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

Full text of the judgment of the Appeals Court

July 29th, 1999

Foreword

North West Lancashire Health Authority is not the only one to have adopted a policy of not funding medical treatment for trans people.

However, this was the first challenge to such a policy where the issue was decided by a court — with a judgment in favour of the three trans women applicants, issued by the High Court in December 1998. The Health Authority later appealed, and in July 1999 the Appeals Court upheld the High Court ruling. The case received extensive press coverage.

The result of tthis case is that it is now illegal for a Health Authority to impose a blanket ban on funding medical treatment for the purposes of gender reassignment.

Note: the assertion in this judgment that the Charing Cross clinic is the only facility in this country for the treatment of transsexualism is incorrect. Although Charing Cross is the biggest such clinic, there are several other NHS centres around the UK which provide treatment for the purposes of gender reassignment, the largest of which is in Leeds. There are also widely-used private-sector facilities.

Claire McNab, August 1999

Judgment

Case No: QBC 1999/0226/4
QBC 1999/0228/4
QBC 1999/0230/4

IN THE SUPREME COURT OF JUDICATURE
COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM MR. JUSTICE HIDDEN
SITTING IN THE QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London,
WC2A 2LL

Thursday 29th July 1999

B e f o r e
LORD JUSTICE AULD
LORD JUSTICE BUXTON
LORD JUSTICE MAY

BETWEEN:

NORTH WEST LANCASHIRE HEALTH AUTHORITY

Appellant

AND:

A, D & G

Respondents

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(Transcript of the handed down judgment of
Smith Bernal Reporting Limited, 180 Fleet Street,
London EC4A 2HD
Tel: 0171 421 4040
Official Shorthand Writers to the Court)

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MR D PANNICK QC and MR G CLARKE (Instructed by Hill Dickinson, Liverpool) appeared on behalf of the Appellant

MR N BLACK QC and MISS S HARRISON (Instructed by Tyndallwoods, Birmingham) appeared on behalf of the Respondent

J U D G M E N T

(As approved by the Court)

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LORD JUSTICE AULD: These are appeals by the North West Lancashire Health Authority against the order of Hidden J. on 21 December 1998 quashing its decisions refusing to fund gender reassignment surgery for A, D and G and its policy on which it based those decisions.

A, D and G suffer from an illness called "gender identity dysphoria", commonly known as transsexualism. Each was born with male physical characteristics, but psychologically has a female sexual identity. Each has been living as a woman for some years. At the material time A and G had each been diagnosed by a specialist consultant to have a clinical need for surgery substituting female for male characteristics, a procedure known as "gender re-assignment surgery". D was awaiting assessment of suitability for such surgery. They all challenge the Authority's refusal to fund their treatment, including surgery, under the National Health Service because of its policy not to do so in the absence of "overriding clinical need" or other exceptional circumstances. They maintain that they are ill and that the Authority's policy, and refusals pursuant to it, to fund treatment for them are irrational. The Authority justifies its policy and refusals on the ground that it has a statutory obligation to care for all within its area and limited financial resources with which to do so, requiring it to give a lower priority to some medical conditions than to others and that transsexualism rightly has a low priority.

Before I turn to the Authority's policy and put it in the context of its statutory duty to provide medical care for all within its area, I should say something about the facilities for and scheme of treatment of persons seeking this sort of treatment. I take this from the unchallenged evidence of a number of leading experts on the treatment of transsexuals put on behalf of the respondents before Hidden J., and which he accepted. There is only one specialist clinic in the country, the Gender Identity Clinic in the Charing Cross Hospital in London. Patients suspected of suffering from transsexualism are normally referred to the Clinic for diagnosis and appropriate treatment from all over the country. The starting point for anyone seeking treatment is a period of consultation with a specialist there to diagnose his or her condition and to assess suitability for treatment. If considered suitable, this may be followed by a course of administration of hormones and psychiatric "monitoring" and a period of living and working as a woman ("the real life test") and, finally, in appropriate cases by surgery. All this may take up to two years or more.

The Authority has no comparable facilities or consultant psychiatrists with similar specialist expertise. If it were to accept responsibility for funding such treatment for a patient within its area, it would have to do so by making an "extracontractual referral" to the Charing Cross Clinic. And the Clinic will normally only accept a patient for that course of treatment against a commitment from the Authority that it will meet the cost of surgery should it prove necessary. In 1995 the cost of surgery was at least £8,000. Transsexualism is a rare condition and only a small number of patients accepted by the Charing Cross Clinic for preparatory counselling, hormonal treatment and monitoring ever reach the stage of surgery.

In 1995 the appellant Authority succeeded the Blackpool Health Authority on its amalgamation with another Authority. Until then the Blackpool Health Authority had funded gender reassignment treatment where a local consultant psychiatrist recommended that it was necessary. In 1993/94 it had referred 13 patients to the Charing Cross Clinic. As will appear, the Authority in 1995 adopted a new highly restrictive policy against such referral, and since then has made no referrals.

The Authority's statutory obligations

The National Health Service Act 1977, by section 1(1), imposes on the Secretary of State a 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 of the people of those countries, and
(b) in the prevention, diagnosis and treatment of illness, and for that purpose to provide or secure the effective provision of services in accordance with this Act."

In section 3, it elaborates on that duty by obliging him -

"… to provide … to such extent as he considers necessary to meet all reasonable requirements- …
(e) such facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as he considers are appropriate as part of the health service;
(f) such other services as are required for the diagnosis and treatment of illness."

It is important to note the qualifications in those provisions, as this Court observed in *R v. North & East Devon Health Authority, ex p. Coughlan* 16th July 1999 (unreported), at page 8 of the transcript. The first is that section 1(1) does not oblige the Secretary of State to provide a comprehensive health service, but "to continue to promote" such a service. The second and third are that section 3 limits his duty of provision of services "to such extent as he considers necessary to meet all reasonable requirements", and, in the case of the facilities referred to in (e), to those "he considers are appropriate as part of the health service".

The 1977 Act provides, by section 13, that the Secretary of State may direct a Regional Health Authority to exercise those functions and that the Authority has a duty to comply with such direction. The Secretary of State, by the National Health Service (Functions of Health Authorities and Administration Arrangements) Regulations 1996 (1996 No. 708), has directed that the appellant and other Regional Health Authorities shall exercise the functions in sections 1 and 3 of the Act, thus imposing on them the duty to provide

"to such extent as [it] considers necessary to meet all reasonable requirements … such … services as are required for the diagnosis and treatment of illness".

The Act, in section 128, defines the word "illness" as including "mental disorder within the meaning of the Mental Health Act 1983 and any … disability requiring medical … treatment or nursing". It is common ground for the purpose of this appeal that transsexualism is an illness in the nature of a mental disorder for the purposes of sections 1 and 3.

The qualifications in the statutory duties imposed by the 1977 Act to which I have referred make plain that it is for the Authority to judge what services it should provide, and to what

extent, to meet all reasonable requirements for them. In *Coughlan* the Court said as to the originating and corresponding obligations of the Secretary of State, at page 9 of the transcript:

"25. When exercising his judgment he has to bear in mind the comprehensive service which he is under a duty to promote as set out in section 1. However, as long as he pays due regard to that duty, the fact that the service will not be comprehensive does not mean that he is necessarily contravening either section 1 or section 3. The truth is that, while he has the duty to continue to promote a comprehensive free health service and he must never, in making a decision under section 3, disregard that duty, a comprehensive health service may never, for human, financial and other resource reasons, be achievable. Recent history has demonstrated that the pace of developments as to what is possible by way of medical treatment, coupled with the ever increasing expectations of the public, mean that the resources of the NHS are and are likely to continue, at least in the foreseeable future, to be insufficient to meet demand.

26. In exercising his judgment the Secretary of State is entitled to take into account the resources available to him and the demands on those resources. In *R v. Secretary of State for Social Services and Ors ex parte Hincks* [1980] 1 BMLR 93 the Court of Appeal held that section 3(1) of the Health Act does not impose an absolute duty to provide the specified services. The Secretary of State is entitled to have regard to the resources made available to him under current government economic policy."

The Authority's policy

In 1995 the Authority adopted a policy allocating a low priority for public funding of procedures it considered to be clinically ineffective in the sense of achieving no or little clinical gain. It was entitled "Medical Procedures Of No Beneficial Health Gain Or No Proven Benefit". It referred, in paragraph 1.1, to its predecessors' policies, under the then "internal market" system, to provide "more effective health care", to "promote effective health gain, rather than … ineffective health care", and of "a limited number of procedures where there should be restrictions on the level of care purchased, or procedures which should not be purchased at all … subject to overriding clinical need". In paragraph 2, under the heading "Background", it set out the Authority's thinking as to what would normally qualify as "effective" health care, that is, medically effective rather than the broader notion of effective allocation of medical resources:

"2.1 … doctors have been carrying out for many years a wide range of medical procedures only marginally related to the promotion of health gain.

2.2 … a wide variety of medical procedures currently in use within the NHS cannot be demonstrated in research trials to have any clinical effectiveness. The NHS Executive has, therefore, urged health authorities to reallocate purchasing priorities to promote the use of more effective treatments at the expense of those which are of no proven benefit.".

Paragraph 2 continued by referring to the sometimes conflicting demands of restrictions on resources and the desire to allow doctors a wide range of clinical judgment, and provided that the Authority should follow the path of other authorities in rationing some services "on social rather than medical grounds".

The Authority set out in paragraph 4.1 a number of procedures which it had identified, after consultation, as falling into the lowest 10% in terms of priority for treatment and which it would not provide "except in cases of overriding clinical need". They included, along with

gender reassignment, cosmetic plastic surgery, reversal of sterilisation, correction of shortsightedness, all forms of alternative medicine undertaken outside the National Health Service and homeopathy "except when the effectiveness of the treatment has been scientifically proven and accepted by a substantial and appropriate body of medical opinion". In the case of gender reassignment, it drew a further distinction, in paragraph 4.3 and resolution (iv), between treatment provided by it and outside its area: "Gender reassignment (surgical treatment and/or specialist counselling outside the District) will not be purchased".

In 1998 the Authority revised its 1995 policy "in the light of two further years of corporate experience and healthcare development". The revision expressed an increased emphasis on the "appropriateness" of treatment for public funding in addition to its medical "effectiveness". It provided, under the heading "Appropriate, effective and cost effective health care":

"2.1 Interventions on the human body are not always related to ill health, but may be related to a desire to achieve an ideal body image or a bodily function that cannot currently be achieved. This is complicated by the fact that their supporters often describe the desire for intervention in medical terminology, and indeed point out that a 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 the resources are used <u>appropriately</u>."

Then, in paragraph 2.2, it set out four possible categories of "[h]ealth care interventions. One of them was for procedures which had not been tested by carefully conducted scientific research and where it was uncertain whether the interventions are effective, ineffective or harmful. The Authority, in its evidence to Hidden J. placed gender reassignment surgery in that category. Such procedures, the Policy stipulated, "should be commissioned only with caution, preferably as part of a formal evaluation" to ensure that resources were used "effectively". The paragraph then concluded with this further cautionary restraint:

"2.3 The fact that a service is effective and appropriate still does not mean that it represents a good use of NHS resources. It may produce only a small and unimportant improvement in health. It may produce benefits for only a small number of people. Its uncontrolled use may consume resources that could more appropriately be used for other patients. In such circumstances, protocols and service agreements, supported by clinical judgments will ensure that the service is available to patients who can expect to achieve the greatest benefits. They will also ensure that the service does not consume resources excessively relative to competing priorities. Resources will thus be used <u>cost effectively</u>."

Paragraph 3, under the heading "Health care that will not be commissioned or which will be commissioned only with restrictions", included gender reassignment along with a number of other procedures including "alternative medicine", surgery for varicose veins, various forms of cosmetic healthcare such as plastic surgery, tattoo removal, face lift and hair transplantation, and reversal of sterilisation. Paragraph 3.11, in setting out the specific restrictions applicable to gender reassignment, in truth almost completely excludes it as a candidate for treatment:

"**Gender reassignment** Persons wishing to adopt the role of the opposite gender … have access to the general psychiatric and psychological services available within the contract portfolio. However, no such service will be commissioned extra-contractually. The Health 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, a diagnosis of a gender identity disorder … 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…."

The second paragraph in that passage indicates, somewhat obliquely, the possibility of some exception to the almost complete ban in the first paragraph. And paragraph 5.1, under the heading "Exceptions", underlines how limited the Authority intended it to be:

" … the Director of Public Health and Health Policy is authorised to consider exceptions to this policy on the basis of overriding clinical need. Such exceptions will be rare, unpredictable and will usually be based on circumstances that could not have been predicted at the time when the policy was adopted. They cannot therefore be defined. However, except when indicated otherwise above, the following circumstances may contribute to a case for exceptional funding:
i) When there is evidence (including consultant advice) that the problem is the cause of serious mental illness, which can be expected to be substantially improved if the exception is granted. (This must be distinguished from the disappointment and reactive depression resulting from ineligibility for treatment, which would not be regarded as exceptional). …"

Thus, the only material illustration in the Policy of the degree of overriding clinical need that might justify an exception is serious mental illness which the treatment could be expected substantially to improve.

The Authority has established a machinery for considering exceptions to those forms of health care that it will not normally provide or which it will provide only subject to restrictions. It is contained in a policy document adopted in 1997. It provides that, in general, the onus is on the referring practitioner to provide the Authority with the information necessary to enable it to determine whether the circumstances of the patient concerned "constitute[s]a 'special case' and a justifiable exception to the policy". It delegates the function of so determining in each individual case to its Director of Public Health & Health Policy. In the event of a patient or a "relevant clinician" disagreeing with the Director's decision, the Policy requires the matter to be referred to a panel consisting of himself, the Authority's Chief Executive, a non-executive director and a general practitioner member of the Authority's Commissioner Body. The function of the panel is to discuss the case and "to ensure that all the necessary information has been taken into account by the Director … in reaching his decision".

The decisions challenged

In 1996 and 1997 the Authority refused the three respondents' requests for funding for extra-contractual referral to the Charing Cross Clinic for diagnosis and gender reassignment treatment. It did so in each case pursuant to its 1995 Policy and notwithstanding recommendations from psychiatric consultants of their suitability for treatment, their own expressions of distress and depression at their inability to obtain it otherwise than through the National Health Service, and, in A's case, her assertion that the resultant stress had caused her to develop epilepsy. In early 1998 panels constituted under the 1997 Policy considered the respondents' "appeals" and recommended their dismissal, the recommendation in each being in similar terms. They reported to the Authority that they had considered: its 1995 and 1998 Policies and a summary of the circumstances and of the information provided by the respondent, her general practitioner and/or consultant psychiatrist and her solicitor. Each panel expressly recorded that they had not considered the cost of treatment or the

appropriateness of the Authority's policy. Their conclusions in each case were: 1) that there were no exceptional clinical features (and that, in A's case, her claim of epilepsy was not substantiated by any medical report and the Authority's medical advisers considered that transsexualism could not be a cause of epilepsy); and 2) that, accordingly, there was no reason to override the Authority's normal policy of refusal of gender reassignment treatment In each case the Authority acted on the panel's recommendation and confirmed its refusal to fund the sought treatment.

The evidence

The Authority put evidence before Hidden J. in support of its policy and its application of it in the respondents's cases in the form of affidavits of Dr. Anthony Sudell, its consultant in public health medicine (the author of the proposal document giving rise to the 1998 Policy) and of Dr. Christopher Harrison, its Director of Public Health and Health Policy.

Dr. Suddell stated that: the Authority had limited resources and many demands on them; it had to try to make the best use of them in order to comply with its statutory duty to provide or secure the effective provision of services for all in its area for whom it is responsible; it followed that it had to consider both its obligation to patients generally as well as to-each patient individually; and, in doing so, it had a responsibility, so far as possible, to keep within its resources; it could not afford all services of proven effectiveness, so had to make difficult decisions; no treatment was absolutely excluded; claims for treatment as exceptional cases were considered and decided individually on their clinical merits and without regard to the cost of the requested treatment. He also emphasised that the case of each respondent was considered on its individual merits. In his description of the 1998 Policy he included gender reassignment treatment among those procedures which the Authority would not normally commission "predominantly on grounds of appropriateness". Later, he also expressed reservations as to its "effectiveness".

As to "appropriateness", the Authority's Policies and Dr. Sudell's elaboration of them indicate that it did not normally regard it as appropriate to fund such treatment however effective it might be. Thus, Dr. Sudell in considering the possible bases on which an individual might be able to establish an exceptional clinical need for gender reassignment treatment, stated:

"31. … there are certain services in respect of which it is difficult to imagine what an exceptional clinical need for services might be. For reasons which I indicate below, one such service is gender reassignment. This does not detract from the consideration of each individually on its merits."

As the three respondents' applications were the only gender reassignment cases which the Authority had been asked to fund as an exception to its Policy, Dr. Sudell sought to give an indication of what might amount to an exception in respect of this and other conditions. He referred to "substantial evidence of serious psychiatric pathology", by which he meant Neither a psychotic illness in which the patient has lost touch with reality or a serious current and depressive illness, which he equated with "a disease". He contrasted such a condition with "a depression resulting from a loss or disappointment", which would not qualify. Later, when dealing with the individual cases of the respondents - and in accord with paragraph 5.1i) of the 1998 Policy - he expressed the threshold of appropriateness as one of proof of "serious mental illness". "Consequently", he stated "the … Authority does not regard 'gender dysphoria' a serious psychiatric pathology" or, as he put it in a second affidavit, "a disease".

Thus, according to Dr. Sudell, despite the Authority's apparent acceptance in these proceedings that transsexualism is an illness, it is unlikely to qualify as an exception to the Policy because it is not a serious illness. l refer to the Authority's "apparent" acceptance of the condition as an illness because, as I have indicated, both its 1995 and 1998 Policies bracketed it with such procedures as tattoo removals, face lifts, hair transplantations and reversal of sterilization; and Dr. Sudell, in the following paragraphs of his first affidavit, reveals a degree of scepticism about the medical nature of the condition:

"42. It is the view of the … Authority (paragraph 2 of the 1998 Policy) that 'interventions on the human body are not always related to ill health, but may be related to a desire to achieve an ideal body image or a bodily function that cannot currently be achieved. This is complicated by the facts that their supporters often describe the desire for intervention in medical terminology'.

43. Consequently, although a condition is recognised by a group of medical practitioners the … Authority would not necessarily regard this as giving it the status of a disease.

44. The … Authority's view is that the comments above apply to gender dysphoria, and therefore that treatment for gender dysphoria is not a condition for which … Authority funded treatment is appropriate. However, psychological distress (which may result from difficulties with gender identity) may be appropriate for … Authority funded treatment, and therefore the … Authority is willing to commission support for such cases within its contracts." [namely, for limited consultation of local practitioners with a view to acceptance of their condition - see below]

Dr. Sudell's second position was that, even if the Authority were to regard transsexualism as a condition appropriate for treatment, it would not fund treatment leading to and including surgery because there was uncertainty about the effectiveness of surgery in two respects. First, in his general indication of what might qualify as an exception - and in accord with paragraph 5.1 i) of the 1998 Policy - he stated that the Authority would require "evidence that the procedure would produce a clinically significant and sustained improvement in the psychiatric condition". He contrasted it with surgery in most cases of illness in that it destroyed healthy, not unhealthy, organs, and expressed the belief that the correct medical strategy would be "to attempt to treat the alleged disease by helping the patients to accept their biological gender". Second, he doubted the accuracy of medical literature indicating a success rate of nearly 88% of reassignment surgery from male to female gender. He pointed to the absence of any controlled randomised studies comparing the outcomes for patients who had and who had not received surgery; he suggested the possibility of bias on the part of those responsible for the medical literature; and he maintained that it did not indicate what the long term results of surgery might be.

Dr. Sudell's reservations on these matters was challenged by a large body of evidence on affidavit and in written statements from leading experts on the subject relied on by the respondents. They included Dr. Ludovicus Gooren from the Netherlands, Professor Russell Reid from the Hillingdon Hospital, Professor Richard Green of the Charing Cross Hospital and a number of other consultant psychiatrists. First, they made the critical point that to consider gender reassignment surgery as simply the removal of healthy organs was to overlook the Authority's ostensible acknowledgement that, healthy organs or no, a transsexual was ill and could remain ill without their removal. Second, they stated with some vehemence that psychotherapy to reconcile transsexuals to their biological gender is inappropriate and ineffective treatment for patients who have satisfied the "real life test". Some stated that to attempt it in such circumstance would be professionally negligent. They

all asserted that hormonal and surgical treatment was recognised as the only suitable and effective treatment for the condition.

Dr. Sudell turned finally to the question of priority, making the obvious and valid point that the Authority had to make many difficult decisions about the allocation of its limited resources between many competing demands, and, in doing so, had to establish priorities for funding. He stressed, in his second affidavit, the Authority's obligations to the general public for whose care it was responsible as well as the interests of each individual applicant for funding. He confirmed what is apparent from both the 1995 and 1998 Polices, that "gender reassignment surgery is considered by the … Authority to be of a low priority".

Dr. Harrison illustrated the severe financial problems for the Authority in making adequate provision for life-threatening and other really serious illnesses, such as heart disease, cancer, kidney disease requiring dialysis, HIV and AIDS and severe osteo-arthritis requiring joint replacements. He contrasted such clearly urgent and substantial demands on the Authority's resources with those of gender reassignment treatment and, more recently, prescription of the drug Viagra for impotence. Toward the end of his affidavit he stated:

"9. The point that I am seeking to make here is that, whilst the Health Authority sympathises with the Applicants, as it does with all those who are experiencing health problems of one kind or another, it has to make judgments as to which services take priority over others. Where a service is considered, albeit reluctantly, to be of such low priority that it should not normally be commissioned, the … Authority has delegated to me authority to consider whether individual patients can be considered as exceptions. I have to, and do, judge each case on its merits by reference to the framework of the authority's clearly stated policy."

Hidden J's judgment

Hidden J. recorded and accepted the parties' agreement and evidence that transsexualism is an illness for which the Authority was obliged to have regard in its duty under section 1 of the 1977 Act "to continue the promotion … of a comprehensive health service" within its area. After fully and carefully rehearsing the competing submissions of counsel for the parties, he noted the guidance given by Sir Thomas Bingham MR in *R v. Cambridge Health Authority, ex p. B* [1995] 1 WLR 898, at 906D-H, that it was for the Authority, not the court, to allocate resources within its limited budget to the best advantage of its many patients. He then found for the applicants in the following brief passage:

"… 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 am satisfied that the respondent's decisions … 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 … Or transsexualism. Those decisions were equally arrived at by consideration of irrelevant matters. 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."

The Judge's order, as expressed, was simply to quash the "decision/policy" of the Authority.

The issues and the submissions

The starting point, as Hidden J. indicated, is that a health authority has a discretion how to allocate its finite budget. In the *Cambridge Health Authority* case Sir Thomas Bingham MR said, at 906ED-E:

"It is common knowledge that health authorities of all kinds are constantly pressed to make ends meet. The cannot pay their nurses as much as they would like; they cannot provide all the treatments they would like; they cannot purchase all the extremely expensive medical equipment they would like; they cannot carry out all the research they would like, they cannot build all the hospitals and specialist units they would like. 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."

Those general considerations are now reinforced by the passages from this Court's judgment in *Coughlan* that I have set out earlier.

Mr. David Pannick, QC, on behalf of the Authority, put those considerations at the forefront of his argument. He referred to the limits on the Authority's resources, the many demands on them, the need to establish priorities and apply them subject to the individual circumstances of each case, and the difficult decisions in that context it had to make. He maintained that the Authority was entitled to give gender reassignment treatment a low priority, having regard both to its assessment of its position in the scale of importance of illnesses for which it had to provide ("appropriateness") and also to its uncertainty as to the effectiveness of hormonal treatment and surgery in producing a healthy outcome. He submitted that the Authority's policy of recognition of transsexualism as an illness, but rating it low in its list of priorities for demands on its finite resources was rational.

He submitted that the Authority's policy in allowing for exceptions to be made where the circumstances justified them in individual cases, but without prescribing the qualifying circumstances, and of considering each of the respondents' cases on their individual merits was also rational, relying on the observations of Bankes LJ in *Rex v. Port of London Authority, ex p. Kynoch Ltd.* [1919] 1 KB 176, CA, at 184, and of Lord Reid in *British Oxygen Co. Ltd. v. Board of Trade* [1971] AC 610, at 625D-E. He submitted that, on the affidavit evidence of Drs. Sudell and Harrison and the documentary material before Hidden J., it was plain that the Authority had considered the circumstances of each individual case on its merits in considering whether it could regard it as an exception to it policy.

Mr. Nicholas Blake, QC, for the Respondents, submitted that the Authority's Policy was irrational and that it unlawfully fettered its discretion. Stripped of legalese, his complaint was that the Authority, in the formulation and application of its policy, demonstrated an inadequate understanding of the nature of transsexualism. He prefaced his submissions by making the point that, although the Authority is exercising delegated powers of the Secretary of State under sections 1 and 3 of the 1977 Act in its area, it must nevertheless give effect to the overall purpose declared in section 1 of promoting an improved comprehensive service

throughout England and Wales for the prevention, diagnosis and treatment of illness. He accepted that it was for each Regional Health Authority and its medical advisers to devise a policy of priorities for the treatment of illnesses of various sorts and severity. However, he submitted that policies should be sufficiently flexible as not to impose a "blanket" denial of treatment even where in individual cases a clinical need for it could be demonstrated. Otherwise, he submitted, entitlement to treatment would depend on where patients live — "post-code rationing" — an outcome clearly contrary to the object of the 1977 Act.

Mr. Blake argued that a necessary starting point in all cases where some priority "rationing" of limited resources is required is a proper understanding of the needs of the patient and of the effectiveness of available treatment. He submitted that the Authority's Policies and its elaboration of them in evidence before Hidden J. demonstrated that it did not understand the nature of transsexualism, its treatability or the consequences of failure to treat it.

As to the appropriatenesss of the condition for treatment, Mr. Blake maintained that unless the Authority has properly directed itself by reference to the consensus of medical opinion on the matter, it could not begin to make an informed decision as to priority. Its fundamental failure of understanding, he submitted, was in according transsexualism, an acknowledged mental illness, the same low level of priority for treatment as cosmetic concerns and choices of life style which were plainly not illnesses. It followed, he reasoned, that for the Authority to single it out, as it did in its 1995 and 1998 Policies, as treatment which it would not purchase outside its area, subject to what seemed to be little more than a theoretical possibility of an applicant establishing an overriding clinical need for it, amounted effectively to a complete embargo on it, which was irrational.

As to the effectiveness of treatment, he criticised the Authority's stance indicated by Dr. Sudell that psycho-therapy to reconcile transsexuals to their condition was as or more effective than hormonal treatment and/or surgery. He submitted that such an approach was irrational in that it defied the widely and well established consensus of medical opinion and literature to the contrary - amply documented in evidence before Hidden J. - that the only effective treatment, depending on the individual case, is a combination of psychiatric evaluation and monitoring, cross-gender living and/or hormonal treatment possibly culminating in surgery. He referred to the recognition of such widely held medical opinion in our own jurisprudence (see e.g. *Corbett v. Corbett* [1970] 2 All ER 33, per Ormrod J at 42c-43A) and in a number of cases in the European Court of Human Rights (see e.g. *Cossey v. UK* [1991] 13 EHRR 622). He also referred to a Department for Education and Employment guide to the Sex Discrimination (Gender Reassignment) Regulations 1999 (1999/1102), published in February 1999, recording a 97% success rate for such treatment. He maintained, therefore, that this is not a case where the Court is asked to resolve a dispute by reference to the test in *Bolam v. Friern Barnet Hospital Management Committee* [1957] 1 WLR 582 where two responsible bodies of medical opinion skilled in the particular treatment in question may have different views. He submitted that, on the evidence before Hidden J., Dr. Sudell's view, not that of an expert in the treatment of transsexuals, is contrary to the only identified body of competent medical opinion on the issue.

Mr. Blake also criticised the Authority's policy by reference to the less restrictive practices of most other Regional Health Authorities in England & Wales. On Dr. Sudell's own evidence before Hidden J., at least 34 out of 41 other Authorities make some form of provision for funding it, including surgery; 13 of those will usually fund it without individual consideration, subject to assessment of suitability; 14 consider each case individually or apply their extra-contractual referral procedures, most funding every case assessed as suitable

for treatment, though a few giving it a low priority; 7 do so up to a fixed maximum number of cases per year; and 7 have similar policies to that of the Authority.

General principles

As illustrated in the *Cambridge Health Authority* and *Coughlan* cases, it is an unhappy but unavoidable feature of state funded health care that Regional Health Authorities have to establish certain priorities in funding different treatments from their finite resources. It is natural that each Authority, in establishing its own priorities, will give greater priority to life-threatening and other grave illnesses than to others obviously less demanding of medical intervention. The precise allocation and weighting of priorities is clearly a matter of judgment for each Authority, keeping well in mind its statutory obligations to meet the reasonable requirements of all those within its area for which it is responsible. It makes sense to have a policy for the purpose — indeed, it might well be irrational not to have one — and it makes sense too that, in settling on such a policy, an Authority would normally place treatment of transsexualism lower in its scale of priorities than, say, cancer or heart disease or kidney failure. Authorities might reasonably differ as to precisely where in the scale transsexualism should be - placed and as to the criteria for determining the appropriateness and need for treatment of it in individual cases.

It is proper for an Authority to adopt a general policy for the exercise of such an administrative discretion, to allow for exceptions from it in "exceptional circumstances" and to leave those circumstances undefined; see *In re Findlay* [1985] 1 AC 318, HL, per Lord Scarman at 335H-336F. In 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, provided that the policy genuinely recognises the possibility of there being an overriding clinical need and requires each request for treatment to be considered on its individual merits.

However, in establishing priorities - comparing the respective needs of patients suffering from different illnesses and determining the respective strengths of their claims to treatment - it is vital for an Authority: 1) accurately to assess the nature and seriousness of each type of illness; 2) to determine the effectiveness of various forms of treatment for it; and 3) to give proper effect to that assessment and that determination in the formulation and individual application of its policy.

Conclusions

As I have said, the Authority has acknowledged in its evidence before Hidden J and in its stance on this appeal that transsexualism is an illness. But its recognition of it in its two Policies is at best oblique and lacks conviction. Indeed, both Policies, read together and as a whole, and Dr. Sudell's elaboration of them strongly indicate that the Authority does not really believe it. The inclusion of transsexualism in the 1995 Policy, which was concerned only with medical procedures which the Authority regarded as of "[n]o beneficial health gain or no proven benefit", and bracketing it with cosmetic plastic surgery and the like are testament to that. The same attitude is evident in the 1998 Policy in its introductory references in paragraph 2, under the heading of "Appropriate, effective and cost effective health care", to "interventions on the human body … not always related to ill health", and again bracketing it with cosmetic surgery and other comparable treatments as "[h]ealth care that will not be commissioned, or … only with restrictions". If there were any doubt about the Authority's true attitude to the condition, it is removed by paragraphs 42 to 44 of Dr. Sudell's affidavit, which I have set out, clearly evidencing its scepticism of the notion that

transsexualism is an illness worthy of medical attention beyond psychiatric reassurance. Where evidence from the policy maker is of a piece with and has as its purpose elaboration of the policy under challenge, it is clearly relevant and capable of throwing light on the true nature of the policy (cf. *R v. Westminster City Council, ex p. Ermakov* [1996] 2 All ER 302, CA., where the Court regarded as exceptional recourse to evidence the purpose of which was to rescue a flawed decision).

It may be that there is some medical support for such scepticism, despite the apparently overwhelming evidence before Hidden J. that transsexualism is an illness which requires treatment. I say nothing about the scope for debate between doctors on the matter. I do not need to do so because the Authority accepts in these proceedings that it is an illness. It follows that its Policies should, but do not, properly reflect that medical judgment and accord the condition a place somewhere in the scale of its priorities for illnesses instead of relegating it to the outer regions of conditions which it plainly does not so regard.

That basic error, one of failure properly to evaluate such a condition as an illness suitable and appropriate for treatment, is not mitigated by the allowance in both Policies for the possibility of an exception in the case of overriding clinical need or other exceptional circumstances. As I have said, such a provision is not objectionable, but it is important that the starting point against which the exceptional circumstances have to be rated is properly evaluated and that each case is considered on its individual merits, see: per Bankes LJ in *R v. Port of London Authority, ex p. Kynoch Ltd.*, at 184; per Lord Reid in *British Oxygen Co. v. Board of Trade*, at 624G-625A; and per Lord Scarman in *re Findlay*, at 335H-336F. The Authority's relegation of what was notionally regarded as an illness to something less, in respect of which an applicant for treatment had to demonstrate an overriding clinical need for treatment, confronted each respondent with a very high and uncertain threshold.

The 1995 Policy gave no indication of what might amount to an overriding clinical need or other exceptional circumstances; nor did the 1998 Policy, save in paragraph 5.1 in which it emphasised the likely rarity and unpredictability of such circumstances, and instanced as a possibility when "the problem" … was the cause of serious mental illness. Expert assessment that a patient needs the treatment would not do; demonstration of the existence of some other illness was a necessary condition for consideration for treatment. The Authority gave a hint in its consideration of the case of A that epilepsy caused by her untreated transsexualism, if established, might have qualified. But, given the Authority's reluctance to accept gender reassignment as an effective treatment for transsexualism - and it would follow logically any condition caused by it - the provision for an exception in a case of "overriding clinical need" was in practice meaningless, as Mr. Blake observed. It was as objectionable as a policy which effectively excluded the exercise by the Authority of a medical judgment in the individual circumstances of each case; cf. *R v. Secretary of State, ex p. Pfizer Ltd.* 26th May 1999 (unreported), per Collins J at page 10 of the transcript of his judgment. Looked at in that light, Dr. Sudell's observation in paragraph 31 of his first affidavit that it was "difficult to imagine what an exceptional clinical need for" gender reassignment might be, is understandable.

I accept, of course, that it is a matter for the medical judgment of the Authority, not the Court, what, if any, effective medical treatment there might be for transsexualism and any sequelae. As Sir Thomas Bingham MR said in the *Cambridge Authority* case, at 905A-B:

" … the courts are not, contrary to what is sometimes believed, arbiters as to the merits of cases of this kind. Were we to express opinions as to the likelihood of the effectiveness of medical judgment, then we should be straying far from the sphere which under our

constitution is accorded to us. We have one function only, which is to rule upon the lawfulness of decisions. That is a function to which we should strictly confine ourselves."

However, if a Regional Health Authority devises a policy not to provide treatment save in cases of overriding clinical need, it makes a nonsense of the policy if, as a matter of its medical judgment, there is no effective treatment for it for which there could be an overriding clinical need. The same applies to any other condition caused by transsexualism such as a mental illness of the seriousness described by Dr. Sudell. If the Authority considers the cause of such a condition to be untreatable by hormonal treatment and surgery, it is hard to see how it could regard the condition itself as an overriding need for such treatment.

In my view, the stance of the Authority, coupled with the near uniformity of its reasons for rejecting each of the respondents' requests for funding was not a genuine application of a policy subject to individually determined exceptions of the sort considered acceptable by Lord Scarman in *Findlay*. It is similar to the over-rigid application of the near "blanket policy" questioned by Judge J in *R v. Warwickshire County Council, ex p. Collymore* [1995] ELR 217, at 224-226,

"which while in theory admitting of exceptions, may not, in reality result in the proper consideration of each individual case on its merits."

In that case the implementation of the policy, not the policy itself, was quashed, Judge J. considering it unnecessary to decide whether the latter was unlawful. The policy there and that in this case are not so obviously unlawful as that in *R v. London Borough of Bexley, ex p. Jones* [1995] ELR 42, where it effectively admitted no exceptions by reference to individual circumstances. Nevertheless, it has the same basic flaw both in form and application. Leggatt LJ said, at 55:

"It is … Legitimate for a statutory body … to adopt a policy designed to ensure a rational and consistent approach to the exercise of a statutory discretion in particular types of case. But it can only do so provided that the policy fairly admits of exceptions to it. In my judgment, the respondents effectually disabled themselves from considering individual cases and there has been no convincing evidence that at any material time they had an exceptions procedure worth the name. There is no indication that there was a genuine willingness to consider individual cases"

Accordingly, given the Authority's acknowledgment that transsexualism is an illness, its policy, in my view, is flawed in two important respects. First, it does not in truth treat transsexualism as an illness, but as an attitude or state of mind which does not warrant medical treatment. Second, the ostensible provision that it makes for exceptions in individual cases and its manner of considering them amount effectively to the operation of a "blanket policy" against funding treatment for the condition because it does not believe in such treatment.

I was at first attracted to Mr. Pannick's alternative submission that, even if the Authority had not properly evaluated the condition of transsexualism, it could, in its allocation of priorities of funding from its finite resources, have lawfully assessed it as not normally worthy of funding and not an exceptional case for treatment in any of the respondents' cases. He suggested that even if the Authority were to reformulate its Policy to meet the concerns that I have indicated, there is an inherent unlikelihood of a different result. In such a circumstance, he submitted, the Court should not interfere with the decisions. He relied upon Sir Thomas Bingham MR's additional reason in the *Cambridge Authority* case, at 907C-D, for not

disturbing its refusal to fund treatment, that it "could, on a proper review of all the relevant material, reach the same decision that it had already reached".

As Mr. Pannick also submitted, the fact that each of the respondents may have had a clinical need for treatment would not render unlawful the application of a properly formulated policy refusing them treatment if they could not show some additional element in the form of "an overriding clinical need" or otherwise. However, my view is that, as the Authority has not genuinely taken as its starting point in the case of each respondent that her condition is or may be an illness worthy and capable of effective treatment, it would be wrong for the Court to assume the Authority's task. That must remain a matter for it both as a matter of medical judgment in the setting of priorities, the allocation of funds to those priorities having regard to its finite resources and in its provision for exceptions in individual cases.

For those reasons I would quash the Authority's 1995 and 1998 Policies insofar as they concern gender reassignment treatment and the decisions the subjects of this appeal based on them, and remit the matter to the Authority for reconsideration of its policy and the decisions on their individual merits. The Authority should reformulate its policy to give proper weight to its acknowledgement that transsexualism is an illness, apply that weighting when setting its level of priority for treatment and make effective provision for exceptions in individual cases from any general policy restricting the funding of treatment for it.

Human rights, European Union law and discrimination

In the light of that holding it is not necessary for me to rule on Mr. Blake's alternative submissions in reliance on the European Convention on Human Rights and on alleged discrimination. However, in response to his arguments, I should say a few words about each of those submissions.

As to the European Convention of Human Rights, it is not yet part of our domestic law and is relevant only, in an appropriate case, to the Court's consideration of rationality. Mr. Blake indicated that the purpose of his fairly detailed submissions and references to Strasbourg jurisprudence was merely to show that transsexualism is a sufficiently serious condition "to raise human rights problems". Such an unfocused recourse to that jurisdiction, whether before or after the statutory absorption of part of the Convention into the law of England and Wales, is not helpful to the Court. Indeed, it is positively unhelpful, cluttering up its consideration of adequate and more precise domestic principles and authorities governing the issues in play. Thus, the deployment of generalised propositions from the ECHR that a person's sexual identity is of sufficient importance to attract the protection of the right to respect for private and family life under Article 8, or that a denial of medical treatment may, if sufficiently serious, amount to "inhuman or degrading treatment" under Article 3, contributes nothing to resolution of the issues here (see e.g. *Rees v. United Kingdom* (1988) 9 EHRR 56; *Cossey v. United Kingdom* (1991) 13 EHRR 622; and the dissenting opinion of Judge Pettiti in *B v. France* (1992) 16 EHRR 1, at 40-41). It is common ground in this case that transsexualism is an illness; the issues are whether the Authority's policy for the public funding of treatment of it properly reflects that and whether it makes proper provision for consideration of each application for treatment on its individual merits.

In any event, Article 8 imposes no positive obligations to provide treatment. The ECHR in *Sheffield and Horsham v. UK* (1998) 27 EHRR 163, which concerned post-operative refusal to accord legal status as a woman, said at 191, para. 52:

"The Court reiterates that the notion of 'respect' is not clear-cut, especially as far as the positive obligations inherent in that concept are concerned: having regard to the diversity of the practices followed and the situation obtaining in the Contracting States, the notion's requirements will vary considerably from case to case. In determining whether or not a positive obligation exists, regard must be had to the fair balance that has to be struck between the general interest of the community and the interests of the individual, the search for which balance is inherent in the whole of the Convention."

Interestingly, the Court added at 193, para.58:

"For the Court it continues to be the case that transsexualism raises complex scientific, legal, moral and social issues, in respect of which there is no generally shared approach among the Contracting States."

As Mr. Pannick observed, if the respondents have no case under Article 8 of failure to respect their private and family life, they could not, a fortiori, establish that they were victims of inhuman or degrading treatment under Article 3 since the same essential issues arise; see *Olsson v. Sweden* (1988) 11 EHRR 259, at 292, pares. 85-87. And, as he also observed, a breach of the article requires "a particular level" of severity which, of course depends on the circumstances of the case. It is plain, in my view, that Article 3 was not designed for circumstances of this sort of case where the challenge is as to a Health Authority's allocation of finite funds between competing demands. As Hidden J. observed, in rejecting similar submissions below:

"The Convention does not give the applicants rights to free healthcare in general or to gender reassignment surgery in particular. Even if the applicants had such a right it would be qualified by the respondent's right to determine healthcare priorities in the light of its limited resources."

Similarly, Mr. Blake's somewhat irresolute resort to the notion of discrimination in the context of the Convention and Union Law is also misconceived. It was that discrimination between those suffering from transsexualism and other illnesses is contrary to Article 14 in that it amounts to discrimination "on the ground of their sex or other status", and contrary to Article 3(1) of Council Directive (79/7/EEC) providing for equal treatment in matters of social security. He relied on *R v. Secretary of State for Health, ex p. Richardson* [1996] ICR 471 for the proposition that medical treatment is part of social security. In fact it is an authority for a much narrower point, namely that a scheme for exemption from prescription charges falls within the Directive. As Mr. Pannick observed, the Court did not hold that the provision of medical treatment, as an aspect of policies on public health, amounts to the provision of social security. Article 129 of the EC Treaty leaves the provision of public health services to Member States.

Mr. Blake also referred to a passage from the opinion of the Advocate General in *P v. S* [1996] ICR 795, at 808, stating that there is unlawful discrimination on grounds of sex where, as a result of "a change of sex" a person is discriminated on the grounds of sex. Clearly, that blindingly obvious and general proposition has nothing to do with the issue in this case which is as to provision of treatment for transsexualism along with other competing demands on finite resources. When pressed as to what form of discrimination he had in mind, Mr. Blake conceded that it was not a difference between the treatment of male and female transsexuals or between transsexuals and anyone else or in any respect other than the necessary difference in provision of treatment for their condition from that of other ill persons for their conditions. That is not a matter of sexual or any other discrimination against which the law provides

protection; it is a matter of different priorities for different illnesses, a matter of medical judgment.

Accordingly, I would dismiss the appeals and make the order I have already indicated.

Lord Justice Buxton

I gratefully adopt the statement of facts and of the relevant legislation set out by my Lord. In view of the importance of this matter I venture to set out my reasons for agreeing with the order that he proposes.

A number of propositions are clearly established, mainly by the decision of this court in *R v Cambridgeshire Health Authority ex p B* [1995] 1 WLR 898. They are:

1. A health authority can legitimately, indeed must, make choices between the various claims on its budget when, as will usually be the case, it does not have sufficient funds to meet all of those claims.
2. In making those decisions the authority can legitimately take into account a wide range of considerations, including the proven success or otherwise of the proposed treatment; the seriousness of the condition that the treatment is intended to relieve; and the cost of that treatment.
3. The court cannot substitute its decision for that of the authority, either in respect of the medical judgements that the authority makes, or in respect of its view of priorities.

I further agree with Mr Pannick's submission that it follows from the foregoing propositions that a health authority can in the course of performing these functions determine that it will provide no treatment at all for a particular condition, even if the condition is medically recognised as an illness requiring intervention that is categorised as medical and curative, rather than merely cosmetic or a matter of convenience or lifestyle.

In all of this, the court's only role is to require that such decisions are taken in accordance with equally well-known principles of public law. Those principles include a requirement that the decisions are rationally based upon a proper consideration of the facts. The more important the interest of the citizen that the decision affects, the greater will be the degree of consideration that is required of the decision-maker. A decision that, as is the evidence in this case, seriously affects the citizen's health will require substantial consideration, and be subject to careful scrutiny by the court as to its rationality. That will particularly be the case in respect of decisions of the nature referred to in the previous paragraph of this judgment, which involve the refusing of any, or any significant, treatment in respect of an identified and substantial medical condition.

I am not satisfied that the decisions of the health authority in this case met these criteria. In reviewing the process whereby those decisions were made, I first remind myself that the decisions are indeed those of the health authority. That is no merely formal observation. What we have to consider is the material, advice and assumptions on which the health authority based its decision, and not, or at least certainly not primarily, the arguments and information adduced by the health authority's advisers to justify those decisions after they had been made.

I therefore turn to the health authority's two statements of policy, of March 1995 and January 1998. Mr Pannick accepted that clinical effectiveness had been the main thrust of the 1995 paper, as demonstrated by the heading, "medical procedures of no proven health gain or no proven benefit". There was no advice given to the health authority about any particular procedure included in the briefing paper, save for the general warning that a wide range of procedures then in use could not be demonstrated in research trials to have any clinical effectiveness. However, as the evidence in this application demonstrated, first, there is a strong and respectable body of medical opinion that considers gender reassignment procedures to be effective in suitable and properly selected cases; and second that it is unreal to submit that body of opinion to research trials of the type envisaged in the health authority's paper. I emphasise that the mere fact that a body of medical opinion supports the procedure does not put the health authority under any legal obligation to provide the procedure: the standard here is far removed from the *Bolam* approach in cases of medical negligence. However, where such a body of opinion exists it is in my view not open to a rational health authority simply to determine that a procedure has no proven clinical benefit while giving no indication of why it considers that that is so.

The January 1998 policy specifically superseded that of March 1995, and it is that policy that applies to the cases before us. The January 1998 document was more expansive in its reasoning than its predecessor, but the treatments that it ruled out of consideration were broadly the same. The policy did not confine itself to treatments of no proven benefit, though that was still an important element in its reasoning. The document however continued, at paragraph 2.3:

The fact that a service is effective and appropriate still does not mean that it represents a good use of NHS resources. It may produce only a small and unimportant improvement in health. It may produce benefits for only a small number of people. Its uncontrolled use may consume resources that could more appropriately be used for other patients. In such circumstances, protocols and service agreements, supported by clinical judgements will ensure that the service is available to patients who can expect to achieve the greatest benefits. They will also ensure that the service does not consume resources excessively relative to competing priorities.

There is, however, no indication that those principles, obviously unobjectionable in themselves, were specifically applied to the case of gender reassignment. Insofar as any detailed reference is made to the latter case, the document contents itself with saying that clinical advice that a patient is suitable for surgery will not be regarded as providing an overriding clinical need or exceptional circumstances justifying intervention: which in its context was tantamount to saying that the service will not be provided at all. It is therefore difficult or impossible to escape the conclusion that gender reassignment is included in 1998 policy for the same reasons as obtained in 1995, and with no more explanation or consideration of why that should be so.

In further explanation of its policy the health authority filed the affidavits of Dr. Harrison and Dr Sudell. The former addressed the very difficult decisions that have to be made in allocating resources between treatments and procedures that are clearly all of medical benefit, even of medical need, for those who receive them. These are certainly pressing and legitimate considerations for a health authority to take into account; but that general factor does not assist in the present case, because there is no evidence that the health authority reached its conclusion on gender reassignment after any review in which gender reassignment was assessed in terms of clinical need and its cost and benefits compared, even in the most outline way, with treatments for other conditions. Nor, indeed, would such a claim on behalf

of the health authority be consistent with Dr Sudell's explanation of the basis on which the decision in relation to gender reassignment was in fact taken.

Dr Sudell, in paragraphs 42 and 44 of his first affidavit, explained the position as follows:

It is the view of the Health Authority (paragraph 2 of the 1998 policy) that "interventions on the human body are not always related to ill health, but may be related to a desire to achieve an ideal body image or a bodily function that cannot currently be achieved"….The Health Authority's view is that the comments above apply to gender dysphoria, and therefore that treatment for gender dysphoria is not a condition for which Health Authority funded treatment is appropriate.

This reasoning does not flow naturally from the arrangement of the 1998 policy document. The general statement at the beginning of the paper about surgery to correct body image applies more naturally to the paragraphs dealing with varicose veins and with a wide range of other cosmetic treatments, which the health authority will not fund. No reference is made to this consideration in the short passage in which gender reassignment is specifically discussed. Nevertheless, assuming that that was the health authority's reason for the 1998 policy, as my Lord points out, Dr Sudell's account only reiterates the conclusion that the health authority is of the opinion that gender reassignment intervention, and in particular surgery, is of no, or no proven, clinical benefit. Dr Sudell himself cites a substantial literature that, on its face, suggests the contrary. Dr Sudell expresses caution about the conclusions of that literature, a view that, as a senior health professional, is clearly open to him. However, there is no indication at all that the health authority had the benefit of those views when adopting its policy, or indeed-that they gave any consideration to the actual status and value of gender reassignment intervention.

I am therefore driven to the conclusion that the health authority has not demonstrated that degree of rational consideration that can reasonably be expected of it before it decides in effect to give no funding at all to a procedure supported by respectable clinicians and psychiatrists, which is said to be necessary in certain cases to relieve extreme mental distress. The decisions therefore cannot stand and must be reconsidered by the health authority. Mr Pannick invited us however to adopt the approach of this court in *Ex p B* [1995] 1 WLR at p907B and decline to remit the matter to the health authority because on all the material the health authority could on reconsideration properly reach the conclusion previously adopted. The two cases are, however, quite different. In *Ex p B* the judge had quashed the health authority's decision because he considered that they had not given proper weight to various factors identified by him. The reason why on any reconsideration the health authority could properly not take those factors into account was that the Court of Appeal did not agree with the judge's view of them; and it would therefore have been inconsistent and indeed, as Bingham MR said, a cruel deception to remit the matter on the basis of those factors. In our case, by contrast, the health authority have in their reasoning not proceeded as this court considers that they should have done.

When the matter is remitted there will still, of course, be many factors that the health authority can properly take into account that may well point towards the original decision being maintained. Those include the cost of the procedures, underlined by expert evidence that once a patient has started on the course of counselling and review that course must necessarily be carried through to surgery in those cases where that is advised; the comparatively small number of patients needing gender reassignment treatment; and the costs and demands of other procedures, as so clearly set out in Dr Harrison's evidence. However, if this court were to assert that the health authority, reviewing those factors, would

necessarily come to the same decision as previously about gender reassignment procedures it would be making exactly the error of substituting its own judgement for that of the health authority.

I would therefore quash the decisions of the health authority and remit them to the health authority for further consideration. Such consideration should address 'the clinical evidence as to the need for and nature of gender reassignment procedures, and to the extent that such procedures continue to be subordinated to other claims on the authority's resources indicate, at least in broad terms, the reasons for the authority's choice.

That suffices to dispose of this appeal, but like my Lord I feel obliged to comment on the role played in the case by the additional arguments advanced by the respondents based on the European Convention on Human Rights [the ECHR] and the law of the European Union [EU].

A respondents notice in each case sought to uphold the decision of the judge on the further grounds:

i) that the learned judge erred in accepting the submissions of the Appellant in respect of the relevance of the European Convention on Human Rights ('ECHR') as informing the legality of the decision and in finding that the refusal of medical treatment did not:

a) subject the Respondent to degrading treatment within the meaning of Article 3 of the ECHR; and/or
b) fail to respect the Respondent's right to private life within the meaning of Article 8 of the ECHR; and/or

ii) that the learned judge, having found that the refusal of medical treatment to the Respondent was unlawful, erred in accepting the Appellant's submissions that the Respondent had not been treated less favourably on the grounds of sex in matters of social security contrary to the Council Directive 79/7/EEC and s 29 of the Sex Discrimination Act 1975.

In his oral argument, though not in his skeleton, Mr Blake resiled from relying on these arguments as independent grounds, but rather suggested that the importance or significance that the systems of jurisprudence referred to would attach to the interests of his clients reinforced the complaints made in relation to the protection of those interests on English law grounds. I cannot agree either with that approach or with the conclusions drawn from it. If the respondents have legitimate complaint to make in respect of breaches of the ECHR or of the law of the EU that is a matter that this or any court will take extremely seriously, in its own right. If they do not have such specific complaint, general reference to ECHR or EU jurisprudence is not in point. However, in order to deal properly with this part of the case, it necessary to look briefly at the aspects of that jurisprudence referred to by the respondents.

Article 3 of the ECHR addresses positive conduct by public officials of a high degree of seriousness and opprobrium. It has never been applied to merely policy decisions on the allocation of resources, such as the present case is concerned with. That is clear not only from the terms of article 3 itself, and the lack of any suggestion in any of the authorities that it could apply in a case even remotely like the present, but also from the explanation of the reach of article 3 that has been given by the Convention organs. Thus in *Tyrer v United Kingdom* (1978) 2 EHHR 1, a case concerned with corporal punishment, the Strasbourg Court held, at paragraphs [30] and [35] of its judgment that

in order for a punishment to be "degrading" and in breach of Article 3 the humiliation or debasement involved must attain a particular level…the Court finds that the applicant was subjected to a punishment in which the element of humiliation attained the level inherent in the notion of "degrading punishment".

More generally, the Strasbourg Commission has on a number of occasions stressed the degree of seriousness of the conduct that article 3 addresses. For instance, the Commission said in its report in the *East African Asians* case, 14 December 1973, at p57,

The Commission recalls its own statement in the First Greek Case that treatment of an individual may be said to be "degrading" in the sense of Article 3 "if it grossly humiliates him before others or drives him to act against his will or conscience"…the word "grossly" indicates that Article 3 is only concerned with degrading treatment which reaches a certain level of severity.

These strong statements clearly demonstrate, if demonstration were needed, that to attempt to bring the present case under Article 3 not only strains language and commonsense, but also and even more seriously trivialises that Article in relation to the very important values that it in truth protects.

The situation is less straightforward with regard to Article 8 of the ECHR. There is no doubt that a person's sexual *behaviour* is an important element in his private life, respect for which is guaranteed by article 8 of the ECHR. It is, however, less easy to see that a person's *sexuality* is, in itself, an aspect of his private life, as that concept is understood in the context of article 8, as opposed to being an evidently important, possibly even overriding, aspect of his personality and personal integrity. That difficult question does not, however, need to be pursued, because it is plain that in this case there has occurred no *interference* with either the applicants' private life or with their sexuality.

The ECHR jurisprudence demonstrates that a state can be guilty of such interference simply by inaction, though the cases in which that has been found do not seem to go beyond an obligation to adopt measures to prevent serious infractions of private or family life by subjects of the state: see *X and Y v Netherlands* 8 EHRR 235[93] and, more generally, Harris et al., *Law of the European Convention on Human Rights* (1995), pp 320-324. Such an interference could hardly be founded on a refusal to fund medical treatment. And in any event this case plainly falls under the reiterated guidance given by the Strasbourg Court in *Cossey v United Kingdom* (1990) 13 EHRR 622[37] and *Sheffield and Horsham v United Kingdom* (1998) 27 EHRR 163[52]:

the notion of 'respect' is not clear-cut, especially as far as the positive obligations inherent in that concept are concerned: having regard to the diversity of the practices followed and the situations obtaining in the Contracting States, the notion's requirements will vary considerably from case to case. In determining whether or not a positive obligation exists, regard must be had to the fair balance that has to be struck between the general interest of the community and the interests of the individual, the search for which balance is inherent in the whole of the Convention.

It is therefore clear that the facts of this case come nowhere near to the type of factual situations addressed by either Article 3 or Article 8 of the ECHR. Mr Blake however said that his reason for not directly relying on the ECHR was not that, but rather that the Human Rights Act 1998 had not yet come into operation. That argument was however unpersuasive because, as I have demonstrated above, a direct claim under that Act, were it in force, would

be bound to fail. And Mr Blake's reason for diffidence as to his respondents notice does not apply in relation to the claim that the treatment of his clients was discriminatory on grounds of sex in terms of Directive 79/7 EEC: since the legislation relied on is directly effective in Community law terms.

In that connexion Mr Blake took us to Case 137-94 [1995] ECR 3407 (*Richardson*), in which the Court of Justice held that a statutory scheme for free medical prescriptions fell under the terms of Article 3 of the Directive, which provides for equal treatment in relation to

statutory schemes which provide protection against the following risks: sickness, invalidity, old age, accidents at work [and] unemployment

He argued that the provisions for the diagnosis and treatment of illness in the National Health Service Act were equally such a statutory scheme. That argument entirely overlooks the fact that the Directive is concerned with *benefits*; that is, the provision of financial assistance, or the defrayment of what otherwise would be charges falling on the subject. That is taken for granted throughout the cases, and is explicit in the discussion in, for instance, Case C243/90 [1992] ECR 1-467[12], cited by the Court of Justice in Case 137-94 at paragraph [8]. It has never been suggested, and is not the case, that a national health service falls into that category.

Quite apart from that difficulty, it is impossible to see how the applicants have been the victims of discrimination on grounds of sex. True it is that they seek a particular treatment related to their sexuality; but that has been refused not because of that sexuality, but on grounds (which I have already held on English domestic law principles to have been inadequately reasoned) of allocation of resources. If it were an act of discrimination simply to refuse treatment that was related to sexuality, the health authority would be obliged to provide such treatment in every case, whatever the other calls on its resources. Mr Blake understandably disclaimed the latter argument; but I fear that it is the inevitable corollary of categorising this case as one of discrimination in terms of Directive 79/7.

That was the primary argument in Community terms, but Mr Blake also relied on Case C13/94 [1996] ECR 1-2143 (*P v S*), in which the Court of Justice held that the protection afforded by Directive 76/207 EEC on the equal treatment of workers extended to transsexuals. He referred in particular to the observation of Mr Advocate General Tesauro at paragraphs [18]-[19] of his opinion that the prohibition of discrimination is an aspect of the general principle of equality. So it is. But the Advocate General was, it does not need to be said, well aware, and so said in the first paragraph of his opinion, that the Directive is concerned with equal treatment as regards access to employment, vocational training and promotion, and working conditions. It simply does not address the facts of the present case. This argument was not improved by an appeal to Article 14 of the ECHR, on prohibition of discrimination. That Article relates only to discrimination in terms of access to rights established by the ECHR. As I have demonstrated, no such rights are engaged in this case.

I have gone into these arguments in some detail because I am disturbed by the appeal to Convention and Community authority that has no sensible connexion with the issues in this case; and by the alternative argument that since those systems protect rights that are in some ways related to the rights asserted in this case they can be used as some sort of support for the applicants' primary case. That approach is misconceived. In a case where neither Convention nor Community rights can be asserted, the case either succeeds or fails on domestic law grounds and on no other. And with the imminent coming into force of the Human Rights Act it will be even more important than it is at present to ensure that

Convention rights are not asserted in inappropriate circumstances; so that they play their proper, and important, role, but only their proper role, in the protection of the citizen's interests.

Lord Justice May

I agree that these appeals should be dismissed for the reasons given by Auld and Buxton LJJ, and I concur in the orders proposed.

The decisions of the Health Authority which the respondents successfully challenged before Hidden J were applications of the Authority's 1995 and 1998 policies. As Auld LJ demonstrates, these policies were made upon the premise that transsexualism is not a disease and that surgical treatment for it is of no proven clinical benefit. But it was accepted before Hidden J and before us that transsexualism is an illness. Mr Pannick QC implicitly accepted that, if "disease" and "illness" might conceivable sometimes have different shades of meaning, the difference is immaterial in the context of the Health Authority's delegated responsibility under section 3 of the National Health Service Act 1977 to provide reasonable facilities for the treatment of illness. The first part of the premise upon which the policies proceeded is therefore erroneous. The strong balance of the evidence before the court is that the second part of the premise is also erroneous. But it is neither necessary nor appropriate for the court to determine that debate.

Health Authorities have to make hard and often invidious decisions in the allocation of avowedly inadequate resources. But those decisions must proceed from proper assessments of the conditions competing for treatment. The decisions in the present cases did not so proceed, and I agree that they and the policies, so far as they relate to transsexualism, require reconsideration.

I also emphatically agree that the European Convention of Human Rights has no impact on these applications and that inapposite forensic reference to cases decided under the Convention was not helpful.

ORDER: All three appeals dismissed. Appellant to pay 66% of the respondents' costs. Leave to appeal refused.

(Order not part of approved judgment)

» by *Claire McNab*