increasing prices) should be controlled. The judgment of the Court in *Gencor*, although given in the framework of a merger case, has begun to tip the balance in favour of a more interventionist approach to oligopolies.

ALBERTINA ALBORS-LLORENS

FUNDING "SEX-CHANGE" OPERATIONS

A CASE which will be of interest to students of medical law, public law and human rights, *North West Lancashire Health Authority* v. *A, D, & G* [1999] Lloyd's Rep. Med. 399, concerned three transsexuals who wanted "sex-change" operations. The health authority's policy was to give low funding priority to procedures it considered of little or no clinical benefit; the authority would not fund "gender reassignment" except in cases of "overriding clinical need" or other exceptional circumstances, though it would fund psychotherapy.

Applying this policy, the authority refused requests by A, D and G for funding to pay for referral to a specialist clinic for diagnosis and gender reassignment, despite the fact that psychiatrists supported their suitability. A, D and G sought judicial review. Hidden J. quashed the authority's refusal as *Wednesbury* unreasonable. His decision was affirmed by the Court of Appeal.

The starting point, said Auld L.J., was that a health authority, in discharging its duty under section 1 of the National Health Service Act 1977 "to continue the promotion ... of a comprehensive health service", had a discretion how to allocate its budget. It was natural that each authority, in establishing its own priorities, would give greater priority to life-threatening and other grave illnesses. A policy of giving lower priority to gender reassignment and to deny it save in exceptional circumstances was not irrational, provided that the policy genuinely recognised the possibility of there being overriding clinical need and required each request to be considered on its merits.

In establishing priorities, he added, it was vital for an authority accurately to assess the nature and seriousness of each type of illness and the effectiveness of various treatments; and to give proper consideration to that assessment in the formulation and application of its policy.

For the purposes of the proceedings, the authority admitted that transsexualism was an illness. Other evidence, however, including policy statements which bracketed treatment for it with cosmetic

surgery, was in conflict with that admission. Consequently, its policy conflicted with its admitted medical judgment.

That "basic error" was not mitigated by the exception for "overriding clinical need" or other exceptional circumstances. Indeed, added Auld L.J., given the authority's reluctance to accept gender reassignment as an effective treatment for transsexualism, the exception was in practice meaningless. If an authority devised a policy not to provide treatment save in cases of overriding clinical need, it made a nonsense of the policy if, as a matter of its medical judgment, there was no effective treatment.

In short, Auld L.J. held that, given the authority's admission that transsexualism was an illness, its policy was flawed in two important respects. First, it did not really regard transsexualism as an illness, but rather as an attitude or state of mind which did not warrant medical treatment. Secondly, the ostensible provision it made for exceptions and its manner of considering them amounted to the operation of a "blanket policy" against funding such treatment because it did not believe in such treatment. The authority should reformulate its policy to give proper weight to its admission that transsexualism was an illness, apply that weighting when setting its level of priority for treatment, and make proper provision for exceptions in individual cases.

Buxton L.J. pointed out that a health authority could still decide not to fund any treatment for a particular condition even if it were recognised as an illness requiring medical rather than cosmetic intervention. There would, he added, be many factors that the authority could properly take into account in reconsidering its refusal, such as the cost of the procedure, the small number of patients needing the treatment, and the costs and demands of other treatments.

Having dismissed the appeal on the basis of the common law, the court did not find it necessary to consider the respondents' submissions that the authority's refusal breached Articles 3 and 8 of the E.C.H.R. and amounted to sexual discrimination in breach of Council Directive 79/7/E.E.C. and section 29 of the Sex Discrimination Act 1975. Indeed, the court regarded these "unfocused" submissions as "positively unhelpful, cluttering up its consideration of adequate and more precise domestic principles and authorities ... " (at p. 410 *per* Auld L.J.). Buxton L.J. observed that with the implementation of the Human Rights Act it would be even more important that Convention rights were not inappropriately asserted. The respondents were awarded only two-thirds of their costs.

The case therefore sounds a cautionary note about the

inappropriate invocation of Convention and Community law. Moreover, following earlier cases like *R.* v. *Cambridge Health Authority, ex p. B.* [1995] 1 W.L.R. 898, it reaffirms that, subject to the supervisory jurisdiction of the courts, the discretion to allocate resources lies with health authorities, and it provides those authorities with some useful guidance. The case is, however, an unusual example of a successful challenge to the exercise of that discretion, reflecting a greater, and welcome, judicial willingness to scrutinise than has been evident in cases such as *R.* v. *Central Birmingham Health Authority, ex p. Collier* (1988, unreported), where the court declined even to seek the authority's reasons why a life-saving heart operation on a baby had been postponed several times.

Not least in view of the inexorably rising demands on limited resources, the courts are likely to face a growing number of difficult questions about resource allocation. What if the authority in this case had argued, supported by a body of medical opinion, that transsexualism is a mental illness but one for which the *only* appropriate treatment is psychotherapy to bring the mental illness into line with the physical reality rather than surgery to bring the physical reality into line with the mental illness? What if an authority declines to fund gender reassignment, and/or heart transplants, and/or drugs for HIV, so as to increase expenditure on health education and/or chiropody and/or health visitors? What procedures, if any, would it be unreasonable *to* fund? What about the (recently reported) amputation of healthy limbs as a treatment for "body dysmorphic disorder"? Would this procedure pass the criminal law test of "reasonable surgical interference"?

The wide room for disagreement surrounding questions of resource allocation makes it all the more likely that patients will be tempted to seek their resolution judicially. The courts ain't seen nothin' yet.

JOHN KEOWN

BETWEEN THE BABY AND THE BREAST

IN *Re C (A CHILD) (HIV Test)* [1999] 2 F.L.R. 1004, a local authority applied for a specific issue order to test a four-month-old baby girl for HIV. The mother of the child first tested positive for HIV in 1990, but adopted a highly sceptical stance towards generally accepted theories about HIV and AIDS, and refused conventional therapy for herself, preferring to rely on a healthy