SONIA ALLAN

# LAW & ETHICS FOR HEALTH PRACTITIONERS

2ND EDITION



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# Law and Ethics for Health Practitioners

*Second Edition*

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# PREFACE

*Law and Ethics for Health Practitioners*, 2nd edition, contains extensively researched information on the professional and practice obligations of health practitioners when providing health services. Critical examination of the law and ethics is presented on a wide array of health law matters, relevant to individual as well as population health.

Discussion of the law illustrates the Commonwealth's integral role in relation to healthcare law and policy while demonstrating that most health law regulation falls to the states and territories and thus may differ across the country. Examination of the role of ethics, professional codes of practice, and guidelines, is integrated into the book to provide health practitioners with a robust understanding of the regulatory environment within which they work. Practical guidance is also provided to demonstrate a process for reasoned decision making when faced with challenging healthcare issues. This exemplifies how health practitioners may move beyond intuitive responses to such issues to consider the ethical and legal dimensions of a problem, options for resolution, and the justification for the decision made.

The book is structured in six sections:

- Section 1 provides an *Introduction to Law for Health Practitioners* examining the Australian legal system, the Australian healthcare system.
- Section 2 provides an *Introduction to Ethics for Health Practitioners,* examining different theories and approaches to ethical decision making, contemporary ethical issues in health care, and ethical collaboration, leadership, and self-care.
- Section 3 examines *Professional Regulation and Key Concepts Relevant to Healthcare Delivery*. This section includes consideration of health practitioner registration and accreditation schemes, healthcare complaints systems, management of patient information, and civil and criminal areas of law relevant to healthcare practice standards and delivery.
- Section 4 focuses on *Matters of Life and Death*, including detailed consideration of the registration of births and deaths, and the Coroners Court. Regarding the beginning of life, Section 4 also examines ethically and legally challenging matters such as abortion, wrongful birth and wrongful life claims, pre-natal injury, assisted reproduction and surrogacy. Regarding the end of life, Section 3 considers advance care planning, the withholding and withdrawal of treatment, and voluntary assisted dying.
- Section 5 moves to examine *Further Practice Considerations*, including the law and ethics regarding blood, tissue and organ donation; the regulation of drugs and poisons; mental health legislation; and child and elder abuse. These matters all reflect individual as well as population health concerns.
- Section 6 draws the discussion throughout the book together, providing further insights into *Law and Ethics in Action*. It contains practical information about working with legal representatives, engaging in litigation and tribunal contexts, and an extensive array of case studies illustrative of legal and ethical dilemmas

practitioners may face. The case studies have been drafted by a wide variety of healthcare practitioners drawn from medicine, midwifery, nursing, paramedicine, pharmacy, physiotherapy, podiatry and speech pathology, enabling modelling of an applied approach to reasoned decision making and the translation of law and ethics into practice based on their experiences in practice.

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# 2 INTRODUCTION TO THE AUSTRALIAN HEALTH SYSTEM



## LEARNING OBJECTIVES

*Upon completing this chapter, you should be able to:*

- explain federal and state/territory government roles regarding health care in Australia
- describe the development and key characteristics of the Australian health system
- explain the Pharmaceutical Benefits Scheme, Medicare and the private health insurance rebate scheme
- describe federal, state and private sector contributions to healthcare funding
- outline the seven key rights set out in the *Australian Charter of Healthcare Rights*.

## INTRODUCTION

Chapter 1 introduced the Australian legal system and the various roles and powers within it. As noted, the Australian Constitution is relevant to whether federal or state governments (or both) have the power to regulate particular issues. The Australian Constitution establishes the legal framework within which Australia's health sector operates. This chapter examines the distribution of powers between the federal and state/territory governments regarding health care. It notes that the expansion of Commonwealth powers has been highly contested, reflecting strong differences in political ideologies regarding the extent to which government should be involved with, fund and control the various aspects of health care. Within this context, the development and key characteristics of the Australian health system are examined, paying particular attention to the Pharmaceutical Benefits Scheme (PBS), Medicare and the private health insurance rebate, which together form the basis of Australia's current universal health system. Other Commonwealth, state/territory and local government responsibilities and their respective contributions to healthcare funding are noted. The chapter ends with an overview of the *Australian Charter of Healthcare Rights*.

### Commonwealth Responsibility For Healthcare Services

The Commonwealth government's power and responsibility regarding health matters has expanded since the Constitution took effect in 1901. At the time of federation, the provision of healthcare services was regarded as primarily a state issue. The Commonwealth was given powers only in relation to health issues considered of national importance; for example, quarantine, invalid pensions and the repatriation of service personnel, as well as responsibility for healthcare services in the federal territories. Since then, Commonwealth powers have been expanded to create the PBS, Medicare and the private health insurance rebate to ensure that Australians have access to medicines and healthcare services in a way that meets their basic healthcare needs, and is accessible to all. This is what is meant by having a 'universal health system'.

The history and functions of the PBS, Medicare and the private health insurance rebate are further discussed below. The Commonwealth also has power and responsibility over a number of other areas that are relevant to the health system such as:

- funding supported work placements, which in turn supports having well-trained health practitioners

- ensuring safe and effective treatments and the research and development required to ensure their safety and efficacy
- funding aged care, Indigenous healthcare services and disability services
- providing accurate information about the health system to ensure it continues to work in the way it should.

A good health system reflects the capacity to respond to health emergencies. It must also be recognised that good health systems don't just treat sick people, they help to keep people healthy in the first place, preventing illness and disease.

Box 2.1 lists the Commonwealth's powers and responsibilities in this regard.

## State Powers and Responsibilities Regarding the Health System

As discussed in Chapter 1, when the Australian Constitution does not explicitly grant the Commonwealth government power in relation to something, such power and responsibility falls to the states. Most regulation regarding health-related matters falls to the states. Responsibility for managing and administering public hospitals is another important example. Box 2.2 lists the main areas that state governments are responsible for in relation to health care and services.

## Shared Responsibilities Between the Commonwealth and States/Territories

Some healthcare services and issues are the responsibility of both the Commonwealth and state/territory governments – that is, they have shared powers or responsibilities. Box 2.3 lists some of these areas.

## Local Governments

Local governments also play an important role in the health system. They provide, for example, essential environmental health services such as sanitation, waste disposal and food safety, plus a range of community-based health and home-care services such as immunisation and maternal child health programs.[1] Health practitioners may deliver such services, or help people access them, depending on what they are.

**BOX 2.1**
**COMMONWEALTH RESPONSIBILITIES FOR HEALTH-RELATED SERVICES AND PROGRAMS**

- After-hours general practitioner and primary care services (Medicare Locals)
- Aged care services subsidies
- Benefits for basic dental services for children and young people
- Community-controlled Aboriginal and Torres Strait Islander primary health organisations
- Health practitioner education (Commonwealth-funded university places)
- Medical research grants
- Medicare
- National coordination and leadership such as responding to pandemics and other health emergencies
- Pharmaceutical Benefits Scheme
- Regulation of private health insurers and rebates for private health insurance premiums
- Regulation of therapeutic goods and medical devices
- Subsidised hearing services
- Vaccine purchases for the national immunisation program
- Veterans' health care

**BOX 2.2**
**STATE/TERRITORY RESPONSIBILITIES FOR HEALTH-RELATED LAW AND SERVICES**

- Ambulance and emergency services
- Civil liability, criminal, guardianship and mental health law
- Food safety and handling regulation
- Funding and management of community and mental health services
- Management and administration of public hospitals
- Patient transport and subsidy schemes
- Preventive services such as breast cancer screening and immunisation programs
- Regulating on health-related matters (e.g. workplace health and safety, assisted reproduction, end-of-life decision making)
- Regulation, inspection, licensing and monitoring of health premises

**BOX 2.3**
**SHARED RESPONSIBILITIES BETWEEN THE COMMONWEALTH AND THE STATES/TERRITORIES**

- Funding of public hospital services based on an agreed national activity-based funding formula as outlined in the *National Health Reform Agreement*
- National mental health reform
- Preventive services such as free cancer screening programs including those under the National Bowel Cancer Screening Program
- Public dental clinics (state responsibility with additional Commonwealth funding provided)
- Registration and accreditation of health practitioners through the Australian Health Practitioner Regulation Agency
- Responding to national health emergencies
- Shared funding for palliative care

## THE HISTORY OF AUSTRALIA'S UNIVERSAL HEALTH SYSTEM

As noted above, Commonwealth powers regarding health care were limited at the time of federation. With this in mind, this section looks at how Australia's universal health system developed, and then examines in greater detail the PBS, Medicare and the private health insurance rebate. Such history is important because it illustrates tensions that have existed over the governance of health care for many years, explains the legal underpinnings of our current health system, and highlights that different political views can influence how health care is governed.

Although the regulation of many healthcare services falls to the states, ensuring access to basic healthcare services for all under a uniform, nationwide system is favourable. However, the question over time has been how best to design such a system. The first steps towards developing a universal health system in Australia occurred in the mid-1940s when the Labor Curtin Government moved to establish a national health system. These attempts were initially thwarted by the Opposition (led by Menzies) and the medical profession protesting against 'socialist values' and a shifting of power from doctors to the state. A High Court challenge subsequently found the Commonwealth did not have the power to establish such a system.[2] Then, in 1944, a referendum aimed at giving the government power to legislate over 14 different matters, including healthcare services, also failed.

In 1946 the Chifley Government (Chifley becoming prime minister following Curtin's death) took the issue to the people again via a referendum focused on enabling the Commonwealth to direct benefits to families and the ill. The referendum was successful, leading to the insertion of section 51(xxiiiA) into the Constitution giving the Commonwealth power regarding:

> *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 insertion of section 51(xxiiiA) complemented Commonwealth powers under section 51(xiv) to make laws concerning insurance, and section 96, to 'grant financial assistance to any state on such terms and conditions as the Parliament thinks fit', and paved the way for developing a national health system. The introduction of the PBS followed, then a variety of changing systems intended to enable access to health care ultimately resulted in the current system of Medicare and a private health insurance rebate scheme.

### Access to Medicines – the Pharmaceutical Benefits Scheme

The PBS is a Commonwealth-funded scheme that allows the Australian population access to a large range of prescription drugs at a low cost through government subsidisation. It originally formed part of post–World War II general social welfare legislation, being established in 1948 to ensure all Australian residents and eligible overseas visitors had access to 'life-saving and disease preventing drugs' at an affordable price.[3] Since its introduction, the PBS has become fundamental in enabling access to medicines within Australia, evolving from supplying a limited number of drugs free of charge to the community, into a broader subsidised scheme.[4]

Under the PBS, medicines or pharmaceuticals are prescribed by doctors or authorised health practitioners who have a PBS prescriber number.[5] The medicines are then dispensed by an approved community

pharmacist,[6] approved public or private hospital authority[7] or approved medical practitioner.[8] The Commonwealth subsidises around 83% of the cost of medicines and the patient funds the rest via a co-payment.[9] People who fall into concessional categories, receiving certain pensions, benefits or cards, pay less. The government subsidy occurs via cash transfers made directly to the approved dispenser of the PBS medications, who must claim on a reimbursement basis for the cost of the medications.

A safety net arrangement applies when the total amount of co-payments paid by a patient (or immediate family) in a calendar year reaches a certain threshold. In such instances, the co-payment reduces to a smaller amount, with the benefit paid to the pharmacist increasing.[10] In the case of concessional patients, the safety net threshold is lower, and when reached, no co-payment is required for the rest of the calendar year.[11]

Medicines eligible for supply under the PBS are listed in the *Schedule of Pharmaceutical Benefits*. To get on the schedule, the Pharmaceutical Benefits Advisory Committee (PBAC) assesses the conditions for which the medicines have been approved in Australia, their clinical effectiveness, their safety and their cost-effectiveness. This information is compared with other listed medicines that treat the same condition. If the PBAC recommends a drug be listed, and the Australian Government agrees, the subsidy is approved.

The PBS also provides other forms of assistance to ensure affordable access to medicines, including funding for public hospitals for certain high-cost drugs (e.g. immunosuppressants used in patients receiving organ transplantation).[12]

To ensure the integrity of the PBS, the government provides information and feedback to health practitioners and dispensers regarding 'accidental non-compliance'. The government will seek to correct behaviour when there may be innocent mistakes or errors and will enforce the law in cases of deliberate exploitation of the program. This includes, for example, using someone else's Medicare card, forging prescriptions, making PBS claims for medicines that were not supplied, falsifying authority information or deliberately prescribing outside restrictions. Professional regulatory consequences and significant criminal sanctions may apply.

### Private Prescriptions

If a medicine is not listed under the PBS schedule, a person will have to pay 'full price' for the medicine as a private prescription. That is, the medicine is not subsidised by the Australian Government and is considered a 'non-PBS medicine'. Note, 'full price' will be determined by both what the pharmaceutical company that produces the drug charges and what the pharmacy charges at the point of sale. Pharmacies may charge differently for non-PBS medicines, so a person who seeks a non-PBS medicine may need to shop around to find the best price. The cost of private prescriptions does not count towards the safety net threshold.

## ACCESS TO HEALTH CARE – EVOLVING SCHEMES

Following the section 51(xxiiiA) amendments to the Constitution, respective Commonwealth governments continued to focus on access to healthcare services as an integral part of Australia's health system. However, systems implemented saw several major restructurings, as laws reflected significantly differing political ideologies. The changes over time include:

- 1948: The Chifley Labor Government enacted the *National Health Service Act*. The legislation was seen as an 'enabling measure' for a national health scheme, introducing a fixed schedule of fees for general practice services, with payment shared between the patient and the government. There was no compulsion on doctors or patients to join.
- 1953: The Menzies Liberal Country Party Coalition Government introduced a voluntary insurance scheme (known as the 'National Health Scheme') that provided for voluntary health insurance funds subsidised by the government, with special welfare arrangements for the needy. The scheme remained for two decades, undergoing only minor changes despite being marred by insurance companies gradually increasing their fees while also rejecting a large number of claims. Such actions left people unable to pay for both insurance and their treatment. When claims were paid, people were met with a widening gap between the cost of treatment and what they

received from their insurance company. The complexity of the system also left 15–17% of Australians uncovered by insurance and unentitled to free health care.

- 1975: The Whitlam Labor Government introduced Medibank, a universal health insurance system.
- 1975: The Fraser Coalition Government introduced significant changes to Medibank ranging from increases in the Medibank levy to reductions in reimbursements for services. By 1981 Medibank had been abolished and a system of voluntary private insurance subsidised by government was reinstated.

The above evolution of the health system illustrates that the governance of health care and its funding is a political issue influenced by differing ideologies. It is important to understand that such ideologies affect healthcare funding and the role of government and insurers. Thus, while the following explains further the current Medicare and insurance system, it is important to know how it evolved and to understand that it is a system that can change over time.

## Medicare

In 1983, following the Hawke Labor Government coming to power, a new scheme – Medicare – was introduced via amendments to the *Health Insurance Act 1973* (Cth), the *National Health Act 1953* (Cth) and the *Health Insurance Commission Act 1973* (Cth). Medicare remains in place today, albeit having seen some changes over the years. Its broad objective is to make health care accessible, according to need, to all Australian citizens and those holding citizenship or visa status from countries with which Australia has a reciprocal healthcare agreement.

Medicare is a compulsory scheme regulated through the federal government and funded through a mix of general revenue and an income tax surcharge known as the 'Medicare levy'. The levy paid is calculated at the rate of 2% of each individual's taxable income, with an additional surcharge of 1% for high-income earners without private health insurance (this system is intended to encourage higher income earners to take out private health insurance to reduce the burden on the Medicare scheme). Low-income earners do not pay the levy, or pay a reduced amount, depending on their income level.

Access to health care is facilitated via Medicare in two main ways:[13]

1. Benefits are provided to people for out-of-hospital medical services via the Medicare Benefits Scheme. Such services include but are not limited to: general practitioner and specialist services; dental care for children in some circumstances; selected diagnostic imaging and pathology services; eye checks by optometrists; and allied health services in limited circumstances.
2. Medicare guarantees free treatment of public patients in public hospitals.

Benefits paid for out-of-hospital medical services are generally 85% of the listed fee for the service in the Medicare Benefits Schedule (75% of the fee for private patients in hospital). Any 'gap' between what the healthcare service provider charges and the benefit is paid by the person who has received the service. When healthcare service providers are willing to accept the Medicare benefit as full payment for a service (i.e. without a gap payment), they bill the government directly and the person receiving the healthcare service is not charged – this is referred to as 'bulk-billing'. 'Free' treatment in public hospitals does not mean there are not any costs associated with such treatment, but rather that the Commonwealth and state governments fund public hospital care.

## Private Health Insurance

The federal government also regulates private health insurance through the *Health Insurance Act 1973* (Cth). This Act enables health insurance companies to offer private insurance to individuals who may choose their private provider and their level of cover. Individuals may seek cover for such services as ambulance, hospital and health care not included in the Medicare scheme (physiotherapy and dentistry, for example).

To encourage people to get hospital insurance and to keep it, there is a government initiative referred to as 'Lifetime Health Cover' (LHC). Pursuant to LHC, if a person takes out hospital cover after age 30, their base premium will be 2% more for each year they are over the age of 30 up to a maximum of 70%. Their partner will also have to pay LHC if they join after age 30. The LHC loading ceases once a person has had private hospital cover for 10 continuous years.

LHC loading does not apply for people born on or before 1 July 1934. There are also special conditions for new migrants to Australia who are aged over the LHC deadline (1 July following their 31st birthday). New migrants to Australia do not have to pay an LHC loading if they take out hospital cover within 12 months of being registered for Medicare. After this time an LHC loading of 2% more for each year the person is aged over 30 when they take out hospital cover will apply. If an Australian citizen is overseas on their LHC loading deadline they will not pay an LHC loading if they purchase hospital cover within 12 months of the day they return to Australia (noting that they are able to return to Australia for periods of up to 90 consecutive days and are still considered to be overseas).

Note, LHC applies only to hospital cover; it does not apply to private health insurance ancillary covers (commonly referred to as 'extras').

## Issues With the Current Scheme

Medicare is not without its challenges. For example, it does not cover some important services such as dental for most adults, some allied health services, and ambulance services. People are required to carry insurance or pay out of pocket for such services. This can be difficult for those who cannot afford such insurance and illustrates that the dual system of Medicare and private insurance does not serve all people. Insurance is costly and premiums continue to rise. Increasingly, Australians are choosing to, or due to financial circumstances must, rely only on Medicare (at March 2023, 45.1% of the population were privately insured for hospital cover and 55% for general treatment[14]).

There are also ongoing issues between the Commonwealth and states/territories regarding the shared responsibility for funding public hospitals. Complaints about long waiting lists for public hospital treatment and long waiting times for emergency services abound. This can create frustrations and may have health implications for people who can only afford public health care. As was noted above, differences in political ideologies, as well as the costs of funding the system, also mean that the structure of the health system, and its funding, may be subject to ongoing change.

## The National Disability Insurance Scheme

In considering access to healthcare services in Australia it is also important to note the National Disability Insurance Scheme (NDIS). The NDIS is an insurance scheme that funds individualised support for people with permanent and significant disability aged under 65, their families and carers. To be eligible for the NDIS a person with a disability must meet certain criteria. Eligible people, known as 'participants', are given an individual plan of support tailored to suit their needs. This could include informal supports that a person receives through family or friends, mainstream services, and other community services. Such support and services are not limited to healthcare services, but healthcare services and supports may be an important part of a person's individual plan.

The relevant legislation is the *National Disability Insurance Scheme Act 2013* (Cth) (NDIS Act). The NDIS Act establishes the National Disability Insurance Agency (NDIA), which has responsibility for delivering the NDIS. The functions and powers of the NDIA are set out in the NDIS Act. Subsidiary legislation is also important. That is, the NDIS rules are made under the NDIS Act and set out further laws on matters of detail in relation to the NDIS and must be read in conjunction with the NDIS Act. Notably, Australia's obligations under the United Nations *Convention on the Rights of Persons with Disabilities* are given effect via the NDIS Act in conjunction with other laws.

## Aged Care

People of all ages have access to Medicare, the PBS and the private health insurance rebate described above. Aged care services provide care to people over 65 and Aboriginal and Torres Strait Islanders aged 50 years or older. The Commonwealth government has a significant role in funding and regulating formal aged care services, which include:

- **home support**, which aims to keep people living independently at home and in the community
- **home care**,[15] which relates to a range of personal care, support, clinical and other services tailored to meet the assessed needs of an individual in their home
- **residential care**,[16] which is personal care or nursing care (or both) provided to a person in a

residential facility that provides accommodation and a range of care services to people who are unable to continue to live in their own home.[17] It is not care in a person's home, in a hospital, in a psychiatric facility or for the frail, or any other care specified in the Act or its Subsidy Principles as not meeting the definition of residential care.

The *Aged Care Act 1997* (Cth) provides the legislative framework for 'home care services' and 'residential care services' and establishes who can provide care, who can receive care, the type of aged care services available and how aged care is funded. Funding is based on assessment of need, including whether such needs may be met by funded aged care services.[18] Home support is not governed by the Aged Care Act but is shaped by program guidelines and requirements specified in grant funding agreements.

Government-funded aged care operates alongside and in conjunction with other services to meet the needs of Australia's older population, including health care, disability services and specialist palliative care. As per recent changes regarding care for people with a disability, there have been changes to government policy in recent years in relation to aged care services that emphasise and encourage consumer-directed care.[19]

## HEALTHCARE EXPENDITURE

Of total current health expenditure most recently measured in 2020–21, the Australian Institute of Health and Welfare reports that the Commonwealth government contributed 42.7%, the state/territory governments contributed 27.9% and non-government sources (individuals, private health insurance and other non-government sources) provided the remaining 29.4%.[20]

The distribution of such expenditure between the various governments and the non-government sectors varies depending on the types of health goods and services being provided. A large share of federal expenditure is directed towards medical services via Medicare and the PBS. The balance of expenditure for these services is sourced from the non-government sector either via insurance premiums or private funds. Expenditure on community healthcare services comes mostly from the state and territory governments. Expenditure on public hospital services is shared by the governments. Non-government sources account for large portions of expenditure on dental services, private hospitals, aids and appliances, medications for which no government benefit has been paid and other health practitioner services.[21]

## THE CHARTER OF HEALTHCARE RIGHTS

Within the above discussed system of health care sits legal and ethical obligations and rights relevant to patients, consumers, families/carers, healthcare providers and facilities. We will consider such ethical and legal obligations throughout the rest of the book; however, it is useful here to end this chapter by noting the *Australian Charter of Healthcare Rights*, which was endorsed in July 2008 by all Australian health ministers (Commonwealth and state/territory) for use across the country. The Charter was reviewed for its 2nd edition, which was published in 2020, following public consultation that took place in 2018 and 2019.[22]

The Charter applies to all health settings anywhere in Australia including public hospitals, private hospitals, general practice, and other community environments. While not law, it expresses and incorporates several obligations health practitioners owe patients under existing law, professional codes and employer policies.

The Charter has three guiding principles: (1) everyone has the right to be able to access health care and this right is essential for the Charter to be meaningful; (2) the Australian Government commits to international agreements about human rights that recognise everyone's right to have the highest possible standard of physical and mental health; and (3) Australia is a society made up of people with different cultures and ways of life, and the Charter acknowledges and respects these differences. Such elements reflect the ethical, legal, social and political values that have evolved since the early days of the Curtin Government.

The seven key rights within the Charter are the rights to access, safety, respect, partnership, information, privacy and give feedback.[23] These rights are further explained in a range of resources developed to support people to understand and use the Australian Charter of Healthcare Rights (the Charter).[24] In addition, the Northern Sydney Local Health District (NSLHD) Consumer and Patient Experience Unit have

partnered with the NSLHD Aboriginal and Torres Strait Islander Health Service to create 'a unique and culturally appropriate and tailored version of the Australian Charter of Health Care Rights (the Charter)'.[25]

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## REVIEW QUESTIONS AND ACTIVITIES

1. Describe the evolution of the health system in Australia, noting the differing political ideologies that have influenced changes and debate.
2. List five characteristics of the Australian health system.
3. Discuss the key elements of the Pharmaceutical Benefits Scheme.
4. Where do people get their health care in Australia?
5. Describe how healthcare funding and regulation is divided between the Commonwealth and the states/territories, and the constitutional basis of the divisions.
6. Identify and discuss the 'rights' patients have pursuant to the *Australian Charter of Healthcare Rights*.