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How the Law Should Help Ration Health Care: A Contextual and Comparative Perspective

Jon Rohde

BOOK REVIEW:

LAW, LEGITIMACY AND THE RATIONING OF HEALTH CARE: A CONTEXTUAL AND COMPARATIVE PERSPECTIVE

Authored by: *Keith Syrett* [*]

Keith Syrett argues for a reappraisal of the role played by public law adjudication in questions of healthcare rationing. As governments worldwide turn to strategies of explicit rationing to manage the disparity between the demand for and supply of health services and treatments, disappointed patients and the public have sought to contest the moral authority of organizations making these rationing decisions. This has led to the growing involvement of law in this field of public policy. The author argues that, rather than bemoaning this development, those working within the health policy community should recognize the points of confluence between the principles and purposes of public law and the proposals which have been made to address rationing's 'legitimacy problem'. Drawing upon jurisprudence from England, Canada and South Africa, the book evaluates the capacity of courts to establish the conditions for a process of public deliberation from which legitimacy for healthcare rationing may be derived.

HOW THE LAW SHOULD HELP RATION HEALTH CARE

Reviewed by: *Jonathan Rohde* [**]

INTRODUCTION

Law, Legitimacy, and the Rationing of Health Care opens by setting an alarming scene. The cost of public health care continues to rise, the need for healthcare resources continues to grow, and governments are continuously forced to make hard decisions about the distribution of

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[*] Dr. Keith Syrett is a Solicitor and Senior Lecturer in Law at the University of Bristol.

[**] Jonathan Rohde is a second year law student and DePaul University College of Law. He is a Health Law Fellow, a staff writer for the Journal of Health Care Law, and a member of the Student Board of Directors for the Health Law Institute. His article "Unilateral Termination of Life-Sustaining Treatment in Neonatal Care: A Legal Overview" was published in the October 2008 edition of Virtual Mentor: American Medical Association Journal of Ethics. Jonathan graduated from Washington University at Saint Louis in 2005 with a degree in English Literature

their limited resources. In his book, Keith Syrett examines these problems, examines potential public policy approaches, and presents the compelling argument that an increased role of public law lends legitimacy to these controversial decisions.[1] Syrett points out the undeniable trend in public healthcare systems in favor of explicit decision making rather than implicit decision making. The increasing demand for explicitness is necessitated by the scarcity of health resources and the inevitable rationing of these resources. Social instability, he posits, is likely to occur when the public is not satisfied with the process or outcome of the rationing. The scope of the book is the interaction of public law with allocative decision-making in the healthcare context.[2]

Syrett employs an intriguing, measured, and meticulous approach to the argument that public law should play a role in health resource rationing. The ethical and theoretical constructions concerning public healthcare policies are comprehensively analyzed and are made accessible to even legal novice. For the American reader, the three areas of jurisprudence from which Syrett draws his comparative analysis (England, Canada, and South Africa) will initially seem unfamiliar. However, Syrett does a commendable job in making them accessible to those of us with minimal experience in foreign jurisprudence. Ultimately the fundamental legal issues encountered by public law in *Law, Legitimacy, and the Rationing of Health Care* provide the most familiar grounds for an American reader. All three legal systems share certain fundamental considerations, such as judicial restraint vs. judicial activism, the propriety of the court usurping the role of the legislature, constitutional and statutory interpretation, and the appropriate role of human rights.

DESCRIPTION

The first two sections of the book are less an assertion that an actual problem exists and more of an attempt at defining the scope of the problem itself. Syrett begins by teasing out the factors that lead to the need to ration healthcare resources. After considering multiple meanings of "rationing," he settles the following definition by Maynard: "rationing takes place when an individual is deprived of care which is of benefit (in terms of improving health status, or the length

[1] Keith Syrett, LAW, LEGITIMACY AND THE RATIONING OF HEALTHCARE, page cited (Margaret Brazier & Graeme Laurie eds., Cambridge University Press 2007).
[2] *Id.* at 11.

and quality of life) and which is desired by the patient."[3] He concludes that even after considering alternatives like "reduction of waste" and "elimination of ineffective treatments," rationing of resources will still be neccessary.[4]

So rationing, according to Syrett's analysis, is inevitable. The author then examines the ways rationing has been attempted thus far, including rationing by price, by denial, by selection, by delay, by deterrence, by deflection, and by dilution.[5] Syrett provides a brief description of these various methods, and also notes that these types of rationing are often at work simultaneously within a healthcare system, "[I]t should be noted that rationing in any given healthcare episode is likely to involve a complex interaction between, and combination of, these techniques, and that these will be deployed at various points by health professionals."[6]

This brings Syrett to a pillar of his thesis: rationing should be carried out in an explicit manner. Explicit rationing "makes transparent the fact that such decisions rest upon resource constraints"[7], as opposed to implicit rationing that "eschews the transparent deployment of rules or principles which define the bass upon which distribution takes place . . .", and the "allocative character of the decision is generally camouflaged beneath clinical judgments."[8] He then takes a sampling of explicit rationing attempts, including the experiences of England[9] and of the Oregon[10] legislature. Syrett notes that while explicit rationing can "enable more comprehensive centralized control to be exerted over health expenditure", it is also problematic in that there is "[g]reater instability, reduced scope for 'blame avoidance', and difficulty in achieving consensus upon underlying substantive principles to guide allocation decisions . . . ."[11] However, while there has been a reaction to some of these negative aspects Syrett contends that once healthcare

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[3] *Id.* at 19 (citing A. Maynard, *Rationing Health Care: an Exploration,* 49 HEALTH POLICY 5, 6 (1999).
[4] Syrett, *supra* at 44.
[5] Syrett, *supra* note 1, at 45-48.
[6] *Id.* at 49.
[7] *Id.* at 54
[8] *Id.* at 53.
[9] *Id.* at 117.
[10] *Id.* (discussing the Oregon Health Services Commission, which sought to establish a package of publicly-funded medical treatments and services in the 1990s).
[11] *Id.* at 73.

rationing is revealed to the public, governments cannot revert to an implicit system.[12]

In other words, the public is unable to 'unknow' that rationing of healthcare resources occurs. Syrett then takes on the issues of who should be in charge of rationing, and what gives that group that right.

In order to determine who may legitimately make explicit rationing decisions with health care resources, Syrett gives an "account of the *state of current thinking and practice* on how to address a significant policy problem which has emerged in modern health systems."[13] He notes that when explicit rationing decisions are made, the question of the legitimate moral authority of those responsible often causes social instability.[14] This potential volatility has lead decision-makers to take refuge in a 'procedural approach', and assert legitimacy through the 'norms of procedural justice'.[15] Syrett cites the example of NICE in the UK which has publicly declared its commitment to the "accountability for reasonableness" model. [16] With the understanding that a largely procedurally dependent approach is being adopted, Syrett then analyzes what role the law has in this environment.[17]

First, Syrett sets out the ethical "accountability for reasonableness" framework. This framework focuses on the need for the administrative body to provide reasons for their decisions, the need for the administrative body to engage in scrutiny of the relevant conditions surrounding the decisions, and the need for an administrative body to have an internal structure for dispute resolutions including and appeals process to allow for revisions and improvement. Syrett then compares "accountability for reasonableness" principles to

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[12] *Id.* at 74 ("[N]ow that the existence of healthcare rationing has been exposed to public view, as has been the effect of the strategies described here, there is no prospect of a wholesale return to the relative stability of the status quo ante of 'concealed' rationing choices, even on the assumption that the medical profession would be prepared to reassume the burden of primary responsibility of allocation of scare resources").

[13] *Id.* at 119 (emphasis in original).

[14] *Id.*

[15] *Id.*

[16] *Id.* at 119 ("This is most evident from the experience of NICE in the UK, which, in addition to its role in gathering and assessing evidence of the clinical and cost-effectiveness of new medical technologies, has publicly avowed its commitment to the 'accountability for reasonableness' model and which, through its Citizens' Council, has sought to integrate deliberative democracy into its decision-making, albeit within limited parameters and with questionable success").

[17] *Id.*

very congruent elements of public law, and contends that public law provides a vehicle for this ethical foundation.

The author then examines the contention by some ethicists that judicial intervention and the specter of litigation should not be involved in health care resource rationing. Syrett attacks the assumption that judicial intervention in the arena of rationing health care resources is undesirable. He argues that exhausting the internal processes of the institution charged with explicit distribution will minimize legal "interference" and the costly burdens of litigation. Through detailed analysis he points out that the "strong correspondence between public law and legitimation would point to the utility of adjudication as a means of responding to the 'legitimacy problem' . . ."[18]

Syrett asserts that courts can serve to key functions in public law and in the distribution of health care resources: "[f]irst, a court case can serve a catalytic purpose, providing information and feeding into a public discussion on the acceptability of health care rationing . . ."[19] "Secondly, the courtroom itself may be seen as a deliberative arena, enabling an exchange of reasoned argumentation to occur between parties and the judge(s) . . . ."[20] This kind of deliberation will "[c]ontribute to the ultimate objective of encouraging wide deliberation within political and civil society upon issues of healthcare rationing."[21]

After establishing a theoretical justification for public law application in decisions of explicit rationing of healthcare resources Syrett turns to how this has worked in practice. He examines the jurisprudence of three countries- England, Canada, and South Africa. English courts, in the absence of recognized human rights provisions concerning the distribution of public health resources, have been reticent to realize a role in the legitimacy problem. The English courts view the distribution as purely "political." They are deferential to the determinations made by the NHS, and have not required the NHS to explain how it arrived at its set of priorities further than the "mere 'tolling of the bell of tight resources.'"[22]

In Canada the courts have been more strict in their scrutiny of limited healthcare resource cases. This partially stems from an indirect right to healthcare attenuated through the Charter of Rights and

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[18] *Id.* at 157. The legitimacy problem consists of identifying how a political order's worthiness is to be recognized. See pages 136-142 for further discussion.
[19] *Id.* at 158
[20] *Id.*
[21] *Id.*
[22] *Id.* at 177.

Freedoms.[23] However, the application of the Charter in the *Chaoulli v. Quebec (Attorney General)* case to the rationing of healthcare resources produced some hotly contested results. The Supreme Court of Canada split 3:3 in its decision as to whether a violation of section 7 had occurred.[24] This has increased "the fear that judges may substitute their own views in place of the original decision-maker, rather than restricting their role to enforcing observance on the part of the decision-maker of procedural conditions . . ."[25] Syrett suggests that this near-activism toes the line between what is a proper and constitutionally supported judicial function and what would is improper judicial activism.[26]

South African jurisprudence provides the strongest support for Syrett's contention that courts can lend stabilizing legitimacy to instability created by the rationing of health resources. South Africa does have an explicit right to access of healthcare in its constitution.[27] Additionally South Africa has a "constitutional culture of justification" that is a remnant from its recent history. There is a strong need for government action to have both justification and transparency. In the *TAC* case the court ruled on a restrictive government policy regarding the treatment of mother-to-child transmission of HIV. The court indicated that the current policy, and the government's subsequent attempt to rationalize it, were lacking. The court applied a "reasonableness test" which, while abstract and open-ended, consisted of inquires into the "[c]oherence, even-handedness, flexibility, inclusiveness, and feasibility of the policy."[28] It declared the policy unconstitutional and ordered several mandatory policies. However, the court included "that the government would be permitted to adapt its policy in a manner consistent with the Constitution if equally appropriate or better measures for the prevention of mother-to-child transmission of HIV became available."[29] Syrett approves of the South

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[23] See *Id.* at 181, the Charter of Rights and Freedoms - specifically in section 7 (right to life, liberty, and security of the person) and section 15 (the right to equal protection and equal benefit of the law without discrimination on certain enumerated grounds (such as sex, age or mental or physical disability) or analogous grounds).

[24] *Id.* at 186.

[25] *Id.* at 206.

[26] *Id.*

[27] *Id.* at 207 (section 27 provides in pertinent part "Everyone has the right to have access to healthcare services, including reproductive healthcare . . . No one may be refused emergency medical treatment.")

[28] *Id.* at 219.

[29] *Id.* at 216.

African court's approach, saying that "[i]t commendably sought to steer a middle course between the largely deferential and non-interventionist stance adopted by the English judiciary, which admits of little deliberation on question of the distribution of healthcare resources, and the activist approach evident in *Chaoulli*, which was widely regarded as constitutionally improper."[30]

Syrett then uses elements of the South African approach to construct his "modest proposal." He asserts that it is vital when adjudicating an alleged violation of the right that "a court [be] obligated to require that a reasoned explanation of the rationing choice presented, in order to ascertain whether the balance which has been struck between individual and community interests can be justified with reference to plausible reasons."[31] This type of moderate intervention is a tool that increases the amount of deliberation between political and social groups. Intervention of public law also requires the rationalization behind the allocative decisions to become transparent to the public, and requires that the decision-maker offer evidenced and reasoned justification for such decisions.[32] This type of transparency may enhance public education concerning such decisions, and helps foster a culture of justification that demands deliberation on rationing.

EVALUATION

Keith Syrett employs an organized and meticulous approach to the questions present in *Law, Legitimacy, and the Rationing of Health Care*. He uses both contextual (examining the current policies and theories in public health law) and comparative analysis (examining the treatment of the scarcity of health resources issue across three countries' jurisprudence) to construct his conclusions.

The contextual analysis is comprehensive. Syrett lays out the pertinent policy or theory, explains its benefits, explains its actual or potential short comings, and then applies it to policies or theories that support his thesis. This well-reasoned analysis provides a comprehensive overview of the subject, which proves to be crucial for those is unfamiliar with this type of material.

The author's comparative analysis is well organized and subtly encourages the reader to support Syrett's conclusions. Syrett primes the reader with the English courts' reluctance to engage in the area of

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[30] *Id.* at 229.
[31] *Id.* at 237.
[32] *Id.* at 233.

public health rationing decisions. He then removes this resistance and replaces the feeling of total inaction by revving the engine of judicial activism by the Supreme Court of Canada. After the reader is frustrated with doldrums of deference, and then alarmed by the acceleration of activism, Syrett presents what he considers an appropriate pace: the "reasonableness test" of the South African Court. The presentation of two extremes (or potential extremes) serves as an excellent device to silently show that the moderate approach does not suffer from drawbacks of the extreme ones.

Syrett sets out his thesis to deal with the legitimacy problem that has persisted with respect to the explicit rationing of limited healthcare resources. "[T]hose concerned with resolving the 'legitimacy problem' to which the rationing of healthcare gives rise should reassess the contribution which may be made by the courts in this area of public policy."[33] He amply illustrates, through his initial case study concerning the rationing of Herceptin in England, that there is a problem. that the problem is serious, and that it will only worsen with time.

His argument for greater legal involvement in this are of public policy is eloquently articulated. Syrett points out, to those that have argued against the courts becoming involved in the rationing of health resources, the festering harmonies present in public law principles and the public policy ethics of "accountability for reasonableness." After showing that there is little basis for such ethical objections, he then does a decent job of quelling most the additional fears associated with the presence of the law on the field of public policy.

The greatest obstacle to his argument is the 'near-hit' occurrence of judicial activism in Canada. He does not ignore this potential roadblock. He instead uses it to clarify the parameters of his position that the law should assume a facilitative role, rather than a substantive one when dealing with limited health resource allocation decisions. He also uses the near-activism to emphasize the effectiveness of adjudication in generating open and pluralistic deliberation within a society, which are both ethical desirables in the field of public policy.

The book is written, admittedly, from a British perspective. One cannot ignore the author's implicit concern with the lack of judicial action by the English courts. Syrett is clearly in favor of public law involvement in the area of health resource rationing (it is a large

[33] *Id.* at 10.

part of his book), and certainly opposed to the English court's reticence. Syrett recognizes the lack of explicit power given to the English courts in this manner, and that "any shift in judicial attitudes is likely only to come about *in response* to developments in public policy elsewhere, especially to a lead taken by government."[34] The English courts see their role as primarily reactive, and Syrett concludes that "[t]heir capacity to facilitate the attainment of legitimacy through the health system as a whole remains inhibited by such an outlook."[35] After reviewing the other two areas of jurisprudence Syrett emphatically states that "scrutiny which is restrained and deferential to the degree that no obligation of justification at all is imposed upon allocative decision-makers amounts to an abdication of the essential democratic function of the judiciary: . . . to secure legal responsibility for decisions which . . . amount to unlawful exercises of administrative power."[36]

Overall, *Law, Legitimacy and the Rationing of Health Care* is successful in advocating that public law should to operate in both a practical and a theoretical arena. Syrett is an organized writer who has skillfully arranged his material for maximum impact. While the more theoretical arguments are essential, the practical applications prove to be more compelling. After reading through the entire book, though, this reader felt like his treatment of the cases in Canada and South Africa could have been more detailed. I was immediately drawn to the Herceptin case study by the way Syrett set up the story, the medicine, and the involvement of the media. I would have liked to see a similar approach taken in the *TAC* (South Africa) and *Caoulli* (Canada) cases by adding them to the introduction of the book. By failing to include these anecdotes, the author may have missed an opportunity to lay a foundation concerning the cultural, legal, and societal considerations that come into play in South Africa as opposed to England and Canada. It was of great benefit, when reading the analysis of the British jurisprudence, to have a kind of "background" already in place, as our American common law tradition was inherited from the British. When the discussion moved to Canada and South Africa, many readers will be left with no foundation from which to build.

I would recommend this book as a thoughtful and comprehensive overview of the policy, theory, and practice of law concerning health resource rationing decisions. Sryett is a very organized writer, and does an excellent job of promoting his position

[34] *Id.* at 178 (emphasis in original).
[35] *Id.*
[36] *Id.* at 243.

through considering both its strengths and shortcoming. His book provides an interesting window into other treatments of human rights claims and a comparative presentation of other nations' approaches for those who are focused in the area of public or constitutional law. It also presents a useful typology of resource rationing and broadly considers the issues that politicians and providers face when determining how to present the rationing choices for those interested in public health law. Finally, the book presents a balanced consideration of benefits and drawbacks of judicial deference and of judicial activism. I recommend it to anyone that has a strong interest in health care policy, and in what type of role the law should play in determining health care priorities.