag, demokratiese dialoog en beraadslaging

Die doel van hierdie artikel is om 'n kritiese herbeskouing te doen van die aard en waarde van die geregtelike rol in situasies waar howe uitspraak gee oor vrae wat verband hou met die toewysing van skaars gesondheidsorghulpbronne *via* die prosesse van publieke reg. Die argument wat gespostuleer word is dat die oorwegende negatiewe perspektief wat ten opsigte van geregtelike betrokkenheid in aangeleenthede van hierdie aard gehuldig word, alhoewel tot 'n mate verklaarbaar, nie daarin slaag om die potensiaal van publiekereg-beregtiging om as 'n *beraadslagende* meganisme te funksioneer, weergee nie. Dit is belangrik omdat die heersende draad in kontemporêre gesondheids-beleidsteorie die daarstelling van prosedures deur middel van beraadslagende reëlings, as 'n respons op die probleme identifiseer, vernaamlik dié van legitimiteit wat gegenereer is deur die evolusie en ontwikkeling van eksplisiete strategieë van prioriteitstelling of die 'rantsoenering' van toegang tot gesondheidsorghulpbronne. Ten einde die vooruitsigte van die howe om te voldoen aan 'n beraadslagende rol van hierdie aard te assesseer, sal 'n vergelykende opname van drie jurisdiksies waarin sodanige aangeleenthede voor die howe gekom het, te wete Engeland, Kanada en Suid-Afrika, uitgevoer word.

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1. Introduction

The objective of this paper is to engage in critical reconsideration of the nature and value of the judicial role in situations where courts adjudicate upon questions connected to the allocation of scarce healthcare resources via the processes of public law.[1] The argument posited is that the predominantly negative perspective which is adopted towards judicial involvement in issues of this type, although to some extent explicable, fails to capture the potential for public law adjudication to function as a deliberative mechanism. This is important because the dominant strand in contemporary health policy theory identifies proceduralisation through deliberative arrangements as a response to the problems, notably those of legitimacy, which have been generated by the evolution and development of explicit strategies of priority-setting or the 'rationing' of access to healthcare resources. In order to assess the prospects of the courts fulfilling a deliberative role of this type, a comparative survey of three jurisdictions in which such issues have come before the courts — England, Canada and South Africa — will be conducted. First, however, it is necessary to examine the concerns which underpin the contention that the role of the courts in this field should be minimal, before moving to a consideration of the significance of deliberative democratic theory in this policy context.

2. The courts and the rationing of healthcare resources

The prevailing attitude towards judicial involvement in cases which turn upon the allocation of scarce healthcare resources has been negative. A leading commentator upon rationing in the United Kingdom's National Health Service (NHS) has argued that 'there is no place for the courts in rationing healthcare. The law is too blunt a weapon in an area of moral and ethical choices that are heavily contingent upon the circumstances prevailing in a particular case'.[2] Similar views have been expressed in relation to the United States[3] and Canada.[4]

One might speculate that such assessments merely reflect a limited conception of the societal function of law. English public lawyers, familiar with the 'colour' metaphors adopted by Harlow and Rawlings to delineate the differing expressions of the relationship between public law (particularly, administrative law) and the state,[5] would classify the perspective adopted by the health policy commentators cited previously as being rooted in the 'red light' view. On this analysis, the role of the courts is to give effect to the rule of law through the articulation and imposition of legal norms. The function of such norms is to *control and constrain* the exercise of discretion by administrative agencies (such as health authorities or other bodies

1 Issues of scarce resources also arise in private law, especially the law of tort, but are beyond the scope of the present paper. For a discussion of these in the English context, see Newdick 2004: Chapters 6 and 7.
2 Hunter 1995:881.
3 See, for example, Daniels and Sabin 1997:341.
4 See, for example, Manfredi and Maioni 2002.
5 Harlow and Rawlings 1997: Chapters 2-5. For a more recent analysis based upon similar imagery, see Tomkins 2002.

involved in the allocation of healthcare resources), the goal being that the state should intervene as minimally as possible in the lives of individual citizens for whom liberty will thereby be maximised. Law and politics are juxtaposed, and adjudication takes the classic form of adversarial argument of fact and legal principle in front of an impartial and politically independent judge.

When viewed in this fashion, it is unsurprising that observers are sceptical of the value of law in assisting in resolving the broad social, ethical and political problems to which the rationing of health resources gives rise. Law is seen as concerned with the individual, rather than the community, and may therefore be regarded as an avenue through which discrete challenges may be mounted *against* collective decisions on allocation. For those who wish to achieve an equitable and politically justifiable form of allocation of resources within health systems as a whole, seemingly *ad hoc* legal challenges risk causing significant disruption as funds are diverted from one service into another in order to comply with the court's ruling. The legal process should therefore be avoided at all costs.

However, this is merely one possible perspective on the nature and function of public law, albeit that in England (and, to some extent, in other common law jurisdictions) it has tended to dominate both practice and theory, given the continuing influence of its main exponent, Dicey.[6] A more facilitative conception, captured in Harlow and Rawlings' 'green light' metaphor, regards law as inextricably linked to politics and views the state as a means for securing individual and collective liberty, for example by the provision of healthcare, educational or social services. On this analysis, the role of the courts is to articulate principles of good administration which will assist decision-makers in carrying out policies in the interests of the community as a whole. Law can therefore function to guide and structure administrative decisions, for example by requiring that such decisions be fully reasoned, based upon evidence and that they take place only after consultation of affected interests. If this alternative vision of law is accepted, then it no longer appears self-evident that rationing choices should be 'insulated' from the legal process. Rather, the law may make a useful contribution by articulating certain procedural values which, if complied with by those who must make rationing choices, would assist in securing the democratic legitimacy of such decisions. It is this positive contribution which this paper seeks to highlight.

Yet, while unfamiliarity with this second, more positive conception of law might explain the attitude taken by those working within the health policy community, an alternative explanation would appear to be demanded if we are to account for the stance of *judicial* restraint on rationing questions, perhaps best captured in Sir Thomas Bingham MR's well-known statement in the English Court of Appeal that 'Difficult and agonising judgments have to be made as to how a limited budget is best allocated to the maximum advantage of the maximum number of patients. That is not a judgment which the court can make.

6 See Dicey 1959.

In my judgment, it is not something that a health authority … can be fairly criticised for not advancing before the court'.[7]

It is submitted that this can best be understood as reflecting interrelated concerns as to constitutional and institutional competence.[8] The former notion may best be understood with reference to the doctrine of separation of powers and the appropriate role for the judiciary in a democratic society. Questions concerning the allocation of scarce resources for public services, such as healthcare, ought not to be resolved by courts because such matters should be subject to some degree of democratic control and accountability: for a court to substitute its evaluation of the public good for that of the legislative or executive decision-maker would be democratically illegitimate. By contrast, institutional competence refers to the capacity of the court to address the questions before it, given the nature of the adjudicative process. Particularly relevant in this regard are two factors. First, adjudication, especially of an adversarial nature, is not well-suited to the resolution of polycentric questions, of which healthcare rationing is an archetypal example.[9] Secondly, decisions on the allocation of healthcare resources are likely to be premised upon the availability of factual information — such as data upon the clinical and cost-effectiveness of a particular treatment — and the bringing to bear of expert judgment upon this information, both of which will restrict the role of a non-specialist judiciary.

To an extent, considerations of constitutional and institutional competence operate with differing intensity at the various levels at which healthcare rationing takes place, although it should be noted that these levels of decision-making are inextricably interwoven. At the 'macro' level, at which decisions are taken as to the proportion of expenditure to be allocated to healthcare as distinct from other items of government expenditure such as defence or education, constitutional competence is most relevant and courts will act in a very restrained manner, regarding such choices as matters of 'high policy' and therefore as wholly non-justiciable. At the 'meso' level, where decisions are taken as to the proportion of healthcare expenditure to be allocated to one treatment *vis-à-vis* another, courts may still express concerns of constitutional competence, especially if the decision is taken by an elected official.[10] However, institutional competence is also relevant here, in that such choices may well entail a comparative evaluation of criteria such as clinical effectiveness which will require specialised knowledge and information which is unavailable to the judiciary. This combination of limitations renders it similarly unlikely that courts will intervene in cases of

7 *R v Cambridge Health Authority, ex parte B* [1995] 2 All ER 129 (CA) 136. Here, the Court of Appeal refused to overturn the decision of the health authority not to provide experimental treatment, at an estimated potential cost of £75,000, to a ten year-old child suffering from acute myeloid leukaemia. For discussion, see James and Longley 1995.

8 See Jowell 1999:451.

9 For the classic statement of the limitations of the judicial role in this regard, see Fuller 1978.

10 See especially *R (on the application of Pfizer Limited) v Secretary of State for Health* [2003] 1 CMLR 19 (CA).

this type. Rather, they are most likely to intervene where decisions are taken to provide or deny access to treatment to a particular individual. As Newdick has argued, 'it is at this micro-level that rationing causes most anguish'[11] and it is reflective of the individualistic nature of common law adjudication that this is the stage at which the legal process is most often engaged, and with the greatest prospect of success. Nonetheless, considerations of competence continue to remain strongly relevant here. In particular, courts are likely to feel deficient in the expertise necessary to determine the appropriateness of the proposed treatment for the individual, as in the *Cambridge Health Authority* case.

In summary, therefore, minimal involvement of the courts in questions of healthcare rationing reflects both theoretical and jurisprudential concerns. However, the existence of competing theoretical perspectives on the function of public law, and variability in degrees of constitutional and institutional lack of competence, suggest that a minimal judicial role is not a *sine qua non* of adjudication in this field of public policy. In order to sketch out an alternative role for the legal process, it is necessary to turn to current thinking in health policy theory.

3. The importance of deliberation

An influential body of recent work within health policy literature has stressed the value of focusing upon the *process* by which rationing decisions are reached, rather than the substantive criteria upon which such choices might be based. The premise underlying this approach is that, given the plural nature of society, consensus on the appropriate social or ethical criteria which should underpin rationing decisions is unlikely to be achieved — in particular, there is likely to be a frequent clash between individual need and a utilitarian calculus of the interests of the broader community, as was apparent from the *Cambridge Health Authority* case. Hence, in the absence of substantive agreement, attention has turned to the design of procedures for decision-making. The rationale and nature of this 'procedural turn' have been clearly expressed as follows:

> Even if there is no "right" answer, this does not mean that all answers are equally valid. Particularly in cases where consensus does not exist, decision-makers should strive for 'morally defensible' decisions, that is, decisions for which all relevant considerations have been duly entertained and the justificatory reasons have been clearly laid out. If others do not accept the answer, they should at least understand and appreciate the reasons that led to it and be able to challenge it on grounds of principle.[12]

11 Newdick 2004:50.

12 Williams and Yeo 2000:126. See also Klein and Williams 2000:21: 'I am not arguing that getting the process right will necessarily produce the 'right' answers. I do not think that in the context of setting health care priorities there is necessarily a 'right' answer, independent of an ever-shifting context. My contention is less ambitious: it is that the right process will produce socially acceptable answers — and that this is the best we can hope for.'

In their emphasis upon procedure, health policy theorists clearly echo the work of legal and political theorists such as Rawls[13] and Habermas.[14] Furthermore, there is a commonality of purpose across the disciplinary boundaries of law, political theory and health policy, in that a fundamental motivation underpinning the 'procedural turn' is to respond to a perceived *crisis of legitimacy* faced by modern states. In the context of healthcare, this arises because demands for resources inevitably exceed supply, with the consequence that some form of prioritisation becomes necessary. While this has always been the case, the mismatch between demand and supply did not generate a significant crisis of legitimacy until recent times, because it was primarily managed through the medical profession: physicians (who were generally trusted by the public to act in their best interests) 'internalised' resource constraints and presented allocative decisions to patients as if they were clinical in nature.[15] However, as governments sought to take greater control over the supply of healthcare (for example, through policies to introduce efficiency in the UK's NHS through the 'internal market' of the early 1990s), so it became publicly visible that access to some services and treatments was being denied on grounds of cost. In these circumstances, questions were raised as to the extent to which the body making the rationing decision possessed the moral authority to deprive individuals of a good which could be regarded as vital for personal well-being and survival. In short, a legitimacy crisis may be said to have developed as affected patients and the wider public expressed 'suspicion, distrust and even resistance' towards those undertaking allocative decisions.[16] Consequently, a major goal for health policy analysts, and for policy-makers, has become the identification of means by which such bodies can reassert their legitimacy.

The primary avenue through which this objective has been pursued is by application of principles derived from recent work in political theory. Within this field, there has been a notable shift from an aggregative conception of democracy — which emphasises the voting process — to a deliberative conception, which focuses instead upon discussion and debate among citizens. It is argued that the legitimacy of law and policy rests not upon an electoral mandate, but rather upon a process of intersubjective reasoning and justification which will encourage individuals to reflect upon their preferences in a non-coercive manner. This process *may* produce a public consensus upon issues of contested moral principle. However, should it not do so, it is nonetheless likely to be more acceptable (*ie* legitimate), both because citizens will have had an opportunity to express their views and because the act of deliberation will generate argumentation and explanation which can be accepted as mutually justifiable even if reasonable disagreement persists, given that inadequate or indefensible reasoning will be rejected in the course of debate.[17]

13 See especially Rawls 1993 and 1997:765.
14 See especially Habermas 1984 and 1996.
15 See Aaron and Schwartz 1984:100-102.
16 Daniels 2000:89.
17 For a more comprehensive explanation of the deliberative approach, see Habermas 1996, Chapter 7; Gutmann and Thompson 1996; Benhabib 1996; Elster 1997; Dryzek 2000a.

In the context of the allocation of scarce healthcare resources, commitment to deliberation entails primarily that rationing decisions should be accessible to the public and that they should be based upon evidence or criteria that citizens can accept as relevant. Thus, rationing choices should be transparent, reasoned and justifiable. Furthermore, deliberation requires that there exist a mechanism through which such decisions may be challenged and disputed, thus providing a means of feedback into the decisional process and reflecting the provisional status of any conclusions reached, which may be superseded by alternative arguments at a later date. Broad stakeholder participation in the body which undertakes rationing choices might also be thought to be of significance, although the authors of the most comprehensive attempt to apply deliberative theory to allocative decision-making in healthcare (by means of the so-called 'accountability for reasonableness' model) have argued that 'consumer participation is not generally either a necessary or a sufficient condition for establishing legitimacy'.[18] Nonetheless, consonant with deliberative theory, these authors do envisage that the fulfilment of these conditions will generate a wider debate, by 'educat[ing] clinicians and patients about the need for limits [on access to healthcare resources]'[19] and thus will set in motion a process of broad public deliberation on the necessity of healthcare rationing and the social or ethical criteria which should underpin rationing choices.

What role might the courts play in the realisation of this deliberative goal? In line with the negative standpoint on law previously outlined, the 'accountability for reasonableness' model is sceptical of the merits of judicial involvement. Its designers assert that:

> The courts are ill-equipped to deliberate about the issues of limit-setting, especially about the more technical matters … Court procedures, for example, bring opposing "experts" to bear, and they leave the final decision up to those with no expertise about the technical matters, whether judges or juries. This may simply not be the best way to deliberate about these matters, despite its appearance of a "democratic" input through the opinion of peers.[20]

However, such an analysis appears to disregard the potential for the legal process to function in a facilitative manner. The judicial articulation and enforcement of values of good administrative decision-making such as reason-giving, provision of evidence and rationality, which are inherent in public law,[21] may serve to assist in the attainment of systemic legitimacy for those who must allocate scarce healthcare resources through the creation of a deliberative judicial space, as will be argued in the following section. For this reason, it is submitted that the potential contribution which may be made by the courts merits closer scrutiny. In particular, the degree of congruence between a number of the key principles of public law and the values which should inform a deliberative approach to the allocation of healthcare resources, coupled with a shared common focus

18 Daniels and Sabin 2002:62.
19 Daniels and Sabin 1998:51.
20 Daniels and Sabin 1997:341.
21 For a discussion along similar lines, see Syrett 2002:18-24.

among writers upon health policy and public lawyers on the evaluation of and possible reform of strategies of legitimation,[22] suggest that the legal process ought to be a central component of a deliberative approach to rationing, not the marginalised source of annoyance which has most frequently been depicted by health policy commentators.

4. Giving effect to deliberation through the courts

Deliberative theorists have tended to focus upon relatively new mechanisms such as citizens' juries and deliberative polls as means of implementing deliberative democracy. More traditional forms such as legislatures and judicial *fora* have been less enthusiastically received, in part because these are seen as integral to the dominant aggregative conception of democracy and also because any deliberation which does take place in these institutions tends to be fragmentary, elite-based and relatively lacking in interactivity. In addition, courts are themselves undemocratic institutions, which clearly renders them problematic as agents of deliberative democracy.[23]

Other theorists, however, have been more willing to accede to a role for the judiciary in fostering deliberative democracy. For example, Rawls regards the Supreme Court as a deliberative in character,[24] while Nino has argued that

> judges can, and should, adopt measures that will promote the process of public deliberation over the issue or a more careful consideration on the part of political bodies … Through such mechanisms, judges would have an active role in contributing to the improvement of the quality of the process of democratic discussion and decision, stimulating public debate and promoting reflective decisions.[25]

It is important to identify the manner in which courts are capable of creating a deliberative space. First, adjudication upon the instant case may itself be seen as deliberative, in that a considered decision is delivered following a process of explanation and justification by both parties: that decision may be viewed as an attempt to appeal to the reason of the losing party who should accept it as justifiable in light of the evidence and principles of law, notwithstanding that (s)he may have suffered as a result. The judicial enforcement of relevant procedural standards should also encourage more reflective, considered decision-making on the part of the rationing agency in future cases if it is to avoid further legal action.

However, Nino's observation also points to an additional sense in which courts may function as deliberative agencies. That is, the public nature of adjudication (enhanced by the increasing accessibility of court judgments through the internet and other media) enables courts to act as 'triggers' for debate, stimulating wider deliberation by offering reasoned decisions which can generate a process of dialogue with other branches of government and which fosters a debate

22 See further, Prosser 1982.
23 See, for example, Dryzek 2000b:6-7.
24 Rawls 1997:231.
25 Nino 1996:215-216.

within the broader civil society. In this manner, the function of public law adjudication should be seen as opening up, rather than closing off, a range of possible policy options which will subsequently receive a full airing. Such adjudication is therefore 'catalytic rather than preclusive',[26] or, in the terms employed by Daniels and Sabin, it is 'educative'.[27]

In order to perform a deliberative task of this nature in the context of the rationing of healthcare, the courts require both the conceptual tools (in the form of relevant legal principles) and a preparedness to regard themselves as institutionally and constitutionally competent to engender a political and public dialogue upon priority-setting. The extent to which these conditions are present will now be analysed, with reference to the three jurisdictions previously enumerated.

4.1 England

Adjudication on issues of healthcare rationing through public law processes in the English courts has taken place almost entirely by means of judicial review of administrative action. Human rights principles are yet to have a major impact in case law on access to medical treatments.[28] For example, although arguments based around the European Convention on Human Rights were raised in the case of *R v North West Lancashire HA, ex parte A, D and G*, the Court of Appeal was highly critical of these, labelling them as 'unfocused', 'unhelpful', 'irresolute' and 'misplaced'.[29]

The consequence of this is that the role of the court as a deliberative forum or catalyst has necessarily been constrained, to date, by the parameters of the principles of judicial review.[30] Traditionally, these have been regarded as

26 Sunstein 2001:11.

27 See note 19 above and accompanying text.

28 But note the decision in *R v North and East Devon Health Authority, ex parte Coughlan* [2001] QB 213, where the closure of a residential care facility for those in need of long-term nursing care — a decision which had been taken on resource grounds — was held to be unlawful on the basis, *inter alia*, that Article 8 (the right to respect for private and family life, home and correspondence) of the European Convention on Human Rights had been violated.

29 [2000] 1 WLR 977 (CA) at 996-7 (Auld LJ). The case involved a challenge brought by three transsexuals whose health authority had refused to fund gender reassignment surgery. It had been argued that Articles 3 (right not to be subjected to inhuman or degrading treatment or punishment), 8 and 14 (freedom from discrimination in respect of enjoyment of other rights) of the European Convention on Human Rights were engaged as a result of the denial of treatment. While these arguments were rejected, the health authority's decision was overturned on the ground, *inter alia*, that it had failed to justify its reasoning for departure from a strong and respectable body of medical evidence as to the effectiveness of the treatment, for which see further below.

30 It seems highly likely that a legal challenge to a decision which denies access to treatment on resource grounds will be formulated on the basis of the Human Rights Act 1998 in the near future. For a threat to use the Act in such circumstances, see *Guardian Unlimited* 8 November 2005. The issue was settled before coming to court.

a less potent form of control than rights-based review, focused as they are merely upon the powers of the decision-maker and the process by which the decision is reached, rather than the substantive content of the choice made: the courts also lack a constitutional mandate to invalidate legislation (or, under the UK Human Rights Act model, to declare that it is incompatible with rights instruments). In such circumstances, the courts have frequently invoked the notions of institutional or constitutional lack of competence to justify allowing the decision-maker a discretionary area of judgment, in accordance with their perceptions as to Parliament's wishes. This deferential approach has been realised through application of the *Wednesbury* test,[31] which permits judicial intervention only in the most egregious cases. This principle provided the jurisprudential underpinning for the restrained approach evident in the leading judgment of Sir Thomas Bingham MR in the *Cambridge Health Authority* case.[32]

Where a court, such as the Court of Appeal in *Cambridge Health Authority*, apparently rests content with a mere 'tolling of the bell of tight resources' and refuses to require the health authority to 'explain the priorities which have led them to decline to fund the treatment' (as had been demanded by Laws J at first instance),[33] the conditions for deliberation are clearly not met. As James and Longley have observed, the court could have assisted in securing legitimacy for the rationing choice by 'structuring decision-making and ensuring that the policy choice made, even if reasonable, is explained and justified … This requires not only that all relevant factors are taken into account but also that they are subjected to a rigorous and open analysis before a conclusion is reached',[34] and its failure to do so may be regarded as regrettable for the reasons outlined in this paper. Paradoxically, it may be argued that the decision in *Cambridge Health Authority* did have a deliberative impact in that it provoked widespread media, public and political debate on the phenomenon of healthcare rationing in the NHS.[35] Nonetheless, this may be seen as having occurred despite, rather than because of, the Court of Appeal's judgment.

More recently, however, the English courts have adopted a somewhat more searching standard of scrutiny in cases concerning the allocation of scarce healthcare resources, reflecting a broader shift in the balance between executive and judiciary and influenced by the development elsewhere in English public law of the more searching standard of scrutiny implicit in the principle of proportionality.[36] In three cases — *R v North Derbyshire HA, ex p Fisher*,[37]

31 *Associated Provincial Picture Houses v Wednesbury Corporation* [1948] 1 KB 223.
32 See note 7 above, and accompanying text.
33 [1995] 1 FLR 1055 (QBD) at 1065-6.
34 James and Longley 1995:373.
35 For discussion, see Ham and Pickard 1998.
36 See Newdick 2004:128.
37 (1997) 8 Med LR 327 (QBD). The case concerned the departure by a health authority from government guidance on the provision of beta interferon for patients suffering from multiple sclerosis. Dyson J held that, while the guidance was not mandatory, any departure from it had to be properly justified.

R v Secretary of State for Health, ex parte Pfizer Limited[38] and *R v North West Lancashire HA, ex p A, D and G* — the courts have shown greater willingness to require the body which restricts access to treatment to provide an explanation of its thinking, particularly in situations where the decision apparently contravenes Government guidance on the availability of a particular treatment, interferes with clinical freedom without proper justification, or contradicts a body of medical thinking.[39] The obligation to provide reasons which is imposed by the courts in these cases should serve to encourage more considered and reflective decision-making on the part of those charged with resource allocation in healthcare. Moreover, it may render rationing choices more accessible and open up the possibility of a fuller and more informed public debate upon allocative decision-making, although it is noteworthy that the only one of these cases which in fact generated a level of public interest approaching that witnessed in the *Cambridge Health Authority* case was *Pfizer*, which concerned the controversial decision to limit the availability of Viagra on the NHS to those with specified medical conditions.

Notwithstanding this development, the continued limitations of principles of judicial review as a means of realising a deliberative approach to the rationing of healthcare should be acknowledged. These were exemplified by a second challenge to the restricted availability of Viagra, in *R (on the application of Pfizer Limited) v Secretary of State for Health*.[40] In this case, the Court of Appeal held that Article 7 of the EC 'Transparency Directive',[41] which requires that publicity should be given to criteria which inform decisions to exclude medical treatments from the coverage of a national health insurance system and that the drug manufacturer be provided with 'a statement of reasons based on objective and verifiable criteria … including, if appropriate, any expert opinions or recommendations on which the decisions are based' had not been breached even though the UK government had merely issued a statement which pointed out that the treatment was expensive, but which provided no further explanation. The court accepted the argument that the government's decision in this case was 'an essentially political judgment, that is not within the province of a reviewing court',[42] and demanded no further analysis of relative priorities or of the clinical or cost-effectiveness of this treatment as compared with others. This appears to fall well short of judicial endorsement of a deliberative approach. Indeed, Simon Brown LJ appears to place responsibility for generation of a wider public debate firmly upon the executive branch, in endorsing the recommendation of the parliamentary Select Committee on Health that '*government* must work

38 [1999] Lloyd's Med Rep 289 (QBD). A government circular which purported to provide interim guidance to doctors on the prescription of Viagra was ruled unlawful as an improper constraint upon clinical judgment, the reasons for which had been insufficiently communicated. Collins J also found that there had been a violation of the EC 'Transparency Directive', for which see n.41 below and accompanying text.

39 For further discussion of these cases, see Newdick 2004:100-109.

40 *R (on the application of Pfizer Limited) v Secretary of State for Health*. The case is analysed in Syrett 2004.

41 Directive 89/105/EEC.

42 *R (on the application of Pfizer Limited) v Secretary of State for Health*, para 8 (Simon Brown LJ).

to achieve a comprehensive framework for health care prioritisation, underpinned by an explicit set of ethical and rational values to allow the relative costs and benefits of different areas of NHS spending to be comparatively addressed in an informed way'.[43] There seems little scope here for a genuine involvement of the judiciary in deliberation on the rationing of healthcare, particularly at the 'macro' and 'meso' levels.

4.2 Canada

4.2.1 Judicial review of administrative action

Principles of administrative law have also been used as the basis of legal challenge to decisions involving the rationing of healthcare resources in Canada. For example, in *Stein v. Quebec (Regie de l'Assurance-maladie)*, the Supreme Court of Quebec held that cancellation of liver cancer surgery on three separate occasions, entailing a delay in surgery well beyond the eight weeks which had been recommended by physicians, was unlawful on account of irrationality.[44] However, it should be noted that the court expressed its awareness of the need to establish constitutional and institutional competence prior to intervention, arguing that it would review 'with caution and deference and will intervene only when the evidence, viewed reasonably is incapable of supporting the findings of fact or when the tribunal's interpretation of the legislation is patently unreasonable'.[45] This appears broadly akin to the *Wednesbury* standard applied in English case law.

4.2.2 Human Rights

From the perspective of deliberative theory, the more interesting form of adjudication in the Canadian context takes place under the Canadian Charter of Rights and Freedoms. Although the Charter upholds civil and political freedoms, and thus contains no right of access to healthcare, it has nonetheless provided the legal basis of challenge in a number of cases involving rationing of resources. The most relevant right has been section 15,[46] which guarantees the right to the equal benefit of the law without discrimination on certain enumerated (such

43 *R (on the application of Pfizer Limited) v Secretary of State for Health*, para 17. See House of Commons Select Committee on Health, para 105 (emphasis added).

44 [1999] RJQ 2416 (SC).

45 Stein v Quebec, para 18.

46 Note also section 7, which protects the right to life, liberty and security of the person. In *Chaoulli v Quebec (Attorney General)* 2005 SCC 35, the Supreme Court of Canada controversially ruled that legislative provisions prohibiting private health insurance for services covered by the public health system was a violation of section 1 of the Quebec Charter of Rights and Freedoms, which safeguards the right to life and personal security, inviolability and freedom. However, no decision was reached on whether there had been a violation of section 7 of the Canadian Charter, although three of the seven judges held that such a violation had occurred. For a comprehensive discussion of the case and its implications, see Flood, Roach and Sossin 2005.

as sex, age or mental or physical disability) or analogous grounds. This has been interpreted as guaranteeing *substantive* equality for Canadians, with the consequence that legislation which has an adverse impact upon an enumerated or analogous group may violate the Charter even if, on its face, it provides for identical treatment.[47]

The presence of this right within the Charter has therefore endowed the judiciary with the constitutional competence to intervene in cases where particular treatments or services are excluded from publicly-funded health provision, notwithstanding the ostensible exclusion of social and economic rights from Charter protection. Thus, in *Eldridge v British Columbia (Attorney General)*,[48] the plaintiffs successfully argued that a refusal to fund sign language interpreters for deaf patients denied them the opportunity to benefit equally with other citizens in the provincial Medicare programme by preventing them from communicating effectively with medical personnel. More recently, in *Auton v British Columbia (Attorney General)*,[49] a group of parents challenged the decision of the government of British Columbia not to provide public funding for a form of intensive early behavioural intervention for autistic children. Their argument succeeded at first instance and on appeal, the courts holding that the refusal amounted to discriminatory differential treatment (in comparison with non-autistic children or mentally disordered adults) in respect of access to 'medically necessary' services. However, the Supreme Court of Canada reversed the decisions of the lower courts, holding that the exclusion of particular 'non-core' treatments and services from public provision was consistent with the overall legislative scheme for publicly-funded health care and that there had consequently been no discriminatory treatment of the plaintiffs contrary to section 15.

Section 15 of the Charter therefore offers the primary *substantive* basis for judicial intervention in healthcare resource allocation cases, enabling the courts to act as deliberative agencies in the first of the senses previously identified, that is, between the parties in the case in question. However, it can be argued that it is other key features of the Charter structure, in combination with the substantive leverage afforded by section 15, which facilitate a deliberative judicial role in the second of the two senses, that of catalysing public and political debate. These are sections 33, the 'notwithstanding' mechanism,[50] and section 1, which is a general limitation clause stipulating that the Charter rights are guaranteed 'subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society'. The former provision enables legislatures to override Charter rights, as interpreted by the courts, for whatever purpose it selects during a renewable five-year period, while the latter places the burden upon government to introduce evidence to justify the limitations which it has placed upon rights in pursuit of a legitimate and important governmental objective.

47 See Jackman 1998:352-371.
48 [1997] 3 SCR 624.
49 [2004] 3 SCR 657.
50 For detailed analysis of the significance of section 33 in respect of the deliberative function of constitutional adjudication, see Kahana 2002.

Taken together, these structural devices facilitate 'dialogic' judicial review in Charter adjudication.[51] On this analysis, a court's ruling initiates a process of dialogue between the courts and the other branches of government as to whether, how, and how far, to give effect to Charter obligations which have been upheld by the judiciary. Inevitably, this political process will feed into a wider debate within civil society, centring upon the right which has been violated, the justification for such violation and the possibility of reconciling the legislative objective with the judicial interpretation. As Roach notes, this may be particularly important in situations where government and legislature are reluctant to 'confront issues of principle and exclusion that they would rather ignore. Dialogic judicial review may serve as a means of placing important and uncomfortable issues on the legislative agenda'.[52] It is submitted that this characteristic renders this form of adjudication especially pertinent to questions regarding the allocation of scarce healthcare resources. Given the controversy and unpopularity which attends any overt restriction upon access to healthcare resources, governments have tended to adopt strategies of 'blame avoidance' on issues of priority-setting.[53] In such circumstances, a ruling by a court under the Charter will serve both to draw public attention to issues on which government might otherwise equivocate and, through imposition of the requirement to provide demonstrable justification under section 1, will inform the public both as to the necessity of rationing healthcare resources and the evidence and principles which are relevant to making priority-setting choices. In this sense, public law adjudication may be said to play the 'educative' function which is regarded by Daniels and Sabin as a vital precursor to any genuine form of public deliberation upon rationing.[54]

The manner in which Charter adjudication contributes to deliberation in the two senses previously outlined may be illustrated by reference to the *Eldridge* and *Chaoulli* cases. In the former, the original decision to refuse funding for medical interpretation services for the deaf had been taken within a committee of the Ministry of Health, following a twenty-minute review of a ministerial briefing note and in the absence of any analysis of the cost-effectiveness of the provision of interpretation services.[55] In these circumstances, the judicial arena provided a much fuller opportunity for deliberation than had been afforded by the legislative process, in that the provincial government was required to offer those affected by the decision an explanation of its reasoning in order to discharge the obligation of demonstrable justification under section 1. Arguably, even if the plaintiffs had failed in this case (as was the ultimate fate of the plaintiffs in *Auton*), this process of reason-giving would have rendered the rationing decision comprehensible and would thus have enhanced its legitimacy. For its part, *Chaoulli* demonstrates clearly the broader 'catalysing' impact of rights

51 The *locus classicus* of dialogue theory is Hogg and Bushell 1997:75, 79. There has been extensive analysis in subsequent literature, see especially the work of Roach 2001 and 2004.
52 Roach 2004:54.
53 See Ham and Coulter 2000:249-50.
54 See note.19 above, and accompanying text.
55 See Jackman 1998:370.

adjudication. In ruling in favour of the plaintiffs, the Supreme Court placed squarely on the political agenda the possibility of the evolution of a 'two-tier' system of health coverage in Canada — a development which had previously been resisted by politicians in view of the political risk attendant upon any perceived attack upon the publicly-funded Medicare system — and also brought into focus the issue of waiting times for treatment within the public health system. The judgment has triggered intense debate within the Canadian media,[56] academia,[57] and the political arena, in the latter case fuelled by the court's decision to suspend the operation of its judgment for a year, enabling at least the provincial government in Quebec (the only government legally obliged to respond to the decision) to canvass all possible options in considering how to react to the judgment.[58]

4.2.3 The limitations of rights adjudication

Notwithstanding the more positive judicial role in resource allocation questions which was outlined in the previous section, it is important not to overstate the deliberative capabilities of Canadian courts under the Charter. While conceptualisation of a resource allocation question as an issue of rights serves to strengthen constitutional competence as compared with adjudication on the basis of principles of administrative law (as in England), courts are frequently still inclined to invoke concerns as to competence, especially of the institutional variant, which lead them to defer to expert judgment in this field. For example, in *Cameron v Attorney General (Nova Scotia)*, which concerned a refusal to provide funding for fertility treatment, the Court of Appeal of Nova Scotia referred to:

> evidence [which] makes clear the complexity of the healthcare system and the extremely difficult task confronting those who must allocate the resources among a vast array of competing claims … The policy-makers require latitude in balancing competing interests in the constrained financial environment. We are simply not equipped to sort out the priorities. We should not second-guess them, except in clear cases of failure on their part to properly balance the Charter rights of individuals against the overall pressing objective of the scheme.[59]

Where a deferential position of this type is adopted, the court will demand less by way of explanation from the decision-maker and its deliberative capacity will accordingly be significantly reduced.

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56 See, for example, *The Globe and Mail* 10 June 2005; *Toronto Star* 10 June 2005; Lewis 2005.

57 In addition to the conference organised by the University of Toronto (16 September 2005), which is reported in Flood, Roach and Sossin 2005, conferences analysing the case and exploring its implications have also been organised, *inter alia*, by Osgoode Hall Law School (26 October 2005) and Dalhousie University (23-25 February 2006).

58 See Roach 2005. For further analysis of the political debate following *Chaoulli*, see Flood, Roach and Sossin generally.

59 (1999) 177 DLR (4th) 611 (CA) at 667.

Moreover, even where the court *does* enforce the obligation of demonstrable justification under section 1, it does not follow that the reasoning which is presented will be sufficiently comprehensive to command acceptance from those who lose out, or to properly inform a debate within civil society. This can be illustrated by reference to the decisions of the various courts in *Auton*.[60] Here, neither of the provincial courts (which both endorsed the clinical and cost-effectiveness of the early behavioural intervention treatment), engaged in a comprehensive analysis of the evidence of effectiveness, merely accepting the plaintiffs' submissions that their children had made significant gains as a result of the treatment and ignoring common health economic metrics such as Quality Adjusted Life Years.[61] Similarly, the Supreme Court of Canada utilised somewhat impressionistic reasoning in overturning the decisions that a refusal to fund was unconstitutional — it simply concluded that the therapy was 'emergent' by reference to the fact that funding was not universally provided in Canadian provinces or US states, overlooking the possibility that this pattern might reflect distinctions in strength of political lobbying, as opposed to equivocal evidence of effectiveness. Admittedly, the presentation of evidence in the courtroom in *Auton* might have supplemented some of the deficiencies in judicial reasoning by providing a more comprehensive explanation of the criteria which underpinned the priority-setting choice. However, since (in contrast to the court judgment) this is not a matter of public record, this is unlikely to assist understanding and deliberation among the broader public.

4.2.4 Assessment

The Canadian approach undoubtedly offers a greater potential for the courts to contribute to deliberation on priority-setting in healthcare than has so far been apparent in English case law. In formulating such issues as questions of human rights under the Charter, the courts may be said to be attaching the enhanced normative weight which is attendant upon conceptualisation of a legal claim as a right, adding potency to the debate upon the allocation of healthcare resources and stimulating greater political, media and public interest in the matter.[62] This catalytic role is further enhanced by the Charter's nature as a dialogic instrument, which may be seen to enhance democracy and to encourage political and public deliberation on the rationing of healthcare. In short, 'the judicial decision causes a public debate in which Charter values play a more prominent role than they would if there was no judicial decision'.[63]

However, Canadian courts continue to remain somewhat deferential to executive expertise and do not always utilise the full potential of the obligation

60 There has also been considerable criticism of the treatment of evidence by the Supreme Court in *Chaoulli*, notably its use of health economics and the conclusions which were drawn from comparative evidence of 'two-tier' health systems elsewhere. For a powerful critique, see Flood, Stabile and Kontic 2005:296-320.

61 For discussion, see D. Greschner and S. Lewis, '*Auton* and Evidence-Based Decision-Making: Medicare in the Courts' (2003) 82 *Canadian Bar Review*.

62 See further Greschner 2002:3.

63 Clayton 2004:42.

of demonstrable justification under section 1 to require comprehensive and 'evidence-based' explanation of the priority-setting decision. To some degree, these restraints on the judicial role may reflect the constitutional status of rights of access to healthcare in Canada. That is, since the Charter does not specifically protect rights of a socio-economic nature, courts remain reluctant to accord these legal protection, even in an indirect manner.[64] As in Cameron, this reluctance tends to be expressed in the language of *institutional* (in)competence, but it is submitted that this is underpinned by continued concerns as to *constitutional* competence, *viz* that courts do not possess the democratic authority to resolve questions of this type within the Canadian legal structure, in view of the absence of an express guarantee of the right to access healthcare within the Charter.

4.3 South Africa

4.3.1 The Constitution

In stark contrast to the two jurisdictions considered above, a legally enforceable constitutional right to access healthcare services exists in South Africa. Section 27 of the Republic's Constitution provides as follows:-

> 1. Everyone has the right to have access to
>
> (a) health care services, including reproductive health care;
>
> (b) sufficient food and water; and
>
> (c) social security, including, if they are unable to support themselves and their dependents, appropriate social assistance.
>
> 2. The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of these rights.
>
> 3. No one may be refused emergency medical treatment.

This provision is designed to secure substantive as well as formal equality in access to healthcare services, imposing a positive duty upon the state to take measures, within available resources, progressively to realise access, with the objective of taking restitutionary or remedial steps to eliminate socio-economic and historical inequalities and disadvantages.[65] As such, it reflects the *transformative* nature of the South African Constitution, that is, that the function of the Constitution is not only to act as a restraint upon state power, but also to facilitate the use of that power to advance ideals of freedom, equality, dignity and social justice.[66] That is — to deploy the 'colour' metaphors which were

64 See Greschner 2002:5 for analysis of the reasons for the low level of Charter litigation on healthcare issues, which the author describes as 'surprising'.

65 Note, however, that it has been argued that, while formal equality in access to healthcare services has been realised, substantive equality is much more problematic to achieve given entrenched structural inequalities and high levels of poverty and disease: see Ngwena 2000.

66 For discussion, see Klare 1998.

cited previously — constitutional law in South Africa has both 'red light' and 'green light' characteristics.

It might seem that the inclusion of the right to access healthcare services in the Constitution and its transformative quality would, together, clearly vest the courts with constitutional competence to adjudicate on questions relating to the allocation of scarce healthcare resources. Nonetheless, it was initially uncertain that such competence existed. In the *First Certification* case,[67] it was argued that socio-economic rights were not justiciable and should not therefore be included in the Constitution.[68] However, the Constitutional Court rejected the argument that concerns as to constitutional and institutional competence operated as a bar upon justiciability, observing that difficulties in respect of the separation of powers and implications for the management of expenditure arose in respect of adjudication upon *all* rights, not merely those of a socio-economic nature.[69] However, it is to be noted that the court regarded socio-economic rights as '*to some extent* justiciable',[70] a statement which might be regarded as permitting future courts to express continued reservations as to competence if they considered it appropriate to do so.

4.3.2 Judicial restraint?

In the first case to be considered by the Constitutional Court under section 27, *Soobramoney v Minister of Health, KwaZulu Natal*,[71] a patient with chronic renal failure challenged a decision to refuse him access to dialysis at public expense. The decision had been taken because insufficient resources were available to treat all patients of this type, and the appellant fell outside the conditions for eligibility. The court held that there had been no violation of section 27(3), which did not cover an ongoing condition such as chronic renal failure, and rejected the argument that the section should be construed consistently with section 11 (the right to life), arguing that the right to medical treatment was addressed directly by section 27. Instead, the court indicated that subsections (1) and (2) of section 27 were more pertinent to the facts of the case, but that no breach of the obligations imposed upon the state by those provisions had occurred, given that the scarcity of resources entailed the making of 'difficult decisions to be taken at the political level in fixing the health budget and at the functional level in deciding upon the priorities to be met', with which a court should be 'slow to interfere'.[72]

67 *Ex parte Chairperson of the Constitutional Assembly: In re Certification of the Constitution of the Republic of South Africa* 1996 (4) SA 744 (CC).

68 For an extremely valuable account of questions of competence on socio-economic rights in the South context, see Pieterse 2004. Note that the taxonomy adopted by Pieterse to analyse concerns over justiciability differs from that employed herein.

69 *Ex parte Chairperson of the Constitutional Assembly*, paras. 77-78.

70 *Ex parte Chairperson of the Constitutional Assembly*, para. 78. Emphasis added.

71 1998 (1) SA 765 (CC).

72 *Soobramoney v Minister of Health*, para 29 (Chaskalson P).

The decision in *Soobramoney* may be regarded as unsatisfactory on a number of levels.[73] From the perspective examined here, the main deficiency of the court's judgment lies in the highly deferential judicial attitude which was adopted toward the government's assessment of the proper use of scarce resources. Significantly, the *Cambridge Health Authority* case was cited in the leading judgment of Chaskalson P,[74] and the outcome is very much in line with the restrained approach taken in that case. That is, while the court did not regard issues relating to the allocation of scarce healthcare resources as wholly non-justiciable (as must follow from the decision in the *First Certification* case), its intervention would effectively be restricted to situations where the government's refusal to provide resources to enable access to healthcare services could be classified as lacking in rationality, or as manifesting bad faith.[75] The consequence of this was that the health provider was placed under no genuine obligation to justify the priorities which had been set, but instead might merely assert the limited availability of resources as justification for denial of the right — in effect, simply 'tolling the bell of tight resources'.[76] As argued previously, the failure to require explanation of the process of reasoning leading to the denial of treatment essentially removes the deliberative capacity of the courts in that it restricts their capability to demand a reflective process of decision-making on the part of the body making the allocative choice, prevents the applicant from gaining a proper understanding of the basis for the decision as it affects him, and limits the ability of the court to contribute to wider public debate upon healthcare rationing through its educative function.

As with the *Cambridge Health Authority* case, it is, therefore, the process of judicial reasoning, rather than the outcome, which is problematic in *Soobramoney*. The decision suggests that, even in a legal system where socio-economic rights have been deemed to be justiciable and where conceptions of transformative constitutionalism should operate to motivate the adoption of a facilitative approach to public law adjudication, courts may still be constrained by concerns as to competence. The consequence is that their capability to contribute to deliberation on issues of healthcare rationing is virtually eliminated.

4.3.3 Towards deliberation

The deferential approach which was taken in *Soobramoney* signalled a judicial reluctance to become directly involved in the progressive realisation of socio-economic rights. However, in two subsequent cases, the judiciary has carved out a much more active role, which would appear to be more clearly consonant with the transformative quality of the Constitution and which, it is submitted, enables them to make a more significant contribution to a broad process of deliberation on resource allocation in healthcare.

73 For critical comment, see Scott and Alston 2000; Ngwena and Cook 2005:135-138.
74 *Soobramoney v Minister of Health*, para 30.
75 *Soobramoney v Minister of Health*, para 29.
76 Note, however, that Sachs J explicitly denies that the judgment of Chaskalson P operates in this manner: *Soobramoney v Minister of Health*, para 52.

In *Government of the Republic of South Africa v Grootboom*,[77] the Constitutional Court went well beyond the rationality and good faith requirements employed in *Soobramoney*, instead addressing the *substantive reasonableness* of a provincial housing plan in light of the state's obligations to provide access to adequate housing under section 26 of the Constitution. In applying this test, the court indicated that it would inquire as to the extent to which the measures which the state had devised and implemented to give effect to socio-economic rights were comprehensive and co-ordinated, whether appropriate financial and human resources were made available and whether the measures were reasonably conceived and implemented, flexible and inclusive (in that they must not exclude a significant segment of society and must respond to the extreme levels of deprivation of people in desperate situations).[78] It should be readily apparent that this represents a much more intensive standard of judicial scrutiny of executive policies and actions than that employed in *Soobramoney* and that it consequently imposes a considerably greater explanatory burden upon government, consistent with the deliberative role for courts outlined in this paper. Indeed, the application of the 'reasonableness' standard of review may be seen as contributing to a 'constitutional culture of justification', in which adjudication upon rights functions as 'a mechanism for inquiring into the justifiability of government decisions'.[79]

However, the limitations of the judicial role articulated in *Grootboom* should also be recognised. The court stopped short of prescribing the temporal order in which competing needs should be met through the government's housing programme and did not seek to specify the precise amounts which should be allocated to rectify the violation of section 26 which it had identified. In part, this result was achieved, as Roux has argued, by the court's exploitation of the 'discretionary gap' which resulted from the lack of clarity as to the applicability of principles of international law to the case arising from South Africa's failure to ratify the International Covenant on Economic, Social and Cultural Rights.[80] While the court considered international human rights jurisprudence (as it was obliged to do under section 39 of the Constitution), notably the interpretation of Articles 2.1 and 11.1 of the International Covenant on Economic, Social and Cultural Rights contained in General Comment 3 of 1990 issued by the Committee on Economic, Social and Cultural Rights,[81] it rejected the argument that section 26 obliged the state to apply its resources first to satisfy the 'minimum core content' of the right of access to adequate housing, as the General Comment specifies. Rather, the minimum core content went to the question of the reasonableness of the measures adopted by the state. The consequence was that there was no free-standing right to a minimum core of provision under section 26(1) regardless of the qualification relating to resources contained in subsection (2). Accordingly, the court was able to afford the government a degree of discretion as to the priorities which it had

77 (2001) (1) SA 46 (CC).
78 *Grootboom*, paras 39-44. For detailed analysis, see Brand 2005:47-51.
79 Van der Walt and Botha 2000:343.
80 Roux 2003:95-98.
81 *Grootboom*, paras 26-33.

set and the level of resources which it had chosen to distribute to its housing programme, while still scrutinising the measures adopted by the state for their reasonableness.

The approach taken in *Grootboom* was followed and further developed in the context of healthcare in *Minister of Health v Treatment Action Campaign (No. 2)*,[82] in which the Constitutional Court ruled that a policy which restricted the availability of the HIV treatment nevirapine to a limited number of pilot research facilities constituted a breach of the state's obligations under section 27(2) read together with section 27(1)(a). That is, the measures taken by the state to achieve progressive realisation of the right afforded by the Constitution were not considered by the court to be reasonable, given that the justification advanced by the government for the restricted availability of nevirapine had failed to distinguish between its objective of evaluating the safety of the treatment and obtaining information on the social, economic and public health implications of providing a comprehensive nationwide programme, and the need to provide access to necessary health care services to those who did not have access to the pilot facilities.[83] In its application of the 'reasonableness' standard, the court also expanded upon the meaning which had been assigned to it in *Grootboom*, notably by requiring that the contents of a programme conceived and implemented by the state should be properly communicated to those affected by it.[84] The court also departed from *Grootboom* in imposing mandatory, rather than merely declaratory, relief, directing the government to remove restrictions on the availability of nevirapine and facilitating its use where medically indicated. However, the order did permit a degree of discretion to the government in enabling it to change its policy if equally appropriate or better means of achieving the objective of preventing mother-to-child transmission of HIV should become available.[85]

As in *Grootboom*, the court in the *Treatment Action Campaign* case was careful to establish bounds to its remit, reflecting a continued attentiveness towards issues of constitutional and institutional competence. Observing that courts were institutionally ill-suited both to undertake the factual and political investigation necessary for deciding how public revenues should most effectively be spent and to adjudicate upon questions that might have multiple social and economic consequences for the community, the Constitutional Court argued that the Constitution instead contemplated 'a restrained and focused role for the courts, namely to require the state to take measures to meet its obligations and to subject the reasonableness of those measures to evaluation'.[86] In particular, the court was anxious to distinguish a constitutionally competent determination of reasonableness which might have budgetary consequences, from a determination which was 'directed at rearranging budgets', which would be regarded as beyond the constitutional competence of the court.[87] As Brand has noted, 'this remark indicates that the court will neither directly interrogate,

82 (2002) (5) SA 721 (CC).
83 *Treatment Action Campaign*, para 67.
84 *Treatment Action Campaign*, para 123.
85 *Treatment Action Campaign*, para 135.
86 *Treatment Action Campaign*, para 38.
87 *Treatment Action Campaign*, para38.

nor prescribe the state's initial allocational decisions at macro-economic level. At the same time, it will not be discouraged to interrogate the reasonableness of state economic measures, even if a finding of unreasonableness would have the consequence that the state would itself have to rearrange its budget'.[88]

One aspect of the restrained role which the court articulated in *Treatment Action Campaign* was its endorsement of the approach taken in *Grootboom* on the issue of the obligation upon the state to satisfy a minimum core content of rights. Indeed, the court seemingly went further in expressing the view that 'courts are not institutionally equipped to make the wide-ranging factual and political enquiries necessary for determining what the minimum core standards … should be',[89] which appears to amount to a statement of the absolute injusticiability of such standards. Ngwena and Cook regard this as somewhat problematic, in that 'it may have the effect of inadvertently failing sufficiently to impress upon the state the compelling nature of socio-economic rights obligations', especially when coupled with the failure of the court to make reference to General Comment 14 of 2000 on the right to the highest attainable standard of health under the Covenant on Economic, Social and Cultural Rights.[90] Certainly, the rather more incomplete reference made to international human rights jurisprudence in *Treatment Action Campaign*, as distinct from *Grootboom*, may be seen as regrettable from the deliberative perspective advanced in this paper. Insofar as the court's judgment may be regarded as initiating a process of dialogue with the other political branches, not to mention a 'transnational exchange of ideas and experience about the rule of law and human rights',[91] deliberation would have been enhanced by reference to relevant international human rights norms. Nonetheless, the overall rejection of minimum core obligations as independent from the question of reasonableness may be understood, as in *Grootboom*, as a means whereby the court sought to minimise overt intrusion into the policy-making and priority-setting functions of the political branches.

Despite this minor reservation, it is clear that the standard of scrutiny adopted in the *Treatment Action Campaign* case permitted the judiciary to engage in a much more searching evaluation of the reasonableness of the justifications put forward by government for limiting access to healthcare services than was evident in cases such as *Cambridge Health Authority* and *Soobramoney*. In this manner, the legal process may be said to contribute to the development of understanding and reflective discourse on questions of access to healthcare resources both among those directly affected by the impugned decision and the wider public, as well as functioning as a mode of debate with the political branches as to how to give effect to the protected right. Indeed, the court implicitly acknowledged that its judgment fulfilled an educative function which might serve to catalyse a broad public and political debate on the appropriate measures to be taken to address the HIV/AIDS crisis in its statement that:

88 Brand 2005: 53.
89 *Treatment Action Campaign*, para 37.
90 Ngwena and Cook 2005:143, 140.
91 Scott and Alston 2000:211.

> It is essential that there be a concerted national effort to combat the HIV/AIDS epidemic. The government has committed itself to such an effort. We have held that its policy fails to meet constitutional standards … This does not mean that everyone can claim access to such treatment, although the ideal … is to achieve that goal. Every effort must, however, be made to do so as soon as reasonably possible. The increases in the budget to which we have referred will facilitate this. We consider it important that all sectors of society, in particular civil society, should co-operate in the steps taken to achieve this goal. In our view that will be facilitated by spelling out the steps necessary to comply with the Constitution.[92]

4.3.4 Assessment

It is submitted that the language used by the Constitutional Court of South Africa in this passage is highly instructive. The court perceives its role as one of *democratic partnership*, of working in concert with governments, legislatures and the broader civil society to alleviate a particular national policy problem. In scrutinising policies, decisions and actions according to the standard of reasonableness, the judiciary 'engage[s] the political branches in rational discussion over the fairness [of its programmes]'[93] and stimulates public reflection and argumentation on these. Public law adjudication (here, that of a constitutional nature) thus functions as a deliberative democratic space, in which legal 'rights cannot be considered brightline boundaries between the spheres of individual freedom and legitimate state power, but rather constitute a social practice and an occasion for deliberation on vital social issues'.[94] It is for this reason that those such as Sunstein who advocate greater deliberation have applauded the Constitutional Court:

> The approach of the Constitutional Court [in Grootboom] stands as a powerful rejoinder to those who have contended that socioeconomic rights do not belong in a constitution. It suggests that such rights can serve not to preempt democratic deliberation but to ensure democratic attention to important interests that might otherwise be neglected in ordinary debate… What the constitutional right requires is not housing on demand but a reasonable program for ensuring access to housing for poor people … This approach ensures respect for sensible priority-setting and close attention to particular needs, without displacing democratic judgments about how to set priorities.[95]

Yet, as Sunstein notes here, in constructing an enhanced democratic role in *Grootboom* and *Treatment Action Campaign*, the Constitutional Court remains acutely sensitive to the proper roles of judiciary, legislature and executive. While acknowledging that, in undertaking the constitutionally-mandated function of evaluating the measures undertaken by the state to give effect to its constitutional obligations for their reasonableness, a judicial decision may well have implications

92 *Treatment Action Campaign*, paras 125-6.
93 Roux 2003:107. See further Fitzpatrick and Slye 2003:680, referring to 'intergovernmental dialogue'.
94 Van der Walt and Botha 2000:344.
95 Sunstein 2001:222, 236.

for the allocation of resources, the court is at pains to emphasise that its role is not to engage directly in allocation of those resources itself. In particular, the court resists the temptation, in both cases, to offer prescriptions as to the order and amounts in which resources should be allocated. In this manner, the court seeks to achieve an 'appropriate constitutional balance' between the judicial, executive and legislative functions,[96] remaining 'respectful of the political branches' primary budget-setting and policy-making powers'.[97]

5. Conclusion

The approach taken by the Constitutional Court on the allocative issues raised in *Grootboom* and *Treatment Action Campaign* stands in contrast to that of the English, and to a lesser extent, the Canadian courts. In the former jurisdiction, the continuing prevalence of administrative law norms in this field has produced a deferential judicial stance, which permits only of a limited level of scrutiny of the justifications advanced by government for the restriction of access to healthcare treatments and services. While there have been some moves to enforce obligations of reason-giving in recent cases, the decision in *R (on the application of Pfizer Ltd.) v Secretary of State for Health* indicates that the English judiciary remains highly troubled by questions of constitutional and institutional competence,[98] significantly reducing the capacity of processes of public law to offer a space for deliberation on issues of the rationing of healthcare. Greater opportunity for deliberation on such questions is afforded by the Canadian courts, especially in view of the interpretation of section 15 of the Charter of Rights and Freedoms as affording substantive as well as formal equality, and the dialogic character of Charter adjudication. Yet, while the latter quality apparently places the Canadian courts in a position to make a contribution to democratic debate with the political branches and within civil society as a whole, the judiciary remains cautious about involvement in issues of resource allocation in healthcare. Judgments evince continued concerns as to competence — particularly of an institutional variant — and fail at times to make the fullest possible use of the deliberative opportunities embodied within the Charter, notably the enforcement of an explanatory obligation upon government under section 1.

It is readily apparent, therefore, that the approach taken in South Africa corresponds most closely with the deliberative role for the courts which has been outlined in this paper. In consequence, courts in that jurisdiction are presently much better placed than their counterparts in England or Canada to contribute to resolution of the problem of legitimacy which arises as a result of the development of explicit strategies of healthcare rationing by government.

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96 *Treatment Action Campaign*, para 38.

97 Roux 2003. Brand 2005:53-54 comments that the distinction between judicial decisions which have the consequence that budgets are rearranged and judicial decisions which themselves rearrange budgets may nevertheless sometimes be blurred, but that assertion that the court is merely fulfilling its proper constitutional function serves to defuse potential conflict with government.

98 Note 40 above and accompanying text.

This is perhaps unsurprising given the transformative nature of the South African Constitution, which emphasises the facilitative dimension of public law adjudication to a much greater extent than is the case in the other two jurisdictions. These remain much more firmly rooted in Diceyan notions of law as a control mechanism, operating above politics and essentially antithetical to collective state activity. There appears to be little space in such conceptions of the function of public law for the courts to engage in a collaborative deliberative democratic partnership with the political branches and civil society of the type witnessed in South Africa.

For advocates, such as the present author, of a deliberative judicial role on issues of healthcare resource allocation, the crucial question is thus whether the more conducive South African approach can inform the future development of public law adjudication in this field in other jurisdictions. On one level, the prospects appear bleak: there seems little realistic possibility of rights of access to healthcare being embodied in existing human rights instruments in jurisdictions which have traditionally been unwilling to accede to legal enforcement of socio-economic rights, meaning that the role of the courts will always be somewhat more restricted than is the case in South Africa.

Yet, even in the absence of the political will to achieve such an objective, it is submitted that the judiciary possesses the capacity to evolve a deliberative role for itself on matters of healthcare rationing. Such evolution will require three steps. First, the courts must show a greater preparedness than they have so far done to utilise those principles of public law which presently exist, particularly those which relate to the provision of justifications for governmental choices, in the healthcare rationing context. That is, a 'harder look' form of scrutiny should be developed, which requires 'reasoned articulation of the factors governing discretionary decisions … [provision of] relevant data and an explanation of inaction and… a more adequate statement of the agency's position'.[99] Secondly, the judiciary must resolve its concerns about constitutional and institutional competence in the context of the allocation of healthcare resources. Here, much can be learned from the South African experience, in which courts, while retaining a 'restrained and focused' approach which respects the respective functions of legislature, executive and judiciary, have shown an awareness of 'the fact… that courts are not ill-equipped to *scrutinise* or *evaluate* budgets or policies just because they are ill-equipped to *engage* in budgeting or policy-making'.[100] Finally, and perhaps most significantly, the judiciary needs to 'rediscover' the facilitative capacity of public law, which, while it has been largely a 'dissenting tradition'[101] relative to the Diceyan 'red light' perspective, has nonetheless informed both the theory[102] and practice[103] of public law even where there is no tradition of transformative constitutionalism of the South African type.

99 Harden and Lewis 1986:274.

100 Pieterse 2004:408 (emphasis in original).

101 Loughlin 2005:397-398.

102 For discussion, see Harlow and Rawlings 1997: Chapter 3. Significant works in this tradition include Robson 1928 (England), and Arthurs 1979 (Canada).

103 A useful source of examples from the practice of public law in England is Woodhouse 1997. It should be noted that, even where English judges have adopted a more

In conclusion, this paper has advanced the case that it is profoundly mistaken to dismiss the contribution which the courts can make as being of no value to, and perhaps even as being in conflict with, attempts to address policy problems — especially of legitimacy — which have arisen as the rationing of healthcare has become more explicit in recent years. Public law adjudication can, in fact, function as a valuable deliberative space which can assist in stimulating debate upon, and building understanding of, the principles and processes by which the inevitable task of healthcare priority-setting may be carried out, thus contributing to the legitimation of state action in this field. However, if such a role is to be undertaken, several significant changes in the application of the principles of public law and in the judiciary's attitude to its function within a democratic society are necessary, at least in certain jurisdictions. While the scale of this task should not be underestimated, it is submitted that it is made somewhat less daunting by the existence of a useful model in the form of the approach recently taken by the Constitutional Court of South Africa.

'green light' perspective, they have tended to stop short of the discourse of 'partnership in democracy' which has been deployed by South African judges, see eg, *R v Lancashire County Council, ex parte Huddleston* [1986] 2 All ER 941 at 945, where Sir John Donaldson MR speaks of 'a new relationship between the courts and those who derive their authority from the public law, one of partnership based on a common aim, namely the maintenance of the highest standards of public administration'.

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