
Medical law reporter

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COMMISSIONS OF AUDIT IN AUSTRALIA: HEALTH SYSTEM PRIVATISATION DIRECTIVES AND CIVIL CONSCRIPTION PROTECTIONS

The use of commissions of audit as vehicles to drive privatisation policy agendas in areas such as health service delivery has become popular with conservative federal and State governments. Such commissions have characteristically been established early in the terms of such governments with carefully planned terms of reference and membership. The policy directions they advocate, unlike election policies, have not come under the intense scrutiny, wide public debate or the opportunities for (dis)endorsement afforded by the electoral process. Governments do, however, anticipate and often accept recommendations from these reviews, and use them as justification to implement policy based on their findings. This highlights the power entrusted to review bodies and the risks to the public interest arising from limited public consultation. An example can be seen in the proposed privatisation of important aspects of Australia's public sector, particularly including those related to health systems delivery, currently entering a new iteration through the work of the National Commission of Audit appointed in October 2013. The NCA follows on from various State audit commissions which in recent years have directed the divestment of government responsibilities to the private and not-for-profit sectors. Through a discussion on the formation of policy frameworks by the NCA and the Queensland Commission of Audit, this column examines the ideological thrust of the commissions and how they synergise to produce a national directive on the future of public sector health services. The practical impacts on health service procurement and delivery in critical areas are examined, using the case of the federally contracted out medical service for asylum seekers and two hospitals in Western Australia, a State which is well advanced in the privatisation of public hospitals. The column then examines the release to the media early in the NCA's process of the submission to introduce a \$6 general practitioner co-payment as a means of testing the response of the medical profession and public. The column also examines how the civil conscription clause in s 51(xxiiiA) of the Australian Constitution may serve to protect practitioner and patient rights should some of these privatisation changes to Australia's health system be challenged in the High Court of Australia.

INTRODUCTION

Australia has had a public-private mixed health care system since the early days of the colonies when charitable organisations and religious orders owned and operated a range of health care facilities in addition to those chiefly supported by the government as a key part of its social contract. But with the formation of the National Health and Hospitals Reform Commission (NHHRC) in 2008, a new era of privatisation and corporatisation began. Chiefly promoted as ending the so-called "Blame Game" between federal and State authorities, the NHHRC laid the groundwork for such system-wide change,

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through initiatives such as activity based funding.¹ The years following the Commission's formation saw a health infrastructure construction boom, much of it implemented under Public Private Partnerships (PPPs) agreements.²

This column discusses how with the election of the Abbott Coalition government and its appointment of the National Commission of Audit (NCA) and the central role therein of the Business Council of Australia (BCA), has injected a new energy and speed, amongst other things, into the process of health system privatisation in Australia. This process will be analysed by comparison with state-based examples of audit commissions and health system-related case studies. Given the centrality of equitable health system provision to most conceptions of the Australian social contract, the column then discusses likely challenges to aspects of this health system privatisation process in the High Court of Australia. In particular, it considers the relevance thereto of the Australian constitutional protection against conscription of health service providers to the private sector located in s 51(xxiiiA).

NATIONAL COMMISSION OF AUDIT

The Federal Treasurer Joe Hockey announced the formation of the NCA in October 2013. A NCA had previously been established in 1996.³ Terms of reference were published online and submissions were called for, with a deadline set at 26 November 2013. The Terms of Reference began by noting that the size of the Commonwealth government had "expanded significantly" since the last audit in 1996 and that it was "essential that the Commonwealth government live within its means and begin to pay down debt".⁴

The NCA is to review the activities of the Commonwealth government to:

- ensure taxpayers are receiving value-for-money from each dollar spent;
- eliminate wasteful spending;
- identify areas of unnecessary duplication between the activities of the Commonwealth and other levels of government;
- identify areas or programs where Commonwealth involvement is inappropriate, no longer needed, or blurs lines of accountability; and
- improve the overall efficiency and effectiveness with which government services and policy advice are delivered.⁵

The Chair of the NCA is Tony Shepherd, President of the BCA, who is supported by Commissioners Amanda Vanstone, Peter Boxall, Tony Cole and Robert Fisher.⁶ Peter Crone, head of the NCA's Secretariat is also the Chief Economist and Director of Policy at the BCA. The BCA also sought to influence the work of the NCA through a submission which denoted "six key tasks that the NCOA must complete if it is to successfully map out a path for sustainable expenditure".⁷ These were:

1. Set the overall parameters for fiscal policy over the next decade ...
2. Undertake a stocktake of expenditure and identify the main growth drivers and risks.
3. Repair the budget as much as possible in the short term ...
4. Identify strategies to restrain growth in major government outlays ...through better targeting of payments and improved service delivery.

¹ National Health and Hospitals Reform Commission, *A Healthier Future for all Australians: Final Report* (Canberra, 2009).

² See, for example, Economic Audit Committee, *Putting the Public First: Partnering with the Community and Business to Deliver Outcomes: Summary Report* (October 2009) p 1.

³ National Commission of Audit, *Report to the Commonwealth Government* (June 1996).

⁴ National Commission of Audit, *Terms of Reference* (2013) p 1, http://www.ncoa.gov.au/docs/NCA_TERMS_OF_REFERENCE.pdf viewed 10 January 2014.

⁵ National Commission of Audit, n 4, p 1.

⁶ Amanda Vanstone was a former Minister in the Howard government; Peter Boxall is the Chairman of the Independent Pricing and Regulatory Tribunal; Tony Cole is the National Practice Leader, William Mercer's Investment Consulting (part of United States-based Marsh McLennan Inc); and Robert Fisher is the former Executive Director of the Western Australian Department of State and Development.

⁷ Business Council of Australia, *Submission to the National Commission of Audit* (December 2013) p 13.



5. Identify areas of overlap, duplication and potential inefficiency between the Commonwealth Government and the states ...
6. Identify how services can be improved in respect of outcomes.⁸

The BCA also proffered “principles for efficient government” focusing on lifting productive capacity, recovering costs, regulating only where market failure occurs, reducing administrative costs and maintaining intergenerational equity. These principles elaborated upon the NCA’s own principles expressed as “respect for taxpayers”, government doing for people “what they cannot do, or cannot do efficiently, for themselves, but no more” and “living within its means”.⁹

The NCA was tasked “to assess the financial position of the Commonwealth, including the state of the balance sheet, including all assets and liabilities, and Commonwealth risk expenditures”.¹⁰

The BCA’s alignment with this was framed as a “need to critically analyse the current position of the government balance sheet, including any emerging risks or contingent liabilities that are not reflected in the current position but may ultimately impact expenditure”.¹¹

Soon after the formation of the NCA, several proposals from submissions related to *reduced* government expenditure in the health sector were put to the media and debated. These included a \$6 co-payment proposal for bulk-billing services made by the Australian Centre for Health Research (ACHR), a small “think tank” set up by the smaller private health funds.¹² The BCA also in its submission referred to health as a key driver of growth in expenditure, explicitly naming “community health service programs (including Medicare), public health service programs (population health, hearing services, blood products, eHealth etc), the Pharmaceuticals Benefits Scheme, and medical research funding”.¹³ The NCA’s “options for greater efficiencies” is consistent with the BCA’s policy position promoting privatisation of Commonwealth assets; increased competition between services, less government and greater use of technology.¹⁴

Health system infrastructure also appears to be within the sights of the NCA. The relevant terms of reference require the NCA to “review and report on the extent, condition and adequacy of Commonwealth sector infrastructure and, if found to be deficient, factors that may have contributed to the current situation and possible remedies”.¹⁵ The BCA’s submission stated that government spending on infrastructure was a means of lifting productive capacity in the economy, along with education, tax reform and deregulation. The BCA went on to express concern that infrastructure spending could be squeezed out of the budget by “real expenditure growth for social security, welfare, health and education”.¹⁶

Health system infrastructure development is likely, however, to involve opportunity costs, for example, in terms of user fees and reduced funding for service provision. In its terms of reference, the NCA flagged that it would consider the use of price signals such as user charges.¹⁷ This accords with the BCA’s submission that a cost-recovery principle apply to infrastructure: “Australia’s infrastructure should be paid for by users or beneficiaries wherever feasible, and there is more that can be done to

⁸ Business Council of Australia, n 7 pp 13-14.

⁹ National Commission of Audit, n 4, p 1.

¹⁰ National Commission of Audit, n 4, p 3.

¹¹ Business Council of Australia, n 7, p 13.

¹² Hughes M, “Mind the Gap: \$6 GP Visit Proposal Ignores the Evidence”, *Crikey* (9 January 2014), <http://blogs.crikey.com.au/croakey/2014/01/09/mind-the-gap-6-gp-visit-proposal-ignores-the-evidence> viewed 10 January 2014.

¹³ Business Council of Australia, n 7, p 9.

¹⁴ National Commission of Audit, n 4, p 2.

¹⁵ National Commission of Audit, n 4, p 3.

¹⁶ Business Council of Australia, n 7, p 2.

¹⁷ The NCA looked at the use of co-payments, user-charging and other types of incentive payments: see n 4, p 3.



increase user charges as a funding source.”¹⁸ The NCA also was tasked to consider asset privatisation (for example, Commonwealth-owned health facilities) as a means of eliciting efficiencies and savings across the forward estimates and medium term.¹⁹

Central to the NCA’s task was to be an examination of the Commonwealth’s roles and responsibilities as a means of navigating Commonwealth-State relations, not least because any impacts on Commonwealth revenues, programs and services would affect the States’ ability to deliver services to the people and promote economic growth. The NCA’s terms of reference required examination of duplication of activities between different levels of government and the opportunity to move activities out of the Commonwealth’s sphere including by means of discontinuation.²⁰ This included considering “the current architecture of Commonwealth-State relations ... to inform the Government’s forthcoming White Paper on the Reform of the Federation”.²¹ The NCA was tasked with identifying “options for a clearer delineation of responsibilities for policy and service delivery”.²² It should be noted in this context that the mooted constitutional referendum to recognise local government in the Constitution was postponed by the 2013 federal election, leaving the basic funding arrangement in the health care sector as one where the Commonwealth is responsible for primary health care and the States look after the hospitals.²³

The appropriateness of the membership and terms of reference of the NCA became the subject of an Australian Senate inquiry, a move that was criticised by senior government figures.²⁴

HEALTH SYSTEM OUTCOMES OF THE QUEENSLAND COMMISSION OF AUDIT

What the likely outcomes will be for the Australian health system from the NCA can be gauged to a certain extent from the activities of a pre-existing State Commission of Audit. The Queensland Commission of Audit (QCA), chaired by Peter Costello, published its final report in February 2013.²⁵ Costello, along with Commissioners Douglas McTaggart and Sandra Harding, were tasked with examining the State’s financial position. Of the 155 recommendations they made in their final report, the Queensland government accepted 122 of them.²⁶ Many of these had significant implications for the health system of that State.

The QCA’s report refers to a “Fiscal Repair Strategy” aimed at regaining Queensland’s AAA credit rating through the rapid pay down of debt by selling assets and shifting service delivery to the non-government sector. The Commissioners did not see a role for taxation in debt reduction, endorsing the government’s “strategy of keeping taxes competitive, and as low as possible which is designed to provide a conducive environment for businesses to invest and to boost economic growth”.²⁷

¹⁸ Business Council of Australia, n 7, p 4.

¹⁹ National Commission of Audit, n 4, p 2.

²⁰ National Commission of Audit, n 4, p 2.

²¹ National Commission of Audit, n 4, p 2.

²² National Commission of Audit, n 4, p 4.

²³ Mitchell D, “Why Local Government Should Not Be Recognised in the Constitution”, *Quadrant* (online) (1 April 2012), <https://quadrant.org.au/magazine/2012/04/why-local-government-should-not-be-recognised-in-the-constitution> viewed 10 January 2014.

²⁴ “Inquiry into Commission of Audit”, *The Australian* (15 January 2014), <http://www.theaustralian.com.au/national-affairs/inquiry-into-commission-of-audit-a-show-trial-joe-hockey/story-fn59niix-1226802120178> viewed 10 January 2014.

²⁵ Queensland Commission of Audit, *Final Report* (February 2013) Vols 1-3.

²⁶ Allens Linklaters, “Focus: Queensland Government responds to Costello Audit Report” (9 May 2013), <http://www.allens.com.au/pubs/govt/fogovt9may13.htm> viewed 10 January 2014.

²⁷ Queensland Commission of Audit, n 25, Vol 1, p 1-11.



The QCA went on to urge greater privatisation:

To ensure the future sustainability of both the State's balance sheet and operating statement in the face of a growing and ageing population, the Commission recommends the State review all current service delivery with a view to adopting higher productivity mechanisms, almost certainly with a greater reliance on private sector delivery.²⁸

The level of reliance on the private sector that the QCA recommended was radical in its coverage. Essentially, the QCA recommended the government withdraw as much as possible from service provision, including health service provision. It expressly supported the neo-conservative ideological position that: "The primary responsibility of the Government is to ensure services are delivered, not necessarily to be the agency that actually does the delivery. It needs to be the 'enabler', not necessarily the 'doer'."²⁹

The QCA went on to garrison its position in regards to privatisation of health services in that State. It recommended that the Queensland government "vigorously resist any cost-shifting from the Australian Government to the State; seek reimbursement for the cost of delivering services that are the responsibility of the Australian Government".³⁰ The QCA recommended the Queensland government "provide core services such as policing, public safety, emergency and justice services, which have a strong public good element" but "work more closely with non-government providers to find the most cost-effective ways of delivering a range of other social services, including public education, public transport, health, housing and community support services, primarily for those most in need in society".³¹ It is worth pausing to consider how such an official body could propose Australians accept that health services do not have a "strong public good element".

Although the QCA was promoted as a means by which the government could receive "independent" expert advice, membership is weighted towards people with corporate interests. The Newman-conservative State government was emboldened by the QCA to engage in a wider round of privatisation of health care. In health, a range of privatisation experiments followed, involving outsourcing, contracting and new forms of PPPs. At the time the final QCA report was published, Queensland already had three major hospital projects worth over \$5 billion under construction,³² as well as smaller health facility redevelopment projects.

AUSTRALIAN HEALTH SYSTEM PRIVATISATION CASE STUDIES

Some case studies are analysed below to evaluate how the NCA's privatisation agenda is likely to be translated into federal government policy and legislation, and what issues and problems this may create both for the federal and State governments and the citizens they represent.

Privatisation of health services to asylum seekers: International Health and Medical Service

For some time now, health services to asylum seekers have to a considerable extent been privatised. While undoubtedly any attempt to provide such services would create major issues, it appears that the profit motive of the private employers has been a considerable factor in creating adverse conditions both for health service providers and their patients.

A lengthy letter, for example, was written by 15 doctors working on Christmas Island and published by Australian edition of *The Guardian* on 20 December 2013. This exposed gross failures in the provision of medical services to asylum seekers on the island. Apart from revealing appalling

²⁸ Queensland Commission of Audit, n 25, Vol 1, p 1-3.

²⁹ Queensland Commission of Audit, n 25, Vol 1, p 1-19.

³⁰ Queensland Commission of Audit, n 25, Vol 1, p 1-23.

³¹ Queensland Commission of Audit, n 25, Vol 1, p 1-11.

³² The Gold Coast University Hospital (\$1.76 billion), opened in November 2013, was built under a Managing Contractor Guaranteed Construction Sum agreement; the Lady Cilento Children's Hospital (\$1.5 billion), merging Brisbane Children's Hospital and the Mater Children's Hospital, will open in November 2014; and the Sunshine Coast Public University Hospital (\$1.8 billion) is being built under a PPP and will open in 2016.



conditions, the letter also revealed the employment conditions imposed on the doctors by their private employer, the International Health and Medical Service (IHMS)³³ who told them they were “being paid to accept the risk”.³⁴

The doctors argued that: “This concept of payment for risk is clearly in conflict with AHPRA’s [Australian Health Practitioner Regulation Agency] code of conduct.”³⁵ The doctors were concerned that if they were found in breach of the code their registration may be revoked. The doctors claimed that there exists a fundamental conflict of interest between their employer, the IHMS, and the Department of Immigration and Border Protection (DIBP). They stated:

We have concerns that decisions made by IHMS regarding the provision of care to patients have been compromised by their relationship with the DIBP. As a result, these decisions are not always in the best interest of the patient ... IHMS must therefore not put its doctors or itself in a situation where financial inducement means that its care for patients is compromised ... In response to complaints by staff regarding the poor delivery of care, management have frequently responded that the DIBP is accepting risk, thus allowing doctors to practice with indemnity. However no third party can absolve a practitioner of their primary responsibilities to the patient or their registration body (AHPRA).³⁶

The doctors were making the point that the federal government had by its policies and legislation created a situation where if they wished to work with asylum seekers as a chosen career path, they had no option but to accept the imposition of duties from a private employer making them work in a particular way. The doctors’ stated in their letter that “many aspects of the IHMS health service fall well below accepted standards for clinical practice and are unnecessarily dangerous”.³⁷ The result of this privatisation of health services by the federal government appears to have been an incursion into the doctor-patient relationship and doctors’ duty to perform their duties to acceptable standards of care which they claim is being thwarted by the IHMS and the relevant federal department.

Privatisation at the Fiona Stanley Hospital and Midland Public Hospital, WA

A different set of issues and problems was raised by privatisation in particular at the Fiona Stanley Hospital (FSH) in Perth, Western Australia. In Western Australia, the process of privatising health care services is much more advanced than other States with major hospital infrastructure projects built in recent years using a variety of privatisation models. Central to this appears to have been Western Australia’s Economic Audit Committee whose report was published in 2009. The report stated that: “The public sector will increasingly act as a facilitator of services, rather than a direct provider, with all areas of service delivery opened to competition.”³⁸ Western Australia, along with other States, also contributed to the formation of the federal government’s privatisation modelling for new infrastructure. A year after the FSH was commissioned, the then federal Department of Finance and Deregulation put out a report called *Public Private Partnerships*. In it the Department made a case for implementing the PPPs model for building social infrastructure. Those involved in forming the PPPs policy framework as outlined in the report were State treasuries, banks, lawyers and the Australian Council for Infrastructure Development (AusCID), now called Infrastructure Partnerships Australia. In

³³ IHMS is contracted by the Department of Immigration and Border Protection to provide health services in detention centres. IHMS is part of International SOS, a company established in 1985 under the name AEA International. International SOS provides a range of medical, travel, insurance, concierge and security services to corporations, non-government organisations and governments. It also bought out Service Médical International, a French company that manufactures medical supplies for the aviation, maritime and oil industries. It is a global corporation with over 6,000 employees: <https://www.internationalsos.com/en> viewed 3 March 2014.

³⁴ Extract of letter published in Marr D, “Doctors Reveal ‘Harmful’ Standards of Medical Care for Asylum Seekers”, *The Guardian* (20 December 2013), <http://www.theguardian.com/world/2013/dec/19/revealed-doctors-outrage-over-unsafe-refugee-patients> viewed 10 January 2014.

³⁵ Extract of letter published in Marr, n 34.

³⁶ Extract of letter published in Marr, n 34.

³⁷ Extract of letter published in Marr, n 34.

³⁸ Economic Audit Committee, n 2, p 1.



2008, the federal government agency Infrastructure Australia (IA) was established. It is a statutory body that advises governments, investors and infrastructure owners on directions for PPP infrastructure developments.

Many health system-related projects arising from this privatisation process are nearing completion. Critical assessment of this process focuses on its failure to consider the needs of health care professionals while promoting an expectation that such professionals are required to accept whatever conditions the government and the private sector impose on them, regardless of how that impacts on quality of care and patient safety. The FSH and the Midland Public Hospital (MPH) exemplify the problems faced by people working under the new privatisation regime.

The 783-bed FSH was commissioned by the Gallop State Labor government under a PPP agreement which saw the government take responsibility for all clinical services and a private contractor (Serco) responsibility for operating all non-clinical services. Hospital construction is due to be completed in October 2014 and Serco is set to take over operations in 2015 with staged service openings. The gap between completion and operation has been reportedly caused by technology problems and most significantly medical recruitment problems. The plan is for existing hospitals Charles Gardiner, Royal Perth, Fremantle and Rockingham to keep running, albeit with reduced capacity and thereby, at least initially, retain clinical staff even when the FSH is fully operational. According to Australian Medical Association (WA) President Dr Richard Choong, the government's recruitment process for FSH was late starting. "The Government is staying with this fantasy that it will simply move staff (to Fiona Stanley) from other hospitals. But who will step into those vacant positions?"³⁹

A Health Department directive sent in May 2012 from the then Director General of Health Kim Snowball stated that some staff would be required to move into the new location ("same job, different location"). Government insiders alleged the directive was deliberately aimed at letting staff know they would be "forced" to work at the new public-private FSH.⁴⁰ The staff shortage was raised again in December 2013, with commentary from health reporter Kara Vickery in *The Sunday Times* claiming a government report cited a shortfall estimated at 115 full-time equivalent clinical staff.⁴¹ The Western Australian government is also under pressure as stories surface in the media about bed number deficits with hundreds of beds being lost at other public hospitals instead of adding capacity.⁴²

An equally important case study concerns the MPH. This is a 307-bed licensed private hospital that will accept public patients paid for by the government. The new hospital, being built in the Swan Valley north of Perth, is set to replace the Swan District Hospital (SDH), which is earmarked for demolition once MPH is commissioned in 2015. The SDH is a public general hospital offering a wide range of services to a catchment population of 190,000 people. However, MPH will have both its clinical and non-clinical services operated by St John of God Inc. As this is a Catholic organisation, there will be restrictions placed on terminations, sterilisations and contraceptive services, as well as reproductive services. This has been criticised in the press for notionally marking out women and men who want these services as patients who need to be segregated from mainstream hospital services.⁴³ The Midland Health Campus will now consist of the MPH, the 60-bed Midland Private Hospital and a separate facility built by the government for services disallowed by the Church, without any shared utility or infrastructure to the MPH.

³⁹ Dr Richard Choong reported in Lampathakis P, "Fiona Stanley Hospital Short on Doctors", *The Sunday Times* (29 December 2012), <http://www.theaustralian.com.au/news/fiona-stanley-hospital-short-on-doctors/story-e6frg6n6-1226545148608> viewed 10 January 2014.

⁴⁰ Lampathakis, n 39.

⁴¹ Vickery K, "Critical Condition: Fiona Stanley Hospital Set to be Short of Staff Even Under Best Case Scenario", *PerthNow* (21 December 2013), <http://www.perthnow.com.au/news/western-australia/critical-condition-fiona-stanley-hospital-set-to-be-short-of-staff-even-under-best-case-scenario/story-fnhocx03-1226788057776> viewed 10 January 2014.

⁴² Dr Richard Choong reported in Lampathakis, n 39.

⁴³ Law P, "Midland Health Campus Abortion Measures 'Stigmatise' Patients, Say the Opposition", *PerthNow* (7 December 2013), <http://www.perthnow.com.au/news/western-australia/midland-health-campus-abortion-measures-stigmatise-patients-say-the-opposition/story-fnhocx03-122677789379> viewed 10 January 2014.



A major concern raised by this health system privatisation example involves a government willing to compromise both the equity and availability of comprehensive high-quality service provision to meet the requirements of private operators. The established practice of mixed private-public provision which has characterised health service provision throughout Australia's history here is eroded and the compact between state and citizen for universal health care is arguably denied by religious interference. Such an example could also provide a precedent for other private health system operators whose reasoning for restricting service provision may be commercial rather than theological.

General practitioner co-payments and emergency department user fees

The NCA received a submission recommending charging patients a \$6 co-payment for a service rendered by a bulk-billing doctor. The proposal stated as its purpose the reduction in avoidable demand "particularly in outer suburban and regional areas" and general practitioner overservicing.⁴⁴ The proposal was in line with the NCA's task of establishing price signals and aligned in principle to ideals of personal responsibility for health and self-provision of services which was framed by the proposal as "reducing moral hazard risks".⁴⁵ This proposal received a lot of attention in the media and the AMA came out against it.⁴⁶

This co-payment would force bulk-billing doctors to collect money on behalf of the Commonwealth, a payment that general practitioners could waive at their own expense.⁴⁷ This might create two classes of bulk-billing and also might undermine profitability of practices in poorer areas. The proposal specifically calls for a freeze on general practitioner attendance schedule fees under Medicare until 2018; annual indexation of rebates; abolition of the Extended Medicare Safety Net (EMSN) threshold caps on general practitioner services and private gap insurance introduced for expenses or co-payments below the EMSN threshold.⁴⁸ Such a fee could encourage patients to go instead to emergency departments (EDs), a realisation that resulted in the suggestion that States be allowed to charge a user fee for such ED visits.⁴⁹ A proposal was also made for private health insurers to cover the gap between what general practitioners charge and the bulk-billing rate. This was opposed on the basis that it would create no incentive for general practitioners to restrain expanding the additional fees they charge.⁵⁰

Such proposals appear to send a signal that the government instituting them does not consider the health of its citizens in the same class of public goods as the police, military or judiciary. Further, it is policy that disregards evidence that such largely privatised health care systems (such as that in the United States) operate at twice the cost of health care systems where the bulk of the services are public, such as those in Australia.

Total health spending accounted for 8.9% of gross domestic product (GDP) in Australia in 2010-2011, slightly lower than the average of 9.3% in Organisation for Economic Co-operation and Development (OECD) countries in 2011. Health spending as a share of GDP is lower in Australia than in the heavily privatised United States system (which spent 17.7% of its GDP on health in 2011) and in a number of European countries including the Netherlands (11.9%), France (11.6%) and Germany (11.3%). Australia ranks above the OECD average in terms of total health spending per capita, with

⁴⁴ Australian Centre for Health Research, *A Proposal for Affordable Cost Sharing for GP Services Funded by Medicare* (2013) p 2.

⁴⁵ Australian Centre for Health Research, n 44, p 2.

⁴⁶ "GP Co-Payments Would Limit Access for Disadvantaged, AMA Warns", *The Guardian* (29 December 2013), <http://www.theguardian.com/world/2013/dec/29/gp-co-payments-access-disadvantaged-ama> viewed 2 January 2014.

⁴⁷ Australian Centre for Health Research, n 44, p 3.

⁴⁸ Australian Centre for Health Research, n 44, p 3.

⁴⁹ Bourke L, "Former Abbott Advisor Flags Possible Fees to Visit Hospital Emergency Wards", *ABC News* (30 December 2013), <http://www.abc.net.au/news/2013-12-30/emergency-room-fee-to-match-doctors-fees/5178156> viewed 10 January 2014.

⁵⁰ Harrison D, "Health Insurance Change Would Increase GP Fees", *The Sydney Morning Herald* (13 January 2014), <http://www.smh.com.au/federal-politics/political-news/health-insurance-change-would-increase-gp-fees-mal-washer-20140113-30qm7.html> viewed 13 January 2014.



spending of US\$3800 in 2010-2011 (adjusted for purchasing power parity), compared with an OECD average of US\$3339. Nonetheless, health spending per capita in Australia remains much lower than in the United States (which spent US\$8508 per capita in 2011) and a number of other OECD countries including Norway, Switzerland and the Netherlands.⁵¹

Between 2000 and 2009 total health spending in Australia increased in real terms by 4.5% per year on average, but as in many other OECD countries, this growth rate slowed down markedly in 2010 to 1.4%. The public sector is the main source of health funding in all OECD countries, except Chile, Mexico and the United States. In Australia, 67.8% of health spending was funded by public sources in 2010, below the average of 72.2% in OECD countries.⁵²

Since 2003, the *United States National Health Care Act* (HR 676), a Bill to fund all medical care in public or non-profit institutions by the United States government, has been reintroduced to every Congress. The Bill is predicated on halving costs by eliminating insurance overheads and denials of coverage (that is, private insurers are prohibited from duplicating federally funded services). Such single-payer health care would undoubtedly increase community health assets (as have similar national health systems in Canada, the United Kingdom, Taiwan and Australia) but remains stalled, particularly because of lobbying against “government-run health care” (but not community assets such as parks, schools, and police, fire, rescue and military services). In many European countries the government covers approximately 80% of total health expenses, but at substantially less total GDP and administration costs than the privatisation-dominated United States.⁵³

CONSTITUTIONAL PROHIBITION AGAINST CONSCRIPTION OF HEALTH SERVICE PROVIDERS TO THE PRIVATE SECTOR

One point of resistance to the process of health system privatisation through the NCA process is likely to be the prohibition on civil conscription of Australian health service providers enshrined in s 51(xxiiiA) of the Constitution. The civil conscription clause was inserted into the Constitution after the 1946 Constitution referendum. It reads:

The Parliament shall, subject to this Constitution, have power to make laws for the peace, order, and good government of the Commonwealth with respect to ...

the provision of maternity allowances, widows' pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services (*but not so as to authorize any form of civil conscription*), benefits to students and family allowances. (emphasis added)

One of the most detailed descriptions of the types of federal legislation prevented by the guarantee in s 51(xxiiiA) was provided by Aickin J in *General Practitioners Society v Commonwealth* (1980) 145 CLR 532 at 565-566:

No doubt a legal obligation to perform particular medical or dental services, or to perform medical or dental services at a particular place, or to perform such services only as an employee of the Commonwealth would be clear examples of civil conscription. An equally clear example would be the prohibition of the performance of medical or dental services by particular qualified practitioners other than in some designated place, though no punishment was attached to failure to practise in that place. Other forms of “practical compulsion” are easy enough to imagine, particularly those which impose economic pressure such that it would be unreasonable to suppose that it could be resisted. The imposition of such pressure by legislation would be just as effective as legal compulsion, and would, like legal compulsion, be a form of civil conscription. To regard such practical compulsion as outside the restriction placed on this legislative power would be to turn what was obviously intended as a constitutional prohibition into an empty formula, a hollow mockery of its constitutional purpose.

The section was construed in *Wong v Commonwealth* (2009) 236 CLR 573 as extending to prohibit any compulsion to carry out work or provide services for the Commonwealth or for its

⁵¹ OECD, *OECD Health Data 2013: How Does Australia Compare* (2013), <http://www.oecd.org/els/health-systems/Briefing-Note-AUSTRALIA-2013.pdf> viewed 10 January 2014.

⁵² OECD, n 51.

⁵³ OECD, n 51; Faunce TA, *Who Owns Our Health* (UNSW Press, Sydney, (2010).



statutory bodies or for any third party (private or governmental) on the direction of the Commonwealth (at [60]).⁵⁴ Defining who is a “conscriptor” in a fragmented system of responsibilities and complex employer arrangements may have the effect of “filing the teeth” of the Constitution and other legislative instruments as advocates shy away from complex cases. Discrete privatisation Acts pertaining to the health care system have not appeared on the statute books, leaving, therefore, a more iterative approach to be adopted to show where the risks of civil conscription may arise in regards to shared responsibilities within complex government-private arrangements.

One of the factors contributing to complexity here is the 25 to 30-year PPP contracts, after which the asset reverts to or is bought back by the government, so the level of government engagement necessarily varies through the lifecycle of the service or asset.

In *Wong*, a case which decisively articulated the scope of the guaranteed protection from civil conscription, Kirby J gave in his minority judgment an interpretation of the Constitution that held that the legal interpreters of the day are responsible for maintaining the Constitution as a viable “working” document ensuring that it is not captured by historical intransigence and that this could be achieved by placing importance on the words of the text to inform a contemporary purpose and context. He said:

to enact laws imposing blanket rules affecting the individual relationship between providers of “medical and dental services” and their recipients, whether for reasons of cost minimisation or for the achievement of particular administrative outcomes in terms of medical or dental practice, could risk invalidation.⁵⁵

This principle in action basically means that the “small business” option for health services provision (with concomitant individual doctor-patient relationships, that is, not a required patient relationship with a health service corporation) is guaranteed to all Australian citizens by the Constitution.⁵⁶

The attention given by Kirby J to the relationship between practitioner and patient may hold the key to any defence against corporate encroachment and interference with the way health professionals choose to practice. Privatisation and corporatisation of health care has been advanced by the commodification of patient information and this poses a threat to the practitioner-patient relationship. The risk is that a “listening relationship” is replaced with the mere act of data collection at the behest of private or government employers. The imposition of data collection metrics on practitioners for corporate use occurs in the hospital sector through activity based funding and in primary care through eHealth developments such as the Personally Controlled Electronic Health Record. Big data analytics is set to improve health outcomes for patients and make the practice of health care and running hospitals more efficient. However, these are not guaranteed outcomes. The commodification of information means it could be traded on prediction markets. These markets, also referred to as pari-mutuel markets, enable traders to place bets on predicted outcomes made possible by data on everything from voter behaviour to the outbreaks of epidemics.⁵⁷

These invented markets, developed by investment banks,⁵⁸ are emerging as an extrinsic commercial force which will impact on how medicine is practiced by having third parties capitalise on the information generated. This raises new questions about the control, ownership and value of patient information and whether practitioners and patients are being conscripted by way of their data exchange. The broader question is whether the civil conscription clause could be used in the future to protect the trade in information between practitioner and patient in an era of activity based funding, eHealth and global data markets.

⁵⁴ Faunce T, “Constitutional Limits on Federal Legislation Practically Compelling Medical Employment: *Wong v Commonwealth*; *Selim v Professional Services Review*” (2009) 17 JLM 196 at 198.

⁵⁵ *Wong v Commonwealth* (2009) 236 CLR 573 at [150].

⁵⁶ Faunce, n 54 at 200.

⁵⁷ Polgreen P, Nelson F and Neumann G, “Use of Prediction Markets to Forecast Infectious Disease Activity” (2006) 44(2) *Clinical Infectious Diseases* 272.

⁵⁸ Cass D, “Goldman and Deutsche to Launch Economic Data Options”, *Risk* (August 2002), <http://www.risk.net/risk-magazine/news/1497236/goldman-deutsche-launch-economic-options> viewed 10 January 2014.



CONCLUSION

This era is marked by an acceleration of public infrastructure privatisation, nationally and globally without a preponderance of evidence that this leads to beneficial economic, social or environmental outcomes. In addition to already privatised facilities, commissions are recommending further privatisation and, at the same time, new models of private investment are continually emerging. This trend, combined with a failure by both major political parties to take their privatisation agendas to the electorate and by sitting governments to reveal the rate of privatisation, makes it difficult for citizens and lawmakers alike to address the issues raised by shifting health care services from the public to the private sphere.⁵⁹ For our system to be so radically changed without the clear knowledge and permission of the citizens and without the sound policy development that comes from institutions taking a considered approach to health governance, each instance of privatisation raises new problems for health professionals which can include unexpected interventions in the practitioner-patient relationship (for example, potentially redefining its historical ethical obligations within a new class of health corporation-doctor-consumer relationship). Taken to its conclusion this may lead to a situation where the directors of health corporations will have to pledge allegiance to a version of the Hippocratic Oath if its principles are to remain a guiding force for the profession.⁶⁰

In this environment, s 51(xxiiiA) provides a significant constitutional prohibition on federal legislation that has the practical import of conscripting health service providers to work in the private sector (so reducing the option of citizens to form individual doctor-patient contracts). According to the reasoning of all judges in *Wong*, this constitutional provision is a guarantee that providers of Australian medical and dental services (a class of persons necessarily broader than registered medical practitioners and dentists) must be protected from federal legislation that erodes their choice of employment. This important constitutional guarantee ensures that providers of medical and dental services are entitled, if they wish, to become independent business people forming their own direct contracts with patients. The civil conscription prohibition in s 51(xxiiiA) in effect operates to set limits to the extent the federal government (through processes such as that involved with the NCA) can undertake health system privatisation in this country. Such a constitutional guarantee cannot be circumvented by the entering of a treaty such as the Trans Pacific Partnership Agreement (TPPA) that is likely to contain a dispute settlement mechanism⁶¹ whereby foreign investors in Australian infrastructure (including health system infrastructure) will be able to challenge as impeding those investments subsequent Australian government efforts to regulate them in the public interest.

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⁵⁹ ABC, *Q&A: Health Debate* (22 April 2013): Question from Brett Holmes (General Secretary of the New South Wales Nurses and Midwives Association): “the Federal Liberals and Nationals are looking at privatising public hospitals, can you explain what you mean by that?” Answer: Peter Dutton (Federal Shadow Minister for Health) “So, Brett, what we’ve said is not that we’re going to privatise public hospitals. I think the ownership of public hospitals should remain where they are now and that is with the State and Territory governments.” Answer: Tanya Plibersek (Minister for Health) “Well, I think one of the great strengths of the Australian system is that it’s a mixed system and there are some excellent – you know, St Vincent’s used to be in my electorate.”

⁶⁰ Faunce, n 53.

⁶¹ Faunce TA, “Trans Pacific Partnership Agreement Favours Foreign Investors Over Citizens Rights”, *The Canberra Times* (4 January 2014), <http://www.canberratimes.com.au/comment/trans-pacific-partnership-agreement-favours-foreign-investors-over-citizens-rights-20140103-309nb.html> viewed 10 January 2014.

