High Court: A, D and G v N-W Lancashire Health Authority

Full text of the judgment of the High Court

December 21st, 1998

Foreword

North West Lancashire Health Authority is not alone in having adopted a policy of not funding medical treatment for trans people.

However, this was the first case of a challenge to such a policy where the issue was decided by a court — with a judgment in favour of the three trans women applicants. The Health Authority later appealed, and in July 1999 the Appeals Court upheld the High Court judgment.

This judgment means that it is now illegal for a Health Authority to impose a blanket ban on funding medical treatment for the purposes of gender reassignment.

Claire McNab, August 1999

Judgment

In the High Court of Justice
Queen's Bench Division
Crown Office list

Royal Courts of Justice
The Strand
London WC2A 2LL

Monday, 21st December 1998

Before
The Honourable Mr Justice Hidden

Regina
-v-
North West Lancashire Health Authority
Respondent

Ex parte MISS A, D and G
Applicant

Mr G CLARKE appeared on behalf of the Respondent

Mr N Blake and Ms S Harrison (instructed by Tyndallwoods, Birmingham B2 5TS) appeared on behalf of the Applicant.

JUDGMENT
(As Approved)

JUDGMENT

MR JUSTICE HIDDEN: These three applicants, Miss A, Miss D and Miss G, all make applications which have been consolidated. I should perhaps take the time at this stage to remind all present that these applications are ones to which orders have been made prohibiting the publication of the names, addresses or any other details liable to disclose the identity of any or all of the applicants.

The decisions they seek to impugn are those of the North West Lancashire Health Authority to maintain a decision to refuse each applicant clinical treatment , namely gender reassignment surgery. Essentially these applicants are transsexuals who were born with male organs and have lived for various periods of time as female, but are now seeking to achieve a situation where their bodies may equate to a female appearance by their undergoing surgery for the removal of their male sex organs.

Such a change to a persons's sex organs is known as gender re-assignment and treatment for that purpose, whether by counselling, the provision of hormones, or the undergoing of surgery is known as "gender re-assignment treatment". A person who, having been born with the sex organs of one sex, suffers from a belief and conviction that that person really belongs to the other sex, suffers from a condition known as "gender identity dysphoria".

Such a condition, it is now accepted by all parties, is an illness and therefore, like any other illness, its treatment has to be considered under the National Health Service Act 1977. The applicants have all applied to the respondent Health Authority for gender re-assignment treatment and each has been refused.

The respondents maintain a policy that such surgery will be refused unless there are exceptional circumstances over and above the clinical need. Each applicant seeks an order of certiorari quashing the said decision and the said policy and ordering that respondent authority reconsider the matter in each case.

The statutory background

Under section 1(1) of the National Health Service Act 1977 (hereinafter the 1977 Act):

"It is the Secretary of State's duty to continue the promotion in England and Wales of a comprehensive health service designed to secure improvement -
a) in the physical and mental health for people in those countries and
b) in the prevention, diagnosis and treatment of illness, and for the purpose to provide or secure the effective provision of services in accordance with this Act."

Under section 3(1):

"It is the Secretary of State's duty to provide throughout England and Wales to such extent as he considers necessary to meet all reasonable requirements -
e) such facilities for the prevention of illness, the care of people suffering from illness and the aftercare of people who have suffered from illness as he considers are appropriate as part of the health service;
f) such other facilities as are needed for the diagnosis and treatment of illness."

Under section 13 the Secretary of State may give directions to a health authority to exercise on his behalf such of the functions as relating to the health service as are specified in the directions and "it shall be the duty of the body in question to comply with the directions."

By virtue of these delegated functions the Health Authority is under a duty to provide "to such extent as they consider necessary to meet all reasonable requirements" such services "as are required" for the diagnosis and treatment of illness. The Health Authority must in the exercise of the delegated functions nevertheless give effect to the overall purpose of the 1977 Statute and operate within the principle of improved comprehensive service throughout England and Wales for the prevention, diagnosis and treatment of illness.

"Illness" is not statutorily defined. Early on in the hearing of this case Mr Clarke for the Health Authority accepted that gender identity dysphoria (hereinafter GID) fell within the description of illness as set out in Section 1(1)B of the 1977 Act and thus, that the respondent Health Authority was under the "duty to continue the promotion … of a comprehensive health service designed to secure an improvement … in the prevention, diagnosis and treatment of illness" and thus of GID.

Transsexualism

This is a condition which has been authoritatively defined by the Council of Europe (recommendation 1117 29th September 1989) as "a syndrome characterised by dual personality, one physical, the other psychological, together with such profound conviction of belonging to the other sex that the transsexual person is prompted to ask for the corresponding bodily 'correction' to be made". It has been described medically (by Moesler and Vassheim) as:

The most extreme form of disturbed identity. The sufferer identifies him or herself completely with the opposite sex. In many cases, the delusional and painful urge to belong to the opposite sex is so pronounced that the sufferer is at risk from auto-aggressive and suicidal activity stimulated and supported by the possibilities offered by modern medical-technology advances. Most transsexuals now seek a sex change by means of hormonal and surgical treatment. Patient satisfaction after the complicated high risk and irreversible procedure of sex change treatment is variously assessed. Recently there gave been reports on successful psycho therapeutic treatment for transsexuals resulting in preservation of the biologically given sex."

On 7th March 1995 the respondent Authority introduced a policy entitled "Medical procedure of no beneficial health gain or proven benefit". That policy recognised that, in preparing purchasing plans, authorities were expected to give consideration to purchasing more effective healthcare and that formally some procedures where there should be restrictions on the level of care purchased or procedures which should not be purchased at all had been identified "subject to overriding clinical need". The paper identified the problem of restrictions on resources and accepted that some services had become rationed on social rather than medical grounds.

The policy at paragraph 2.5 stated that a number of health authorities had now restricted the services that they were prepared to purchase. In paragraph 3 the paper identified the consultation to which the authority had gone through and then set out its conclusions as proposals in paragraph 4.0. It then listed a number of procedures which "will not be purchased except in cases of overriding clinical need". Among them was gender re-assignment (as well as, among others, as cosmetic plastic surgery and reversal of sterilisation).

Nearly three years later on 13th January 1998 the authority produced a "Policy in relation to the purchase of appropriate, effective and cost effective healthcare". This document recognised that in preparing their plans and commissioning healthcare they were expected to take account of the effectiveness and appropriateness of various treatments and interventions. Paragraph 2.1 noted that:

"Interventions on the human body are not always related to il-health but may be related to a desire to achieve an ideal body image or a bodily function that cannot currently be achieved. That is complicated by the fact that their supporters often describe the desire for intervention in medical terminology and indeed point out that the lack of complete well-being may itself be a health problem. Nevertheless reasonable health authorities will wish to define the limits of the interventions which they wish to commission and thus ensure that resources are used appropriately."

In paragraph 3.11 gender re-assignment was dealt with. The paragraph set out that:

"Persons wishing to adopt the role of the opposite gender (male to female or female to male) have access to the general psychiatric or psychological services available within the contract portfolio. However no service will be commissioned extra contractually. The Heath Authority will not commission drug treatment or surgery that is intended to give patients the physical characteristics of the opposite gender.

In the event of requests for special consideration and diagnosis of a gender disorder (ICDF64) evidence that the person has successfully adapted to the opposite gender role or clinical advice that the person is suitable for surgery will not (separately or in combination) be regarded as overriding clinical need or exceptional circumstances."

It should be noted at this time for the comprehension of future argument that, in the passage at 3.6 as to cosmetic surgery, after having dealt with the situation of children and people of all ages following trauma or healthcare, it was said that "other cosmetic treatment will not normally be commissioned". There was then set out a table which listed examples of treatment that would and would not be considered to be of a cosmetic nature. The treatment of gynaecomastia (male breasts) was set out as "(not normally regarded as cosmetic)".

Mr Blake, who appears for the applicants, says that the first issue is whether the respondent's policy of not funding gender re-assignment treatment (subject to "overriding clinical need") is unlawful as taking into account irrelevant considerations and/or failing to take into account relevant considerations and/or otherwise irrational? The second is "does the policy constitute an unlawful fetter on clinical discretion?". The third is "does the policy and its application constitute discrimination contrary to the equal treatment directive (79/7/EEC) in matters of social security and/or the Sex Discrimination Act 1975 Section 29?".

Mr Blake said that all three applicants are resident within the North-west Lancashire area and have been diagnosed by a Consultant Psychiatrist as suffering from a Gender Identity Disorder (GID), commonly referred to as "transsexualism". They also fall within a very rare category of people with GID whose specialist diagnosis is that gender re-assignment is necessary to treat their condition.

He says that it is the policy of the respondent Health Authority, which was introduced in March 1995, not to purchase or to restrict the purchase of "medical procedures of no beneficial health gain or of no proven benefit" consistent with their intention to "purchase effective treatments". The respondent has included GRT within the category of medical procedures of no beneficial health gain or of no proven benefit. That means that if assessment is by specialists outside the Health Authority, who determine whether gender re-assignment is the necessary treatment and if that treatment is hormonal treatment and surgery, it is all excluded from funding in cases of overriding clinical need.

The respondent authority has categorised Gender Identity Disorders as "not … related to ill-health but may be related to a desire to achieve an ideal body image or bodily function that cannot currently be achieved". They have also concluded that the correct treatment for all those with GID, including transsexuals, like the applicants, is psycho therapy. Such treatment with a view "to the person accepting their biological gender" the Local Authority do consider appropriate to fund.

Mr Blake submits that the respondent has been unable to identify what "overriding clinical needs" would constitute exceptions in these cases and state that they require substantial evidence of serious psychiatric pathology in order to consider mental illness as an exceptional reason for funding the procedure. This in turn is exemplified as a psychotic illness or a serious depressive illness.

The consequence for these applicants is that their specialist clinicians have advised that they need medical treatment such as hormonal treatment and surgery, the funding for which these applicants are unable to obtain by reason of the policy of the respondents. All three have been living lives as women for a number of years. They have already had hormonal and other treatment which has meant that some gender re-assignment has already taken place and they therefore have the physical characteristics of both sexes. They do not have the funds available to complete the prescribed medical treatment for their condition which profoundly affects all aspects of their personal lives.

There is the additional complication that if, as the evidence suggests to be likely, they develop a further and additional serious psychiatric pathology other than being transsexual, they may then constitute an exception to this policy but, in that event, they will be precluded medically from pursuing the gender re-assignment surgery because of the existence of the requirements for a stable personality in order to undergo the operation and transformation.

It is Mr Blake's submission that the recognised standard form of treatment in England and Wales for transsexualism is referral of suspected transsexuals to a GID clinic with a view to diagnoses and appropriate treatment. That treatment Mr Blake submits to be hormones and surgery. However, he says that comparable facilities to those offered by the Charing Cross GID clinic are not available from consultant psychiatrists within the area of the respondent Health Authority. Therefore, given the specialised nature of diagnosis and treatment of those suffering from GID, diagnosis and treatment requires an extra contractual referral outside the normal arrangements of the respondents.

Mr Blake says, therefore, that the legal issues in this application are primarily concerned with whether the respondents could lawfully consider that arrangements for such referrals were not "necessary to meet all reasonable requirements". Mr Blake submits that the first appropriate concern to be addressed by the respondent either in formulating the policy or in applying that policy to a particular case is whether there has been shown to be "demonstrable clinical need" for the treatment in question. That is largely a matter for the expert clinicians in the field and involves consideration of whether the condition causing the ill-health can be effectively treated by clinical intervention.

Mr Blake submits that, while there may be a need to ration or restrict financial support for treatment, where there is a demonstrable clinical need, rationing could not remove the possibility of a patient with demonstrable clinical need being deprived of the effective treatment needed because of the misfortune of geographical residence. Legitimate local differences in priority and the scale and extent of public provision of treatment for recognised illnesses cannot operate so as to distort the principle of improved comprehensive coverage throughout the country that in one region the service is funded and and in another it is excluded from funding.

Mr Blake submits that when a Health Authority is deciding whether, when and how to authorise an extra contractual referral, the fundamental starting point is to understand the

clinical needs of the patient as assessed by the responsible professional. Without that there can be no proper assessment of rationing or the giving of priority in the distribution of resources. (See the *R v Cambridge Health Authority ex parte B [1995] 1 WLR 898 at 901 to 905*). He concedes that the allocation of scarce resources on a tight budget may not be a question for the Court to resolve and in practice would be difficult for a court to review on grounds of perversity. However, the Court will ensure that the competent Health Authority has asked the right question and addressed material issues before arriving at a policy or the application of a policy which is lawful. The court can examine the respondent's decision to ensure that their consideration of priority does not take into account irrelevant considerations, nor fail to take relevant ones into account.

Mr Blake submits that the decision concerns human rights. He says that Article 8 of the European Convention on Human Rights is engaged in this decision in that a person's sex is fundamental to their identity and at the very least the right to respect for one's personal identity and integrity, both moral and physical, and private life is within Article 8. He submits that there may possibly even be relevance in Article 3 in relation to even the prohibition on any inhuman or degrading treatment. Higher standards are expected when the decision in administrative review engages humans rights, questions and expectations. That is so even in advance of incorporation (See *R v Ministry of Defence ex parte Smith [1996] QB 517*).

Mr Blake submits that Parliament cannot have intended that a statutory power under the 1977 Act should be exercised in such a way as to violate the United Kingdom's obligations under the European Convention on Human Rights. (See *R v the Secretary of State for the Home Department ex parte Thompson Venables [1998] AC 407 at 499*).

Mr Blake dealt with the history of the three applicants in relation to the impugned decision. He said that they all come within the area of the former Blackpool Health Authority which until 1995 could either provide free assignment treatment, including surgery for transsexualism, or could commission extra contractual referrals in the case of GID diagnosis/treatment, whenever local psychiatrists had recommended such a course as being necessary. He referred to the new policy in March 1995 of the respondents new amalgamated Health Authority, to which I have already referred, entitled "Medical procedures of no beneficial health gain or no proven benefit". That policy was directed to "purchasing more effective healthcare and procedures which promote health gain rather than on the purchase of ineffective healthcare". That policy proposed that gender re-assignment "will not be purchased" subject to an express proviso of "overriding clinical need". It was under this policy that each of the applicants was refused the extra contractual referral recommended by the consultant psychiatrist employed by the respondents for further diagnoses and gender re-assignment treatment. Paragraph 3.11 of the policy under "Gender Re-assignment" said that "The Health authority will not commission drug treatment or surgery that is intended to give patients the physical characteristics of the opposite gender".

Dr Sudell, the respondent's Consultant in Public Health Medicine, explained in his affidavit why the respondent adopted this policy and was closely involved in the decisions to decline to fund gender re-assignment surgery for the applicants. He concluded that he could see "no overriding clinical need which would justify the allocation of of the Health Authority's limited resources to the treatment requested". It was implicit from his affidavit that the respondent did not consider gender re-assignment to be in the category of services proven to be of benefit.

Mr Blake points out that even Dr Sudell quotes Canadian figures on the effectiveness of gender re-assignment surgery, quoting the figure of 87.8 of patients with a satisfactory outcome, but also pointing out that for patients for whom the operation is unsuccessful they have had an irreversible mutilating operation to a healthy organ.

Mr Blake submits that on the hypothesis that the treatment is effective the case against funding proceeds on the basis that it is not appropriate to fund such treatment however effective. Gender re-assignment is compared erroneously to such other decisions as sterilisation reversal and cosmetic or other weight loss procedures. Such a comparison, says Mr Blake, connotes a failure to acknowledge that transsexualism is a psychiatric disorder whereas dissatisfaction with one's self-image or previous decisions with respect to fertility or body shape is not. Mr Blake submits that that is entirely contrary to the medical consensus as to the nature of the transsexual medical condition and points to passages in the affidavits of Green and Gooren and others to substantiate that. He says that Dr Sudell's affidavit and the policies of 1995 and 1998 establish that the respondents have concluded the appropriate treatment for which they will make available funding for diagnosed transsexuals is pyscho therapy with a view to reconciling the person to their biological sex. That is not a conclusion which is open to the respondent to make, says Mr Blake, given the literature and learning and unchallenged evidence in respect of the ineffectiveness of such an approach. Mr Blake says it represents the assertion of an outmoded and discredited medical view and is contrary to the now long-standing clinical consensus of how to treat the condition. (See *Corbett v Corbett 1970 2 AER 33 at 42*). There, in passage dealing with sex change operations, Ormrod J said:

"The difficulties under which these people inevitably live result in various psychological conditions such as extreme anxiety and obsessional states. They do not appear to respond favourably to any known form of treatment and consequently some serious minded and responsible doctors are inclining to the view that such operations may provide the only way of relieving the psychological distress."

Mr Blake emphasised that there is no evidence that the 1995 policy was preceded by expert review of gender re-assignment surgery which is contracted for in at least 34 out of 41 Health Authorities in England and Wales. There are also different provisions permitting at least counselling, assessment surgery and hormonal treatment which are permitted in at least five of the remaining seven authorities about whom there is information. GRS is also practised throughout Europe, except Albania and Andorra.

Mr Blake submits that the respondent's decision to include all forms of gender re-assignment treatment on a list of treatment that "will not be purchased" was an unlawful decision. That was for six reasons: first, it deprived sufferers from a serious medical condition resident in the respondent's area of the acknowledged appropriate treatment for the alleviation of their condition for no good medical reason; second, it was a conclusion reached without adequate research or understanding of the nature of transsexualism and its treatment; third, it was based on an erroneous equation of transsexualism with cosmetic preferences and other treatments to produce a better body image; fourth, it denied equality of treatment with like cases, see, for instance gynaecomastia (male breasts) and illnesses such as schizophrenia where funding is not restricted; fifth, it ignored the fact that GID clinics only recommend surgical intervention in a small minority of cases; sixth, it was a decision that left sufferers untreated and in a state where their right to life and not to be subjected to degrading treatment or disproportionately interfered with.

Mr Blake adds that the purported proviso for "overriding clinical need" was in practice meaningless since the respondents failed to recognise that gender re-assignment is the only effective treatment for diagnosed transsexuals who had passed the "real life" test and were otherwise suitable for surgery. If the clinical assessment of demonstrable need was incapable of overriding the policy, then nothing could override it. Further, the suggestion by the respondents that psychotic depression or suicidal state might be a good reason for authorising the treatment was itself based on an error in understanding the medical evidence. A patient could only be suitable for surgical treatment if he had a stable mind and had come to a clear and ordered decision and, thus, psychotic depression was a counter-indication of successful surgery. The requirement that the patient be suffering another illness in addition to the illness of GID demonstrated that the ban on GID treatment was in fact blanket and admitted of no exception. To require the condition to go untreated until it had caused an additional severe illness disregarded the duty on Health Authorities to prevent illnesses and constituted inhuman or degrading treatment. The respondent's refusal to fund diagnosis and assessment for gender re-assignment treatment meant that a suffer would not be able to establish a clinical need, let alone an overriding clinical need for the treatment. They were unable to satisfy the preconditions for any gender re-assignment treatment as a result of the application of the policy.

Mr Blake said that this was not a question of a court being asked to resolve a dispute between two responsible bodies of medical opinion skilled in the particular treatment in question. (See *Bolam v Friern Hospital Management Committee [1957] 1 WLR 582 at 586*). Dr Sudell's expertise was in public health provision and not in the treatment of transsexuals. The evidence showed that there was no other competent body of medical opinion supporting the position of the respondents and that the material relied on by the respondents was incomplete, out of context and in any event unsubstantial and marginal to the medical consensus.

On the other hand, the fact that in appropriate cases surgical intervention was the appropriate medical treatment for confirmed transsexuals had long ben recognised by the medical profession and this was acknowledged by the courts in *Corbett and Corbett*. That had also been recognised by the government in *Rees v United Kingdom* in the ECHR where it was submitted "that the provision by the State of the necessary surgical and other facilities constitutes an important element in securing the right to respect for the private life of the individual as guaranteed by Article 8(1)".

The treatment of counselling the individual to accept the biological sex was not an effective remedy for relieving the condition of GID, as was shown by the high rate of suicide and/or mutilations reported in the cases of transsexuals denied appropriate long-term treatment. Surgical treatment when applied only after recent assessment in the heightened conditions of the "real life" test achieved a high degree of success in removing the illness which the Mate Cole figures put at between 71 and 90 percent. Those were impressive statistics of success, it was submitted. A responsible view of the technique could not conclude that it was experimental, unproven or with a high risk of failure or collateral harm. Successful re-assignment that includes surgery in appropriate cases could thus be said to resolve the underlying psychiatric condition. It was wrong to conclude that the treatment removed healthy tissue but left the illness untreated. Finally, Mr Blake again stressed that the opposing evidence was non-existent and Dr Sudell's passing reference to abstracts of published papers did not provide it.

Mr Blake said that the policy did not ration or restrict re-assignment treatment. It effectively forbade it to the small minority of GID sufferers who both needed it and were suitable for it. He pointed out that a retention of overriding discretion that is theoretical only and delusory in practice did not deprive a policy of its illegitimate absolute character (see *R v Warwickshire County Council ex parte Collymore [1995] ELR 217 at 224 to 226*).

The respondent's policy applied to all diagnosed transsexuals without distinction and no consideration had been given to priority as between cases of acceptable clinical need as transsexuals. No distinction was drawn between young distressed transsexuals and those who were older. A policy of priority of treatment that was formulated on a flawed consideration of demonstrable clinical need was not a lawful policy. It was tainted by the taking into account of irrelevant considerations and a failure to take into account relevant considerations. Further, there was no financial evaluation ever made of the inappropriate treatment supposedly on offer, namely counselling to reconcile a person to their biological gender, as well as a consequent recourse of treatment for psychiatric disorders which arose through the absence of opportunity for gender re-assignment treatment. Mr Blake submitted that the decisions should be quashed and should be remitted for reconsideration on their individual merits, removing the reference to GID treatment from the respondent's 1998 policy so that there was no irrevocable presumption against acceding to proven need.

As a final argument Mr Blake relied on discrimination and said there was an enforceable duty under Community Law not to discriminate on the grounds of sex in the provision of services for the treatment of sickness (*R v Secretary of State for Health ex parte Richardson [1996] ICR 471 at 492*). Section 29 of the Sex Discrimination Act 1975 also prohibits discrimination in the provision of services on grounds of sex. To treat transsexuals differently from others suffering from illness and indemonstrable clinical need of measures to cure illness was discriminatory.

Mr Clarke, who appeared for the respondent, argues that there are seven issues raised by these applications.

1. Is the respondent's policy under which the decisions were made *ultra vires*?
2. Is the policy an unlawful fetter on discretion?
3. Is the policy irrational?
4. If the challenge to the policy fails is the decision in each individual case irrational?
5. Does the Court have jurisdiction to rule on the applicants' complaints of sex discrimination?
6. Is healthcare "social security" for the purposes of the equal treatment Directive?
7. If so, are the decisions contrary to the Directive?

The respondent's main answer to that is that exercised its judgment in the allocation of limited healthcare resources and these applications invite the Court to intervene in matters of judgment which are the province of the respondent. Mr Clarke draws my attention to *R v Cambridge Health Authority ex parte B [1995] 1 WLR at 898* and says it is clear from such decisions that the allocation of any Health Authority's budget is a matter for the Authority.

Mr Clarke argues that the applicants are wrong in their contention that the respondent has fettered its discretion by policy. The evidence shows that the respondent has acted with proper regard for its obligations to fund healthcare, taking account of the appropriate effectiveness and priority. He says that gender re-assignment procedures may be purchased

in exceptional cases and that each of the applicant's cases have been considered on its merits and the respondent has reasonably formed the view that it cannot justify allocating funds for the treatments requested.

Mr Clarke says it is nothing to the point that clinicians advising the applicants favour the treatment. That does not render the respondent's decision susceptible to Judicial Review. He argues that the function of Judicial Review is not to resolve differences of opinion between clinicians and that much of the detailed medical evidence relied upon by the applicants is irrelevant to the real issues before the Court. He says that is is notable that, although the applicants ostensibly seek a reconsideration of the decisions, the whole thrust of their case is that their doctors are right, that any doctor who disagrees with them must be wrong, and the applicants must be given treatment at public expense. Mr Clarke argues that this approach invites a form of intervention in public decision-making which is outside the scope of Judicial Review.

He takes me to *Ex parte B* as the leading case on the allocation of healthcare resources which manifests the reluctance of the courts to intervene in decisions in this area. There the Court of Appeal held that limited resources are a relevant consideration even when life was potentially at stake. The shortage of Health Service funds was recognised to be common knowledge and the Court felt it was for the Authority's judgment and not that of the Court to allocate a limited budget to the maximum advantage for the maximum number of patients. Sir Thomas Bingham, Master of the Rolls, as he then was, said at 906c:

"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 eye to the real world if the court were to proceed on the basis that we do live in such a world. It is common knowledge that Health Authorities of all kinds are constantly pressed to make ends meet. They cannot pay their nurses as much as they would like, they cannot build more hospitals and specialist units they would like. Difficult and agonising judgments have to made as to how a limited budget is best allocated to the maximum number of parties. That is not a judgment which the court can make."

Mr Clarke submits that the point in this case is that the Health Authority cannot look at individual cases in isolation. It has to make its judgments by reference to the needs of the population which it serves. Mr Clarke says the point here is as apposite in the present case as in *Ex parte B*.

Mr Clarke draws comfort from Jowitt J's judgment in *R v East Lancashire Health Authority ex parte B [1997] COD 267*. The learned judge acknowledged that Health Authorities do not have "bottomless pockets" and that they "have to decide how resources are to be shared between competing interests".

He also drew comfort from *R v London Borough of Brent ex parte B [1994] ELR 357*, a child care case which demonstrated the reluctance to intervene in decisions as to allocations of public resources. There Auld J, as he then was, stated at 377E:

"The weight which a Local Authority should give to the general circumstances of children in need for whom it must provide day care one way or another, when balancing them against its financial and budgetary constraints, must … be a matter for its judgment and experience. It is

certainly a matter upon which the court would be rarely competent to intervene on grounds of irrationality."

Mr Clarke drew my attention to evidence of the constraints within which the respondent had to operate and the balancing exercise which they had to perform in the affidavits of Dr Sudell and Dr Harrison. (Dr Sudell paragraphs 15 to 20, 53 to 55 and 4 to 7 and Dr Harrison paragraphs 3 to 10).

Mr Clarke said that the respondent's policies were set out in the 1995 policy on "Medical procedures of no beneficial health gain or proven benefit", the 1997 policy for assessment of possible exceptions to purchasing policy and the policy in relation to purchase of appropriate, effective and cost effective healthcare. He denied the applicant's contention that the policies were *ultra vires* and were an unlawful fetter on discretion and also the contention that they were irrational.

As to *vires* he submitted that the allocation of limited resources and the planning of priorities are plainly appropriate subject matters for the formulation of policies by a public authority. He took me to *Bristol City Council ex parte Bailey and Bailey 27 HLR 307*, a case on local authority housing repairs, which I decided, where I said at page 320:

"Mr Barrie … argued that the council was entitled to adopt a policy for establishing the priorities for limited grant aid to be awarded. The council and the court had to bear in mind financial realities … The policy adopted here by the council does expressly preserve the possibility of discretionary applications being considered on their merits and that the council would listen to any applicant who would wish to put forward an application for a discretionary grant outside the scope of that formal policy … I am firmly of the view that Mr Barrie's contentions are correct … The council were entitled to formulate a policy for the way that they have done in order to deal with the difficulties which arose from lack of resources which were available to them."

As to both *vires* and fettering its discretion the respondent submits that since it is appropriate and reasonable for a body such as a Health Authority to state what its policy is it is also appropriate and reasonable for it to indicate possible exceptions to the policy. Mr Clarke relies on a passage from Lord Reid's speech in *British Oxygen Company Limited v Board of Trade [1971] AC 610 at 625D*. Lord Reid said:

"What the authority must not do it to refuse to listen at all. But a Ministry or a large authority may have had to deal already with a multitude of similar applications and then they will almost certainly have evolved a policy so precise that it could well be called a rule. There can be no objection to that, provided that the authority is always willing to listen to anyone with something new to say - of course I do not mean to say that there need be an oral hearing."

(See also *R v Law Society ex parte Reigate Properties [1993] 1 WLR 1531*).

Mr Clarke says that applying those requirements identified in those cases to the respondent's policies for the allocation of healthcare resources, clearly the respondent has satisfied those requirements.

As to the fettering of discretion Mr Clarke takes me to *R v Ministry of Agriculture Fisheries and Food ex parte Hamble Fisheries (Offshore) Limited [1995] 2 AER 714 at 722A* where Sedley J said there are:

"Two conflicting imperatives of public law: the first is that while a policy may be adopted for the exercise of a discretion, it may not be adopted with a rigidity which excludes consideration of possible departure in individual cases …; the second is that a discretionary public law power must not be exercised arbitrarily or with partiality as between individuals or classes potentially affected by it … The line between individual consideration and inconsistency, slender enough in theory, can be imperceptible in practice."

In the same case at 722 the learned judge went on to suggest that the formulation of a policy together with exceptions is a legitimate mode of resolving the potential conflict between the two imperatives. In that way policy was a means of securing a consistent approach to individual cases. Each case should be determined in light of policy but not in such a way that the policy automatically determines the outcome.

Mr Clarke submits that here the respondent has clearly stated comprehensible policies and has considered each case individually in the light of the policy but on its merits.

As to irrationality Mr Clarke says that simply relying on the existence of a clinical need begs the question as to allocation of resources. Any applicant for funding must have some clinical need otherwise there would be no question of a Health Authority providing funding for such an applicant. The question for the Health Authority in every case is whether or not the clinical need is such as to justify public expenditure in a situation where expenditure on one form of treatment reduces the amount available for another and the respondent cannot meet all clinical needs. In that situation it is entirely reasonable for the respondent to formulate policy based on appropriateness, effectiveness and priority. The respondent's approach accords with that indicated in the Department of Health's observations quoted by the applicants in paragraph 4.9 of their submissions. The main considerations are appropriateness and priority which naturally go together. What is appropriate for a public authority to spend money on depends on a large extent on priorities. What is "appropriate" in this context is not necessarily the same as it is "appropriate" looking purely at an individual case without regard to funding constraints.

Mr Clarke submits the applicants concentrate on effectiveness in their application and do so without regard to any issue of resource allocation. Much of their medical evidence is concerned to address a non-issue, namely whether or not gender dysphoria is a medical condition, as to which Mr Clarke says there is and has been no dispute. The applicants' medical advisors and experts, who are advocates for their particular specialist field, consider the matter only from the perspective of clinical responses to particular cases in an ideal world situation. Because they consider particular treatments to be warranted they proceed from that to say that it must be unlawful for the respondent to refuse to commit public funds to the requested treatment. By failing to have any regard to resources allocation the applicants medical evidence misses the central point in this case.

As to the Wednesbury challenge to the decisions in individual cases, which is the applicants' alternative argument if their attack on the respondent's policies fails, Mr Clarke says each individual case is an instance of a budget allocation decision and is not reviewable for he reasons set out in *Ex parte B*.

Mr Clarke turns to the applicants' allegations of sex discrimination on the part of the respondent and says that if the allegation is that the respondent has discriminated on grounds of sex in the provision of services to members of the public, it is surprising that no such claim has been made as required by Section 65 of the Sex Discrimination Act 1975 in the County Court.

Mr Clarke submits that in any event it is only if the case falls within the scope of Directive 79/7/EEC on equal treatment of matters of social security that the allegation of discrimination could succeed. While the applicants rely on *R v Secretary of State for Health ex parte Richardson [1996] ICR 471* in support of the contention that medical treatment is social security, Mr Clarke says that *Richardson* does not support that proposition but simply establishes that a scheme for exemption from prescription charges falls within the Directive. The applicants do not cite any domestic or European Court of Justice authority which brings the decisions in this case within the scope of the Directive and do not identify any debatable point of Community Law which might require an Article 177 reference to the European Court of Justice.

Mr Clarke says that, more particularly, there is no evidence that the respondent had to discriminate against the applicants on the ground of their gender or their status as transsexuals. The decisions of the respondent had not been made because the applicants are transsexuals but rather because of the respondent's judgment that the allocation of resources to the treatment requested is not medically justified.

As to the applicants' arguments on the European Convention on Human Rights Mr Clarke submits the Convention is an aid to interpretation of English Law where the law is unclear (see *Ex parte Brind [1991] 1 AC 696*) but in the present situation the law is clear and no convention right has been infringed. Article 8 of the Convention prohibits interference by a public authority with private life, save for interference which is in accordance with the law and necessity in a democratic society.

The ECHR has repeatedly declined to accept that the refusal to alter the Birth Certificate of a person who has undergone gender re-assignment constitutes a breach of Article 8 (see *Cossey V United Kingdom [1990] 13 ECHR 622*; *X, Y and Z v United Kingdom [1997] TLR 208*; *Sheffield and Horsham v United Kingdom European Court of Human Rights 30th July 1998*).

Mr Clarke points out that in the last two cases the court said:

"Transsexualism raises complex scientific, legal, moral and social issues in respect of which there is no generally shared approach among the contracting states."

The court also expressed reservations about whether the notion of "respect" for private life creates positive obligations.

In the present case there has been no interference by the respondent in the applicants' private lives. The Convention does not give the applicants rights to free healthcare in general or to gender re-assignment surgery in particular. Even if the applicants had such a right it would be qualified by the respondent's right to determine healthcare priorities on the light of its limited resources.

Mr Clarke says that the submission that the respondent's decisions amounted to "inhuman or degrading treatment" contrary to Article 3, which would put the decisions in the same category as torture, cannot seriously be pursued. Article 3 confers no right to publicly funded medical treatment.

Finally, as to discrimination, the Convention does not create a freestanding right to protection from discrimination, but the position is that the substantive rights guaranteed by the Convention should be enjoyed without discrimination. There is no sex discrimination in this case says Mr Clarke.

It is convenient to state here that I agree with the submissions of Mr Clarke both in respect to the European Convention on Human Rights and relation to the Directive and decisions of the ECJ in relation to sex discrimination. In both of these matters I am satisfied that Mr Clarke's submissions are right and will not further consider the applicant's claim under these two heads which I find to have been disproved by the respondent's arguments.

Mr Blake, in reply for the applicants, stressed that in the Child B case the Court was saying that it could not substitute its view of how resources should be spent for that of the authority, not that it could not have carefully examined whether the Authority had asked the right questions and taken proper consideration of all the relevant circumstances. Supervision of the decision making process was precisely the Court's function in those cases argued Mr Blake.

He said that the applicants submit that demonstrable clinical need for appropriate treatment to relieve illness is enough to preclude a policy of never purchasing services unless one is suffering from an additional illness. The applicants had never argued that any need results in the right to treatment, that a policy to exclude treatment of demonstrable need could not be undertaken. That was irrespective of whether rationing or balancing other costs might mean that not every GID sufferer will always receive the necessary treatment immediately.

There was no other possibility of receiving National Health service treatment that the responsible experts considered necessary. No one would advise on re-assignment treatment unless that was necessary to relieve the condition. No psychiatrist or other clinician was stating that there was an effective or suitable alternative treatment that could be provided by the respondents to address those needs. It was entirely accepted that where there was a broad discretion an Authority was entitled to apply a lawful policy consistent with the policy for the purposes of the Statute to ensure broad equity in the treatment of similar cases. What the authority could not do was adopt a policy that is so restrictive in theory or practice as to (i) be inconsistent with the policy of purchase of the Statute and (ii) to deny effective individual consideration of cases. The policy had to be lawful and consistent with the statute before it was afforded the status of a presumptive decision.

Mr Blake argued that this present policy did not pass the test for the reasons he had already argued. It led to rationing by postcode and a blanket denial of treatment for those in need of effective treatment who were ill. He submitted finally that the restrictive nature of the policy and its inconsistency with the purpose of the Statute was demonstrated by the respondent's difficulty in understanding what overriding clinical need could be once the expert's assessment of the patient's need for treatment is excluded. To require patients to suffer from another disease before treating them was absurd. To require them to suffer pathological

psychiatric disorder as a result of non-treatment before treating them was absurd and ineffective since effectively it would preclude a transsexual from surgery.

I now turn to indicate the findings that I have to make in relation to these applications. I begin by reminding myself of the guidance given to the Court by the case of *R v Cambridge Health Authority ex parte B* that it was for the Health Authority's judgment and not that of the Court to allocate limited budgets to the maximum advantage for the number of patients. Nonetheless in formulating policy or in applying policy to a particular case before it the Authority has to consider whether there is a demonstrable medical need for the treatment in question. The court will not seek to allocate scarce resources in a tight budget but will ensure that the Health Authority has asked the right questions and has addressed the right issues before arriving at a policy that is lawful. The authority has to tackle the vexed problem of transsexualism and it has decided that gender re-assignment "will not be purchased". It is true that it has come to that conclusion subject to the proviso of overriding clinical need, but since it is unable to define or exemplify what is meant by such words, such words either add nothing or alternatively unlawfully fetter the Authority's discretion in the question it is seeking to answer. To conclude that it will provide counselling but it will not provide hormone treatment or surgery is a conclusion to which it is not entitled to come.

I have concluded on all the arguments addressed to me by Mr Blake on behalf of the applicants I am satisfied that, save as to the European question, those arguments are right. It follows that Mr Blake's arguments prevail over those of Mr Clarke.

I am satisfied that the respondent's decisions impugned by these applications are Wednesbury unlawful and irrational. They were arrived at without consideration of relevant matters, such as the question of what is (a) proper treatment or what is recognised as the illness involved in gender identity dysphoria, GID, or transsexualism. The policy itself is unlawful because it fetters the respondent's exercise of its discretion in discharging its duty of providing treatment and providing facilities for the prevention of illness and the cure of persons suffering from that illness.

I am satisfied finally that the applicants' arguments must prevail and the orders of certiorari must go.

Ms Harrison: I am most grateful for your Lordship's judgment. In those circumstances, my Lord, there are only two matters: first is the question of costs, and we seek the applicants' costs to be paid by respondents and to be taxed. The applicants are legally aided, my Lord.

I would also like confirmation that the orders that your Lordship made at the beginning of the application for Judicial Review that the applicants not be identified continue.

Mr Justice Hidden: I will continue that order until further order.

Ms Harrison: I am grateful, my Lord.

Mr Justice Hidden: As to costs?

Mr Clarke: My Lord, I cannot oppose the order for costs and I said I do not object to the continuation of those orders.

Mr Justice Hidden: Very well, I will say costs to be paid by the respondents to be taxed.

Mr Clarke: My Lord, I think my learned friend then formally needs an order for legal aid taxation.

Mr Justice Hidden: Order for legal aid taxation, if required, Ms Harrison.

Mr Clarke: The second matter that I must address my Lord on is the matter of leave to appeal. My Lord, I do ask my Lord to grant leave to appeal to the respondent really for these reasons: it is clear this is a matter which concerns not only this particular authority but many other authorities. My Lord has had evidence of the various stances adopted by other authorities. My Lord will recall that numerous other authorities have a stance which is the same as or quite similar to that of this authority. This is going to therefore be a matter of considerable importance throughout the Health Service and engages obviously the very difficult questions and issues which are raise by the issue of transsexualism and, with the greatest of respect to my Lord, it is, as far as I am aware, the first decision which really touches directly on these points and, accordingly, would be an appropriate matter for scrutiny by the Court of Appeal.

My Lord, that is my application.

Mr Justice Hidden: Thank you. Ms Harrison, anything to say?

Ms Harrison: My Lord, I only say by observation that although there are broader issues involved in this case, in fact your Lordship's judgment turned upon a particular application of policy in respect of transsexuals and a particular failure to make properly an assessment of the nature of the illness and, in my submission, that is not a point of law. The principles are basic principles of requiring to take into account the relevant circumstances.

Mr Justice Hidden: The practice direction says that leave should not be granted, I think, unless there is a matter of principle or practice — I cannot remember the exact words.

Ms Harrison: My Lord, yes. I think that would be just putting into prose what has been the position for a long time now. There must be an important issue of law that the Court of Appeal needs to consider and while, of course, this is an unusual area and has its own complexities, your Lordship's judgment has been on the basis of applying ordinary principles of Judicial Review to these particular factual circumstances and in those circumstances, my Lord, I say there is not a distinct and novel point of law that arises as a result of your Lordship's judgment to say that leave to appeal is appropriate.

Mr Justice Hidden: Mr Clarke?

Mr Clarke: My Lord, we would say that there is an important question of principle here at stake, because of course my Lord has taken the step which the Court does not often take of intervening in respect of a decision which does engage questions of resource allocation, and that is an issue of broad principle and an issue which applies across the Health Service for the reasons I have indicated. My Lord, therefore we would submit that it it is an appropriate case for the matter to be considered by the Court of Appeal, my Lord, and I make the application on that basis.

Mr Justice Hidden: Thank you, Mr Clarke, I shall not give you leave in this case. I think if you want to get leave you must get it from the Court of Appeal. I am sorry.

Mr Clarke: My Lord, yes.

(**The court adjourned**)

» by Claire McNab