

THE GOOD, THE BAD AND THE UNHEALTHY: AN ASSESSMENT OF AUSTRALIA'S COMPLIANCE WITH THE INTERNATIONAL RIGHT TO HEALTH

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The understanding of the international right to health has flourished with the content of the right being detailed in Article 12 of the ICESCR. Despite the wide spread adoption of the ICESCR, few countries look to international standards when making domestic health care decisions. This paper seeks to explore how Australia's health care programs comply with the international right to health, despite successive Commonwealth governments making little attempt to comply with the international standards.

I INTRODUCTION

It seems as though the health care system and both the Commonwealth and State government¹ choices regarding it are rarely far from the headlines. The

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¹ Historically health rights in the Australian constitution have been the subject of political compromises. Danuta Mendelson. 'Devaluation of a Constitutional Guarantee: The History of Section 51 (xxiiiA) of the Commonwealth Constitution' (1999) 23 Melb. U. L. Rev. 308; see also James A. Gillespie, *The Price of Health: Australian Governments and Medical Politics 1910-1960* (Cambridge University Press, 1991). At Federation, the States retained powers that were in their jurisdiction, unless the power was granted to the Commonwealth. In 1901, the only power that was assigned to the Commonwealth government, in terms of health, was found under section 51 ix (powers over quarantine); the residual powers over health remained with the States. Mendelson, *infra*, 311. The *Constitution* was subsequently amended to grant the Commonwealth government further powers in relation to health. Section 51 now states:

..make laws for the peace, order, and good government of the Commonwealth with respect to 'xxiiiA) 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.

See *Pharmaceuticals Benefits Case* (1945) 71 CLR 237 and *Federal Council of the British Medical Association in Australia and Others v The Commonwealth and Others (Pharmaceutical Benefits Case 2)* (1949) 70 CLR 201. Despite this expanded power, State governments also retained jurisdiction in the area of health; therefore the healthcare system relies on cooperation between the two levels of government. See Genevieve Howse, 'Managing Emerging Infectious Diseases: Is a Federal System an

public is constantly bemoaning the public health care system and the media is quick to point out the flaws of the system.² Governments, meanwhile, are being forced to make choices about an ever more costly health care system and balancing it with a finite budget. Like most governments, in Australia, decisions about the health care system are based upon domestic policies; there is little public consideration for international health care standards.³ Despite this lack of consideration, the international right to healthcare has been flourishing.

The understanding of the international right to health, which includes the right to health care, has been the subject of significant academic literature and growing recognition. In 1946, the Constitution of the World Health Organization was one of the first international legal documents that mentioned the right to health.⁴ Two years later the right to health was included in the

Impediment to Effective Laws?' (2004) 1 (7) *Australia and New Zealand Health Policy*, 2, online: *Australia and New Zealand Health Policy*, <<http://www.anzhealthpolicy.com/content/1/1/7>>.

² See Samantha Maiden and Joe Kelly, 'Abbott gets final say in health debate as Liberals win toss' (23 March 2010) *the Australian*, online: *the Australian* <<http://www.theaustralian.com.au/politics/abbott-gets-final-say-in-health-debate-as-liberals-win-toss/story-e6frgczf-1225844187397>>.

³ The lack of concern for international health standards and opinions when crafting domestic policy has recently come to the forefront of public attention. In October 2014, with several countries in West Africa battling an Ebola outbreak, the Commonwealth government adopted strict quarantine standards to protect the Australian public from a potential domestic outbreak of the disease. According to the adopted policies, the Commonwealth government will no longer issue visitor visas for anyone from the affected countries; furthermore Australian residents visiting countries dealing with an Ebola outbreak will be forced to undergo a 21-day quarantine period prior to returning to Australia. The decision to suspend travel visas with Ebola-infected countries was the first of its kind among westernized countries (although Canada has since begun a similar process). Australia's decision has been met with criticism from many international organizations and goes against the recommendations made by the World Health Organization. Despite universal condemnation from international organizations over concerns that these new visa regulations violate 2005's International Health Regulations (which Australia is a party to), Australia's new visa policies for Ebola infected countries remains in place. See ABC News, 'Federal Government to stop processing visa application from countries affected by Ebola' (27 October, 2014) online: ABC News <<http://www.abc.net.au/news/2014-10-27/government-visa-applications-ebola/5845048>>; Simon Cullen, ABC News, 'Ebola Crisis: UN calls out 'acts of discrimination' against West African countries' (22 November, 2014), online: ABC News <<http://www.abc.net.au/news/2014-11-22/isolating-ebola-ridden-countries-act-of-discrimination-says-un/5911148>>; Helen Branswell, CBC News, 'Ebola: Canada suspending visas for residents of outbreak countries: Move follows similar policy in Australia' (October 31, 2014), online: CBC News <<http://www.cbc.ca/news/politics/ebola-canada-suspending-visas-for-residents-of-outbreak-countries-1.2820090>>.

⁴ The Constitution states that '[t]he enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.' Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948 [Constitution of WHO]. See also the World Health Organization,

*Universal Declaration of Human Rights (UDHR)*⁵ and subsequently codified in the *International Covenant on Economic, Social and Cultural Rights (ICESCR)*.⁶ This paper will explore how the Australian health care system meets the requirements of the international right to health as defined in the *ICESCR*. It will begin with an analysis of the health care system and the contents of the international right to health. The paper will conclude with an assessment of how the Australian system meets the international standards.

II THE AUSTRALIAN HEALTH CARE SYSTEM

Over the course of the twentieth century, the Australian health care system has undergone dramatic changes.⁷ This section will begin with an examination of the current Australian health care system. The analysis will be divided into two stages: the first part will focus on the public health care system; the second part will focus on the private health care system. The analysis of the public health care system will consist of a discussion of the Medicare system, the Pharmaceutical Benefits Scheme and other publicly funded health programs. The analysis of the private health care system will examine what is covered by the system, its make-up and the regulatory framework of the system.

A *The Current System: Medicare*

Since the end of the Second World War, various Commonwealth governments have tried to develop a national health care system.⁸ By the early 1980's, with the most recent attempt at universal health care failing, millions of Australians were without health insurance; it is of little surprise that health care was one of

online: <<http://www.who.int>>. See Aart Hendrick, 'The Right to Health in National and International Jurisprudence' (1998) 5 *Eur. L.J.* 389, 389.

⁵ GA Res. 217(III), UN GAOR, 3d Sess., Supp. No. 13, UN Doc. A/180 (1948) 71. See generally, Gerhard Erasmus, 'Socio-Economic Right and Their Implementation: The Impact of Domestic and International Instruments' (2004) 32 *Int'l. J. Legal Info.* 243, 252.

⁶ *International Covenant on Economic, Social and Cultural Rights* 16, December, 1966, G.A. Res. 2200 (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 3, 6 I.L.M., entered into force Jan. 3, 1976.

⁷ Gillespie, *above n 1*; Mendelson, *above n 1*.

⁸ See Fran Baum, *The New Public Health*, 3rd ed. (Oxford University Press, 2008); Australian Medical Association 'About the AMA' online: www.ama.com.au; Karen Wheelwright, 'Commonwealth and State Powers in Health-A Constitutional Diagnosis' (1995) 21 *Monash U. L. Rev.* 53, 58; Sandra Taylor, Michele Foster & Jennifer Flemins, eds., *Health Care Practice in Australia: Policy, Context and Innovations* (Oxford University Press, 2008); Richard B. Scotton, 'The Doctors' Health Fund: Medibank: From Conception to Delivery and Beyond' (2000) 173 *Medical Journal of Australia*, online: <http://www.mja.com.au/public/issues/173_01_030700/scotton/1/scotton1.html>.

the deciding factors in the 1983 national election.⁹ By 1984, the new government had created Medicare, a program that would allow Australians access to medical services and hospital care for little or no out-of-pocket costs. Since its introduction, Medicare has been in continuous operation.¹⁰ Medicare's main objective 'is to remove (or reduce) financial barriers to access to health care for all Australian residents...'¹¹ Medicare is a federally funded program that relies on State governments for delivery.¹²

1 Who Does Medicare Cover?

Medicare provides free or low cost health care for all Australians, New Zealanders and holders of a permanent visa residing in Australia.¹³

⁹ The Hawke Labor government won the election with the promise of reinstating a national health care system See Gillespie, *above n 1*.

¹⁰ Taylor, *above n 8*, 55. In 1983, the Commonwealth government passed the *Health Legislation Amendment Act 1983* (Cth). This Act, which introduced Medicare, consisted of a series of amendments to the *Health Insurance Act 1973* (Cth), the *National Health Act 1953* (Cth), and the *Health Insurance Commission Act 1973* (Cth). These older acts created Medibank, the national health insurance system, enacted by a previous government.

¹¹ SJ Duckett, *The Australian Health Care System*, 3rd ed. (Melbourne: Oxford University Press, 2008) 50.

¹² Since both levels of governments play a critical role in the health care system, a significant amount of cooperation is needed to ensure its effective delivery.

The Australian Health Ministers' Advisory Council (AHMAC) is key to State/Commonwealth cooperation. The AHMAC is made up of the senior health officials of both the Commonwealth and State governments; it considers health matters that have been referred to it by a State or Commonwealth health minister. An Overview of Health Status, Health Care and Public Health. Occasional Papers Series No. 5 (Health and aged Care) 1999, online: Department of Health and Ageing <<http://www.health.gov.au/internet/main/publishing.nsf/Content/health-historicpubs-hfsocc-occfirst5.htm>> 17. Essentially, AHMAC's role is to provide a forum for Australian Government, State and Territory Governments and the Government of New Zealand to discuss matters of mutual interest concerning health policy, health services and programs...[and to]...promote a consistent and coordinated national approach to health policy development and implementation.

See the Australian Health Ministers' Advisory Council online: <<http://www.ahmac.gov.au>> .

¹³ Commonwealth Department of Health and Aged Care (Financing and Analysis Branch), *The Australian Health Care System: An Outline*, September 2000, online: Commonwealth Department of Health and Aged Care:

<<http://www.health.gov.au/internet/main/publishing.nsf/Content/healthsystem-overview-contents>>, 6. In 1973, New Zealand and Australia entered into an informal agreement, *the Trans-Tasman Travel Arrangement*, which allows citizens from either country to live and work in either country without restrictions. See Department of Immigration and Citizenship, *New Zealand Citizens Entering Australia*, online: <<http://www.immi.gov.au/allforms/travel-documents/new-zealand.htm>>. This arrangement also grants access to the Australian health care system for New Zealand citizens living in Australia and vice versa. See the *Trans-Tasman Travel Arrangement*, online: the Department of Foreign Affairs and Trade <http://www.dfat.gov.au/geo/new_zealand/selected_docs.html>. Certain categories of Australians are eligible for special arrangements in addition to general Medicare coverage. This extra coverage is generally reserved to members of armed forces and veterans. These extra programs will not be examined. See, An outline, *ibid.*, 5.

Furthermore, Medicare also covers ‘medically necessary’ treatment to citizens of the eight countries that have reciprocal health care agreements with Australia, when the citizens are visiting or residing in Australia.¹⁴

2 *What Does Medicare Cover?*¹⁵

(a) *Doctors and Health Care Services Outside of Hospital*

Medicare provides Australians with free or low cost health care; it includes coverage for visiting a doctor outside of a hospital.¹⁶ A clinically relevant service is defined as ‘one that is generally accepted in the medical, dental and optometrical profession, as the case may be, as being appropriate for the treatment of the patient to whom it is provided.’¹⁷ Currently, the medical procedures that are considered clinically relevant, and thus covered by Medicare, can be found in the Medicare Benefits Schedule (MBS).¹⁸

The MBS is non-exhaustive and subject to change.¹⁹ To maintain currency, the services covered by the MBS are subject to regular reviews by the Commonwealth Department of Health.²⁰ Furthermore, depending on medical advances, new procedures can be added to the list. For a new medical

¹⁴ ‘Medically necessary’ treatment is defined as ‘any ill health or injury which occurs while you are in Australia and requires treatment before you return home.’ See Australian Government, Medicare, online: <www.medicareaustralia.gov.au>. The following eight countries are eligible for Medicare coverage: Great Britain, Finland, Ireland, Italy, Malta, the Netherlands, New Zealand, and Sweden. The extent of the coverage depends on the wording of the reciprocal agreements. An Outline, *ibid.*

¹⁵ Medicare does not cover every medical treatment; accordingly, these services have been listed as not being covered: ‘private patient hospital costs (for example, theatre fees or accommodation); dental examinations and treatment (except specified items...); ambulance services; home nursing; physiotherapy, occupational therapy, speech therapy, eye therapy, chiropractic services, podiatry or psychology (except specified items...); acupuncture (unless part of a doctor’s consultation); glasses and contact lenses; hearing aids and other appliances; the cost of prostheses (except External Breast Prostheses covered by the External Breast Prostheses Reimbursement Program); medicines (except for the subsidy on medicines covered by the Pharmaceutical Benefits Scheme); medical and hospital costs incurred overseas; medical costs for which someone else is responsible (for example a compensation insurer, an employer, a government or government authority); medical services which are not clinically necessary; surgery solely for cosmetic reasons; examinations for life insurance, superannuation or membership of a friendly society; eye therapy.’ See Australian Government, Department of Human Services, *What Medicare Covers* (7 Oct 2010), online: Australian Government <<http://www.medicareaustralia.gov.au/public/claims/what-cover.jsp#N1006B>>.

¹⁶ Overview, above n 12, 26. See also Gwendolyn Gray, ‘Reform and Reaction in Australian Health Policy’ (1996) 21 *J. Health Pol. Pol’y & L.* 587.

¹⁷ *Health Insurance Act 1973* (Cth) s. 3. See also, *ibid.*, 26.

¹⁸ See the MBS online: Department of Health and Ageing, <<http://www.mbsonline.gov.au>>.

¹⁹ ‘The Medicare Benefits Schedule changes to reflect, for example, the availability of new medical technologies, changing medical practice, and the government’s current policy and parameters for determining which professional services are eligible or ineligible...’ An Overview, above n 12, 26.

²⁰ *Ibid.*

procedure or technology to be added to the list it must be assessed by the Medical Services Advisory Committee. The Committee will judge it on the basis of 'safety, cost-effectiveness and real benefit to patients.'²¹

(b) *How Are These Services Paid For?*

All benefits covered by Medicare are assigned a fee schedule (an amount set by the government dictating the amount it will pay for each service).²² The Commonwealth government cannot force the conscription of doctors; as such, doctors are free to establish their own price for each service.²³ There are two ways this can be dealt with by Medicare. The first is that the patient agrees to the doctor's price, has the procedure and pays the doctor directly for the service. The patient will then apply to Medicare and be reimbursed, to the maximum allowed by the fee schedule.²⁴ If the doctor charged more than the maximum allowed by the fee schedule, the patient pays the difference.²⁵

The out of pocket payment option is risky for patients with chronic health problems. The patient may end up paying significant out of pocket money to have treatment continued year round. The government, recognizing that patients suffering chronic diseases may be disadvantaged, has created safety nets for patients.²⁶ The safety net is designed so that if 'one person's or a family's 'gap' payments exceed a certain threshold amount in a calendar year, all further benefits in that year are paid at up to 100 per cent of the Schedule fee.'²⁷

²¹ The Medical Services Advisory Committee (MSAC) provides an advisory opinion to the Minister for Health and Ageing. The decision on whether to include a new service on the MBS rests with the Minister. Department of Health and Ageing, *Medicare Benefits Scheme*, online: <<http://www.health.gov.au>>. See also, the Australian Health Care System: An Outline, above n 13, 7. The government will also remove obsolete services from the list; again, the medical service will be assessed by the MSAC for safety, cost-effectiveness and real benefit to the patient. If a service is obsolete, the MSAC will recommend its removal. An Overview, *ibid.*, 26.

²² An Outline, *ibid.*, 7.

²³ *Federal Council of the British Medical Association in Australia and Others v The Commonwealth and Others (Pharmaceutical Benefits Case 2)* (1949) 70 CLR 201.

²⁴ The maximum recoverable fee varies depending on the service. For instance, a patient will recover the full fee schedule for general practitioner services (this means the full price listed on the MBS); for all other out-of-hospital services, the patient will recover 85% of the MBS fee schedule. The difference between these two amounts is known as the gap payment. Therefore, for some services the patient will have to pay the gap payment and any additional out of pocket expenses if the doctor charges above the amount in the fee schedule. See Department of Health and Ageing, *Medicare: How do I pay my doctor?*, online: Medicare <<http://www.medicareaustralia.gov.au>>.

²⁵ An Outline, above n 13, 7-8.

²⁶ *Ibid.*, 7.

²⁷ *Ibid.*, 8.

The second way of dealing with doctors' bills is bulk-billing.²⁸ With bulk-billing, the patient does not pay for the bill; rather, the doctor will send the patient's account directly to Medicare and receive payment from Medicare for the cost of the procedure.²⁹ If a doctor chooses this method, the payment received from Medicare will be considered the full and final payment of the patient's account.³⁰ Put another way, this means that the doctor will only charge the prescribed government fee for the service. Bulk billing is the most common method of dealing with doctors working outside of the hospital.³¹

²⁸ See *Health Insurance Act 1973* (Cth) as amended, s. 20A. This section states: '(1) Where a medicare benefit is payable to an eligible person in respect of a professional service rendered to the eligible person or to another eligible person, the first-mentioned eligible person and the person by whom, or on whose behalf, the professional service is rendered (in this subsection referred to as *the practitioner*) may enter into an agreement, in accordance with the approved form, under which:

- (a) the first-mentioned eligible person assigns his or her right to the payment of the medicare benefit to the practitioner; and
- (b) the practitioner accepts the assignment in full payment of the medical expenses incurred in respect of the professional service by the first-mentioned eligible person.'

²⁹ *Ibid.* In bulk-billing the patient assigns his/her right to payment of the Medicare benefit to the physician. See *Health Insurance Commission v Peverill* (1993-1994) 179 CLR 226, 238-239. The physician will receive 100% of the Medicare Benefit Schedule as full and final payment. See Elizabeth Savage & Glenn Jones, 'An analysis of the General Practice Access Scheme on GP incomes, bulk billing and consumer copayments' (2004) 37 (1) *Australian Economic Review* 31; see also Stephen Duckett & Sharon Willcox, *The Australian Health Care System*, 4th ed. (South Melbourne: Oxford University Press, 2011) 169.

³⁰ A doctor does not have to bulk-bill. See *Health Insurance Commission v Peverill* (1993-1994) 179 CLR 226, 249. Doctors can even choose to bulk-bill for certain patients (ie pensioners) but not for others.

³¹ An Outline, above n 13, 8. Although the majority of services are bulk-billed, bulk-billing went through a period of decline. Bulk-billing hit its low in December 2003, when only 66.5% of services were bulk-billed. Hal Swerissen & Lucinda Jordan, 'Factors affecting Medicare affordability' (2004) 10 (3) *Australian Journal of Primary Health* 144, 144. Beginning in 2003, the Commonwealth government introduced incentives to increase physician participation in bulk billing. The first was the introduction of additional payments to physicians who bulk billed concession card holders (welfare recipients, elderly) and children under the age 16; these payments were an additional \$7.85 over and above the MBS schedule. See Duckett, *above n* 29, 169. This incentive was criticized as undermining the universality of the Medicare program by creating special rights for groups of individuals. See Savage, *above n* 29, Susan E. Day, et al, 'Strengthening Medicare: Will increasing the bulk-billing rate and supply of general practitioners increase access to Medicare-funded general practitioner services and does rurality matter' (2005) 2 (18) *Australia and New Zealand Health Policy*, online: <<http://www.anzhealthpolicy.com/content/2/1/18>>. The Australian Medical Association argued that the decline in bulk billing was because the Medicare reimbursements for services were far lower than what a general practitioner could charge in the private sector. See Parliament of Australia, Parliamentary Library, *The Decline in Bulk Billing: Explanations and Implications* (2002), online: Parliamentary Library <<http://www.aph.gov.au/library/pubs/CIB/2002-03/03cibo3.htm>>. In 2005 the Australian government increased refunds for general practitioner services from 85% to 100% of the scheduled fee for physicians who bulk billed their patients. These incentives have resulted in an increase in bulk-billing. See Duckett, *above n* 29, 169; see also the Commonwealth Department of Health and Ageing, *Rise in Bulk Billing Rates* (12 February 2010), online: <<http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr10-nr-nr025.htm>>.

3 Hospital Services Covered by Medicare

Medicare also covers hospital care. Hospital care consists of accommodation, medical and nursing care in a public hospital.³² Essentially, public patients³³ will receive free medical, paramedical and pharmaceutical care by a doctor (chosen by the hospital); additionally, patients will receive meals and accommodations during their hospital stay.³⁴ State governments run the public hospitals, while the Commonwealth government contributes significant funding.³⁵ In exchange for funding, the State government agrees that it will provide a network of hospital services and 'allow all consumers to be able to access inpatient services in these hospitals as 'public patients' free of any cost.'³⁶

Hospitals are widely used in Australia. In 2009-2010, there were 753 public hospitals and 573 private hospitals.³⁷ A total of 56 900 hospital beds

³² An Outline, *ibid.*, 6. A public hospital is a State or Territory owned hospital. *Ibid.*, 6.

³³ A public patient is an individual who does not use private health insurance for his or her medical care; rather he or she is admitted to the hospital as a Medicare patient. See Australian Government, *Medicare*, online: <<http://www.medicareaustralia.gov.au/public/migrants/language/files/english-medicare.pdf>>.

³⁴ Private medical patients can also use the public hospitals; in this situation, private patients would be able to choose their doctors. See Australian Bureau of Statistics, 'Year Book Australia 2002: Health, Private Health Insurance' (2002), online:

<<http://www.abs.gov.au/Ausstats/abs@.nsf/0/65b36914fa1a512dca256b35001586ca?OpenDocument>> 6 (Health Care Delivery and Financing). See also, An Outline, above n 13, 6.

³⁵ The Commonwealth government has classified health expenditure into five categories: funding for health care services provided to eligible veterans; subsidization of the private health care market; direct expenditure on specific Commonwealth government health programs (this is over 60% of the government expenditure and includes programs such as the Pharmaceutical Benefits Scheme and the Medicare Benefits Scheme); non-specific tax expenditure; and specific purpose payments/grants to the states.

Specific Purpose Payments (SPPs) fund over 42% of the public hospital services that are run by the state governments. They also support infectious disease control and health promotion campaigns.

The most important specific purpose payment is the National Healthcare Agreement. For the current version of the National Healthcare Agreement, see online: Commonwealth Government, Federal Financial Relations-National Healthcare Agreement,

<http://www.federalfinancialrelations.gov.au/content/national_agreements/healthcare/Healthcare_Agreement.pdf>. Accordingly, the NHA outlines the Commonwealth government's funding commitment to the States and provides the terms and conditions for such funding; the funding is based on clearly identified health outputs and outcomes.

³⁶ Duckett, *above n* 11, 51.

³⁷ Australian Institute of Health and Welfare 2011. Australian hospital statistics 2009-10. Health services series no. 40. Cat. no. HSE 107. Canberra: AIHW (April 2011) ('Australian Institute'). Public hospitals can be broken down into the following categories: 75 principal referral hospitals (these are primarily located in major cities and provide many services, including emergency departments and in and out-patient services-which may include pathology, pharmacology, radiology and dialysis, etc.); 11 specialist women's and children's hospital (these hospitals specialise in pediatric and women's health care and are found in the major Australian cities: Sydney, Melbourne, Brisbane, Perth and Adelaide); 43 large hospitals (services include emergency departments and in and outpatient services; services are not as varied as the principal referral hospitals); 92 medium hospitals (the majority of these

were available in public hospitals and 28 038 beds in private hospitals.³⁸ This averaged to approximately 2.57 public beds and 1.27 private beds available per 1000 population.³⁹

B *Pharmaceuticals*

The Pharmaceutical Benefits Scheme (PBS), in operation since 1 June 1948, is one of Australia's oldest government health programs.⁴⁰ PBS's goal is 'to provide all Medicare-eligible persons with access to effective and necessary prescription medications at a reasonable cost to the patients and to the nation.'⁴¹ This program is popular; the PBS subsidizes approximately 75% of all prescriptions dispensed in Australia.⁴²

There are two categories in the PBS which will determine how much of the cost of the prescription is subsidized. The first category is the concessional category; included in this category are individuals who can receive certain pensions and benefits from the Departments of Family and Children's Services or Veteran's Affairs.⁴³ These individuals will be required to make a co-payment of \$5.90 on the prescription; the remainder of the cost is subsidized.⁴⁴

hospitals do not have a formal emergency department and offer limited outpatient clinics); 154 small acute hospitals (deliver acute care for admitted patients and have a narrow range of services); 17 psychiatric hospitals; 8 specialist rehabilitation hospitals; 8 specialist mothercraft hospitals; 83 small non-acute hospitals (generally found in rural areas); 78 multi-purpose services (hospitals in rural areas that have combined with other services such as residential aged care) and 184 other small or specialist hospitals.

Public hospitals can also be described by the services they offer, for instance: 411 public hospitals offer domiciliary care services; 78 level III intensive care units; 9 in-vitro fertilisation units; 167 renal dialysis centres; 48 major plastic/reconstructive surgery units; 26 neonatal intensive care units; 260 nursing home care units; 241 obstetric/maternity care units; 125 oncology units; and 143 rehabilitation units. For a complete list of units, see Australian Institute, 88-90.

Private hospitals are divided into the two following broad categories: acute and psychiatric hospitals (there are 280 private hospitals that provide these services); there are also 293 private free standing day hospitals. Australian Institute, 10.

³⁸ *Ibid.* Out of the 56 900 public hospital beds, 2088 are in public psychiatric hospitals.

³⁹ *Ibid.*

⁴⁰ Gillespie, *above n 1*.

⁴¹ An Outline, *above n 13*, 9.

⁴² *Ibid.* Pharmaceutical companies are not required to submit their drugs to be covered by the PBS. Drugs are rarely commercially successful if they are not covered by the PBS; most patients generally request drugs that are covered. See Richard Kingham and Joanna Wheeler, 'Government Regulation of Pricing Reimbursement of Prescription Medicines: Results of a Recent Multi-Country Review' (2009) 64 *Food & Drug L.J.* 106.

⁴³ *Ibid.* Concession card holders include individuals who are receiving: disability support, age pension, widow allowance, and newstart allowance (unemployment insurance). For a complete list of eligible individuals see Centrelink, online: Department of Human Services <<http://www.centrelink.gov.au>>.

⁴⁴ See the Pharmaceuticals Benefit Scheme, online: <<http://www.pbs.gov.au>>.

All other individuals fall into the general category. For a general patient, he or she will be required to pay a co-payment of \$36.10 (this amount changes yearly with the consumer price index; it is current as of January 2013); the remainder of the cost is subsidized.⁴⁵ 'If the prescription involves a more costly but equivalent brand, the subsidy may be limited to the lower cost brand (the minimum pricing policy).'⁴⁶

The Pharmaceutical Benefits Advisory Committee (PBAC) is vital to the implementation of the PBS.⁴⁷ Established under section 101 of the *National Health Act 1953*, the PBAC's purpose is to

make recommendations to the Minister from time to time as to the drugs and medicinal preparations which it considers should be made available as pharmaceutical benefits under this Part and shall advise

⁴⁵ Government of Australia, Department of Health and Ageing, *About the PBS* (2011) online: <<http://www.health.gov.au/internet/main/publishing.nsf/Content/health-pbs-general-faq.htm>>. The Pharmaceutical Benefits Pricing Authority 'makes recommendations to the Minister on prices for new brands of pharmaceutical items that have been recommended for listing on the Pharmaceutical Benefits Scheme (PBS), and for new vaccines recommended for inclusion on the National Immunisation Program, by the Pharmaceutical Benefits Advisory Committee (PBAC).' See the Department of Health and Ageing, *Policies, Procedures and Methods Used in the Recommendations for Pricing of Pharmaceutical Products 2009*, online: <<http://www.health.gov.au/internet/main/publishing.nsf/Content/health-pbs-pbpa-pricing-policiesdoc~about-pbpa>>.

⁴⁶ *Ibid.* See also Stephen J Duckett, 'Drug Policy Down Under: Australia's Pharmaceutical Benefits Scheme' (2004) 25 (3) *Health Care Financing Review* 55, for a discussion on the minimum pricing policy. Similar to the Medicare gap payments safety net, the government has created a safety net for individuals using the PBS. If an individual, or family, spends more than \$1317.20 on prescriptions per year, the copayment fee will drop from \$36.10 per prescription to the concessional card rate of \$5.90. See the PBS online: Department of Health and Ageing <<http://www.pbs.com.au>>.

⁴⁷ The PBAC, established under the *National Health Act 1953* (Cth), consists of 'an officer, being a pharmacist, of the Department of Health, six medical practitioners appointed by the Minister from among ten medical practitioners nominated by the Federal Council of the Australian Medical Association, a pharmacist appointed by the Minister from among three pharmacists nominated by the Pharmacy Guild of Australia and a person appointed by the Minister to represent consumers. By s 101(2) the Minister may also appoint as member of the Committee a pharmacologist and not more than three additional medical practitioners.' *Pfizer Pty Ltd v Birkett* [2001] FCA 828 [9]. Furthermore, in 1993, the PBAC established a sub-committee, the Economics Sub-Committee of the PBAC. This sub-committee has three main responsibilities: 'review and interpret economic analyses of drugs submitted to the PBAC; advise the PBAC on these analyses; and to advise the PBAC on technical aspects of requiring and using economic evaluations.' Department of Health and Ageing, *Pharmaceutical Benefits Advisory Committee*, online: <<http://www.health.gov.au/internet/main/publishing.nsf/content/health-pbs-general-listing-committee3.htm>>. In 1988, the PBAC established the Drug-Utilisation Sub-Committee; this sub-committee collects data on drug utilisation in Australia. Department of Health and Ageing, *Pharmaceutical Benefits Advisory Committee*, online: <<http://www.health.gov.au/internet/main/publishing.nsf/content/health-pbs-general-listing-committee3.htm>>.

the Minister upon any other matter concerning the operation of this Part referred to it by the Minister.⁴⁸

The main role of the PBAC is to make recommendations to the Minister for Health and Aged Care on what drugs should be included on the PBS.⁴⁹ Prior to making any recommendations, the PBAC will evaluate the drug's safety, quality and cost-effectiveness.⁵⁰

At present, the PBS subsidizes '600 kinds of drugs in nearly 1500 formulations'.⁵¹ The list of drugs on the PBS is not closed. The Minister for Health and Aged Care, on the recommendation of the PBAC, can add or remove drugs on the list.⁵² If the PBAC is convinced that a new drug is safe, high quality, effective and cost-effective, it will recommend to the Minister to declare the drug covered by the scheme.⁵³ At that point, the Minister can either decide to declare the new drug covered by the scheme or decline the PBAC's recommendation.⁵⁴ Even if the Minister adds the drug to the PBS, it is still subject to Parliamentary scrutiny.⁵⁵

The PBS is designed to promote the addition of new medicines, under a transparent system. Companies are given the opportunity to propose new drugs to the PBAC. Proposed drugs are evaluated based on effectiveness,⁵⁶

⁴⁸ *National Health Act, 1953* (Cth) s. 101.

⁴⁹ Department of Health and Ageing, Pharmaceutical Benefits Advisory Committee, online: <<http://www.health.gov.au/internet/main/publishing.nsf/content/health-pbs-general-listing-committee3.htm>>.

⁵⁰ *Ibid.* The cost effectiveness criteria of the PBS has meant that, on average, prescriptions drugs cost significantly less in Australia than in most other Western countries; some prescription drugs are 50% cheaper in Australia than in the United States. Frances H. Miller, 'Consolidating Pharmaceutical Regulation Down Under: Policy Options and Practical Realities' (2006) 25 *U. Queensland L.J.* 111, 112-113.

⁵¹ An Outline, above n 13, 9.

⁵² *Pfizer Pty Ltd v Birkett* [2001] FCA 828 [1].

⁵³ An Outline, above n 13, 9. 'The cost-effectiveness guidelines used by the PBS, provide that a drug will be listed if it is: 1) needed for preventing or treating significant medical conditions not already covered, or inadequately covered, by existing PBS drugs, and is acceptably cost-effective, 2) more effective, less toxic (or both) than a drug already listed for the same reasons, and is acceptably cost-effective, and 3) at least as safe and effective as a drug already listed for the same reasons, and shows similar or better cost-effectiveness.' Miller, *above n* 50, 113. Note that a pharmaceutical company has the right to appeal a PBAC decision. According to section 105 of the *National Health Act 1953* (Cth), a right of appeal lies with the Administrative Appeals Tribunal.

⁵⁴ The Minister can only make such declarations if the drug is referred by the PBAC. If the PBAC chooses not to recommend the drug the Minister cannot override its recommendation and declare the drug to be covered by the scheme. See *Pfizer Pty Ltd v Birkett* [2001] FCA 828 [7].

⁵⁵ *Ibid.*

⁵⁶ Effectiveness has been defined as '[t]he extent to which a therapy produces a benefit in a defined population in uncontrolled or routine circumstances.' Pharmaceutical Benefits Advisory Committee,

cost-effectiveness⁵⁷ and 'clinical'⁵⁸ place of a product compared with other products already listed in the PBS for the same or similar indications' or 'clinical place of the product compared with standard medical care or the benefits for patients the new products will provide compared to the cost of achieving those benefits.'⁵⁹ The ability to update the PBS is crucial-it ensures that Australians receive the best available medicine for their health care needs.

C Other Health Care Services and Programs

Medicare and the PBS are Australia's two largest publicly funded health care programs; however, other publicly funded health programs exist. These programs, funded by the Commonwealth government, include: aged care and disability services,⁶⁰ drug and alcohol treatment services,⁶¹ rural health initiatives, such as the flying doctor,⁶² and vaccination and cancer screening

1995 Guidelines for the Pharmaceutical Industry on Preparations of Submission to the Pharmaceutical Benefits Advisory Committee, online Department of Health and Ageing <www.health.gov.au>.

⁵⁷ Cost effectiveness is defined as 'a proposed drug is considered cost-effective by the PBAC if the Committee considers that, for a specified main indication, the incremental benefits of therapy involving the proposed drug over therapy involving its main comparator(s) justify its incremental costs and harms.' Cost-effectiveness is assessed in the following manner: 'An economic evaluation that compares therapy involving the proposed drug with therapy involving its main comparator(s) having common clinical outcome(s) in which costs are measured in monetary terms and outcomes are measured in natural units.' *Ibid.* The PBAC has instituted guidelines to review instances where a drug has been ruled out for recommendation based on cost-effectiveness even though the drug 'treats a serious, disabling or life-threatening condition, where there are no other realistic treatment options for that condition.' In that situation, PBAC may hold a stakeholders' meeting ('Stakeholders may include the drug's sponsor or manufacturer, patient groups, medical specialists and general practitioners with a particular recognised interest in the drug, and the Department of Health and Aged Care.') 'The aim of these meetings is to inform stakeholders of the situation, to seek their views, and if possible to define a listing restriction acceptable to the parties which will give the best possible cost-effectiveness, even if at a level which would normally be unacceptable' See PBAC online: Department of Health and Ageing online:

<<http://www.health.gov.au/internet/main/publishing.nsf/Content/health-pbs-general-listing-pbacguidelines.htm>>.

⁵⁸ Clinical has been defined as 'pertaining to health outcomes rather than economic outcomes, eg clinical performance or clinical comparison; of or by clinicians, eg clinical department, clinical use.' *1995 Guidelines*, above n 56.

⁵⁹ *Ibid.*

⁶⁰ For a comprehensive list of publicly funded programs and services, see Department of Health and Ageing, online: <<http://www.health.gov.au>>. See *Nursing Homes Assistance Act 1974* (Cth); the National Disability Agreement which seeks to improve services for people with disabilities, Australian Government: Department of Families, Housing, Community Services and Indigenous Affairs <http://www.facs.gov.au/sa/disability/progserv/govtint/Pages/policy-disability_agreement.aspx>.

⁶¹ There are over 650 publicly funded specialist alcohol and drug treatment facilities in Australia. See Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia, 2008-2009: Report on the National Minimum Data Set*, Cat. No. HSE 92, Canberra.

⁶² For a discussion on the rural health initiatives, see below n 190.

programs.⁶³

D Private Health System

Prior to Medicare, private health care was the central component of the Australian health care system.⁶⁴ After the introduction of Medicare, the popularity of private health coverage plummeted and most Australians relied on Medicare for their health care needs.⁶⁵ The Australian government, aware of the vital role the private sector plays in the provision of health care services, began heavily subsidizing the private system.

By 1997 the government, overwhelmed with the cost of the public system, sought to address the decline in private health insurance by introducing the *Private Health Insurance Incentive Scheme*.⁶⁶ The first part of the scheme was designed to encourage high-income earners to purchase private health insurance. To do this, the government introduced changes to the Medicare levy.⁶⁷

The second part of the *Private Health Insurance Incentives Scheme* was a 'non means tested 30% rebate introduced in 1999 as a tax incentive to reduce

⁶³ See the Immunise Australia Program, online: Department of Health and Ageing <<http://immunise.health.gov.au/>>; see also cancer screening programs for colon cancer, breast cancer and cervical cancer, online: Department of Health and Ageing, *Cancer Screening*, <<http://www.cancerscreening.gov.au>>.

⁶⁴ Taylor, *above n* 8, 57.

⁶⁵ *Ibid.* See also Timothy Stoltzfus Jost, 'Private or Public Approaches to Insuring the Uninsured: Lessons from International Experience with Private Insurance' (2001) 76 N.Y.U.L. Rev. 419, 455; Gwendolyn Gray, 'Reform and Reaction in Australian Health Policy' (1996) 21 J. Health Pol. Pol'y & L. 587. Furthermore, the citizens dropping out of private health care insurance were generally young, healthy Australians; this meant that the individuals keeping private health care insurance were high risk members who were more likely to use the private services. An Overview, *above n* 12, 21.

⁶⁶ Commonwealth Government, Australian Bureau of Statistics, *Private Health Insurance: A Snapshot 2004-2005*, (2006) online: Australian Bureau of Statistics <<http://www.abs.gov.au/ausstats/abs@.nsf/mf/4815.0.55.001>>.

⁶⁷ The Health System and the Law (Hot Topic 30, November 2000) 3, online: State Library of New South Wales <http://www.legalanswers.sl.nsw.gov.au/hot_topics>. See also Adrian Kay, 'Tense Layering and Synthetic Policy Paradigms: The Politics of Health Insurance in Australia' (2007) 42(4) Australian Journal of Political Science 579, 579. The funding of Medicare includes a Medicare levy, based on a person's taxable income. An outline, *ibid.* At present, the Medicare Levy is generally around 1.5% of taxable income. The rates do vary according to the schedule established under the *Medicare Levy Act*. Additionally, the government has introduced a Medicare levy surcharge. This surcharge applies to high income individuals (this is determined by the Commonwealth government; it is currently around \$70,000 per year), who have failed to purchase private health insurance. *Medicare Levy Act* 1986 (Cth). *A New Tax System (Medicare Levy Surcharge-Fringe Benefits) Act* 1999 (CTH) ss 5 and 12(2). The Medicare levy surcharge is, generally, an additional 1% of taxable income. See Australian Government, Australian Taxation Office, *Medicare Levy: Overview*, online: Australian Taxation Office <<http://www.ato.gov.au>>.

the price of private insurance.’⁶⁸ Essentially, this granted, anyone who purchased health insurance from a complying health insurance provider, a 30% reduction on the actual cost of insurance premiums.⁶⁹ The 2009 government budget changed this scheme; the private health insurance rebate is now means tested.⁷⁰

The final part of the scheme is ‘lifetime health cover’. Lifetime health cover is used to encourage a lifetime use of private health insurance. People

who joined a health insurance fund before their 30th birthday and who maintained hospital cover would pay lower premiums throughout their lives compared to someone who joined later. Those who joined after 30 years of age would pay an extra 2% premium for every year.⁷¹

These incentives have led to a surge in the purchase of private health care insurance, the proportion of Australians covered by private health insurance rose to 46% within two years.⁷²

1 *Services Covered by Private Health Insurance*

Private health insurance in Australia ‘both complements and competes with Medicare.’⁷³ Private health insurance may cover private hospitals and a range

⁶⁸In January 1999, the Government introduced a ‘30% rebate on premiums paid for private health insurance. See also Year Book, *above n* 34, 264. See Taylor, *above n* 8, 150.

⁶⁹ Australian Government: Medicare Australia, Private Health Insurance. Online: <www.medicareaustralia.gov.au/public/claims/private-health.jsp>. (20/10/2009) Not all private health insurance holders are eligible; the individual must hold a private health insurance policy with an approved fund/insurer to qualify.

⁷⁰ See Australian Government, *Budget 2008-2009*, online: Commonwealth Government <<http://www.budget.gov.au/2008-09/>>. See also, ABC News, ‘Swan takes Knife to Health Rebate’ Posted 12 May 2009, online: ABC News:

<http://www.abc.net.au/news/stories/2009/05/12/2568506.htm>. Now, ‘[s]ingles who earn \$120,001 or more and couples who earn over \$240,001 will no longer receive any private health insurance rebate.’ Furthermore, singles who earn over \$90,001 or couples who earn over \$180,001 will only receive a 10% rebate. Singles who earn more than \$75,001 and couples who earn more than \$150,001 will receive a 20% rebate.

⁷¹ The Lifetime Health Cover, introduced in 2000, rewards membership loyalty and deters individuals who join an insurance company just before they need to make a claim and then drop their coverage once they are better. Year Book, *above n* 34, 2. See Taylor, *above n* 8, 150.

⁷² As of 2010, the private health care sector funds around a third of all health care in Australia. The Health System and the Law, *above n* 667 3. See also Kay, *above n* 67, 579. See also Year Book, *ibid*. As of March 2013, 46.9% of the population had health insurance that covered hospital care; 54.7% of the population had general treatment health insurance (services provided outside of the hospital). See Private Health Insurance Administration Council, *Private Health Insurance Australia, Quarterly Statistics, March 2013*, online: <<http://phiaac.gov.au/wp-content/uploads/2013/05/Qtr-Stats-Mar13.pdf>>.

⁷³ An Overview, *above n* 12, 20.

of non-hospital and other health-related services.⁷⁴ It can cover

against all or part of hospital theatre and accommodation costs in either a public or private hospital, medical costs in hospital, and costs associated with a range of services not covered under Medicare including private dental services, optical, chiropractic, home nursing, ambulance and natural therapies.⁷⁵

Private health insurance grants Australians the freedom of choice of doctor, hospital and flexibility in time of treatment.⁷⁶ In contrast, with Medicare, while these provisions are generally covered, a patient must choose the state sponsored doctor, hospital or treatment times.⁷⁷ Private health insurance also covers more services than Medicare, it may also cover, dental care, physiotherapy, and other ‘ancillary services.’⁷⁸ Even with private health insurance, Australians will generally incur an out-of-pocket expense or co-payment for medical care outside of a hospital.⁷⁹

2 *Current Make-up of the Private Health Care System*

In Australia there are almost 50 health insurance organisations; of these 28 are ‘open’ memberships; 16 are ‘closed’ or restricted memberships.⁸⁰ The majority of these (41 health insurance organisations) are not-for-profit.⁸¹ All private

⁷⁴ Taylor, *above n 8*, 58.

⁷⁵ Year Book, *above n 34*.

⁷⁶ An Overview, *above n 12*, 20.

⁷⁷ An Outline, *above n 13*, 6.

⁷⁸ *Ibid.* Private health insurance may cover ‘private patient hospital costs (for example, theatre fees or accommodation); dental examinations and treatment; ambulance services; home nursing; physiotherapy, occupational therapy, speech therapy, eye therapy, chiropractic services, podiatry or psychology; acupuncture; glasses and contact lenses; hearing aids and other appliances; the cost of prostheses; medical and hospital costs incurred overseas; and eye therapy.’ See *What Medicare Covers*, *above n 15*.

⁷⁹ *Ibid.*

⁸⁰ Accordingly, ‘open membership organisations provide policies to the general public, [whereas] a restricted membership organisation provides policies only through specific employment groups, professional associations or unions.’ See online, ‘How Health Insurers Work’ at <www.privatehealth.gov.au>. One of the largest private insurance organisations is Medibank Private, which is owned and operated by the Australian government; although the Abbott government has recently announced an intention to sell Medibank. Medibank Private, *A Fine History*, online: Medibank <<http://www.medibank.com.au>>. See Daniel Hurst, ‘Medibank Private sale to go through as government announces share float’ *The Guardian* (26 March 2014), online: <<http://www.theguardian.com/world/2014/mar/26/medibank-private-sale-to-go-ahead-as-government-announces-share-float>>.

⁸¹ Taylor, *above n 8*, 58. In 2009, Medibank made the transition from a not-for-profit entity to a for-profit entity. See Medibank, *Annual Report 2010*, online: Medibank <http://www.medibank.com.au/Client/Documents/Pdfs/MPL_Annual_Report_2010.pdf>.

health insurance providers in Australia are governed by and must be registered under the *Private Health Insurance Act*.⁸²

The Commonwealth government heavily regulates the entire industry.⁸³ ‘The Australian’s regulatory structure is stringent, as premium and access regulations apply to the whole private insurance market.’⁸⁴ The Australian government has created bodies to oversee the implementation of private health insurance system: the Private Health Insurance Administration Council (PHIAC)⁸⁵ and the Private Health Insurance Ombudsman.⁸⁶ Additionally, the Commonwealth government has created community rating schemes for private health insurance.

(a) *Community Rating*

Community rating is a prohibition placed on insurance companies which

⁸² *Private Health Insurance Act 2007* (Cth); see ‘How Private Health Insurance Works’ online: Australian Government Site Initiative, Private Health Insurance <www.privatehealth.gov.au>.

⁸³ For instance, all Australians are eligible to purchase private health insurance and cannot be denied private insurance based on their age, medical history or disabilities. Insurance companies can still exclude coverage of pre-existing medical conditions for a maximum period of one year. Medical treatment for the pre-existing medical conditions is still eligible for coverage under the public system. See Medibank Private online: <<http://www.medibank.com.au/Member-Services/Online-Claims.aspx>>. It has been argued that the Commonwealth does not properly regulate private health insurance. Duckett, *above n 11*, 57. In 2005, the government repealed its price approval processes and has failed to replace them. *Ibid.* After studying, Australia’s private health care insurance industry, the OECD concluded,

Private funds have not effectively engaged in cost controls. They seem to have limited tools and few incentives to promote cost-efficient care, and there are margins for some funds to improve administrative efficiency, thereby reducing administrative costs. PHI appears to have led to an overall increase in health utilisation in Australia as there are limited constraints on expenditure. Insurers are not exposed to the risk of managing the entire continuum of care. The Medicare subsidy to private in-hospital medical treatments has also reduced funds’ accountability for the real cost of private care. Policies to reduce medical gaps have led to some price increase and may have enhanced supply-side moral hazard incentives. Finally, the rebate on PHI premiums has posed pressures on public cost, as it represents tax resources that have alternative uses.

Francesca Colombo & Nicole Tapay, ‘Private Health Insurance in Australia: A Case Study’ (2003) OECD Health Working Papers [87], online: the OECD <<http://www.oecd.org/dataoecd/5/54/22364106.pdf>>.

⁸⁴ Colombo, *ibid* [87].

⁸⁵ The PHIAC ‘is the main regulatory body supervising health insurance organisations.’ Its key functions include: providing comparative data to the health insurance industry and the public; monitoring solvency and capital adequacy of health insurance funds; and, administering the Health Benefits Re-Insurance Trust Fund. See Duckett, *above n 11*, 58.

⁸⁶ The Private Health Insurance Ombudsman operates more as a mediator. The Ombudsman ‘receives and investigates complaints (from consumers, hospitals, medical practitioners, or health insurance organisations) about health insurance and private hospitals.’ *Ibid.*, 58.

prevents them from considering factors such as health when calculating insurance premiums. It means that 'the cost of premiums is equalised across the community rather than based on the actual health risk.'⁸⁷ The purpose of community rating is to create laws to ensure that prevent insurance companies from discriminating against consumers on the basis of a variety of factors, including disability, age, gender, sexuality or general claims history.⁸⁸ It ensures that all Australians have equal access to private health insurance.⁸⁹ In Australia, community rating is primarily implemented using reinsurance.⁹⁰

The purpose of reinsurance is to lower the risks of insuring specific groups who are considered to be bad insurance risks: the elderly and the chronically ill.⁹¹ Reinsurance is a technique used by insurance companies to offset the potential large costs that may occur as a result of insuring a high risk individual.⁹² Basically, other insurance pools that have a higher portion of low risk individuals (and therefore cheaper premiums) make a contribution to the reinsurance pool under which eligible high risk individuals will receive transfers. Reinsurance shares the costs of insuring the high risk members.⁹³ Typically the reinsurance pool is created and controlled by the government with all carriers of private health insurance having to make a contribution to the reinsurance pool, in proportion of their size, but all can draw from it for high cost patients.⁹⁴ Overall reinsurance is meant to control the cost of premiums thus making private health insurance more accessible to a larger portion of the population.⁹⁵ Now that the Australian health care system has been described, the paper will proceed to the next stage of analysis: the right to health.

⁸⁷ Taylor, *above n 8*, 58.

⁸⁸ *Ibid.*

⁸⁹ Industry Commission, *Private Health Insurance: Report No. 57* (Australian Government Publishing Service, Canberra: February 28, 1997) [4], online: <<http://www.pc.gov.au/ic/inquiry/57privatehealth/finalreport>> [Industry Commission Report]. The purchase of PHI increases sharply with income levels: in Australia, only 20% of the lowest income households held PHI, while almost 70% of the households in the top income bracket held PHI. Industry Commission, *ibid.*, 172.

⁹⁰ An Overview, *above n 12*, 21.

⁹¹ *Ibid.*, xlv. See also, M Brennan, 'Chaoulli v. Quebec: Can Canada Implement a Privatized Health Care System in Compliance with International Human Rights Law?' (LL.M thesis, University of Essex 2006) [unpublished] where this is discussed.

⁹² Washington State: Office of the Insurance Commissioner, *Pooling Risk, Reducing Cost*, online: <<http://www.insurance.wa.gov/legislative/factsheets/PoolingRiskReducingCost.asp>>.

⁹³ Industry Commission Report, *above n 89*, xlv.

⁹⁴ Duckett, *above n 11*, 58.

⁹⁵ Industry Commission Report, *above n 89*.

III THE CONTENT OF THE RIGHT TO HEALTH

In the past 60 years, the concept of a right to health has been widely discussed, but what is meant by the right to health? Article 12 of the *ICESCR*, the ‘cornerstone protection of the right to health in international law,’⁹⁶ states:

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
 - (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
 - (b) The improvement of all aspects of environmental and industrial hygiene;
 - (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
 - (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

Since 1989, the United Nations’ Committee on Economic, Social and Cultural Rights (CESCR) has written General Comments on the rights listed in the *ICESCR*.⁹⁷ In 2000, the CESCR issued General Comment 14 which deals with the scope and content of the right to health.⁹⁸ This paper will examine the content of the right to health as defined in article 12 of the *ICESCR*. The

⁹⁶ Paul Hunt, *Report of the Special Rapporteur*, Commission on Human Rights, (59th Session), E/CN.4/2003/58 (13 February 2003) [11]. *General Comment No. 14: The Right to the Highest Attainable Standard of Health*, U.N. CESCR, Comm. On Econ., Soc. and Cultural Rts., 22nd Sess., Agenda item 3. U.N. Doc. E/C.12/2000/4 (2000). [7].

⁹⁷ For a complete list of General Comments, see the Office of the United Nations High Commissioner for Human Rights, online: <<http://www2.ohchr.org/english/bodies/cescr/comments.htm>>. These General Comments help clarify the scope of the socio-economic rights contained in the *ICESCR*. General Comments are meant to be a descriptive tool and are not legally binding; however, with socio-economic rights, General Comments have been ‘used to address deficiencies in law.’ Conway Blake, ‘Normative Instruments in International Human Rights Law: Locating the General Comment’ (2008) Center for Human Rights and Global Justice Working Paper, Number 17, 23. Blake argues that in socio-economic rights, the General Comment has taken on a ‘legislative orientation’ 23. In recent years, General Comments have been used by both domestic courts and regional human rights tribunal to help interpret legal rights. See *Legal Resources Foundation v Zambia*, Communication No. 211.98, May 2001; *Suresh v Canada (Minister of Citizenship and Immigration)* (2002) SCC 1, 1 SCR. 3; *United States v Bakes* 987 F Supp 44 (D Mass 1997); see generally Blake, 16-21.

⁹⁸ The General Comment on the Right to Health has four distinct parts: Part I focuses on the normative content of Article 12; Part II discusses State parties’ obligations under article 12; Part III discusses violations of the right to health; and Part IV discusses implementation of the right to health at the national level. See *General Comment No. 14, above n 96*.

primary focus of the analysis will be on the right to health as detailed in General Comment 14.⁹⁹ It should be remembered that the right to health contains all the obligations that arise from its classification as a human right.

A *Human Rights Obligations*

All human rights impose three types of duties on a state: the duty to respect, the duty to protect and the duty to fulfill.¹⁰⁰ These duties apply equally to Article 12 of the *ICESCR*. General Comment 14 has contributed to the understanding of what these obligations mean in relation to the right to health.

1 *The Duty to Respect*

The duty to respect requires states to cease any acts that directly violate the right.¹⁰¹ According to General Comment 14, the State must ‘refrain from interfering directly or indirectly with the enjoyment of the right to health.’¹⁰²

⁹⁹ The General Comment is the most authoritative interpretation of the content of the right to health. Office of the United Nations High Commissioner for Human Rights, ‘Committee on Economic, Social and Cultural Rights-General Comments’, online:

<<http://www2.ohchr.org/english/bodies/cescr/comments.htm>>. See also Paul Hunt & Judith Mesquita, ‘Mental Disabilities and the Human Right to the Highest Attainable Standard of Health’ (2006) 28 Hum. Rts. Q 332, 341. See also Blake, *above n 97*, 9.

¹⁰⁰ See generally, United Nations, Office of the High Commissioner for Human Rights, *What are Human Rights?* (1996-2011) OHCHR

<<http://www.ohchr.org/en/issues/Pages/WhatareHumanRights.aspx>>. See, Committee on Economic, Social and Cultural Rights, *The right to adequate food (Art. 11)*, UNESCOR, 20th Sess., UN Doc. E./C.12/1999/5 (1999) [15], which states: ‘The right to adequate food, like any other human right, imposes three types or levels of obligations on States parties: the obligations to *respect*, to *protect* and to *fulfil*.’ See Committee on Economic, Social and Cultural rights, *General Comment 13: The Right to Education (art. 13)*, 21st Session, 1999, UN Doc. HRI/GEN/1/Rev.5, (2001) [46], which states: ‘The right to education, like all human rights, imposes three types or levels of obligations on States parties: the obligations to respect, protect and fulfil.’ See also, Paul Hunt, ‘The Right to Health: A Way Forward at the International Level’ (Reclaiming Social Rights: International and Comparative Perspectives, 1996) 107, 112; Victor Dankwa, Cees Flinterm & Scott Leckie, ‘Commentary to the Maastricht Guidelines on Violations of Economic, Social and Cultural Rights’ (1998) 20 Hum. Rts. Q. 705, 713.

¹⁰¹ *General Comment No. 14*, *above n 96* [50]; See also, Eitan Felner, ‘A New Frontier and Economic and Social Rights Advocacy? Turning Quantitative Data into a Tool for Human Rights Accountability’ (2008) 9 SUR, Int’l J. on Hum. Rts. 109, 110. See generally, David Marcus, ‘The Normative Development of Socioeconomic Rights through Supranational Adjudication’ (2006) 42 Stan. J. Int’l. L. 53, 57.

¹⁰² *General Comment No. 14*, *above n 96* [33]. Furthermore, according to the *Limburg Principles* a violation of the *ICESCR* is defined as ‘a failure by a state party to comply with an obligation...failures may be acts of commission or omission, either desisting from particular kinds of activities or fulfilling specific requirements.’ Chapman, *above n 43*, 398. The *Limburg Principles* are ‘a set of authoritative guidelines on the interpretation of the *ICESCR* designed by a group of experts in the field of international law.’ See Hendrick, *above n 4*, 393. Ten years after the declaration of the principles, the principles were revisited and a new set of guidelines, the Maastricht Guidelines were published.

When a state's actions, policies or laws contravene the established standards of the *ICESCR*, these can be viewed as a failure to fulfill the obligation to respect the right to health.¹⁰³ General Comment 14 has stated the following are specific examples of a violation of the duty to respect:

the suspension of legislation or the adoption of laws or policies that interfere with the enjoyment of any of the components of the right to health; and the failure of the State to take into account its legal obligations regarding the right to health when entering into bilateral or multilateral agreements...¹⁰⁴

2 *Duty to Protect*

The second dimension of a state's obligations is the duty to protect. This duty requires a state to prevent a third party from violating or interfering with an individual's enjoyment of his or her human rights.¹⁰⁵ This obligation 'encompass[es] a responsibility on states to regulate the behavior of third parties so that the possibility that private persons, acting within the private domain, can violate these rights is precluded.'¹⁰⁶ Essentially, for a state, the obligation to protect imposes the following obligations: state parties must adopt specific measures that prevent third parties from violating obligations arising under article 12.¹⁰⁷ This responsibility is important for the development of national health care systems; states often allow private corporations to deliver health care services. While the government may be allowed to contract out delivery of the health care service, it cannot contract out of its obligations relating to the right to health.¹⁰⁸ Given the large role that private health care providers play in the Australian health care system, the requirement of government regulation of private health insurance companies is a serious issue.

¹⁰³ *Ibid.*

¹⁰⁴ *General Comment No. 14, above n 96* [50].

¹⁰⁵ Alicia Ely Yamin, 'The Future in the Mirror: Incorporating Strategies for the Defense and Promotion of Economic, Social and Cultural Rights into the Mainstream Human Rights Agenda' (2005) 27 *Hum. Rts. Q.* 1200, 1216. See generally, Ramin Pejan, 'The Right to Water: The Road to Justiciability' (2004) 36 *Geo. Wash. Int'l L. Rev.* 1181, 1187.

¹⁰⁶ Dankwa, *above n 100*, 714.

¹⁰⁷ *General Comment No. 14, above n 96*, [33].

¹⁰⁸ Paul Hunt and Rajat Khosla, 'The Human Right to Medicines' (2008) 8 *SUR, Int'l J. On Hum. Rts.* 99, 104. Private insurance companies may adopt policies that refuse coverage to individuals with preexisting conditions. If a state fails to properly regulate the insurance industry, it can result in a failure to protect the right to health. See Audrey R. Chapman 'Conceptualizing the Right to Health: A Violations Approach' (1997-1998) 65 *Tenn. L. Rev.* 389, 407.

3 *The Duty to Fulfill*

Finally, the duty to fulfill requires a state to take action to guarantee a right.¹⁰⁹ In the right to health, the obligation to fulfill contains three sub-obligations: facilitate, provide and promote.¹¹⁰ It requires that State parties, ‘adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health.’¹¹¹ In terms of the right to health, General Comment 14 has stated that there is an obligation to provide a public, private or mixed health insurance system and states must ensure the appropriate training of doctors and other medical personnel.¹¹²

As stated, all human rights have three common duties: the duty to respect, protect and fulfill. When mentioned in this manner, it is difficult to see how they clarify the content of the right to health; however, when perceived from potential violations of each of these obligations, the content of the right to health becomes clearer. Showing how a state can violate the right to health, also demonstrates what a state must do to fulfill its obligations under the right to health; this in turn adds to the understanding of the content of the right.

B *The Right to Health*

The right to health was originally defined as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.’¹¹³ Today, the right to health is understood as a right to a number of

¹⁰⁹ Dankwa, *above n 100*, 714. See Ida Elisabeth Koch, ‘The Justiciability of Indivisible Rights’ (2003) 72 *Nordic J. Int’l L.* 3, 15. This duty is often viewed as the most difficult to implement because it forces a state to take actions that may have far reaching implications. Pejan, *above n 105*, 1187. Koch sees the duty to fulfill a human right as requiring a state to transfer to a welfare based system. Government action will be required.

¹¹⁰ *General Comment No. 14, above n 96*, [33].

¹¹¹ *Ibid.* Despite the ICESCR’s progressive realization clause (see below note 217), some obligations are immediately enforceable; failure to do so amounts to a violation of the right. *General Comment No. 14, above n 96* [30]. As such, ‘[a] minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights is incumbent upon every State party.’ Chapman, *above n 108*, 409. Audrey Chapman has attempted to identify core obligations of the right to health that are subject to immediate fulfillment. She identifies the following duties: insufficient expenditure or misallocations of public money (the World Health Organization recommends a target of 5% of GNP of each state be allotted to health care expenditures, see *ibid.*, 412); failure to provide basic obstetric services to make pregnancy and child birth safe (*ibid* 414); and, failure to undertake sufficient public health measures to protect against combat infectious diseases (*ibid* 415). These potential violations have subsequently been confirmed in General Comment 14 as violations of the right to health (*General Comment No. 14, above n 96* [36], [37], and [52]).

¹¹² *General Comment No. 14, ibid.* [36].

¹¹³ See generally, Hunt, *above n 100* and *above n 96*. It is important to note that the right to health does not directly correlate to the right to be healthy. Brigit Toebe, ‘The Right to Health and the Privatization of National Health Systems: A Case Study of the Netherlands’ (2006) 9:1 *Health and*

freedoms and entitlements relevant to a person's health and it takes into account an individual's own biology and socio-economic preconditions as well as the states' available resources.¹¹⁴

The freedoms include the right to control one's health and body...and the right to be free from interference...[t]he entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable standard of health.¹¹⁵

As such, the right to health contains far more than simply the right to health care.¹¹⁶ While the right to health does include 'timely and appropriate health care,' it also includes the right to health's underlying determinants.¹¹⁷

In the *ICESCR*, article 12 is divided into two separate parts: the first part contains the general definition of the right to health and will form the primary focus of the paper; article 12.2 provides a list of examples of a state party's obligations under the right to health.¹¹⁸ Since Article 12.2 only provides a list of examples, the content and meaning of these are, in general, self-evident.¹¹⁹

Hum. Rts. 103, 103. A state cannot guarantee a person's good health. *General Comment No. 14, above n 96* [9].

¹¹⁴ *Ibid.* See also Toebes, *ibid.*, 103.

¹¹⁵ *General Comment No. 14, ibid* [8]. Brigit Toebes, *The Right to Health as a Human Right in International Law* (Antwerp: Intersentia, 1999), 38. While the CESCR did not adopt the definition of health as outlined in the Constitution of the WHO, it does acknowledge that the right to health is broader than simply a right to health care. *General Comment No. 14, ibid.*, [4]. Hunt, *above n 96*, [1].

¹¹⁶ *Ibid.*

¹¹⁷ See generally *ibid.* Underlying determinants are requirements that are necessary for the fulfilment of the right to health. These include 'access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions and access to health-related education and information, including on sexual and reproductive health.' *Ibid.* [11]. See Hunt, *above n 96*, [23]. The full realization of the right to health is dependent upon other human rights; including the rights 'to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement'. *General Comment No. 14, ibid.*, [7].

¹¹⁸ *Ibid.* [7].

¹¹⁹ *Article 12.2*

The steps to be taken by the State Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

- (a) The provision for the reduction of the still-birth rate and of infant mortality and for the healthy development of the child;
- (b) The improvement of all aspects of environmental and industrial hygiene;
- (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

a. *Article 12.1*

The State Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

According to General Comment 14, the right to health, as outlined in article 12.1 contains ‘the following interrelated and essential elements’: availability,¹²⁰ accessibility,¹²¹ acceptability,¹²² and quality.¹²³ These essential elements have

(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

Article 12.2 (a) deals with the improvement in maternal and child health care and the improvement and promotion of sexual and reproductive health. It seeks to have State Parties improve access to family planning services, pre and post-natal health care and access to information related to these categories. *General Comment No. 14, above n 96*, [14].

Pursuant to article 12.2 (b), States should adopt measures to prevent health and safety accidents in the workplace. It also refers to the adoption of measures to ensure adequate housing, sanitation, hygienic working conditions and ‘discourages the abuse of alcohol, and the use of tobacco, drugs and other harmful substances.’ *General Comment No. 14, above n 96*, [15]. See also UN General Assembly resolution 45/94 ‘Need to ensure a healthy environment for the well-being of individuals’ A/RES/45/94, 68th plenary meeting, 14 December 1990; See also the Rio Declaration on Environment and Development, U.N. Conference on Env’t and Dev., Report of the United Nations Conference on Environment and Development: Rio Declaration on Environment and Development, Principle 22, U.N. Doc. A/CONF.151/26/Rev.1 (Vol. I) Annex 1 (Aug. 12, 1992).

Under article 12.2 (c), States must create educational programs for diseases that are related to an individual’s behaviour. Furthermore, State parties are required to promote the social determinants of good health, including: environmental safety, economic development and gender equity. *General Comment No. 14, above n 96*, [16]. Finally, this article also contains the right to treatment. The right to treatment includes, ‘the creation of a system of urgent medical care in cases of accidents, epidemics and similar health hazards...’ and the creation and enhancement of immunization programs. *General Comment No. 14, above n 96*, [16].

Article 12.2 (d) focuses on health care. Accordingly article 12.2 (d) obligates, ‘[t]he creation of conditions which would assure to all medical service and medical attention in the event of sickness.’ *General Comment No. 14, above n 96*, [17]. This right includes access to health care services for both physical and mental illness. A State party has the obligation to provide ‘equal and timely access to basic preventative, curative and rehabilitative health services...’ *General Comment No. 14, above n 96* [17]. The General Comment elaborates further and states that it also includes ‘the improvement and furtherance of participation of the population in the provision of preventive and curative health services, such as the organization of the health sector, the insurance system...’ *General Comment No. 14, above n 96* [17]. Health care can be understood as ‘clinical and therapeutic measures that health professionals and medical systems provide for sick people.’ Paul O’Connell, ‘The Human Right to Health and the Privatisation of Irish Health Care’ (2005) 11 (2) M.L.J.I. 76, 76-84; Mervyn Susser, ‘Health as a Human Right’ an Epidemiologist’s Perspective on Public Health’ (1993) 89 American Journal of Public Health 418, 420. The right to health care ‘entitles right-holders to the ‘goods and services’ that aid in the achievement of health, and consequently, obligates the government to ensure access to these goods and services.’ Puneet K Sandhu, ‘A Legal Right to Health Care: What Can the United States Learn From Foreign Models of Health Rights Jurisprudence?’ (2007) 95 Cal. L. Rev. 1151, 1160.

¹²⁰ *Ibid*, [12 (a)].

¹²¹ *Ibid*, [12 (b)].

been identified as a useful analytical tool to help determine the content of the right to health.¹²⁴

(a) *Availability*

Availability means that '[f]unctioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party.'¹²⁵ The exact level of health care services that must be made available depends on the state's level of development.¹²⁶ According to Brigit Toebes, the CESCR has laid out clear indicators related to the availability of health care services.¹²⁷ Namely, the CESCR examines the ratio of hospital beds and the number of nurses and doctors for a given population.¹²⁸ Additionally, availability means that an adequate number of hospitals, clinics and 'other health-related buildings' must be available.¹²⁹

While availability includes services to support the underlying determinants of health, this analysis is limited to an analysis of health care provisions and the CESCR statement that it should 'assess the aggregate of hospital beds and the population per nurse and doctor.'¹³⁰ There are approximately 3.0 public beds and 1.3 private beds per 1000 population in Australia.¹³¹ There are also approximately 111 general practitioners per 100 000 people, or 3.0 medical practitioners per 1000 people.¹³² Availability of health care services in Australia

¹²² Ibid, [12 (c)].

¹²³ Ibid, [12 (d)].

¹²⁴ Paul Hunt, *Report of the Special Rapporteur*, Economic and Social Council, 60th session E/CN.4/2004/49 (16th February 2004) [41]. *General Comment No. 14*, above n 96.

¹²⁵ Ibid.

¹²⁶ *General Comment No. 14*, *ibid.* [12 (a)]. Availability also includes services that are tied to the underlying determinants of health, such as adequate sanitation facilities, safe and potable drinking water and trained medical and professional personnel.

¹²⁷ See Brigit Toebes "Towards an Improved Understanding of the International Human Right to Health" (1999) 21:3 Hum. Rts. Q. 661, 665-667. Toebes drew her assessment of how the CESCR measures availability of health care services from minutes of the meetings of the CESCR. See generally, *Summary Record of the 12th Meeting*, U.N. ESCOR, Comm. On Econ., Soc. & Cult. Rts., 12th Sess., 52, U.N. Doc. E/C. 12/ 1995.

¹²⁸ Toebes, *Ibid.*, 667.

¹²⁹ *General Comment No. 14*, above n 96, [12 (a)]. See also Hunt and Mesquita, above n 99, 346. To that end, the CESCR also states that governments should encourage medical personnel to open practice in their home countries. Toebes, above n 127, 667.

¹³⁰ Ibid.

¹³¹ An Overview, above n 12, 9. See also OECD Health Data 2011, *Frequently Requested Data-Release Version June 2011*, online: OECD <<http://www.oecd.org>>.

¹³² Internationally, Australia compares well to other countries. The same statistics for New Zealand are 74.9/100000 population for general practitioners and 2.13/1000 medical practitioners per

is criticized; like many countries, waiting lists are widely used.¹³³

‘A waiting list is a register of patients waiting for surgery, often categorised according to surgical specialty, surgeon or procedure.’¹³⁴ The state provision of health care services is dependent upon a fixed government budget; as such ‘[w]ithin certain boundaries, waiting time is an acceptable tool for planning health care service delivery.’¹³⁵ It is only when patients are waitlisted and then experience an exacerbation of their health problems as a result of waiting that the real problems associated with waitlists occur.¹³⁶

In the most recent report to the CESCR on Australia’s compliance with the *ICESCR*, NGOs highlighted this problem. Accordingly, it was stated that, ‘[p]rovision of public health care in Australia is suffering from chronic

population. The UK has 65.4 general practitioners per 100,000 people and 1.75 medical practitioners per 1000 people. See Ministry of Health New Zealand, *Doctors in New Zealand* at http://www.moh.govt.nz/moh.nsf/wpg_Index/About-Statistics+about+doctors#doctors. (October 2009).

¹³³ Many factors give rise to an increased reliance on waitlists. Accordingly, ‘[e]xternal causes include demographic trends which have not been timely addressed (such as the ageing [sic] population). Changes in the organisation of health care delivery and in patients’ attitudes are also contributing factors, as is the overemphasis on cost containment. Among the most common external reasons however are scarcity, in terms of manpower, facilities and financial means (at micro-meso- and macro-level) against the background of increased demand for health care and increased possibilities of a highly technological nature. Internal inefficiencies in relation to appointment –planning, job-organisation, working hours, operation room schedules also contribute to unacceptable waiting times.’ See H. Roscam Abbing ‘Criteria for the management of waiting lists and waiting times in health care, a Council of Europe Report and Recommendation’ (2001) 8 *European Journal of Health* 57, 58. Regardless of the underlying causes of waitlists, the end result is the same: the patient is unable to access health care services in a timely manner. Frances C Cunningham, ‘Medicare: Diagnosis and Prognosis’ (2000) 173 *Medical Journal of Australia*, 1, online:

<http://www.mja.com.au/public/issues/173_01_030700/cunningham/cunningham.html>. Stephen McMahon & Marianne Betts, ‘Half-yearly report card shows Victorian hospitals failing all of us’ *The Herald Sun* (30 April, 2010) online: <<http://www.heraldsun.com.au>>; Anthony Deceglie, ‘Patients waiting up to 55 hours for a hospital bed’ *The Sunday Times* (20 November, 2010) online: <<http://www.perthnow.com.au/news/western-australia/patients-waiting-up-to-55-hours-for-a-hospital-bed/story-e6frg13u-1225957467428>>; Simon Benson, ‘Julia Gillard dumps pledge to cut hospital waiting times’ *The Herald Sun* (11 February, 2011) online: <<http://www.heraldsun.com.au>>

¹³⁴ Owen M Bradfield, ‘Waiting Lists: Waiting for Evidence’ (2008) 32(4) *Australian Health Review* 589, 589. Not all waiting lists use the same time measurement to determine the wait; for instance, some waiting lists use the median waiting time, others use expected waiting time and still others will use the ninetieth centile waiting time. Each of these can result in different times and should be viewed cautiously when doing a comparison of wait times. See Bradfield, *ibid*, 590.

¹³⁵In fact, for elective surgeries, 10% of patients had to wait more than 203 days for their medical care. Stephen J Duckett, ‘Private Care and Public Waiting’ (2005) 29 (1) *Australian Health Review* 87, 87; with the introduction of waitlist management tools, these times have declined. See Australian Health Ministers Conference Final Communique, Dated November 13 2009, online: AHMAC <<http://www.ahmac.gov.au/site/home.aspx>>. See Abbing, *above n* 133, 58.

¹³⁶ *Chaoulli v. Québec (Attorney General)*, 2005 SCC 35, [2005] 1 SCR 791.

underfunding, a decaying public hospital system...¹³⁷ The lack of funding has meant that medical resources are stretched and that not all patients can access a medical or hospital service when needed. An inability to obtain health care services in a timely fashion can pose serious health problems for any patient left on a wait list.¹³⁸ With availability being a key obligation under Article 12, an inability to obtain health care services in a timely manner is a serious concern; Australia has introduced several measures to combat waiting lists.

Since State governments are responsible for the management of public hospitals, the management of wait lists generally fall within their purview. The Commonwealth government has claimed that States are taking an active role in the reduction of wait times for hospital services; in its report to the CESCR, the Commonwealth government reported:

...several States now employ coordinators at public hospitals to develop and implement waiting list initiatives that improve outcomes for patients waiting for elective surgery. An elective surgery patient management policy is currently being developed to streamline waiting lists across public hospitals.¹³⁹

The most recent elective surgery performance data shows ‘more Australians are receiving elective surgery procedures thanks to the sustained efforts of the Commonwealth, State and Territory Governments under the Commonwealth’s \$600 million Elective Surgery Waiting List Plan.’¹⁴⁰

Additionally, in an attempt to reduce pressures on the public health system, the government also heavily subsidizes private health insurance.¹⁴¹ That being said, studies have concluded that strong private health care systems, do not lead to lower wait times in the public system; actually, it may be far worse.

[n]ot only do parallel private systems not appear to reduce pressure on the public system, but they may also have the perverse effect of

¹³⁷ *Freedom Respect Equality Dignity: Action, NGO Submission to UN Committee on Economic, Social and Cultural Rights*, Addendum, (May 2009), online: Human Rights Law Resource Centre <<http://www.hrlrc.org.au/files/ICESCR-ngo-report-addendum-may-2009.pdf>>.

¹³⁸ The patient’s health can deteriorate, exacerbating the health issues and in worse case scenarios, may lead to death. See *Chaoulli*, above n 136.

¹³⁹ Australia’s Reporting Under the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the International Covenant on Civil and Political Rights (ICCPR), the Common Core Document, online: the Department of Foreign Affairs and Trade: <http://www.dfat.gov.au/hr/reports/ICESCR-iccpr/core_doc.pdf>, [551].

¹⁴⁰ *Ibid.* See also, Final Communique, above n 135. Waiting list coordinators help prevent waitlists that arise as a result of organizational disarray.

¹⁴¹ Duckett, above n 135, 87 (*original footnotes omitted*). See above for a discussion on the subsidization of the private health care system.

increasing the apparent inefficiency of the public sector. Evidence from the United Kingdom suggests that parallel private systems may attract healthier patients and perform relatively less complicated procedures, thereby increasing the average complexity and dependency of patients continuing to use the public system.¹⁴²

Often times, strong private health systems lead to longer waiting times in the public system.¹⁴³ This can occur because of ‘significant interactions between the public and private markets, not least that the surgeons who operate on public patients are often the same surgeons who operate on private patients.’¹⁴⁴ As such, an introduction of a privatized health insurance system does not necessarily correlate with a direct increase in the availability of health care services.

While the Australian government has comparable statistics to other OECD countries in relation to hospital beds and physicians per population; concerns over availability of health care services remain. Australia rations access to health care services using waiting lists; while these can be an effective management tool in health care services, if it leads to an exacerbation of a patient’s health condition, it is problematic. Australia has adopted several

¹⁴² See Table 1 Private Health Insurance and Public Sector Waiting Lists and Waiting Times, Selected Nations, Late 1990s, compiled by Carolyn Hughes Tuohy, Colleen M. Flood & Mark Stabile, “How Does Private Finance Affect Public Health Care Systems? Marshalling the Evidence from OECD Nations” (2004) 29 *J. Health Pol. Pol’y & L.* 359, 359. See also Colleen Flood & Terrence Sullivan, ‘Supreme Disagreement: Highest Court Affirms an Empty Right’ (2005) 173 *CMAJ* 142,142.

¹⁴³ International studies from both Canada and the UK have shown that privatized health care systems can increase waiting times for the public system. See Tuohy, et al., *ibid.* ‘Time series analysis of United Kingdom national data found that a 1% increase in a waiting time variable (measured as cost of waiting) was associated with a 0.6% increase in demand for private care.’ Furthermore, a Canadian study ‘found that ophthalmologists’ practice patterns affected the waiting times for their patients: for surgeons who only operated in the public sector, the median waiting time for a cataract operation was 7 to 8 weeks; for surgeons who operated in both the public and private sectors, the public waiting time was 15 to 20 weeks.’ Duckett, *above n* 135, 88. See also Claudia Sanmartin, et al., ‘Waiting for Medical Services in Canada: Lots of Heat, But Little Light’ (2000) 162 (9) *CMAJ* 1305, 1307. See also, T. Timothy, J. Hall & I. Preston, ‘Private and Public Health Insurance in the UK’ (1998) 42 *Eur Econ Rev* 491, 491-497. Additionally, see Flood and Sullivan, *ibid.* ‘[P]rivate facilities may improve waiting times for the select few who can afford to jump the queue, but may actually make the situation worse for other patients because much-needed resources are diverted from the public health care system to private facilities.’ Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada* (Ottawa, 2002) 139; Timothy Caulfield, ‘*Chaoulli v. Québec (Attorney General)*: The Supreme Court of Canada Deals a Blow to Publicly Funded Health Care’, online: <[http://www.law.uh.edu/healthlaw/perspectives/September2005/\(TC\)ChaoulliComment.pdf](http://www.law.uh.edu/healthlaw/perspectives/September2005/(TC)ChaoulliComment.pdf)>.

¹⁴⁴ Duckett, *above n* 135, 88. Duckett goes on to state, ‘[t]he payment per hour for the fee-for-service activity in the private sector is generally greater than for sessional payments for the same operations in the public sector. This gives surgeons a perverse incentive to maintain high waiting times in the public sector to encourage prospective patients to seek private care.’ *Ibid.*, 88.

methods (wait list coordinators, increased funding, subsidization of the private health care system) in an attempt to control wait lists. If it wishes to comply with article 12 of the *ICESCR*, Australia will need to proceed cautiously with the methods it chooses to use to combat wait lists. The strengthening of private health care systems does not necessarily correlate with a reduction in wait times. Australia should continue to implement measures to decrease reliance on wait times, but it should do so cautiously.

(b) *Acceptability*

Acceptability is a second essential element of the right to health.¹⁴⁵ It requires that facilities, goods and services are created and delivered in a manner that is culturally sensitive to the needs of the community.¹⁴⁶ All services and entitlements of the right to health must take into account an individual's cultural background, sex, and religion to ensure that patients are treated in a culturally sensitive manner that best protects their human dignity.¹⁴⁷ Acceptability also requires that programs are designed to promote the health of individuals and that these programs ensure the confidentiality of those involved.¹⁴⁸

In Australia, acceptability of health care services is often tied to Aboriginal health care and the desire to be culturally sensitive to traditional health practices.¹⁴⁹ Cultural sensitivity should also be a significant concern for the remainder of the Australian population. Australia is a nation of immigrants and in more recent years, the makeup of Australia's migrants has changed.¹⁵⁰ These immigrants 'face problems of communication through language and a

¹⁴⁵ *General Comment No. 14*, above n 96, [12 (c)].

¹⁴⁶ *Ibid.*

¹⁴⁷ *Ibid.*, [12 (C)]. Such measures could include requirements that women, whose religion forbids them from being in contact with non-related males, be treated by female medical physicians, or that programs relating to sexual health are made available to both male and females. See Dhurbajyoti Bhattacharya, 'The Perils of Simultaneous Adjudication and Consultation: Using the Optional Protocol to CEDAW to Secure Women's Health' (2009-2010) 31 *Women's Rts. L. Rep.* 42, 43 where the author discusses the impact of discrimination against women in health care.

¹⁴⁸ *General Comment No. 14*, above n 96.

¹⁴⁹ Stephen J Duckett, 'The Australian Health Care System: Reform, Repair or Replace?' (2008) 32 (2) *Australian Health Review*, 322, 328.

¹⁵⁰ Historically, western Europeans were the primary source of immigration. Today, the top 10 citizenships of migration consist of India, China, South Africa, Phillipines, Korea, Malaysia, Sri Lanka, Indonesia, the United Kingdom and the United States. Department of Immigration and Citizenship, *Report on Migration 2007-2008*, online: Department of Immigration and Citizenship <<http://www.immi.gov.au/media/statistics/pdf/report-on-migration-program-2007-08.pdf>>.

lack of cultural sensitivity in the health care system.¹⁵¹ The Commonwealth government has adopted initiatives that are designed to reinforce the consumer side of health care.

In 2008, the *Australian Charter of Health Care Rights* was endorsed by the Commonwealth government and State health ministers; this document replaced the States' patient charters.¹⁵² The Charter guarantees the right to be treated in a way that is sensitive to the patient's culture and beliefs; it guarantees the right to the use of interpreters to ensure effective communication and it also has access and privacy guarantees.¹⁵³ Essentially, the *Australian Charter of Health Care Rights* provides a set of guarantees that each patient is entitled to during their health care treatment.

The Commonwealth government has also attempted to strengthen patient rights in the health care system through the establishment of complaint procedures. Under the terms of the National Health Care Agreement, states and territories must maintain a consumer complaints board that hears complaints about any aspect of the public health system.¹⁵⁴ If a patient has been

¹⁵¹ Duckett, *above n 11*, 299. Dollis, et al 'Removing Cultural and Language Barriers to Health', National Health Strategy Issues Paper No. 6, Melbourne: National Health Strategy.

¹⁵² See the *Australian Charter of Health Care Services* online: <<http://www.health.vic.gov.au/patientcharter/publications/index.htm>>.

¹⁵³ *Ibid.*, Principle 3. For a full list of guarantees and rights, see the *Australian Charter*, *ibid.*

¹⁵⁴ See the National Health Care Agreement, s 25 (f), online: Department of Health and Ageing <<http://www.health.gov.au>>. Often times, complaints to such boards are about 'the way in which consumers are treated in terms of dignity and communication when they interact with the health care system.' See Duckett, *above n 11*, 299. The complaints boards have a variety of options for redressing consumer complaints. For instance, Queensland's Health and Quality Complaints Commission can decide to handle a complaint in the following ways:

1. The complaint can be closed and no further action taken. This may be for a number of reasons, which we will clearly explain to you.
2. You accept an outcome that resolves your complaint, such as:
 - Explanation - a detailed explanation to help you understand what happened and why.
 - Changes in policy or procedure - the healthcare provider recognises problems and undertakes action to correct them. This can prevent the same thing happening to another patient.
 - Apology - the provider acknowledges deficiencies in their practice and apologises to you for any harm caused.
3. We refer your complaint to the provider's registration board, or to another organisation that has the authority to deal with it.
4. We accept your complaint for action through:
 - Conciliation: a confidential, impartial and flexible process to resolve complex complaints. Download our fact sheet Conciliating your complaint
 - Investigation: only a small number of consumer complaints are referred for investigation, as this function is reserved for serious, widespread healthcare issues that has, or could put, patients at risk.

treated by a hospital or doctor in a manner that is culturally insensitive, he or she will be able to seek redress through the complaints board.¹⁵⁵

Furthermore, the Commonwealth government has also created a complaints mechanism for the private health care system. In 1995, the federal Private Health Insurance Ombudsperson was created.¹⁵⁶ The Ombudsperson 'can deal with complaints, investigate, make recommendations to the Minister of Health, and publish information about complaints against private insurers.'¹⁵⁷ The jurisdiction of the ombudsperson is strictly limited to 'complaints about a health insurance arrangement.'¹⁵⁸ The Commonwealth ombudsperson will deal with complaints about Medicare.¹⁵⁹

The Commonwealth government must ensure that both the public and private sectors of its health care system are culturally acceptable. Thus far, it has adopted several measures to ensure that health care is acceptable to the entire population; it has adopted a Patients' Charter and has ensured the establishment of a complaints procedure for both the private and public health care system. Such measures are an important start to ensure acceptability of

See Queensland Government, Health and Quality Complaints Commission, *Outcomes*, online: Queensland Government <<http://www.hqcc.qld.gov.au/home/inner.aspx?pageid=475>>. See also the New South Wales Complaints Commission, online: <www.hccc.nsw.gov.au/>; Western Australia's Health and Disability Services Complaints Office, online: <www.healthreview.wa.gov.au/>; Victoria's Office of the Health Services Commissioner, online: <www.health.vic.gov.au/hsc/>; South Australia Health and Community Services Complaints Commissioner, online: <www.hcsc.sa.gov.au/>; and Tasmania's Health Complaints Commissioner, online: <www.healthcomplaints.tas.gov.au/>.

¹⁵⁵ These boards also deal with complaints over the quality of care received in hospital or by a physician. For example, see Queensland Government, Health and Quality Complaints Commission, *Outcomes*, online: Queensland Government

<<http://www.hqcc.qld.gov.au/home/inner.aspx?pageid=475>>.

¹⁵⁶ Tuohy, *above n* 142, 313.

¹⁵⁷ *Ibid.*

¹⁵⁸ The patient may complain about a 'private health fund, a broker, a hospital, a medical practitioner, a dentist or other practitioners (as long as the complaint relates to private health insurance).' The Private Health Insurance Ombudsman online: <<http://www.phio.org.au>>. Any complaints about the quality of care or treatment are heard by each state's individual complaints board. Once a complaint is made to the Ombudsperson, '[t]he Ombudsman's staff may be able to explain what has happened and why, and this often solves the complaint. Otherwise, the Ombudsman's staff will contact your health fund or the body you are complaining about to get their explanation and any suggestions they have for fixing the problem.[...] Where complaints are more complex, the Ombudsman will write to the health fund or other body, seeking further information or recommending a certain course of action.' The Private Health Insurance Ombudsman online: <<http://www.phio.org.au>>.

¹⁵⁹ 'The Commonwealth Ombudsman safeguards the community in its dealings with Australian Government agencies. The Ombudsman's office handles complaints, conducts investigations, performs audits and inspections, encourages good administration, and carries out specialist oversight tasks.' See Commonwealth Ombudsman, online: Government of Australia <<http://www.ombudsman.gov.au/>>.

health care services. Australia should ratify the Optional Protocol to the *ICESCR*; this would allow an individual, after he or she has exhausted the domestic courts and complaints procedures, the opportunity to pursue his or her claim at an international level.¹⁶⁰ This additional protection would further demonstrate Australia's commitment to ensuring that its health care services meet the acceptability requirements under Article 12.

(c) *Quality*

The third essential attribute of the right to health is quality.¹⁶¹ Quality means that programs, health facilities or goods and services must be scientifically and medically sound and of good quality.¹⁶² Quality requires, amongst others: properly trained and skilled medical personnel,¹⁶³ scientifically approved medical procedures, and safe and potable water.¹⁶⁴

Australia has several boards and councils to ensure that only properly trained and skilled medical personnel are licensed. The first is the Australian Medical Council. The Australian Medical Council develops accreditation standards for medical schools; it also conducts reviews of medical programs to ensure that they are continuously meeting the requirements of the Australian Medical Council.¹⁶⁵ The licensing of medical doctors in Australia is overseen by the Medical Board of Australia.¹⁶⁶ The Medical Board of Australia develops standards for the medical profession; it also establishes registration requirements for medical practitioners and students.¹⁶⁷ While national standards are established by the Medical Board of Australia, each state and territory has a Medical Board that registers physicians in their respective jurisdiction using the national criteria established by the Medical Board of

¹⁶⁰ While a decision of the CESCR would not be legally binding, political consequences may still occur. Additionally it provides the possibility that domestic laws may change as a result. See for example, *Nicholas Toonen and Australia*, United Nations Human Rights Committee, Communication No. 688/1992. Nicholas Toonen and Australia, Doc: CCPR/C/50/D/4/1992 (4 April 1994).

¹⁶¹ *General Comment No. 14*, *ibid.* [12 (d)].

¹⁶² *Ibid.*, [12].

¹⁶³ Toebes highlights this requirement as a key consideration for the CESCR. Based on the guidelines for country reporting to the CESCR, this criterion was highlighted by the CESCR. See *The Nature of States Parties Obligations*, General Comment No. 3, U.N. ESCOR, Comm. On Econ. Soc. & Cult. Rts., 5th Sess., Sup. No. 3. See also Toebes, *above n 127*, 667.

¹⁶⁴ *General Comment No. 14*, *above n 96*, [12(d)].

¹⁶⁵ 'The AMC's purpose is to ensure that standards of education, training and assessment of the medical profession promote and protect the health of the Australian community.' See the Australian Medical Council, online: <<http://www.amc.org.au/index.php/about>>.

¹⁶⁶ See the Medical Board of Australia, online: <<http://www.medicalboard.gov.au/About.aspx>>.

¹⁶⁷ *Ibid.*

Australia.¹⁶⁸

In addition to the licensing of health care practitioners, government standards ensure the quality of the prescription drugs and medical procedures that are covered by the public health care system. Both Medicare and the PBS have strict testing and advisory committees to ensure that new medical technologies or medicines will only be included if they can meet a standard of high quality, safety and effectiveness.¹⁶⁹ While the Australian government does not dictate the specific services covered under the private health care system, the system operates under a strict regulatory framework.¹⁷⁰ This framework is meant to ensure the quality of the private health insurance system.

Despite attempts to ensure quality of care in health care services, there are still problems. A significant problem is a patient's continuity of care.¹⁷¹ For instance, for patients with multiple health issues, numerous doctors will need to be consulted; in fact, one survey found that 44% of patients had seen 4 or more doctors in the past two years.¹⁷² One of the detrimental effects of so many

¹⁶⁸ Ibid. There is also a national registration and accreditation system for nurses and midwives. See Nursing and Midwifery Board of Australia, online:

<<http://www.nursingmidwiferyboard.gov.au/Registration-Standards.aspx>>.

¹⁶⁹ An Outline, above n 13, 7. In 1994, the Commonwealth government enacted the *Health Legislation (Professional Services Review) Amendment Act, 1994* (Cth); this provision created the Professional Services Review Scheme (PSR Scheme). See *Health Insurance Act, 1973* (Cth), Part VAA. The PSR Scheme investigates the provision of services by a medical professional to ensure that the medical professional has not engaged in 'inappropriate practice.' It seeks to protect patients and the community from the effects of inappropriate practice. See the PSR Scheme, online: <<http://www.psr.gov.au>>. When determining whether the medical professional has engaged in inappropriate practice, the Committee will examine whether the treatment was appropriate (was it clinically relevant and necessary) and whether the medical professional had kept adequate records. See *Health Insurance Commission v Grey*, [2002] FCAFC 130; leave to appeal ref'd, (2003) 24 (4) Leg. Rep SL3. See also Robin Bell, 'Medicare Regulation through Professional Services Review-Lessons Learned' (2006) 23 (2) *Law in Context* 113. There are concerns regarding the role of the pharmaceutical industry in the assessment of drugs on the PBS, as well as the relationship between doctors and pharmacists in general. For instance '[i]n a controversial move early in 2001, the government restructured the membership of PBAC to include a person with strong industry links.' See Duckett, above n 46. For criticisms of the Health Technology Assessment in Australia, see Terri Jackson, 'Health Technology assessment in Australia: Challenges Ahead' (2007) 187(5) *MJA* 262. Ken J. Harvey, 'Saving money on the PBS: ranibizumab or bevacizumab for neovascular macular degeneration?' (2011) 194(11) *MJA* 567. Thomas A Faunce, Gregor Urbas & Lesley Skillen, 'Implementing US-style anti-fraud laws in the Australian pharmaceutical and health care industries' (2011) 194(9) *MJA* 474.

¹⁷⁰ Included in this framework are the *National Health Act 1953* (Cth) and the *Health Insurance Act 1973* (Cth). See Taylor, above n 8, 58.

¹⁷¹ Duckett, above n 149, 324.

¹⁷² Cathey Schoen, et. al, 2005 *Commonwealth Fund International Health Policy Survey of Sicker Adults in Six Countries*, (November 2005) 3. Online:

<<http://www.commonwealthfund.org/Content/Surveys/2005/2005-Commonwealth-Fund-International-Health-Policy-Survey-of-Sicker-Adults.aspx>>.

doctors is the need to ensure consistency in treatment and the exchange of proper medical information. Government initiatives in this area have mainly centred on e-health initiatives, including the implementation of a national electronic health records system.¹⁷³ Such a system allows doctors (dealing with the same patient) 'to communicate quickly and securely with other health providers across the hospital, community and primary medical settings.'¹⁷⁴ Electronic health records have to be balanced against the privacy rights of individual patients;¹⁷⁵ however, they show an indication to improve the overall quality of the health care system.

Australia has tried to develop programs that ensure the quality of its health care system. Practitioners are subject to licensing that must meet individual standards and procedures are carefully evaluated before they are listed for coverage under the public health system. While criticism of the quality of health care system remains, overall Australia has legislated in key areas of quality control.

¹⁷³ E-health 'is a term used to describe the combined use of electronic communication and information technology in the health sector.' See Christopher Bartlett and Klaus Boehncke: E-Health Enabler for Australia's Health Reform (Prepared for the National Health & Hospitals Reform Commission) 27 November 2008, online: <<http://www.health.gov.au/internet/nhhrc/publishing.nsf>> 1. In the 2010/2011 Commonwealth budget, the government committed \$466.7 million to the development and implementation of Personally Controlled Electronic Health Records (PECHR). This system which has started rolling out has had some security concerns in relation to patient privacy. Belinda Bennett, 'New Challenges for Old Law? The Development of E-Health in Australia' (2001) Sydney L. Rev. 404, 409-410. See also The Report of the National Electronic Health Records Taskforce, online: Australian Health <http://www.health.gov.au/healthonline/ehr_rep.htm>.

¹⁷⁴ Bartlett, *ibid*, 19.

¹⁷⁵ Meredith Carter, 'Integrated electronic health records and patient privacy: possible benefits but real dangers' (2000) 172 MJA 28. The Commonwealth government does have some privacy law protections, including the *Privacy Act, 1988* (Cth); pursuant to this *Act* specific guidelines have been implemented in the area of privacy of health law. See *Guidelines under section 95 (a) of the Privacy Act, December 2001*, (Cth). Furthermore, the State of Victoria, the State of New South Wales and the Australian Capital Territory have passed privacy acts that deal specifically with health records. See *Victorian Health Records Act, 2001* (VIC); *Health Records and Information Privacy Act, 2002* (NSW); and, *Health Records (Privacy and Access) Act, 1992* (ACT). Queensland and South Australia have implemented guidelines for privacy in health information. Queensland, *Information Standard 42*; South Australia, *Cabinet Administrative Instruction no 1. Of 1989*. Tasmania, prior to 2005 had specific Information Privacy Principles dealing with health information; this area is dealt with under the general privacy legislation *Personal Information and Protection Act 2004* (TAS). See Colin Thomson, 'The Regulation of Health Information Privacy in Australia' (January 2004), online: National Health and Medical Research Council <<http://www.nhmrc.gov.au/publications/synopses/nh53syn.htm>>. See also Nicolas P. Terry & Leslie P. Francis, 'Ensuring the Privacy and Confidentiality of Electronic Health Records' (2007) U. Ill. L. Rev. 681 and Roger S. Magnusson, 'The Changing Legal and Conceptual Shape of Health Care Privacy' (2004) *International and Comparative Health Law and Ethics: A 25-Year Retrospective*, J.L. Med. & Ethics 680.

(d) *Accessibility*

The final essential attribute is accessibility.¹⁷⁶ Accessibility can be further divided into four sub-components: physical accessibility, economic accessibility, information accessibility and non-discrimination.¹⁷⁷

(i) *Physical Accessibility*

Physical accessibility means that the facilities, goods and services must be within physical reach of the entire population; including those in rural areas.¹⁷⁸ The CESCR is particularly concerned with rural areas; state parties should adopt measures that encourage doctors and nurses to establish practice in rural areas.¹⁷⁹

The Australian government has a system which provides public health care to all citizens regardless of social status, health status, and other factors. Despite the universal nature of Medicare, problems with accessibility of the health care services exist. The two major areas of physical accessibility that will be discussed are: physical accessibility for persons with disabilities and physical accessibility for rural Australians.

Physical accessibility to health care services is a concern for persons with disabilities; if an individual is unable to access the building, the health care services themselves are also inaccessible. Pursuant to Article 12 of the *ICESCR*, a state must ensure that buildings and health care facilities and services are physically accessible to persons with disabilities; this requirement has also been included in the *Convention on the Rights of Persons with Disabilities (CRPD)*.¹⁸⁰

To guarantee physical accessibility for persons with disability, Australia has implemented the *Disability Discrimination Act 1992 (DDA)*. This Act 'prohibits discrimination against people with a disability or their associates in a range of areas including transport, education, employment, accommodation and

¹⁷⁶ *General Comment, No. 14, ibid.* [12 (b)].

¹⁷⁷ *Ibid*, [12 (b) (i)-(iv)].

¹⁷⁸ It also requires that the underlying determinants of health are within physical reach and that such services are provided for the entire population, including persons with disabilities. *Ibid.* [12 (b) (ii)]. Furthermore, particular emphasis is placed on physical accessibility for groups that are marginalized or particularly vulnerable, including: women, elderly, ethnic minorities and persons with disabilities. *Ibid*, [12 (b) (ii)]. *General Comment No. 14* states that medical services and the underlying determinants of health should be made available to rural areas. *Ibid* [12(b)(ii)]. See also Toebes, *above n 127*, 667.

¹⁷⁹ See Toebes, *above n 127*, 667-669.

¹⁸⁰ Australia has ratified the *CRPD* and is obligated to meet the requirements contained therein. See *Convention on the Rights of Persons with Disabilities* webpage, online: United Nations <www.un.org./disabilities/convention/questions.shtml>.

premises to which the public is entitled to enter or use.¹⁸¹ Some of the requirements of the *DDA* are implemented through the *Building Code of Australia* which provides legislative requirements for access for persons with disabilities. Despite the adoption of the *DDA*, there are problems with accessibility for persons with disabilities; these issues stem from the lack of enforcement of the *DDA*.¹⁸² Thus, despite having laws in place to ensure accessibility to buildings and public services for persons with disabilities, the failure to enforce these laws means that Australia is not complying with its international obligations.

Another concern for Australia, in terms of physical accessibility of health care services, is derived from Australia's very geography. The vastness of the Australian continent has given rise to numerous problems; most notably, the unequal distribution of health care services.¹⁸³ Australia has been criticized for the lack of equitable distribution of health care services between rural and metropolitan areas.¹⁸⁴ General Comment 14 specifically states 'medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas.'¹⁸⁵

¹⁸¹ Australian Building Codes Board, Access for People with Disability, online: <http://www.abcb.gov.au/index.cfm?objectid=7384D701-28B9-11DE-835E001B2FB900AA>. The Building Codes Board 'is a joint initiative of all levels of government in Australia and includes representatives from the building industry' whose primary job is to uphold the building Code of Australia. See the Australian Building Codes Board online: <<http://www.abcb.gov.au>>. In order to comply with the *CRPD*, the Australian government amended the *Disability Discrimination Act* with the *Disability Discrimination and Other Human Rights Legislation Amendment Act 2009* (Cth). The amending *Act* included such provisions as amending the Australian definition of 'reasonable accommodation' to match the definition found in the *CRPD*; it also included the *CRPD* as a ground that a person can rely on in litigation. See *Amendment Act, ibid.*, Schedule 2(20). See also Paul Harpur, "Rights of Persons with Disabilities and Australian Anti-Discrimination Laws: What Happened to the Legal Protections for People Using Guide or Assistance Dogs" (2010) 29 U. Tas. L. Rev. 49.

¹⁸² Glenda Beecher, 'Disability Standards: The Challenge of Achieving Compliance with the Disability Discrimination Act' (2005) 11(1) Australian Journal of Human Rights 5; Margaret Thornton, 'Disabling discrimination legislation: The High Court and judicial activism' (2009) 15 (1) Australian Journal of Human Rights 1; Richard Sahlin, 'Legislating discrimination protection for persons with disabilities in Australia and Sweden: a comparative analysis' (2008) 13 (2) Australian Journal of Human Rights 209. Lynn J. Harris, 'The Americans with Disabilities Act and Australia's Disability Discrimination Act: Overcoming the Inadequacies' (1999) 22 Loy. L.A. Int'l & Comp. L. Rev. 51; and, Beth Gaze and Rosemary Hunter, 'Access to Justice for Discrimination Complainants: Courts and Legal Representation' (2009) 32(3) UNSW L.J. 699.

¹⁸³ See Taylor, *above n 8*, 85; see also Baum, *above n 8*, 55.

¹⁸⁴ John Wakerman & John S Humphries, 'Rural Health: why it matters' (2002) 176 (10) MJA 457, online: Medical Journal of Australia <http://www.mja.com.au/public/issues/176_10_200502/wak10183_fm.html>.

¹⁸⁵ *General Comment No. 14, above n 956* [12 (b)].

For generations, Australia has struggled with getting doctors to establish medical practices in rural areas; the problem of public funding of rural hospitals and a lack of service to rural communities has been widely documented.¹⁸⁶ The needs of rural patients and the structure of the health care services in rural areas are unique to Australia.¹⁸⁷ Both geographical and financial burdens exist for rural residents trying to access a standard of health care equivalent to their metropolitan counterparts.¹⁸⁸ Not surprisingly, 'one of the few areas of initiative and growth in the 1990's and early twenty-first century has been rural health.'¹⁸⁹ In the early 1990's the *Rural Health Strategy* was launched.¹⁹⁰ This led to the establishment of the National Rural Health Alliance (NRHA). Accordingly, '[t]he NRHA's vision is equivalent health and well-being in rural, regional and remote Australia by the year 2020.'¹⁹¹ To this end, 550 annual Commonwealth scholarships, provided through the NRHA, are provided to rural based medical students who are encouraged to set up practice in their rural communities.¹⁹² Other initiatives include the development of telehealth and telemedicine;¹⁹³ and the establishment of the

¹⁸⁶ NACLC Australia's compliance with the ICESCR Fact Sheet: Access to Health 1; the addendum can be found online: The Office of the High Commissioner for Human Rights <http://www2.ohchr.org/english/bodies/cescr/docs/ngos/FREDA_Australia_AddendumCESCR42.pdf> [235]. See also Cunningham, *above n 133* [2]; NW Wilson, et al. 'A critical review of interventions to redress the inequitable distribution of healthcare professionals to rural and remote areas' (2009) *Rural and Remote Health* 9, online: <www.rrh.org.au>.

¹⁸⁷ Many rural health questions focus on Aboriginal health care. The Commonwealth government has adopted numerous initiatives to ensure adequate health care is provided to isolated Aboriginal Communities. For instance, the Australian Primary Health Care Access Program provides funding for health care services to Aboriginal communities. See Baum, *above n 8*, 55. Despite this, the status of health care for Aboriginals in Australia is deplorable. This has been a point of serious contention and criticism by the CESCR. See the CESCR comments made available on 22 May 2009. Committee on Economic, Social and Cultural Rights. Forty-Second Session, Geneva 4-22 May 2009. E/C.12/AUS/CO/4 (22 May 2009).

¹⁸⁸ Aside from the geographical impediments to accessing health care services, rural patients also face greater financial burdens. '[R]ural residents rely substantially on public sector health services, due in part to the lack of private services in these areas, but also because compared to urban residents, rural residents are far less likely to have private health insurance. People living in rural areas generally incur greater financial penalties when accessing health care.' Taylor, *above n 8*, 84-85.

¹⁸⁹ Baum, *above n 8*, 55.

¹⁹⁰ Taylor, *above n 8*, 82.

¹⁹¹ National Rural Health Alliance, About Us-Vision and Core Values, online:<<http://nrha.ruralhealth.org.au>>.

¹⁹² See the Rural Australia Medical Undergraduate Scholarship (RAMUS) Scheme, online:<<http://nrha.ruralhealth.org.au/scholarships/?IntCatId=7>>.

¹⁹³ These services allow doctors to use state of the art technology to link up with patients in rural communities. The doctor can examine the patient using a camera, look at a patient's x-rays through the television and communicate with the local doctor without the patient travelling to a metropolitan based practice. See, Louise Hall, 'Remote Diagnosis a Plus' *The Sydney Morning Herald*, October 9, 2006, online:

Royal Flying Doctor Service.¹⁹⁴

Physical Accessibility requires both the ability for a patient to physically access a building and for equitable distribution of health care services between rural and metropolitan areas. For the former requirement, as discussed, Australia has domestic legislation in place to ensure that disabled Australians are able to access medical facilities; although the enforcement of these laws is often lacking. Recently, Australia strengthened these guarantees with the adoption of the UN *Convention on the Rights of Persons with Disabilities* and its Optional Protocol. Now, if a disabled person has been denied access to medical facilities because of his or her disability and he or she has exhausted the domestic court system, he or she has an international platform.¹⁹⁵

Australia also has a significant problem with the provision of health care services in rural areas. Australia is a country with a large land mass and isolated communities; it is difficult to establish health care centres in these areas. The CESCR is particularly concerned with rural areas and believes that state parties should adopt measures that encourage doctors and nurses to establish practice in rural areas; Australia has done so and it should continue with these programs.¹⁹⁶ In order to comply with its obligations under article 12, the Commonwealth government will have to continue to develop these initiatives in the future; any reduction in funding to these government initiatives may be seen as a violation of the right to health.¹⁹⁷

<<http://www.smh.com.au/news/technology/remote-diagnosis-a-healthy-plus/2006/10/09/1160246042291.html>>.

¹⁹⁴The Royal Flying Doctor Service has been providing services to various rural communities since 1928. The doctors and nurses of the Flying Doctor service care for over 270,000 patients annually. See online: The Royal Flying Doctor Service <<http://www.flyingdoctor.org.au>>. See also, Taylor, *above n 8*, 84.

¹⁹⁵In practice, the ability to access the international platform means that once an individual has exhausted domestic remedies, the individual may submit a communication to the Committee on the Rights of Persons with Disabilities. Once received, the Committee can review the communication and can make recommendations and findings on the matter; these are then communicated to the State party. See, the *Optional Protocol to the Convention on the Rights of Persons with Disabilities*, G.A. Res. 61/106, Annex II, U.N. GAOR, 61st Sess., Supp. No. 49, at 80, U.N. Doc. A/61/49 (2006), *entered into force* May 3, 2008, online: United Nations <<http://www2.ohchr.org/english/law/disabilities-op.htm>>. While the decisions of the Committee are not domestically binding, changes may still occur. The case of *Toonen*, *above n 160*, occurred as a result of a complaint to the Human Rights Committee.

¹⁹⁶See Toebees, *above n 127*, 667.

¹⁹⁷In order to meet the requirements of the *ICESCR*, Australia needs only to progressively realize these rights; however, the elimination of a program that achieves the rights contained in the *ICESCR* will be viewed as a violation. See *General Comment No. 14*, *above n 96*; see also *above n 127*, 667.

(ii) *Economic Accessibility*

Economic accessibility refers to affordability.¹⁹⁸ It requires that health care facilities, goods and services are affordable to all segments of the population.¹⁹⁹ General Comment 14 states that ‘payment for health care services...has to be based on the principle of equity, ensuring that these services, whether publicly or privately provided, are affordable for all...’²⁰⁰ There is a clear recognition that health-care services, as well as services related to the underlying determinants of the right to health, can be either public or private in nature. Nonetheless, part of the economic accessibility entails that any privatization of health care services ‘does not constitute a threat to the affordability’ of such services.²⁰¹

The introduction of Medicare was meant to alleviate financial burdens to health care. While all Australians have public health insurance and can access a basic level of health care services, economic accessibility for all is still a problem. Financial barriers to some specialist services (in terms of high out of pocket expenses) still exist.²⁰² This means that not all individuals are able to access the same quality of specialized care. In recent years, the Commonwealth government has continued to add to the list of medical procedures and pharmaceuticals that are covered under the public system.

The area of concern for equitable economic accessibility centres on the private health care system. In Australia, private health insurance covers both the services offered in the public system and services that are not subsidized in the public system. Even for health care items that are covered under both systems, the private system often offers better services (for example: private rooms during hospital stays and choice of treating physician). Individuals who cannot afford to buy private health care coverage are not able to afford these choices offered. Critics of mixed health care systems are concerned with the creation of a two tier health care service.²⁰³

¹⁹⁸ *General Comment No.14, above n 96, [12 (b) (iii)]*.

¹⁹⁹ *Above n 127, 669*. It requires, ‘[p]ayment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all...’

²⁰⁰ *General Comment No. 14, above n 96, [12 (b)]*.

²⁰¹ Summary Record of the 12th Meeting, U.N. ESCOR, Comm. On Econ., Soc., & Cult. Rts., SR. 12 (1988) (Committee Member Mr. Neneman remark regarding Chile). *Above n 127, 666*.

²⁰² Duckett, *above n 149, 323*.

²⁰³ See Roy J. Romanow (commissioner), Commission on the Future of Health Care in Canada-final report (Building on Values the Future of Health Care in Canada) November 2002, 6. See also, Denisard Alves & Christopher Timmins, ‘Social Exclusion and the Two-Tiered Healthcare System of

In any type of mixed health care system, a state will have to be cautious that a two-tiered health care system is not created. The Commonwealth government has taken aggressive measures to make the private health care system accessible. The private health care system is heavily subsidized.²⁰⁴ Despite this subsidization, private health insurance is still out of reach for poorer Australians; the majority of private health insurance purchasers are from higher income brackets.²⁰⁵ Although private health insurance is out of reach of poorer Australians, these individuals still have access to health care services through the public system. Article 12 requires that individuals are able to access health care, regardless of ability to pay; with both a public health care system and a heavily regulated private health care system, all Australians are able to economically access basic health care services.²⁰⁶

(iii) *Information Accessibility*

Information accessibility means that individuals must be able to 'seek, receive and impart information and ideas concerning health issues.'²⁰⁷ Individuals should be given all the information necessary to make informed decision about their health.²⁰⁸ While access to information is important, this right has to be carefully balanced against the right of an individual to have his or her medical concerns treated confidentially.²⁰⁹

Aside from covering the cost of patient/doctor consultations in the public system, the Australian government has developed programs to ensure that health information is accessible. For starters, pursuant to the *Australian Charter of Health Care Services*, patients have informational rights regarding their health status and treatment options.²¹⁰ For individuals not attending at a doctor's office or hospital, the government has developed systems that allow Australians easy access to medical information. For example, all Australian

Brazil' (2001) Inter-American Development Bank, Research Network Working Paper #R-436; Joe V. Guadagno & Chris H. Polman, 'A Dutch Window into the development of a two-tier healthcare system' (2010) *BMJ* 340.

²⁰⁴ See *above* n 70 and surrounding discussion on the health insurance rebate and lifetime coverage.

²⁰⁵ The higher rates of private health insurance for higher incomes are also partly attributable to the Medicare levy surcharge tax; this tax is meant to encourage the purchase of private health insurance.

²⁰⁶ A person using the public service may not have access to the same services in private health care.

²⁰⁷ *General Comment No. 14, above* n 96, [12].

²⁰⁸ For instance, in terms of prescription medicine, a patient should be given reliable information about the benefits and risks of the medicine. Hunt *above* n 108, 102.

²⁰⁹ *General Comment No. 14, above* n 96, [12 (b)].

²¹⁰ See the *Australian Charter of Health Care Services, above* n 152.

states and territories have developed telehealth programs.²¹¹ Australia also has other sources of information available for health consumers, including websites covering a wide range of medical information and television campaigns that inform the public of particular health issues.²¹² Aside from these technological advances, the government does encourage and sponsor interpreter services in public hospitals.²¹³ The use of interpreters allows patients to effectively communicate with their treating physicians, thus allowing the patients to make informed decisions regarding their health care.²¹⁴

Information accessibility requires that a government provide the means for a patient to obtain information regarding his or her health issues. Through the increased development of electronic communications and services, Australia has designed programs that allow individuals to gather information on health, if they choose to do so; thus, these programs help fulfil Australia's obligations under article 12. Australia should continue to implement and develop these programs.

²¹¹ Telehealth is in the process of being implemented. In 2011 the Royal Australian College of General Practitioners produced *Standards for general practices offering video consultations*; these standards are designed to improve safety and quality in video consultations between a patient (normally living in a rural area) and a specialist. See the Royal Australian College of General Practitioners, *Telehealth Standards*, online: <<http://www.racgp.org.au>>. Other initiatives, such as remote monitoring of patients' vital signs have also been successfully implemented. Cartwright, C., R. Wade & K Shaw, 'The Impact of Telehealth and Telecare on Clients of the Transition Care Program (TCP)' (2011) *Health and Wellbeing Research Cluster*, Southern Cross University, online: <<http://aslarc.scu.edu.au>>. See also Uniquist, Report for Department of Health and Ageing: Telehealth Assessment-Final Report (28 June 2011), online: Department of Health and Ageing <<http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf>>. For more information on telehealth initiatives in each state, see Telehealth Queensland information online: <<http://www.smartstate.qld.gov.au/resources/about/telehealth.shtm>>; see Telehealth NSW online: <http://www.health.nsw.gov.au/news/2006/20060922_00.html>; See Government of Western Australia, Department of Health, Telehealth, online: <<http://www.wacountry.health.wa.gov.au/index.php?id=171>>; See Government of Victoria, Department of Health, online: <<http://www.health.vic.gov.au/>>; Government of south Australia, SA Health, online: <<http://www.sahealth.sa.gov.au>>. See I Blignault & V Snook 'Towards a National Approach to Telehealth Evaluation: The Work of the Australian New Zealand Telehealth Committee' (1999) in J Walker, et al. (eds). HIC 99, Health Informatics Society of Australia.

²¹² See the Department of Health and Ageing, online: <<http://www.health.gov.au>>.

²¹³ The Australian Charter of Health Care Rights, *above n* 152. See also, Pamela W Garrett, et. al 'How are Language Barriers Bridged in Acute Hospital Care? The Tale of Two methods of data Collection.' (2008) 32 (4) *Australian Health Review* 755, 760.

²¹⁴ In *Eldridge*, the Supreme Court of Canada discussed the importance of interpreters when accessing health care services. See *Eldridge v British Columbia (Attorney General)*, [1997] 3 SCR 624, 151 DLR (4th) 577.

(iv) *Non-Discrimination*

Finally, the last component of accessibility is non-discrimination.²¹⁵ This means all of facilities, goods and services related to health must be made available to all members of the public, without discrimination on any of the prohibited grounds.²¹⁶ The principle of non-discrimination is not subject to the progressive realization clause found in section 2 of the *ICESCR*.²¹⁷ General Comment 14 states, ‘...many measures, such as most strategies and programmes designed to eliminate health-related discrimination, can be pursued with minimum resource implications through the adoption, modification or abrogation of legislation...’²¹⁸ A failure to immediately eradicate discrimination in health care services is a violation of the right.

The public health care system is available to all Australia citizens and

²¹⁵ *General Comment No. 14, ibid.* [12 (b)(i)].

²¹⁶ *Ibid.* [18]. The *ICESCR*, in article 2.2 and article 3, prohibits discrimination on the grounds of ‘race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status, sexual orientation and civil, political, social or other status, which has the intention of nullifying or impairing the equal enjoyment or exercise of the right to health.’ *Ibid.* [18]. See generally, Hunt, *above n 124*, [34-37].

²¹⁷ Article 2(1) of the *ICESCR* states:

Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present covenant by all appropriate means, including particularly the adoption of legislative measures.

The progressive realization element is an acknowledgment that full achievement of the rights contained in the *ICESCR* will take time; therefore, not all obligations arising from the rights are immediately enforceable. *General Comment 3: The Nature of States parties obligations (Art. 2, par.1)* U.N. CESCR, Comm. On Econ., Soc. and Cultural Rts., 5th Sess., (1990). States are under an obligation to ‘begin immediately to take steps towards the full realization...and to move as expeditiously as possible...’ The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights (1987) U.N.Doc E/CN.4/1987/17, articles 16, 21. As a corollary of this right, any retrogressive measures taken by the government will be considered a prima facie violation of its obligations under the *ICESCR*. Paul Hunt, ‘Mission to the WTO’ Commission on Human Rights, 60th Sess. E/CN.4/2004/49/Add.1 (2004), [40].

The CESCR has stated that, ‘[t]he progressive realization of the right to health over a period of time should not be interpreted as depriving States’ parties obligations of all meaningful content. Rather, progressive realization means that States parties have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of article 12.’ *Ibid.* [31]. The concept of progressive realization applies to many of the *ICESCR*’s rights and therefore a state is obliged to progressively realize many rights at the same time. As such, rights are competing for limited state resources, yet the *ICESCR* ‘does not provide any rules for prioritizing the allocation of resources to specific rights, nor has the Committee provided any concrete rules in this regard.’ M. Magdalena Sepulveda, *The Nature of the Obligations Under the International Covenant on Economic, Social and Cultural Rights* (New York: Intersentia, 2003) 335.

²¹⁸ *General Comment no. 14, above n 96*, [18].

permanent residents.²¹⁹ In Australia, and in most mixed health care systems, the private health care system carries the biggest risk of discriminatory practices because the private health care system relies on insurance companies. Companies are not parties to international human rights conventions and do not have the same obligations as states in regards to the treatment of individual citizens.

Private health insurance is a market commodity; companies need to show a profit, or at minimum, cover operating costs. To that end, insurance companies often try to put up barriers of access for private health insurance. In an unregulated market, private health care coverage can be denied if an individual has a pre-existing medical condition or is above a certain age; at minimum, these individuals would have to pay a higher premium.²²⁰ In General Comment 20, the CESCR states that '[d]enial of access to health insurance on the basis of health status will amount to discrimination...'²²¹ Furthermore, the *Convention on the Rights of Persons with Disabilities* prohibits discrimination against persons with disabilities in the provision of health insurance and mandates that a person with a disability 'be provided with the same range, quality and standard of free or affordable health care.'²²²

Australia's private health care system is tightly monitored. Private insurance providers are prohibited from increasing premiums based on age and health status. Community rating and reinsurance play a central role in eliminating discrimination in the Australian private health system. The government needs to continue to monitor private insurance companies; Australia cannot relinquish its international obligations simply because a third party provides the service.

Another potential ground for discrimination in the health care system is poverty. The public system is offered to all citizens and permanent residents regardless of ability to pay. Again, the private health care system runs the biggest risk of discriminating based on economic or social situation. The purchase of private health insurance increases sharply with income levels: only

²¹⁹ Issues with the physical access to buildings for persons with disabilities and accessibility to medical/hospital services for rural residents have been discussed in accessibility.

²²⁰ Industry Commission Report, *above n* 89, xlv.

²²¹ *General Comment No. 20: Non-Discrimination in Economic, Social and Cultural Rights (Art.2, para.2)*, U.N. CESCR, Comm. On Econ., Soc. And Cultural Rts., 42nd Sess., Agenda item 3. U.N. Doc. E/C.12/GC/20 (2009), [33].

²²² Article 25 of the *Convention on the Rights of Persons with Disabilities*, UN GAOR, 61st Sess., Annex I, UN Doc. A/RES/61/106 (2006), online: The United Nations <<http://www.un.org/disabilities/convention/conventionfull.shtml>>.

20% of the lowest income households held private health insurance, while almost 70% of the households in the top income bracket held it.²²³ Despite this, the Australian government has tried to make private health care more affordable to lower income individuals through government subsidization of the product. Nonetheless, not all Australians can afford to purchase private health insurance; without a public health care system to rely on, many Australians would be denied health care based on economic status.²²⁴

The final ground of discrimination that will be examined is discrimination based on race and ethnic origin. In Australia, overt discrimination based on race and ethnic origin is extremely rare.²²⁵ That being said, adverse effect discrimination is still a problem in the Australian health care system. In Australia, race plays a role in determining access and outcome to health care services; these issues are generally tied to culturally sensitive health care services. For instance, Aboriginal Australians have a significant health gap when compared to other Australians.²²⁶ Australia should continue to adopt programs that fix health inequalities in Australia, especially in relation to Aboriginal health care.

IV CONCLUSION

The Australian health care system, like many in the Western world, is constantly evolving. Each successive government has come to power and has shaped the health care system either through the implementation of new

²²³ Industry Commission, *above n* 89, 172.

²²⁴ Discrimination based on economic/social condition is tied to economic accessibility. Despite the widespread availability of the public health care system, socio-economic status impacts health outcomes. 'Socio-economic status is a critical determinant of health status, with lower socio-economic status generally associated with poorer overall health.' Philip Lynch, 'Homelessness, Poverty and Discrimination: Improving Public Health by Realising Human Rights' (2005) 10 Deakin L. Review 233, 239.

²²⁵ Australia's recent decision on denying visas to tourists and immigrants from countries fighting Ebola has been called discriminatory; these new rules apply specifically to an individual based on his or her nationality. Such openly discriminatory laws are not found in Australia's domestic health care system (ie in the provision of health care services by a doctor or in a hospital setting). See Simon Cullen, ABC News, 'Ebola Crisis: UN calls out 'acts of discrimination' against West African countries' (22 November, 2014), online: ABC News < <http://www.abc.net.au/news/2014-11-22/isolating-ebola-ridden-countries-act-of-discrimination-says-un/5911148>>.

²²⁶ See Tom Calma, 'Indigenous health and human rights' (2008) 14 (1) Australian Journal of Human Rights 21; Angela Campbell, 'Type 2 Diabetes and Children in Aboriginal Communities: The Array of Factors that Shape Health and Access to Health Care' (2000) 10 Health L.J. 147, 148-149; National Aboriginal Community Controlled Health Organisation (NACCHO), *Submission to the Commonwealth Parliamentary Inquiry into the Needs of Urban Dwelling Aboriginal and Torres Strait Islander Peoples* (March 2001) online: NACCHO <<http://www.naccho.org.au/Files/Documents/Urbaninquirysubmission.pdf>>.

programs or increasing/decreasing the budget for the system. These successive Commonwealth governments have dramatically increased Commonwealth power in the area of health; an area that was originally within state jurisdiction. These changes have required increased cooperation between the state and Commonwealth governments, which, given the complex and political nature of health care, has not always been easy. Out of this highly complex legal system, the Australian health care system began to take shape.

The Australian health care system is a dynamic balance between a public health care system and a parallel private health care system. The public health care system gives access to basic doctor, hospital, and pharmaceutical services to all Australian citizens and permanent residents. This system is based on need, rather than on ability to pay. As discussed there are a few notable problems with the public health care service that will need attention in order to fully comply with Article 12 of the *ICESCR*. For instance, the Commonwealth government will have to continue to support and encourage rural health development. This area remains problematic given how closely related it is with Aboriginal health care needs.²²⁷ Another major obstacle for the public health care system is the issue of waiting lists. In many instances, patients have to wait weeks for critical surgeries; such delays may indicate a lack of availability of health care services. The Australian government has attempted to deal with this problem by increasing funding to its private health care system; this approach should be taken with caution. Studies have indicated that a parallel private system will often increase waiting times in the public system.

Finally, Australia also has a heavily subsidized and regulated private health insurance system. The Australian government has tried to make the private system more accessible through significant government subsidies. As discussed various initiatives were adopted, including lifetime cover and a 30% rebate program. While these have increased the participation rate of Australians in the private health insurance system, in a mixed system, there is always the potential that a two-tiered health care system will be created; this system will be based on wealth and not on actual medical need.

A final consideration for Australia's private system is the issue of discrimination. Any differential treatment in accessing private medical

²²⁷ All major health indicators are lower for Aboriginal communities, indicating that the population is not receiving adequate health care. Also, the purchase of private health insurance is significantly lower in these communities. This issue is beyond the scope of the paper, for information on aboriginal health, see *ibid*.

insurance on the basis of age, disability or health status would constitute a violation of article 12 of the *ICESCR*. Furthermore, discriminatory practices, which are not subject to the progressive realization principle, need to be immediately eradicated. Australia's private health insurance is government regulated to ensure that individuals are not denied private health insurance on the basis of health status or age. Without such controls, it is possible that a private health system, left alone to only market devices, may adopt practices that can be perceived as discriminatory.

Health care in Australia is complex. At present, the Australian health care system has done well to comply with the obligations imposed under Article 12 of the *ICESCR*. There is however, one major caveat, any government will have to be willing to closely monitor its public health care system and also closely regulate its private health care system. Only through government involvement and regulation can Australia's system achieve the obligations outlined in Article 12 of the *ICESCR*. Additionally, any cuts to programs or health care services may derail Australia's progress in implementing its obligations under Article 12. Australia, despite the difficult economic times facing all countries, should proceed with extreme caution when making budget allocations for its health care system.