
Resource allocation and rationing must be regarded as among the most pressing problems and challenges of contemporary healthcare law and the publication of *Law, Legitimacy and the Rationing of Health Care. A Contextual and Comparative Perspective* is a most welcome addition to the rather scarce academic legal texts in this area of law.¹

From the very beginning, Syrett engages the reader by making vivid the relevance and complexity of rationing in healthcare; the variety of factors that need to be taken into account when making rationing decisions; and the political, financial, medical, legal and not least human dimension of the underlying issues. Already in the introduction, he outlines one of the main themes of his book, i.e. that the law has a positive role to play in the context of the rationing debate. Emphasising the common interests of health policy makers and public lawyers in the legitimation of public power (p. 10), Syrett identifies the intention behind his book as follows: ‘to present a critical reading of public law adjudication which emphasises the facilitative capabilities of legal principles, values and processes to assist in the resolution of problems of legitimation’, and to put forward ‘a modest case for a more positive attitude towards the engagement of the courts with decision-making of this type, in contrast to the widely held view that law is an irritant which should, as far as possible, be excluded from intrusion upon allocative decision-making in the health-care context’ (p. 11).

Chapter 2 which is entitled ‘Why “Ration” Health Care Resources?’ provides an insightful analysis of the reasons that make rationing necessary (pp. 29-33). Drawing on ample statistical material as well as texts from health economics and policy, Syrett examines the various factors that are frequently said to increase the demand for and costs of healthcare and accordingly to make rationing a growing necessity. In particular, he challenges simplistic visions such as that the ageing of the population is the main factor that raises the costs of healthcare and discusses issues such as the impact of changes in individual and national income; advances in medicine and medical technology; and patient expectation on the provision and rationing of healthcare (pp. 34-43).

Having presented a convincing case that rationing is unavoidable, Chapter 3 explains ‘How Rationing Takes Place’. Here, Syrett first of all provides an overview of the various forms which healthcare rationing can take. These reach from the more obvious and publicly visible rationing tools of denial of access to certain forms of healthcare and selection based on the characteristics of the patients, such

¹) Until the publication of Syrett’s book, Newdick, *Who Should We Treat*, (OUP: Oxford, 2nd ed. 2005) was one of the few monographs providing an in-depth academic analysis of rationing issues.
as age, to mechanisms that are less clearly associated with rationing, such as waiting lists (pp. 45-48). Large parts of the chapter then deal with the question of who should ration. Closely linked to this is the discussion of whether rationing should take place implicitly, in the form of clinical decisions by healthcare professionals, or explicitly by politicians or healthcare managers. To stress the rationing component of clinical decisions is interesting and, at least in the context of the legal discussion of healthcare rationing, unusual. Syrett demonstrates that clinical decisions by physicians as to what treatment to offer a patient might have a rationing effect and are sometimes motivated by rationing considerations, instead of being made exclusively with the best interests of the individual patient at heart. Rationing that takes place in this form will usually be disguised from the patient, the healthcare professional’s decision instead being presented as based on clinical grounds.

For a medical lawyer, it is intriguing to be introduced by Syrett to authors who seem to be in favour of implicit rationing on the grounds that it might be merciful towards the patient to hide healthcare rationing behind a veil of clinical justifications and that it presents a good way to avoid conflicts that could be caused if treatment were openly withheld for financial reasons and scarcity of resources (pp. 55-58). Syrett criticises this view and emphasises that deceiving the patient for his/her own good shows a lack of respect for patient autonomy and amounts to unacceptable paternalism. The inherent betrayal and deceit might harm the physician-patient relationship. He, moreover, rightly points out that implicit rationing takes away from the patient any possibility to challenge rationing decisions (pp. 59-60). A strong case in favour of explicit rationing is then presented, based on the consideration that rationing choices only invite an open political and moral debate if they are made openly and explicitly. Syrett demonstrates that explicit rationing ensures transparency of the decision-making process and facilitates accountability and consistency, as the decision-maker needs to develop a set of criteria at which to orientate rationing decisions. (pp. 60-62).

From here, the book moves on to a theoretical discussion of ‘Rationing and the Problem of Legitimacy’ (Chapter 4). The main issue of that chapter is to tackle, based on an analysis of key texts on legitimacy,² the question of how rationing decisions can receive legitimacy, given that they raise moral dilemmas for which there is no easy answer, and will indeed often have to be made in the light of conflicting moral values within society. Explaining some of the moral approaches to rationing, such as clinical need (pp. 86-87), the utilitarian position that resources should be allocated according to Qalys (quality adjusted life years) (pp. 88-90) and highlighting the problems inherent in these approaches as well as