



Justifying justiciability: healthcare resource allocation, administrative law and the baseline judicial role

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ABSTRACT

A long-standing problem in United Kingdom law concerns the proper relationship between judicial review and healthcare resource allocation. Traditionally, decisions concerning healthcare resource allocation are non-justiciable. This position has already been departed from in the positive law, but few within the academic literature have discussed the theoretical justification for such a departure. This article draws upon the literature on public law theory and makes three theoretical arguments in favour of this departure. First, the doctrine of non-justiciability is an inflexible – and thus inappropriate – form of judicial restraint. Second, one cannot sensibly distinguish cases with an allocative impact (which are justiciable) from decisions concerning healthcare resource allocation. The latter therefore should not be non-justiciable. Third, the *ultra vires* theory entails that decisions concerning healthcare resource allocation should be both justiciable and consistent with the requirements of the rule of law – such that these decisions must be subject to the possibility of both procedural and rationality review. This establishes a baseline judicial role in healthcare resource allocation.

Keywords: administrative law; judicial review; National Health Service (NHS); non-justiciability; rationing; resource allocation.

INTRODUCTION

This article relates to a significant question in United Kingdom (UK) medical and administrative law. The question is this: to what extent, if at all, should decisions concerning healthcare resource allocation in the National Health Service (NHS) be subject to judicial review? In the 1990s, the prevailing judicial view was that the matter is non-justiciable.¹ Healthcare resource allocation is a ‘political’ matter which should be addressed outside the courtrooms, and preferably in the chambers of Parliament. To this, the court will not – and shall not

* I would like to thank Anne Davies and the anonymous reviewers. Any errors are entirely mine.

1 See *eg R v Cambridge Health Authority, ex p B* [1995] 1 WLR 898, 906.

– intervene.² As we shall see, this all is in the past: the doctrine of non-justiciability no longer holds good in the positive law.

This article seeks to provide a theoretical account that underpins the departure from non-justiciability. It will be contended that this change in the positive law is amply justified, by reference to the literature on public law theory. Three arguments will be made to this effect. First, the doctrine of non-justiciability is an inappropriate form of judicial restraint, due to its lack of flexibility. Even if judicial restraint is justifiably called for, the doctrine of non-justiciability is not a suitable means to achieve this. Second, one cannot sensibly distinguish cases with an allocative impact (which are without more justiciable) from decisions concerning healthcare resource allocation. Therefore, the latter – like the former – should be justiciable. Third, the *ultra vires* theory tells us that the power of decision-makers – even for those responsible for healthcare resource allocation – is necessarily limited. Parliament intends that this limitation be maintained by way of judicial review, and so these decisions must be justiciable. One can go even further: since the *ultra vires* theory requires the decision-makers to act compatibly with the rule of law, we can appeal to the requirements of the rule of law to ascertain what principles of administrative law must (at minimum) exist. Through this line of reasoning, we can see why both procedural *and* rationality review must be available to challenge a decision concerning healthcare resource allocation.³ This discussion establishes a baseline judicial role concerning healthcare resource allocation in UK law.

To those well-versed with this area of medical and public law, it may be intuitively questioned how a piece on the doctrine of non-justiciability would further contribute to the academic literature. A number of experts on this area – such as Newdick, Syrett and Wang – have already noted the departure from non-justiciability in the positive law: the courts have no longer seen the issue of healthcare resource allocation as non-justiciable and have conducted judicial review upon

2 *R v Secretary of State for the Environment, ex p Nottinghamshire County Council* [1986] AC 240, 247.

3 By procedural and rationality review, this article is referring to the two well-known grounds of review in administrative law (as referred to by Lord Diplock in *Council of Civil Services Unions v Minister for the Civil Service* [1985] AC 374) that an applicant may invoke – as opposed to the kinds of remedies that should be available to the applicant, should a challenge be successful. The latter will also be discussed below.

this premise.⁴ It may thus seem like a piece examining the issue of non-justiciability is all but tackling an issue of the past.

But this would be painting too simple a picture. Whilst the positive law has undoubtedly moved on, most of the academic literature has focused on what led to the legal development (eg the social/institutional context of the NHS, or the emergence of a ‘culture of justification’ in UK public law).⁵ These contributions are of course valuable, but they leave the question of theoretical justification – ie *whether* (and, if so, *why*) this move is theoretically justified – largely unanswered. Naturally, we academics should not be satisfied with the statement that ‘the positive law has moved on’, nor should we be satisfied with just knowing that ‘factor X has caused the positive law to move on’: we must further engage in an inquiry of *whether* this departure is justified. As is well known (and as will be discussed later), the famous case of *B* provides us with one of the most authoritative statements on why courts should maintain a stance of non-justiciability.⁶ The clear changes in the positive law since the days of *ex p B* implied disagreement with this authoritative statement by Lord Bingham MR. But few judges and academics have sought to provide an academic exposition of this disagreement. This gap in the literature calls for a piece that engages in public law theory, so as to provide the relevant theoretical grounding for this well-documented change in positive law. This is what this contribution seeks to achieve.

Looking beyond the area of medical law, the litigation in this area has also received attention from public lawyers. It is interesting to note that the public law literature does not seem to have caught up with the developments in this area. In 2007, King described the area of healthcare resource allocation as an area where the doctrine of non-justiciability remains potent.⁷ But *even* at the time – as those familiar with this area have noted – the courts had already begun with a more active role in judicial review.⁸ Nevertheless, in the latest edition of

- 4 Christopher Newdick, *Who Should We Treat? Rights, Rationing, and Resources in the NHS* 2nd edn (Oxford University Press 2005) 100–104; Keith Syrett, *Law, Legitimacy and the Rationing of Health Care: A Contextual and Comparative Perspective* (Cambridge University Press 2007) 164–177; Daniel Wei L Wang, ‘From *Wednesbury* unreasonableness to accountability for reasonableness’ (2017) 76 *Cambridge Law Journal* 642, 644–649; Keith Syrett, ‘Healthcare resource allocation in the English courts: a systems theory perspective’ (2019) 70 *Northern Ireland Legal Quarterly* 111, 114–116.
- 5 See eg Newdick (n 4 above) 94–109; Wang (n 4 above) 642, 653–656; Syrett, ‘Healthcare resource allocation’ (n 4 above) 117.
- 6 *B* (n 1 above) 906.
- 7 Jeff A King, ‘The justiciability of resource allocation’ (2007) 70 *Modern Law Review* 197, 199–200.
- 8 Newdick (n 4 above) 93–105; Syrett, *Law, Legitimacy and the Rationing of Health Care* (n 4 above) 172–177.

De Smith's Judicial Review – which was published in 2018 – King's piece and *ex p B* have still been cited with approval as representative of the current law. The statement of law remained that 'the allocation of resources is regarded as a matter which is not normally amenable to judicial review'.⁹ This represented an alarming – and fundamental – disconnect between the literature on medical law and public law.

This piece, therefore, is not nugatory. It makes two direct contributions to the literature across two important fields of law. First, this piece contributes to the medical law literature by justifying – through public law theory – a development that has been thoroughly noted, but clearly undertheorised. Second, this piece contributes to the public law literature by bridging its disconnect with the medical law literature. This piece will therefore be interesting to not only medical lawyers: but also public lawyers that are also invested in the issue of resource allocation.

Before we proceed any further, there are three caveats that should be noted concerning the intended scope of this article. First, this article is only concerned with the judicial role in healthcare resource allocation insofar as UK law is concerned. Although the comparative literature on health litigations beyond the UK can be helpful to this exploration, this article is not crafted with other jurisdictions in mind;¹⁰ nor is there an implied suggestion that the approach in UK law should be taken in other jurisdictions.¹¹ Second, the reference to public law theory here refers to a mixture of theoretical contributions from *both* administrative law and constitutional theory in the UK law literature (both of which will be discussed extensively below). The *ultra vires* debate is a prominent debate in the administrative law literature, whereas the literature on the rule of law and judicial restraint are two well-known facets of the constitutional theory literature. The aim here is to unite the precepts arising from these contributions with the judicial treatment of

9 Lord Woolf, Sir Jeffrey Jowell QC, Catherine Donnelly, Ivan Hare QC and Joanna Bell, *De Smith Judicial Review* 8th edn (Sweet & Maxwell 2018) [5-150].

10 That is, this article is simply focused on the UK domestic law – although other jurisdictions can remain relevant to the analysis.

11 A suggestion that has been made elsewhere: see eg Colleen M Flood and Aeyal Gross, 'Litigating the right to health: what can we learn from a comparative law and health care systems approach' (2014) 16 *Health and Human Rights Journal* 62, 66–67, 69; Daniel Wei L Wang, 'Right to health litigation in Brazil: the problem and the institutional responses' (2015) 15 *Human Rights Law Review* 617, 640–641. If such a move is to be taken, Syrett and Newdick's contributions (see Keith Syrett, 'Evolving the right to health: rethinking the normative response to problems of judicialization' (2018) 20 *Health and Human Rights Journal* 121; Christopher Newdick, 'Can judges ration with compassion? A priority-setting rights matrix' (2018) 20 *Health and Human Rights Journal* 107) may provide a good starting point. This matter will, however, be beyond the scope of this article, as we are only concerned here with UK law alone.

healthcare resource allocation. Third, this article only seeks to justify a *baseline* for the judicial role in healthcare resource allocation: that there must be both procedural and rationality review of such decisions, and that the doctrine of non-justiciability cannot be adopted. This does not (nor is it intended to) preclude further debate on the particular form and intensity of review which courts should apply,¹² including the possibility of judicial deference.¹³

THE DOCTRINE OF NON-JUSTICIABILITY: SETTING THE SCENE

To the readers that are less familiar with this area of law, it will be important to first canvass the material developments in the positive law – before we proceed to justify them. It will be convenient to – as Newdick and Wang did – divide the case law into two batches.¹⁴ The first batch of judicial challenges against resource allocation in the NHS reveals a very high degree of judicial restraint. Take *Hincks*.¹⁵ The applicants applied to the court, complaining that the health services in the area were insufficient. Lord Denning MR rejected the application. He noted the ‘grievances which many people feel nowadays about the long waiting list to get into hospital’.¹⁶ But he went on to say ‘[s]o be it. The Secretary of State says that he is doing the best he can with the financial resource available to him: and I do not think that he can be faulted in the matter.’¹⁷ Or take *Collier*.¹⁸ There the court faced a challenge against the NHS’s refusal to conduct life-saving surgery on a child, allegedly because no bed in the intensive care unit was available. The application was swiftly dismissed. Stephen Brown LJ noted that ‘even assuming ... there is immediate danger to health ... [t]his court is in no position to judge the allocation of resource by this particular

12 For it is one thing to ask whether there should be rationality review, and another to ask what intensity with which it should be conducted: see Paul Craig, ‘Judicial review, methodology and reform’ [2022] Public Law 19, 25–26.

13 For which it may be said that there must be a baseline intensity of review: see Cora Chan, ‘Proportionality and invariable baseline intensity of review’ (2013) 33 LS 1. But the question with which this article is concerned is even logically prior to this: the argument is for the (baseline) existence of review, and not the (baseline) intensity of it.

14 Newdick (n 4 above); Wang (n 4 above); cf Syrett ‘Healthcare resource allocation’ (n 4 above) 114.

15 *R v Secretary of State for Health, West Midlands Regional Health Authority and Birmingham Area Health Authority, ex p Hincks* [1980] 1 BMLR 93.

16 Ibid 96.

17 Ibid.

18 *R v Central Birmingham Health Authority, ex p Collier* (unreported, 6 January 1988, Court of Appeal).

health authority ... The courts of this country cannot arrange the lists in the hospital.’¹⁹ The most widely known instance of non-justiciability is perhaps *B*. There a child suffered from acute leukaemia. The health authority refused to fund the proposed treatment of chemotherapy and bone-marrow transplant for the child – which could potentially save her life – partly on the ground that it was not an appropriate use of public funds. Sir Thomas Bingham MR held:

I have no doubt that in a perfect world any treatment which a patient, or a patient’s family, sought would be provided if doctors were willing to give it, no matter how much it cost, particularly when a life was potentially at stake. It would however, in my view, be shutting one’s eyes to the real world if the court were to proceed on the basis that we do live in such a world ... 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.²⁰

There is, however, a caveat here. As Syrett explained, the courts did not *formally* classify decisions on healthcare resource allocation as non-justiciable: ‘they retained the capacity to intervene’ when the decision was *Wednesbury* unreasonable.²¹ But this possibility of intervention never really transpired:²² as Syrett then added, the courts have applied the rationality review in such a stringent manner that ‘allocative decisions were, in effect, *insulated from any judicial scrutiny*, even on procedural grounds’.²³ As Endicott rightly suggested of the first batch of case law, ‘the courts will give *practically no protection* against bad decisions in the allocation of a limited budget among competing

19 Ibid.

20 *B* (n 1 above) 906.

21 Syrett (n 4 above) 114. Rationality review is – especially when one looks towards other jurisdictions and the international right to health – not the only way through which judicial scrutiny may take place. For instance, it is possible for courts to use reasonableness and proportionality as such tools: see Katharine G Young, ‘Proportionality, reasonableness and economics and social rights’ in Vicki C Jackson and Mark Tushnet (eds), *Proportionality: New Frontiers, New Challenges* (Cambridge University Press 2017) 249–250, 252–259. But since we are only concerned with the UK law context here – and challenges to healthcare resource allocation decisions in this context have almost always been made through administrative law, rather than human rights law (see Flood and Gross (n 11 above) 67) – we will focus thereafter on rationality review alone. This is not necessarily the case for other contexts of resource allocation, where human rights law can play a more important role: see eg Ellie Palmer, *Judicial Review, Socio-Economic Rights and the Human Rights Act* (Hart 2007) ch 5.

22 Wang (n 4 above) 653.

23 Syrett (n 4 above) ‘Healthcare resource allocation’ 114 (emphasis added). See also Palmer (n 21 above) 162, 164–165.

needs'.²⁴ This led to what in practice was a doctrine of non-justiciability over decisions concerning healthcare resource allocation: *no* applicant, however aggrieved and wronged, will receive protection from judicial intervention. (This position is, however, not true, as we shall see, in respect of the second batch of case law.)

In other words, whilst the court did not apply a *de jure* doctrine of non-justiciability (whereby judicial review is in principle ruled out), it still applied a *de facto* doctrine of non-justiciability (whereby judicial review is in principle available, but is in practice ruled out). When the later analysis referred to 'non-justiciability', it was meant to refer to this *de facto* doctrine of non-justiciability. To this article, however, this distinction is not a material one. Why is that so? For if one believes that judicial review exists to uphold a certain value – eg accountability²⁵ or the rule of law²⁶ – this value will be lost if judicial review becomes unavailable. On this count, it will not matter whether its unavailability is *de jure* and *de facto*: the value secured by judicial review will still be lost if courts hold that judicial review remains in principle available, but that it be only available on grounds that can never be established in practice. Similarly, if there are arguments against the unavailability of judicial review (eg that certain undesirable consequences follow from the unavailability of judicial review), the validity of these arguments is naturally predicated on the premise that judicial review is unavailable. But again, this premise can be established insofar as judicial review is indeed unavailable – whether this is proven by way of a doctrine of *de jure* or *de facto* non-justiciability. It makes no difference *how* judicial review is rendered unavailable: it only matters here that it is indeed rendered unavailable.

This doctrine of non-justiciability can be readily seen from the academic commentary on the abovementioned cases. James and Longley contended that the judgment in *B* 'did little to move substantive review in this area on from the earlier cases of *ex parte Collier* ... which had been notable only for their lack of perceptive analysis and the ritual invocation of *Wednesbury* principles'. The decisions 'in essence not only gave health authorities a free hand to allocate resources as they chose, but also weakened the potential role of the courts'.²⁷ As mentioned earlier, Wang separated the authorities on reviewing NHS

24 Timothy Endicott, *Administrative Law* 5th edn (Oxford University Press 2021) 272 (emphasis added).

25 Paul Craig, 'Accountability and judicial review in the UK and EU: central precepts' in Nicholas Bamforth and Peter Leyland (eds), *Accountability in Contemporary Constitution* (Oxford University Press 2013) 185.

26 See eg T R S Allan, *Law, Liberty, and Justice: The Legal Foundations of British Constitutionalism* (Clarendon Press 1994) ch 8.

27 Rhoda James and Diane Longley, 'Judicial review and tragic choices: *Ex parte B*' [1995] Public Law 367, 371–372.

resource allocation decisions into two stages. The first stage concerns the authorities that have already been referred to – such as *Hincks* and *Collier*. In those cases,

the courts restrained themselves to a minimal level of scrutiny of the allocative choices and trusted primary decision-makers to make the best decisions. The court's reasoning was straightforward: resources are scarce, not all health needs can be met, and thus rationing is necessary; and health authorities are best able to do this.²⁸

The doctrine of non-justiciability did not subsist. The second batch of cases on resource allocation decisions in the NHS reveals that the courts have moved onwards. It has already been mentioned that this article is not the first to make this observation. So the aim here is only to briefly canvass this move in preparation for the theoretical account in the next section. There are a number of cases within this batch: but it will be quite unnecessary to go through each of them here. The aim here is only to illustrate the legal development with two cases: *A, D and G*²⁹ and *Otley*.³⁰

In *A, D and G*, the applicants were patients suffering from gender identity dysphoria. They applied for funding for their treatment – which included gender reassignment surgery. The health authority refused. It did so on the basis of its policy. It said that if a treatment was regarded as ‘clinically ineffective’ – and gender reassignment surgery was regarded as such a treatment – it would be accorded a ‘low priority’. The aim of this policy was to ensure that the resources of the NHS were ‘used appropriately’.³¹ No funding would be provided, unless there was an ‘overriding clinical need or exceptional circumstances’.³² The health authority did not find that the applicants had satisfied such criteria. In return, the applicants’ contention was that this policy was irrational.

Auld LJ proceeded differently. He first applied *B* and held that ‘[t]he precise allocation and weighting of priorities is clearly a matter of judgment for each authority’.³³ This was unobjectionable, as the court should not substitute the judgment (as opposed to conducting a rationality review) of the resource allocation decision. But instead of applying the doctrine of non-justiciability, he proceeded to find the policy irrational. This finding of irrationality was not done on the basis of challenging the *medical* assessment by the decision-maker –

28 Wang (n 4 above) 643, 645–646.

29 *R v North West Lancashire Health Authority, ex p A, D and G* [1999] EWCA Civ 2022, [2000] 1 WLR 977.

30 *R (Otley) v Barking and Dagenham NHS Primary Care Trust* [2007] EWHC 1927 (Admin).

31 *A, D and G* (n 29 above) 983.

32 Ibid 984.

33 Ibid 991.

for which the health authority clearly possesses relative institutional competence. Thus, Auld LJ held that '[i]n my view, a policy to place transsexualism low in an order of priorities of illnesses for treatment and to deny it treatment save in exceptional circumstances such as overriding clinical need is not in principle irrational'.³⁴ The flaw of the policy was that it was illogical. The health authority recognised that gender identity dysphoria *was* an illness. But it did not recognise gender reassignment as an effective treatment: and so *no* overriding clinical need could ever have been recognised. The problem therefore was not a flawed medical judgment, but one of logic: if the policy purported to identify exceptions, it must do so 'genuinely'.³⁵ In this case, the policy was applied in a way which *de facto* imposed a blanket ban on funding for gender identity dysphoria: and the exception was therefore a pretence. This shows that the court is willing to carefully scrutinise the nature of the particular issue thrown up in the case: a decision on healthcare resource allocation may be illogical on grounds that can be readily scrutinised by the court, although it may not possess medical expertise which matches that of the health authorities.

The second case is *Otley*. The applicant suffered from metastatic colorectal cancer. She had received chemotherapy previously, but her body's response was poor – so poor, indeed, her doctor found the treatment 'of absolutely no value'.³⁶ She discovered the drug Avastin in her own capacity, and self-funded five rounds of it. Her body's response was excellent. She then applied to the NHS for funding further Avastin treatment. According to NHS policy, treatment with Avastin would not be funded unless there were exceptional circumstances. This was because Avastin was not regarded as a sufficiently cost-effective drug. It was found that the applicant did not fit the exceptionality criteria, and so funding was refused. The challenge is founded on the basis that it was irrational for the health authority not to regard the applicant as an exceptional case.

Just as in *A, D and G*, the doctrine of non-justiciability did not apply. Mitting J held in favour of the applicant. He found that 'on any fair minded view of the exceptionality criteria ... [the applicant's] case was exceptional'.³⁷ The query, again, is not one based on any competing medical expertise asserted by the court. The matter, rather, is one in which the court is sufficiently competent to make a fair assessment. One can see that from the applicant's contention:

[The applicant] was at the time when the decision was made, as she had been throughout, relatively fit. She was young by comparison with

34 Ibid.

35 Ibid.

36 *Otley* (n 30 above) [2].

37 Ibid [26].

the cohort of patients suffering from this condition. Her reactions to other treatment ... had been adverse. Her specific clinical history suggested that ... Avastin had been of benefit to her. By comparison with other patients, she, unlike many of those the subject of the studies, had suffered no significant side-effects from a cocktail which included Avastin.³⁸

The question, then, was whether the applicant's circumstances were such that her case was exceptional. The court is not required to substitute the judgment of the decision-maker. It need only see whether the judgment is irrational. It will do so, logically, by comparing the usual case of a patient requesting Avastin treatment to the applicant's case. It is true that the judge cannot perform a medical assessment of the applicant, or readily understand the scientific studies on the drug to comprehend its usual effectiveness. But, as Chan noted, it must be remembered that, although the court may be generally less competent than a decision-maker, the deficit of institutional competence can potentially be remedied. An information gap, for instance, can be addressed by a disclosure of information or expert evidence.³⁹ In *Otley*, this was the basis upon which the court found itself in an appropriate position to interfere: the court may proceed on the basis of the applicant's expert evidence to assess if the NHS decision was properly made. The theme here is similar to that in *A, D and G*: although we are faced with a decision concerning healthcare resource allocation, it may remain true that the court possesses sufficient competence to assess the rationality of the decision. If so, the doctrine of justiciability would appear to be too excessive a response to the needs of judicial restraint.

Pausing here, *A, D and G* and *Otley* are highly instructive on two counts. First, they have demonstrated to us – as a matter of legal reality – that the courts have no longer applied the doctrine of non-justiciability. This is despite the fact that cases such as *Collier* and *B* have never been formally overruled. Second, they have shown us that the issues thrown up in a judicial review of decisions concerning healthcare resource allocation can be ones that courts are relatively competent to assess (this will be further developed in the next section).

38 Ibid [20].

39 Cora Chan, 'A principled approach to judicial deference for Hong Kong' in Guobin Zhu (ed), *Deference to the Administration in Judicial Review: Comparative Perspectives* (Springer 2019) 217.

THE THEORETICAL CASE FOR JUSTICIABILITY

As has been mentioned in the introduction to this piece, there is a critical gap in the literature on this important legal development: few have attempted to inquire whether (and if so, why) this development is theoretically justified. This piece aims to fill this gap. As Syrett noted, the standard case *for* non-justiciability – adopted by the judges in the first batch of cases – is two-pronged.⁴⁰

- a. *Institutional competence*: courts are not sufficiently competent to adjudicate on issues of healthcare resource allocation. Various (sometimes overlapping) reasons for this conclusion have been advanced. Judges are only legally trained (with little background in say healthcare economics and healthcare management),⁴¹ whereas healthcare resource allocation can engage complex scientific, political and moral issues.⁴² The adversarial nature of the proceedings may make it difficult to gather information comprehensively, especially when the litigants before the court may not represent the general run of patients⁴³ and given the polycentricity involved.⁴⁴ Courts are also compelled to apply

40 Syrett, *Law, Legitimacy and the Rationing of Health Care* (n 4 above) ch 5. This point can also be seen in many of the pieces cited within this section.

41 Ibid 131, 144–145; Daniel Wang and Benedict Rumbold, 'Priority setting, judicial review, and procedural justice' in Anelka M Phillips, Thana C de Campos and Jonathan Herring (eds), *Philosophical Foundations of Medical Law* (Oxford University Press 2019) 187–189; Woolf et al (n 9 above) [5–150]; Stefanie Ettelt, 'Access to treatment and the constitutional right to health in Germany: a triumph of hope over evidence?' (2020) 15 *Health Economics, Policy and Law* 30, 32. See further Leticia Morales, 'Judicial interventions in health policy: epistemic competence and the courts' (2021) 35 *Bioethics* 760, 761–763, but also 764–765.

42 Wang (n 11 above) 635–636.

43 Christopher P Manfredi and Antonia Maioni, 'Courts and health policy: judicial policy making and publicly funded health care in Canada' (2002) 27 *Journal of Health Politics, Policy and Law* 213, 218–219; Ettelt (n 41 above) 32, 36–38; Syrett, *Law, Legitimacy and the Rationing of Health Care* (n 4 above) 130, 147–148. There can be further problems. The litigants may seek to adduce evidence that favours their predetermined conclusion – whilst ignoring evidence pointing to the contrary direction: see Susan Haack, 'What's wrong with litigation-driven science? An essay in legal epistemology' (2008) 38 *Seton Hall Law Review* 1072, 1077. The litigants may also conduct their cases in a way that focuses only on one aspect of the health policy (particularly if this may favour this case), without presenting the whole picture to the court: see Manfredi and Maioni (ibid) 222, 228. This can make it even more difficult for the court to impartially and comprehensively assess all the relevant evidence that concerns health policy.

44 Wang (n 11 above) 630, 636; Ettelt (n 41 above) 32; Daniel Wei L Wang, 'Priority-setting and the right to health: synergies and tensions on the path to universal health coverage' (2020) 20 *Human Rights Law Review* 704, 723–724.

legal reasoning, which may not be the most suitable for evaluating policy alternatives in an open-minded manner.⁴⁵

- b. *Constitutional legitimacy*: in a constitutional democracy, the issue of healthcare resource allocation falls within the province of the political branches of government (ie the executive and legislature). In light of this, courts should not attempt to substitute their own policy preferences on this issue: but they should leave the decision to those that enjoy more democratic legitimacy.⁴⁶

For these two reasons – so the standard case goes – the matter of healthcare resource allocation is not appropriate for determination by courts; that is, it should be non-justiciable.⁴⁷ Indeed, the UK courts are not entirely ‘out of the woods’ yet with the standard case. Although the courts do not necessarily adopt the full form of non-justiciability (as seen in the first batch of cases), similar concerns have still rippled in the second batch of cases – calling on occasions for an acute curtailment of the judicial role beyond procedural matters in healthcare resource allocation, based particularly on concerns for the court’s relative lack of institutional competence.⁴⁸ So, although the standard case is not now precisely followed, it has continued to play an influential role in the positive law. An examination of its validity is thus particularly apt and important.

The theoretical account here consists of two related, but distinct, propositions: (a) the standard case for non-justiciability (based on institutional competence and constitutional legitimacy concerns) is flawed; and (b), from the perspective of public law theory, all healthcare resource allocation decisions should be justiciable. The departure from the doctrine of non-justiciability is perforce theoretically justified: and (it follows) that there should be a baseline judicial role concerning healthcare resource allocation. Before we proceed any further, one must first be clear about the relationship between these two propositions.

45 Manfredi and Maioni (n 43 above) 218, 222, 226, 234. This may be echoing some more generalist concerns, as reflected in Jeremy Waldron, ‘Judges as moral reasoners’ (2009) 7 *International Journal of Constitutional Law* 2.

46 Syrett, *Law, Legitimacy and the Rationing of Health Care* (n 4 above) 132; Wang and Rumbold (n 41 above) 187–189; Woolf et al (n 9 above) [5–150]; Ettelt (n 41 above) 32; Wang (n 44 above) 714. See also Pavlos Eleftheriadis, ‘A right to health care’ (2012) 40 *Journal of Law, Medicine and Ethics* 268, 282.

47 Syrett, *Law, Legitimacy and the Rationing of Health Care* (n 4 above) 128–129; Woolf et al (n 9 above) [1–040].

48 Keith Syrett, ‘Health technology appraisal and the courts: accountability for reasonableness and the judicial model of procedural justice’ (2011) 6 *Health Economics, Policy and Law* 469, 471, 473, 477–480; Wang and Rumbold (n 41 above) 186–187, 190. Nevertheless, one can still see a material distinction between the second batch of cases from the first: see Newdick (n 4 above) 93, 98–102, 105–107; Wang (n 4 above) 643–651.

These two propositions are distinct: the former is a negative case *against* non-justiciability, whilst the latter is a positive case *for* justiciability. It is logically possible – for instance – for a critic to disagree with the standard case for non-justiciability, but to present an alternative case for non-justiciability. In light of this possibility, the negative case alone may not suffice. But even if any alternative case is now to be made, that critic will have to respond to the positive case for justiciability propounded in this piece. This is why the theoretical account consists of two distinct – but mutually reinforcing – propositions.

Against the standard case: inflexibility

The doctrine of non-justiciability is an inappropriate form of judicial restraint, due to its overt inflexibility. The standard case for non-justiciability posits that courts lack institutional competence⁴⁹ and constitutional legitimacy⁵⁰ compared to the decision-maker in healthcare resource allocation decisions, and the courts must be sensitive to these differences. Let us assume here that the court is generally less capable and constitutionally legitimate than a decision-maker in the context of healthcare resource allocation, as has been suggested by many in the academic literature.⁵¹ The argument here does not deny these concerns, but only doubts whether non-justiciability properly follows from this premise. To say that this *invariably* leads to a doctrine of non-justiciability in healthcare resource allocation (as the first batch of case law suggests) ignores two facts: (a) the extent to which the court lacks institutional competence and constitutional legitimacy can vary; and (b) other factors may also influence the proper extent of judicial restraint. In other words, the doctrine of non-justiciability applies a ‘spatial’ approach to judicial restraint.⁵² This concept arose from the literature relating to judicial deference in human rights cases, but it equally applies here. It means that the courts will carve out ‘wholesale subject areas as automatically warranting a small or large degree of deference’.⁵³ In this case, the degree of judicial restraint is the furthest one can go: non-justiciability. The idea is that whenever

49 E Palmer, ‘Resource allocation, welfare rights—mapping the boundaries of judicial control in public administrative law’ (2000) 20 *Oxford Journal of Legal Studies* 63, 76.

50 Martin Chamberlain, ‘Democracy and deference in resource allocation cases: a riposte to Lord Hoffmann’ [2003] *Judicial Review* 12 [13]; Keith Syrett, ‘Impotence or importance? Judicial review in an era of explicit NHS rationing’ (2004) 67 *Modern Law Review* 289, 295; *R (Pfizer Ltd) v Secretary of State for Health* [2000] EWCA Civ 1566, [2003] 1 CMLR 19 [17].

51 See eg Manfredi and Maioni (n 43 above); Woolf et al (n 9 above) [5-150]; Wang (n 44 above) 723–724.

52 King (n 7 above) 421.

53 Chan (n 39 above) 217.

we have a decision concerning healthcare resource allocation (as the input) the court will automatically proffer non-justiciability (as the output) regardless of other contextual factors. This discussion leads us to two criticisms against the doctrine of non-justiciability, as posited by the standard case and the first batch of case law.

The first criticism is that, even within the area of healthcare resource allocation, the court is not inevitably inapt. While the court may not have a varying democratic mandate, it does have a varying degree of institutional competence compared to the decision-maker. Let us contrast two decisions that we have canvassed earlier: *B* and *A*, *D* and *G*. In both cases, the health authorities refused to fund the applicant's treatment by reason of budgetary concerns. But there is nevertheless a critical difference. In *B*, the attack was taken against the balancing of the applicant's individual needs and the authority's financial constraints. The court found itself out of its depth – compared to the health authority – and so applied the doctrine of non-justiciability. In *A*, *D* and *G*, the attack was taken against the funding *policy*. The challenge was that the policy was illogical. The policy stated that the funding would only be given in exceptional circumstances. But, at the same time, the doctors in charge did not believe that there could be an effective treatment for gender identity dysphoria (from which the applicant suffered), so the applicant could never have fulfilled the criteria under the policy. The policy is therefore irrational: it purports to provide a policy of exceptionality, whilst in fact it is a 'blanket policy'.⁵⁴

It is not here suggested that *B* is right to apply a doctrine of non-justiciability. But it is suggested that, by contrasting these two cases, one can see how – even within the area of healthcare resource allocation – the court's relative institutional competence is not uniform. In *B*, the challenge was more about the delicate and difficult task of managing resources and balancing various needs to be met by the NHS. In *A*, *D* and *G*, the challenge was more about the logicity of the policy. There is no reason why a doctor is in any better a position than a judge to assess this matter. Indeed, a judge – who is experienced in dealing with logic and reasons – would likely be a better expert than a doctor. As Chan suggested, after identifying the issue to be dealt with 'the court should then ask whether it indeed suffers from incompetence thereon. If it is a question of logic or one concerning which the court has all of the relevant information it needs to decide, then the court suffers no institutional incompetence.'⁵⁵

54 *A*, *D* and *G* (n 29 above) 993–994; Keith Syrett, 'Rationing, resource allocation, and appropriate medical treatment' in Sara Fovargue and Alexandra Mullock (eds), *The Legitimacy of Medical Treatment: What Role for the Medical Exception?* (Routledge 2015) 207–208.

55 Chan (n 39 above) 220.

The second (related) criticism is this: by taking a formalist approach, the doctrine of non-justiciability ignores matters which may be relevant to the appropriate degree of judicial restraint – beyond the fact that the issue of healthcare resource allocation is touched upon. In a separate article, King discussed the various approaches to judicial restraint. There is the non-doctrinal approach – where the judges will ‘use their good sense of restraint on a case-by-case basis rather than employ any conceptual framework’.⁵⁶ There is the formalist approach – where the courts will ‘apply abstract categories’ that ‘they believe properly allocate decision-making functions between different branches of government’. Prominent ones include ‘law’, ‘politics’, ‘principle’ and ‘policy’.⁵⁷ There is, finally, the institutional approach to judicial constraint. It ‘focus[es] on the comparative merits and drawbacks of the judicial process as an institutional mechanism for solving problems’: and in applying it, the courts will weigh the relative institutional competence of the court as a factor towards the degree of judicial scrutiny (eg a balancing stage).⁵⁸ The doctrine of non-justiciability is a formalist approach. It labels certain decisions (ie those decisions concerning healthcare resource allocation) as non-justiciable.⁵⁹

This means that the doctrine of non-justiciability is subject to King’s arguments against the formalist approach to judicial restraint. There are several of them. First, it is highly rigid and ignores any adverse consequences it produces. This encourages a view that, as long as a decision follows this ‘doctrine’ – and is hence conceptually correct – ‘its consequences are of minor importance’. This may be true in the context of healthcare resource allocation decisions. It may be easy for judges to simply invoke the doctrine of non-justiciability, while ignoring the potentially disastrous consequences (eg death, when one thinks about the NHS context) that this may have on the rejected applicants.⁶⁰ Second, it ‘obviate[s] the need for ... analysis’. It stops the court from thinking why, in this particular case and with this particular context, it should not intervene.⁶¹ Rather, it will say to itself: since we are concerned with healthcare resource allocation – and so the doctrine of non-justiciability is engaged – this is the end of the matter.⁶² But this may not be true. Some cases may feature additional factors – which could well influence the proper approach for the courts to take – such

56 Jeff A King, ‘Institutional approaches to judicial restraint’ (2008) 38 *Oxford Journal of Legal Studies* 409, 410–411.

57 *Ibid* 414–416.

58 *Ibid* 410, 427.

59 *Ibid* 420–422.

60 *Ibid* 414.

61 *Ibid* 415.

62 *Ibid* 421.

as if the matter involves highly important interests (eg the survival of the applicant) or rights (eg the right against non-discrimination). The third point is related to, but distinct from, the second: the doctrine of non-justiciability carries with it an uncompromising approach. It deems all decisions concerning healthcare resource allocation non-justiciable, while not recognising that the appropriate degree of judicial restraint may vary.⁶³ Even assuming that *some* healthcare resource allocation decisions may be properly non-justiciable, it does not mean *all* of them, regardless of context, are. A court that is truly sensitive to the constitutional needs for judicial restraint would recognise that, at times, a lesser degree of judicial restraint would be properly called for. The doctrine of non-justiciability does not fulfil this need.

These two heads of criticism meet up to form the proposition that the doctrine of non-justiciability lacks flexibility. In the literature about deference in human rights litigation, Allan contended that the doctrine of deference is illegitimate, partly because it can ‘collapse into a non-justiciability doctrine’.⁶⁴ To this Kavanagh retorted:

Both deference and non-justiciability are based on concerns about the institutional limits of the judicial role when compared to the competence, expertise and democratic legitimacy of the elected branches. This is what makes them similar doctrines. However, deference and non-justiciability also differ in significant ways ... Deference ... is a more flexible doctrine which is not antithetical to judicial scrutiny. There are degrees of deference and establishing the appropriate degree is a matter of balancing all the relevant factors in the individual case. Rather than being a blanket rule preventing scrutiny, deference maintains some flexibility by requiring the courts to assess their institutional competence to deal with a particular issue, and to show restraint to the extent that their competence is limited ... The relative flexibility of the doctrine of deference and the fact that it does not remove certain issues from judicial scrutiny altogether, are the main advantages of deference over non-justiciability.⁶⁵

These words ring equally true here. They demonstrate to us the ineptitude of the doctrine of non-justiciability as a proper approach to exercising judicial restraint, even in the context of healthcare resource allocation. This theoretical discussion can be bolstered by reference to other examples we see in comparative law – where the extent of judicial restraint applied towards scrutinising healthcare resource allocation is more flexibly adjusted. One more well-known example is the South African jurisprudence on the right to health, where the court applies a

63 Ibid 418, 421–422.

64 T R S Allan, ‘Human rights and judicial review: a critique of “due deference”’ (2006) 65 Cambridge Law Journal 671, 688–689.

65 Aileen Kavanagh, ‘Defending deference in public law and constitutional theory’ (2010) 126 Law Quarterly Review 222, 244–245.

standard of reasonableness to the impugned decision.⁶⁶ This standard does not preclude the need for judicial deference, based on grounds reflected in the standard case for non-justiciability. In the landmark decision of *Soobramoney*,⁶⁷ the court held that the court should accord deference to healthcare resource allocation decisions – in light of the difficulty this involves – and expressly cited *B* with approval.⁶⁸ But, as Young noted, the reasonableness standard is ‘context-driven’ and can be much more exacting than the *Wednesbury*⁶⁹ standard of review – applying substantive control on government decision-making particularly when the decision affects the more vulnerable sectors of society.⁷⁰ This displays flexibility in the exercise of judicial restraint, although the starting point prescribed by *Soobramoney* is based on concerns very similar to the standard case for non-justiciability considered herein (indeed, *B* was itself cited with approval).

Another interesting example is the German right to health. The German right to health guarantees a right to substantive treatment,⁷¹ but it is not an unqualified right that neglects entirely the relevance of cost-effectiveness.⁷² The right is ‘criteria-based’: that only in a limited category of life-threatening cases, the court will require treatment to be provided; and although there still needs to be some clinical evidence in favour of the treatment sought, the threshold to be met is clearly relaxed.⁷³ This move is a clear response to the need to adjust the proper judicial role, based on the impact of the decision on the individuals affected.⁷⁴ Whilst these examples may not necessarily represent the most suitable approaches for UK law, they at least illustrate how

66 *Minister of Health v Treatment Action Campaign* [2002] ZACC 15; 2002 (5) SA 721 [30]–[39], [52], [58]–[59].

67 *Soobramoney v Minister of Health (Kwazulu-Natal)* [1997] ZACC 17, 1998 (1) SA 765.

68 *Ibid* [19], [29]–[30]; see also *Treatment Action Campaign* (n 66 above) [38].

69 *Associated Provincial Picture Houses Ltd v Wednesbury Corporation* [1947] 1 KB 223.

70 Young (n 21 above) 252–255, 261, 268.

71 Ettelt (n 41 above) 38.

72 Cf Wang (n 11 above) 621–624, 626, 629.

73 Ettelt (n 41 above) 34, 36–40; see also Newdick (n 11 above) 117.

74 Palmer (n 21 above) 188; Mark Elliott, ‘From bifurcation to calibration: twin-track deference and the culture of justification’ in Hanna Wilberg and Mark Elliott (eds), *The Scope and Intensity of Substantive Review: Traversing Taggart’s Rainbow* (Hart 2015) 70, 76–79; Ernest Lim and Cora Chan, ‘Problems with *Wednesbury* unreasonableness in contract law: lessons from public law’ (2019) 135 *Law Quarterly Review* 88, 98–100.

judicial restraint in the context of healthcare resource allocation can be flexibly exercised⁷⁵ – short of a doctrine of non-justiciability.

Against the standard case: allocative impact

It cannot be controversial that cases with an ‘allocative impact’ – ie where ‘the effect of the decision is to impose a *financial burden* upon public resources’⁷⁶ – *are*, without more, justiciable. This requires some elaboration. When we speak of cases with an allocative impact, the relevant financial burden may come in many forms. They include damages awarded, legal costs, ‘costs of administrative compliance’ and ‘diversion of resources’ to avoid future liability and future claims allowed by the judgment.⁷⁷ What is common amongst these scenarios is that the court – through rendering a decision – compels the re-allocation of public resources by the authorities.⁷⁸ It may be that, after the decision, the costs of a certain government department would gravely increase – as a result of which the central Government may have to reallocate its limited budget, so more funds will go to that department. Or the central Government may decide otherwise: and ask the government department to live with its current budget. Then the reallocation will have to be done within the government department: it may have to cut certain parts of its existing services and staffing, so as to support its increased expenditure. None of this would have occurred but for the judgment. There is, strictly speaking, no court order (as in a mandatory injunction) compelling this resource reallocation. But the reallocation remains, in reality, compelled by the judgment.

Most importantly – subject to a qualification below – decisions with an allocative impact are *inevitable*. Take, by way of example, cases dealing with the liability of the police in negligence to the victims of criminals such as *Hill*⁷⁹ and *Michael*.⁸⁰ Chamberlain explained

75 Indeed, in judicial review relating to other contexts such as social care and taxation, the courts have sometimes acted with a more flexible form of judicial restraint – although similar concerns of institutional competence and constitutional legitimacy may arise: see eg Palmer (n 21 above) 222–224, 233–239; Jeff A King, ‘The pervasiveness of polycentricity’ [2008] Public Law 101.

76 King (n 7 above) 208 (emphasis added).

77 Ibid 209.

78 Ibid 218. This does not thereby suggest that *whenever* the court makes any decision, it will thereby compel a re-allocation of public resources. (This is due to a qualification that will be addressed below.) Rather, the suggestion is that there are these very commonplace scenarios where a court will compel a re-allocation of public resources – and no one will seriously suggest that these cases should be without more non-justiciable.

79 *Hill v Chief Constable of West Yorkshire* [1989] AC 53.

80 *Michael v Chief Constable of South Wales Police* [2015] UKSC 2, [2015] AC 1732.

that 'whichever way [the court] decide[s]', the decision will have an allocative impact. 'If the police are liable, some resources will have to flow from' other parts of the budget – the intended beneficiary of which could be the other parts of the public – 'to the victims'. If the police are not found liable, 'the result will be that the victims will be denied the resources they would otherwise have had'.⁸¹ One can go even further than Chamberlain's analysis. The decision – whichever way it is decided – does not only affect the victim in the immediate case. It also affects the future victims whose claims will be affected by the ruling (say how the decision in *Hill* will affect the victim in *Michael*). The decision may also influence how the police will in the future conduct themselves. Government policies may be adjusted: if liability will be more stringently imposed, defensive behaviour may occur and more resources may be dedicated towards avoiding future liability. The contrary is also true. On this analysis, it does not really matter how a judicial challenge to healthcare resource allocation is framed – whether by way of legality, procedural, rationality or other grounds of review – the decisions will still inevitably have an allocative impact (which can be unknown, unforeseen and even possibly, unknowable and unforeseeable). The same analysis may conceivably be made of many decisions in contract, property and commercial law – but it is not necessary to repeat the analysis once more.⁸²

Since cases with an allocative impact are perforce inevitable, it is uncontroversial that this cannot *per se* provide a defence to judicial scrutiny: ie these cases are *not per se* non-justiciable. For otherwise, the judicial role may have to be destroyed altogether. If we proceed from this starting point, we can see how one may come into conflict with the standard case for non-justiciability: for a legal challenge to the decision on healthcare resource allocation is – of course – a case with an allocative impact. So the standard case for non-justiciability must therefore *distinguish* the decisions on healthcare resource allocation (which, the critic says, are non-justiciable) from other cases with an allocative impact (which are justiciable).

One possibility is to invoke King's analysis: he distinguishes cases with an allocative impact from a separate category of cases – which he calls 'discretionary allocative decision-making'. This category of cases is defined as where a decision-maker makes a 'discretionary' decision to allocate public resources, *and* the decision 'take[s] account of the cost of the allocation'.⁸³ And cases of 'discretionary allocative decision-making' – unlike mere cases with an allocative impact – can be non-justiciable. King further suggests that decisions concerning healthcare

81 Chamberlain (n 50 above) [14].

82 King (n 75 above) 109.

83 King (n 7 above) 197–200.

resource allocation fall within this category, since he expressly cites *B* as an example of ‘discretionary allocative decision-making’. In positing the distinction, King is aware that the distinction may come under attack. An argument may be run to the effect that:

[A] judicial decision causing allocative impact amounts to the same thing as judicial review of discretionary allocative decisions. In both cases the court forces the government to reallocate from one area to another and on an issue that is better decided by the government. If this is the case, then why make the distinction in the first place?⁸⁴

The idea is simply this: if we accept that cases with an allocative impact to be properly adjudicated upon by courts, it seems rather odd to find challenges to ‘discretionary allocative decision-making’ to be entirely unsuited for adjudication. For, subject to a qualification below, both categories of cases are – after all – about the courts forcing government to reallocate resources. One possible defence for the distinction (says King) is ‘that even where precisely the same financial sums are at stake, there may be institutional reasons for allowing the courts to decide legal questions having allocative impact’ – but not more than that. While ‘[i]t may be better for a court to have the decisive say on’ legal issues such as ‘a statutory duty’, ‘legitimate expectation’, it is ‘quite another thing for a court to decide whether a mere one thousand pounds is better allocated to either of two people with putatively similar legal rights’.⁸⁵

If this defence succeeds, it seems like the critic may potentially maintain the standard case for non-justiciability over healthcare resource allocation – whilst accepting cases with an allocative impact to be properly justiciable. But there are at least two possible responses to a defence run on this line. First, this defence posits a formalist distinction between ‘legal’ and ‘non-legal’ questions. Yet a critic that uses this reason to justify a bar against rationality review seems to forget that rationality review *is* a legal question. *Wednesbury* is undoubtedly a legal test – begging a question of law – as much as its counterpart⁸⁶ proportionality is a question of law.⁸⁷ The critic may then seek to draw a distinction between different kinds of questions of law. The critic may say that rationality review is, although a question of law, heavily influenced by political matters like resource allocation.

84 Ibid 218.

85 King (n 7 above) 219. See a similar point concerning social rights adjudication in Daniel Wei L Wang, ‘Social rights adjudication and the nirvana fallacy’ [2018] Public Law 482, 484.

86 These two doctrines being analogous: see Rebecca Williams, ‘Structuring substantive review’ [2017] Public Law 99.

87 *Kwok Cheuk Kin v Secretary for Constitutional and Mainland Affairs* [2017] HKCFA 44, (2017) 20 HKCFAR 353 [29].

This is different from some more ‘purist’ questions of law, like statutory interpretation that has an allocative impact. This distinction does not withstand scrutiny. For, first, it seeks to cover a problematic formalist distinction (‘legal’ and ‘non-legal’) with another layer of problematic formalist distinction (along the lines of ‘legal but political’ and ‘legal but apolitical’). Second, and most importantly, the critic is seeking to justify not a mere doctrine of deference, but a doctrine of non-justiciability. It is clear, since *Miller (No 2)*,⁸⁸ that the fact that a legal question is embroiled in a political context does not mean it is non-justiciable. As Baroness Hale and Lord Reed explained:

[A]lthough the courts cannot decide political questions, the fact that a legal dispute ... arises from a matter of political controversy, has never been sufficient reason for the courts to refuse to consider it ... [A]lmost all important decisions made by the executive have a political hue to them. Nevertheless, the courts have exercised a supervisory jurisdiction over the decisions of the executive for centuries.⁸⁹

The second response is this: this defence misunderstands the nature of rationality review. There are two distinct concepts that have been mixed up in this defence, and indeed in the older cases such as *Collier*: (a) the court substituting the resource allocation decision to be made by the decision-maker and (b) the court interfering with resource allocation decisions by applying rationality review. These concepts are familiar ones in the literature concerning *Wednesbury* and proportionality review. Concept (a) refers to the proposition that

the reviewing court will decide the case *de novo* as if it had been the primary decision-maker ... on this view the court considers the facts, makes its own decision as to what the proportionate outcome should be and does so without giving any particular weight to the primary decision-maker.⁹⁰

Per the defence, the courts are institutionally incompetent to substitute the judgment of the decision-maker. Rationality review in concept (b), however, does *not* involve this. It does not require the courts to directly compete with the expertise of the decision-maker, for the court is not purporting to ‘reassess the matter afresh and decide ... that funds ought to be allocated in one way rather than another’.⁹¹ On Daly’s analysis, the court is simply examining if the ‘indicia of unreasonableness’ – such as ‘illogicality’ and ‘disproportionality’ – exist.⁹² It is one thing

88 *R (Miller) v The Prime Minister* [2019] UKSC 41, [2020] AC 373.

89 *Ibid* [31]. See also John Laws, ‘Law and democracy’ [1995] Public Law 72.

90 Paul Craig, ‘The nature of reasonableness review’ (2013) 66 Current Legal Problems 131, 141.

91 Paul Craig, *Administrative Law* 9th edn (Sweet & Maxwell 2021) [21-002].

92 Paul Daly, ‘*Wednesbury*’s reason and structure’ [2011] Public Law 238, 242–247.

to say that the courts do not have the expertise to allocate healthcare resources from scratch – which no doubt is a difficult task particularly for lawyers and can engage concerns of institutional competence⁹³ – but quite another to say that the courts do not have the expertise to even scrutinise the coherence of the premises and reasoning underpinning the decision altogether. *A, D and G* is an example where the court can quite competently undertake the latter task, without claiming to be able to undertake the former task. For it is fairly possible for parents to criticise a teacher at a primary school, without having all the expertise for pedagogy themselves; the relationship envisaged here between courts and decision-makers in rationality review is similar. Rationality review does not (and cannot) entail the substitution of judgment,⁹⁴ just as the parent does not by criticising the teacher thereby take over the teacher's role: and it follows that one may not object to rationality review on the basis that the courts are thereby substituting the judgment of the decision-maker.

It may be said that, even so, the court may remain less institutionally competent than the decision-maker in conducting the rationality review. This argument does not negate the possibility where institutional competence (or other factors, such as the extent of the allocative impact) can be relevant as a factor for judicial deference.⁹⁵ But judicial deference (building on Kavanagh's distinction earlier) is different from non-justiciability.⁹⁶ The foregoing analysis establishes that no clear-cut *binary* can be drawn between cases with an 'allocative impact' and 'discretionary allocative decision-making' – such that one may conclude that the former should not be *per se* non-justiciable, whilst the latter should (*per* the standard case) be categorically non-justiciable. In the lack of a good reason to sustain this analytical binary, both categories of cases should be justiciable – which therefore constitutes a baseline judicial role. But nothing said here precludes the possibility of judicial deference when rationality review is being applied: to defer in this more limited sense will *not* resurrect this analytical binary (to which this argument objects). Indeed, the need for deference has been accorded importance by the restrictive formula of the rationality review in *Wednesbury* – which enshrines an inherent

93 Wang (n 11 above) 635–636.

94 Lord Irvine of Lairg, 'Judges and decision makers: the theory and practice of *Wednesbury* review' [1996] Public Law 59, 60–61; Paul Craig, 'Reasonableness, proportionality and general grounds of judicial review: a response' (2021) 2 Keele Law Review 1, 3, 23; Craig (n 12 above) 24–25.

95 See eg Wang (n 85 above) 483–485.

96 Kavanagh (n 65 above) 244–245.

element of judicial restraint.⁹⁷ In light of this, it seems disproportionate to render judicial review unavailable altogether through a doctrine of non-justiciability.

It is, however, important to revert to the qualification hinted at earlier. The foregoing argument is predicated on the assumption that the court compels the reallocation of resources through adjudicating on healthcare resource allocation. But is this assumption sound? The literature has helpfully demarcated different possibilities upon which healthcare resource allocation is challenged. Wang and Newdick, for instance, have respectively recognised that such challenges may potentially result only in a ‘procedural’ remedy: the court will only ‘quash the decision and remit the decision to the [decision-maker] for reconsideration’. This is to be distinguished from a ‘substantive’ remedy, whereby the court will make a court order for treatment to be provided.⁹⁸ This distinction is important: for the former remedy does not necessarily require the decision-maker to (upon reconsideration) reach a different decision: it may reach the same result (eg against the applicant), provided that it now meets all the legal requirements that it may have breached (when the decision was first struck down by the court).⁹⁹ In this case, it may plausibly be argued that the court has not compelled the decision-maker to reallocate resources – such that its actions will not amount to ‘discretionary allocative decision-making’.

What may follow from this is that the argument in this section should be qualified: it may only apply insofar as the court applies a substantive remedy, but not a procedural remedy. But two points must be attached to this qualification, such that the effect of this should not be overplayed. First, the distinction between procedural and substantive remedies is not clear-cut. It has sometimes been said that the position in UK law is that only procedural – not substantive – remedies will be given.¹⁰⁰ But it has also been recognised that the line can often be blurred: for instance, the court may revert a decision for reconsideration – but has set such a high bar for the decision-maker that, in effect, it may well have prescribed a certain course of action.¹⁰¹ Or short of this, it is possible to envisage a case that has generated so much media attention and political pressure that – after

97 Michael Taggart, ‘Proportionality, deference, *Wednesbury*’ [2008] New Zealand Law Review 423, 427–429; see also Elliott (n 74 above) 65–66; Paul Craig, ‘Varying intensity of judicial review: a conceptual analysis’ [2022] Public Law 442.

98 Wang (n 11 above) 641; Newdick (n 11 above) 112, 115–117.

99 See eg *R (SB) v NHS England* [2017] EWHC 2000 (Admin), [2018] PTSR 576 [105].

100 See eg Newdick (n 11 above) 111–112; Wang and Rumbold (n 41 above) 189; cf *R (S (A Child)) v NHS England* [2016] EWHC 1395 (Admin) [36].

101 Newdick (n 11 above) 112, 114–115.

the court has decided to quash the decision as being unlawfully made – the decision-maker may ultimately be pressured into granting the applicant funding, despite the procedural remedy given. In these cases where the procedural remedy has slipped into (what is in practice) a substantive remedy, the foregoing argument may still apply.

Second, it has been accepted throughout the literature that, if one is to be sceptical of the judicial role in healthcare resource allocation, it is cases with substantive remedies that are the most potentially problematic. Procedural remedies are by contrast more acceptable.¹⁰² But this argument will mean that insofar as courts award substantive remedies – such that they compel the reallocation of resources – the doctrine of non-justiciability cannot justifiably apply, since no good reason exists to distinguish this type of case from cases with an allocative impact. Although this reasoning does not strictly cover cases when courts provide procedural remedies, it *must* follow from this that the doctrine of non-justiciability cannot equally apply here – for otherwise one would be accepting a *greater* degree of judicial restraint for cases awarding procedural remedies than in substantive remedies (which, as shown above, should be justiciable). Therefore, there must be a baseline judicial role – whether procedural or substantive remedies are being awarded.¹⁰³

The case for justiciability: the *ultra vires* theory

The *ultra vires* theory entails that there should be, at least, a meaningful degree of judicial scrutiny over decisions concerning healthcare resource allocation. As is well-known, there has been a vibrant debate as to the constitutional foundation of judicial review.¹⁰⁴ One of the main contenders is the *ultra vires* theory. The theory maintains that decision-makers were conferred by Parliament only a limited jurisdiction. They must not be able to exceed that jurisdiction: doing so would mean they would be acting *ultra vires*.¹⁰⁵ This justifies the court's power to conduct judicial review: the courts are only enforcing

102 As shown in Wang (n 44 above) 715–721, 723–724; see also Newdick (n 11 above) 116–118.

103 This does not, of course, preclude discussion based on whether procedural or substantive remedies should be preferred: see Newdick (n 11 above) 116–118; Wang (n 44 above) 715–721, 723–724. The argument simply means that either way, the judicial role cannot be excluded for this reason.

104 See the discussion in Thomas Adams, '*Ultra vires* revisited' [2018] Public Law 31.

105 *Anisminic Ltd v Foreign Compensation Commission* [1969] 2 AC 147, 194–195; Dawn Oliver, 'Is the *ultra vires* rule the basis of judicial review?' in Christopher Forsyth (ed), *Judicial Review and the Constitution* (Hart 2000) 4.

the limits of jurisdiction,¹⁰⁶ thereby giving effect to what Parliament intends (ie the jurisdiction of the decision-makers must remain limited).¹⁰⁷ As Lord Sumption explained in *Privacy International*:

If Parliament on the true construction of an enactment has created a tribunal of legally limited jurisdiction, then it must have intended that those limits should have effect in law. The only way in which a proposition can have effect in law, is for it to be recognised and applied by the courts.¹⁰⁸

It follows, therefore, from the limited jurisdiction of a decision-maker's power that the decision-maker's discretion must not be unconstrained. A discretionary power that remains unchecked by judicial scrutiny means that it will not be limited.¹⁰⁹ This, however, will be the result of a doctrine of non-justiciability – whether it be a *de jure* or (as it is here) *de facto* doctrine of non-justiciability. No one suggests that health authorities have an unlimited jurisdiction. There can be no such suggestion, because the health authority is a public authority that has its limited powers derived from legislation.¹¹⁰ There is thus a paradox: a decision-maker who has limited jurisdiction will be immune from meaningful judicial scrutiny. This contradicts the very essence of the *ultra vires* theory. As Farwell LJ observed, 'it is a contradiction in terms to create a tribunal with limited jurisdiction and unlimited power to determine such limit at its own will and pleasure—such a tribunal would be autocratic, not limited'.¹¹¹

The critics may argue that a decision on healthcare resource allocation is different from other discretionary powers in that – *per* the standard case for non-justiciability – this is a matter that (a) has not been assigned by Parliament to courts¹¹² and (b) on which courts are not competent to adjudicate. But even if so – once an *ultra vires* analysis is applied – these concerns can no longer lead us to the conclusion that the decision should be non-justiciable. This is because

106 Christopher Forsyth, 'Of fig leaves and fairy tales: the *ultra vires* doctrine, the sovereignty of Parliament and judicial review' in Christopher Forsyth (ed), *Judicial Review and the Constitution* (Hart 2000) 30.

107 Paul Craig, '*Ultra vires* and the foundations of judicial review' in Christopher Forsyth (ed), *Judicial Review and the Constitution* (Hart 2000) 48; Christopher Forsyth and Mark Elliott, 'The legitimacy of judicial review' [2003] Public Law 286, 287.

108 *R (Privacy International) v Investigatory Powers Tribunal* [2019] UKSC 22, [2019] 2 WLR 1219 [210].

109 *Anisminic* (n 105 above) 194.

110 This has been the case throughout the history of the NHS: see Charles Webster, *The National Health Service: A Political History* 2nd edn (Oxford University Press 2002).

111 *R v Shoreditch Assessment Committee, ex p Morgan* [1910] 2 KB 859, 880.

112 See eg *Nottinghamshire County Council* (n 2 above) 247.

it remains that the jurisdiction of the decision-maker is limited. It may be that the court should allow more room for manoeuvre for a decision-maker. But there is no inherent qualification in the *ultra vires* theory that it does not apply in a socioeconomic context: it applies to all forms of limited powers conferred by Parliament on a decision-maker, *including* one to allocate resources. It is immaterial that courts are not as knowledgeable about healthcare resource allocation: the *ultra vires* analysis remains applicable, and the doctrine of non-justiciability will clearly contradict that. Nor is it material that this matter has been assigned by Parliament to government ministers: because the very idea of *ultra vires* is precisely premised on a primary duty being discharged by Government. The court's role has always been supervisory – with this premise in place.¹¹³

If we pause at this juncture, the foregoing analysis may face a formidable hurdle. We may conclude from the *ultra vires* theory that it is wrong for judicial review of healthcare resource allocation to be *entirely* unavailable – as is the case with the doctrine of non-justiciability. But this does not, at first sight, preclude the possibility that – as raised by Wang and Rumbold – we may exclude the *rationality review* of healthcare resource allocation, whilst maintaining the availability of procedural review.¹¹⁴ In such a case, the health authority does not enjoy the unlimited power that Farwell LJ feared: the power of the health authority remains limited by the supervisory jurisdiction of the court, even though the full extent of judicial review may not be available. So, it seems that whilst this argument constitutes a positive case for *justiciability*, it does not go much further than that.

This conclusion appears intuitive, but there is more to the *ultra vires* theory that is of value here. The beauty of the *ultra vires* theory is that not only is the *existence* of judicial review justified by reference to legislative intent (as we have seen earlier), but that even the *controls* over discretionary powers (ie the grounds of review) were justified by reference to legislative intent.¹¹⁵ This is so because – according to the leading proponents of the *ultra vires* theory, such as Allan, Forsyth and Elliott – Parliament does not stop at intending that the power of decision-makers must remain limited. Parliament also intends that discretionary powers must be exercised '*in accordance with the rule of law*'. The court's role is – in turn – to give specific content to the rule of

113 *Anisminic* (n 105 above) 194–195.

114 Wang and Rumbold (n 41 above) 186–189; see also Syrett (n 48 above) 480, 486; Wang (n 44 above) 723–724.

115 Craig (n 107 above) 49.

law, by developing the grounds of review in administrative law.¹¹⁶ This way, the grounds of judicial review are all but reflective of legislative intent. For instance, Elliott suggested:

*The rule of law, which is a fundamental [principle] of the British constitution, clearly favours the exercise of public power in a manner that is fair and rational. It is entirely reasonable to assume that, in the absence of clear contrary enactment, Parliament intends to legislate in conformity with the rule of law ... Thus Parliament, intending to legislate in conformity with the rule of law, is taken only to grant such administrative power as is consistent with the requirement of that constitutional principle. It is therefore taken to withhold from decision-makers the power to act unfairly and unreasonably, while recognising that the detailed requirements of fairness and rationality can most appropriately be determined by the courts through the forensic process.*¹¹⁷

This passage connotes two propositions that are of great importance: (a) Parliament intends that decision-makers can only act in line with the rule of law; and (b) the rule of law requires both procedural fairness and rationality in decision-making. If *both* these propositions are accepted, it is clear that judicial review over decisions on healthcare resource allocation must at least include both procedural and rationality review – for otherwise we will risk defeating Parliament’s intent to uphold the rule of law in the context of healthcare resource allocation. Or to put the same point in another way, courts must hold the decision-makers to the rule of law:¹¹⁸ and this *requires* the existence of, *inter alia*, rationality review. This is, in itself, a direct and complete response to the critic’s earlier point. The remaining analysis will perforce focus on whether these two propositions are indeed correct.

Proposition (a) is hardly disputable. As Elliott rightly explained, to suggest otherwise would be to suggest that Parliament is unconcerned with whether the rule of law is upheld. It is clearly more plausible to attribute to Parliament an intention that the rule of law should

116 Paul Craig, ‘Competing models of judicial review’ [1999] Public Law 428, 429–430 (emphasis added); Mark Elliott, ‘The *ultra vires* doctrine in a constitutional setting: still the central principle of administrative law’ in Christopher Forsyth (ed), *Judicial Review and the Constitution* (Hart 2000) 95, 98; Forsyth and Elliott (n 107 above) 287, 290; T R S Allan, ‘The constitutional foundations of judicial review: conceptual conundrum or interpretive inquiry?’ (2002) 61 Cambridge Law Journal 87, 104; T R S Allan, ‘Constitutional dialogue and the justification of judicial review’ (2003) 23 Oxford Journal of Legal Studies 563, 565.

117 Elliott (n 116 above) 95–96 (emphasis added).

118 A C L Davies, ‘The administrative state and the fundamentals of public law’ in Elizabeth Fisher, Jeff King and Alison Young (eds), *The Foundations and Future of Public Law* (Oxford University Press 2020) 257.

be upheld.¹¹⁹ Allan agreed expressly with Elliott. To him, '[t]he preservation of the rule of law, as a basic protection against arbitrary power, is always an essential first premise': it is only right to reject the view that Parliament should be seen as 'neutral' about the manner in which discretionary power is exercised.¹²⁰ This is particularly true when viewed in light of the fact that the UK is a 'liberal democracy that preserves a basic separation of powers between the principal organs of government'; and with this constitutional context, it 'can be scarcely controversial' that Parliament will 'intend to honour the most fundamental requirements of the rule of law'.¹²¹ And if any further proof is needed – as Lord Carnwath has rightly stressed in the recent landmark case of *Privacy International* – the rule of law has received express statutory recognition in section 1 of the Constitutional Reform Act 2005.¹²² All of this provided solid proof for the correctness of proposition (a).

Let us then turn to proposition (b). Clearly, to deny the validity of the second proposition would be to deny that fair procedures and rationality are not 'dimensions of the rule of law'.¹²³ Since no one would seriously suggest that we should retain rationality review and remove procedural review – almost every academic in this field will gladly contradict this proposition¹²⁴ – the real controversy can really only be whether rationality in government is a dimension of the rule of law. This is what calls for some further thought here. Raz suggested that a 'commonly agreed' aim of the rule of law is to 'avoid *arbitrary government*'.¹²⁵ He later defines this conception of arbitrary government as follows: '[a]rbitrary government is the use of power that is indifferent to the proper reasons for which power should be used'.¹²⁶ There is thus an important relationship between the rule of law and the existence of reason. Endicott's work on this relationship is particularly instructive. He argues – like Raz does – that 'the rule of law is opposed to the arbitrary use of power':¹²⁷ '[a]rbitrary government is ... a departure

119 Elliott (n 116 above) 98 (emphasis added).

120 Allan, 'The constitutional foundations' (n 116 above) 104.

121 Allan, 'Constitutional dialogue' (n 116 above) 571–572.

122 *Privacy International* (n 108) [120].

123 Allan 'The constitutional foundations' (n 116 above) 99.

124 See eg Syrett, *Law, Legitimacy and the Rationing of Health Care* (n 4 above) 144–146, 231; Syrett, 'Healthcare resource allocation' (n 4 above) 117; Wang and Rumbold (n 41 above).

125 Joseph Raz, 'The law's own virtue' (2019) 39 *Oxford Journal of Legal Studies* 1, 5 (emphasis original).

126 Ibid.

127 Timothy Endicott, 'the reason of the law' (2003) 48 *American Journal of Jurisprudence* 83, 91.

from the rule of law, in favour of rule by the *mere will of rulers*'.¹²⁸ It is noteworthy that Endicott stressed that the rule of law is opposed to the 'mere' will of rulers: for to him, the defining feature of an arbitrary act is an act done *just because* 'the actor so wills' – and '*without any (other) justification of reason*'.¹²⁹

It already follows from this that respect for the rule of law will naturally require a minimum degree of rationality in government decision-making. For, by combining the insights by Endicott and Raz, we can draw this conclusion: if we *are* to have the rule of law, we must avoid arbitrary government; and if we *are* to avoid arbitrary government, we must (by definition) ensure that government decision-making is rational. So, if judges are to safeguard the rule of law, this will call for the availability of rationality review.¹³⁰ This is why Endicott regards rationality review as an 'anti-arbitrariness doctrine': for through this doctrine, judges may demand that decision-making must be 'distinguishable from the mere arbitrary wills and private affections ... of the officials'. This doctrine is 'very closely allied to the rule of law because it gives the judges a way of standing against arbitrary decision making – and the rule of law, too, is opposed to the arbitrary use of power'.¹³¹

But there are two caveats to this analysis, which will ultimately qualify the baseline that this article is seeking to establish. First, this analysis only affirms the existence of rationality review; it does not preclude judicial deference when the rationality of decision-making is assessed. This is because – whilst courts must seek to prevent any arbitrary use of power – they should also 'do so in a way that gives the initial decision maker a leeway that corresponds to the reasons why the power was allocated to that person or institution'.¹³² This is a concession that may be made, but this concession does not detract from the core thesis here: not only must decisions of healthcare resource allocation be *justiciable*, they must also be subject (at least) to both procedural *and* rationality review.

Second (which is related to the first caveat), this analysis does not prescribe the exact form and nature of rationality review. An important feature of the modified *ultra vires* theory is that courts are given much autonomy in defining the particulars of judicial review, given that

128 Timothy Endicott, 'Arbitrariness' (2014) 27 Canadian Journal of Law and Jurisprudence 49, 49 (emphasis added).

129 Endicott (n 127 above) 90 (emphasis added).

130 Ibid 91–92.

131 Timothy Endicott, 'Why proportionality is not a general ground of review' (2020) 1 Keele Law Review 1, 9–12, 23.

132 Endicott (n 24 above) 243.

these have not been developed by Parliament.¹³³ One implication of this is that various forms of judicial control – concerning the same ground of review – can be legitimated through the same analytical method.¹³⁴ Since the current baseline of the judicial role is developed by reference to the modified *ultra vires* theory, we can only infer through this line of reasoning that the rule of law *requires* (as we have seen) the *existence* of both procedural and rationality review. But the precise specificities of these grounds of review is another question and is not readily answered by reference to the modified *ultra vires* theory. One cannot conclude from the reasoning in this section whether courts should offer procedural or substantive remedies upon finding an illegal act,¹³⁵ or the precise form¹³⁶ and intensity of rationality review that should be adopted.¹³⁷

That is: this thesis will not provide a ready answer to preferring one model of the judicial role in health litigation over another.¹³⁸ But we do know that there must be a *baseline*: that however valid concerns based on institutional competence and constitutional legitimacy are, there cannot be a doctrine of *de jure* or *de facto* non-justiciability; for this will surely contradict the requirements of the rule of law (embedded within the modified *ultra vires* theory) and the very point of an *ultra vires* analysis. Procedural and rationality review must at least be present as part of the baseline judicial role, and judicial deference (even if justifiably given – a possibility accepted in the first caveat) cannot amount to (either *de jure* or *de facto*) non-justiciability. This is the limited but significant contribution that this article makes.

CONCLUSION

To conclude, three propositions have been made. First, concerns in favour of judicial restraint – even if valid – do not justify a doctrine of non-justiciability. This doctrine is inflexible and is perforce unjustified. Second, we can all agree that cases with an allocative impact are justiciable. Since we cannot sensibly distinguish decisions

133 Forsyth and Elliott (n 107 above) 287.

134 This feature of the model has indeed been turned into a critique of it: see Craig (n 91 above) [1-012], [1-016].

135 See the discussion in Newdick (n 11 above) 116–118; Wang (n 44 above) 715–721, 723–724.

136 See eg the various possibilities of understanding rationality review outlined in Yossi Nehushtan, ‘The true meaning of rationality as a distinct ground of judicial review in United Kingdom public law’ (2020) 53 *Israel Law Review* 135; see also Daly (n 92 above) 242–247; Hasan Dindjer, ‘What makes an administrative decision unreasonable?’ (2021) 84 *Modern Law Review* 265.

137 Craig (n 12 above) 25–26.

138 See the models as outlined in Newdick (n 11 above); Wang (n 44 above).

concerning healthcare resource allocation from such cases, the doctrine of non-justiciability cannot be sustained. We can tell from the first two propositions that the standard case for non-justiciability is flawed. Third, the *ultra vires* theory entails that not only must decisions concerning healthcare resource allocation be justiciable: they should also be subject to both procedural and rationality review in the UK courts, by reference to the requirements of the rule of law. These propositions together establish a baseline judicial role over healthcare resource allocation in UK law and ultimately *justify* the move from non-justiciability (as posited by the first batch of case law) in the current UK jurisprudence.

There are two messages that underlie this article that may be useful for broader purposes. First, it is important to remember – for academics in medical law and public law alike – that the NHS *is* a public authority that derives its power from legislation and is thus subject to the rule of law.¹³⁹ This means that – despite all the good things that may be said of the NHS – external control must be imposed to ensure that it measures up to what the rule of law requires.¹⁴⁰ The departure from the doctrine of non-justiciability over decisions concerning healthcare resource allocation is one facet of this: but this overarching message should be borne in mind in a much broader range of contexts. Second, this article clearly does not offer a comprehensive theory of the judicial role in healthcare resource allocation in UK law. This article only offers a baseline judicial role that must be maintained, concerns of institutional competence and constitutional legitimacy notwithstanding. But it does not mean this article is entirely irrelevant to the development of such a comprehensive theory: for instance, the discussions here on the need for flexibility in judicial restraint may be relevant to ascertaining the appropriate intensity of review; the discussion here also tells us that such a comprehensive theory *cannot* violate the baseline established here.

139 Davies (n 118 above) 257.

140 Ibid.