
EDITORIAL INTRODUCTION: RENEWING THE POLITICAL ECONOMY OF HEALTH AND HEALTH CARE IN AUSTRALIA

One of C. Northcote Parkinson's celebrated examples in his collection of essays, *Parkinson's Law: The Pursuit of Progress* (1958), relates to the meeting of a committee charged with the construction of a new nuclear power plant. The committee's agenda includes three items: approving plans for the plant, discussing the potential for a new bicycle shed for employees and addressing its own refreshment expenses. Members of the committee have difficulty in comprehending the implications of nuclear power, so there is little to discuss about the proposal for a new reactor and it is unblinkingly approved within minutes. However, most of the committee are familiar with bicycle sheds, so they can have a lively debate on the preferred shade of paint for the shed and how to minimise costs associated with its construction. Finally, all members of the committee are knowledgeable of coffee, leading to the most comprehensive discussion of the meeting on the subject of whether to get a new coffee machine. Penny wise, pound foolish, indeed.

Parkinson's satirical example is particularly prescient in reflecting on the nature of debates over the contemporary health system in Australia. As exemplified by the promulgation of contrasting viewpoints arising in light of the proposed changes to Medicare announced in the 2014-15 Commonwealth Budget, matters relating to healthcare are rarely far from political or scholarly discourse. Regular deliberations over the allocation of public funds to different priorities, the projected augmentation of costs associated with an aging population and the appropriate mix of state and corporate provision, for instance, serve as an *aide-mémoire* that the direction of healthcare remains a contested arena of social policy.

On the other hand, despite the plethora of scholarly research which demonstrates the manner in which political, economic and social factors are pivotal determinants of population health (see, for example: Marmot

and Wilkinson 2006; Stuckler and Basu 2013), transforming these dynamics as a means of shaping health outcomes has largely remained off the political agenda in Australia. Since the 1980s, in particular, consideration of these broader determinants has been overwhelmingly disregarded in public policy. Embedded within neoliberal ideology, and thus articulated according to the now-familiar rhetoric of ‘choice’, ‘efficiency’ and ‘productivity’, the locus of public health policy during this period has, instead, centred on the purportedly voluntary behaviour of individuals and provision of technoscientific solutions to manage individual circumstances of ill-health – many of which would have been unlikely to have arisen under different political economic conditions (Chernomas and Hudson 2013). Concomitantly, health-related costs are regularly presented as inexorably ballooning due to the discrepancy between the infinite demand for healthcare (driven by factors such as the aging population and perpetually rising public expectations) and finite public spending *already* being at the limits of affordability (for example, Banks 2008; Commonwealth Government 2014). The result is that policy has increasingly been framed in terms of the twin objectives of ‘cost containment’ and ‘efficiency’ – that latter which, it is assumed, can best be achieved through processes of further marketisation and privatisation of provision processes (NCOA 2014; *cf.* Leys 2009). In turn, modest measures through which the state could advance the conditions of the least-healthy sections of the population, such as ensuring adequate public housing, introducing a more progressive tax regime, or moderating the increasing precariousness of work, have been accorded low priority, while inequality has inevitably escalated. In other words, as with so many other government policies, fiscal priorities and questions of allocation within policy programs have taken precedence over addressing more complex political economic questions.

It is with the intention of critically addressing some of these broader considerations that this special issue of the *Journal of Australian Political Economy* has been published. As the contributions to the issue collectively demonstrate, health outcomes are the product of a wide range of factors – including, but not limited to, healthcare. For this reason, it is necessary to also address the broader *social determinants* of health and healthcare, such as the macroeconomic state of the domestic economy, the quality and accessibility of education and other public services, levels of inequality, the stability of the global economy and so forth. Yet, while highlighting such broader determinants, the articles also

progresses further up the causal chain to confront how they are, themselves, shaped by the operation of *power relations* in the context of contemporary Australian and global capitalism. While the broad nexus of social factors shaping health outcomes has begun to receive attention in some international forums, such as the increased emphasis accorded to inequality as a driver of poor health outcomes by the World Health Organisation (WHO 2008), political economic analysis offers a unique contribution by pointing to the need to examine the structural factors responsible for these dynamics. As Vicente Navarro (2009:423) quips, 'It is not *inequalities* that kill people...it is *those who are responsible for these inequalities* that kill people', requiring consideration of the political and class determinants of inequality and the inequality-health relationship. To this end, the articles that follow pay particular attention to the configuration of ideas, interests and institutions driving the contemporary neoliberalisation of the Australian health system.

Explicit and critical engagement with the political economic foundations of the Australian health system is especially significant in light of the present changes to the Australian health system proposed by the Federal Coalition Government. Exemplifying the narrowly technocratic focus satirised in Parkinson's example above, the amplified threat of a rhetorical 'budget emergency' has been employed to justify a plethora of measures which reorient the universalist character of the Australian public health system along commercial lines. In this case, an industrial concept of 'efficiency', consistent with the gradual commodification of healthcare evident in Australia over the last three decades, is being substituted for the objective of addressing health needs, exemplified by the introduction of the \$7 co-payment for GP fees. This measure, alongside reforms such as transferring health agencies to the Department of Health with diminished funding, abolishing Medicare Locals and divesting \$80 billion in (primarily health and education) funding from the states, will have the effect of converting Medicare into little more than a reactionary 'safety net', overwhelm hospitals, increase extant inequalities and wind-up universal access to healthcare. The withdrawal of state funding will also have the doubly-destructive effect of diminishing the quality and quantity of public services provided by the states, while also pressuring them to increase their own goods and services taxes. Such policy actions thus fail to address and, indeed, undermine these social determinants. In the context of a general decline in myriad public services and living standards due to an increased emphasis on austerity,

they also weaken those institutions, such as Medicare, which may have buffered against the adverse influence of such diluted social structures on health outcomes (see Wilkinson and Pickett 2009; Stuckler and Basu 2013).

Concomitantly, in emphasising the broader social ontology of health, this special issue also raises questions concerning the type of health system most desirable in Australia. The institutional development of the present system has entrenched what McAuley (2012) refers to as an ‘illness’ model of healthcare, in which the latter remains understood in largely medicalised terms as centred on providing for people who are unwell. From this perspective, the prime beneficiaries are medical provider interests – such as pharmacists and medical specialists and, increasingly, the financial sector through private insurance companies – able to secure the ongoing means for capital accumulation through medical interventions in the major causes of mortality (cancer and cardiovascular diseases). However, as argued above, while medical interventions may *care* for individuals with these conditions and improve their quality of life, they cannot *cure* such problems without addressing the social determinants of the health system, as well as the political and class foundations of these factors (Coburn 2009; Nararro 2009). The proposed \$20 billion medical research future fund – presented as the saving grace in the Coalition Government’s otherwise austere health program of ‘death by a thousand cuts’ – for instance, serves only to further biomedicalise healthcare: focussing on technoscientific solutions to individual ailments, rather than addressing the range of socially-determined forces shaping health (see Clarke *et al.* 2010). Simultaneously, the locus of change in programs promoting lifestyle and behavioural interventions to prevent disease and promote positive health outcomes is grounded in an equally reified ontology of health (Chernomas and Hudson 2013).

Instead, by analysing what political economic factors are shaping the current state of health in Australia, the contributions to this special issue also reflect on the elements of system based on an alternative ontology of ‘wellness’. That is, how is the Australian health system intertwined with an understanding of what makes a ‘good society’ in contemporary Australian capitalism? As part of their critique of the neoliberalisation of the health system, the articles consequently make the case for a consideration of broader strategies – both state- and citizen-directed –

that include economic, political, social and cultural interventions seeking to shape the *social* (as distinct from *individual*) determinants of health.

Critical engagement with such analytical and normative concerns was also pivotal to the research agenda and practice of our friend and colleague, the late Professor Gavin Mooney. Since their untimely and horrific deaths in late 2012, testimonials of the life and work of Gavin and his wife, Delys Weston,¹ have spanned across both traditional and social media, as well as appearing in the pages of academic journals.² On the one hand, this special issue of *JAPE* is, in part, intended as a contribution to the ongoing chorus paying tribute to Gavin's immense impact on the critical study of political economic issues relating to health. Indeed, it is difficult to overstate his scholarly influence: as a critic of prevailing mainstream economic accounts, he was a founder of the modern study of the political economy of health, contributed over 200 publications on myriad issues in this area and received several honorary doctoral degrees in recognition of his work. Moreover, both his scholarship and practical activities were guided by a strong commitment to objectives of social justice and he worked to undermine and replace many of the extant institutional and ideological structures that entrenched poor health and inequality.

Nevertheless, the objective of this special issue is to act as more than a fugacious testimonial. We believe that the greatest tribute that can be

¹Given the focus of this special issue, the remarks made here will centre on the contribution of Gavin Mooney and his contribution to the political economy of health. However, it is equally important to acknowledge the formidable intellect, commitment to social justice and strong personality exhibited by Delys Weston. In paying tribute to Del and Gavin, Robin Bunton (2013:502-3) laments that the former's promising 'academic career, like many women of her generation, was developed in later life and is now cut short'. Yet, he also points to how both 'Del and Gavin personified their work values in so many ways: in their generosity as colleagues, and in their warmth and humanity as friends.' As part of their shared belief in social justice and belief in the importance of listening to the voices of those without power, both 'stubbornly refused to make public matters technical ones and insisted that the voices of people were heard alongside those of experts.' Further reflections on the personal and professional lives of Del and Gavin can be found at: www.gavinmooney.com.

² *Social Science & Medicine* produced a particularly useful collection of academic papers in a special issue that reflects on Mooney's contribution to the political economy of health. This issue is available at: <http://www.journals.elsevier.com/3social-science-and-medicine/news-and-virtual-special-issues/virtual-special-issue-to-celebrate-the-work-of-gavin-mooney/>.

paid to Gavin is to build on the legacy he left behind by ‘taking stock’ of some of the key political economic issues facing the contemporary Australian health system and, in turn, highlighting the need for ongoing critical research and political activity. His critical and inclusive epistemology opened up areas for further study by his colleagues and students on myriad topics, such as inequality, the ontology of health, the operation of power relations, global health institutions, economic theories of health, alternative health systems and so forth. In turn, by considering many of these themes, we anticipate that this special issue meets the spirit of Gavin’s declaration that ‘[t]here is a need not only for greater tolerance of other voices but also for a burgeoning of encouragement of debate’ (Mooney 2002:201–2) and contribute to a renewed critical political economy of health in Australia.

Organisation of the Issue

This special issue of *JAPE* is divided into four parts: Part One ‘Equity and the Neoliberalisation of Health in Australia’; Part Two ‘Globalisation and the Australian Health System’; Part Three ‘Australia’s Health System in the Comparative Perspective’; and Part Four ‘Alternative Health Arrangements’. While each of the articles included takes one of these themes as its primary focus, the content of each chapter demonstrates the highly interrelated character of each of these themes. Indeed, we hope that this volume will demonstrate the extent to which theoretical and policy-related questions relating to the political economy of health in Australia will benefit from critical consideration of the myriad issues arising from these themes collectively rather than as separate entities.

The links between inequality and health outcomes are well-established (see, for example: Wilkinson and Pickett 2009; Stuckler and Basu 2013). Even in countries such as Australia where the Medicare system ensures that few pecuniary barriers hinder the provision of healthcare, the poor still face greater hurdles to receiving care quantitatively and qualitatively equal to that enjoyed by the wealthy. This ‘inverse care’ law, in which healthcare is provided in inverse proportion to its need, was first noted by Tudor Hart in 1971, yet it is still the rule and has only been accentuated under neoliberalism to the extent that the World Health Organisation (2008:26) concluded that ‘[s]ocial injustice is killing people on a grand scale.’ Most significantly, however, this problem cannot be read off the

operation of economic forces alone. Rather, addressing the relations between inequality and health necessitates first comprehending the broader social and political determinants of the prevailing health system and the constellation of power relations underpinning these factors. Thus, in *Part One*, the contributing authors examine issues associated with access to quality and affordable health care as shaped by the unique interactions between neoliberal institutions and norms of universalism and social equity in the Australian system. They collectively demonstrate the ways in which neoliberal policies have undermined some of the positive social determinants of health, while also weakening the social institutions which may have cushioned the negative influence on health of weakened social structures.

- The first article, by Ben Spies-Butcher, casts a critical eye on Medicare as a staple of Australia's health system. The introduction of Medicare has indisputably facilitated wide-ranging access to high-quality healthcare. Conversely, through an analysis of the ideas, interests and institutions shaping its development as a medium of universal health insurance, Spies-Butcher argues that its fusion of a quasi-market system with strong egalitarian commitments means that the Medicare is also potentially corrosive of equality by contributing to the development of a 'dual welfare state' (Stebbing and Spies-Butcher 2010).
- This question of universality is then addressed in greater detail in the following article by David Baker, who examines the personal and social costs associated with increased incidence of charging out-of-pocket expenses for healthcare. As Baker demonstrates, the objectives of 'fairness and affordability' traditionally underpinning Australia's system have already been adversely affected through increased charging of out-of-pocket expenses and, indeed, will only be further eroded through the current legislative agenda.
- Freya Bunday concludes by analysing the introduction of the \$7 compulsory co-payment fee proposed in the 2014-15 Commonwealth Budget as an extension of the current financialised trajectory of healthcare and provision of other goods and services in Australia. This, in turn, has important implications for questions of praxis: presenting significant challenges and opportunities for those opposing the co-payment policy itself and its broader political economic foundations.

Part Two broadens the scope of analysis to consider relations between the Australian health system and contemporary global capitalism. In particular, it addresses two interrelated questions: ‘who makes global health policy?’ and ‘for whom?’ As the purported reference point for the global governance of health, the Constitution of the World Health Organisation (WHO 1948) posits that ‘[t]he enjoyment of the highest standard of health is one of the fundamental rights of every human being’, with the rejoinder that ‘[g]overnments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.’ From this perspective, through its capacity to shape both the prevailing healthcare system and social determinants of health, public policy is responsible for securing positive health outcomes as a basic right for its citizens. Yet, as the articles in this section demonstrate, the Australian health system is increasingly embedded within global governance structures in which states are working with commercial interests to define standards and the focus of policy priorities – both domestically and at the global level – in such a way as to favour commercial interests through the commodification, privatisation and deregulation of health systems (see also Koivusalo 2009; Rushton and Williams 2012). Consideration of the institutional background, objectives and power relations underpinning these structures highlights that, through actions integrating Australia ever-deeper into neoliberal trade processes in particular, the state has increasingly prioritised securing the conditions for ongoing accumulation over institutionalising those for an effective, equitable local health system (Loeppky 2009).

- By analysing the development of Investor-State Dispute Settlement (ISDS), Pat Ranald demonstrates how a supra-national legal system has been constructed and enforced through trade and investment agreements, primarily to secure global regulations which favour the commercial interests of powerful states’ transnational corporations. By analysing the use of ISDS mechanisms by global tobacco companies against the national regulation of tobacco advertising, Ranald demonstrates how the operation of political economic power in global health governance may limit the scope for national health policies, the priorities of these policies and the global distribution of health resources.

- David Legge, Deborah Gleeson, Hans Lofgren and Belinda Townsend then analyse Australia's position on intellectual property (IP) and medicines within three global forums. It demonstrates that Australia has adopted a largely non-transparent, pro-IP stance in these therein – reflecting particular ideological and geopolitical alliances – and argues that it must be held accountable for positions taken which may affect the cost of medicines and access to treatment in developing countries.
- The final article in this section, by Julie Smith, Judith Galtry and Libby Salmon, considers the liberalisation of trade in certain medical products. The authors argue that while Australasia leads a 'white gold boom' in infant formula exports to Asia, there is a surprising silence about its effects on population health. By examining this trade from an integrated feminist economic and human rights perspective, they review its health consequences and draw on lessons from tobacco control experience to argue for a more effective global constellation of regulatory institutions.

The processes characterising the neoliberalisation of the health system examined in the two previous sections are, of course, not exceptional to Australia (Panitch and Leys 2009). Rather, they are constitutive of a broader set of political economic processes which arose with the neoliberal counter-revolution in the 1970s (see Cahill 2014). What is of particular significance, however, is the manner in which Australia's deeply-entrenched and popular system of public healthcare has increasingly been converted from its status as a primarily public good to the field of capital accumulation, while still retaining its universalist character (as outlined in Part One in Spies-Butcher's article). In order to understand the operation of this apparently antagonism in the context of contemporary capitalism, *Part Three* includes two articles which examine the experience of two other countries with strong systems of public healthcare: Canada and Cuba. Thus, while important studies of the political economy of health in their own right, these articles also prompt pertinent reflections on the trajectory of the Australian system. How does the contemporary neoliberalisation of the Australian system compare with and relate to other countries with traditionally robust, universalised public healthcare systems? Which groups have benefitted and which have suffered – and which may continue to do so – based on these trends? What are the implications for Australia's capacity to address the

multiple, overlapping health challenges it faces today – both domestically and in a regional and global context?

- In examining the nexus of forces which have enabled market incursions into the arena of health delivery and the transformation of healthcare into a commodity in Canada, Rodney Loeppky's article is particularly valuable as a mirror to the Australian system given the structural similarities between the two. For Loeppky, the commodification of the modern Canadian health system has been driven by common global imperatives, as well as the historical and institutional peculiarities of Canadian capitalism. These pressures have, in turn, produced a system exhibiting strong pressures towards both accelerated biomedical accumulation and increasing privatisation of healthcare delivery.
- Tim Anderson, in contrast, argues that while closer cooperation between the two countries over the delivery of Pacific health aid offers significant possibilities for securing a range of social objectives, it is first necessary to overcome the antinomies between their respective health systems. In turn, for such a partnership to function effectively, both countries must find accommodations on critical issues, such as making the island nations full partners, harmonising on elements of institutional development and coordinating major programs.

Part Four maps out some of the challenges and opportunities associated with the development of conceptual tools and institutional configurations which diverge from those detailed in the previous sections. Consideration of such alternatives is especially pertinent in the contemporary context, in which processes of neoliberalisation continue to de-democratise and deepen the commodification of Australia's health system, while also undermining the broader political economic conditions necessary for positive, equitable health outcomes. In turn, rather than offering an idealistic 'shopping-list' of policy priorities, the articles in this section focus on questions of praxis. Specifically, it presents processes of decommodification and reinstitutionalising democratic political processes as the mutually-reinforcing fulcra on which non-neoliberal, progressive health systems should be constructed.

- Paul Simpson, Jill Guthrie and Tony Butler reflect on Gavin Mooney's work and scholarship championing the notion of 'citizens' juries' in offender health. Acknowledging that health is a social institution and rejecting the assumption that communities of lay-people are incapable of providing meaningful input on complex and contentious policy issues, the article presents citizens' juries as a means to replace extant market-led regimes with community-led policies. The role of the 'public' in shaping the priorities and form of health systems is thus presented as paramount to democratic and equitable outcomes.
- This rationale is then examined further in a short symposium based on a seminal article on the potential for citizens' juries by Gavin Mooney and Scott Black. The original article, along with the reflections of three public health experts – Pat Neuwelt, Peter Sainsbury and David Legge – together emphasise that societies must become more genuinely democratic through greater public participation in the decision making processes which establish principles and priorities for health and healthcare.

The contributions to this special issue evidently extend across a range of interrelated topic areas. There are, of course, many other subjects that deserve attention when considering the political economy of health in Australia beyond those covered in this volume. Contemporary concerns relating to Aboriginal and Torres Strait Islanders, persons with disabilities, mental health, workplace health and safety, and medical technology, for instance, will hopefully be addressed by articles gracing the pages of future editions of *JAPE*. Conversely, it is anticipated that the discussions featured over the following pages – both individually and collectively – will contribute to a shift away from the narrow terms of the debate over the health system and foster a critical re-engagement with the political economic foundations of health and healthcare in contemporary Australian capitalism. In the current juncture, in which institutionalised principles of equity and fairness in the system are under sustained attack, the need for a renewal of scholarly debate and attendant political activity related to such matters is more salient than ever.

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