Article

Australian National University

Federal Law Review
2023, Vol. 51(2) 232–256


Article reuse guidelines:
sagepub.com/journals-permissions
DOI: 10.1177/0067205X231165872
journals.sagepub.com/home/flr
Sage

Commonwealth Power to Improve Access, Quality, and Efficiency of Medical Care: Does section 51 (xxiiiA) of the *Constitution* Limit Politically Feasible Health Policy Options Today?

Fiona McDonald*, Stephen Duckett and Emma Campbell*****

Abstract

Legal and political battles about health policy in the immediate post-war years have cast a long shadow in Australia. The 'civil conscription' sub-provision in s 51(xxiiiA) (health and welfare power) of the Australian *Constitution* is still cited as a major barrier to developing health policy. But long after the High Court moved on from a very restrictive interpretation of Commonwealth powers, policymakers appear to be cautious about testing whether the Commonwealth has power to make laws about medical services to pursue a bold agenda about access, quality, and efficiency of medical care. In this article we will first describe the origin and phrasing of s 51(xxiiiA), the main head of power, then trace the development of the interpretation of the civil conscription sub-provision, and finally discuss whether politically realistic policy options are likely to founder on the shoals of High Court interpretation. We argue that the civil conscription limitation in s 51 (xxiiiA) in the *Constitution* looms larger as a policy constraint on regulation of health care by the Commonwealth government in the minds of decision-makers, and as a weapon in the hands of stakeholders, than contemporary analysis of it warrants.

Accepted 27 July 2022

* Co-Director Australian Centre for Health Law Research, Queensland University of Technology, Australia; Adjunct Associate Professor, Department of Bioethics, Dalhousie University, Canada; Senior Research Fellow, New Zealand Centre for Public Law, Victoria University of Wellington, New Zealand. We thank Audette Smith for research assistance.

** Former Director, Health and Aged Care Program, Grattan Institute, Australia; Honorary Enterprise Professor, Department of General Practice and Melbourne School of Global and Population Health, University of Melbourne, Australia.

*** Former Intern, Grattan Institute, Australia.

I Introduction

Legal and political battles about health policy in the immediate post-war years have cast a long shadow over health policy in Australia.[1] The phrasing of the provision about 'medical services', inserted in the *Constitution* in the immediate post-World War II years, was initially given a constraining interpretation by the High Court. But, long after the Court had moved on from a very restrictive interpretation of Commonwealth powers, policymakers still appear to be cautious about testing whether the Commonwealth has power to make laws about medical services. This is necessary to pursue a bold agenda about access, quality, and efficiency of medical care. The 'civil conscription' provision in s 51(xxiiiA) (health and welfare power) of the *Constitution* is still cited as a major barrier to health policy.[2] For example, the Commonwealth government has recently argued that the clause stops it from limiting co-payments that doctors and/or private health insurers may charge over and above the Medicare payment.[3]

There has been limited, and no recent, scholarly analysis of the impact of the civil conscription provision in s 51(xxiiiA) in general[4] and on the Commonwealth's powers in respect of health policy in particular,[5] although there has been some examination of its impact on specific issues (privatisation, corporatisation, takeover of hospitals).[6]

In this article, we first describe the policy choices made as part of the 'making of Medibank',[7] then discuss the origin and phrasing of s 51(xxiiiA), the main head of power; we then trace the development of the interpretation of the civil conscription provision; and, finally, discuss whether politically realistic policy options are likely to founder on the shoals of High Court interpretation.

1. Sidney Sax, *A Strife of Interests: Politics and Policies in Australian Health Services* (Allen and Unwin, 1984); James A Gillespie, *The Price of Health: Australian Governments and Medical Politics* (Cambridge University Press, 1991); Anne-Marie Boxall and James A Gillespie, *Making Medicare: The Politics of Universal Health Care in Australia* (UNSW Press, 2013).
2. This paper does not examine broader claims about whether there should be a Commonwealth takeover of some or all areas of health services in Australia, which has been mooted at times (including as threatened by the Australian Labor Party under Kevin Rudd's leadership). See Scott Brenton, 'Policy Capacity Within a Federation: The Case of Australia' in Xun Wu et al. (eds), *Policy Capacity and Governance: Assessing Governmental Competences and Capabilities in Theory and Practice* (Springer International Publishing, 2018) 337.
3. The Australian Department of Health and Ageing, Submission No 4 to Senate Standing Committees on Community Affairs, Parliament of Australia, *Inquiry into the Health Insurance Amendment (Extended Medicare Safety Net) Bill 2009* (2009).
4. James Kennan, 'The Possible Constitutional Powers of the Commonwealth as to National Health Insurance' (1975) 49 *Australian Law Journal* 261; Thomas Faunce, 'Constitutional Limits on Federal Legislation Practically Compelling Medical Employment: *Wong v Commonwealth*; *Selim v Professional Services Review Committee*' (2009) 17 *Journal of Law and Medicine* 196; Fiona McDonald, 'Regulation of Health Professionals and Health Workers' in Ben White, Fiona McDonald, and Lindy Willmott (eds), *Health Law in Australia* (Thomson Reuters, 3rd ed, 2018) 647.
5. Karen Wheelwright, 'Commonwealth and State Powers in Health: A Constitutional Diagnosis' (1995) 21(1) *Monash University Law Review* 53; Danuta Mendelson, 'Devaluation of a Constitutional Guarantee: The History of Section 51(xxiiiA) of the Commonwealth Constitution' (1999) 23 *Melbourne University Law Review* 308; J McMillan, *Commonwealth Constitutional Power Over Health* (Consumers' Health Forum of Australia, 1992).
6. Thomas Faunce, '*Selim v Lele* and the Civil (Industrial) Conscription Protection Against Federal Legislation Controlling or Privatising Australian Public Hospitals' (2008) 16 *Journal of Law and Medicine* 36; Caroline Colton and Thomas Faunce, 'Commissions of Audit in Australia: Health System Privatisation Directives and Civil Conscription Protections' (2014) 21 *Journal of Law and Medicine* 561; C Yazidjoglou and Thomas Faunce, 'Corporatisation of Community Pharmacy and the Constitutional Provision of Civil Conscription for Medical Service Providers' (2016) 24 *Journal of Law and Medicine* 41; Sharon Scully, 'Does the Commonwealth Have the Constitutional Power to Take Over Public Hospitals?' (Research Paper No 36 2008–2009, Parliamentary Library, Parliament of Australia, 30 June 2009).
7. From a book co-authored by Dr R B Scotton, one of the developers of Medibank: Richard B. Scotton and Christine R. Macdonald, *The Making of Medibank* (School of Health Services Management, University of New South Wales, 1993).

https://doi.org/10.1177/0067205X231165872 Published online by Cambridge University Press

We argue that the civil conscription limitation in s 51(xxiiiA) of the *Constitution* looms larger as a policy constraint on regulation of health care by the Commonwealth government, in the minds of decision-makers, and as a weapon in the hands of stakeholders, than contemporary analysis of it warrants.

II The Making of Medibank

The shift from voluntary health insurance provided by private insurers to a compulsory scheme provided by government was contentious, both publicly and within the Australian Labor Party ('ALP'), which led the change. Some within the Labor Caucus argued for a salaried scheme modelled on the United Kingdom's National Health Service,[8] but the ALP leader, Gough Whitlam, was well aware of the constitutional constraints to implementing such a scheme.

The constitutional provision, as discussed below, limited Commonwealth power over medical services so as not to involve 'civil conscription'; resorting to compulsion in the policy process was therefore 'studiously avoided'.[9] In his 1957, Chifley Memorial Lecture, Whitlam complained that the 'remarkable decision' of the High Court meant that it was:

> impossible for an Australian government to follow the British and New Zealand health schemes unless it was prepared entirely to abdicate to the medical profession in determining the cost and method of running the scheme.[10]

In his subsequent Curtin Memorial Lecture in 1961 (entitled 'Socialism within the Australian Constitution'), Whitlam again railed against the 1949 interpretation of the *Constitution*:

> The least defensible decisions of the High Court have been in the two pharmaceutical benefits cases. In the second case in 1949 such a fantastic interpretation was given to the ban in the *Constitution* on civil conscription in the provision of medical and dental services that a national health service on the New Zealand or British models is ruled out.[11]

Similarly, in their dissenting report on the Senate Select Committee on Medical and Hospital Costs, the Labor Senators bemoaned that 'Under the *Constitution*, compulsion or conscription cannot be imposed on health personnel …'.[12]

There are two threads running through these comments. Firstly, there is a sense of regret that nationalisation of the medical profession was precluded. In reality, despite loose language in the debates on the introduction of the 'civil conscription constraint' in the *Constitution*, discussed further below, the understanding of the constraint right from the start was that medical practitioners could not be forced into government employment.

8. Moss Cass, then a member of the ALP's policy committee, recalled that the committee debated 'nationalising' the medical profession, although 'we all knew that in the light of the *Pharmaceutical Benefits* case it would be unconstitutional': Ibid. See also Anne-Marie Boxall and James A Gillespie, *Making Medicare: the politics of universal health care in Australia* (NewSouth Publishing, 2013) 44–5 ('*Making Medicare*').
9. Michael Crommelin and Gareth J Evans, 'Explorations and Adventures with Commonwealth Powers' in Gareth J Evans (ed), *Labor and the constitution, 1972–1975: essays and commentaries on the constitutional controversies of the Whitlam years in Australian government* (Heinemann Educational Australia, 1977) 24–75.
10. Gough Whitlam, *On Australia's Constitution* (Widescope, 1977) 29.
11. Ibid 60.
12. Senate Select Committee on Medical and Hospital Costs, *Report* (Government Printer, 1969).

https://doi.org/10.1177/0067205X231165872 Published online by Cambridge University Press

But it is the second thread that is more telling. The UK National Health Service ('NHS') did not (and still does not) involve employment of general practitioners. In the UK, GPs are contractors to the NHS, with a national contract regularly negotiated between the British Medical Association and the NHS.[13]

In the late 1950s and early 1960s, Whitlam and Labor were contemplating hospital-centric reform, with salaried medical staff in public hospitals, presumably to be based on the unconstrained hospital benefits power in s 51(xxiiiA). The Medibank model adopted by Labor in the late 1960s had a dual — medical payment and hospital — approach.[14] But, the Medibank model was not the only option contemplated at the time: as well as considering salaried practice in community health centres and hospitals, the Party flirted with capitation arrangements.[15]

In addition to limiting the policy options, the perception of what was meant by 'civil conscription' also hamstrung the process of implementation — where any compulsion of doctors and dentists was thought to be explicitly excluded and so government's hand vis à vis the medical profession was weakened. Again, Whitlam identified the perceived constitutional constraint and articulated the problem, 'The present constitutional position is quite unsatisfactory, in which … the medical profession participates in any scheme only on its own terms'.[16]

The second thread in the comments recognises that the medical profession might have a de facto veto power — that even contractual arrangements might be precluded by the breadth of the civil conscription limitation.

Contemporary health policy uses financial incentives to influence and shape service delivery,[17] but what we see, especially in Whitlam's comments, is a sense that anything the medical profession might view as not in its interest is precluded.

Lukes has argued that power manifests in many forms, with one of the most powerful being the ability to shape what is considered as even being on the agenda.[18] Section 51(xxiiiA) was clearly much on Whitlam's mind as he was formulating what was feasible and what was not, and so it is no surprise that the more radical options — of salaried practice and even contracted practice as in the United Kingdom model — did not feature in the final design of Medibank as implemented.

III The Path to Section 51(xxiiiA)

The Whitlam government was not the first Labor government to have its path to reform constrained by the *Constitution*. Part of the Curtin-Chifley Labor government's post-war reconstruction agenda was improving access to health care. Its initial foray was the *Pharmaceutical Benefits Act 1944 (*Cth*)* ('*PB Act 1944*'), which, in essence, sought to make certain medicines free for the public.[19] It was a significant piece of legislation for the government, held up as an exciting policy that would deliver

13. See, eg, NHS Employers, *2016/17 General Medical Services (GMS) contract Quality and Outcomes Framework (QOF): Guidance for GMS Contract 2016/17 London* (Guidelines, 2016).
14. Gough Whitlam, 'The Alternative National Health Programme' (1968) 3(4) *Australian Journal of Social Issues* 33.
15. See Boxall and Gillespie, *Making Medicare* (n 8).
16. Whitlam, *On Australia's Constitution* (n 10) 30.
17. Anthony Scott, Miao Liu and Jongsay Yong, 'Financial Incentives to Encourage Value-Based Health Care' (2018) 75(1) *Medical Care Research and Review* 3.
18. Steven Lukes, *Power: A Radical View* (Palgrave Macmillan, 2009).
19. T H Kewley, *Social Security in Australia 1900–72* (Sydney University Press, 2nd ed, 1973); Clyde Sloan, *A History of the Pharmaceutical Benefits Scheme 1947–1992* (Australian Government Public Service, 1995); M S Goddard, 'How the Pharmaceutical Benefits Scheme Began' (2014) 201(1) *The Medical Journal of Australia.*

https://doi.org/10.1177/0067205X231165872 Published online by Cambridge University Press

'a complete medical service … available to every person without any direct charge and without regard to his economic status'.[20]

Medical practitioners, however, were generally opposed to this legislation, with many seeing it as the beginning of a plan to nationalise healthcare.[21] Executive members of the Victorian Medical Association requested that the Victorian Attorney-General contest the Act's validity and the matter came before the High Court in *Attorney-General (Vic) ex rel Dale v Commonwealth*[22] ('*Pharmaceutical Benefits case*'). This case turned on the question of whether the Commonwealth parliament had the power to enact the relevant legislation. The government claimed that the Section 81 power to appropriate public moneys 'for the purposes of the Commonwealth'[23] was sufficient to authorise legislating on pharmaceutical benefits. The High Court concluded that this approach was not legally sound. It reasoned that any Act to appropriate public moneys under Section 81 must also be supported by a legislative head of power, such as those enumerated in Section 51. As there was no such power relating to 'the control of doctors, chemists, the sale of drugs and the conduct of persons who deal with doctors and chemists',[24] the *PB Act 1944* was held to be invalid.

The High Court's narrow interpretation of the Section 81 appropriations power had significant implications for the Labor government's post-war policy agenda. It meant that various existing Commonwealth social services Acts were suddenly of dubious legality, because their subject matter was not supported by a Section 51 legislative head of power.[25] In response, the government sought to amend the *Constitution* to create a broad social services power, to ensure that federal social services benefits would be able to continue.[26]

A *The Parliamentary Compromise*

The Chifley Labor Government introduced the *Constitution Alteration (Social Services) Bill 1946*, which proposed altering the *Constitution* to add a further legislative power under Section 51. The proposed addition would allow Parliament to make laws for the peace, order, and good government of the Commonwealth with respect to:

> The provision of maternity allowances, widows' pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services, benefits to students, and family allowances.[27]

In moving the second reading of the Bill, Attorney-General Dr Evatt linked the legal motivations for the change to the outcome of the *Pharmaceutical Benefits* case. He stated that the 'object of this Bill is to alter the *Constitution* so that this Parliament can continue to provide directly for promoting

20. John Dewdney, 'Health Policy Formulation in Australia' (1987) 2 *International Journal of Health Planning and Management* 51, 53.
21. Goddard, 'How the Pharmaceutical Benefits Scheme Began' (n 19) 24.
22. (1945) 71 CLR 237 ('*Pharmaceutical Benefits case*').
23. *Australian Constitution* s 81.
24. *Pharmaceutical Benefits Case* (n 22) 258 (Latham CJ).
25. This included those providing for maternity allowances, child endowment, widows' pensions, unemployment and sickness benefits, and hospital benefits; Thelma Hunter, 'Pharmaceutical Benefits Legislation, 1944–50' (1965) 41(95) *Economic Record* 412.
26. Commonwealth, *Parliamentary Debates*, House of Representatives, 27 March 1946, 646–7 (Herbert Evatt).
27. *Australian Constitution* s 51(xxiiiA).

https://doi.org/10.1177/0067205X231165872 Published online by Cambridge University Press

social security in Australia',[28] and 'to place Australian social service legislation on a sound legal footing'.[29]

The Federal Opposition, led by Mr Robert Menzies, supported the proposed social services amendments. It was strongly opposed, however, to the Bill's reference to 'medical and dental services'.[30] The Opposition feared that this terminology would give the government power to nationalise the medical and dental professions in Australia[31] — something to which Menzies said his party had a 'very great objection'.[32]

International events at the time undoubtedly contributed to this fear of the legislation's potential. In Britain in 1946, the Labour Government just passed the *National Health Service Act*, which nationalised the hospital system and led to the creation of the NHS. Similarly, in New Zealand, attempts to nationalise medical services had been prominent in political discourse for the previous decade.

With the British Medical Association ('BMA') acting as the representative organisation of the medical profession in Australia, New Zealand, and the UK, Australian doctors were particularly aware of these international developments. Australian and New Zealand doctors could follow debates about Britain's introduction of the NHS through the pages of the *British Medical Journal*, which they received as part of their membership.

The BMA had lobbied hard against nationalisation schemes overseas,[33] and in Australia it was once again the loudest voice in protesting against the government's proposal. Its members, for example, submitted to Parliament that medical practitioners were opposed to 'any form of service [leading] directly or indirectly to [the profession] becoming full-time salaried servants of the State …'.[34] The BMA heavily lobbied Menzies to see their wishes safeguarded.[35]

The government's broad responses to opposition questioning about the Bill, such as Dr Evatt's explanation that the legislation 'would enable the Commonwealth to make use of the services of doctors and dentists to provide national medical and dental services',[36] did little to allay Liberal or the BMA's concerns.

Feeling the effect of these pressures, the federal opposition was determined to remove, or at the very least alter, the suggested provisions regarding medical and dental services. Reportedly upon the advice of the President of the BMA's Australia branch,[37] Menzies proposed an amendment to the Bill that authorised the government to legislate on medical and dental services, but with the proviso that such legislation would not be 'so as to authorise civil conscription'.[38]

28. Commonwealth, *Parliamentary Debates* (n 26).
29. Ibid.
30. Danuta Mendelson, 'Devaluation of a Constitutional Guarantee: The History of Section 51(xxiiiA) of the Commonwealth Constitution' (1999) 23(2) *Melbourne University Law Review* 308, 311.
31. Commonwealth, *Parliamentary Debates*, House of Representatives, 27 March 1946, 648 (Percy Spender).
32. Commonwealth, *Parliamentary Debates*, House of Representatives, 3 April 1946, 900 (Robert Menzies).
33. John Pater, *The Making of the National Health Service* (King Edward's Hospital Fund for London, 1981) 112; Bruce Brown, 'Nordmeyer, Arnold Henry' in *Dictionary of New Zealand Biography* (New Zealand, 2000).
34. Commonwealth, *Parliamentary Debates*, House of Representatives, 17 March 1949, 1661 (Earle Page).
35. Goddard, 'How the Pharmaceutical Benefits Scheme Began' (n 19) 524.
36. Commonwealth, *Parliamentary Debates*, House of Representatives, 3 April 1946, 899 (Herbert Evatt).
37. Ronald Sackville, 'Social Welfare in Australia: The Constitutional Framework' (1973) 5(2) *Federal Law Review* 248; Sally Wilde, 'Serendipity, Doctors and the Australian Constitution' (2005) 7(1) *Health and History* 41.
38. Commonwealth, *Parliamentary Debates*, House of Representatives, 9 April 1946, 1214 (Robert Menzies).

While the term 'civil conscription' was new and hence its meaning unclear,[39] the analogous phrase 'industrial conscription' had a more settled interpretation due to its inclusion in several pieces of contemporary legislation.[40] An amendment to the *National Security Act 1939*, for example, had removed a prohibition on industrial conscription so that the government could '[require] persons to place themselves, their services and their property at the disposal of the Commonwealth'. The term had surfaced again in the 1944 referendum on federal powers for post-war reconstruction, with campaigns explaining that industrial conscription entailed '[giving] up your right to choose your own way of living and [taking] orders to go to the job selected for you'.[41]

Menzies noted that he had drawn his proposed 'civil conscription' phrasing directly from this idea of 'industrial conscription'.[42] He argued that 'if industrial workers are to be put beyond the danger of industrial conscription, then what is good for them should be good for professional workers also'.[43] Hence, politicians and lawyers at the time understood civil conscription to denote a similar concept of protecting against conscription of professional workers to service of the State. The 'yes' campaign for the 1946 referendum, which was supported by both federal parties, evidenced this shared understanding. In their campaign materials, it was stated that the protection against civil conscription meant 'one thing', namely 'that doctors and dentists cannot be forced to become professional officers of the Commonwealth under a scheme of medical and dental services'.[44] Final confirmation of the phrase's interpretation came through formal advice from the Solicitor-General and two officers of the Attorney-General's Department, who submitted that 'the only kind of legislation which the amendment would preclude would be such as compelled doctors or dentists in effect to become servants of the Commonwealth, or to have the whole of their professional activities controlled by Commonwealth direction'.[45]

With the partisan differences apparently reconciled, and presumably believing the meaning of the constitutional amendment was clear, Dr Evatt accepted the amendment on behalf of the Government. The Bill proposed amending the *Constitution* to include:

> (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 authorise any form of civil conscription), benefits to students and family allowances.

The proposed amendment to the *Constitution* was put to Australian voters at referendum in September 1946 and passed.[46]

39. *Wong v Commonwealth of Australia; Selim v Lele, Tan and Rivett constituting the Professional Services Review Committee* ('*Wong*') (2009) 236 CLR 573, 584 (French CJ and Gummow J).
40. This legislation included: the *Emergency Powers Act 1920* (UK); *Public Safety Preservation Act 1923* (Vic) and *National Security Act 1939* (Cth).
41. *Wong* (n 39) 587 (French CJ and Gummow J).
42. Ibid 590 (French CJ and Gummow J).
43. Commonwealth, *Parliamentary Debates*, House of Representatives, 10 April 1946, 1215 (Robert Menzies).
44. *Wong* (n 39) 624 (Hayne, Crennan and Kiefel JJ).
45. Ibid 625 (Hayne, Crennan and Kiefel JJ).
46. Perhaps because of this narrowing of the scope of s 51(xxiiiA) discussed in subsequent sections of this paper, the 1988 Constitutional Commission did not recommend that s 51(xxiiiA) be amended to delete the civil conscription provision. It received no submissions on this question: Commonwealth of Australia, *Final Report of the Constitutional Commission 1988* (Australian Government Publishing Service, 1988) 626.

https://doi.org/10.1177/0067205X231165872 Published online by Cambridge University Press

IV The Courts and s 51(xxiiiA)

There have been three High Court cases which have shaped the interpretation of s 51(xxiiiA). Soon after the *Constitution* was amended, the meaning of 'civil conscription' was tested in the High Court, where a majority proffered a broader meaning of civil conscription than had been contemplated in parliamentary debates — and hence a potentially much wider limitation on what governments could do.[47] However, there have been dramatic shifts in interpretation of the civil conscription sub-provision since then, with the High Court subsequently narrowing its scope in *General Practitioners Society in Australia v the Commonwealth* ('*GPS Case*') and *Wong v the Commonwealth; Selim v Professional Services Review Committee* ('*Wong*').[48] In this section, we trace the changes in the High Court's interpretation over time.

A *The Initial Interpretation of Civil Conscription — The Limitation is Very Broad (the BMA Case)*

The first case before the High Court to consider the impact of the civil conscription sub-provision was *British Medical Association v Commonwealth* ('*BMA* case'),[49] a test case to determine the scale and scope of the limitation. The case challenged certain sections and regulations emerging from the *Pharmaceutical Benefits Act 1947* ('*PB Act 1947*').[50] The Court ignored the expectation of what was meant by civil conscription which informed the parliamentary debate and asserted a very broad interpretation of what was precluded.

One of the first issues for the High Court to consider was whether the civil conscription issue was moot because the *PB Act 1947* was an exercise of the pharmaceutical benefits power and so the civil conscription limitation did not apply. Latham CJ left open the question as to whether the civil conscription provision applied only to the provision of medical and dental services, and not to pharmaceutical, sickness, or hospital benefits.[51] Dixon, Rich, McTiernan, and Williams JJ found that the civil conscription provision attached only to the provision of medical and dental services.[52] Later, in *Alexandra Private Geriatric Hospital Pty Ltd v the Commonwealth* ('*Alexandra*'),[53] the High Court stated it was settled that the civil conscription provision is attached to medical and dental services. However, it was 'not irrelevant' to other aspects of s 51(xxiiiA)[54] to the extent that medical and dental services are provided pursuant to the provision of another benefit.[55] The *BMA* case also settled that the civil conscription provision applied only to the Commonwealth — it had no application to the states.[56]

47. *Federal Council of the British Medical Association in Australia v Commonwealth* (1949) 79 CLR 201 ('*BMA Case*).
48. *The General Practitioners Society in Australia v Commonwealth* (1980) 145 CLR 532 ('*GPS Case*); *Wong* (n 39)
49. *BMA Case* (n 47).
50. *Pharmaceutical Benefits Act 1947* (Cth) ('*PB Act* 1947').
51. Ibid 250–1 (Latham CJ).
52. See Ibid 261 (Dixon J); 254 (Rich J); 282 (McTiernan J); 286 (Williams J). See also *Final Report of the Constitutional Commission 1988* (Australian Government Publishing Service, 1988) 626.
53. (1987) 162 CLR 271 ('*Alexandra*').
54. Ibid 279 (Mason ACJ, Wilson, Brennan, Deane and Dawson JJ).
55. Ibid.
56. *BMA Case* (n 47) 253 (Latham CJ). See also the NSW Supreme Court in *Kassam v Hazzard; Henry v Hazzard* [2021] NSWSC 1320 at [275–77] ('*Kassam*'). The Kassam case also dismissed an argument that the order was made in furtherance of a joint scheme between the Commonwealth and New South Wales. The court noted there was no factual basis for this claim as there was no evidence of a joint agreement, let alone a requirement for the state to act at the behest of the Commonwealth.

https://doi.org/10.1177/0067205X231165872 Published online by Cambridge University Press

Section 7A of the *PB Act 1947* imposed a fine on a doctor for not using a standard prescription form. This was enough for a majority of the High Court to deem the specification of how doctors should undertake prescribing confirmed that it amounted to 'medical service'. It appeared that it was this exercise of compulsion, as some of the judges termed it, that led the majority to conclude it infringed the civil conscription sub-provision and should be struck out of the *PB Act 1947*. In the minority, Dixon J concluded that the impugned provisions did not create a duty to attend the patient or prescribe. The only duty is triggered once the doctor or dentist decides to prescribe, and that duty is limited to formalities of the paperwork which is a non-medical, financial, or administrative purpose.[57]

The majority's conclusion, that regulating prescription paperwork constitutes civil conscription, shows that the majority in the *BMA* case adopted a very broad view of civil conscription. Latham CJ stated:

> The term 'civil conscription' is wider than industrial conscription. It is applicable in the case of any civilian service, ie non-military, work or service. It could properly be applied to any compulsion of law requiring that men should engage in a particular occupation, perform particular work, or perform work in a particular way.[58]

Contrary to the early views in the parliamentary debate that civil conscription was parallel to industrial conscription and compulsory service to the state, the Court now suggested that it also encompassed 'performing work in a particular way'. Latham CJ went further to discuss whether the conscription needed to be direct and explicit or whether it could be indirect:

> There could in my opinion be no more effective means of compulsion than is to be found in a legal provision that unless a person acts in a particular way he shall not be allowed to earn his living in the way, and possibly in the only way, in which he is qualified to earn a living.[59]

The others in the majority found that civil conscription could arise through a practical compulsion to provide a service.[60] However, the minority took a more limited view, with Dixon J stating: '… a wide distinction exists between … a regulation of the manner in which an incident of medical practice is carried out … and … the compulsion to serve medically or to render medical services'.[61] Dixon continued: 'no doctor is any less a private practitioner than he was immediately before the Act was passed'.[62] McTiernan J (also in the minority) noted: 'practical necessity or moral duty is not conscription'.[63]

It was immediately clear from *BMA* that the Commonwealth could not make laws which impacted on the practice of medicine — even to the extent of regulating the form of a prescription. More importantly was the discussion of just how broad 'civil conscription' might be: the *BMA Case* suggested that practical compulsion might potentially have a very large ambit.

57. *BMA Case* (n 47) 277 (Dixon J).
58. Ibid 249 (Latham CJ).
59. Ibid 253 (Latham CJ).
60. Ibid 256 (Rich J); 293 (Webb J).
61. Ibid 278 (Dixon J).
62. Ibid 284 (Dixon J).
63. Ibid 283 (McTiernan J).

https://doi.org/10.1177/0067205X231165872 Published online by Cambridge University Press

During the 1960s and 1970s, when Australia's universal health insurance scheme was being designed and implemented, as noted above, one option under consideration was a salaried scheme. Such a scheme was thought to be precluded under the broad reading which therefore influenced the shape of Australia's universal health insurance arrangements in terms of what could be seen as constitutionally possible.[64]

B *The High Court Revisits the Civil Conscription Sub-provision in the 1980s and Narrows the Policies Precluded*

The civil conscription sub-provision was not reconsidered for another 31 years, until 1980, when the High Court revisited it in the *GPS Case*.[65] By 1980, universal health insurance had been introduced in the form of Medibank and then slowly unwound by the Fraser-led Coalition government.[66] But remnants of government-provided medical benefits remained and their regulation stimulated a further case testing consistency with s 51(xxiiiA). The *GPS Case* narrowed the scope of the civil conscription limitation to where there was 'practical compulsion'.

The *GPS Case* focused on a series of requirements imposed upon pathologists by the *Health Insurance Act 1973* (Cth) ('*HI Act*') and so directly related to the provision of medical benefits, potentially triggering the civil conscription provision. The majority of the High Court reformulated the test and adopted Dixon J's approach in the *BMA Case*, which distinguished between regulating practice and a 'compulsion to serve'. The Court determined that civil conscription was a 'practical and legal compulsion' to provide a service or to exclude a health care provider from providing a service.[67] Thus, any requirement to engage in practice or perform a particular service would amount to civil conscription. Barwick J thought it would be a rare set of circumstances where practical compulsion would apply.[68] Gibbs J determined '[conscription] connotes compulsion to serve rather than regulation of the manner in which services are provided',[69] with the latter, regulation, not infringing the civil conscription constraint. In general, the Court concluded that the *HI Act* did no more than provide that if the patient is to receive the prescribed Commonwealth benefit the practitioner assists by following the incidental provisions of the Act.[70] Aickin J provided some examples of what might amount to civil conscription, including a prohibition on performing medical or dental services, a requirement to perform services in a particular place, or to perform services only as an employee of the Commonwealth.[71] The majority's view was that the impugned provisions in the *HI Act* regulated the way some incidents of practice are carried out but did not relate to the service itself: no one was under a legal compulsion to become an approved pathology provider.

The *GPS Case* therefore narrowed the *BMA Case* from any interference in the way doctors did their job, to 'a legal or practical compulsion' to provide a service. However, it left continuing

64. Though Kennan in 1975 presciently concluded that 'While the phrase "civil conscription" in s 51(xxiiiA) was narrowly construed in the case of *The British Medical Association v. The Commonwealth*, a future challenge to national health insurance legislation may result in a broader construction': James Kennan, 'The Possible Constitutional Powers of the Commonwealth as to National Health Insurance' (1975) 49(6) *Australian Law Journal* 261, 267.
65. *GPS Case* (n 48).
66. See Stephen Duckett, 'Chopping and Changing Medibank Part 1: Implementation of a New Policy' (1979) 14(3) *Australian Journal of Social Issues* 230.
67. *GPS* case (n 48) 550 (Gibbs J).
68. Ibid 538 (Barwick CJ).
69. Ibid 557 (Gibbs J).
70. Ibid 538 (Barwick CJ).
71. Ibid 565 (Aickin J).

https://doi.org/10.1177/0067205X231165872 Published online by Cambridge University Press

uncertainty about the new test, especially regarding what might constitute a practical compulsion. In the *GPS Case,* Aickin J suggested that an example of a practical compulsion to provide a service would be economic pressure of such a type that it would be unreasonable to suppose the pressure would or could be resisted.[72]

C *The High Court Revisits Practical Compulsion to Provide a Service — Wong in 2009*

The practical compulsion through economic pressure example was tested 29 years after the *GPS Case*, in 2009, in *Wong*.[73] By then, Medicare had been introduced as a universal health insurance scheme and *Wong* related to the sections of the *HI Act* about 'inappropriate practice' or over-servicing.[74] The *HI Act* imposed a maximum penalty of a 3-year disqualification from billing Medicare if a practitioner was found through professional standards review to have 'over-serviced' — that is, provide a service which did not have a clear clinical justification.[75] The majority in *Wong* held that the provision of the *HI Act* imposing the penalty did not constitute a breach of the civil conscription sub-provision. The section provided a compulsion to participate in Medicare but not a compulsion to provide a particular service or to work for the Commonwealth.[76] Kirby J, although in the majority, was unpersuaded by the distinction in the *GPS Case* between compulsion to serve and regulation of the way service is performed; he preferred the broader definition in the *BMA Case*.[77]

A similar conclusion, distinguishing between the practise of medicine and access to Medicare rebates, was reached in the *Alexandra* case decided in 1987.[78] The case centred on the provision of hospital benefits and thus was not directly subject to the civil conscription sub-provision. The plaintiffs challenged provisions of the *National Health Act 1953* (Cth) relating to approved nursing homes.[79] They argued that the impugned provisions in the *National Health Act* imposed significant regulatory controls on nursing homes that exceeded the Commonwealth's legal capacity, because s 51(xxiiiA) only allowed the Commonwealth to provide benefits, not to regulate. The High Court unanimously noted that there should be no objection to adopting a private enterprise approach by allowing nursing homes to voluntarily choose to receive a government subsidy. The High Court stated:

> it is not for the Court to determine that argument or to pass upon the wisdom or the suitability of the particular scheme that the legislature has chosen to institute, so long as the Court is unable to say that it lacks sufficient connexion to the head of power.[80]

What might amount to civil conscription after the *Wong* case? Kirby J in *Wong* offered some obiter comments on this point. A law pretending to be about finances but, which really intruded into the individual relationship between patient and doctor, or that created blanket rules that intruded on that relationship, or requirements that are so detailed and intrusive as to be coercive and

72. Ibid 566 (Aickin J).
73. *Wong* (n 39).
74. *Health Insurance Act 1973* (Cth) Part VAA. See especially s 106U.
75. Ibid s 82.
76. *Wong* (n 39) 633–4 (Hayne, Crennan and Kiefel JJ).
77. Ibid 609 (Kirby J).
78. *Alexandra* (n 53).
79. *National Health Act 1953* (Cth) ('*National Health Act*'). A civil conscription argument was in the statement of claim but not pursued in argument.
80. *Alexandra* (n 53) 283 (Mason ACJ, Wilson, Brennan, Deane and Dawson JJ).

https://doi.org/10.1177/0067205X231165872 Published online by Cambridge University Press

disproportionate to the legitimate interest of the Commonwealth, might be unconstitutional.[81] Any attempt by the Commonwealth to nationalise or force doctors or dentists into full-time or part-time work would infringe the civil conscription provision. But he also noted:

> how to define the point where the necessary, proper and inescapable intrusion into the private arrangements between the provider of 'medical and dental services' and a recipient of such services passes beyond legitimate scrutiny for reasons of upholding the lawfulness and integrity of such payments and is converted, by its sheer detail and intrusiveness, into a prohibited 'form of civil conscription'. No easy formula is available to identify that point.[82]

D *Reaffirming the Narrow Scope of Civil Conscription*

The High Court and other courts have touched on the scope of s 51(xxiiiA) in a number of cases in the last 25 years, all of which reaffirmed the narrow scope of the civil conscription limitation. Recall that it was an administrative requirement about a pharmaceutical formulary that led to the expansive interpretation in *BMA;* subsequent cases have authorised a generous interpretation of what is allowable.

It has long been clear that everything necessary (incidental powers) to the effective exercise of a constitutional power is included in the grant of the power unless there is an express prohibition.[83] However, the majority in the *BMA Case* suggested the civil conscription sub-provision placed limits on the scope of the incidental powers.[84] Dixon J, in the minority, said that even if the *PB Act 1947* did constitute a duty to provide a service in a particular way, the power in the *Constitution* to regulate matters that are incidental to the power would apply.[85] Dixon J's view was affirmed in *GPS,* Gibbs J noting 'if the incident of practice which is regulated is not medical or dental, but financial and administrative, it is clearly outside the prohibition [civil conscription]'.[86] Similarly, Gibbs J noted that something that related incidentally to the course of medical practice, rather than the medical service itself, would be allowed by the incidental powers provision. For example, a legislative provision that imposes more administrative work but does not affect performance of medical duties would be a use of the incidental powers.[87]

The same acceptance of incidental powers was affirmed in the *Alexandra* case where the High Court held that the requirements under the *National Health Act* amounted to a scheme to provide money to a nursing home to provide care to a patient. Broader requirements, such as quality standards, are incidental to the subject matter of the power, and justifiable given the need to ensure patients receive quality care appropriate to the cost of the program.[88]

Decisions by the Federal Court in *Yung v Adams* ('*Yung*')[89] and the Full Federal Court in *Selim v Lele*[90] noted the Commonwealth's interest in ensuring that the medical services it funds are provided with the appropriate level of care and skill. In *Yung,* Davies J expressed the view that the

81. *Wong* (n 39) 618 (Kirby J).
82. Ibid 617 (Kirby J).
83. *Australian Constitution* s 51(xxxix); *Baxter v Ah Way* (1909) 8 CLR 626, 637 (O'Connor J).
84. *BMA Case* (n 47) 250–1 (Latham CJ); 291 (Williams J); 292 (Webb J).
85. Ibid 274 (Dixon J).
86. *GPS Case* (n 48) 558 (Gibbs J).
87. Ibid 557 (Gibbs J).
88. *Alexandra* (n 53).
89. (1997) 150 ALR 436 ('*Yung*').
90. (2008) 167 FCR 61, 80.

https://doi.org/10.1177/0067205X231165872 Published online by Cambridge University Press

Commonwealth 'has no general power to regulate the activities of medical practitioners' but does have power 'in relation to conduct which is related to the payments which are made by the Commonwealth under the Act by way of medical benefits and the like'.[91] This approach was also followed in *Wong*: the incidental power must be exercised proportionally to the fulfilment of the power.[92]

In addition to the incidental power arguments, there has also been discussion by the federal courts about what constitutes administrative powers in respect of legislation, such as the *HI Act*, that impacts on doctors. The Federal Court of Australia heard a series of cases relating to findings of the Professional Standards Review process about inappropriate practice by doctors.[93] All of these cases tested the legitimacy of what is and is not allowable (billing) practices of medical practitioners.

Yung and *Tankey v Adams* ('*Tankey*')[94] were both brought before the Court on appeal from the Professional Services Review Tribunal, having been heard initially by the Professional Services Review Committee. *Health Insurance Commission v Grey* ('*Grey*')[95] was also brought before the Court only after consideration by the Professional Services Review Committee. The professional standards review system was challenged in *Tankey* and *Grey*, where the respondents argued that the Professional Services Review bodies were being unconstitutionally vested with judicial power.

If the Federal Court agreed with this argument, the system and any penalties issued would have been invalid, because the Commonwealth is prohibited under section 71 of the *Constitution* from granting judicial power to non-judicial bodies.[96] However, the Federal Court held that no judicial power was being exercised in these cases. It cited various features of the Professional Services Review schema that suggested the power was administrative, not judicial, in nature. These included the fact that repercussions for doctors were not imposed as punishment, but as a protection against abuse of the system;[97] that disqualification orders were 'much more akin' to a professional judgment than a legal demand;[98] that the Review was not concerned with the ascertainment of legal rights and obligations;[99] that the process required peer review, which is 'a delegated administrative function of government';[100] and that the Committee and Tribunal were unable to directly enforce their own determinations.[101] Further, the Federal Court noted that simply because the bodies were set up to consider 'inappropriate practice', a concept defined by statute, did not mean that they were automatically judicial entities.[102]

The civil conscription sub-provision was recently considered by the Supreme Court of New South Wales in *Kassam*.[103] This case considered a number of grounds challenging orders issued under s 7(2) of the *Public Health Act 2010* (NSW) which prevented 'authorised workers' from leaving an 'area of concern' they lived in and prevented some people working in certain industrial sectors without being vaccinated for COVID-19. An argument was made by one plaintiff group that

91. *Yung* (n 89) 442 (Davies J).
92. *Wong* (n 39) 618 (Kirby J).
93. *Yung* (n 89); (2000) 104 FCR 152 ('*Tankey*'); (2002) 120 FCR 470 ('*Grey*').
94. *Tankey* (n 93).
95. *Grey* (n 93).
96. *R v Kirby; Ex parte Boilermakers' Society of Australia* (1956) 94 CLR 254.
97. *Yung* (n 89) 472 (Davies J).
98. *Tankey* (n 93) 159 (Ryan, O'Connor and Weinberg JJ).
99. Ibid 162 (Ryan, O'Connor and Weinberg JJ).
100. Ibid.
101. Ibid.
102. Ibid 161 (Ryan, O'Connor and Weinberg JJ); *Grey* (n 93) 487 (Beaumont, Sundberg and Allsop JJ).
103. *Kassam* (n 56).

https://doi.org/10.1177/0067205X231165872 Published online by Cambridge University Press

requiring a person in a specified industry to be vaccinated had the effect of conscripting both patient and doctor. The Court noted that nothing in the impugned order or the Act imposes any compulsion on a doctor to vaccinate anyone. The civil conscription provision does not apply to the acquisition of a medical service but only to the provision of the service.[104]

E *What is Allowable*

The judgments of the courts in these cases provide several key lessons that can guide future healthcare legislation. They affirm that the government can use Medicare as something of a bargaining chip, validly threatening to restrict access to the scheme unless medical practitioners abide by certain government-imposed regulations. Additionally, they show that the government may set up institutions to ensure there is adherence to those regulations: so long as these bodies retain administrative qualities (like those enumerated by the Court in *Tankey* and *Grey*), and do not become judicial in their function, they will be legally valid. Any of these regulations, however, need to be mindful of the distinction between services and payments — the Commonwealth power to regulate the way in which doctors and dentist ply their trade, specifically the content of the clinical interaction, remains limited.

V Contemporary Health Policy Relevant Principles

The clear policy constraints of the civil conscription sub-provision in s 51(xxiiiA) remain real, but somewhat theoretical: it is unlikely that any political party would now attempt to force doctors or dentists to work for the government or for a private entity, or would attempt to control directly how a doctor or dentist should treat patients. But the issue of 'incidental powers' and the role of government in regulating practice will be increasingly important in shaping the potential limits of health policy in the future.

A key concern of public policy is ensuring value for money and equity in the distribution of benefits. As we shall show in this section, the High Court has recognised the legitimacy of that concern and, provided that strategies to achieve the policy goals are proportionate, it is unlikely that they will infringe s 51(xxiiiA).

A *Responsibility for Taxpayers' Money*

In *Wong*, Kirby J stated that the *Constitution* requires that taxpayers' monies are 'lawfully and properly expended',[105] and he recognised that enacting detailed administrative provisions to effect this would not amount to any form of civil conscription.[106] Kirby J noted that mechanisms proportionately undertaken to assure that funds are lawfully expended would not in and of themselves constitute civil conscription, even if they involve a burden, even a coercive one, on providers of medical or dental services.[107] A high degree of specificity in monitoring, supervision, and checking is expected and would not be second-guessed by the courts, as long as the measures seem reasonably appropriate.[108] Similarly, in *Alexandra* the High Court noted:

104. Ibid [272].
105. Ibid.
106. *Wong* (n 39) 616 (Kirby J).
107. Ibid 617 (Kirby J).
108. Ibid 618 (Kirby J).

https://doi.org/10.1177/0067205X231165872 Published online by Cambridge University Press

> some kind of scheme was essential to ensure both that the provision would be effective in meeting the needs of such patients and, capable of being held within reasonable budgetary limits.[109]

Latham CJ also acknowledged this as a general principle in the *BMA Case*,[110] although later qualified this after considering his broad interpretation of the civil conscription provision. This was revisited in the *GPS Case*, where Gibbs J noted 'the purpose of the impugned provisions appears to be to protect the public revenue against abuses of the system under which such benefits are provided'.[111]

B *Value for Money*

While not directly a s 51(xxiiiA) case, *Health Insurance Commission v Peverill* ('*Peverill*')[112] addresses the question of whether a benefit payable under s 51(xxiiiA) can be retrospectively changed by legislation. The change was to reduce the amount paid to the doctor for the provision of a pathology service. Medicare payments in *Peverill* were seen as payments to patients,[113] and assignment of those payments to a doctor as part of bulk-billing did not create a contract between the doctor and the Commonwealth government about those payments nor give rise to a property interest. Importantly, an entitlement for payment from Medicare was not created, Brennan J describing it as 'what is, as between the Commonwealth and the claimant for the Medicare benefit, a gratuitous payment'.[114]

The justices approached this case on the assumption that there was a legitimate government responsibility to contain health care costs:

> Clearly enough, the underlying perception was that it was in the common interest that these competing interests be adjusted so as to preserve the integrity of the health care system and ensure that funds allocated to it are deployed to maximum advantage and not wasted in windfall payments.[115]

The High Court also recognised that there are several factors which government can take into account in setting the Medicare fee, including 'the capacity of government to pay and the future of health services in Australia'.[116]

C *Equity is a Valid Policy Consideration*

Broader considerations about legitimate policy purposes were examined in the *Alexandra* case. A unanimous High Court appeared to acknowledge an equity argument, arising from the specific principles developed under s 40AA(7) to guide the Secretary to set fees, in particular paragraph 2(4)(c) 'the need to ensure that the cost to nursing home patients of nursing home care is not excessive or unreasonable'.[117] The High Court stated that if aged care facility fees were not subject

109. *Alexandra* (n 53) 282 (Mason ACJ, Wilson, Brennan, Deane and Dawson JJ).
110. *BMA Case* (n 47) 245 (Latham CJ).
111. *GPS Case* (n 48) 549 (Gibbs J).
112. (1994) 179 CLR 226 ('*Peverill*').
113. Ibid 246 (Dawson J), 256 (Toohey J).
114. Ibid 244 (Brennan J); see also McHugh J's reference to a 'gratuitous statutory entitlement' at 260.
115. Ibid 237 (Mason CJ, Deane, and Gaudron JJ).
116. Ibid.
117. *Alexandra* (n 53) 278 (Mason ACJ, Wilson, Brennan, Deane, and Dawson JJ).

https://doi.org/10.1177/0067205X231165872 Published online by Cambridge University Press

to control by the Commonwealth, some of the more needy may not be able to obtain aged care and take advantage of the benefit.[118] Specifically, the High Court stated:

> It seems to us to be impossible to say that the control of fees charged to qualified nursing home patients in an approved nursing home is not a reasonable and perhaps necessary ingredient of a scheme designed to render effective the provision of sickness and hospital benefits to nursing home patients.[119]

The policy concerns of the Commonwealth about responsibility for taxpayers' money, value for money, and equity have thus all been explicitly acknowledged by the courts as part of the calculation about the scope of the civil conscription sub-provision.

D *Four Guideposts*

As we have shown, cases determined in the past 40 years have narrowed the interpretation of civil conscription contained in s 51(xxiiiA) and upheld an interpretation of Commonwealth power which allows the Commonwealth to put limits on medical and dental professionals' access to Medicare.

The original interpretation of section 51(xxiiiA) did not allow government to regulate the form of a prescription, causing Labor leader Whitlam to condemn the abdication of control to the medical profession. The evolution of the High Court's thinking on the legitimacy of government regulation has paralleled global shifts in health policy. The Second World War saw international attention to meeting social needs, including access to healthcare. The Chifley government's policies were the Australian example of this.

Over time, funders became more overtly concerned about constraining spending leading to the development of an 'implicit bargain: clinical freedom under global cost control'.[120] The contemporary High Court approach is consistent with that: government may not be able to regulate what a medical practitioner does in a clinical encounter but can regulate to ensure value for money and good public policy. Importantly, the development of the High Court interpretation of section 51(xxiiiA) shows it is not now as constraining as Whitlam feared.

The High Court's reasoning in these cases can be used to determine four guideposts within which policy could be developed which would not offend subsection 51(xxiiiA).

1 *The Commonwealth Can Impose Reasonable Conditions on Payments to Medical Practitioners to Ensure Value for Money — This Includes Measures to Ensure Probity and Quality (the Reasonable Conditions Rule)*

This rule can be derived from the *GPS*,[121] *Wong*,[122] *Alexandra*,[123] and Peverill,[124] cases and the incidental powers. Peverill,[125] and *Alexandra*,[126] especially suggest that the High Court accepts that

118. Ibid 274, 282 (Mason ACJ, Wilson, Brennan, Deane, and Dawson JJ).
119. Ibid 283 and 284 (Mason ACJ, Wilson, Brennan, Deane, and Dawson JJ).
120. R G Evans, 'Healthy Populations or Healthy Institutions: The Dilemma of Health Care Management' (1995) 13(3) *The Journal of Health Administration Education* 453–72.
121. *GPS Case* (n 48).
122. *Wong* (n 39).
123. *Alexandra* (n 53)
124. *Peverill* (n 111).
125. Ibid.
126. *Alexandra* (n 53).

https://doi.org/10.1177/0067205X231165872 Published online by Cambridge University Press

government ought to be able to ensure value for money and equity in the way s 51(xxiiiA) spending occurs.

French CJ and Gummow J in *Wong*[127] summarised the important distinction in the *GPS Case*:

> between regulation of the manner in which some of the incidents of the practices of medical practitioners were carried out and the compulsion, legal or practical, to carry on that practice and provide the services in question. The laws under challenge were held to be of the former character and thus were valid.[128]

Reasonable administrative requirements to achieve broader policy goals are clearly now legitimate.

2 *The Right to Practice is Not a Right to Bill. The Government Has no Obligation to Offer All Doctors the Right to Earn an Income From Medicare (the Separation of Practice and Payment Rule)*

This rule — which goes to the heart of practical compulsion — is derived from *Wong*[129] and *Peverill.*[130] As Hayne, Crennan, and Kiefel JJ concluded in *Wong*, 'a practical compulsion to participate in the Medicare scheme does not … provide for a form of civil conscription'.[131]

In the past, the medical profession has argued that the critical relationship in medical practice is between the doctor and the patient, and the payment relationship is a matter between the patient and the doctor, into which government — and insurers — should not intrude.[132] Medibank and then Medicare was seen as potentially threatening this relationship in the sense of third-party intrusion into the doctor-patient relationship. What is now clear from *Wong*[133] is that regulating the flow of Medicare benefits to patients — and hence to the doctors who treat them — is allowable. *Peverill*[134] shows that the payment of benefits does not create or involve a contract between government and doctor, and so concomitantly not creating such a contract does not involve compulsion. Regulating the payment flow is not the same as regulating the clinical work of a doctor and hence is not civil conscription relating to a medical service, or even relevant practical compulsion.

3 *If a Medical Practitioner Voluntarily Decides to Participate in a Funding Arrangement Offered by the Commonwealth, That Cannot Create Civil Conscription, and the Conditions of the Funding Arrangements Bind the Medical Practitioner (the Voluntary Participation Rule)*

This rule can be derived from *Alexandra*[135] and *Wong*[136]. The High Court noted in *Alexandra* that:

127. *Wong* (n 40).
128. Ibid 580 (French CJ and Gummow J).
129. Ibid.
130. *Peverill* (n 112).
131. *Wong* (n 39) 633 (Hayne, Crennan, and Kiefel JJ).
132. Mark G Field, 'The Doctor-Patient Relationship in the Perspective of "Fee-for-Service" and "Third-Party" Medicine' (1961) 2(4) *Journal of Health and Human Behavior* 252–62; Shaun Gath, 'Enhanced Consumer Rights in Private Health Care: Have the "Lawrence Amendments" Delivered?' (1999) 6 *Journal of Law and Medicine* 241–52.
133. *Wong* (n 39).
134. *Peverill* (n 111).
135. *Alexandra* (n 53).
136. *Wong* (n 39).

https://doi.org/10.1177/0067205X231165872 Published online by Cambridge University Press

> If it be accepted … that the Parliament could legislate for the establishment of Commonwealth hospitals to provide nursing home care directly to patients in need of such care, there can be no objection to … inviting proprietors of private nursing homes voluntarily to undertake to provide the necessary services in return for a government subsidy. In that approach to the problem it is to be expected that the Parliament should be concerned to see that the intended real beneficiary, the patient, receives care of a quality appropriate to the cost of the programme.[137]

There are two critical caveats to the voluntary participation rule. The first caveat is, per Kirby J in *Wong*, the provision should be about payments of benefits and should not go further into the clinical sphere.[138] If it does it converts a law about benefits into one about the way a doctor practises medicine in an encounter which attracts benefits.

The second caveat is about practical compulsion: the more medical practitioners' options are limited, the less participation is truly voluntary. But while choice of speciality is voluntary, constraints on payments to those specialists, for example limiting the number of specialists who can bill Medicare, is unlikely to be practical compulsion, especially where other routes to practise, such as public hospital practise, remain.

4 *There are Other Relevant Sections of the Constitution Which Potentially Provide Power for Specific Legislation (the Alternative Sources of Power Rule)*

The civil conscription sub-provision is directly attached to s 51(xxiiiA) and, indeed, only to part of that section. Other heads of power can also be used to effect policy objectives.[139] Medical practice has become increasingly corporatised, and corporatised practices can be regulated by reliance on the corporations power(s 51(xx)); payments to doctors in hospitals can be made under the hospital benefits power; and the sickness benefit power might also be used in some circumstances. Given the wide scope of the corporations power,[140] this may be particularly relevant for future legislation to support policy goals.

VI Contemporary Health Policy and S 51(xxiiiA)

The High Court's interpretation of s 51(xxiiiA) has changed substantially since the first case in 1949, but the original tight constraint on what was allowable seems to be retained as a contemporary constraint on policy. The basic design of Medicare has remained unchanged since it was introduced, with few attempts to take advantage of the less restrictive approach to what is seen as allowable. The fundamental model of private fee-for-service practice has continued, with medical practitioners (and medical enterprises) continuing to have autonomy over what services they provide, where, and at what price. As Whitlam foreshadowed, 'the medical profession participates in any scheme only on its own terms'.[141] Of course, it is in the interest of the medical profession to argue that the Commonwealth government's power to constrain the work of doctors in any way is prohibited by the operation of section 51(xxiiiA). The more Commonwealth power to regulate is limited, the more

137. *Alexandra* (n 53) 282 (Mason ACJ, Wilson, Brennan, Deane, and Dawson JJ).
138. *Wong* (n 39).
139. McMillan (n 5).
140. Anna Olijnyk, 'The Corporations Power in Williams' (2015) 39(2) *University of Western Austarlia Law Review* 418, 418–25.
141. Whitlam (n 10) 30.

https://doi.org/10.1177/0067205X231165872 Published online by Cambridge University Press

autonomy doctors have and the less their accountability for billing and services. Risk-averse, politically sensitive, and/or non-interventionist governments and bureaucrats will also talk-up the perceived limits set by section 51(xxiiiA).

The initial loss in the High Court in the 1940s appears imprinted in the minds of policymakers, and some commentators, even though the High Court has essentially rejected every challenge to policy since then. The slow narrowing of what might fall afoul of the civil conscription constraint broadens the area of potential Commonwealth legislation, but despite this, government has not availed itself of the full contemporary policy possibilities.

In this section we discuss four policy objectives — reducing financial barriers to access, improving geographic equity, improving efficiency, and improving accountability and quality — and sketch potential strategies for achieving those objectives in a way consistent with the *Constitution*. All four objectives and proposals relate to out-of-hospital care, because the Commonwealth power over hospital care is much broader than its power over medical services: section 51(xxiiiA) gives the Commonwealth power to make laws about 'hospital benefits', a power not limited by the civil conscription constraint (see *Alexandra*).

A *Reducing Financial Barriers to Access*

In 2019–2020 about $9 billion was spent by government and patients on out-of-hospital primary medical care (defined as unreferred services and practice nurses); about 81% of this was spent for Medicare rebates for bulk-billed services, about 10% on rebates for services which were not bulk billed, and about 9% on out-of-pocket payments by patients.[142]

Governments over the years have aimed to increase the proportion of services bulk billed — especially for general practice visits — through targeted payments such as additional payments to encourage bulk-billing for some groups and general incentives such as increasing the rebate for all services to 100% of the scheduled fee.[143] Despite these initiatives, about 10% of all primary care attendances are billed to the patient, and patients face an average out-of-pocket payment of $40.84 for each of these visits.[144] Some cannot afford this: in 2019–2020, 3.7% of people who needed to visit a general practitioner (GP) deferred the visit or missed out on a visit because of cost.[145] Only about two thirds of Australians have all their GP visits bulk-billed, leaving one third with out-of-pocket payments for at least for some of their visits.[146]

Financial incentives on practices still leave people missing out on care because of cost, so a critical policy question is whether government can go further and mandate bulk-billing to address financial barriers to access. Phrased that crudely, probably not. However, a policy could be designed to increase bulk-billing rates which does not involve practical compulsion. This would rely on the *voluntary rule* to achieve the policy objective with a 'participating provider' scheme. In brief, government might restrict access to some or all Medicare items to those practices which voluntarily decided to opt into

142. Australian Institute of Health and Welfare, *Health expenditure Australia* 2019–20 (AIHW, 2021).

143. Glenn Jones, Elizabeth Savage and Jane Hall, 'Pricing of General Practice in Australia: Some Recent Proposals to Reform Medicare' (2004) 9 (suppl 2) *Journal of Health Services Research & Policy* 63–8; Luke B Connelly and James R G Butler, 'Insurance rebates, incentives and primary care in Australia' (2012) 37(4) *Geneva Papers on Risk and Insurance: Issues and Practice* 745–62.

144. July 2020 — March 2021; 'MBS Quarterly Statistics — Year to Date Dashboard', *The Australian Government Department of Health* (Web Page, 7 June 2021) <https://www1.health.gov.au/internet/main/publishing.nsf/Content/MedicareStatistics-1>.

145. Australian Bureau of Statistics, *Patient Experiences in Australia: Summary of Findings*, 2019–20 (16 November 2020).

146. Stephen Duckett, Anika Stobart and Linda Lin, *Not so universal: How to reduce Medicare out-of-pockets* (Grattan Institute, 2022).

https://doi.org/10.1177/0067205X231165872 Published online by Cambridge University Press

participation. New items — such as telehealth or enrolment payment items — might be candidates for restriction to participating practices. A condition of participation might be that all patients be bulk-billed.

Doctors not opting into participation would still be able to practice medicine outside this scheme but would rely solely on patient out-of-pocket payments. Demand for doctors charging full out-of-pocket payments would decline marginally because the effective price for patients would increase. Literature suggests that a 10% increase in price leads to only a 2% decrease in demand for GP services.[147] The fact that about 10% of services are currently not bulk-billed suggests there is a market distinct from bulk-billed practice and that some patients are willing to pay out of their own pockets for GP services. Some of these people will continue to make out-of-pocket payments to see a non-participating GP of their choice.

GPs are probably under-remunerated for the work they do, relative to other clinical specialists, and so a participating doctor scheme, implemented with a requirement to bulk-bill, might be more politically attractive if it were accompanied by an increase in the average rebate for each service.

B *Improving Geographic Equity*

Medical services are very unevenly distributed across Australia, with more doctors per head located in wealthier suburbs than in regional and remote locations.[148] At present the geographic distribution of medical practitioners is only weakly regulated by government, with strategies essentially providing carrots with no sticks. The result is that there are significant distortions in access for patients. Despite a host of training initiatives and subsidies to encourage Australian-trained doctors to work in areas of need — defined either by geography or speciality — rural and regional areas rely very heavily on international medical graduates for their medical workforce.

There is currently a two-stage process for medical practitioners to enter practice. The first gate occurs after completion of a doctor's first hospital-based post-graduate year, when medical practitioners become eligible to be registered to practise. Almost all doctors then undertake further training, and many qualify into one of the clinical colleges.

Eligibility to bill Medicare, and to be issued with a Medicare provider number, is a separate process from medical registration. Only a subset of doctors are issued with a provider number — those who have completed training or who are in an approved training position, the latter only while they are in training.[149] Doctors who do not complete speciality training (including general practice training) can continue to work as medical practitioners in hospitals or in non-clinical roles. At present all medical practitioners who complete their speciality training, including general practice training, are issued with a provider number. This raises the question of what would happen if government limited the number of new provider numbers on issue to specific geographies or specialities? Would this infringe subsection 51(xxiiiA)?

Under geographic provider-number restrictions, government would advise, for each geographical area, how many new provider numbers would be available in which specialities, including general practice, in that area. Registered medical practitioners could apply for these provider numbers, and thus gain the right to bill Medicare for services provided to patients in those areas.

147. Rosemary Kate Elkins and Stefanie Schurer, 'Introducing a GP Co-payment in Australia: Who Would Carry the Cost Burden?' (2017) 121(5) *Health Policy* 543.
148. Australian Institute of Health and Welfare, *Rural & Remote Health* (AIHW, 2021).
149. *Health Insurance Act* (n 74).

https://doi.org/10.1177/0067205X231165872 Published online by Cambridge University Press

Government could also allow transfer of provider numbers to other locations after a designated period, or give priority in the allocation process based on longevity of practise or other criteria.

Medical practitioners who do not apply for, or who are not allocated, a provider number could continue to practice medicine anywhere, but their patients would not be eligible for a Medicare rebate, or, in another variant, would receive a significantly reduced Medicare rebate. It is highly likely that such a scheme would increase the number of Australian-trained doctors practising in rural and remote Australia and would encourage a more even distribution of specialists and general practitioners in line with community needs.

Gibbs J specifically referred to location controls in the *GPS Case* and noted that such controls:

> might well be regarded as imposing a form of civil conscription. It is necessary in every case to consider the true meaning and effect of the challenged provisions, in order to determine whether they do compel doctors or dentists to perform services generally as such, or to perform particular medical or dental services; if so, they will be invalid.[150]

Aickin J also referred to location controls:

> No doubt a legal obligation to perform particular medical or dental services, or to perform medical or dental services at a particular place, or to perform such services only as an employee of the Commonwealth would be clear examples of civil conscription. An equally clear example would be the prohibition of the performance of medical or dental services by particular qualified practitioners other than in some designated place, though no punishment was attached to failure to practise in that place. Other forms of 'practical compulsion' are easy enough to imagine, particularly those which impose economic pressure such that it would be unreasonable to suppose that it could be resisted. The imposition of such pressure by legislation would be just as effective as legal compulsion, and would, like legal compulsion, be a form of civil conscription. To regard such practical compulsion as outside the restriction placed on this legislative power would be to turn what was obviously intended as a constitutional prohibition into an empty formula, a hollow mockery of its constitutional purpose.[151]

A system of geographical allocation of provider numbers does not involve any form of directing how a doctor might provide medical care, and importantly, given the *Wong*[152] case, is about regulating how much is paid in rebates. The views of Gibbs and Aickin JJ make it clear that *requiring* a medical practitioner to work in a particular location is probably *ultra vires* but regulating provider numbers may not be 'practical compulsion'.[153] Differential rebates (rather than no rebates) may reduce the extent to which provider number controls give rise to practical compulsion but would also reduce the impact of the policy.

Differential rebates could be structured as a proportion of the standard rebate — acting as a stick, rather than the carrot of an increased rebate for working in a particular geographic area, which has

150. *GPS Case* (n 48) 558 (Gibbs J)
151. *GPS Case* (n 48) 565 (Aickin J).
152. *Wong* (n 40).
153. *GPS Case* (n 48) 558 (Gibbs J), 565 (Aickin J).

https://doi.org/10.1177/0067205X231165872 Published online by Cambridge University Press

been a policy tried in the past[154] — or might apply to only some types of services, for example, discounting rebates for procedures or care-management items.

About half Australia's medical workforce work mainly in private practice,[155] but there is no reason for medical graduation and medical registration to be regarded as a guarantee of the right to earn an income as a Medicare-eligible private practitioner. Employment is not guaranteed in any other profession, and employment should not be an assumption for medicine. Given that provider numbers are only necessary for a particular type of medical practice, namely private practice,[156] it is arguable that geographic provider-number limits would not involve practical compulsion and hence would not infringe s 51(xxiiiA).[157]

C *Improving Efficiency*

Medicare, and its predecessor Medibank, were developed and implemented when the typical model of service provision was small, often solo, practice.[158] That time is long gone. Medical services are increasingly provided by corporations, some listed on the stock exchange, with the medical encounter provided by salaried medical practitioners, or medical practitioners engaged by the corporation under contract, including under revenue-sharing arrangements. This change has been particularly significant in provision of diagnostic services, such as pathology and radiology, where a handful of private corporations provide more than 80% of services in each speciality.[159]

These changes in ownership provide opportunities for changed payment and regulation options. Instead of uncapped fee-for-service payments, corporations could be invited to tender for provision of laboratory or imaging services in a particular region. The head of power could still be section 51(xxiiiA), but because corporations would be invited to tender and participation would be voluntary, it is unlikely that the civil conscription limitation would be infringed.

Under a tender arrangement, pathology and radiology services would either be removed entirely from the Medicare schedule, or a parallel scheme could be implemented whereby only a professional fee would be retained in the schedule and the work of diagnostic imaging and medical laboratory technologists, and associated equipment and supplies, would be paid for under the tender. The *voluntary participation rule* derived from *Wong*[160] and *Alexandra*[161] would suggests that this reform would not fall afoul of s 51(xxiiiA).

154. Jongsay Yong et al., 'Do Rural Incentives Payments Affect Entries and Exits of General Practitioners?' (2018) 214 *Social Science & Medicine* 197–205; John Humphreys and John Wakerman, 'Learning from History: How Research Evidence can Inform Policies to Improve Rural and Remote Medical Workforce Distribution' (2018) 26(5) *Australian Journal of Rural Health* 329–34.
155. Australian Government Department of Health, 2018 *Doctors in focus Canberra* (The Department, ('2018 Doctors in focus').
156. Importantly, medical practitioners could work in public hospitals, caring for public patients. Public hospitals and medical practitioners are prohibited from billing Medicare for services provided to public patients.
157. In contrast, Faunce, without any argument, asserts that s 51(xxiiiA) 'may also constrain … federal laws' requiring doctors to work in areas of need' at Faunce, 'Constitutional Limits on Federal Legislation Practically Compelling Medical Employment' (n 4) 204.
158. Ione Fett, 'Australian Medical Graduates in 1972' (1974) 1(18) *Medical Journal of Australia* 689–698.
159. Stephen Duckett and Danielle Romanes, *Blood Money: Paying for Pathology Services* (Grattan Institute Report No 2016-01, 22 February 2016) 29.
160. *Wong* (n 39).
161. *Alexandra* (n 53).

https://doi.org/10.1177/0067205X231165872 Published online by Cambridge University Press

The High Court has also previously given a broad reading of the corporations' power and so restriction of provision of pathology and radiology services outside the tender arrangement could potentially also be based on that head of power.

D *Improving Accountability and Quality*

In 2019–20, Medicare paid a total of almost $25 billion in rebates, yet despite this, there is little information to ensure accountability and value for money. Data collected by Medicare is generally limited to the item number, with no requirement to report diagnosis, or reason for attendance, or incidental treatments not separately billed. There is almost no publicly available information about the quality of individual general practices.

Billing information collected by Medicare from each visit includes the age, gender, and address of the patient, and the item number, but unlike in other countries, information about diagnosis and reasons for the visit are not collected. Diagnostic information might be able to be deduced by matching medications prescribed, but there is not always a one-to-one match with diagnosis and prescriptions. This dearth of information contrasts with the situation with hospitals, where information is collected about diagnoses and procedures performed on all patients, public and private. This makes it possible to measure quality and efficiency of care.[162] The lack of information on out-of-hospital care means it is not possible to measure whether different medical practices are better or worse on average in managing patients with different conditions, and whether variation in testing patterns or prescribing is because of differences between the patients being seen or whether it is due to the doctor's behaviour.

It is now clear that the Commonwealth government has power to oversee the quality of services it funds. It would be reasonable to impose a condition that patients in a practice would be eligible for payments only if the practice agreed to provide information about its patients, in a way that protected patient privacy but enabled monitoring of probity and quality.

The Commonwealth also has power to impose conditions and collect information to ensure probity and value for money. Again, a scheme could be initiated so that practices which wanted to be eligible for Medicare rebates could be invited to register for participation. Participating practices could be subject to a broad range of evidence-based requirements to ensure quality and value for money.

A recent Grattan Institute report outlined how a participating dental practice scheme might work, including that participating practices would agree:

- Not to charge co-payments for eligible treatment to any person covered by the scheme, and, as part of documented treatment plans, to provide clear information to patients when services are being provided outside the scheme;
- To provide detailed information about each service provided, including by participating in a new common e-dental record;
- To obtain feedback from patients on their experience of care and the outcomes of their care;

162. Terri Jackson et al., 'Measurement of Adverse Events Using 'Incidence Flagged' Diagnosis Codes' (2006) 11(1) *Journal of Health Services Research & Policy* 21–26; Robert B. Fetter et al., 'Case Mix Definition by Diagnosis Related Groups' (1980) 18(2 (supplement)) *Medical Care* 1–53.

https://doi.org/10.1177/0067205X231165872 Published online by Cambridge University Press

- To adopt evidence-based protocols, including risk and severity screening tools, for managing standard conditions in a cost-effective way; and
- To participate in quality improvement and utilisation review programs.[163]

A participating medical practice scheme could be similar.

VII Conclusion

A stream of economics thinking over the past few decades has been about identifying when organisations should seek to provide procure services internally, through hierarchies, and when market mechanisms are better.[164] When section 51(xxiiiA) was inserted in the *Constitution*, the fear was the government would seek to implement a hierarchical NHS style service in Australia. Policy thinking has moved on since then, as have High Court interpretations. Government now seeks to make sure the market can work effectively — 'managing through markets', as Evans phrases it[165] — using modern policy options to improve access, quality, and efficiency of service provision. What we have shown in this paper is that section 51(xxiiiA) probably does not inhibit politically feasible policy options to improve medical services in Australia.

The policy options outlined above have mostly been framed within the context of section 51(xxiiiA), with the Commonwealth making direct payments to medical and dental practices. An alternative approach would be for Commonwealth to make payments for medical and dental services to the meso-level organisations it has created, Primary Health Networks (PHNs). PHNs are incorporated as companies which have voluntary entered into contracts with the Commonwealth for funding and which use that funding to 'commission' services from a range of primary care providers. Over time, a greater proportion of medical services could be commissioned with providers invited to tender for new services and voluntarily agreeing to the conditions associated with that. The proportion of funding allocated under this approach could increase over time and might include new services (eg, mental health services within general practices) and re-direction of existing payments, such as out-of-hours payments.

The *Constitution* enables social policies but also appropriately limits how the Commonwealth government can intervene in the medical marketplace. Policymaking can be quite problematic if the scope of political power is unclear, as has been the case with section 51(xxiiiA). For a crucial period of the last half of the 20th century, the Commonwealth powers to make laws about medical services were seen to be strictly limited by a constraint that such laws could not authorise civil conscription, potentially including any form of practical compulsion, which had a wide scope. But commencing

163. Stephen Duckett, Matt Cowgill, and Hal Swerissen, *Filling the Gap: A Universal Dental Scheme for Australia* (Grattan Institute Report No 2019–02, 17 March 2019).

164. Oliver Eaton Williamson, *Markets and Hierarchies: Analysis and Antitrust Implications* (The Free Press, 1975); Oliver Eaton Williamson, 'Transaction-Cost Economics: The Governance of Contractual Relations' (1979) 22(2) *Journal of Law and Economics* 233; Oliver Eaton Williamson, *Economic Organisation: Firms, Markets and Policy Control* (Wheatsheaf Books Ltd, 1986); Oliver Hart, *Firms, Contracts, and Financial Structure* (Clarendon Press, 1995); Oliver Eaton Williamson, 'The Theory of the Firm as Governance Structure: From Choice to Contract' (2002) 16(3) *Journal of Economic Perspectives* 171; Oliver Hart, 'Incomplete Contracts and Public Ownership: Remarks, and an Application to Public-Private Partnerships' (2003) 113(486) *The Economic Journal* C69; Oliver Eaton Williamson, 'Transaction Cost Economics: The Natural Progression' (2010) 100(3) *American Economic Review* 673; David Frydliner, Oliver Hart, and Kate Vitasek, 'A New Approach to Contracts: How to Build Better Long-term Strategic Partnerships' (2019) 97(5) *Harvard Business Review* 116.

165. Evans (n 120).

https://doi.org/10.1177/0067205X231165872 Published online by Cambridge University Press

with a 1980 case, a distinction has begun to be drawn between regulation of services and regulation of access to Medicare benefits — and the scope of what would be seen as practical compulsion has begun to be limited. It is now clear that the Commonwealth can take reasonable steps to ensure value for taxpayers' money and that a right to practice medicine is not the same as a right to bill Medicare. This opens up a range of policy possibilities for government to improve the quality, efficiency, and equity of access to health services.

But this change in interpretation began 40 years ago, and the narrow scope of the limitation has been in place longer than the initial very broad limitation — post-1980 vs the period from 1949 to 1980. Despite this, governments, stakeholders, and some commentators still act as if the pre-1980 restrictions apply. This may be because the original restrictions were seen as so restrictive that they continue to dominate the memory of decision-makers and commentators or simply ignorance of the evolving High Court interpretation. It also may be in part due to stakeholder interest in the status quo and a limited role of government as well as policy timidity that some changes may founder on the shoals of real politic. Policymaking would be better if it was constrained only by the real limitations of the *Constitution*, rather than the imagined ones of yesteryear.

ORCID iD


Fiona McDonald https://orcid.org/0000-0002-0784-3954

https://doi.org/10.1177/0067205X231165872 Published online by Cambridge University Press