
Medical law reporter

Editor: Thomas Faunce*

THE HEALTH LEGISLATION AMENDMENT ACT 2013 (QLD) AND QUEENSLAND'S HEALTH ASSETS PRIVATISATION DISPUTE

*New legislation in Queensland has provided a "pathway" for the privatisation of health assets and services in Queensland, which effectively realigns the health care system to the financial market. This column explores how this legislation contained the antecedents of the Queensland doctors' dispute when doctors roundly rejected new employment contracts in February 2014. It also argues that such legislation and its attendant backlash provides a valuable case study in view of the federal government's 2014 budget offer to the States of extra funding if they sell their health assets to fund new infrastructure. The move to privatise health in Queensland has also resulted in a government assault on the ethical credibility of the opposing medical profession and changes to the health complaints system with the introduction of a Health Ombudsman under ministerial control. The column examines these changes in light of *R (Heather) v Leonard Cheshire Foundation* [2001] EWHC Admin 429, a case concerning the obligations of a private entity towards publically funded clients in the United Kingdom. In discussing concerns about the impact of privatisation on the medical profession, the column points to a stark conflict between the duty to operate hospitals as a business rather than as a duty to patients.*

INTRODUCTION

On 29 October 2013, the Queensland government under the premiership of Campbell Newman passed legislation (*Health Legislation Amendment Act 2013* (Qld)), amending the *Health Legislation Amendment Act 2011* (Qld), the *Hospital and Health Boards Act 2011* (Qld), the *Public Health Act 2005* (Qld), the *Queensland Institute of Medical Research Act 1945* (Qld), the *Queensland Mental Health Commission Act 2013* (Qld) and the *Transplantation and Anatomy Act 1979* (Qld). The most controversial thrust of these amendments concerned the development of what may be termed the "health care market" in Queensland, as an extension of a policy development phase that began in 2012 when the Queensland Commission of Audit published its *Interim Report* recommending radical privatisation of government assets and services, leaving only those State mechanisms that serve, amongst other things, the protection of property, legislation, courts, police and emergency services in government control.¹

One of the key amendments made by the *Health Legislation Amendment Act 2013* to the *Hospital and Health Boards Act 2011* (Qld) was the setting up of the legal framework for the transfer to private investors of health system assets and the revenue streams they generate. Under the newly inserted s 273A of the *Hospital and Health Boards Act*, the Minister for Health is granted the power to transfer land or interests in land held by the State or a Hospital and Health Service (HHS) by issuing a transfer notice.

* BA LLB (Hons), B Med, PhD; Australian Research Council Future Fellow; Professor, College of Law and College of Medicine, Biology and the Environment (joint appointment), Australian National University.

Correspondence to: Thomas.Faunce@anu.edu.au.

¹ Queensland Commission of Audit, *Interim Report* (June 2012).



- (1) This section applies to each of the following interests held by the State or a Service –
 - (a) freehold land;
 - (b) a lease under the *Land Act 1994*;
 - (c) a reserve under the *Land Act 1994*;
 - (d) any other interest in land.
- (2) The Minister may do any of the following by gazette notice (a *transfer notice*) –
 - (a) transfer an interest held by the State to a Service;
 - (b) transfer an interest held by a Service to the State or another Service;
 - (c) transfer or grant, to the State or another Service, an associated interest;
 - (d) vary an associated interest held by the State or another Service.

Section 273A also provides that: “A transfer notice has effect despite any other law or instrument” (s 273A(6)); “Transfer of a liability of the State under a transfer notice discharges the State from the liability, except to the extent stated in the notice” (s 273A(8)); and “No government duties, fees or charges are payable for anything done under a transfer notice” (s 273A(9)).

In addition, the newly inserted s 273C of the *Hospital and Health Boards Act* provides that decisions are not reviewable:

- (1) Unless the Supreme Court decides that a decision relating to a transfer notice is affected by jurisdictional error, the decision –
 - (a) is final and conclusive; and
 - (b) can not be challenged, appealed against, reviewed, quashed, set aside or called in question in any other way, under the *Judicial Review Act 1991* or otherwise (whether by the Supreme Court, or another court, a tribunal or another entity); and
 - (c) is not subject to any declaratory, injunctive or other order of the Supreme Court, another court, a tribunal or another entity on any ground.
- (2) In this section –

decision, relating to a transfer notice, includes –

 - (a) a decision to give a transfer notice; and
 - (b) a decision or conduct leading up to or forming part of the process of making a decision to give a transfer notice.

The impact of these new provisions can best be appreciated by an analysis of the *Hospital and Health Boards Act* before the amendments commenced. Section 4 of the *Hospital and Health Boards Act* states that it “recognises and gives effect to the national health system agreed by Commonwealth, State and Territory governments”. These principles include the Medicare principle of universality (taxpayer-funded, accessible and equitable hospital services) as well as the national health system principles requiring services to be framed around patients, families and communities using an integrated approach to health care delivery. This includes health services that are focused on prevention, health maintenance and continuum of care; are based on needs; and are high-quality and affordable primary, community, hospital and aged care services that give heed to patient experience, social inclusion and sustainability.

The object of the *Hospital and Health Boards Act* is to “establish a public sector health system”, with regard to local decision-making, accountability and community engagement within the framework of “Statewide health system management” in regards to “planning, coordination and standard setting” (s 5). The key structural change resulting from the *Hospital and Health Boards Act* was the establishment of 17 HHSs,² each run by a Hospital and Health Board that “controls the Service for which it is established” (s 22). The boards are responsible for the operations of hospitals. Under the Act, a HHS is a corporate body that represents the State; it has the “powers of an individual” (corporate powers), which allows it to enter into contracts and agreements and charge for service provisions (s 20(1)).

The ability to charge for services was a key mechanism in establishing competition between HHSs and the private sector (s 16(2)(b)). Section 16 sets this up through service agreements between each HHS and the Chief Executive responsible for disbursements from the State-managed fund

² All Hospital and Health Services have at least five board members with the exception of the Torres Strait-Northern Peninsula Hospital and Health Service which is run by an administrator: <http://www.health.qld.gov.au/services/torresstrait-np/>.



(s 53H). Service agreements must state the “funding to be provided to the Service for the provision of services, including the way in which the funding is to be provided”, such as activity based funding (s 16(1)(b)).³ The HHSs are in the unenviable position of having to live within their allocations without the concomitant power to control revenue, including revenue raised through activity based funding efficiencies, as revenue is returned to the State pool account (s 53D(3)(a)). This means that efficient HHSs cannot bolster their own funding pool through efficiency gains but their funds may be reallocated to less efficient services.

The main function of a HHS is “to arrange for the provision of health services to public patients in private health facilities” (s 19(2)(k)). This provision effectively facilitates privatisation, whereby services and patients are outsourced to private providers, leaving the government, and by default the taxpayer, with just the bill to pay.

Ministerial power resides in directing all funding, including activity based funding payments and block funding from the Commonwealth, through to the administrator of the State pool fund (ss 53D-53E). In the matter of control of land and assets, a HHS may not buy or sell, grant or lease land or buildings without permission of the Minister and Treasurer (s 20A(1)-(2)). In this regard what powers a HHS does hold over land and assets can be restricted by regulation (s 20(2)).

Further, the Minister can make recommendations for the appointment, suspension or removal of members, including the chair and deputy chair, to the Hospital and Health Boards (ss 23(2), 27A(c), 28(e)). This means the influence local communities may have naturally assumed would flow to them through choosing their own board is not fully realised. The influence of the medical profession is also diminished, with the mandatory appointment of only one clinician per board. Of the 16 boards, just one has a chair with a health background. The three sectors represented by most of the chairs are business, law and local government. This suggests that the health service that doctors once dominated at the operational level as well as highly influenced at policy and planning levels has been replaced by a system that counts doctors and health care workers generally as inputs rather than stakeholders.⁴

The loss of power experienced by health professionals is reflected in the Queensland Commission of Audit’s stated principle that:

There is a need for greater workforce flexibility and mobility, so that resources can be readily redirected to areas of highest priority – by removing restrictive workplace practices which add unnecessary costs without delivering improved output. Industrial relations and enterprise bargaining arrangements should not fetter the ability of managers to manage.⁵

THE QUEENSLAND DOCTORS’ DISPUTE

In February 2014, a public dispute between Queensland doctors and the Queensland government arose more particularly as a result of an amendment to the Act that enabled the Chief Executive to issue health employment directives regarding conditions of employment that could *override* employment contracts. The conditions governing health executives and senior health service employees covered remuneration, classification levels, terms of contracts, conditions for non-contracted employees and professional development and training (s 51A(2)). Health employment directives were made binding on employees, the department and a HHS (s 51E(1)-(2)), with doctors losing recourse to take employment disputes to the Queensland Industrial Relations Commission.

³ The activity based funding model is used to calculate funding allocations for *public hospital services* (whether those services are provided in public hospitals or private hospitals). Based on the classification of health care professionals’ work into units of billable activities, this model enabled commodification through quantification of business outputs (treatments) and provided basic data to determine key business measures such as profitability and market risk.

⁴ Biographies of current board members are available at: http://www.health.qld.gov.au/about_qhealth/org_structure/hh/contact.asp#cairms.

⁵ Queensland Commission of Audit, *Final Report* (February 2013) Vol 1, p 1-10.



Supported by this legislative framework, a short clause was inserted into the contracts of senior medical officers and visiting medical officers stating that doctors shall not put “at risk the profitability of the service”. That this clause was rejected by the medical profession brings to light the tension between medicine as practised on behalf of patients and medicine practised on behalf of profit-reaping private corporate entities.

The commitment to ethics and the social power of a generally esteemed medical profession present a real problem to governments and their lobbyist backers wishing to privatise the health system. In Queensland, this problem appears to have been tactically fought in part by the government undermining the doctors’ reputation with the public through claims that those doctors were rorting the health system. Further, the Newman government, cognisant of the need to make some gesture towards community consultation, launched the Strong Choices campaign costing over \$6 million using “virtual town hall” meetings and an online questionnaire to attempt to legitimise the government’s health system privatisation agenda.⁶

In an attempt to appear conciliatory, Minister Springborg moved another Amendment Bill ensuring that high-income guarantee contracts (covering senior medical officers and visiting medical officers) prevail over directives in regards to any inconsistency between the directive and a contract. The Minister also stated that the high-income guarantee contract would prevail over employment regulations under s 282 of the *Hospital and Health Boards Act* and s 193 of the *Industrial Relations Act 1999* (Qld).⁷ The *Hospital and Health Boards Amendment Bill 2014* (Qld) was passed on 3 April 2014, but it did not go sufficiently far to dispel doctors’ concerns over the contracts.⁸

Yet Minister Springborg had relented only in kind but not in attitude, reiterating in a speech introducing the Bill that:

Workforce reform is a key strategy under the *Blueprint for Better Healthcare in Queensland*. The introduction of individual employment contracts for senior employees, including doctors, represents a key step to rationalise and simplify the industrial relations framework within the public health system. Individual contracts ensure performance, productivity, accountability, quality, more flexible value for money and patient care. Modern high-performing service industries rely heavily on performance based contracts to deliver better, additional and enhanced services.⁹

Apart from eschewing formal negotiations with the medical profession, the government also ran a concerted informal campaign to not only diminish the public reputation of the doctors, but their capacity to influence it. Queensland Health attempted to gag the unions and the Australian Medical Association Queensland by seeking an injunction to stop what they considered to be misinformation about the new employment contracts being distributed to practitioners, which they claim to be a contravention of the *Australian Consumer Law* by engaging in misleading conduct.¹⁰

THE RISE OF THE HEALTH SYSTEM FINANCIAL MARKET IN QUEENSLAND

The new Queensland health system legislation needs to be viewed in the context of the neo-liberal agenda (driven in large measure by multinational consultancies such as KPMG, PwC, Ernst & Young and McKinsey) to redefine the global health system market. The familiar “real economy” Australian health market (like that in the United Kingdom and Canada) involves privately owned health care assets and services competing for customers with public health entities. The finance sector health

⁶ The online questionnaire, the centre piece of the campaign, was designed to elicit a “positive” response to the privatisation plans and therefore does not pass a bias test as a means of accurately gauging what the citizens consider to be in their interests.

⁷ Queensland, Legislative Assembly, *Parliamentary Debates* (1 April 2014) p 910 (first reading speech of the *Hospital and Health Boards Amendment Bill 2014* (Qld)).

⁸ Union representative Dr Sandy Donald stated that concerns still remained, notably the makeup of the contract review committee and dispute resolution clauses: see Ryan B and Gramenz E, “Doctor’s Contracts Dispute: Queensland Parliament Passes Amendment Laws”, *ABC News* (4 April 2014), <http://www.abc.net.au/news/2014-04-04/doctors-contracts-dispute-qld-parliament-passes-amended-laws/5366662>.

⁹ Queensland, n 7, p 910. See also Queensland Health, *Blueprint for Better Healthcare in Queensland* (2014).

¹⁰ “Qld Govt Takes Doctors to Court”, *Medical Observer* (2 April 2014), <http://www.medicalobserver.com.au/news/qld-govt-takes-doctors-to-court>.

market, however, trades financial products like stocks, shares and derivatives based on the assets and revenue streams of those private health care businesses. The ownership of those businesses and the value assigned to their assets resides with private individuals, domestic and foreign health care corporations, holding companies, banks, private equity investment corporations, shareholders, superannuation funds and taxpayers (government).

The relationship between the health care industry and the health system financial markets increasingly is based on assets, the collateral attached to them and the revenue streams they generate. Implicit in this relationship is the process of privatisation which has been in train in Queensland since the start of the 1980s.¹¹ Privatisation releases public assets onto the markets, along with the construction of new infrastructure under business models like public-private partnerships.¹² This demand is driven by the finance sector, technologies like high-frequency trading, foreign investors, including sovereign wealth funds and superannuation funds. The head of the Queensland Investment Corporation,¹³ Damien Frawley, speaking about investment and the \$1.6 trillion superannuation sector in Australia, stated that there was an “incredible global appetite”, for investment but there were simply not enough assets on the market.¹⁴

Superannuation, in particular, has been identified as a source of assets that could be made available for trade on markets and subsequently for investment in infrastructure projects, such as health systems.¹⁵ The superannuation sector has grown significantly since the mandatory contribution superannuation scheme was introduced in 1996. According to Deloitte, assets in superannuation are set to rise to 180% of gross domestic product and reach \$7.6 trillion by 2033.¹⁶

Increasing the volume of trade on the markets through the privatisation of public assets and constructing new infrastructure using government revenues, then subsequently leased or sold off to the private sector, has been a long-held strategy promoted by finance sector players such as investment banks, hedge funds and asset management corporations and the Business Council of Australia. In its submission to the National Commission of Audit in 2014, the Council stated that:

Governments should recycle funds currently locked up in mature assets by selling them to the private sector (eg superannuation funds) and reinvesting the proceeds in new projects.¹⁷

Peter Costello, himself an investment advisor, as Chair of the Queensland Commission of Audit brought his “investment” perspective¹⁸ to the framing of recommendations around asset sales, recommending in the Commission’s 2013 report that:

The Government must make better use of its balance sheet, by releasing capital locked up in mature assets to pay down debt, lower interest costs and free up funds for investment in new infrastructure.¹⁹

¹¹ Jeanes M, “Private Health Care in the Pink – And the Black”, *The Australian Financial Review* (7 April 1997).

¹² For example, the Sunshine Coast Public University Hospital, due to open in 2016, is being built under a public-private partnership. It has been the centre of public controversy because the public rejected the plans to make it a private hospital.

¹³ The Queensland Commission of Audit recommended the privatisation of State-owned Queensland Investment Commission (which includes super fund QSuper) in 2013: Queensland Commission of Audit, n 5, Vol 1, p 1-12.

¹⁴ “Super Funds Need Assets: QIC Boss”, *The Australian Financial Review* (9 April 2014) p 21.

¹⁵ SMART Infrastructure Facility, University of Wollongong, *Green Paper: Infrastructure Imperatives for Australia* (2014).

¹⁶ These figures account for legislated rises in the Superannuation Guarantee rate up to 12% by 2019: Deloitte, *Dynamics of the Australian Superannuation System* (2013).

¹⁷ Business Council of Australia, *Submission to the National Commission of Audit* (December 2013) p 17.

¹⁸ Costello founded investment advisory group, BKK Partners along with Goldman Sachs alumni, Alistair Walton, Andrew Stuart and Jeremy Mead in 2009. He resigned from the firm in 2013 to take up the role as head of the Future Fund. Goldman Sachs values highly their alumni stating on its website on 14 April 2014, “Our alumni contribute to the rich history and tradition of the firm, and we are proud that so many remain actively connected. Not only does this help validate our culture, it provides a real, tangible value”: see Goldman Sachs, <http://www.goldmansachs.com>.

¹⁹ Queensland Commission of Audit, n 5, Vol 1, p 1-12.



Investment in new health system infrastructure will drive further growth in the finance sector, which has been growing at a rate of 5.1%, placing it just below the value of manufacturing and agriculture combined at 10% of gross domestic product.²⁰ This growth is likely to get another boost if the finance sector is deregulated.²¹

The implications of this growth in capital being directed towards assets including health care assets like hospitals is that these institutions established to serve the public equitably will in effect be stolen or kidnapped to become captive generators of wealth for their private corporate owners and the greed-driven speculators in the financial sector who are earning substantial fees, bonuses and commissions from mergers and acquisitions and other deal making, asset management and trading on the markets. Politically, at the federal level, privatisation is being pushed hard, with Treasurer Hockey offering the States an extra 15% funding pegged against the sale value of their assets if they reinvest in infrastructure.²² In Queensland, Campbell Newman has been more circumspect with privatisation plans, stating that although his government had accepted the recommendations of the Queensland Commission of Audit to privatise the State's assets, he would nonetheless seek approval for privatisation at the next State election in 2015.

The development of the financial markets for health assets is cast into contractual arrangements at the procurement stage in public private partnership agreements. Health facilities built under these agreements generally include contract clauses that allow investors to cover off risks like movement in interest rates and inflation, by trading swaps on the derivatives markets. It is a form of risk management that is highly speculative in nature, indeed somewhat analogous to going to the race track, placing bets and then hedging those bets by placing more bets. The temptations are high for public officers to promote privatisation for their own self interest. Executive positions in the public service can morph into much higher paid positions in the private sector with incomes increasing fivefold simply on the basis of sector transition.²³

The question health professionals and health administrators have to ask is whether their workplaces are "too important to fail". In other words, will health services now in private hands be exposed to financial ruin if the markets go awry? It has been said that the:

pressure on medical professionalism has come from market fundamentalist health policies that emphasise consumer individualisation of risk and responsibility, along with the value prioritisation of short-term budgetary efficiencies and corporate profits.²⁴

The fundamental economic concept that the Queensland Commission of Audit, the Productivity Commission and the National Commission of Audit have promoted as establishing standards and stability in the health delivery system is competition specifically in terms of contestability:

Better value for money in the delivery of front-line services can be achieved through contestability, as this will encourage more efficient and more innovative service delivery, whether by the public sector or the private sector (public sector service providers should not be immune from competitive pressures).²⁵

In a health care sector that is calibrated to the market – contestability is not framed within the context of the commercial sphere of individual practitioners competing with each other, but rather as an economic concept applied to justify the incursion of corporations into an established monopoly

²⁰ Industry Super Australia, *Finance and Capital Formation in Australia* (November 2013) p 14.

²¹ Hockey made four international appointments to the advisory panel for the Financial System Inquiry representing global investment interests: Jennifer Nasson from JP Morgan; Sir Michael Hinze founder of CQS hedge fund; David Morgan from private equity group JC Flowers; and Andrew Sheng from Fung Global Institute, an Asia-focused think tank. For information about the Inquiry, see <http://fsi.gov.au>.

²² Grattan M, "Hockey Offers Sell-off Sweetener to States to Fund Infrastructure", *The Conversation* (28 March 2014), <http://theconversation.com/hockey-offers-sell-off-sweetener-to-states-to-fund-infrastructure-24971>.

²³ For example, the income of chief executive officers of the Water Board and other public utilities have increased.

²⁴ Faunce TA, *Who Owns Our Health?* (UNSW Press, Sydney, 2007) p 42.

²⁵ Queensland Commission of Audit, n 5, Vol 1, p 1-10.

structure that does not naturally offer competitive characteristics.²⁶ Contestability theory is used to justify deregulation, as the theory asserts that companies will behave competitively, even monopolies, if there are no “barriers”, like regulation and foreign investment controls hindering potential competitors from entering the market.

What patients and citizens are being convinced to accept and the medical profession coerced to accept is an economic-driven health delivery system in place of a health care system where professionals schooled in ethics have power and influence:

The ideals of public service in the Hippocratic Oath were increasingly viewed as promises constituting one half of a social contract, the consideration for which was medical practitioners’ lucrative monopoly position.²⁷

HEALTH OMBUDSMAN ACT 2013 (QLD)

The legislative realignment of the Queensland health care system to the market also has involved changes to the health complaints systems. These changes appear to be designed to ensure the professional complaints system is compatible with business objectives and conformable to ministerial control. The *Health Ombudsman Act 2013* (Qld) creates the new statutory position of Health Ombudsman and the Office of Health Ombudsman, and replaces the Health Quality and Complaints Commission by repealing the *Health Quality and Complaints Commission Act 2006* (Qld). The *Health Ombudsman Act* also establishes the position of Director of Proceedings who is responsible for determining whether complaints (called “notifications” under the *Health Practitioner Regulation National Law Act 2009* (Qld)) are prosecuted or referred to the Queensland Civil and Administrative Tribunal.

The main objects of the *Health Ombudsman Act* set out in s 3 are to:

protect the health and safety of the public ... promote professional, safe and competent practice by health practitioners ... and high standards of service delivery by health service organisations.

From 1 July 2014, the Health Ombudsman will review all serious complaints (a role previously split with the Australian Health Practitioner Regulation Agency) due to amendments to the National Law making Queensland a co-regulatory jurisdiction and allowing it to modify how Pt 8 of the National Law, covering disciplinary action, is applied in Queensland.

Section 14 of the *Health Ombudsman Act* permits the Health Ombudsman to act immediately to suspend a registered practitioner or prohibit a health practitioner from practising, if persons are deemed to be at “serious risk” and action is required to “protect public health and safety”. The Health Ombudsman may also facilitate a resolution to a complaint, investigate and report, or establish an inquiry and report on the complaint. Further, the Health Ombudsman may refer a matter to the director of proceedings for a decision to pass the complaint to the Queensland Civil and Administrative Tribunal. Some less serious matters and complaints concerning registered health practitioners may be referred to the national Regulation Agency or to the Commonwealth and other States where appropriate. The independence of the Health Ombudsman is stated clearly in s 27 of the Act, “the health ombudsman must act independently, impartially and in the public interest”, in regards to performance of his or her functions.

However, the Minister can direct the Health Ombudsman to undertake an investigation (s 81); conduct an inquiry, the terms of reference for which, could be changed by the Minister anytime during the course of the inquiry (s 152); and request reports and other information under Pt 13, which includes directing the Health Ombudsman to give confidential information to an “engaged” person at the Minister’s request (s 174). The Health Ombudsman cannot refuse any of these requests. The Minister has the power to appoint and fire the Health Ombudsman, eclipsing any power he or she had

²⁶ That competitive markets depend on informed consumer choice and that patients generally do not have the medical knowledge to make those choices is a known market distorting factor in health care. Governments outsourcing patient care to private hospitals and service access designated by the level of health insurance purchased also removes the patient from the market formula.

²⁷ Faunce, n 24, p 16.



over appointments under the previous Commission. The Australian Medical Association Queensland raised concerns in June 2013, about these points in the legislation as they allowed political interference in the health complaints system to occur lawfully.²⁸

These sections of the Act taken together greatly heighten the risk of undue political influence, if not coercion, of the Health Ombudsman as his or her budget and position is not protected from ministerial direct action. Further, the Ombudsman has no protocol at his or her disposal to refuse a request. Such risks are contrary to the *Wellington Declaration*,²⁹ proclaimed by the International Ombudsman Institute³⁰ in 2012. The Institute:

*[s]tresses that it is an expression of democratic maturity and the rule of law that governments and parliamentary majorities shall allow criticism voiced by independent Ombudsman institutions. As a consequence, an Ombudsman diligently fulfilling his/her mandate, shall not be subject to any form of physical, mental or unjustified legal coercion.*³¹

The lack of separation between the Minister and the Health Ombudsman across the complaints process is concerning, particularly given that a complaint may be directed against a practitioner, entity or service employed by Queensland Health for whom the Minister is responsible. There can be no claims of Health Ombudsman independence without a circuit breaker between the Minister's discretionary powers and the Ombudsman's functions.

The power of the Minister to direct the work of the Health Ombudsman also exists through the direct payment of monies by Queensland Health to fund the Ombudsman. This holds the potential for indirect political inference through ministerial control over Ombudsman workloads, acting as default means for setting priorities and planning. The International Ombudsman Institute has made clear that it:

*[o]pposes any financial restrictions which would limit the independence of the Ombudsman and restrict the ability of an Ombudsman to protect the fundamental rights of all persons.*³²

The risk of political interference is also heightened by s 288(1) which allows the Minister to prepare prescribed conduct documents, "to provide guidance to health service providers, persons receiving health services and entities performing functions under this Act about the standard of services that should be provided by health service providers or a related matter".

A person may have regard to a prescribed conduct document when making a decision under this Act about –

- (a) what constitutes appropriate conduct or practice for a health service provider; or
- (b) what is an appropriate way for a health service provider to provide a service. (s 288(3))

The decoupling of the Australian Health Practitioner Regulation Agency from the complaints management process in Queensland may also harbour some attempt to isolate, at least at an administrative level, one of the central concerns of practitioner registration and regulation, the principles and medical ethics underpinning the practitioner-patient relationship.

Under the *Health Ombudsman Act*, a health service provider includes an individual practitioner or entity providing a health service such as a public HHS (*Hospital and Health Boards Act 2011* (Qld)); private health facility (*Private Health Facilities Act 1999* (Qld)); ambulance service; or medical, dental, pharmaceutical or physiotherapy practice. The inclusion of private practitioners and entities is a major departure from the traditional role of the Ombudsman in investigating complaints against public (government) entities. The question arises whether an organisational model developed to deal with public maladministration has the requisite background to bring the depth necessary to adequately deal with professional regulation.

²⁸ AMA Queensland, "Queensland's Health Ombudsman: What Does It Mean For You?", http://amaq.com.au/icms_docs/165012_Queenslands_new_Health_Ombudsman_-_what_does_this_mean_for_you.pdf.

²⁹ International Ombudsman Institute, *Wellington Declaration* (adopted 13 November 2012).

³⁰ The International Ombudsman Institute promotes the work of its 155 member institutions through funding of research, training and publication on issues related to the role of ombudsman institutions internationally.

³¹ *Wellington Declaration*, cl 13.

³² *Wellington Declaration*, cl 10.



HEALTH DELIVERY IN A MARKET ECONOMY VERSUS ETHICAL HEALTH CARE: R (HEATHER) v LEONARD CHESHIRE FOUNDATION

The radical restructuring of Queensland's health system discussed above bears comparison with health system privatisation in England and Wales. Since 2002, large components of the National Health Service (NHS) workforce had been transferred to the private sector (cleaning, catering, laundry and maintenance, then technical diagnostic staff). New contracts with NHS consultants imposed productivity targets, tighter managerial control of workloads and limits on private practice. This pushed many consultants to leave the NHS or set up private chambers to sell their services. Private GP clinics (funded by companies such as Virgin) were increasingly established. Private health insurers were installed at the heart of NHS commissioning and patients encouraged to take out private insurance to "top-up" an increasingly narrow range of tax-payer funded services. The agenda was to replace the idea of paying for the health of citizens out of taxation with the less efficient but more corporately profitable system of private-insurance based managed care.³³

In a landmark case concerning health system privatisation in the United Kingdom, *R (Heather) v Leonard Cheshire Foundation*,³⁴ claimants sought judicial review of a decision to remove them from their homes. They were long-stay residents of the Leonard Cheshire Foundation, a charity that provides accommodation and care services to the disabled. The basis of the claim was that their places were funded by the government (local authority and health authority) and therefore the Foundation was exercising functions of a "public nature". They also claimed that their residences were "home[s] for life" as expressed by the Foundation's own policy. The Foundation's directors, called trustees, stated that, "its functions are wholly private ... and it denies being under the substantive obligations contended for by the Claimants, which are only applicable to public authorities".³⁵ Burton LJ considered the question of whether the Foundation "is, or is not, a public authority", as being consequential to the claimants raising the issue of the Foundation's obligations to them.³⁶

Reference was made to s 6 of the *Human Rights Act 1998* (UK), which makes it unlawful for public authorities to act incompatibly with the *European Convention on Human Rights*, and also to the meaning of "public function" in Pt 54.1 of the *Civil Procedure Rules* (UK). Burton LJ reiterated that:

It is only if Leonard Cheshire is a public authority in relation to [the obligations] that it could have owed [the claimants] a duty under section 6(1) of the *Human Rights Act* to comply with the Convention; and it is only if it is a public authority that it could have owed the duties imposed by public law on such authorities.³⁷

The increased privatisation of governmental functions may involve the loss of judicial review of those functions and of the decisions made when exercising them.³⁸ However, judicial review in the *Leonard Cheshire Foundation* case was sought through the lens of human rights, made possible in the United Kingdom by an interpretive provision requiring legislation to be consistent with the *Human Rights Act* and the *European Convention on Human Rights*.

The *Leonard Cheshire Foundation* case considered the substantive differences between public and private bodies, and the consequent allocation of duties that were incumbent on such a definition. Burton LJ said that:

In this connection, it should be borne in mind that non-governmental bodies often differ from governmental authorities in relation to their financial resources. Whereas private bodies must nearly always balance their income and expenditure, at least over the medium term, and have limited assets

³³ Player S, "Ready for Market" in Davis J and Tallis R (eds), *NHS SOS: How the NHS Was Betrayed – And How We Can Save It* (Oneworld Publications, London, 2013) p 38.

³⁴ *R (Heather) v Leonard Cheshire Foundation* [2001] EWHC Admin 429.

³⁵ *R (Heather) v Leonard Cheshire Foundation* [2001] EWHC Admin 429 at [6].

³⁶ *R (Heather) v Leonard Cheshire Foundation* [2001] EWHC Admin 429 at [10].

³⁷ *R (Heather) v Leonard Cheshire Foundation* [2001] EWHC Admin 429 at [19].

³⁸ *R v Servite Houses; Ex parte Goldsmith* (2000) 3 CCLR 325.

and income, governmental bodies may have access to tax revenues: if expenditure rises, they may increase taxes, or their revenue from tax-collecting authorities. A purely private body is, within legal constraints, generally entitled to act in its own economic interests; it will often be compelled to act in those interests.³⁹

This statement implies that economic interests of private entities cannot be denied or ignored, and brings into question the compatibility of public service provision by private entities. That economic interests amount to “profitability” is supportive of the whole capitalist enterprise that promotes private business *growth* even though organisational viability can be achieved at cost, without the profit motive.

CONCLUSION

Moves in Queensland to privatise the health system and to give more power to the Minister to influence the membership of the Hospital and Health Boards as well as the Health Ombudsman are concerning and demonstrate an alliance between the private sector and the government to the detriment of the public interest. The private insurance “managed care” health care model advocated for Queensland mirrors that of the United States, which is widely known to be the most expensive model of the OECD countries with one of the lowest average life expectancies of 78 years. By comparison, Australia’s predominantly public health care system currently nets a life expectancy of 82 years for almost half the cost.⁴⁰

The power of the finance sector to direct government policy is discussed in an article by a former chief economist at the International Monetary Fund, in which he said:

the American financial industry gained political power by amassing a kind of cultural capital – a belief system. Once, perhaps, what was good for General Motors was good for the country. Over the past decade, the attitude took hold that what was good for Wall Street was good for the country. The banking-and-securities industry has become one of the top contributors to political campaigns, but at the peak of its influence, it did not have to buy favors the way, for example, the tobacco companies or military contractors might have to. Instead, it benefited from the fact that Washington insiders already believed that large financial institutions and free-flowing capital markets were crucial to America’s position in the world. One channel of influence was, of course, the flow of individuals between Wall Street and Washington ... It has become something of a tradition for Goldman Sachs employees to go into public service after they leave the firm.⁴¹

The importance of strong institutions as a means of supporting individual morality and virtues has been championed by legal scholars like Schlink who said:

There’s no recipe that institutions won’t tumble and fall. I think it is important that institutions are understood not as something “out there” and me and my feelings and my morality is somewhere else. But it’s important that people can feel engaged in institutions with their morality, with their creativity, with everything they have. I think that’s the only way to strengthen institutions against something like 1933.⁴²

Finally, the Queensland Commission of Audit stated that: “There is no universal rule on what should be publicly or privately owned or managed.”⁴³ It would appear true enough that decisions of this nature are captive of balance sheet accounting. That there are, however, universal principles

³⁹ *R (Heather) v Leonard Cheshire Foundation* [2001] EWHC Admin 429 at [72].

⁴⁰ See OECD, “Life Expectancy at Birth” in *Health at a Glance 2013: OECD Indicators* (OECD Publishing, 2013) p 25. According to the OECD, “Health Expenditure in Relation to GDP” in *Health at a Glance 2013: OECD Indicators* (OECD Publishing, 2013) p 155-156, the United States spends 17.7% of its GDP on health, well above the OECD average, whereas Australia spends 8.9% of its GDP.

⁴¹ Johnson S, “The Quiet Coup”, *The Atlantic* (1 May 2009). Dom Strauss-Kahn, the current head of the International Monetary Fund, said of Johnson’s essay that the “basic argument is true”: see interview in *Inside Job* (Documentary directed by Charles Ferguson, 2010) at 00:18:30.

⁴² Interview with Bernhard Schlink by Ramona Koval, *ABC Radio National* (20 August 2009), <http://www.abc.net.au/radionational/programs/bookshow/bernhard-schlink-in-conversation/3059854#transcript>.

⁴³ Queensland Commission of Audit, n 5, Vol 1, p 1-7.



governing the position of patients and the practitioners who treat them, is historically ratified and well documented.⁴⁴ This is a position of strength held by health institutions to create governance structures rooted in the ideals embodied by the trinity of medical ethics, the nation state and the social contract. That this is embraced by the doctors in Queensland is made clear by their *Health Vision* document,⁴⁵ which frames their vision of health care around *values* of compassion, trust and knowledge.

The big question with multinational consultancies such as KPMG, PwC, Ernst & Young and McKinsey circling the Australian public hospital system like greedy sharks, is whether the Queensland health privatisation model will soon be rolled out as a nationwide model. If that happens, it will not be because Australian citizens want it, but because the organs of our democracy have been stolen from us by governments acquiescent to global healthcare corporations with insatiable greed and ruthless business methods.

*Caroline Colton BA Dip Lib
Research Associate
and*

*Thomas Faunce
Professor, ANU College of Law and College of Medicine, Biology and the Environment (joint
appointment), the Australian National University*

⁴⁴ The key oaths and principles are discussed in Faunce, n 24.

⁴⁵ AMA Queensland, *Health Vision* (2013), http://amaq.com.au/page/Advocacy/AMA_Queenslands_Health_Vision.