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COVID-19, rationing and the right to health: Can patients bring legal actions if they are denied access to care?

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As health providers worldwide respond to the COVID-19 pandemic, clinicians and communities are asking questions about who will be given access to scarce healthcare resources. While resource allocation decision-making frameworks have been developed, or adapted, to govern the unprecedented impacts of the pandemic, access to healthcare may, now and in the future, be restricted in ways previously unimaginable. While the broader community may accept the need for rationing, individuals denied COVID-19 or other care might look to the law to protect their interests. Clinicians may have questions about any legal consequences of denying patients access to health services. This article explores the nature of health rights in Australia and the difficulties in bringing legal cases that challenge resource allocation decisions during a pandemic or its aftermath.

The right to health

The right to health is central to the work of the United Nations and lies at the core of the 1948 Universal Declaration of Human Rights and other international human rights instruments.[1] Article 12(1) of the International Covenant on Economic, Social and Cultural Rights (the Covenant) states that '[e]very human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity'.[2]

Australia is a signatory to the Covenant and all Australian jurisdictions have anti-discrimination laws,[3] which prevent discrimination when accessing health services (a negative right to health), a positive expression of the right to health (an obligation to provide access) has not been directly incorporated into domestic law, except in a limited fashion in Queensland.[4] In contrast, in countries such as South Africa and Canada there are constitutional rights to health, and legislative ones in countries such as Israel and New Zealand.[5]

Commonwealth legislation does not explicitly enshrine a positive right to health as envisaged by the Covenant. The Australian Government argues international obligations are maintained through laws funding access to health services.[6] While the World Health Organization acknowledges that the provision of universal health coverage is the practical expression of the right to health, it is not the same as creating an actual right.[7] An individual having access to a range of health services does not guarantee them any specific service or treatment, especially in situations of scarcity.

COVID-19, rationing and jurisdictional human rights legislation

Three Australian jurisdictions have introduced human rights legislation: Queensland; Victoria; and the Australian Capital Territory (ACT). Victoria and the ACT's legislation are much the same, in that they have a limited right to health arising from a right to life.[8] This legislation does not compel providers to actually provide particular services.[9] This is

unlikely to be effective in resource allocation matters, as in other jurisdictions this type of right has been found to be limited, especially in cases where the treatment is considered futile, ineffective, or not in accordance with clinical guidelines.

In Queensland there is an explicit right to health, albeit a limited one. The Queensland *Human Rights Act 2019* contains a right to health services, which is defined as:

(1) Every person has the right to access health services without discrimination
(2) *A person must not be refused emergency medical treatment that is immediately necessary to save the person's life or to prevent serious impairment to the person*.[10]

While these provisions are a first for an Australian jurisdiction, the rights found in the Covenant are only partially put into effect, as the right to health is confined to emergency medical treatment. While these provisions may ensure access to emergency care they are unlikely to oblige a provider to provide ongoing treatment as may be required to treat COVID-19, or other conditions which have waiting lists. It is also uncertain how this right intersects with the common-law, which has established that a doctor is not under a legal duty to provide treatment that will not benefit the patient, or is not in the patient's best interest, which may be relevant in the COVID-19 pandemic context.[11]

The limited nature of these rights is attributable human rights legislation in Australia being designed to hold public authorities to a high standard of human rights, not to create mechanisms for legal action by individuals to uphold those rights. The respective jurisdictional Human Rights Commissions, who under this legislation address the majority of cases, do not have the power to compel public authorities to provide particular treatments or invalidate legislation, and as such may only declare that legislation, or a decision, is inconsistent with human rights. In cases related to the allocation of health resources, the public authority may only be required to remake the decision, showing a clear and transparent process, not provide the actual treatment.

<u>COVID-19, rationing and civil liability legislation</u>

Whether a COVID-19, or another, rationing decision could be the subject of a negligence claim is dependent on state and territory civil liability legislation.

While wording differs between the jurisdictions, civil liability legislation holds that if a professional can find another professional that would have undertaken the same acts, negligence cannot be established. For example, in Queensland the Act reads:

> *'A professional does not breach a duty arising from the provision of a professional service if it is established that the professional acted in a way that (at the time the service was provided) was widely accepted by peer professional opinion by a significant number of respected practitioners in the field as competent professional practice*.'[13]

This makes it unlikely that a negligence claim for a resource allocation matter, in a pandemic or because of it, would be successful if clinicians or independent experts are required to limit service provision using a broadly agreed upon guideline, for example

the ANZICS Guiding principles for complex decision making during Pandemic COVID-19.

Furthermore, the limited nature of public resources and inevitable requirement of public health services to ration is recognised in civil liability legislation, with the resource decisions of public authorities not open to challenge in the context of negligence claims.[14] The nature of COVID-19 and any resultant resource allocation in response to it, or immediately subsequent to it, makes it unlikely that a resource allocation decision would attract civil liability. Additionally, emergency and disaster management legislation may also apply if a state of emergency has been declared. If resource allocation decisions were made during a declared state of emergency legal proceedings could not be brought against anyone acting pursuant to the powers under that legislation whose actions or omissions were undertaken in good faith.[15]

COVID-19, rationing and Administrative Law

Whether a COVID-19 or another rationing decision could be satisfactorily resolved through an administrative law process is influenced by the limited nature of judicial review processes and remedies available. Administrative law is concerned with the procedural, rather than substantive matter of a decision. Meaning that it is only concerned with the way the decision was made, not the actual outcome.

This is because the role of the court is not to determine the merits of a decision of another branch of government, but rather to establish: whether the decision-maker had the power to make the decision; whether they made that decision lawfully; and whether they considered all relevant information to ensure that decision-making power has been exercised appropriately. In relation to decisions to deny access to resources during the COVID-19 pandemic, or in its aftermath, at best an individual would only have an entitlement to a fair decision making process, not a right to a particular healthcare treatment per se.

COVID-19, rationing and healthcare complaints legislation

Whether a COVID-19 or another rationing decision could be satisfactorily resolved through a healthcare complaints process is limited by the nature and purpose of this type of legislation. Although all Australian jurisdictions have legislated systems dealing with complaints about the provision of health services, they do not necessarily provide avenues to challenge rationing decisions. While these systems seek to uphold patient's rights, such as those outlined in the Australian Charter of Healthcare Rights, legally enforceable rights are not created. This is because the intent of this type of legislation is to, amongst other things, create a procedural framework to resolve complaints in the most efficient manner possible, not to create a mechanism for pursuit of claims against health providers, public or private.[16] While a complaint about a resource allocation decision can be made to a health complaints body, it is likely that the broader context of a pandemic, resource constraints and policies would limit any recourse.

Conclusion

The COVID-19 pandemic has raised questions about how scarce resources should be allocated, the complexities of balancing ethical perspectives and future healthcare realities. It has also raised concerns about the legal consequences of making these decisions. Unlike other countries, Australia does not have a constitutionally or legislatively protected right to health. A review of available legal avenues shows that there is little legal recourse for a person in Australia who is denied care based on resource grounds, especially if there is a broad consensus of professional opinion that it is necessary in a situation of a pandemic, or its fiscally challenged aftermath.

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2. International Covenant on Economic, Social and Cultural Rights, New York, 16 December 1966, Australian Treaty Series 1976 No 5, http://www.austlii.edu.au/au/other/dfat/treaties/1976/5.html.
3. *Age Discrimination Act 2004* (Cth); *Disability Discrimination Act 1992* (Cth); *Racial Discrimination Act 1975* (Cth); *Sex Discrimination Act 1984* (Cth); *Discrimination Act 1991* (ACT); *Anti-Discrimination Act 1977* (NSW)*; Anti-Discrimination Act 1992* (NT); *Anti-Discrimination Act 1991* (Qld); *Equal Opportunity Act 1994* (SA); *Anti-Discrimination Act 1998* (Tas); *Equal Opportunity Act 2010* (Vic); *Equal Opportunity Act 1994* (WA).
4. *Human Rights Act 2019* (Qld) s 37.
5. C Flood and A Gross eds, The right to health at the public/private divide: A global comparative study (Cambridge University Press 2014).
6. Review of Australia's Fourth Periodic Report on the Implementation of the International Covenant on Economic Social and Cultural Rights, https://www.humanrights.gov.au/our-work/legal/review-australias-fourth-periodic-report-implementation-international-covenant at 06 March 2020.
7. World Health Organization, Policy brief, anchoring universal health coverage in the right to health: What difference would it make? https://www.who.int/gender-equity-rights/knowledge/anchoring-uhc/en/ at 06 March 2020.
8. *Charter of Human Rights and Responsibilities Act 2006* (Vic) s 9; *Human Rights Act 2004* (ACT) s 9.
9. *R (on the application of Rogers) v. Swindon NHS Primary Care Trust and another* [2006] EWCA Civ 392.
10. *Human Rights Act 2019* (Qld) s 37.
11. *Airedale NHS Trust v Bland* [1993] AC 789.
12. *Civil Liability Act 2003* (Qld) s 22 (1).
13. *Civil Liability Act 2003 (Qld)* s 35.
14. *Health Ombudsman Act 2013* (Qld); *Health Complaints Act 2016* (Vic); *Health Care Complaints Act 1993* (NSW), s 3; *Health and Disability Services (Complaints) Act 1995* (WA); *Human Rights Commission Act 2005* (ACT) s 6 (j); *Health and Community Services Complaints Act 2004* (SA), s 3; *Health and Community Services Complaints Act 1998* (NT); and *Health Complaints Act 1995* (Tas).
15. *State Emergency and Rescue Management Act 1989* (NSW).