Judicial Restraint When Reviewing Health Care Rationing Decisions: A Healthy Approach?

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Despite being amenable to judicial review, health care rationing decisions are typically approached with a high degree of judicial restraint and deference to decision-making bodies. This approach has persisted through numerous sector reforms in New Zealand. The reasons for restraint are institutional and constitutional. The former category includes the polycentric and commercial nature of the decisions, and the level of expertise involved. The latter includes respect for parliamentary intention, the court's lack of democratic mandate and concerns about misuse by commercial parties. All of these reasons for restraint can be countered but not entirely discredited. While a high degree of restraint is not warranted, an examination of Canadian jurisprudence indicates a high degree of scrutiny is not justified either. The "accountability for reasonableness" model highlights that the usual grounds of judicial review can be more effectively applied to health care decisions, thereby enhancing the decision-making procedure and hence the outcomes.

I INTRODUCTION

The impact of health care rationing decisions on people's lives can hardly be understated. In a system based on universal access, the issue is especially important because public funding is often the only way to access health care.[1] For commercial parties, such as pharmaceutical companies, funding also enables access to the New Zealand market. Without these subsidies, patients cannot purchase treatments and services, and thus commercial parties cannot sell and profit.[2]

Decision-makers therefore wield a significant amount of power and control. Although numerous models have been used to structure the exercise of that power, the decision-making bodies are invariably amenable to judicial review in principle.[3] Despite these dual factors of amenability and public

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1 Timothy Jost "Health Care Rationing in the Courts: A Comparative Study" in Frances Miller (ed) *Rights and Resources* (Dartmouth Publishing, Aldershot, 2003) 465 at 465.

2 See, for example, *Bishop v Central Regional Health Authority* HC Palmerston North M47/97, 11 July 1997 at 4.

3 See, for example, *Reckitt and Colman (New Zealand) Ltd v Pharmaceutical Management Agency Ltd* [1997] NZAR 464 (HC) at 474.

importance, health care rationing decisions remain the quintessential example of judicial restraint, being characterised by the concepts of deference and non-justiciability.[4]

After introducing the legal context of health care decision-making, this article examines the reasons given by the judiciary for their restraint. The English approach is similar so it is used concurrently. Counter-arguments are then discussed. It is suggested that this restraint puts health care rationing decisions on a pedestal unnecessarily and creates an unjustifiably onerous barrier for review.

Finally, some ideas are proposed about where this leaves the approach to judicial review. In particular, this article questions whether there is potential for a merits review by drawing on Canadian jurisprudence. It also asks whether better quality decision-making can be encouraged by reappraising how the usual procedural grounds of review are applied to health care decisions.

II LEGAL STRUCTURE OF THE HEALTH CARE SYSTEM

New Zealand has traditionally had a universal health care system that is primarily funded by the Government and that generally provides free access to all citizens.[5] However, the way the system has been structured to achieve that goal has varied significantly. New Zealand's health care system has undergone three major reforms in an attempt to control expenditure in the face of advances in technology, rising demand and the increasing complexity of illnesses. Restructuring has also meant that a wide variety of stakeholders have sought review of health care decisions. These stakeholders range from individual patients[6] and local community groups[7] to pharmaceutical companies[8] and commercial providers competing for government contracts.[9]

The Welfare System

From 1938, the health care system was largely part of a welfare state model.[10] The original idea, to create a national health service that encompassed all services, was frustrated by resistance from private practitioners.[11] Thus, the sector was provided for in three ways: public health care services, private health

4 Keith Syrett *Law, Legitimacy and the Rationing of Health Care: A Contextual and Comparative Perspective* (Cambridge University Press, New York, 2007).

5 Ministry of Health "Health Expenditure Trends in New Zealand 1997–2007" (May 2010) <www.health.govt.nz>.

6 See, for example, *Shortland v Northland Health Ltd* [1998] 1 NZLR 433 (CA).

7 See, for example, *Napier City Council v Health Care Hawkes Bay Ltd* HC Napier CP29/94, 15 December 1994.

8 See, for example, *Pharmaceutical Management Agency Ltd v Roussel Uclaf Australia Pty Ltd* [1998] NZAR 58 (CA).

9 See, for example, *Lab Tests Auckland Ltd v Auckland District Health Board* [2008] NZCA 385, [2009] 1 NZLR 776.

10 Robin Gauld "One Country, Four Systems: Comparing Changing Health Policies in New Zealand" (2003) 24 International Political Science Review 199 at 203–204.

11 At 203.

care services directly subsidised by the government and additional benefits such as disability support.[12] The concurrent private sector continues today.

This regime implicitly rationed resources, meaning decisions were made on a case-by-case basis without an explicit overall scheme.[13] Patients were not usually informed when given a lower priority or denied treatments.[14] Consequently, there was little judicial review because patients either received the treatment they wanted or were unaware that they had been refused treatment in favour of somebody else.[15] This system was unsustainable because implicit rationing can be inconsistent and does not necessarily keep health spending within a big picture budget.[16] By the 1990s, New Zealand had made significant and arguably irreversible moves towards an explicit rationing scheme.[17]

The Market Model

The Health and Disability Services Act 1993 established the new system and marked two important changes. First, it explicitly acknowledged rationing, noting that services must be provided within resource constraints.[18] The National Advisory Committee on Core Health and Disability Support Services was established to ration explicitly, by creating a list of core services to be funded.[19] It abandoned the impossible task in favour of creating guidelines for deciding who would access treatments (micro-rationing) rather than whether the treatment should be available overall (macro-rationing).[20] Today, it publishes both evidence-based guidelines that determine patients' priority levels and criteria for accessing treatment.

Secondly, it adopted a market model whereby the Government transferred health care to the private sector and, as such, decision-makers, funders and service providers needed to operate in a commercial manner.[21] The idea was that market forces drive costs down and increase efficiency, thereby producing equal or greater health benefits at less cost.[22] To achieve this, the sector was modelled on State Owned Enterprises (SOEs).[23] Public health services became Crown Heath Enterprises (CHEs): incorporated companies responsible to the shareholding Minister and required to profit.[24]

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12 At 203–204; Social Security Act 1964; and Disabled Persons Community Welfare Act 1975.

13 Joanna Manning and Ron Paterson "'Prioritization': Rationing Health Care in New Zealand" in Rebecca Cook and Charles Ngwena (eds) *Health and Human Rights* (Ashgate Publishing, Aldershot, 2007) 399 at 401.

14 Syrett, above n 4, at 47–48 and 134.

15 At 47–48 and 134.

16 Manning and Paterson, above n 13, at 401–402.

17 Syrett, above n 4, at 52–68.

18 Section 4.

19 Section 6.

20 Manning and Paterson, above n 13, at 401–403.

21 See, for example, *Bishop*, above n 2.

22 Gauld, above n 10, at 204–206.

23 See *Southern Community Laboratories Ltd v Healthcare Otago Ltd* HC Dunedin CP30/96, 19 December 1996 at 7–8.

24 Health and Disability Services Act 1993, ss 11(2) and 37.

The primary rationing bodies — Regional Health Authorities (RHAs) — were body corporates responsible for providing health services within their budgets by contracting with private practitioners.[25] They had a duty to consult within their regions and seek advice about the health needs of that population.[26] The Pharmaceutical Management Agency Ltd, now Pharmac, was also incorporated to evaluate the cost-effectiveness of new drugs.[27] As a monopsonist, Pharmac seeks to control the rise in drug costs in a marketplace dominated by patent-holding oligopolists.[28]

The legislation provided some means of accountability. RHAs and CHEs were subject to the Public Finance Act 1989, the Audit Office, the Ombudsman and reporting requirements on progress and financial status.[29] The Minister of Health was responsible for achieving the scheme's objectives.[30] The responsible Minister retained the ability to give directions about which services were to be provided.[31] Generally, this represented a major change from the earlier welfare-based system.[32]

The Current System

The current system under the New Zealand Public Health and Disability Act 2000 expressly recognises resource constraints in more aspirational terms.[33] The Act retreats markedly from the market model and re-organises the main decision-making bodies. Pharmac is now a statutory body.[34] District Health Boards (DHBs) are public body corporates that replace RHAs and encompass CHE services.[35] DHBs are more flexible: they can contract, fund directly or enter cooperative and collaborative arrangements.[36] The Ministry of Health delegates to DHBs via contract and therefore retains some control, requiring compliance with national Ministry policies.[37] The Minister has residual power to enter funding arrangements.[38]

The Act's underlying policy — to enhance community voice in the health system — is expressed in two ways.[39] First, DHB boards consist of seven elected members and up to four members appointed by the Minister,

25 Sections 10 and 32–33; and Manning and Paterson, above n 13, at 401–403.
26 Health and Disability Services Act 1993, s 34.
27 Gauld, above n 10, at 206.
28 At 206.
29 Health and Disability Services Act 1993, ss 14–16, 24–26, 41–42 and sch 2.
30 Section 12.
31 Sections 25 and 40.
32 Gauld, above n 10, at 204–206.
33 *Lab Tests*, above n 9, at [61].
34 New Zealand Public Health and Disability Act 2000, s 46.
35 Sections 5(3)(d) and 21.
36 Sections 23–25.
37 Ron Paterson "Regulation of Health Care" in PDG Skegg and Ron Paterson (eds) *Medical Law in New Zealand* (Brookers, Wellington, 2006) 3 at 4–8.
38 New Zealand Public Health and Disability Act 2000, s 10.
39 Skegg and Paterson, above n 37, at 5–7.

who must ensure adequate Māori representation.[40] The Minister may also appoint "Crown monitors", remove members for dissatisfactory conduct and issue statutory directives.[41]

Secondly, though specific consultation duties were recently repealed, DHBs must have regard to the needs of their population when forming policies and seek Ministerial approval.[42] Pharmac has a discretionary duty to consult as widely as it thinks is necessary but is otherwise independent: board members are appointed and are not subject to Ministerial direction.[43]

The Court of Appeal in *Lab Tests Auckland Ltd v Auckland District Health Board* emphasised that these changes were not drastic for the purposes of judicial review.[44]

Comparison with Other Jurisdictions

England has a similar system.[45] The Secretary of State has the primary duty to provide health services[46] — though it has been clarified that the duty is not absolute, being subject to resource constraints.[47] The National Health Service (NHS) primarily runs on a contracting model.[48] Health Authorities (HAs) are established as regional funding allocation bodies and the Minister may give directions or guidance.[49] The National Institute for Health and Clinical Excellence (NICE) is England's version of Pharmac.[50] Primary Care Trusts (PCTs) are comparable to DHBs in that they are responsible for providing services in their region.[51]

Canada, on the other hand, is based on a public insurance scheme. Funding is similarly split at a national and regional level under the Canada Health Act 1985. The Act sets out five criteria that provincial systems must meet in order to receive national funding.[52] These criteria include universal access, comprehensiveness and a public non-profit health care system — though private contracting may be used to obtain services.[53]

The amount of national funding available indirectly forces compliance.[54] Each province has its own legislation to establish a health system that

40 New Zealand Public Health and Disability Act 2000, s 29.

41 Sections 30–33.

42 Sections 38–40; and New Zealand Public Health and Disability Amendment Act 2010.

43 Sections 49 and 52.

44 *Lab Tests*, above n 9, at [63].

45 See generally Christopher Newdick *Who Should We Treat? Rights, Rationing and Resources in the NHS* (2nd ed, Oxford University Press, New York, 2005).

46 National Health Service Act 1977 (UK), ss 1 and 3(1).

47 *R v Secretary of State for Social Services, ex parte Hincks* (1980) 1 BMLR 93 (CA).

48 Jost, above n 1, at 477.

49 See generally *R v North Derbyshire Health Authority, ex parte Fisher* (1997) 38 BMLR 76 (QB).

50 See Michael Rawlins "In pursuit of quality: the National Institute for Clinical Excellence" (1999) 353 The Lancet 1079.

51 Health Act 1999 (UK), s 2.

52 Canada Health Act RSC 1985 c C-6, ss 7–12.

53 Jocelyn Downie, Timothy Caulfield and Colleen Flood *Canadian Health Law and Policy* (2nd ed, Butterworths, Ontario, 2002).

54 Downie, Caulfield and Flood, above n 53.

provides separately for medically necessary services and hospital services.[55] There is no cost to the patient, but some provinces limit fees or services by agreement with medical professionals.[56] Block funding is commonly used, where the government assigns each hospital a total budget.[57] Rationing is thus delegated, but it is still susceptible to review.[58]

Despite the varied mechanisms for distributing funding, there is a fundamental common theme of universal health care funded by taxes. Similarly, all systems face the same cost pressures.[59] The judicial approaches to rationing decisions have been consistently similar in both New Zealand and England, so they are discussed interchangeably in the section that follows. Canada's jurisprudence provides a useful point of comparison and is discussed later in this article.

III JUDICIAL APPROACHES TO RATIONING DECISIONS

Although there has been widespread acknowledgement that decisions about health care rationing are in principle amenable to review, they have generally been approached with great restraint.[60] While the grounds of review remain the same as other types of cases, the courts have shown reluctance to analyse health care rationing issues closely under these grounds of review.[61] More importantly, the courts have been hesitant to fetter the wide discretion of decision-making bodies, particularly with regards to the adequacy of their procedures.[62] So, in effect, the application of judicial review has been less demanding on decision-makers in the health care context.[63]

Two cases exemplify the high degree of judicial restraint. In *R v Central Birmingham Health Authority, ex parte Collier*, the complainant's son required urgent heart surgery, which had been cancelled three times. He could not show any bad faith or *Wednesbury* unreasonableness, so the Court decided that treatment was denied for good reasons, despite there being no evidence of what those reasons were.[64]

In New Zealand, the high point is *Shortland v Northland Health Ltd.* Despite the patient's own assertions that he enjoyed a good quality of life and did not want to die, treatment guidelines deemed him unsuitable for dialysis because he suffered from dementia and could not care for himself. The Court of Appeal denied that any issue of resource allocation arose, despite clear

55 Downie, Caulfield and Flood, above n 53.

56 See generally *Flora v Ontario Health Insurance Plan* 2008 ONCA 538, (2008) 76 Admin LR (4th) 132.

57 See generally *Eldridge v British Columbia (Attorney General)* [1997] 3 SCR 624.

58 At 627.

59 Jost, above n 1.

60 *He Putea Atawhai Trust v Health Funding Authority* HC Auckland CP497/97, 8 October 1998 at 5–7.

61 See *Roussel Uclaf*, above n 8, at 64.

62 *New Zealand Private Hospitals Association - Auckland Branch (Inc) v Northern Regional Health Authority* HC Auckland CP440/94, 7 December 1994 at 42–43.

63 Syrett, above n 4.

64 *R v Central Birmingham Health Authority, ex parte Collier* EWCA, 6 January 1988 (available via Lexis.com).

evidence that efficient resource allocation was the purpose of the guidelines. Instead, the Court decided the case on the grounds of medical "best interests" and deferred to the expertise of medical professionals.[65]

It is important to unpack the reasons behind this trend of judicial restraint to determine whether it is justified.

General Observations: A "Pick and Mix" Approach

The case law discussed below shows that the courts have been inconsistent in the reasons they give for their restraint. These reasons are often stated without question. That could be a reflection of the confused state of judicial review, as Hammond J has suggested.[66] Yet as health care rationing decisions are the quintessential example of restraint, it could also be a reflection of the judiciary's unwillingness to discuss the issue at all.[67] Only recent decisions in New Zealand and England show the close analysis of the whole legislative scheme that is common in other cases.[68] Nonetheless, the "pick and mix" approach to justifying judicial restraint is unsatisfactory and suggests that judicial attitudes could be reappraised, at least to gain some coherence.[69]

Thematic Analysis

The starting point for this thematic analysis is Syrett's categories of institutional and constitutional reasons for restraint.[70] Although the reasons are intertwined, considering them individually prevents the fallacy of the sum of the parts being greater than the whole.[71]

1 Institutional

Institutional objections refer to the limitations of the court process, as compared with other decision-making processes. Syrett suggests that justiciability is the issue, meaning that the court process is not conducive to making the decision under review.[72]

(a) Polycentricity

The court is seen as poorly suited to polycentric decision-making.[73] A polycentric decision is one in which the outcome affects more than just

65 *Shortland*, above n 6.
66 *Lab Tests*, above n 9, at [371]–[378].
67 See generally *Shortland*, above n 6.
68 See generally *Walsh v Pharmaceutical Management Agency* [2010] NZAR 101 (HC); and *Lab Tests*, above n 9.
69 Chris Finn "The Justiciability of Administrative Decisions: A Redundant Concept?" (2002) 30 Fed L Rev 239.
70 Syrett, above n 4, at 129.
71 Finn, above n 69, at 241.
72 Syrett, above n 4, at 128–129.
73 Finn, above n 69, at 242.

the immediate parties to the case.[74] Health care is the classic example of polycentricity for a number of reasons.[75]

First, health care decisions always have opportunity costs: if the money goes to fund drug X, it cannot fund treatments Y and Z, and therefore the system misses out on the health gains those treatments could achieve. Lord Denning noted that plaintiffs cannot complain about one aspect of the health system not being provided because the administration of a health system is much wider than such discrete decisions.[76] The court process is ill-suited to examining this broader picture because it only looks at evidence directly relevant to the case at hand. It would struggle to consider what is the best answer for the system as a whole.[77]

Secondly, limits must be established because patients' demand for treatment is potentially endless but funding is not.[78] The court hears the merits of individual cases — this favours patients because they can generally make a case for why they have an interest in receiving treatment.[79] But that procedure is not conducive to placing limits on the number who succeed, as the court cannot compare the case at hand to the multitude of contemporaneous competing demands on the same funding.[80] The result is that if patients can proceed on a case-by-case basis, the court cannot ensure that those who are successful have not taken the place of a more worthy or needy patient, let alone take into account the wide-ranging effects on the overall budget.[81]

Conversely, decision-making bodies have policies for ensuring that the best decisions are made for the whole system. Therefore, they are better at balancing the competing interests of the numerous individuals who rely on the provision of health services.[82] The court has recognised that it cannot make decisions on who should get treatment and who should not.[83] The European Court of Justice has held that a right to access treatment in Member States is available in principle, but cannot be used to "queue jump" unless the waiting list is intolerably long.[84]

Thirdly, the limits on who may be heard in the review process mean that other affected people do not have a chance to participate. For example, if the Court in *R v Cambridge Health Authority, ex parte B* ruled that the plaintiff could have the treatment ahead of other cancer patients, those other patients would have no recourse.[85] On the other hand, decision-making bodies

74 Lon Fuller "The Forms and Limits of Adjudication" (1978) 92 Harv L Rev 353 at 394–396.

75 At 394–396.

76 *Ex parte Hincks*, above n 47, at 95–96.

77 Finn, above n 69, at 242; and Syrett, above n 4, at 128–133.

78 *Ex parte Hincks*, above n 47, at 95–96.

79 See *R v Cambridge Health Authority, ex parte B* [1995] 1 WLR 898 (CA).

80 *Ex parte Collier*, above n 64.

81 *Ex parte B* (CA), above n 79, at 906.

82 At 906–907.

83 *R v Central Birmingham Health Authority, ex parte Walker* (1987) 3 BMLR 32 (CA).

84 *R (on the application of Watts) v Bedford Primary Care Trust* [2006] QB 667 (ECJ) at 720 and 725.

85 *Ex parte B* (CA), above n 79.

take into account all patients.[86] Additionally, many argue that the democratic process is a better means of determining the decision-making process and maintaining accountability, because it enables greater participation by the public, all of whom are affected by the decisions.[87]

Polycentricity is arguably the main factor underlining judicial restraint because when it is removed, the court focuses on the individual's claim to justice. In *R (on the application of Rogers) v Swindon NHS Primary Care Trust*, the Court considered that the complications of scarce resources did not apply because the funding bodies being reviewed were directed not to consider cost.[88] Similarly, in *R v North and East Devon Health Authority, ex parte Coughlan*, the House of Lords considered that the plaintiff's legitimate expectation amounted to a promise, which changed the weighting of the test.[89] Only an overriding public concern could justify the unfairness to the plaintiff, thereby greatly reducing the rationing element of the case.[90]

The polycentricity problem is exacerbated by the adversarial nature of the court process. The parties only put forward evidence that is advantageous to their side of the argument.[91] In contrast, decision-making bodies seek empirical, unbiased information that is more conducive to determining the best decisions for the whole system.[92]

(b) Expertise

Health care rationing is a complex field that involves a number of specialist disciplines.[93] The court feels its expertise is in interpreting and applying the law, not weighing complicated evidence.[94] Thus the court should defer to expert opinion rather than relying on its limited understanding of the issue. In *Lab Tests*, the Court of Appeal said that:[95]

> ... the decision was made by an evaluation panel comprising well-experienced people from both inside and outside the ARDHBs [Auckland Regional DHBs]. ... [W]e do not think that a court is well placed to assess on a judicial review application the medical, economic and other complexities raised.

The most striking example of this is *Shortland*.[96] The Court deferred to

86 Syrett, above n 4, at 128–133.

87 At 132–133.

88 *R (on the application of Rogers) v Swindon NHS Primary Care Trust* [2006] EWCA Civ 392, [2006] 1 WLR 2649 at [57].

89 *R v North and East Devon Health Authority, ex parte Coughlan* [2001] QB 213 (CA) at [60].

90 At [57] and [82].

91 Syrett, above n 4, at 147–148.

92 At 148.

93 *Lab Tests*, above n 9, at [340].

94 Ron Paterson "Rationing health care: A legal perspective" (paper presented to The Fourth Annual Medico-Legal Summit, Auckland, September 1996) at 11–12.

95 *Lab Tests*, above n 9, at [340].

96 *Shortland*, above n 6.

medical professionals — who cannot be compelled to treat a patient against their better judgement — by categorising the decision (which was based on rationing guidelines) as purely clinical.[97]

(c) Commercial Nature

Judges also employ restraint because of the commercial aspect of New Zealand's health care model. Decision-making bodies use market forces to secure the best prices for the best services.[98] It is said that judges lack the experience and expertise required to assess which options are the most economically efficient.[99]

Although the decisions range from purely commercial to public interest matters,[100] the court is often reluctant to afford "public importance" arguments much significance: such "public importance" only means the body is not immune from review.[101] The court sees impartial, faultless decision-making processes as a hindrance to — rather than a requirement of — acting as an effective commercial player:[102]

> The imposition of onerous procedural obligations may unduly fetter the DHBs' power to negotiate effectively, thus handicapping them in attempting to deal with determined private sector service providers[.]

By extension, as a neutral body, the court is ill-equipped to make the self-interested decisions required to be commercially effective. In *Pharmaceutical Management Agency Ltd v Roussel Uclaf Australia Pty Ltd*, Pharmac was revising the funding classifications of antibiotics.[103] Thomas J supported an obligation of even-handedness that required Pharmac to review all competitors at the same time, but the majority disagreed, apparently less influenced by the heavy losses Pharmac caused to commercial parties.[104]

2 Constitutional

Constitutional objections are founded on the court's role in a democratic system of government underpinned by the doctrine of separation of powers.[105] The objections are based on the concept of deference, referring to the judiciary's respect for the other branches of government.[106]

97 See also Manning and Paterson, above n 13, at 404–410.
98 For example, by tendering contracts.
99 *Reckitt and Colman*, above n 3, at 475.
100 *Southern Community Laboratories Ltd*, above n 23, at 16.
101 *He Putea Atawhai Trust*, above n 60, at 5–7; and *Reckitt and Colman*, above n 3, at 474.
102 *Lab Tests*, above n 9, at [78].
103 *Roussel Uclaf*, above n 8.
104 At 61, 67–69 and 83–84.
105 Syrett, above n 4, at 133.
106 At 133.

(a) Parliament's Intent

Parliament has specifically assigned the task of making health care rationing decisions to certain bodies. Because it has chosen not to allocate the primary role to the courts, it is argued that the courts should not use judicial review to extend their jurisdiction.[107] Instead, they should respect any wide discretions conferred by Parliament. The Court of Appeal's close analysis of the legislative framework in *Lab Tests* clearly indicates that the judiciary considers Parliament to have limited their role to considering process in judicial review applications.[108]

(b) Accountability

Similarly, the legislation indicates that Parliament has carefully designed the system to have certain checks and balances, making a heavy-handed approach by the court unnecessary.[109] For example, the Court went to great lengths in *Lab Tests* to describe other accountability mechanisms, concluding that a close standard of review was not warranted as the Act provided other ways of ensuring accountability.[110]

(c) Accountability for Ideology

Related to the idea of accountability is the court's restraint when a case relates to moral and political choices that underpin the health system.[111] The judiciary often comments that these decisions should be made by institutions with a democratic mandate.[112] The correct procedure for holding democratic institutions accountable for these decisions is through democratic processes, such as media lobbying and voting.[113] In *Lab Tests*, Hammond J commented:[114]

> [I]n my experience, judges do not like making merit decisions. They are relieved when "government" makes a clear or at least workable decision. Knowing — or purporting to know — what is best for somebody or something else is a dangerous enterprise[.]

Thus, in addition to respect for Parliament, deference is also motivated by the judiciary's discomfort with making such decisions.

(d) A Competition of Price Not Rights

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107 *Bishop*, above n 2, at 22.

108 *Lab Tests*, above n 9, at [19]–[20] and [36]–[60].

109 At [59]. See generally *Bishop*, above n 2.

110 At [59], [63], [80]–[84] and [89].

111 Such as Pharmac's goal of cost-efficiency. See Syrett, above n 4, at 149.

112 Finn, above n 69, at 244–250.

113 Syrett, above n 4, at 132.

114 *Lab Tests*, above n 9, at [385].

The commercial context in New Zealand has led to concern that judicial review exposes health care rationing bodies to excessive litigation. Although public bodies cannot be immune from review, the court risks becoming an additional battleground for commercial parties to compete on price.[115] This was recognised by the Court in *Lab Tests*, which described numerous commercial health care providers as disappointed tenderers or applicants, not genuine plaintiffs.[116] Consequently, the court rejects arguments that it should be influenced by the public importance of the matter at hand.

Health is not unique in this regard and it does not give commercial parties special licence to challenge decisions.[117] Moreover, the court has little sympathy for the view held by many commercial health organisations that government funding bodies are exercising monopsony power. In *Bishop v Central Regional Health Authority*, it was noted that private practices could still charge the public so the market was not completely dominated.[118]

IV DO THESE REASONS JUSTIFY JUDICIAL RESTRAINT?

Given the high degree of restraint, it is necessary to examine the strength of the arguments outlined above. It is suggested that while they cannot be entirely rejected, they are certainly overstated.

Polycentricity

It must be accepted that the court cannot take into account the big picture issues of the health care system and that it is often artificial to think of the issues that arise in these types of cases as being discrete. However, there is still room to consider them in an individual way. Although the decision-making process is complex and ongoing, it is often broken down into distinct steps.[119] An error in one these steps — such as weighing the evidence in an illogical manner — is likely to compromise the quality of the overall process and the end decision.[120] A poor decision may also compromise the overall system, particularly as decisions involve assessing the potential improvement of new treatments over existing ones.[121] Judicial review may thus ensure the quality of the decision by ensuring the quality of the individual steps.[122]

Bingham LJ thought review was problematic because it is impractical to produce evidence of the multitude of factors that would need to be taken into account:[123]

115 See *Lab Tests*, above n 9. See also *Roussel Uclaf*, above n 8.

116 *Lab Tests*, above n 9, at [88], [337] and [344].

117 *Napier City Council*, above n 7, at 27–28.

118 *Bishop*, above n 2, at 22.

119 See, for example, the facts of *Walsh*, above n 68.

120 *Roussel Uclaf*, above n 8, per Thomas J dissenting.

121 See, for example, the facts of *SmithKline Beecham (New Zealand) Ltd v Minister of Health* HC Wellington CP428/91, 26 June 1991.

122 Syrett, above n 4.

123 *Ex parte B* (CA), above n 79, at 906.

> [I]t would be totally unrealistic to require the authority to come to the court with its accounts and seek to demonstrate that if this treatment were provided for B[,] then there would be a patient C[,] who would have to go without treatment.

That may have been true when resources were rationed on an ad hoc basis. But today, explicit rationing means decision-making bodies use overt, comprehensive criteria or guidelines that encompass the multitude of factors. Most bodies openly publish these criteria or guidelines.[124] With evidence of the decision-making process more accessible, decision-making bodies can no longer simply "toll the bell of tight resources".[125] Some cases have gone so far as to suggest it shows irrationality not to have a policy for decision-making in place.[126] Moreover, decisions are rarely so specific that they consider which individuals would miss out if another treatment were funded. More often, the decision to fund a new treatment is arrived at by comparing the effectiveness and price of the new treatment with the effectiveness and price of existing treatments, meaning that a benchmark for comparison already exists.[127]

Finally, it must be remembered that judicial review will not require a treatment to be funded.[128] It can merely require the decision-maker to revisit the decision. This point was noted by the Dobbs J in *R (on the application of Eisai Ltd) v National Institute for Health and Clinical Excellence*:[129]

> It is important to stress that this is not ... a challenge to a decision by NICE or the NHS not to fund treatment for certain AD sufferers. Nor is ... the claimant asking the court to rule that NICE recommend treatment ... It is also not about the court having to decide whether an AD sufferer is worth £2.50 a day, a figure which is said to be the cost of treatment with the drug.

In light of this, the concern that judicial review of individual funding decisions could disrupt the overall system is unfounded.

Expertise

It is possible for a judicial body to decide cases involving expert opinion, including in the medical field. The Health and Disability Commissioner (HDC) is a layperson in the sense that he does not have any medical expertise, yet he judges whether a medical practitioner has breached patients' rights or professional standards.[130] Admittedly, the HDC process is more inquisitorial

124 Syrett, above n 4, at 52–68.

125 *R v Cambridge Health Authority, ex parte B* (1995) 25 BMLR 5 (QB) at 17.

126 *R v North West Lancashire Health Authority, ex parte A* [2000] 1 WLR 977 (CA) at 991.

127 See, for example, *Roussel Uclaf*, above n 8, at 73.

128 See generally *Walsh*, above n 68.

129 *R (on the application of Eisai Ltd) v National Institute for Health and Clinical Excellence* [2007] EWHC 1941 (Admin), (2007) 98 BMLR 70 at [3].

130 Skegg and Paterson, above n 37, at 23–56.

and advised by an independent board.[131] It is, therefore, more conducive to getting an accurate picture of expert opinion than the adversarial court process, in which the parties only provide self-serving evidence.[132] Moreover, health care decisions are often controversial among experts so parties can usually get support to make the issue appear finely balanced, even if that is not in fact the case.[133] These difficulties justify the courts' preference to defer to the decision-making body.[134]

But the court can still play a role. By overseeing the experts' debate, the court can establish whether the decision-making body reasoned well: it can respond to dissenting expert opinion. If it cannot respond, the court exposes an error in the expert's opinion on which the decision was based. For example, in *R (on the application of Otley) v Barking and Dagenham NHS Primary Care Trust*, the plaintiff's expert argued that the decision-makers had mistaken facts and considered irrelevant factors.[135] The decision-makers could not respond so the decision was quashed, despite the fact that the procedure and policies for making the decision were not flawed.[136] The Court would not have uncovered this error had it simply deferred to the decision-making body's expertise.

Furthermore, not all decisions will require expert evidence. Review is sometimes an exercise in logic — a skill the judiciary possesses.[137] For example, in both *Rogers* and *R v North West Lancashire Health Authority, ex parte A*, the Courts looked at the larger policy framework and compared it to the chosen methods of funding.[138] The framework approved the treatments in both cases and accorded them a low funding priority: they were only available in exceptional cases. These decisions were open to the PCTs to make, given their expertise. Yet the PCTs' guidelines about exceptional cases made it impossible for any patient to qualify. Both Courts concluded that the decisions were irrational: no expert could acknowledge and fund a treatment and then make access impossible.

In *R v North Derbyshire Health Authority, ex parte Fisher*, non-compulsory national guidance clearly established the cost-efficiency of the treatment.[139] The HA adopted a policy of funding treatment in clinical trials only, but no trials existed so access was also impossible. Although the HA had more discretion in this case, the Court rejected its reasoning as illogical.

These cases demonstrate that the court can look at what the health funding bodies needed to consider and decide whether they were logically capable of coming to their conclusion.

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131 See *Stubbs v Health and Disability Commissioner* HC Wellington CIV-2009-485-2146, 8 February 2010.

132 Syrett, above n 4, at 147–148.

133 For an example of conflicting expert evidence, see *Walsh*, above n 68.

134 At [210].

135 *R (on the application of Otley) v Barking and Dagenham NHS Primary Care Trust* [2007] EWHC 1927 (Admin), (2007) 98 BMLR 182.

136 *Otley*, above n 135.

137 See, for example, *Chaoulli v Quebec (Attorney General)* 2005 SCC 35, [2005] 1 SCR 791.

138 *Ex parte A*, above n 126; and *Rogers*, above 88.

139 *Ex parte Fisher*, above n 49.

Parliamentary Intent

Parliament has not enacted any privative clauses. So, although the judiciary is not the primary decision-maker, there is no reason to exclude its role in judicial review.[140]

Accountability

Democratic processes alone are imperfect methods of accountability. From a theoretical perspective, part of accountability and legitimacy is acting within the bounds of the law, which the judiciary supervises when performing its constitutional function of upholding the rule of law.[141] This includes the court monitoring discretionary powers by interpreting their limits. These powers cannot be too wide: they should be constrained by their purpose.

Moreover, the fact that certain bodies, like Pharmac, are removed from democratic processes raises questions about whether the political arena is the best forum for making decisions of this nature. Admittedly, the adversarial system of the court does not lend itself to public participation or empirical truth finding.[142] Judges also have no higher authority on the moral and ideological underpinnings of health care rationing.[143] Yet the judiciary may contribute to finding the best outcome. Political debate can be self-serving and simply reflect the position of the ruling majority — an imperfect way of deciding where the middle ground between competing interests lies.[144]

Judicial reasoning is often more principled and participation in the court process more structured: proofs and arguments are based on the law, not personal or political beliefs.[145] Therefore, although neither system is perfect, the judiciary can improve the democratic process by ensuring that decisions are not determined merely by appealing to rhetoric and the tyranny of the majority. The court's capacity in this regard is developed in the fifth section of this article.

From a practical point of view, the effectiveness of democratic accountability is overstated. It is naive to suggest that votes are determined purely by a government's stance on the health care system, let alone the singular issues that arise in judicial review — such as refusing one treatment.[146] In fact, voting also contains elements of polycentricity: it is not singularly motivated by discrete issues.

Accountability is limited even when the voting process is targeted at health care rationing bodies like DHBs.[147] These bodies tend to be constrained

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140 See generally *Reckitt and Coleman*, above n 3.

141 Syrett, above n 4, at 136–140. See generally *Eldridge*, above n 57.

142 Syrett, above n 4, at 147–148.

143 At 148–150. See also *Lab Tests*, above n 9, at [379].

144 Syrett, above n 4, at 148–156.

145 At 148–156. See also *Chaoulli*, above n 137, at [58]–[83].

146 Alan Parkin "Allocating Health Care Resources in an Imperfect World" (1995) 58 Mod L Rev 867 at 875.

147 At 875.

by government policy and lack influence.[148] Additionally, it should be noted that in the *Lab Tests* scandal about alleged bias, the accountability mechanisms were not used.[149] Other bodies are not subject to the Minister's directions or to the control of the electorate.[150] Thus this important power is further removed from the electorate's control.[151] These holes in the power of political accountability do not necessarily justify judicial intervention. However, they do undermine the argument for restraint based on the accountability provided by the democratic process.

The court seems to have implicitly assumed a role as the last forum for plaintiffs seeking accountability. Often plaintiffs in successful cases of judicial review have already exhausted their lobbying capabilities to no avail.[152] In *Napier City Council v Health Care Hawkes Bay Ltd*, residents concerned about the closure of the local hospital to emergencies had already organised petitions to Parliament.[153] Both *Walsh v Pharmaceutical Management Agency* and *Rogers* followed widespread media campaigns lobbying for Herceptin funding.[154] In *ex parte Fisher*, there had been media coverage and direct contact with a Minister.[155]

Although the judiciary cannot usurp the legislature's choice of primary decision-maker, it can contribute to the debate. Examples of this include requiring fair consultation procedures, transparency in decision-making and challenges to discrimination.[156] These ideas are developed later in this article.

Commercial Nature

Parliament may have assigned the role of decision-making to a commercial body, but that is no reason to adopt automatically a higher degree of restraint.[157] Thomas J's observations in *Roussel Uclaf* — that a commercial private body could benefit from rigorous procedures — are correct in essence.[158] All self-interested commercial parties would choose to have the best possible procedures in place. The majority's disagreement in *Roussel Uclaf* can be seen as one of degree, not fundamental to the general proposition. They would not impose an onerous process because Pharmac's own resources for making decisions are limited.[159] This is also consistent with what a commercial party would do: weigh the value of the best possible process (and the importance of the decision) against the cost of using that process. Thus in general, good quality decision-making is required by public and private bodies.

148 At 872.
149 *Lab Tests*, above n 9.
150 For example, Pharmac.
151 Parkin, above n 146, at 875.
152 Syrett, above n 4, at 123–128.
153 *Napier City Council*, above n 7.
154 *Walsh*, above n 68; and *Rogers*, above n 88.
155 *Ex parte Fisher*, above n 49.
156 Syrett, above n 4.
157 *Eldridge*, above n 57, at [35]–[42].
158 *Roussel Uclaf*, above n 8, at 83–85
159 At 66.

Additionally, the analogy with commercial entities is flawed. Decision-makers are not subject to the same accountability-producing market pressures as private companies.[160] Arguably the self-interest of an ordinary business does not completely apply: if there are shareholders in the body in question, it is usually just the Minister, and there is little personal profit to be made. These decision-makers are also not subject to the same competition that drives better performance in other areas.[161] The public cannot choose to be served by a different public body, except by imperfect democratic mechanisms. Purchasing private health insurance is a limited alternative. It does not diminish the decision-making power of these bodies nor match the coverage of the public sector.[162] Health care is a classic example of when the commercial model breaks down,[163] hence why the 1993 reforms failed.[164] This means the judiciary should not assume that the commercial aspect of funding health care warrants relaxed procedures or less oversight.

Competition of Price Not Rights

This element of judicial reasoning is hardest to challenge, though it is worth noting the problem is not unique to health care rationing.[165] The court could simply be more sympathetic to patient plaintiffs than commercial plaintiffs — an approach named the "sliding scale".[166] Yet what would stop a commercial party "sponsoring" an affected patient to take the case? The court is still being misused. Equally, when a commercial party brings a genuine challenge to an ordinarily reviewable error, that challenge should not be treated with undue severity. To do so would miss the opportunity to improve the quality of decision-making.

All that can be said in rebuttal is that the court is alive to the issue and can identify a genuinely concerned patient (as opposed to a challenge primarily concerned with cost).[167] Therefore, individuals have been more successful because they have tended to have genuine claims, rather than because they have been treated more favourably on the "sliding scale".[168]

V WHAT THEN IS THE ROLE OF JUDICIAL REVIEW?

The counter-arguments set out above do not entirely dismantle the pedestal

160 Cam Donaldson and Karen Gerard *Economics of Healthcare Financing: The Visible Hand* (2nd ed, Palgrave Macmillan, Basingstoke, 2005).

161 Donaldson and Gerard, above n 160.

162 Gauld, above n 10.

163 Jost, above n 1.

164 Gauld, above n 10, at 205–206.

165 Terence Arnold "Deference, Substantive Unfairness and the 'Hard Look' Doctrine" (paper presented to Judicial Review in Commercial Cases Conference, Auckland, 1 April 2011).

166 Paul Craig "Proportionality, Rationality and Review" [2010] NZ L Rev 265.

167 See, for example, *Lab Tests*, above n 9.

168 See, for example, *ex parte A*, above n 126.

on which health care rationing decisions have been placed. It would still be inappropriate for the court to become the primary decision-maker. Yet it seems that the hurdle has been set too high and that judicial review has the potential to improve the quality of decision-making by quashing poor decisions.[169]

In light of this reappraisal, what role should the judiciary play? Two standards are discussed: a proportionality-based standard that reviews the merits, and a revised approach to the "usual" grounds of judicial review.

Close Scrutiny Review

A higher standard of scrutiny could be conducted on a standard akin to proportionality. Proportionality essentially requires the plaintiff to establish some harm — usually an infringement of their rights — and the public body being challenged must then justify it by arguing it has a worthy goal.[170] The court weighs the relative value of these competing interests and assesses whether the actions taken to achieve the goal justify the wrong to the plaintiff: were they appropriate and did they harm the plaintiff as minimally as possible?[171] The exact formulation of proportionality review differs, but it is essentially underpinned by these ideas in a way that causes the public body to justify its actions.[172]

1 Comparison with Canada

Canada also has a tradition of deference with regards to health care rationing decisions. However, plaintiffs have recently used the Canadian Charter of Rights and Freedoms (the Charter) to review health care rationing legislation or its substantive effect on proportionality grounds.[173] Canada thus provides an opportunity to examine the potential of high scrutiny review.[174]

Eldridge v British Columbia (Attorney General) involved deaf patients in British Columbia who argued that failing to fund sign language interpreters in hospitals was discriminatory.[175] The Court held that discrimination in funding decisions did not need to be overt: if the effect was to disadvantage the group it would equally be a breach of the right.[176] So to say that there was no discrimination because deaf people could still access free health care and translation services were "ancillary", was a "thin" interpretation of discrimination — particularly as communication is crucial.[177] British

169 Syrett, above n 4.

170 Craig, above n 166.

171 Craig, above n 166.

172 Craig, above n 166.

173 Canadian Charter of Rights and Freedoms, Part I of the Constitution Act 1982, being Schedule B to the Canada Act 1982 (UK).

174 Syrett, above n 4, at 179–183.

175 *Eldridge*, above n 57.

176 At [29].

177 At [51] and [69]–[76].

Columbia could not establish a reasonable limitation on the right just by pointing out that economic and social policies were involved.[178] Nor was the breach a minimal infringement, particularly compared with the negligible cost of the services.[179] The plaintiffs therefore succeeded.

British Columbia argued the case would open the floodgates to claims for services by other disabled groups. However, the Court interpreted the plaintiffs' claim as asking for a service to enable access to existing services, not as a claim for a new health care treatment.[180] Moreover, it would not grant an injunction ordering that the service be provided, because other options could be available to remedy the breach. A declaration was enough.

The floodgates were opened to a degree, although the cases were ultimately unsuccessful. In *Auton v British Columbia (Attorney General)*, the plaintiffs argued that failure to fund therapy for autistic children was discriminatory because therapy for other disabilities was provided.[181] The Court held that even universal health plans cannot cover all services so it is not discriminatory just to be denied a treatment.[182] The comparison group for discrimination was non-disabled people: the issue being whether those non-disabled people were provided with a similar treatment, not whether treatments were provided for other disabilities.[183]

The plaintiffs in *Cameron v Nova Scotia (Attorney General)* sought funding for IVF treatment.[184] Without the treatment older people would be less likely to reproduce. However, the treatment was not the only option for having children. Thus it was neither "medically necessary" nor depriving them of their non-existent right to reproduce. The policy reflected that a universal system focused on the greatest net good, not individual demands for treatment.[185] The floodgates were successfully kept shut: the Court was alive to challenges that were framed only in the language of rights, but which lacked the substance of *Eldridge's* case.

The right to life has also been used in a successful Charter challenge. In *Chaoulli v Quebec (Attorney General)*, the plaintiff challenged Quebec's prohibition on concurrent private health care services.[186] The goal was to contain costs by preventing the private and public sectors competing for resources — particularly staff. The majorities in the lower Courts reasoned that the right to life was engaged, though the case was intimately connected with social and economic factors. However, there was no breach because Quebec's policy aimed to ensure equal access regardless of financial

178 At [85].
179 At [85]–[90].
180 At [92].
181 *Auton v British Columbia (Attorney General)* 2004 SCC 78, [2004] 3 SCR 657.
182 At [41].
183 At [55].
184 *Cameron v Nova Scotia (Attorney General)* (1999) 177 DLR (4th) 611 (NSCA).
185 At 652.
186 *Chaoulli*, above n 137.

position.[187] The majority of the Supreme Court disagreed. Economic issues were not engaged because the issue here was the ability to spend one's own money, not public funds.[188] Health care clearly concerns the right to life and waiting lists, although inevitable, infringe a patient's right because the risk of death increases the longer a patient waits.[189]

Quebec's justification of minimising costs was substantial. But the plaintiff did not have the burden of proving that private insurance would achieve a better system.[190] Moreover, Quebec's evidence showed its position was overstated and based more on emotive political discourse than principled argument.[191]

The Court also held that deference was not required because it only needed to understand the social policies being challenged, which did not involve usurping the decision-maker or require special expertise.[192] Reforms had been promised many times and the judiciary was the plaintiff's "last line of defence". In a functioning democracy, the court allows structured participation and protects those without a voice when an injustice is committed against them.[193] By taking this liberal approach with the evidence and the role of the court, the majority concluded that Quebec had failed to justify its policy.

2 *Preliminary Objections*

Some preliminary objections to applying this approach in New Zealand should be noted. These cases are based on a constitutional structure that gives the court a more powerful jurisdiction to determine legislative inconsistencies, which is not comparable to New Zealand.[194]

Additionally, New Zealand lacks human rights instruments of the same strength as the Charter. The right to life in the New Zealand Bill of Rights Act 1990 was not intended to apply to socio-economic rights.[195] Nor has that interpretation been successfully used in case law. For example, in *Shortland*, the Court adopted a causation argument that regarded the underlying disease of the patient — not a lack of health care — as the cause of his death.[196] Although this reasoning is questionable, it demonstrates that the judiciary is not comfortable converting the right to life into a right to services.[197]

The Code of Health and Disability Services Consumers' Rights gives

187 At [6]–[12].
188 At [34].
189 At [40]–[44].
190 At [58].
191 At [74]–[83].
192 At [87]–[89].
193 At [90]–[95].
194 See generally David Mullan "Proportionality — A Proportionate Response to an Emerging Crisis in Canadian Judicial Review Law?" [2010] NZ L Rev 233.
195 Geoffrey Palmer "A Bill of Rights for New Zealand: A White Paper" [1984–1985] I AJHR A6.
196 *Shortland*, above n 6, at 444–445.
197 Manning and Paterson, above n 13, at 401–410.

patients the right to access the level of care they need.[198] But even this is interpreted as a right to a certain standard of care once it has been accessed, rather than a right to demand treatment per se.[199] The defence that the health care provider acted reasonably in the circumstances also specifically takes into account resource constraints.[200] The point is reinforced by the Accident Compensation Scheme, which excludes treatment for injuries resulting from a lack of resources.[201] Conversely, other jurisdictions allow negligence claims that arise from a lack of resources.[202]

However, some authors argue that a lack of human rights instruments does not necessarily preclude using a proportionality standard.[203] It is unnecessary to debate the merits of that claim because it will be shown that proportionality is poorly suited to reviewing health care rationing decisions.

3 Has the Canadian Position Been Overstated?

Later case law shows that the potential of this standard of review is overstated. *Clarken v Ontario Health Insurance Plan (General Manager)* was the next "true" discrimination case, which involved cutting foreign students' health care entitlements.[204] Containing expenditure was a reasonable goal and, although the policy affected over 100,000 people, the Court would not assume there were unlimited resources for everyone.[205] The Court afforded a degree of deference because the decision involved weighing competing demands for scarce resources.[206] The Government's arguments established that the discrimination was not arbitrary, illogical or disproportionate.[207] Thus *Clarken* demonstrates that even in a true discrimination case seeking to extend funding, the court cannot intervene and must defer to the government's judgement.

Moreover, *Chaoulli* was substantially distinguished in *Flora v Ontario Health Insurance Plan*, another challenge based on the right to life.[208] *Chaoulli* involved a prohibition on seeking treatment but in *Flora* the Government had merely declined to fund the benefit in all cases.[209] That was considered reasonable. *Chaoulli* also involved the plaintiff's right to spend his own money, whereas *Flora* related to the allocation of public money.[210] Lastly, the Court held that there cannot be a positive obligation to provide

198 Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, sch 1, cl 2, Right 4.

199 Manning and Paterson, above n 13, at 400.

200 At sch 1, cl 3.

201 Accident Compensation Act 2001, s 32(2).

202 See *Bull v Devon Area Health Authority* (1989) 22 BMLR 79 (CA).

203 Compare Craig, above n 166; and Tom Hickman "Problems for Proportionality" [2010] NZ L Rev 303.

204 *Clarken v Ontario Health Insurance Plan (General Manager)* (1998) 52 CRR (2d) 74 (Ont Div Ct).

205 At 87.

206 At 88.

207 At 88–89.

208 *Flora*, above n 56.

209 At [88] and [101].

210 At [106].

services based on purely economic rights.[211]

Thus even Canadian jurisprudence suggests that a rights-based approach is not a principled means of review. The court inevitably restrains itself in practice because many of the reasons for deference still apply and a high standard of scrutiny brings the court too close to primary decision-making.[212]

The underlying idea that the infringing party must provide a justification for infringement of a right in proportionality review is also misplaced. This principle could apply if the infringement of a right were balanced against a public body's financial justification for the decision. By taking a deontological approach, the court could say that the decision-making body cannot put that price on life and strike down the individual decision while retaining the integrity of the underlying policy.[213]

However, the justification in health care rationing decisions is not a lack of money but rather that there are countless other individuals who also have rights and are in need of treatment.[214] The utilitarian reasoning of health care rationing decisions does not fit well within the individual-based framework of rights.[215] Therefore, proportionality's weakness is that requiring justifications from health care rationing bodies does not advance the analysis: such justifications can easily be outweighed by the numerous competing rights of other patients, except in those very limited circumstances of *Eldridge* and *Chaoulli*.

Procedural Legitimacy

Syrett advocates for the "accountability for reasonableness" model, which centres on the procedural aspects of the decision. The model highlights another weakness of proportionality: in a pluralistic society of competing demands, no decision will ever be justifiable to all. However, the process of coming to the decision may enhance the acceptability and legitimacy of the decision in the eyes of the public.[216]

The model requires a decision-making process to have four fundamental elements to it.[217] First, the process must have accountability, which requires reasons for decisions to be provided to keep the process transparent. Secondly, there must be relevance, in that the reasons are connected to the end decision. Thirdly, a forum to appeal the decision must be accessible so that aggrieved parties may be heard. Finally, there must be regulation, meaning that these limits are enforced against the decision-maker.

The model is directed at the structure of the overall decision-making

211 At [106].

212 See also Syrett, above n 4, at 179–206.

213 Richard Mullender "Judicial Review and the Rule of Law" (1996) 112 LQR 182. See also Finn, above n 69.

214 See earlier discussion on polycentricity.

215 Mullender, above n 213.

216 Syrett, above n 4, at 142–147.

217 At 142–147.

system. Yet the focus on procedure invites greater involvement by the courts on traditional judicial review grounds. By adopting less restraint and greater scrutiny than has previously been applied, the court may have a role in overseeing adherence to the model's values. This improves the quality and legitimacy of the decision-making process.[218] Judicial review is always contextual so this article is restricted to general comments about how the potential of procedural fairness, illegality and irrationality might be enhanced in the review of health care rationing decisions.

1 Procedural Fairness

(a) Improving the Quality of Decisions

Procedural fairness is a cornerstone of decision-making because it assures that a *fair* decision is made. It can also assist a decision-maker in ensuring that the *right* decision is made. For example, if a decision-maker fails to consult, they may fail to receive evidence that is valuable and influential.[219] Thomas J observed in *Roussell Uclaf* that when judicial review cases question the procedure of the decision-making, they also question "a facet of its reasoning process; part of the 'procedure of the mind'",[220] and thus they question the correctness of the conclusion. So if the flaw in the procedure is connected to the reasoning process, the outcome may be questioned without requiring *Wednesbury* unreasonableness.[221] This connection is key.

The majority's decision in *Rousell Uclaf* can be seen in that light. The majority ruled that Pharmac's procedure of reviewing similar pharmaceuticals separately lacked this connection: any imperfect procedural steps were not arbitrary and did not prejudice the ultimate outcome.[222] Likewise in *SmithKline Beecham (New Zealand) Ltd v Minister of Health*, Heron J refused to hear submissions on mistake of fact because they were not connected to a procedural error — the plaintiffs simply believed that the final decision was wrong.[223] By comparison, a connection was found in *Walsh*.[224] The initial decisions were made without consultation. All subsequent decisions and consultation were also flawed because these were based on the assumption that the initial decisions were correct.[225]

Therefore, procedural grounds are an indirect way for the court to review the decision's quality — by looking at the reasoning process — without requiring the same level of expertise as the decision-maker.

This function of procedural fairness means that the court cannot

218 At 142–147.

219 *Walsh*, above n 68, at [191] and [204]–[208].

220 *Roussell Uclaf*, above n 8, at 95.

221 At 94.

222 At 69.

223 *SmithKline Beecham*, above n 121, at 8.

224 *Walsh*, above n 68, at [191] and [201].

225 At [201].

accept a decision-maker's argument that it would not change its mind, had it conducted a better procedure and been confronted with new material. To do so would be for the court to rule on the significance of the information and essentially to make the decision itself. This was noted by the Court in *ex parte A*:[226]

> However, if this court were to assert that the health authority, reviewing those factors, would necessarily come to the same decision as previously ... it would be making exactly the error of substituting its own judgement for that of the health authority.

The court should acknowledge that just as it cannot usurp the role of primary decision-maker, it cannot predict how certain pieces of information would affect the outcome.[227]

(b) Immunity from Commercial Challenges

The procedural fairness ground does not tend to be particularly susceptible to misuse by commercial parties. The plaintiffs in such cases tend to have specific and minute complaints about the process that cannot be said to have been unfair or consequential. For example, in *SmithKline Beecham*, the pharmaceutical company could not show that their submissions would have been any different if Pharmac had given them more notice.[228] Essentially, they were seeking a review of the merits of the decision. Any disguised attempt to review the merits will be revealed by detailed analysis of the decision-making process — which the court can do because it does not involve expert knowledge.

(c) Improving the Democratic Forum for Appeal

Though the court is not democratic and its institutional features are not conducive to public participation, challenges on procedural grounds can ensure that adequate public participation occurs.[229] It was noted in *Chaoulli* that the courts can be a forum for those who are overlooked in the democratic process.[230] That is particularly true when the decision involves a minority interest in a majoritarian society.[231]

Democracies and health care rationing tend to be utilitarian, ensuring the greatest good for the greatest number of people. This conflicts with the deontological principle that individuals have rights, which should not be

226 *Ex parte A*, above n 126, at 1000.

227 *Walsh v Pharmaceutical Management Agency* HC Wellington CIV-2007-485-1386, 3 April 2008 at [240]. Other parts of this judgment were reported in *Walsh*, above n 68.

228 *SmithKline Beecham*, above n 121.

229 Syrett, above n 4, at 147–158.

230 *Chaoulli*, above n 137, at [96].

231 Syrett, above n 4, at 149–152.

overlooked in the process.[232] The court is built around protecting individuals and can thus strike the balance by ensuring participation is fair, even if it cannot make the decision itself.[233]

For example, in *Napier City Council*, the local residents were concerned that their needs were being sacrificed to achieve the greatest reduction in costs.[234] Ellis J thought it was the court's role to ensure participation and she required a greater degree of consultation so that the local residents were not overlooked:[235]

> Refusal of relief would leave the plaintiff to pursue its remedies in the political arena. It could approach the Ministers of the Crown and the CRHA or it could bring further pressure to bear in support of the petition and Mr Braybrooke's Bill. ... In my view this would be to admit that the Court had failed to support the due process of communication and consultation that is envisaged by the Health and Disability Services Act 1993.

The democratic importance of the court upholding procedural fairness is supported by the aforementioned trend that successful cases have often followed an exhaustive process through other democratic avenues. By comparison, in *R (on the application of Longstaff) v Newcastle NHS Primary Care Trust*, the plaintiff sought judicial review without exercising his right to respond to an adverse decision beforehand, so there was no procedural breach.[236]

Some public bodies are specifically removed from democratic processes. One reason for this is the fact that they base their decisions on sophisticated scientific evidence. It is intended that their independence not be impeded by public participation.[237] Nevertheless, decisions in health care rationing are not purely scientific. Some choices are based on societal values and often decisions must consider the significance of the illness.[238] Public submissions may attest to that in terms that statistical and scientific data cannot convey.[239] Thus decision-making bodies ought to be susceptible to public opinion, though the extent of the particular process required may vary depending on the type of decision made.[240]

(d) Result

The court should impose strict standards of procedural fairness on decision-

232 Mullender, above n 213.
233 Syrett, above n 4, at 149–152.
234 *Napier City Council*, above n 7.
235 At 36–37.
236 *R (on the application of Longstaff) v Newcastle NHS Primary Care Trust* [2003] EWHC 3252 (Admin).
237 Parkin, above n 146, at 875.
238 At 870.
239 See also Syrett, above n 4, at 123–128.
240 *Napier City Council*, above n 7, at 36–38.

making bodies when the plaintiff has used the available statutory and democratic processes, and the lack of fairness is connected to the end decision. Therefore, where consultation is obliged or implied by statute, this process must be rigorous and closely scrutinised. Where the statute is not prescriptive, as in *Walsh*, the court should err on the side of requiring greater consultation.[241]

It also means that decision-making bodies cannot voluntarily restrict prerequisites to a fair procedure. For example, a confidentiality clause was imposed when NICE contracted with an independent expert adviser, preventing certain aspects of their decision-making from being fully explained. NICE had the power to negotiate that clause and could not rely on a self-imposed limitation.[242]

Similarly, Ellis J in *Napier City Council* commented that the commercial environment does not reduce the need to follow proper procedure:[243]

> Finally, the Court is well aware of the need to be ever vigilant of [citizens'] rights to participate in the mechanics of government, especially when it relates to the provision of essential and personal services. It is important too to stress that such powerful entities such as CHEs are not to proscribe such participation on the grounds that they are commercial or business operations. It is often said that information is power and that is what this case is about.

The stricter scrutiny will not interfere with commercial decision-making because it is determined in light of the administrative burden of undertaking the process. In some cases, decision-making bodies will need to expend more resources to ensure adequate consultation.[244] However, with that precedent in place, it is likely to lift the standards of the decision-making process overall. It has also been observed that the decision-making process is lengthy anyway. Having to reconsider certain aspects is usually insignificant by comparison.[245]

(e) Does This Conflict with Precedent?

Lab Tests appears to stand for less scrutiny of procedural fairness.[246] The plaintiff, Diagnostic Medlabs, had competed against Lab Tests for a DHB contract to provide laboratory services. The plaintiff alleged bias or procedural unfairness because of a lack of consultation in accordance with the DHB's own policies — the founder of Lab Tests being a former member of the DHB board — and mistakes of fact being made about Lab Test's capabilities.

The Court of Appeal refused to broaden the scope of consultation

241 *Walsh*, above n 68, at [189] and [201].

242 *R (on the application of Eisai Ltd) v National Institute for Health and Clinical Excellence* [2008] EWCA Civ 438 at [56]–[59].

243 *Napier City Council*, above n 7, at 38.

244 *Walsh*, above n 68, at [273].

245 *Eisai Ltd*, above n 242, at [65].

246 *Lab Tests*, above n 9.

requirements on a DHB beyond what was specifically mentioned in the statute.[247] Self-imposed good practice policies that required a greater level of consultation were not legally binding.[248] The objective of community participation in the legislation was not absolute.[249] That is consistent with the closer scrutiny approach because consultation should not be based on self-imposed policies of good practice, as that may vary regionally or as it suits the decision-making body. Lastly, no duty to consult can be absolute: it must depend on context.

The Court also held that it was inappropriate to impose procedural fairness when the public body was exercising its power to contract. But the decision must be understood in its context. The procedural fairness pleading went outside the usual grounds of review and would have been difficult to justify in any case.[250]

Additionally, the Court held as a finding of fact that none of the grounds had been breached.[251] Most importantly, the Court's scrutiny revealed that this was not a public law case: the procedure complained of was a tendering private law process. It did not involve deciding what services would be provided to the public, just how they could be delivered by the competing parties.[252] The Court acknowledged that a successful complaint could be brought by non-tendering parties affected by the decision, such as PHOs. But the duty to consult had not been triggered here: the proposal affecting PHOs was only a long-term goal in a flexible contractual arrangement. Such consultation would only be required if the proposal were implemented by the DHB.[253] The decision can therefore be read consistently with the stricter standard proposed here, which was not appropriate in these factual circumstances.

2 *Illegality*

It is difficult to propose general reform of the illegality ground of review because health care rationing decisions are inherently contextual. They occur in a complex policy environment and vary immensely depending on the type of decision and the subject matter in question. That said, the court should scrutinise this policy environment to use it as a framework for decision-making.

Although health care policies are often expressed in aspirational terms — more open to interpretation than Ministerial directions — they can be authoritative.[254] Moreover, the decision-maker's approach to policy guidance can shed light on the reasoning process. The doctors' decision would have

247 At [313]–[316].
248 At [306]–[310] and [314].
249 At [296].
250 *Lab Tests*, above n 9, at [85] and [208].
251 At [94].
252 At [316] and [332].
253 At [323] and [326]–[327].
254 See, for example, [314].

been unfounded in *Shortland* if they failed to consider the individual circumstances of the patient, even though these circumstances were not mentioned in the policy.[255] In *ex parte Fisher*, a comparison of the PCT's funding policy with the national policy showed that the PCT had disagreed with expert evidence about the treatment's effectiveness, which it was not empowered to do.[256]

The court should also be realistic about the availability of treatment outside the public system. Why would patients bother challenging a decision in court if they could reasonably purchase the treatment themselves? So, availability will often be an irrelevant consideration.

Similarly, *Shortland* avoided the issue by concluding that failing to treat a patient for resource reasons did not cause his death. That reasoning is contrived.[257] The pragmatic and intuitive approach in *Chaoulli* is preferable because understating the importance of a decision lacks transparency and risks downplaying the importance of good decision-making.[258]

3 Unreasonableness

Early English cases seemed to have faith that the reasons for a decision must be sound, even when they were not known to the court.[259] But in an age of explicit rationing — particularly where identifiable formulae exist for decision-making — a lack of reasons is normally unacceptable.[260] Thus it has been suggested that a decision without reasons must fail.[261]

Requiring reasons has caught several decisions that failed for *Wednesbury* unreasonableness because the explanations provided by the decision-maker highlighted their illogical nature.[262] That requirement can also significantly enhance transparency.[263] Therefore, pointing to resource constraints and nothing more in a health care context will usually be insufficient.

Admittedly, much of the expert evidence takes the court's scrutiny too close to the merits. But the court should accept that expert debate will test if a decision is well reasoned, by requiring the decision-makers to respond to criticism.[264] When dissenting expert opinion is coupled with a procedural defect, it is more likely that a mistake has been made. A court should feel more comfortable finding a breach of procedural fairness than scrutinising the merits.

Additionally, expert opinion is not always necessary. Sometimes,

255 Manning and Paterson, above n 13, at 401–408.
256 *Ex parte Fisher*, above n 49, at 89–92.
257 Manning and Paterson, above n 13, at 401–408.
258 Syrett, above n 4.
259 *Ex parte Collier*, above n 64.
260 Syrett, above n 4.
261 *Ex parte A*, above n 126, at 991.
262 See, for example, *ex parte A*, above n 126.
263 At 141–143.
264 See generally *Otley*, above n 135.

review simply requires the court to extract the principle behind a policy or decision, which it is equipped to do.[265] For example, the Court in *Chaoulli* saw past the rhetoric and commented that the arguments were based on emotion rather than evidence.[266] Thus it was not a matter of preferring one expert's opinion to another's.[267]

4 General Comments

Review is thus still limited to procedural grounds, but it may require decision-making bodies to tighten their standards in order to comply. Limiting review mostly to process, rather than merits, reduces the fear of polycentricity: the court is not making the decision for the health funding body and is therefore not affecting the balance of the system.[268] The court is simply ensuring good quality decisions are made and therefore improving the system.

These suggestions for improvement largely reflect the standards that are applied to most other types of judicial review cases. As such, they could also be seen in reverse: not advocating for a special type of involvement, but providing reasons why less restraint is justified and beneficial. It is unhelpful to try to place review of health care rationing on the continuum from restraint and deference to high-scrutiny review. Health care rationing decisions will vary, as will the appropriate level of scrutiny. Context is still everything in judicial review.

VI CONCLUSION

In many ways, this article seeks to point out that the court fails its constitutional role by adopting a categorical attitude towards health care rationing decisions. That categorical attitude is reflected in the inconsistent and unquestioning manner of the court when giving the various reasons for their restraint.

Although none of these reasons are patently wrong, a reappraisal of the underlying ideas and their application shows that they overstate the constitutional and institutional limitations of the court. Therefore, some restraint is justified, but not to the extent that it is dismissive and indifferent to worthy plaintiffs because of the subject matter of the case.[269] Such a specious approach is unwarranted in an area of law as dynamic and contextual as judicial review.

Yet, the court's close scrutiny of the merits of the decision is equally unwarranted: it seeks to increase judicial intervention where it is unjustified. It requires individualised justifications for decisions, which operates awkwardly in an area of decision-making based on the balancing of competing rights in

265 *Chaoulli*, above n 137, at [85]–[87].
266 At [85]–[87].
267 At [85]–[87].
268 Finn, above n 69, at 242–244.
269 Finn, above n 69.

a pluralistic society.

The focus should instead be on process. If the process is legitimate and acceptable, it is likely the decision will be as well. The usual grounds of procedural fairness, mandatory relevant considerations and unreasonableness can accommodate judicial enforcement of such a process.

Approximating where the depth of review would sit on a sliding scale is a fruitless task. It is more useful to point out judicial review's potential to enhance the legitimacy, acceptability and quality of the process — and thus the final decision. By counterbalancing the reasons for restraint with these observations, the way is paved for future cases to scrutinise the facts at hand and determine the appropriate action to take.