

Illness v wellness models of health care

Published in D!ssent Number 40, Summer 2012-13

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Canberra's layout is a pointer to governments' policy priorities, particularly those priorities which endure through changes in government.

The pick bureaucratic location is the Parliamentary Triangle. "Central agencies" – the Treasury, the Department of Prime Minister and Cabinet, and the Orwellian-named Department of Finance and Deregulation – are clustered around Parliament House, in buildings which would not look out of place in old East Berlin. In the Triangle casually clad tourists flitting between attractions mingle with public servants in dark suits and stylish dresses flitting between what must be very important meetings.

Across the lake, in more commercial surroundings, are Departments such as Infrastructure & Transport, and Education, Employment & Industrial Relations. For aspect the pride of place is the new \$600 million ASIO building, with sweeping views over the Parliamentary Triangle and in winter the snow-capped Brindabellas.

Well away from the centre of power, however, is the Department of Health and Ageing, in a building tacked on to the Westfield Mall in Woden Valley. Its employees are indistinguishable from the crowds seeking bargains in the Big W clothing shop.

Apart from brief bouts of enthusiasm when the Chifley Government tried to bring in a UK-style national health service, and the Whitlam Government took Medibank all the way to a double-dissolution election, the Commonwealth has tended to see health policy mainly in terms of containing a big call on the budget and sustaining a truce between interest groups.

Public expenditure dominates most policies, particularly those where expenditure is dependent on open-ended demand. Health programs take almost 20 percent of the Commonwealth Budget, and it has been impossible to contain their growth. Health takes even a greater share of state budgets, about 25 percent. A projection of Tasmania's budgets shows that in 2053 all of that state's budget will be given over to health care (by which time there may even be some turnover in that State's Legislative Council).

In general, the Commonwealth tries to keep a check on health outlays so that forward estimate projections (usually over four years, time enough to clear an election) look respectable, and to ensure that medical lobbies, pharmaceutical firms, consumer groups representing people with chronic conditions, and state governments aren't going to give too much political trouble – a "peace in our time" strategy. And, of course, Coalition governments include private health insurers in that group, even though they do no more than impose a bureaucratic load on health care, distort economic incentives, and contribute to health care price inflation. (See *D!ssent* 30, Spring 2009)

State governments, for their part, direct their efforts at squeezing what they can from the Commonwealth for their hospitals, and hope that they can get through an electoral cycle without too many hospital horror stories appearing in the tabloid press.

Health care is delivered through a messy set of programs, some entirely publicly-funded, some with co-payments, some means tested, and many where patients bear open-ended financial risk. Some are arranged around demographic groups (e.g. indigenous), some around conditions (e.g. mental health). Services are delivered through a mixture of government, corporate, small business and not-for-profit agencies.

There is no consistent set of principles underpinning health policy. Programs have been introduced in response to the needs and political fashions of the time – for example the Pharmaceutical Benefits Scheme in the early 1950s and Medibank (later Medicare) in the 1970s.

Different programs have very different design principles, and they have not been brought together. Government policy has been largely concerned with the funding of health care, but the task of bringing the elements together to provide a user-friendly delivery system has hardly been addressed. Initiatives such as “Medicare Locals” are more about coordination than integration.

When compared with the policy-directed changes that have swept through the manufacturing, finance and utility industries over the last thirty years, the industry delivering health care has remained comparatively untouched. Health care, however, is a huge and growing industry, employing 11 percent of the workforce, and, like any old established industry, provider interests such as pharmacists and medical specialists have secured themselves privileged positions – in economic terms the capacity to extract “economic rents” – and increasingly the financial sector in the shape of private insurance is extracting income from the industry, without adding value.

It is an industry concerned with looking after people who are unwell. As some observers say, noting the oxymoron, it’s a “sickness” model of health. It’s bound to get more expensive as our population ages and as new diagnostic and treatment technologies allow us to detect and treat conditions that would have once gone undetected or untreated.

Yet we know that the great advances in health have come not only from wonder cures, such as antibiotics, but also from activities well outside the medical field. Engineers have probably saved more lives than doctors through providing clean water, sewers, refrigeration and safer means of transport. Regulations relating to food processing, seat belts and working conditions have saved lives and prevented debilitating ill-health. Children’s school experiences, both through specific learning about diet and hygiene and through participation in physical activities have major influences on lifetime health.

Yet these concerns lie largely outside the ambit of the health portfolios of Australian governments. Within these portfolios are small appropriations for “public health”, but they are squeezed down to about two percent of expenditure, and are specifically directed to programs such as sexual health and obesity, where there are few issues that transcend portfolio boundaries.

There is little economic analysis applied to health programs – only in the case of new drugs and appliances is there a routine application of cost-benefit analysis. Otherwise the main

concern is to contain budgetary outlays, rather than any consideration of community-wide costs. In other words, as with so many government programs, fiscal considerations within program allocations take precedence over economic considerations.

Of course the present government has had a major public health achievement with Nicola Roxon's victory on cigarette plain packaging and moves to slash travellers' concessions on duty-free tobacco. But this owes more to a political opportunity to do battle with some unloved multinationals (it would have been much harder to take on retail pharmacists) and some favourable accounting conventions. The benefits will accrue to the community over many years and by any reasonable economic evaluation it would be considered as good public policy. But in terms of government finances it is costly because it will reduce revenue from excise duty. Had these costs been charged back to the health budget, the initiatives would never have made first base because they would have required savings from elsewhere within the health budget. The tobacco initiatives show what can be achieved when short-term fiscal concerns do not get in the way of good economics, but they were about exploiting a once-off opportunity rather than any shift in policy thinking.

This narrow fiscal focus and the reluctance to take on privileged groups mean that the "illness" model has an inertia which leaves it largely unquestioned. As a consequence health tends to get overlooked in many important policy areas that lie outside the "illness" industry.

While we have clean water, good sewers and reasonably safe food, there are many further advances to be made in public health, but unless there is some blindingly obvious health implication of a government policy, health does not get a look-in.

As an example, typical of the way governments think, the NSW Government has recently released its infrastructure strategy, concerned mainly with transport infrastructure and also with hospital and school buildings, but these are entirely separate categories. It forecasts a massive growth in freight transport, but makes no mention of the health impacts of diesel particulate emissions and references to noise pollution from trucks are about inconvenience, rather than health. Cycling doesn't get a look-in at all, even though safe cycling networks have significant health benefits. This is not to single out NSW – it simply provides the latest example of compartmentalised thinking in governments.

When researchers start to look at the relationships between public policy and health outcomes, the picture becomes very complex and rich. As work progresses on the social determinants of health more relationships are found. The 2009 work of Richard Wilkinson and Kate Pickett, who wrote *The Spirit Level: Why Greater Equality Makes Societies Stronger* found strong correlations between conditions such as inequality, poor education and social exclusion on one side and health on the other. Of course correlation does not prove causation, but their evidence of causality is strong, some of it being two-way or "reflexive" – poor health contributes to social exclusion, and social exclusion contributes to poor health.

Similarly Michael Marmot, in his "Whitehall Studies" of British public servants, found that after controlling for all reasonable variables, being in a low position in the hierarchy with little autonomy was bad for health. (He blew away the myth of "executive stress".)

If we were to move from compartmentalised thinking of health policy, the Health Department would surely have to move from Woden to the Parliamentary Triangle, because the health minister and policy-related staff would be working on almost all aspects of government policy, particularly those relating to employment and to income and wealth distribution, as is

the present case with Treasury. Health would become a central agency, and a prestigious place to work – a dark suit department. A health impact statement would sit alongside other checklists in cabinet submissions. In the fashion of bureaucratic language, the health department would come to be seen as a “profit centre” rather than as a “cost centre”. State health ministers would be elevated from a mendicant role to sit at the right hand of premiers.

It’s not easy to predict what policies would emerge from such an arrangement, but they would surely be a break from our present path, and, in the broadest sense of economic efficiency, would almost certainly have better economic outcomes. We may find our cities becoming more cycle and pedestrian friendly. We may find people spending less time gawking at others playing sport and more time doing something themselves. We may find more people tending to community gardens. Above all, we may find stronger support for those policies which reduce social exclusion and economic disparities.

These are all economic benefits, but they won’t show up in the national accounts. If we cycle to work rather than taking the car or bus, there is less money changing hands; if we spend Saturday afternoon orienteering there is no stadium ticket showing up in the national accounts, and if we grow our own potatoes the turnover of supermarkets is just a little less. If we don’t need a band tightening or a triple bypass a few thousand dollars goes off the GDP.

Who, other than an autistic accountant, would say these are not economic benefits? And even by the traditional metrics of economic benefits there would be improvements, because people with good health are readier to participate in the labour force and are less dependent on distributive welfare.

Some people would say such an elevation of the health portfolio would be a radical move, but in reality it is simply a way of bringing more integration into government programs – “joined up government” in the jargon of public administration. It is not just about Commonwealth arrangements, for it also goes along with the need to achieve more integration in state programs, particularly at the ground level. As any social worker will confirm, there is a huge skew in the distribution of those calling on state services such as policing, emergency medical care, special needs at school and emergency housing. The same individuals and extended families are heavy users of all these services. All such services relate closely to health, and health policy may be the means of integrating such services.

But if we think that such moves would be a mere tinkering at the edges of a broken system, then Gavin Mooney, a health economist who has worked for various governments around the world, and for the WHO and OECD, has a stronger view on reform. His book *The health of nations: towards a new political economy* is critical of approaching health policy through a social determinates framework, which he sees as an ameliorative solution rather than one which addresses the fundamental structures of society and its economic arrangements.

Quoting political scientist and economist Vincente Navarro, Professor of Public Policy at Pompeu Fabra and Johns Hopkins Universities, he says:

It is not inequalities that kill people. It is the people who produce and reproduce inequalities through their public and private interventions that kill people

His vision is of health care “as a social institution”. He opposes top-down policy-making in which governments “adopt a paternalistic approach and, together with the medical profession ... determine what sort of health care and what sort of health-care system people are to get”. He believes “that societies must become more genuinely democratic with much more

participation in decision making, in setting principles and priorities”, and in giving effect to such decision-making he puts heavy weight on mechanisms such as citizens’ juries. He dismisses both market-based and utilitarian approaches to allocation of scarce resources.

His work extends into the very ways our societies are organized. As the title suggests he advocates “a new political economy”, and not just a political economy of health care. At one point, in seeking a solution, he simply says “We need to abandon capitalism”, and in another “the choice is between capitalism and the planet. Only one can survive”. He tends to see politics as a Manichean struggle, rather than a practical exercise in working around roadblocks to do some good, as Roxon has done with smoking.

Those who seek better health outcomes without fundamental transformation will still find much in his work with which they will agree, and which stimulates further thought. He makes many strong points relevant to developing countries, where the institutions of the Washington Consensus (the World Bank and the IMF) have forced what he identifies as market-based approaches to health care which have resulted in social stratification and huge misallocation of scarce resources in favour of the well-off.

Conservative reformers will surely agree with Mooney that we can do better than the private insurance models of the USA and Australia, but can we do better than the universal systems of the Nordic countries (where Mooney has worked)? Is the only path to a healthy society the abandonment of capitalism? Mooney sings the praises of Cuba and Venezuela, countries which, in relation to their standards of living, have excellent health services, but are there not paths to good health other than the Marxist path?

After all, in accordance with John Rawls’ principles, we can and do arrange our societies so that in some domains we are socialist, while in others we are libertarian. In Australia’s case, we have the tradition of the “social wage”, based on equality of access to services such as health care and education, which can easily sit alongside competitive market-based structures elsewhere in the economy. The social wage was trashed under the Howard administration, but surely its restoration would be a more practical approach than a complete social and political transformation.

Certainly there needs to be more engagement on setting principles and priorities, but this is more complex than Mooney suggests, because, unlike other government services such as roads, education and public transport, health care is something with which most of us have very little experience through most of our lives. Only if we have the misfortune of suffering a chronic disease do we have any in-depth understanding of our needs, particularly what they may be in the last years of our lives.

We need an open debate on principles of health policy – a debate we have never had – but it needs to be an informed debate, in line with Robert Reich’s model of “civic discovery”, in which, through an iterative process involving citizens and policy experts, practical and consistent policy solutions can emerge. Citizens’ juries may play a part, but a precondition is a much more serious engagement with public policy than we seem to be capable of at present. That debate has to break away from two entrenched positions – the “left’s” romantic attachment to free services, and the “right’s” attachment to private health insurance and an interpretation of publicly-funded health care as “charity”.

Economists mindful of the numerous failures in health care markets, including the distortions caused by private insurance, would have little trouble in agreeing with Mooney’s dismissal of

unbridled market forces. Nor would most moral philosophers find difficulties with his scepticism of markets.

His dismissal of utilitarianism, which is the basis for cost-benefit allocation, is more troublesome however. Cost-benefit analysis, like the law, generally treats people with equality. Health care measures such as “quality-adjusted life years” do not distinguish between paupers and plutocrats, aboriginal people and others, men and women. If, in his idealized society based on communitarian principles which abandon utilitarianism, what mechanisms does he envisage to suppress the emergence of a new class of entrenched privilege?

Perhaps the sort of social transformation Mooney seeks will eventuate, but none of us will be around to see it occur. There are many Marxists who believe that capitalism has some way to run before it collapses on its own contradictions – the revolution of 1917 was a few hundred years too early and in any case Russia was still feudal rather than capitalist.

In the meantime, while we await the revolution, his work is a stimulating contribution to our thinking on health policy. In its obituary column in early October *The Economist* referred to the historian and philosopher Eric Hobsbawm as “the last interesting Marxist”. It appears they were not aware of Gavin Mooney’s work.

Gavin Mooney *The health of nations: towards a new political economy* (Zed Books London and New York 2012). Available in paperback and hard binding, no electronic version.

Note after publication. On December 21 2102, a few days after this review was published, Professor Gavin Mooney and his partner Dr Del Watson were murdered at their home in Tasmania.