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CONDLIFF v NORTH STAFFORDSHIRE PRIMARY CARE TRUST: CAN HUMAN RIGHTS REDRESS INEQUITIES IN UNITED KINGDOM AND AUSTRALIAN COST-CONTAINMENT-DRIVEN HEALTH CARE REFORMS?

A recent case from the English Court of Appeal (R (on the application of Condliff) v North Staffordshire Primary Care Trust [2011] EWCA Civ 910, concerning denial by a regional health care rationing committee of laparoscopic gastric bypass surgery for morbid obesity) demonstrates the problems of attempting to rely post hoc on human rights protections to ameliorate inequities in health care reforms that emphasise institutional budgets rather than universal access. This column analyses the complexities of such an approach in relation to recent policy debates and legislative reform of the health systems in the United Kingdom and Australia. Enforceable human rights, such as those available in the United Kingdom to the patient Tom Condliff, appear insufficient to adequately redress issues of inequity promoted by such "reforms". Equity may fare even worse under Australian cost-containment health care reforms, given the absence of relevant enforceable human rights in that jurisdiction.

INTRODUCTION

Tom Condliff was a 62-year-old former policeman who, partly as a result of congenital problems, developed diabetes and other disorders related to what is becoming one of the most intractable non-communicable diseases in developed nations: obesity. Condliff was 1.88m (6ft 2in) tall and weighed 140 kg (22 st). He was diagnosed as being morbidly obese with a body mass index (BMI) greater than 40 kg/m2. Condliff alleged that his gaining weight also was due to a needle phobia that restricted his access to insulin. He attempted to lose weight using standard non-surgical methods (including dietary, lifestyle and drug therapies). None were successful. His co-morbidities included renal impairment, hypertension and obstructive sleep apnoea.[1]

Condliff's doctors determined that the most effective and safe treatment for his condition was laparoscopic gastric bypass surgery. This surgery could have been paid for by the National Health Service (NHS) if it were approved by the local (North Staffordshire) Primary Care Trust (PCT) at a cost of around £5,500.[2] In order to be eligible under an "individual funding request" (IFR) for this particular surgery, a patient must meet a number of criteria, including that the patient's BMI be greater than 50 kg/m2. At the time of his application, Condliff's BMI was about 43 kg/m2. On this basis, the PCT responsible for approving funding of the surgery in February 2010 rejected Condliff's application.

Condliff's condition continued to worsen to the extent that within six months he had become reliant on the use of a wheelchair and was largely confined to his house. He was unable to attend church, swelling and pain in his hands prevented him from playing the guitar, and his diabetes had resulted in the development of retinopathy and renal failure. He became incontinent, and his wife's

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[1] *R (on application of Condliff) v North Staffordshire Primary Care Trust* [2011] EWCA Civ 910 at [3] (Toulson LJ).

[2] Doward J, "Bias Against Obesity Cost Me Fight for Gastric Band", *The Observer* (31 July 2011), http://www.guardian.co.uk/society/2011/jul/31/tom-condliff-gastric-band-appeal viewed November 2011.

nightly rest was interrupted to deal with the consequences of this. He was unable to undertake any activities of daily living independently, including dressing and showering himself (at [3]). He wrote again to the PCT asking that it reconsider his case. He claimed that if he was in the catchment area of the adjacent Stoke PCT he would have been allowed the operation as the rationing cut-off point there was lower (including a BMI of 35 kg/m2).

On 13 October 2010 the North Staffordshire PCT again rejected Mr Condliff's application on the grounds that he did not meet the eligibility criteria; neither did he meet the grounds for exceptionality under the IFR policy (at [3]).

The specified test for exceptionality in the IFR policy provided (at [16]):

> 4.2.4 The application should demonstrate each and all of the following three criteria:
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> 1. It does not in fact seek to introduce a new treatment for a definable group (however small) …
> 2. The patient is significantly different from the general population of patients with the condition in question who are currently excluded from funding.
> 3. The patient is likely to gain significantly more benefit from the intervention than the average patient with the condition.

With respect to the consideration of the social factors affecting Mr Condliff and outlined in his application, the policy went on to state (at [16]):

> 4.2.5 Social factors (for example, but not limited to, age, gender, ethnicity, employment status, parental status, marital status, religious/cultural factors) will not be taken into account in determining whether exceptionality has been established.

This exclusion is referred to in the judgment as "the social factors exclusion" (at [30]). Justification of the exclusion clause is outlined in the Appendix to the IFR policy (at [17], emphasis added):

> Non-clinical factors:
>
> Patients often seek to support an application for individual funding on the grounds that their personal circumstances are exceptional. This assertion can include details about the extent to which other persons rely on the patient, or the degree to which the patient has contributed, or is continuing to contribute, to society. The PCT understands that everyone's life is different and that such factors may seem to be of vital importance to patients in justifying investment for them in their individual case. However, including such non-clinical, social factors in any decision-making raises at least three significant problems for the PCT:
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> - Across the population of patients who make such applications, the PCT is unable to make an objective assessment of material put before it relating to non-clinical factors. This makes it very difficult for the Panel to be confident of dealing in a fair and even-handed manner in comparable cases.
> - The essence of an individual funding application is that the PCT is making funding available on a one-off basis to a patient where other patients with similar conditions would not get such funding. If non-clinical factors are included in the decision-making process, the PCT does not know whether it is being fair to other patients who are denied such treatment and whose social factors are entirely unknown.
> - The PCT is committed to a Policy of non-discrimination in the provision of medical treatment. If, for example, treatment were provided which had the effect of keeping someone in paid work, this would tend to discriminate in favour of those of working age and against the retired. If a treatment were provided differentially to patients who were carers this would tend to favour treatment for women over men. If treatment were provided in part on the basis that a medical condition had affected a person at a younger age than that at which the condition normally presents, this would constitute direct age discrimination.
>
> …
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> In reaching a decision as to whether a patient's circumstances are exceptional, the Panel is required to follow the principle that non-clinical or social factors including social value judgments about the underlying medical condition or the patient's circumstances are *never* relevant.

Condliff appealed the second decision of the North Staffordshire PCT to the administrative arm of the England and Wales High Court arguing that the PCT policy of excluding social or non-clinical factors breached his human rights under Art 8 of the *European Convention on Human Rights* (the Convention) which was applicable in that jurisdiction by virtue of the *Human Rights Act 1998* (UK).

That argument was rejected at first instance by Waksman J (*R (on the application of Condliff) v North Staffordshire Primary Care Trust* [2011] EWHC 872 (Admin)). Condliff then appealed to the Court of Appeal (Kay, Hallett and Toulson LJJ) in *R (on the application of Condliff) v North Staffordshire Primary Care Trust* [2011] EWCA Civ 910.That appeal and its implications for present United Kingdom and Australian health care policy debates and reforms are the subject of this column.

CONDLIFF'S HUMAN RIGHTS CLAIMS AND HEALTH CARE EQUITY

Unable to manage his medical condition, Condliff had sought assistance from the taxpayer-funded United Kingdom National Health Service. Section 3 of the *National Health Service Act 2006* (UK) imposes a public law duty on the Secretary of State to provide health care services to meet all reasonable requirements. This section is the statutory basis of universal health care in the United Kingdom. Yet, the PCT system arose after 2000 as an outcome of a United Kingdom health reform process that preferentially emphasised institutional payment by results and marketed its advantages in terms of patient choice, rather than equity and universality of access (at [4]-[8]).

In other words, Condliff was faced with a PCT required to focus on its institutional cost containment rather than universal coverage. In order to bring equity to the "reformed" system, his only option became an appeal to human rights. He argued that PCT's IFR criteria for exceptionality amounted to a breach of his human rights (at [28], [32] and [33]). Specifically, he argued that the "social factors exclusion" was a breach of Art 8 of the Convention (at [26]):

1. Everyone has the right to respect for his private and family life, his home and his correspondence.
2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

Condliff claimed that the concept of "private life" in Art 8 extends to respect for the physical and moral integrity of the person.[3] He argued that Art 8 imposes a positive obligation on the PCT to provide him with medical treatment (at [28]). He then claimed that s 6 of the *Human Rights Act 1998* (UK) made it unlawful for a public authority to act in a way that was incompatible with a Convention right (at [27]).

To establish his claim, Condliff needed to prove that the PCT failed to satisfy the three-stage test that the Strasbourg Court administering the Convention had developed to determine whether or not a given interference fits within the exceptions set out in Art 8(2).[4] First, he could claim the PCT's interference was arbitrary and so not made in accordance with the law. He might claim the PCT's policy was not proportionate to its aims, did not find a basis in health care best practice and was based upon a false notion of non-discrimination, in particular the false and arbitrary dichotomy between the "clinical" and "non-clinical" aspects of an individual's health. Secondly, he could assert that the PCT's policy and decision was not done in the pursuit of a legitimate aim; and thirdly, it was not necessary under a process of fair balancing with individual rights in a democratic society. He could argue that where, such as here, an important individual right is at stake and he had endured great disadvantage, a positive obligation may arise under Art 8.[5]

These arguments were rejected by the Court of Appeal. Toulson LJ (Kay and Hallett LJJ agreeing) stated that Art 8 was a qualified rather than an absolute right and, as such, allowed for the state to interfere with it in certain circumstances, including in protecting the rights of others. He found that there had never been a case that extended Art 8 on respect for private and family life to impose a positive duty to provide medical treatment (at [37] and [41]). Toulson LJ held (at [47]) that the "difficult assessments required in the fair administration of a healthcare system with limited resources" are legitimate issues for the PCT.

[3] *X v The Netherlands* [1985] ECHR 4 at [22].

[4] *Olsson v Sweden (No 1)* [1988] ECHR 2.

[5] *Marckx v Belgium* (1980) 2 EHRR 330.

> The PCT had grappled with the difficult ethical and practical questions involved in setting its IFR policy. In arriving at that policy the PCT has struck what it considers to be a fair balance between the interests of individuals and the community (for example whether patients who are carers should have priority over others) and a fair balance between different patients with similar health conditions.

Toulson LJ acknowledged that the application by the PCT of its IFR policy had severely compromised the patient's independence, dignity of life and life expectancy (at [55]).

Toulson LJ referred to other unsuccessful Art 8 cases such as *Sentges v The Netherlands* (2003) 7 CCLR 400 (state failing to provide a patient with a robotic arm), *Pentiacova v Moldova* (Applic No 14462/03 4 January 2005, state's failure to provide patient with adequate dialysis treatment) and *Molka v Poland* (Applic No 56550/00 11 April 2006, state's failure to provide wheelchair-bound patient with positive assistance to vote in local elections). He held that such cases supported the view that the PCT's IFR policy fell within the "margin of appreciation" in allocation of their scarce resources that the Strasbourg Court had allowed states in respect of their Art 8 obligations (at [52]). Toulson LJ thus held that the PCT's IFR policy did not contravene the Convention and dismissed Condliff's appeal.

Major health policy debates and reforms are under way in both the United Kingdom[6] and Australia.[7] These debates emphasise mutually inconsistent goals such as "equity", "personal choice" and institutional "cost containment". Taking Tom Condliff's case as a leitmotif, this column now examines the claim that human rights can adequately protect equity in cost-containment-driven health system reforms under way in the United Kingdom and Australia.

HUMAN RIGHTS AND PROPOSED UNITED KINGDOM HEALTH SYSTEM REFORMS

In many developed nations after the Second World War, the sacrifice of young men and women for the good of the state elicited a social compact which included the provision of schemes whereby the state, through taxation revenues, provided all citizens with equitable access to health care. Such a system is often called "universal health care". In many jurisdictions this became a human right enshrined in constitutions. It became a recognised aspect of the right to health expressed in Art 12 of the *United Nations International Covenant on Civil and Political Rights* (ICCPR).

In the United States, health care over the past four decades has been progressively handed over to private corporations, with a semblance of equity inserted by legislation for instance requiring privatised emergency departments to see patients or catering for special groups such as military service veterans. To gain access to health care, United States citizens have either to take out private health insurance, have it provided by their employer or be poor enough to qualify for special programs and the second-tier hospitals in which they operate. In such a privatised (or "managed") health care system, doctors work chiefly for large corporations, private health insurers increase premiums each year above the inflation rate and patients suffer the "moral hazard" of their insurer potentially deciding it is more profitable to refuse, delay or minimise their claim rather than honour their paid-up premiums.

In countries such as Canada, France the United Kingdom and Australia, however, universal health care has evolved to be a taxpayer-funded system under which the state covers the bulk of medical bills of all its citizens. The focus on providing equitable access for all citizens in those nations has promoted an ethos in which the best doctors and high-quality resources are focused on the public system. In some such countries (like Australia) more wealthy citizens can take out private health insurance that allows a choice of doctor or specialist hospital and escalation up surgical waiting lists. Yet, even in those systems, corporate lobbying and policy reforms have seen a rise of the institutional profit and user-pays model, eg through progressively increasing co-payments that patients must make to access health care or medicines, or even by taxpayer subsidies of private health insurance.

[6] United Kingdom, Department of Health, *Equity and Excellence: Liberating the NHS* (July 2010) p 5, http://www.official-documents.gov.uk/document/cm78/7881/7881.pdf viewed August 2011.

[7] Braithwaite J, Skinner CA, and Döéry ML, "A Values-based Health System" (2011) 194 MJA 259.

Management of morbid obesity such as that of Tom Condliff is a good case study to evaluate how equity has survived or may be protected under contemporary health care system reforms in the United Kingdom and Australia that appear to be shifting the policy emphasis away from universal coverage.

Obesity is considered by some health policy-makers to be primarily the responsibility of the individual and so such patients may be particularly disadvantaged under user-pays or profit-driven health system reforms.[8] There are many broader equity issues, however, in ceding primary responsibility to such patients, not least of which is that it ostensibly relieves governments and corporations of responsibility for managing the adverse outcomes of market-oriented policies encouraging obesity. The corporate sector, eg, has been criticised for supporting a model where the type of food it manufactures and promotes profitably encourages overeating and then even more profitable remedial surgery.[9]

On a larger canvas Tom Condliff, in other words, may be viewed as a victim of a supranational corporate culture that encourages indulgence with food to the point of individual addiction and that has contributed to a global epidemic with almost 1.5 billion people now considered to meet standard criteria of obesity.[10] The United Nations General Assembly recently conducted a high-level meeting on this issue.[11] Condliff may also have been disadvantaged by incessant corporate lobbying to convince policy-makers to shift from universal coverage models towards "user-pays" or "institutional cost containment" organised systems.

The PCT in Condliff's case was being forced by health system reforms to deny the relevance of social factors (such as the location of fast food chains selling high calorie foods in lower socio-economic areas) to the causation of obesity.[12] The PCT's policy was an outcome of reforms that ran against basic universalist principles that prioritised equity of access to health care. It, in effect, required rejected patients such as Condliff to rely on human rights protections, despite this exercise probably being beyond their resources and understanding, as well as being ineffective.[13] This health care reform process is continuing in the United Kingdom and it is to that newest round of reforms we now turn.

In July 2010 the United Kingdom Government released a White Paper entitled *Equity and Excellence: Liberating the NHS*. The title of the Paper is itself worthy of comment with its implication that "liberating" it (or "privatising", these terms being generally synonymous in the language of trade law and corporate lobbying parlance) may in some way inevitably make it more equitable and excellent.

The NHS was established in 1948.[14] It now has a budget of over £102 billion.[15] The proposed NHS reforms (*Health and Social Care Bill 2011* (UK)) assume roughly £20 billion in efficiency

[8] Townsend R, "Public Health Policy and Personal Responsibility in Sport – Competitive and Collaborative?" (2007) *Sports Law eJournal* p 2, http://www.epublications.bond.edu.au/cgi/viewcontent.cgi?article=1004&context=slej viewed November 2011.

[9] Dixon JB, Pories WJ, O'Brien PE, Schaeur PR and Zimmet P, "Surgery as an Effective Early Intervention for Diabesity: Why the Reluctance?" (2005) 28(2) *Diabetes Care* 472.

[10] Caballero B, "The Global Epidemic of Obesity: An Overview" (2007) 29 Epidemiol Rev 1.

[11] United Nations General Assembly, *High-level Meeting on Non-communicable Diseases*, http://www.un.org/en/ga/president/65/issues/ncdiseases.shtml viewed 11 November 2011.

[12] As to observations that health care systems as currently envisaged may not meet the needs of these groups see Lewis S and Leeder S, "Why Health Reform?" (2009) 191(5) MJA 270 at 270-271.

[13] International Council of Human Rights Policy, *Enhancing Access to Human Rights* (2004) p 9, http://www.ichrp.org/files/reports/44/123_report_en.pdf viewed November 2011.

[14] United Kingdom Government, *About the NHS*, http://www.nhs.uk/NHSEngland/thenhs/about/Pages/overview.aspx viewed September 2011.

[15] Hodge M (chair), *UK Parliament Commons Public Accounts Committee Report* (2011), http://www.parliament.uk/business/committees/committees-a-z/commons-select/public-accounts-committee/news/nhs-productivity-report viewed September 2011.

savings by 2014, in part by cutting the government's management costs.[16] How these savings are to be achieved is not clearly set out in the Bill. A legitimate concern is that they will arise from denial of care and a diminution of equity.

These health systems reforms were not justified by direct reference to evidence that the NHS was producing substandard patient outcomes, or that it was comparatively expensive.[17] In fact, it has been argued that command-and-control-style systems like the NHS are actually much more effective at managing resource scarcity, global cost containment and allocating resources equitably than private insurance-dominated models such as those in the United States which run at approximately twice the cost and increase profits when patients with insurance are denied care.[18] In 2009 the United Kingdom spent about 9.8% of its gross domestic product on the NHS compared with United States expenditure of 17.4% of its GDP on government health programs, principally Medicare and Medicaid.[19]

The ostensible aim of the reforms was expressed by Prime Minister David Cameron, Deputy Prime Minister Nick Clegg and Secretary of State for Health Andrew Lansley in terms that appeared to emphasise the value of patient choice above equity:

> First, patients will be at the heart of everything we do. So they will have more choice and control, helped by easy access to the information they need about the best GPs and hospitals. Patients will be in charge of making decisions about their care.
>
> Second, there will be a relentless focus on clinical outcomes. Success will be measured, not through bureaucratic process targets, but against results that really matter to patients – such as improving cancer and stroke survival rates.
>
> Third, we will empower health professionals. Doctors and nurses must be able to use their professional judgment about what is right for patients. We will support this by giving frontline staff more control. Healthcare will be run from the bottom up, with ownership and decision-making in the hands of professionals and patients.
>
> Of course, our massive deficit and growing debt means there are some difficult decisions to make. The NHS is not immune from those challenges. But far from that being reason to abandon reform, it demands that we accelerate it. Only by putting patients first and trusting professionals will we drive up standards, deliver better value for money and create a healthier nation.[20]

The White Paper suggests policy importance should be given to the alleged fact that most patients, who are by definition vulnerable, want more "choice" with regard to their health care.[21] The notion that obtaining more "choice" about their health care is of greater concern to most patients than "affordable access" to it has been strongly questioned.[22]

The reforms create structures in which doctors and patients must interact so that budgetary constraints are met. They would place patients within a consortium that will have a budget allocated which will be used to pay for specialists and hospital care.[23] The consortium will be responsible for

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[16] Hodge, n 15.

[17] Appleby J, "Does Poor Health Justify NHS Reform?" (2011) 342 BMJ d566; Davis K, Schoen C and Stremikis K, *Mirror, Mirror on the Wall: How the Performance of the US Health Care System Compares Internationally* (The Commonwealth Fund, 2010), http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2010/Jun/1400_Davis_Mirror_Mirror_on_the_wall_2010.pdf viewed September 2011.

[18] Moran M, "Understanding the Welfare State: Health Care" (2002) 2(2) *British Journal of Politics & International Relations* 135.

[19] OECD, *Health Expenditure and Financing United Kingdom and the United States*, http://www.stats.oecd.org/Index.aspx?DataSetCode=SHA viewed September 2011.

[20] United Kingdom Government, n 14, p 1.

[21] United Kingdom Government, n 14, p 1.

[22] Farmer S, Cunningham A and Hawker M, "Evidence Submission (Quantitative): Do the Public Really Want More Choice in the NHS? Using Data from the British Social Attitudes Survey 2007 to Verify Government Claims", *Lancet* (10 May 2011), http://www.ukpolicymatters.thelancet.com/?p=868 viewed September 2011.

[23] *Health and Social Care Bill 2011* (UK), cl 25, http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Actsandbills/HealthandSocialCareBill2011/index.htm viewed September 2011.

choosing between purchasing services from existing NHS specialists or alternative providers (not-for-profit or for-profit organisations). This method has already been introduced in Cumbria. General practitioners in that region are "in charge of managing the budget for all prescription costs, running GP surgeries, commissioning services from local hospitals and budgeting for new local care plans, such as community nurses".[24] Cumbrian general practitioners have placed their emphasis on providing primary care in their surgeries and, as a result, hospital procedures have reduced by 53%, saving almost £300,000 a year.[25] It has been suggested that the government could simply have mandated that general practitioners have more responsibility within the existing PCT structure.[26]

Under the proposed model, each consortium will be considered a body corporate.[27] Importantly, it is supposed that general practitioner consortia will be subject to the EC's *Public Procurement Remedies Directive* (2009).[28] These will impose fines, demand bid costs and annul contracts if the new consortia fail to perform according to market rules.[29] For example, a losing bidder can commence legal proceedings against a contracting authority's contract award decision and this will result in an automatic injunction against that decision being applied immediately. It is the potential for this to happen that is partly responsible for causing consternation and concern among doctors who will be responsible for making procurement decisions.[30] A way around this is for a consortium to contract out that component of their practice.[31]

One concern is that these health care reforms may even have been constructed so that companies, including such United States-based giants as United Health Group and BUPA, may step in to relieve the soon-to-become administratively overburdened clinicians and provide management services for consortia. This would leave the NHS budget in the hands of for-profit corporations that would increase profits with each instance of care they minimised or denied.[32] In such a setting it is unlikely that a patient such as Tom Condliff would fare well. His condition would require repeated visits and an expensive procedure with the risk of ongoing problems from his co-morbidities. Being involved with too many such patients would create serious risks that such a consortium would be unable to meet its budget.

Part 3 of the Bill deals with the role of the Monitor as the economic regulator and sets out the law with respect to competition. Clause 71 makes specific reference to the "requirements as to procurement, patient choice and competition", stating that commissioning health care services for the NHS "protects and promotes the rights of patients to make choices with respect to treatment or other health care services provided for the purposes of the NHS".[33] The Bill also includes mechanisms for the licensing of providers, setting prices and arrangements for insolvency and for a system of special administration to ensure continuity of designated services when providers fail.[34] The implementation of these provisions will arguably result in a system of market regulation of the NHS, but at the cost of

[24] Brennan S, "NHS Reform: The GPs on the 'Dark Side'", *Guardian* (5 January 2011), http://www.guardian.co.uk/society/2011/jan/05/nhs-reform-gp-commissioners-cumbria viewed September 2011.

[25] Norridge E, *Implementing GP Commissioning* (Policy Exchange, 2011), http://www.policyexchange.org.uk/images/publications/pdfs/Implementing_GP_Commissioning_-_Apr__11.pdf viewed September 2011.

[26] Norridge, n 25.

[27] *Health and Social Care Bill 2011* (UK), Sch 2, Pt 9.

[28] Freshfields Bruckhaus Deringer, *Public Procurement: Implementation of the Remedies Directive in the UK* (2009), Summary Note, http://www.freshfields.com/publications/pdfs/2009/dec09/27240.pdf viewed September 2009.

[29] *Health and Social Care Bill 2011* (UK), cll 61, 66.

[30] British Medical Association, "Government Health Reforms Still Pose an Unacceptably High Risk to the NHS", *Media Release* (2 September 2011), http://www.web2.bma.org.uk/pressrel.nsf/wlu/SHAN-8LALHK?OpenDocument&vw=wfmms viewed September 2011.

[31] Ham C, "Competition in the NHS in England" (2011) 342 BMJ d1035.

[32] Samuel A, McKee M, Lister J and Reynolds L, *Liberating the NHS: Source and Direction of the Lansley Reform* (29 August 2011), http://www.pcwww.liv.ac.uk/~alexss/nhs.pdf viewed September 2011.

[33] *Health and Social Care Bill 2011* (UK), cl 71(1)(b).

[34] *Health and Social Care Bill 2011* (UK), cl 113.

equity of access to health care and the diminution of the principle of universal coverage. Other criticisms of the proposed reforms include the charge that quality of care will be compromised.[35]

The Department of Health counters by referring to safeguards, suggesting that the Monitor "will ensure that competition works in the interests of patients and taxpayers. The NHS Commissioning Board will work with the Monitor to regulate prices and strengthen incentives for providers to improve quality and efficiency."[36] The access of patients in the United Kingdom to human rights remedies was not mentioned among these safeguards. This is a telling omission. It suggests that the lobbyists backing the reforms might find such a safeguard against inequities arising while "liberating" or "privatising" the NHS too confronting for the public arena.

Indeed, the reforms seemed unnecessary, given evidence that improvements in access to health care are not predicated on such a "liberalised" approach but rather on investing money at the strategically right point. The minimum level of funding for improvements in outcomes under such an approach can be calculated.[37]

A global examination of health systems demonstrated that Jonkoping County in Sweden spends the least on care and gets the most equitable and high-quality results.[38] In the early 1970s Sweden was among the first countries to make a national universalist commitment to primary care and preventive services rather than hospital care. By comparison with other industrialised countries, Sweden manages to moderate resource and cost levels against superior access and medical outcomes.[39] Compared to systems in other industrialised countries and international standards, the Swedish system manages to balance superior access and medical outcomes with moderate resource and cost levels.[40] In such a system, patients like Tom Condliff, burdened with the stigma of self-inflicted illness and facing protracted, complex and expensive treatment, nevertheless would get the access to health care they require simply because by doing so the health care system was affirming that the principle of equity is more important to the social compact than cost containment or profit.

Many British medical professionals have expressed opposition to the latest health reform proposals. The British Medical Association, the Royal College of Nursing and the Royal College of General Practitioners have refused to support the reforms, instead urging the government to re-think them. They claim that the government's reform plans "pose an unacceptably high risk to the NHS, threatening its ability to operate effectively and equitably, now and in the future".[41] Over 150 members of the NHS Consultants' Association have written to the government expressing their concerns regarding, and resistance to, the "marketisation" and "privatisation" of the health care system.[42] Concern has been expressed that "the removal of the duty of the Secretary of State for Health to provide a comprehensive health service; the role of Monitor in the promotion of competition; the enforced nature of competition through the promotion of the choice agenda, has a higher priority than tackling fair access and health inequalities".[43]

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[35] Kmietowicz Z, "Lansley Writes Price Competition Out of the Health Bill" (2011) 342 BMJ 1481.

[36] House J, "UK National Health Reform Mobilises Doctors" (5 March 2011) 377(9768) *Lancet* 797.

[37] Lewis and Leeder, n 12.

[38] Baker GR, MacIntosh-Murray A, Porcellato C, Dionne L, Stelmacovich K and Born K, "Jönköping County Council", *High Performing Healthcare Systems: Delivering Quality by Design* (Longwoods Publishing, Toronto, 2008) pp 121-144.

[39] Baker et al, n 38.

[40] Baker et al, n 38.

[41] Beattie J, "Doctors Blast Damaging Health Reforms", *Mirror* (7 September 2011), http://www.mirror.co.uk/news/politics/2011/09/07/doctors-blast-damaging-health-reforms-115875-23401510/#ixzz1XZ3g7LMj viewed September 2011.

[42] Ramesh R, "NHS Reform Bill Must Be Resisted, Leading Doctors Tell Royal Colleges", *Guardian* (11 September 2011), http://www.guardian.co.uk/society/2011/sep/11/doctors-letter-resists-nhs-reform viewed September 2011.

[43] NHSCA, *Open Letter to the Royal College Presidents Regarding the Proposed Reforms*, http://www.nhsca.org.uk/docs/nhscarcp.pdf viewed September 2011; Foster M, "Doctors Turn to Peers to Block Reforms", *BMA News* (8 September 2011), http://www.web2.bma.org.uk/nrezine.nsf/wd/CPAN-8LHKZ5?OpenDocument&C=10+September+2011 viewed September 2011.

Of most relevance to the present argument it seems implicit in the United Kingdom health system reforms that the capacity in the United Kingdom since the early 2000s for appeals to human rights[44] is being presented as an assurance that the new health care system will function equitably.[45]

On the basis of cases such as that of Tom Condliff, however, it is evident that human rights law (particularly where, as in the United Kingdom, it does not include an enforceable right to health services, even in emergency situations) offers little real protection against the injustices likely to arise in the process of reforming a health care system from a focus on equity and universal access to one emphasising corporate profit and/or institutional budgetary constraint.

HUMAN RIGHTS AND THE PROPOSED AUSTRALIAN HEALTH SYSTEM REFORMS

Australia and the United Kingdom share a common heritage of political commitment to universalist health care. Nonetheless, there are fundamental differences between the political and legal environments in the United Kingdom and Australia likely to influence the direction of any cost-containment-driven health reform process. These are not only the federal nature of the Australian polity, but a deficiency of substantive human rights claims available to Australian citizens against their governments.

The fact that the Australian health care system remains partly under the control of State and Territory governments may be one of its main protections against "liberalisation/privatisation" (particularly through pressures exerted by multilateral trade agreements such as the World Trade Organisation's *General Agreement on Trade in Services* (GATS) as well as bilateral and regional trade agreements.

Unlike the United Kingdom, Australia lacks a dedicated, enforceable human rights instrument in any form (whether statutory or constitutional).[46] The oft-lauded protections for human rights derived from the common law, such as remain, are subject to extinguishment by legislation in a process which the Australian High Court seems reluctant to inhibit.[47] Additionally, although specific States and Territories in Australia have enacted interpretive-based human rights statutes, the High Court has expressed considerable reluctance to support them and the protections they offer citizens against an increasingly corporate-captured parliamentary system.[48]

There were many similarities in the initial stages of the recent health reform process in both the United Kingdom and Australia. Just as the British Government commissioned a "kitchen cabinet" of interested parties made up largely of for-profit insurance company executives, so too did the Australian Government establish the National Health and Hospitals Reform Commission (NHHRC) in 2008 to consider options for health care reform. A major difference, however, was that "liberalisation/privatisation" appeared not to be a strong element of the Australian health care reforms, unless one understands that eroding state control over health care delivery is an important step towards that.

The NHHRC was established by the Rudd Federal Government on 25 February 2008, for the purpose of developing long-term health reforms for a changing Australia.[49] Dr Christine Bennett, who was the then Chief Medical Officer of the health insurance corporation BUPA Australia Ltd, chaired

[44] *Human Rights Act 2004* (UK).

[45] British Medical Association, n 30.

[46] Arzey S and McNamara L, "Invoking International Human Rights Law in a 'Rights-Free Zone': Indigenous Justice Campaigns in Australia" (2011) 33 *Human Rights Quarterly* 733 at 735.

[47] Faunce TA and McEwan A. "The High Court's Lost Chance in Medical Negligence: Tabet v Gett (2010) 240 CLR 537" in "Medical Law Reporter" (2010) 18 JLM 275.

[48] *Momcilovic v The Queen* (2011) 85 ALJR 957; [2011] HCA 34.

[49] See the NHHRC website, http://www.health.gov.au/internet/nhhrc/publishing.nsf/Content/home-1 viewed 8 November 2011. In this article, the term "changing Australia" refers to some of the challenges the NHHRC's final report indicated were facing the Australian health system. These include an increasing ageing population, increased chronic health issues and extensive problems in rural and remote medicine: see National Health and Hospitals Reform Commission (NHHRC), *A Healthier Future for All Australians: Final Report* (NHHRC, Canberra, June 2009) p 165.

the Commission.[50] This is significant as the central motivation of any reform committee can usually be gleaned from an analysis of the experience and motivations of its chairperson. There were nine other commissioners, including a general practitioner, public policy experts and professors.[51] The NHHRC's terms of reference included issues of "blame-shifting" occurring between State and federal governments, preventative medicine and improvements to health care for the elderly, chronically ill and people living in rural and remote areas.[52]

The NHHRC published its final report entitled *A Healthier Future for All Australians* (the Final Report) in June 2009. The recommendations emphasised the importance of access and equity and creating an "agile" and sustainable health care system.[53] Health policy commentators were entitled to be most nervous about the seemingly pro-corporate constructive ambiguity of the term "agile". On 2 August 2011 Prime Minister Gillard announced that she had "entered [into] a health reform agreement with every [S]tate and [T]erritory in the nation".[54] In the period between February 2008 and August 2011, a complex set of processes had been embarked upon to develop options for reform, and then to attempt to implement them.[55] Commentators referred to the "prolonged gestation" and "protracted birth" of the Rudd Government's health reform plan.[56]

The reforms that have actually begun to be implemented have not required a formal change to the constitutional text in Australia.[57] Yet many of them have involved the making of agreements between the Prime Minister of Australia and the Premiers and Chief Ministers of the States and Territories that substantially alter one of the major remaining areas of non-federal responsibility. These agreements were made at meetings of the Council of Australian Governments (COAG) in 2010[58] and 2011.[59]

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[50] See NHHRC, n 49, pp iii and 182. BUPA is the parent company to MBF, a large health insurance company: see BUPA, *The Bupa Story*, http://www.bupa.com.au/about-us/about-bupa/our-story viewed 8 November 2011.

[51] NHHRC, n 49, pp 182-185.

[52] NHHRC, n 49, p 181.

[53] NHHRC, n 49, pp 3-12.

[54] Prime Minister Julia Gillard and Health Minister Nicola Roxon, *Transcript of Joint Press Conference* (2 August 2011) p 1, http://www.parlinfo.aph.gov.au/parlInfo/download/media/pressrel/972512/upload_binary/972512.pdf;fileType=application/pdf#search=%22health%20reform%22 last viewed 9 November 2011.

[55] A sense of the many stages that the health reform process went through up to mid-2010 can be gained from Parliament of Australia, Senate Finance and Public Administration References Committee, *Council of Australian Governments Reforms Relating to Health and Hospitals* (2010) at [2.1]-[2.25]. For a brief overview of the process up to the early months of 2011, see House of Representatives Standing Committee on Health and Ageing, *Advisory Report on the National Health Reform Amendment (National Health Performance Authority) Bill 2011* (2011) at [1.3]-[1.8]. A briefing paper provided by the Council of Social Service of New South Wales explains some of the factors which led to the health agreements needing to be renegotiated in 2011: see Council of Social Service of NSW (NCOSS), *National Health Reform: Outcomes of the 30th Council of Australian Governments (COAG) Meeting, 13 February 2011* (Briefing Paper, NCOSS, February 2011) p 3, http://www.ncoss.org.au/resources/NCOSS-Briefing-paper-on-COAG-Health-Reform-Agreement-13Feb2011.pdf viewed 6 September 2011. See also for comments Keane B, "Benefits of Health Reform Will Be in Decades Ahead", *Crikey* (online) (2 August 2011), http://www.crikey.com.au/2011/08/02/real-benefits-of-health-reform-package-will-be-in-decades-ahead last viewed 9 November 2011.

[56] Hickie IB, "The 2010 Rudd Plan: Will it Actually Deliver Better Health Services?" (2010) 192 MJA 511 at 511. The health reform plan to which Hickie refers was itself superseded by the reform plan announced by Julia Gillard and Nicola Roxon in August 2011: see House of Representatives Standing Committee on Health and Ageing, n 55 at [1.7]; Keane, n 55.

[57] On 3 March 2010, in a speech before the National Press Club, then Prime Minister Kevin Rudd indicated that if the States and Territories refused to become signatories to the reforms that the Commonwealth was suggesting at that point, then the Rudd Government would ensure that a referendum was held to change the text of the *Constitution* to give the Commonwealth the power to reform the Australian "health system" on its own. See Prime Minister Kevin Rudd, "Better Health, Better Hospitals: The National Health and Hospitals Network", speech to the National Press Club, Canberra, 3 March 2010, p 2, http://www.pandora.nla.gov.au/pan/79983/20100624-1429/www.pm.gov.au/node/6534.html viewed 6 September 2011. There was no suggestion in Prime Minister Gillard's press conference of 2 August 2011 that the health reform that the changes announced would require a referendum to implement: see Gillard and Roxon, n 54.

[58] For details see Parliament of Australia, Senate Finance and Public Administration References Committee, n 55 at [2.17]-[2.25].

[59] Council of Australian Governments (COAG), *Heads of Agreement – National Health Reform (Attachment A)* (13 February

The 2011 *National Health Reform Agreement* that was finalised by Prime Minister Gillard has been judged to be more modest in its scope than the changes proposed by Kevin Rudd.[60] However, the new health reform agreement indicates that the current government's reforms are still designed (among other things) to alter the way in which public hospitals are funded and to improve the ways in which the performance of health services is reported.[61]

Despite the somewhat byzantine nature of both the health reform proposals themselves, and the process by which they were generated and agreed to, it is possible to trace some ideas consistently through this process which would be relevant to a claim upon a health service such as that made by Tom Condliff. One such idea is the importance of aiming to ensure that the health reform process addresses issues relating to people's ability to access health services.[62] Many of the reforms mooted in the health reform process of recent years have been structured to maximise impact on this equity goal.[63] The focus of the following discussion is on the reforms dealing with the implementation of Access Targets for patient waiting times for emergency and elective surgery. These are the reforms that would be most relevant to access to health care in Australia for a patient such as Tom Condliff.

In the NHHRC's Final Report it indicated that the importance of ensuring that the Australian system improves to permit access to health services on an equal basis was a point made in "[m]any of … [the] submissions" it received.[64] The Final Report affirmed that "[e]nsuring that everybody can get access to effective and high quality health services is one of our most important priorities".[65] Consonant with this belief, one of the "three reform goals" that the Commission suggested could be the focus of government attention was "[t]ackling major access and equity issues that affect health outcomes for people now".[66] This led the Commission to conclude that the Australian health system was in need of "an ongoing way in which we can continuously measure and report on whether people are getting access to the health services they need".[67] In turn, the report recommended that "National Access Targets" (NATs) be generated as a tool to achieve this goal.[68] In its interim report (produced in 2008) it had advocated the development of "National Access Guarantees and Targets" which would be limited to the provision of hospital services.[69] The Final Report recommended that NATs be developed as performance measures "across the whole continuum of health services".[70]

2011), http://www.coag.gov.au/coag_meeting_outcomes/2011-02-13/docs/communique_attachment_20110213.pdf last viewed 9 November 2011.

[60] See Keane, n 55; and Grattan M, "Second Best, But it's Not Worthless", *Sydney Morning Herald* (online) (3 August 2011), http://www.smh.com.au/opinion/politics/second-best-but-its-not-worthless-20110802-1i9vh.html last viewed 9 November 2011.

[61] See *National Health Reform Agreement* (2011), cl 3.

[62] For example, the fact sheet the government has prepared explaining why health reform is needed indicates that the reforms aim to "improve access" to health services. See eg Australian Government, Department of Health and Ageing, *Delivering National Health Reform* (1 August 2011), http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/nhra-agreement-fs viewed September 2011.

[63] For example, according to the *National Health Reform Agreement*, the implementation of "activity based funding … based on a national efficient price" was also designed to "improve patient access to services": *National Health Reform Agreement* (2011) cl 3(a).

[64] NHHRC, n 49, p 81.

[65] NHHRC, n 49, p 81.

[66] NHHRC, n 49, p 3. The other two "reform goals" were the need to alter the Australian "health system so that it is better positioned" to adapt to changes in the Australian people and environment, and ensuring that the health care system that was created was flexible and sustainable (see also on p 3). Some of the recommendations made by the NHHRC under these two headings also arguably have an impact on the extent to which people can access health services in Australia. However, to discuss all the recommendations made by the NHHRC is beyond the scope of this article.

[67] NHHRC, n 49, p 90.

[68] NHHRC, n 49, pp 20, 90-93 and 259.

[69] NHHRC, n 49 p 90.

[70] NHHRC, n 49 p 90.

If the NATs had been created in this form, then a patient such as Tom Condliff would have a better chance of getting prompt access to the surgery he needed. The NATs as guarantees, in effect, were central to the equity aspect of the new reforms, their capacity to remain consistent with the ideals of universalist coverage.

The Commission wanted the NATs, by which State and Territory hospital systems were held accountable for their federal funding, to be the product of consultation with relevant stakeholders including the community.[71] The NHHRC signalled that some of the NATs "may evolve" into the stronger-sounding access mechanism of "National Access Guarantees".[72]

Nevertheless, the Commission sounded a note of caution that indicated a chink in its commitment to equity and universal coverage. It emphasised that NATs should only become "'guarantees' … [if it was possible to] ensure that this does not distort how funds are allocated across the health system".[73] It indicated that more "work" needed to be done to ascertain how a "guarantee" might be practically implemented,[74] and noted that such a scheme had implications for the funding arrangements underpinning the health system.[75] Indeed, the Commission also admitted that even its proposal that NATs be enforced by paying "'bonuses' to those health services that meet the targets" was a suggestion that needed "[s]ubstantial work" if it were to apply to health services beyond the hospital system.[76]

The COAG communiqué summarising the outcomes of the meeting of the Prime Minister, Premiers and Chief Ministers on 19-20 April 2010 stated that a component of the deal struck at that meeting was the fact that all governments in Australia (except the Western Australian Government) agreed "to the staged implementation of a four-hour National Access Target" for the emergency departments of all public hospitals (except for those in Western Australia).[77] This meant that "where it was clinically appropriate", all persons who went to an emergency department in a public hospital would be "admitted" and either "referred for treatment or discharged within four hours".[78] There was an exception for hospitals in remote and other areas of Australia where there were significant impediments to accessing a general practitioner. Such hospitals were given the scope to set a different target (which would be agreed between the Commonwealth and the relevant State or Territory).[79]

All State and Territory governments would be given government funding to help ensure that these targets could be met (including $250 million for "reward payments").[80] In 2010 the *National Health and Hospitals Network – National Partnership Agreement on Improving Public Hospital Service* (the 2010 Partnership Agreement) was finalised. At this point the Commonwealth and the various States appeared to agree that this NAT was to apply to 95% of people who went to an emergency department

[71] NHHRC, n 49, p 91.

[72] NHHRC, n 49, pp 20 and 91.

[73] NHHRC, n 49, p 91.

[74] NHHRC, n 49, p 91.

[75] NHHRC, n 49, p 91.

[76] NHHRC, n 49 at 91.

[77] Council of Australian Governments (COAG), *Council of Australian Governments Meeting 19 and 20 April 2010, Canberra Communiqué* (20 April 2010) p 8, http://www.coag.gov.au/coag_meeting_outcomes/2010-04-19/docs/communique_20_April_2010.pdf last viewed 9 November 2011. It is worth noting that Western Australia had implemented a similar "four hour rule" program for its emergency departments in some of its hospitals in 2009. See Expert Panel Review of Elective Surgery and Emergency Access Targets Under the National Partnership Agreement on Improving Public Hospital Services, *Report to the Council of Australian Governments 30 June 2011* (2011) pp 26-27 (Expert Panel Review).

[78] COAG, n 77, p 8.

[79] COAG, n 77, pp 8-9.

[80] COAG, n 77, p 8.

for treatment, as long as it was "clinically appropriate" to do so.[81] The scope for "smaller rural and remote hospitals" to negotiate their own targets was also adverted to in the agreement.[82]

An aspect of the National Access Target proposal made by the NHHRC likely to be most relevant to a patient such as Tom Condliff was incorporated into the agreements announced by COAG in April 2010. This was a series of "elective surgery access targets". Within a certain timeframe, 95% of people in particular "categories" who were scheduled to have elective surgery "would be treated within clinically recommended times".[83]

In the 2010 Partnership Agreement, however, the reform regarding elective surgery waiting time targets had mutated again and away from what might be regarded as an enforceable equity guarantee. Schedule A to the 2010 Partnership Agreement indicated that the Commonwealth would provide funding so that "a National Access Guarantee" regarding elective surgery could be implemented.[84] This Guarantee stipulated that:

> [F]rom 1 July 2012 … public hospital patients will not wait significantly longer than the clinically recommended time for their urgency category. This means that patients must have their surgery (if it is clinically safe to do so):
> – for a Category 1 patient who has already waited 30 days – within the next five days;
> – for a Category 2 patient who has already waited 90 days – within the next 15 days; and
> – for a Category 3 patient who has already waited 365 days – within the next 45 days.[85]

These targets were to be met by 1 July 2014.[86]

The next significant step in the Australian health reform process occurred when COAG met again on 13 February 2011. The communiqué from that meeting noted that the leaders of the Commonwealth, States and Territories had "signed a Heads of Agreement on National Health Reform … and a revised National Partnership Agreement on Improving Public Hospital Services".[87] It also stated that one of the objects of the health reform process was to ensure that the Australian health system provided "universally *accessible* health care".[88]

In terms of the "four hour" NAT for emergency departments, and the NAT and "National Access Guarantee" for elective surgical procedures, cll 37 and 38 of the Heads of Agreement signalled that the Heads of Government were committed to the use of these standards to help ensure that the Australian hospital system was functioning well.[89] Indeed, the revised Partnership Agreement (known as the *National Health Reform Agreement – National Partnership Agreement on Improving Public Hospital Services*) included substantially similar versions of the NATs and "National Access

[81] COAG, *National Health and Hospitals Network – National Partnership Agreement on Improving Public Hospital Services* (2010), cll C1 and C38. As at November 2011, this document appears to no longer be available online. A hard copy of the 2010 Partnership Agreement is in the possession of the author. The broad outlines of this part of the 2010 agreement appear to be adverted to in Australia Government, *A National Health and Hospitals Network for Australia's Future* (2010) pp 89-90, http://www.pandora.nla.gov.au/pan/118026/20100707-1501/www.health.gov.au/internet/yourhealth/publishing.nsf/Content/report-redbook/$File/HRT_report3.pdf last viewed 9 November 2011. However, this agreement has been superseded: see discussion below.

[82] COAG, n 81, cl C11.

[83] COAG, n 77, p 9.

[84] COAG, n 81, cl A2.

[85] COAG, n 81, cl A1(c). In its review of the (identical) elective surgery targets which were agreed to in February 2011, the Expert Panel commented that the use of "categories" reflects the categorisation systems which are used by doctors "based on a clinical judgment about their need for surgery". The different categories are based on the length of time within which it is "desirable" that a patient be admitted for elective surgery, and also on the basis of whether the condition necessitating the surgery is likely to become an "emergency". However, the Expert Panel also noted that the precise categories used vary between different States. See Expert Panel Review, n 77, pp 36-38.

[86] COAG, n 81, cl A46.

[87] COAG, *Council of Australian Governments Meeting, Canberra, 13 February 2011, Communiqué* (13 February 2011) p 2, http://www.coag.gov.au/coag_meeting_outcomes/2011-02-13/docs/communique_20110213.pdf last viewed 9 November 2001.

[88] COAG, n 87, p 2 (emphasis added).

[89] COAG, n 59, p 6.

Guarantee".[90] However, the Heads of Agreement also stipulated that, in order to assess how these standards (including the NATs and National Access Guarantee) would be implemented, "COAG … [would] seek the advice of an Expert Panel".[91] This "Expert Panel" was duly established.[92] Among the recommendations that this Expert Panel made were that

- the "four hour" NAT applying to emergency department be given a new name, the "National Emergency Access Target" (NEAT);[93]
- that the newly-named NEAT be revised down so that 90% of people going to emergency departments be seen within four hours and that the "clinically appropriate caveat" be "incorporated" within that lower "target";[94] and
- that the target for elective surgery and the "National Access Guarantee" be removed and replaced with a "National Elective Surgery Target (NEST)".[95]

The NEST would mean that, over a period of time, hospitals would aim to have 100% of patients "treated within clinically recommended times".[96] These recommendations appear to have been included in the (current) *National Health Reform Agreement – National Partnership Agreement on Improving Public Hospital Services*.[97]

In terms of access by a patient such as Tom Condliff, it is worth noting that, in relation to NEAT, this 2011 agreement stipulates that "the target is not intended to overrule clinical judgment" and indicated that it was for the relevant "clinician" to judge if a person needed to stay in an emergency department for longer than four hours.[98] Interestingly, the mechanism of "reward funding" was retained as one way in which the Commonwealth Government aimed to ensure these targets were implemented.[99]

The Australian health care reforms, though patterned as mentioned, in a jurisdiction that lacks enforceable human rights (and in particular no constitutional guarantee of access to health care in emergency situations), seem to utilise the human rights language of "guarantees" without genuine policy commitment. By way of contrast, Norway incorporates a waiting time guarantee within its *Patient Rights Act 1999* which provides a "right to care" based on the medical need of the patient, the expected utility of care and a reasonable relationship between costs and the effectiveness of treatment. This guarantee was altered in 2004 to give every patient in Norway access to health care within a specified time as determined by the doctor in charge.[100] Under such a guarantee, Tom Condliff would have received a better outcome.

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[90] That is, cll A1(c), C1, C11, C38 appear in identical terms in both documents. The content in cl A46 of the 2010 Partnership Agreement is located in cl A45 in the revised version agreed in February 2011. Interestingly, the funding promised in cl A2 of the revised agreement differs slightly. See COAG, n 81; and COAG, *National Health Reform Agreement – National Partnership Agreement on Improving Public Hospital Services* (February 2011), http://www.coag.gov.au/docs/nap_improving_public_hospital_services.pdf last viewed 9 November 2011.

[91] COAG, n 59, cl 39, pp 6-7.

[92] Expert Panel Review, n 77, pp 1-2.

[93] Expert Panel Review, n 77, p 29 (Recommendation 4).

[94] Expert Panel Review, n 77, p 30 (Recommendation 5).

[95] Expert Panel Review, n 77, p 47 (Recommendation 11).

[96] Expert Panel Review, n 77, pp 47-48 (Recommendations 11 and 12).

[97] COAG, *National Health Reform Agreement – National Partnership Agreement on Improving Public Hospital Services* (July 2011), cll A1 and C1. A signed version of this document is not available, but an unsigned version is available on the Commonwealth's *Your Health* website, http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/npa-improvingpublichospitals-agreement/$File/National%20Partnership%20Agreement%20on%20Improving%20Public%20Hospital%20Services.pdf last viewed November 2011, and also on the COAG website at http://www.coag.gov.au/docs/nap_improving_public_hospital_services.pdf last viewed 9 November 2011.

[98] COAG, n 97, cl C2.

[99] COAG, n 97, cll A2, C3, C4.

[100] Norheim OF, "Rights to Specialised Health Care in Norway: A Normative Perspective" (2005) 33(4) *Journal of Law, Medicine and Ethics* 641 at 645.

As the current version of the Australian health reforms indicate, however, Australia has moved away from the language of "guarantees" and back to a discussion of "targets", a move that is perhaps in keeping with the Australian reluctance to federally codify human rights of any description, let alone a constitutional right of access to health care, eg in emergencies. It is a move that, in the absence of such rights, would leave a patient such as Tom Condliff doubly exposed: to a system which under corporate lobbying pressure appears to be edging closer to privatisation but one which lacks the human rights protections that might ostensibly offer comfort to patients vulnerable to its resultant inequities.

Australia (and patients in that nation with problems resembling those of Tom Condliff) may become even more exposed on this front if supranational corporate lobbying pressure to erode universalist components of its Pharmaceutical Benefits Scheme (PBS), such as undermining science-based cost-effectiveness analysis through inclusion of an annex specifically applicable to it (and not to Medicare in the United States) in the *Trans Pacific Partnership Agreement* currently being negotiated, is successful.[101] Another major threat to universalist health care in Australia is lobbying for health savings accounts. Deloitte Access Economics director Lynne Pezzullo has lobbied senior federal bureaucrats to create employer or self-funded health savings accounts (HSAs) like superannuation under which the Federal Government would make co-contributions to the health accounts of low-income workers and the public hospital system would remain free only for the delivery of emergency or essential health services.[102] Such a scheme would diminish the disposable income patients have to spend on their health and subject them to the moral hazard that, when they wished to draw on the saved funds, they would have been lost on the stock exchange or the funds manager may deem it more lucrative to find a reason to deny or delay the claim. Imagine the indignities a patient such as Tom Condliff would suffer under such a system.

CONCLUSION

The following illustrates the language used to advertise laparoscopic gastric bypass surgery in the "liberalised/privatised" United States health care system:

> Our patient financing offers you a full range of payment plans. Our 3, 6, 12, & 18 month No Interest payment plans feature monthly payments as low as 3% of the balance and let you pay within the specified time without incurring interest charges. Simply make your minimum monthly payment and pay off your entire balance during the agreed upon time period, and for patients/clients with higher treatment fees who would prefer more time to pay with lower monthly payments, our 24, 36, 48, & 60 month extended payment plans offer a low, fixed 11.9% interest rate and an extended term. We offer a variety of affordable financing programs through your doctor's office with flexible payment options and low monthly payments. With available loan amounts from $1000 to $25,000 we have a loan program for every budget, even for those with less than perfect credit. The key benefits of our patient financing programs include:
>
> - Fixed rates starting as low as 5.9%
> - Interest Rebate programs for up to 12 months
> - Fixed low monthly payments
> - Terms from 12 months to 84 months
> - No prepayment penalty
> - Bad credit financing available with a Co-Applicant
> - Easy application form with quick approval decisions.[103]

Obviously, equity can best be maintained in a health care system that prioritises universal access as a core value under its social contract. Inclusion of a "right to health" or more specifically a "right to

[101] Faunce TA and Townsend R. "The Trans-Pacific Partnership Agreement: Challenges for Australian Health and Medicine Policies" (2011) 194(2) MJA 83.

[102] Faunce TA, "Health Savings Accounts: Just Another Greedy Corporate Scam", *The Conversation* (25 October 2011), http://www.theconversation.edu.au/health-savings-accounts-just-another-greedy-corporate-scam-3970 viewed 14 November 2011.

[103] Bariatric Surgery Specialists, *Patient Financing for Gastric Bypass Surgery*, http://www.obeseinfo.com/patient_financing.htm viewed 13 November 2011

health care" or "right to emergency health care" in many countries' constitutions is a way in which such equity can be retained or inserted into a health care system. Such a mechanism allows a series of judicial cases in which the state is reluctantly made to conform its policies to those constitutional rights.[104] For example, a judicial decision in Ghana linked the right to health in the context of a "user-pays" privatised health system to enforceable rights against arbitrary detention when a patient there was unable to pay his health bill and was refused release from hospital as a result.[105] Citizens in neither the United Kingdom nor Australia have such a right to health care.

Too often, however, even when citizens do have access to a constitutional right to health care or even related human rights (as in the case of Tom Condliff), they have failed on the basis that the relevant government has been presumed to have a margin of appreciation as to how they allocate their scarce financial resources in satisfaction of such economic, social and cultural human rights.[106] This applies even under the Convention (although it does not contain a right to health per se) and it has been argued that the European Court of Human Rights is profoundly reluctant to confront negative state decisions regarding resource allocation on health care.[107]

The socio-economic factors behind an illness such as that of Tom Condliff (the relevance of which was denied by the PCT's policy) are recognised by the World Health Organisation as closely correlating with the cause, diagnosis and treatment of disease.[108] In truth, morbid obesity of the type suffered by Tom Condliff is not able to be attributed solely to "lifestyle choices" but rather to "socio-political, socio-economic, socio-environmental and socio-cultural environments".[109] Health reforms such as those analysed here manifestly do not support the foundational social virtue of equity in that they allow governments and insurers to shift responsibility for (and cost of) an individual's "lifestyle choices" onto that consumer.[110]

There is, indeed, a fundamental assault on equity as a foundational social virtue implicit in blaming people for making poor choices that lead to poor health outcomes and then also expecting them to make choices regarding their health care. We know that social inequality limits autonomy.[111] Autonomy, in other words, is strongly associated with educational and financial empowerment so the least educated, poorest and unhealthiest are also the least autonomous.[112]

In both the United Kingdom and Australia, successive governments have failed to invest in social inclusion programs that would have the effect of decreasing the health disparity between the social

[104] Young K, "Securing Health Through Rights", in Pogge T, Rimmer M and Rubenstein K (eds), *Incentives for Global Public Health* (Cambridge University Press, UK, 2010) p 360.

[105] Perelman J and Young K, "Freeing Mohammed Zakari: Rights as Footprints", in White L and Perelman J (eds), *Stones of Hope: How African Activists Reclaim Human Rights to Challenge Global Poverty* (Stanford University Press, Palo Alto, 2011) pp 122-145.

[106] *Soobramoney v Minister of Health (Kwazulu-Natal)* Constitutional Court of South Africa, 1 October 2005 (CCT32/97) [1997] ZACC 17; 1998 (1) SA 765 (CC).

[107] Sokol D, "Bariatric Surgery and Justice in an Imperfect World" (2011) 343 BMJ d4944.

[108] World Health Organisation, *World Health Statistics 2011*, http://www.who.int/gho/publications/world_health_statistics/EN_WHS2011_Full.pdf viewed September 2011.

[109] Friel S, *Health Equity in Australia: A Policy Framework Based on Action on the Social Determinants of Obesity, Tobacco and Alcohol* (Australian National Preventative Health Taskforce, 2009), http://www.health.gov.au/internet/preventativehealth/publishing.nsf/content/0fbe203c1c547a82ca257529000231bf/$file/commpaper-hlth-equity-friel.pdf viewed September 2011; Doctors for Global Health, *Review of US Health Care Law from a Human Rights Perspective*, p i, http://www.dghonline.org/content/health-care-reform-us viewed August 2011.

[110] Friel, n 109.

[111] Lindbladh E, Lyttkens C, Hanson B and Osetergren P, "Equity is Out of Fashion? An Essay on Autonomy and Health Policy in the Individualised Society" (1998) 46(8) *Social Science & Medicine* 1017; see also Chapman A, "The Social Determinants of Health, Health Equity and Human Rights" (2010) 12(2) *Health and Human Rights* 17.

[112] Tomlinson J, *Patients Not Profits. How Markets Dehumanise Health* (2011), http://www.abetternhs.wordpress.com/patients-not-profits-how-markets-dehumanise-health viewed September 2011.

"classes" (eg effective education, employment and housing programs).[113] In both the United Kingdom and Australia, there is no constitutional right to health or even a right to emergency medical services that can be enforced against a government or the private corporations that (in the near future) that government may allow to run its health care system for profit.

Yet universal access to health care, like universal education and the attempt to create universal employment, should be a basic responsibility of a nation state which seeks to elicit loyalty from its citizens. Andrew Lansley, the United Kingdom Secretary of State for Health, recognised this in his manifesto announced some years ago:

> [I]f we want to reduce inequalities, we should be less concerned with distributing health funding allocations towards the areas of deprivation – except to the extent that there is existing morbidity and demand – and rather more concerned with the effectiveness of measures to raise people's general standards of living through, for example, helping them off benefits and into work.[114]

Equity and universal coverage, however, are not what the United Kingdom or Australian health care reforms appear designed to achieve. At the time of writing, it is too soon to judge the extent to which these initiatives to implement access targets for emergency and elective surgery will make health care services more accessible in Australia.[115] On the one hand, it is clear that the Australian Labor Government has gone to some lengths to ensure that its health reform initiatives in this area were the product of consultation and were informed by the views of experts.[116] What was missing from these reforms, however, was debate and policy oriented towards constitutionally enforceable rights to health care, particularly in emergencies. That is the type of human rights guarantee that should have been emerging from both the United Kingdom and Australian health reforms.

Instead, the case of Tom Condliff demonstrates the ineffectual nature of relying on non-health-care-specific human rights doctrines to rectify the systematic failure of any health system to adequately prioritise equity and justice in relation to access to service decision-making. Ostensibly enforceable human rights that do not go as far as to provide a constitutional guarantee of health care, particularly in emergencies, will not adequately redress issues of inequity promoted by the "liberalisation/privatisation" of health care systems.

POSTSCRIPT

After his unsuccessful appeal, the North Staffordshire PCT was presented with further medical evidence of Mr Condliff's case, found he met the criteria of exceptionality and granted funding for the surgery.[117]

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[113] See Friel, n 109.

[114] Lansley A, "The Future of Health and Public Service Regulation", speech, 9 July 2005, http://www.andrewlansley.co.uk/newsevent.php?newseventid=21 viewed September 2011.

[115] Indeed, speaking of the health reforms agreed in 2011 in general (and not the access targets in particular), Keane indicates it is the "taxpayers of the next three decades" who will benefit from these reforms: see Keane, n 55.

[116] As was noted approvingly by FitzGerald G and Ashby R, "National Health and Hospital Network for Australia's Future: Implications for Emergency Medicine" (2010) 22 *Emergency Medicine Australasia* 384 at 384 in relation to the health reform process as a whole up to 2010.

[117] BBC, *Tom Condliff Told NHS will Pay for Gastric Band Surgery* (15 August 2011), http://www.bbc.co.uk/news/uk-england-stoke-staffordshire-14525854 viewed November 2011.