Galloping Consumption

Health Care Choices and the Public Purse, Sidney Sax, Allen and Unwin, Sydney 1990. Reviewed by Gwen Gray.

The Australian health care system, like that of many Western countries, has been the site of pitched political battles throughout the 20th century. Time after time, conflict has raged between the major political parties and between governments and a range of vested interests including the medical profession, hospital boards, private insurance agencies and private hospitals. Consumers of health care have not been an organised force and their input into policy development has been negligible.

The fundamental point of dispute is the extent to which governments should intervene in the provision and financing of health services. Opponents of the welfare state argue that health should be left primarily to the market, like any other commodity, with doctors and other producers retaining as much economic freedom as possible. Conflicts erupted in New South Wales (1904-1914), Tasmania (1914-1919) and in Queensland in the decades after 1915, as governments tried to take control of hospitals. Intense controversies surrounded unsuccessful attempts to introduce national social insurance in 1928 and 1938. The Chifley government's efforts to set up a national health service in the 1940s contributed mightily to that government's downfall. More recently, the Whitlam and Hawke Labor governments have found themselves embroiled in serious confrontations with doctors and other interest groups over the introduction of Medibank and Medicare, systems of national health insurance. Health policy, then, is an intensely controversial area, with the potential to give rise to high political costs for interventionist governments.

Clearly, these circumstances are not conducive to comprehensive, thoughtful consideration of health policy options. The more that issues are exposed to scrutiny, the more obvious will be the embedded conflicts of interest. Controversial questions such as the way the health system is organised, the way doctors are paid and the kinds of services that are produced are therefore avoided as far as possible. Government intervention, since the 1940s, has focused primarily on different ways of paying for an existing set of institutions and services. The prior question of what sort of institutions and services would constitute a good health system has not been examined by mainstream policy-makers.

As the title suggests, Dr Sax's book discusses a range of policy options and their implications for the public purse, a timely contribution since control of public spending is a high priority issue with the potential to determine the kinds of health services made available. Two very important assumptions underpin the analysis: first, that the structure of the health system will remain unchanged and, second, that funding levels will not be increased.

The first set of arguments addressed are those for and against the welfare state. Dr Sax concludes that we need "a synthesis of the two value systems", the one based on individualism and free enterprise and the other on collective responsibility for provision of certain public goods. Next, health status and strategies designed to overcome health inequalities are discussed. As has been known for many years, there is a strong association between poor health and poverty and low levels of education.

Dr Sax sees the responsibility for dealing with social and environmental hazards as falling largely outside the purview of health authorities. He is highly critical of "the priests of the new public health faiths and fads" who argue that 'health' expenditures are heavily skewed towards treatment services for sickness rather than towards prevention and holistic primary health care. 'New public health' advocates under-value the contribution of conventional medical services, he argues. The solution is not to transfer funding from curative to preventive programs. Rather, a much more comprehensive approach should be adopted within the present structure. There should be more emphasis on training and education of health professionals, rigorous evaluation of existing services, better monitoring of the environment, more support services especially for the aged and a greater research effort.

There cannot be equal access to services, of course, unless the better off and wealthy are somehow prevented from buying services not provided free or at low cost by collective means. Such services include private hospital and nursing home care, non-insured services such as those provided by nurses, nutritionists, naturopaths, podiatrists, dentists, physiotherapists, counsellors and so on, various aids and appliances and home help and other support services. The question is rather that of deciding upon an acceptable standard of care to which everyone has access. Dr Sax argues that the present system of universal insurance, Medicare, is more equitable than the private insurance systems of the past.

Most of the remaining chapters of the book deal with costs and the implications of cost control or closely related issues. Contrary to a common claim, often put forward by opponents of the welfare state and others opposed to government intervention in health, the provision of free services does not induce people to rush out and demand unnecessary services. In any case, only general practitioner services are initiated by patients. Most services (specialist, radiology, pathology, hospital admissions and so on) are initiated by doctors. The use of medical services did increase in the first two years of Medicare. Indeed, this was one of the main objectives of introducing the scheme. It was intended that the 19% of people without insurance cover under the voluntary

system should not be faced with financial barriers to service use. In recent years, where service use has increased, it is in the area of doctor initiated services, particularly high cost, high technology diagnostic services.

Health service evaluation is an unexplored concept in Australia but one that Dr Sax recommends be given serious consideration. There has been little examination outside medical circles of the kinds of services which ought to be provided: debate has focused on systems of financing the services which have gradually evolved. However, there are legitimate concerns about the appropriateness and value of many services, Dr Sax argues. Medical science, while effective in treating many conditions, has done little to prolong life in recent decades and costs have increased dramatically. There are large variations between services provided from area to area and from country to country, as well as big differences in per capita expenditures on health care. As policy-makers in Canada and other OECD countries have realised since the 1970s, high levels of spending do not necessarily result in better health outcomes. Dr Sax argues that rigorous evaluation processes and continuing education schemes should be instituted not only to ensure quality of care but also to ensure that cost containment does not result in "arbitrary reductions in access to care or in its quality". The public, patients and governments want evidence of quality and appropriateness. The medical profession is challenged to put its house in order. The alternative might be "officious intrusion by outsiders".

Within the constraints set by the (realistic) assumptions that present structures and funding levels will be retained at least in the medium term, Dr Sax's prescriptions offer the prospect of considerable improvements in the health system. However, many of the problems identified by the new public health and women's health movements would remain. These include the impact of the fee-for-service system of remuneration and the focus of the present system on medical and hospital services with few resources devoted to primary health care and prevention. Structural change would be needed to address these issues.

The fee-for-service system of remuneration promotes the production of insured services. This is so whether the insurance system is a national publicly run system or a private system. Unless governments or insurance agencies are willing to extend the range of insured services to those provided by other health professionals such as physiotherapists, naturopaths and so on the range of affordable services available will remain very narrow. Doctors, of course, vehemently oppose such an extension.

The second undesirable aspect of fee-for-service is that the more patients doctors see, that is, the shorter time spent with each patient, the higher the income earned. Thus, the system works against extended consultations which might include counselling selling, information provision and so on.

Again, private practice on a fee-for-service basis leaves doctors free to decide where to locate practices. Such systems are characterised by a serious mal-distribution of services, particularly specialist services. Under the present Australian system where doctors, unlike their Canadian counterparts, are allowed to charge patients a fee that is higher than the benefit level, it is economically advantageous to practise in an area where people have the means to pay the co-payment.

The community health program introduced by the Whitlam government was an attempt to overcome many of these problems. Centres employing teams of health professionals on a salaried basis were established in all states. Ideally, these centres would provide a very wide range of services, including primary, secondary and tertiary preventive care and people would gradually come to participate in decisions affecting their health through a process of community development. Decisions about where to locate centres were influenced by the mal-distribution of services, so that the program was a means for overcoming geographic inequalities. As Dr Sax has argued elsewhere, the community health program was far more radical than national health insurance, which merely provided better financial underpinning for the existing system. Therefore, it was bitterly opposed by the medical profession.

During the Fraser period, funding was gradually reduced, meeting the budgetary objectives of that government and gaining the approval of the medical profession. The Hawke government promised to restore funding to 1975 levels and this it did in 1983, except that the interim increase in population was not allowed for. As under the Fraser government, funding for community health services was incorporated in the identified health grants but no conditions were placed on use. The Hawke government, like its predecessor, has therefore chosen not to play a role in policy development for community health. Between 1983 and 1988, tight constraints were kept on increases in the identified health grants: funds were escalated by a formula based primarily on increases in award wages which were, of course, lower than increases in the CPI.

Those who hoped that new life would be breathed into community health under a Commonwealth Labor government have therefore been disappointed. From this perspective, the 1980s represents a lost opportunity: even a modest annual increase in Commonwealth funds over the eight-year period would have resulted in a far wider choice of services than currently provided in private medical practices. A slow but steady expansion of programs at the community level is probably the only feasible way to alter the focus and structure of the system. A head-on confrontation with the medical profession such as in the 1940s when the Chifley government tried to introduce a salaried medical service would probably produce very little change. An incremental expansion of community health services, however, would not only give consumers a choice of providers and a much greater choice of services but would begin to orient the system towards health promotion, involving people at the local level in decisions which affect their health and the health of their environments.

Advocates of the new public health and other critics of present arrangements charge that the term 'health system' is a euphemism. The system is so heavily geared towards the

provision of medical and hospital services that it is, in fact, a 'sickness system'. The distribution of health expenditures is cited as evidence of distortion. In 1986-87, hospitals, nursing homes, medical services and drugs consumed 79% of the total health budget. Only 4% was spent on community health services, health promotion and illness prevention combined. The focus of the system on high technology diagnosis and treatment, the power of vested interests and the pressures to introduce even more new technologies means that in the absence of increased funding and concerted efforts by policy-makers the present distribution of services will remain.

Under these circumstances, comprehensive health care will not be available at the community level. Groups such as Aborigines, people of non-English speaking background and women will probably continue to see services as inappropriate to their needs. The setting of health targets is likely to be a token effort and strategies to improve the health outcomes of the population will be funded on a shoestring. The concerns of more radical reformers who take a 'social' view of health are unlikely to figure prominently on the political agenda. In this view, health promotion is a process through which people themselves develop the capacity to shape their environment, thereby enabling them gradually to gain control over factors which determine health. Unlike Dr Sax, these people believe that social and environmental hazards should be addressed within the health system as well as in other sectors.

One noticeable omission from the book is all but the briefest mention of the women's health movement. This movement, which began in the late 1960s, has had some success in recent years in having its concerns heeded by Australian policy-makers, although funding for initiatives is still miniscule. Like the new public health movement, the women's health movement represents a challenge to the dominant system of curative medical care and there is considerable congruence in objectives. The basic aim of the women's health movement is to create a situation where women are empowered to take increasing control over aspects of their lives which influence health. Women in the movement want information on which to base their own decisions about health, access to community based services run by women and participation in decision-making at all levels of the health system. Efforts are also made to sensitise "mainstream" services to the needs and perspectives of women. While the movement cannot be said to have changed the shape of the health system, its influence is growing steadily and analyses which ignore its existence are seriously incomplete.

The Australian health care system has not been reviewed comprehensively since the 1940s. Rather than developing in a context of planned objectives, it has grown like Topsy, the result of a mix of decisions and compromises by individual doctors, professional bodies, hospitals and governments.

The National Health Strategy, set up recently to review the system over the next two years, thus provides an opportunity to evaluate current arrangements and to examine the trenchant critiques that have been levelled at the system. The review's terms of reference are wide, covering issues such as cost containment, demand for services, quality, access, the role of the private sector, community services, preventive services and financial and organisational arrangements. Such a wide ranging inquiry should produce information of value to policy makers in the 1990s.

Knowing what might produce a better health service, however, does not overcome the political obstacles to action. Powerful vested interests will fight policies that are not in their interests, and treasuries and finance departments will resist proposals that increase spending. As Dr Sax notes, "radical change is rare" in the health system. It is to be hoped, however, that such incremental changes as are introduced in future will be informed by a better understanding of what constitutes health and a health care system and that the criticisms of those who want the system oriented towards comprehensive primary health, the needs of groups such as women, and the achievement of health goals will be heard and respected.

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The WPO Bytes Back

Bad Attitude: The Processed World Anthology, edited by Chris Carlsson. Verso $29.95. Reviewed by McKenzie Wark.

***Processed World* is a wonderful little magazine, available mostly from anarchist bookshops. It combines stories, graphics, humour, satire, with an eclectic blend of far-left thinking. It is, for the most part, written by and for office workers. In a nutshell it tries to be a forum in which a Left culture might emerge—one of, for and from the white collar working class.**

There is not much heavy rhetoric or jargon in *Processed World*. It is not a magazine given much to preaching a party line. There are many first-hand accounts of office life and political struggles in the workplace. There are stories which are amusing and with which anyone who has worked in similar circumstances can identify. There are other stories from which one can learn. This anthology is both entertaining and useful.

If a justification is required for the heavy emphasis on gags, comics and

witty slogans in *Processed World* and in this fine anthology, it lies in the fact that many office workers are cut off from earlier forms of working-class culture and the resources for resistance and leverage they provided. The transformation of the American economy from one which employed people mostly in agriculture and manufacturing to one employing people in services and paperwork, while not as complete or inevitable as theorists of the 'high-tech path' make out, is nevertheless a fact of life. Something similar has happened to working life in Australia, too.

Given this transformation, cultivating working-class culture in these new pockets of employment is as important as trying to organise them industrially or politically. Perhaps in the long run more important. No union will ever last long as a genuine expression of working class interests and aspiration if it is not organically connected to its membership by cultural mores, practices, beliefs and attitudes. The criticisms *Processed World* makes of American unions on this score sound chillingly familiar.

The kind of culture which tends to coagulate around the loose editorial practices of *Processed World* is not without its faults. Its anarchic glee at childish pranks and petty sabotage is perhaps an understandable outgrowth of the alienated experience of temporary workers who have no need to get along with any particular company and no stake in the productivity of the firm which a full-time worker might feel. *Processed World* is not able to make the conceptual separation between power within the work process and the power to stop the work process.

They are right, nevertheless, to question the sacrifice of any and every human value to productivity, to the endless production of more and more bits and bobs of a processed world. On the positive side, their critique extends out from pointless work to the pointless things pointless work produces: toxic food, cancerous suburbs and the endless search for the perfect weapon.

Not all of the rich mix of Californian alternative culture in *Processed World* translates into Australian terms, but there is a lot to learn from here. This magazine is really a very thoughtful experiment in alternative communication.

Every trade union and community group publication should have a copy of this book. There are plenty of cartoons and graphics which could be reused. At $29.95 it's expensive but pretty good value, so get your local library to order it for you. It is the sort of thing that should be treated as a community resource.

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