Economics and public health:

An exploration

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Abstract

Economics has become a dominant framework for analysing problems in public health and health care and for proposing policy solutions. A separate sub-discipline of health economics has grown out of the welfare economics tradition to develop specific methods for economic inquiry into health care issues. The encroachment of economics into health care and public health has not occurred without consternation from within the health field. Part of the reason for this concern arises from a mismatch between the worldview of public health and that of mainstream economics. However, this mismatch is largely unexamined, and there has been limited attempt to address the mismatch and to propose alternative approaches to economic questions in public health.

This thesis examines the project of public health in some detail, making reference to the consensus documents of the World Health Organization that set out the values base of public health and define its approach and some of its activities. Public health is a collective activity, mostly undertaken outside of markets and is primarily concerned with impacts on populations. It is inherently political and focuses on populations as its unit of analysis. This contrasts to the approach of mainstream economics, which presumes that economic decisions are primarily private decisions and focuses on individuals as its unit of analysis. The differing worldviews constitute an impasse between mainstream economics and this view of public health. The solutions of neo-classical economics are often at odds with the public health approach.

An alternative view of economics, from the heterodox Institutional School may provide an alternative approach to economic questions in public health. In contrast to neoclassical economics, it claims to be holistic and not to engage in methodological individualism and to be explicitly concerned with questions of power. The case studies of role of government and ageing as a public health issue provide a lens through which the neoclassical approach can be examined and contrasted to the public health approach. These case studies are based on reports written for Australian governments by neoclassical economists. The two case studies are then inspected from an institutional perspective to examine whether

this approach does indeed generate explanations and solutions that are more compatible with a public health approach. Other insights into the reports that can be gained from an institutional perspective are also discussed.

Declaration

This work contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution, and to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text.

I give consent to this copy of my thesis, when deposited in the University library, being made available in all forms of media, now and hereafter known.

Signed: _____ Date_____

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Chapter 1: Introduction

Introduction

Ideas have the potential to be extremely powerful in both understanding and shaping our world. The notion that ideas should themselves be studied and understood is not a new one. In relation to public health, Sylvia Tesh has detailed the impact that ideas can have on efforts to define the causes of diseases and their remedies and highlights the relationship between facts and values, both in the search for the causes of disease and in the process of developing preventive policy.[1] In economics, Mark Blyth has argued that economic ideas are powerful political tools, since whoever defines the economy has a profound political resource.[2]

This is a thesis about the history of ideas in public health, concentrating on ideas from economics. It is not a thesis in economics or health economics, although it is, in part, informed by my understanding of the two. The influence of economics in areas of public policy outside of what has traditionally been thought of as *the economy* has grown steadily in the last quarter of the 20th century and its growth in influence continues into the 21st-century. In tandem with this has been reassertion of the neoclassical paradigm as the single legitimate paradigm for understanding economic matters. Whereas in the post-war period, Keynesian economics was considered to be mainstream, now neoclassical economics claims the mantle.

However, there is a much wider variety of schools of economic thought than just the neoclassical and the Keynesian schools, although none of the others has enjoyed the same status of *mainstream* for as long as these two. Along with Marxist economics, they are the most widely practiced schools, sitting on the

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[1] Tesh, SN (1988) *Hidden Arguments: Political Ideology and Disease.* Rutgers, The State University.
[2] Blyth, M (2002) *Great Transformations.* Cambridge: Cambridge University Press.

political spectrum from right (neo-classical) to left (Marxist). In addition to the Marxist there are at least nine other heterodox schools of economic thought.[3]

One school that has some claim to once being mainstream is the American Institutional School. Originating in the American mid-West in the late 19th century, it reflected local experience of economic phenomena. At least two of its earliest practitioners were influential in their day. Wesley Clair Mitchell founded the National Bureau of Economic Research in 1920 and was President of the American Economic Association in 1924; John Commons also served as President of the American Economic Association, in 1917. Thorstein Veblen experienced some celebrity especially through his writings in *The Dial* and Veblen is said to have 'exerted an important influence upon philosophers, sociologists and historians, who found his approach to the problems of economic life and his methods of analysis more closely related to modern scientific thought than the economic of the schools'.

Following some dominance in American economic thinking in the earlier part of the 20th century, institutional economics experienced a decline in interest, but survived in a number of key Economics Departments in American universities, in particular, the Universities of Wisconsin and Texas and The New School for Social Research. Other prominent economists who have been linked to institutionalism include Robert Heilbroner, John Kenneth Galbraith and Gunnar Myrdal.[4]

From 1958 several *dissenting* economists met during the annual meeting of the American Economics Association and formed an organisation that later became the Association for Evolutionary Economics (AFEE). Initially a push to reduce discrimination by journal publishers and textbook editors against publishing non-mainstream papers, this organisation has provided a focus for economists who are

[3] The History of Economic Thought Website managed by the New School for Social Sciences in New York list a total of ten including Utopians and Socialists, The Fabian Socialists, The German, English and French Historical Schools, The American Institutionalist School, Joseph Schumpeter and Evolutionary Economics, The Soviet Planning Economists, the Neo-Marxian/Radical Political Economy School and Economics at the New School. See: http://homepage.newschool.edu/het/

[4] The Association for Evolutionary Economics recognised Heilbroner's, Galbraith's and Myrdal's contribution by naming them, respectively, the 1993, 1977 and 1976 recipients of the annual Veblen-Commons Award, which recognizes career-long scholarly excellence.

interested in institutions. Institutional economics now boasts two scholarly journals, *The Journal of Economic Issues*, first published in 1967, and the *Journal of Institutional Economics*, established in 2005.[5] Institutional economists are also published in a number of other journals that recognise the relevance of heterodox contributions to economic thought.

My interest in exploring the contribution of a heterodox school of economic thought developed from frustration with the limitations of mainstream economics, especially as applied to public health. These frustrations relate to mainstream economics' mostly limited scope, its assumptions and its methodology: while it claims to be concerned with how societies use scarce resources to decide what will be produced, how and for whom, it has a very constricted view on markets, narrowly conceived. When it does consider phenomena that occur outside of markets, the analysis forces them into the terms of a market model. The narrow scope of mainstream economics is in contrast to public health, which recognises a role for not only market but also government and community organisations in providing for the public health needs of the community in ways that recognise the particular culture, social structure and history of the community.

A second source of frustration with mainstream economics relates to its particular assumptions about rationality, self-interest and maximisation. Rationality in mainstream economics equates to behaviour that satisfies preferences. This is a very narrow view of rationality and there are few examples of cases where it has been conceded that behaviour is irrational. The assumption of self-interest ignores the range of interests individuals have in their families and in the community and in behaviour that is reasonable but may not be self-interested. Such behaviour may be motivated by care for future generations or for the intrinsic value of the environment, rather than anthropocentric concerns; or it may arise from custom or habit. Finally, mainstream economics assumes that the primary objective of action is maximisation of preferences for consumers and of profits for companies. Not

[5] The Journal of Economic Issues is published by the Association for Evolutionary Economics. The Journal of Institutional Economics is published by Cambridge Journals.

only individuals but also societies wish to maximise. The *bottom line* in mainstream economics is that what is maximised is what accrues to individuals. A key underlying theme in the case studies of this thesis is the maximisation of national income or gross domestic product (GDP), which goes unquestioned as the primary economic good to be achieved.

Public health also strives for maximisation. It strives to maximise the health of the population but what it seeks does not necessarily lie with individuals. The conditions for good health, which lie outside of individuals, are important to public health, as are the processes that are in place for participation in decision-making about issues that affect health and about health care. Unfortunately, attempts 'attempts by epidemiologists to evaluate the health of a population immediately reduce to aggregated individual data such as morbidity and mortality rates as the criteria of achievement.

The final area of frustration is with methodology, particularly individualism. Mainstream economics nails its plaque firmly to the wall of methodological individualism, the tenet that all phenomena can be explained in terms of individuals. It goes further than this, however, and engages in abstracted individualism and economic individualism. Abstracted individualism treats individuals and their wants as existing independently of the society in which they live. Economic individualism presumes that economic arrangements that are left to individuals are most likely to both reflect what individuals want and to be efficient. Each of these kinds of individualism is problematic for public health because it limits the scope of inquiry and excludes matters that public health has recognised as important factors in shaping health at a population level. Public health does not deny the importance of individuals but mainstream economics sees them only in isolation and does not recognise the importance of other, non-individual factors in their behaviour, health and satisfaction.

These frustrations arise from a view of Public Health that is consistent with that outlined by The World Health Organization (WHO) in the series of documents on

health promotion that started with the Declaration of Alma Ata.[6] Public health is also interested in a range of goods, not just outcomes, but processes as well. In particular equity and participation have been defined by the WHO as important elements of public health. In mainstream economics appropriate outcomes are presumed to be those that a market model would produce. The appropriate process is the market and hence, outcomes such as improved health status or the provision of a service, rather than processes are the main focus of evaluation. This narrow focus of mainstream economics, particularly in relation to health, extends to its concentration on the use of specific resources (usually in health care), rather than to the social and economic arrangements which produce health.

Intellectual focus and social significance

My frustrations regarding mainstream economics promote questions about how economics might be done differently; specifically, how it might accommodate the concerns of public health for equity and participation, and how it can deal with issues at a population or holistic level. In an attempt to explore the possibilities, I have chosen to apply the heterodox school of Institutional Economics to two case studies of issues important to public health about which mainstream economics has had quite a lot to say. The choice of material evolved over a period of about two years and builds on work being done by some of my colleagues in public health.

Professor Gavin Mooney, who has been interested in its application to the health-economic issues facing indigenous Australians, first alerted me to the potential significance of institutional economics. I carry a long-standing interest in population ageing that became much more focused on the economic approaches to it when, as a junior member of academic staff, I was asked by Dr Neville Hicks to present a session on the EPAC report on ageing, to his *Public Health and Ageing* masters course. Another colleague, Mr John Moss, drew my attention to the significance of the *audit commission* phenomenon and the commissions' reports as a

[6] World Health Organization (1978) *Primary Health Care (The Declaration of Alma-Ata)*. WHO.

significant digest of the economic approach to public administration and the role of government.

The reading in the history of economic models and the empirical instances of health issues under the economic gaze allowed me to focus on the scope that institutional economics might offer for thinking about the challenges presented by an ageing population and for the role of government, which is minimised in mainstream economics but substantial in Australian public health. Institutional economics covers a broad range of issues using a variety of approaches. In contrast to mainstream economics, institutional economics is not defined in terms of any particular policy proposals. It draws on disciplines other than economics and places institutions at the centre of inquiry. Rather than seeing the economy from within, as primarily a collection of markets, institutionalists view the economy as embedded both in the natural environment and in a broader set of social, cultural, political and power relationships -- in which individuals, likewise, are embedded. In each of these respects, institutional economics appears to have more in common with public health than does mainstream economics. The aim of this thesis is to test the extent to which it provides approaches to problems in public health and avenues for inquiry that reflect a worldview similar to that of public health.

Mainstream economics has become an important contributor to policy debates in health care and also in other areas of public policy that affect health. Mainstream economics is not applied simply as a tool for better understanding a problem -- a positive approach -- but attaches a heavy normative tone to the application of economics to public policy generally and to health care. The normative element of the application of mainstream economics is evident in the presupposition that the market is the best model for organising any activity that involves the use of resources. The justification for this is the criterion of *efficiency*, which can be defined as using the least amount of resources to produce what people demonstrate they value most through their willingness to pay for it. Many of the goods and services that sustain health can be bought and sold in markets and, to the extent that this is so, both economic growth and markets have contributed to

improving the health of the public in developed countries since early Victorian times. However civic activity has been important, also. Civic decision-making has altered the distribution of goods away from a market distribution that reflects efficiency towards one that reflects a range of values that markets are unable to express. This distribution differs from the market distribution in terms both of what kinds of goods are produced and for whom they are produced. [7]

Institutional economics claims to provide an opportunity to step out of the straight-jacket of markets and to explore a range of ways of making economic decisions that can accommodate concerns that transcend individuals and reflect a range of values other than efficiency. Therein lays the social and public health significance of this thesis. Mainstream economics risks undermining the social if it treats everything that is not mediated through market activity as inferior to markets. Public health is likewise threatened as a broad, participatory activity because much of what a community decides it wants to achieve in public health cannot be achieved without the involvement of government in the context of a robust participatory democracy. Institutional economists have called for a *higher efficiency*, which includes security, equity, freedom and compassion, and is a matter for economics because these matters define the kind of economy we have. In mainstream economics these things are treated as *non-economic* and, where they are given importance, they are defined narrowly: *national security* is important but not economic security for the masses; freedom is defined in terms of freedom from interference, rather than freedom to develop and participate[8]; equity is regarded as dangerous because it blunts incentive and compassion is treated as a private, rather than a public, matter and consigned to the non-economic realm.

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[7] For an introduction to the literature on economic growth and health, see McKeown, T. (1976) The Modern Rise of Population. Edward Arnold: London; for an introduction to the role of civic decision-making, see Szreter, S. (1988b) The Importance of Social Intervention in Britain's Mortality Decline: Re-interpretation of the Role of Public Health. *Social History of Medicine,* 1:1: 1-39 and Szreter, S. (2002) Rethinking McKeown: the relationship between public health and social change. *American Journal of Public Health,* 92: 722-725.

[8] Freedom from interference (negative liberty) is the classical definition of freedom, requires that the state and the community keep out of the individual's way and is implicit in mainstream economics. Freedom to develop one's potential (positive liberty) 'requires the means, education and access to culture to participate fully in community life' Sawer, M. (2000) The ethical state: Social liberalism and the critique of contract. *Australian Historical Studies,* 31: 67-90

Security, equity and freedom are important for public health, also. Economic insecurity is deleterious to health. Inequity creates disparities in health that can drag down the overall health of the population as they inhibit particular individuals and groups. Freedom to participate in decision-making about oneself and one's environment and the capacity to do so is fundamental to public health. Compassion is not a particular feature of public health, but does drive much work in it. Compassion is, however, evident in public debates about health care and is exemplified by the *rule of rescue*, the 'powerful human proclivity to rescue endangered life'.[9] Institutional economics, it appears, provides scope for examining questions of public health importance from an economic framework whilst maintaining concern for the public health mission.

Outline of the thesis

This thesis is organised in three broad sections. The first section, comprised of chapters 2 and 3, sets out the case for investigating institutional economics as an alternative to the dominant neoclassical paradigm for examining questions in public health. The second section, comprised of chapters 4, 5 and 6, examines the approach and content of public documents that broadly make up two case studies; one on demographic change and the other on the role of government. The third section, comprised of chapters, 7, 8, 9 and 10, applies the approach of institutional economics to the two case studies and to the two sets of public documents on which the case studies are based.

Chapter 2 surveys the relationship between economics and public health and identifies areas of potential conflict and shortfall for mainstream economics as applied to public health questions. Public health, as outlined by the World Health Organization (WHO) in the Declaration of Alma Ata and as defined by the American Epidemiological Association, concentrates on protecting and promoting the health of the population by a range of means.[10] The key strategy for doing this

[9] Hadorn, D. (1991) Setting health care priorities in Oregon. Cost-effectiveness meets the rule of rescue. *Journal of the American Medical Association,* 265: 2218-2225. 2218.
[10] Last, J (2001) *A Dictionary of Epidemiology*. New York: Oxford University Press; World Health Organization *Primary Health Care (The Declaration of Alma-Ata).*

is primary health care, which reflects and evolves from the community and addresses its main health problems through a range of methods both within and outside the health sector.[11]

Primary care both requires and develops community and individual self-reliance and participation supported by referral systems across the range of appropriate health care workers. Public health focuses on populations and rests on a value base that rejects inequalities as being unacceptable because of their unhealthy effects, whilst explicitly linking health to both economic and social development. It considers participation in health care by individuals and communities to be both a right and duty and places responsibility on governments to provide adequate health and social measures to improve health in a spirit of social justice.

Mainstream economics does not explicitly place health or any other particular good above another. By endorsing markets as a superior form of social and economic organisation, it implicitly promotes individualistic, rather than community, goals; self-interested, rather than community-minded, thinking; and competitive, rather than cooperative, behaviour. In addition it employs a reductionist and individualist methodology. Both philosophically and methodologically, it is at odds with the values and approaches of public health. This is significant because there has been an increase in the influence of mainstream economics in all areas of public policy in Australia in the last quarter of the twentieth century and because 'neoclassical economics does not adjust to the world as it is: rather it adjusts the reality to itself'[12], a phenomenon that has been documented in the case of health economics.[13]

Chapter 3 examines the case for applying institutional economics as an alternative with a perspective that appears to be more compatible with a public health view of the world. In contrast to mainstream economics, it claims to be holistic, rather

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[11] World Health Organization *Primary Health Care (The Declaration of Alma-Ata).*
[12] Galbraith, JK. (1989) A Look Back: Affirmation and Error. *Journal of Economic Issues,* 23: 413-416
[13] See: Ashmore, M, Mulkay, M and Pinch, T (1989) *Health and efficiency: a sociology of health economics.* Milton Keynes and Philadelphia: Open University Press.

than reductionist, to reject the primary focus on individuals and to draw on a range of disciplines in its approach.

The second section of the thesis introduces two case studies, on population ageing and on public administration, which are used, later, to test the hypothesis that institutional economic theory can provide an account of public health problems more satisfactory than the account offered by mainstream economics. The case study of demographic change was selected because population ageing represents one of the most common contemporary issues in public health and one to which mainstream economics has devoted considerable attention. Public administration was chosen as a case study, because, in Australia, at least, most public health activity is mediated, if not undertaken directly, by governments. The approach to government that has been taken by the *audit commissions* is important, because of the parameters that it would set for government activity in public health.

Chapter 4 opens the case study on *demographic change* and examines the various reports on the economics of population ageing that have been published in Australia by the Commonwealth government or its statutory authorities since the late 1980s. These reports followed a fairly standard format but became more detailed in content over time. Their approach included methodological individualism, the assumption of rationality and the presumption that the goal of government policy was maximisation of national and of individual income. Methodological individualism presumes that the ageing of individuals and their behaviour is the key issue in population ageing. Rationality and maximisation lead to conclusions that individuals need to take more responsibility for their old age and that, unless they do so, a tax revolt and a brain drain among younger, overtaxed generations will follow.

The resolutions that these reports offer are based on abstracted individualist and market solutions. The reports on ageing performed original modelling of the various economic and fiscal outcomes for Australia for 40 years hence, that is, as far out as 2044-45. However, on the whole, they relied heavily on theory, rather than evidence, as the basis for their discussion and to inform their modelling. I do not argue that the authors of the reports should necessarily have engaged in

empirical research in order to provide a more complete picture of the complex economic story of population ageing. I do argue that they ignored intellectual approaches that could have led them to examine alternative evidence, capable of leading to the consideration of a wider range of causes of dependency and of policies to prevent avoidable dependency and to support those who had become dependent.

Chapter 5 introduces the National Commission of Audit, which reported in 1996 after the election of the Howard Coalition Government.[14] It straddles the two case studies and addresses issues both of the role of government and the ageing population. It is presented separately from chapters 4 and 6 because it introduces some issues that are either not clearly evident in the reports on ageing or the State commissions of audit or are dealt with in a slightly different manner. These issues include globalisation, which is offered in the National Audit as a justification for reviewing the function of government and provides a template for its future role; public sector performance; privatisation; purchaser provider models of health care; the social security system, and ageing and health care costs.

Chapter 6 examines the reports of the commissions of audit that were set up in each State government from the late 1980s until 1994, by newly elected Liberal governments. These reports exemplified a mainstream economics approach to the role of government. In particular, they promoted a very restricted role for government and the privatisation or marketisation of government activities in the name of efficiency. They did this on the basis of a theory for which no evidence is provided in the reports. On the contrary, evidence that existed prior to these reports or has become available since indicates that these strategies are not as efficient as the theory suggests.

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[14] For the benefit of non-Australian readers... although *Liberal* originally implied social liberalism, in Australia at present it is a vehicle for those committed to individualism and market liberalism. See Sawer. The ethical state: Social liberalism and the critique of contract. and Brett, J (2003) *Australian Liberals and the moral middle class : from Alfred Deakin to John Howard*. Cambridge, UK ; Port Melbourne, Vic.: Cambridge University Press.

The third section of the thesis examines the potential contribution that institutional economic theory can make to the examination of these two case studies. Chapter 7 draws together the themes from the previous three chapters and introduces specific strands on institutional economics that are identified as providing an alternative that could address my specific concerns with the reports on ageing and the audit commission reports. Chapter 8 considers the issues raised in the reports on ageing through the lens of institutional economics – specifically in the version synthesised by Clarence Ayres from Thorstein Veblen's institutionalism and John Dewey's instrumentalism. Applying the resulting notions of ceremonial and instrumental functions of institutions to the problem of population ageing shifts the focus of inquiry away from individuals. Instead, the focus is on matters such as the habits of thought and beliefs that underpin patterns of saving for retirement, as well as decisions about workforce participation and retirement. The same framework is applied in Chapter 9 to health care, which features as an issue in both the reports on ageing and the audit commission reports. Each report fails to address questions of community and integration, warranted knowledge and participatory democracy that are central to this institutionalist line of thought.

Chapter 10 returns to the question of the role of government, examining it in the institutional framework. Mainstream economics recognises a relatively narrow range of legitimate reasons for governments to act. These reasons are articulated most clearly in the audit commission reports and relate to ensuring that markets can work well and encompass law and order, property rights and market failure, including monopoly, externality and public good. Institutional economics argues that the market is but one of the ways in which the community provisions itself and that issues of power and participation are also reasons for governments to play a role in the economy.

Chapter 11 takes a more general turn, looking at the reports on ageing and the audit commissions collectively in an institutional framework. Applying the Veblenian notions of ceremonial and instrumental institutions indicates that these two sets of exercises, on balance, were largely ceremonial; they are based on ceremonial values that are justified by appeal to tradition and in the formulation

of suitable myths (ideologies) that mystify the origin and legitimacy of their existence and put them largely beyond critical scrutiny. They are judged within the community on the basis of their *ceremonial adequacy* and their logic is sufficient reason.[15]

I conclude with a discussion of the public health significance of this thesis and discuss some of the alternative ways that the issues canvassed in the reports on ageing and the audit commission report might be approached with the institutional framework in mind. This turns out to be somewhat similar to the processes that are recommended by the WHO in relation to the provision of primary health care.

[15] Bush, PD. (1987) The Theory of Institutional Change. *Journal of Economic Issues,* 21: 1075-1116

Chapter 2: Neo-classical economics, health economics and public health

Introduction

Neo-classical economics has re-emerged as the dominant and now mainstream economic paradigm of the second half of the twentieth century, at least, and the bulk of economic writing about health, illness and aged care has its origins in the neoclassical framework. Public health has particular objectives and activities that are not always compatible with the perspective and underlying assumptions of this mainstream economics. It also accounts for only a small percentage of spending on health[1]. Thus, mainstream economics has found it more rewarding to concentrate its effort on the delivery of health care, rather than public health.

Conversely, when applied to public health questions, the perspective of mainstream economics frequently is less than satisfying to public health workers. McKeown and McKinlay demonstrate that substantial parts of improvements in the health of the community occur as a result of factors other than specific medical interventions, whether the focus of interest be infectious diseases in the 19th and early 20th century in England and Wales and in the United States, or chronic (degenerative) diseases in the 20th century in the United States.[2] Clinical treatment of illness and neoclassical economics have lived a form of intellectual symbiosis but if factors other than medical care have been significant in the improvement of health, then an economic perspective alternative to mainstream economics may be productive. Institutional economics, which is used more widely in development and environmental economics, looks beyond specific technologies, individual behaviour and market transactions in isolation and may provide a more

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[1] In 2000-01, Public health expenditure accounted for 2.4 percent of government spending on health and only 1.6% of total spending on health. Australian Institute of Health and Welfare (AIHW) (2005) *Health Expenditure Australia 2003–04.* AIHW Cat. No. HEW 32 (Health and Welfare Expenditure Series No. 25). Canberra: AIHW.

[2] McKeown, T (1979) *The role of Medicine: Dream, mirage or nemesis?* Oxford: Basil Blackwell; McKinlay, JB and McKinlay, SM. (1977) The questionable contribution of medical measures to the decline of mortality in the US in the twentieth century. *Millbank Memorial Fund Quarterly - Health and Society*: 405-428; McKinlay, JB, McKinlay, SM and Beaglehole, R. (1989) A review of the evidence concerning the impact of medical measures on recent mortality and morbidity in the United States. *International Journal of Health Services,* 19: 181-208

productive paradigm for generating economic questions about resource allocation and public health. This thesis seeks to develop alternative economic views on public health and health care. The first step therefore is to examine the meaning of public health, its assumptions, value and activities and to identify areas of similarity and of difference with mainstream economics.

Public health tends to be a creedal term, so a working definition of it needs to be articulated if it is to be used in effective double harness with economics. The Public Health Association of Australia uses the definition first articulated by Acheson[3]. Public health is 'the art and science of preventing illness and promoting health through the organised efforts of society'. The International Epidemiological Association has a more deliberate definition of public health as:

> one of the efforts organised by society to protect, promote and restore the people's health. It is the combination of sciences, skills, and beliefs that is directed to the maintenance and improvement of health of all the people through collective or social actions. The programs, services, and institutions involved emphasise the prevention of disease and the health needs of the population as a whole.[4]

The essential elements of this definition are that public health involves organised effort, or collective action, and the focus is on the health of the all of the people, not merely those who come under medical notice.

Some important features of public health are readily discernible from this definition. First, the efforts with which public health is concerned are 'organised by society' through 'collective or social actions', so public health is rooted in a conception of society that is able to generate collective goals, and act with and on behalf of citizens to achieve collective goals. Second, public health is interested in the population as a whole, including the well, and in addition to any aspirations which individuals may have for their own health. Third, public health sets out to produce, promote, protect and restore health, which implies a wide range of personal, professional and social activities.

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[3] Secretary of State for Social Services (1988) *Public health in England. "Acheson report."* London: HMSO.
[4] Last *A Dictionary of Epidemiology.*

This definition is limited somewhat by its implicit assumption that public health is limited to efforts that are explicitly aimed at maintaining or improving health. Health can be affected either actually or potentially through a whole range of activities and arrangements that do not include impacts on health as an intended consequence. This is recognised in what is known as healthy public policy within the so-called *new public health*.

At the conference of Alma-Ata in 1978 the World Health Organization (WHO) recognised that the main determinants of health are outside the health care sector.[5] The product of that conference, a document called *The Declaration of Alma-Ata*,[6] was followed by the *Ottawa Charter for Health Promotion*[7] (1986), *Adelaide Recommendations for Healthy Public Policy*[8](1988), *Sundsvall Statement on Supportive Environments for Health*[9] (1991), the *Jakarta Declaration on Leading Health Promotion into the 21st Century*[10] (1998), *Bridging the Equity Gap*[11] (2000) and *The Bangkok Charter for Health Promotion*[12] (2005). These documents recognise the potential of the broader social and economic environment to influence health. The later WHO report *Macroeconomics and Health*[13], focuses on the effect of health on economic development. The set of documents provides a framework for defining the extent of consensus in the international public health community about the values and approaches that should underpin efforts to improve the health of all people.

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[5] Beaglehole, R and Bonita, R (1997) *Public Health at the Crossroads*. Melbourne: Cambridge University Press.
[6] World Health Organization *Primary Health Care (The Declaration of Alma-Ata)*.
[7] World Health Organization (1986) *Ottawa Charter for Health Promotion*. World Health Organization.
[8] World Health Organization (1988) *Adelaide Recommendations on Healthy Public Policy*. Second International Conference on Health Promotion, Adelaide, South Australia, 5-9 April 1988.: WHO.
[9] World Health Organization (1991) *Sundsvall Statement on Supportive Environments for Health.* Third International Conference on Health Promotion, Sundsvall, Sweden, 9-15 June 1991: WHO.
[10] World Health Organization (1998) *New players for a new era - leading health promotion into the 21st century.* Fourth International Conference on Health Promotion: WHO.
[11] World Health Organization (2000) *Bridging the Equity Gap 5-9th June 2000, Mexico City.* The Fifth Global Conference on Health Promotion Health Promotion.: WHO.
[12] World Health Organization (2005a) *Bangkok Charter for Health Promotion.* The 6th Global Conference on Health Promotion: WHO.
[13] Sachs, JD (2001) *Macroeconomics and Health: Investing in health for economic development: Report of the commission on economics and health.* World Health Organization/Harvard University.

The *Declaration of Alma Ata* sets out its values base in a number of statements about health, such as these:

Health is a fundamental right. This potentially controversial position give moral significance to health. Along with education, it is a necessary condition for exercising autonomy and liberty. This right is limited by the declaration in recognition of differences in levels of resources available in and among communities.

Gross inequalities in health status are unacceptable; a statement that relative health status is important as well as absolute health status.

Promotion and protection of health is essential to sustained development. This is a statement that health has instrumental value as a means of ensuring sustained development, showing concern for the future and perhaps, future generations:

Better quality of life and world peace. Quality of life is a broad term that suggests not just the consumption of goods and services, but of well-being derived from sources other than consumption of resources.

In addition, the Declaration sets out some of the means by which health at the level of *the public* can be achieved. First, economic and social development is essential to attain health for all and to reduce gaps in health status. The promotion and protection of health, in turn, is essential for sustained economic and social development. Thus, the process is an evolutionary one in which economic and social development interacts with, draws from and enhances health development. Second, individual and collective participation provides for individuals to achieve health and well-being, not just by their own activities but by collective efforts to produce goods which individuals cannot and affirms the importance of active involvement in setting economic and social arrangements and making decisions that affect health. Third, governments, as vehicles for solidarity and social action, have responsibility for intercalating those goods with the objective of health.

Later elaborations from the WHO gave more attention to the relationship of social goods with health outcomes. Thus, the First International Conference on Health

Promotion in Ottawa in 1987, focused on the needs of industrialised countries and outlined the elements of health promotion activity as being to Build Healthy Public Policy, to Create Supportive Environments, to Strengthen Community Action, Develop Personal Skills and Reorient Health Services (away from treating disease, towards promoting health). The Adelaide declaration focussed on Healthy Public Policy, and highlighted the importance of an explicit concern for health and equity in all areas of policy and of making social and physical environments health enhancing ad ensuring that people have access to the essentials for a healthy and satisfying life.At Sundsvall in 1991, the issue of Creating Supportive Environments was further explored, highlighting the social, political, economic dimensions of supportive environments and the need to recognise and use women's skills and knowledge in all sectors. The four key strategies identified for doing this explicitly recognised empowerment of people and community participation as essential factors in a democratic health promotion approach and the driving force for self-reliance and development. The Jakarta conference in 1997 gave health promotion credit for having the capacity to 'create the greatest health gain for people, to contribute significantly to the reduction of inequalities in health, to further human rights, and to build social capital'. The Mexico conference recommended strengthening the art and science of health promotion and strengthening political skills and actions for health promotion, especially through democratic processes, social and political activism, reorientation of health service and, improved interactions between all players. The Bangkok conference resolved that all sectors must act to advocate for health based on human rights and solidarity, including: investing in sustainable policies, actions and infrastructure to address the determinants of health; building capacity for policy development, leadership, health promotion practice, knowledge transfer and research, and health literacy; regulating and legislating to ensure a high level of protection from harm and enable equal opportunity for health and well-being for all people, and; building alliances with public, private, non-governmental and international organisations and civil society to create sustainable actions. Further, that health promotion should be: central to the global development agenda; a core responsibility for all of government; a key focus of communities and civil society,

and; a requirement for good corporate practice. Finally, the Sachs report has the aim 'to assess the place of health in global economic development' and 'offers a new strategy for investing in health for economic development'. As such the Sachs report does not add materially to the values base of public health, rather, it treats public health as an instrument of economic development, rather than as a human right (which has been the orientation of the other reports).

This summary of the WHO documents indicates that public health assumes maintenance and improvement of health as a shared good. Health is 'a resource for everyday life, not the object of living' (Ottawa Charter) and, along with education, is fundamental to opportunity and autonomy. While it may not be the object of living, it certainly makes for a better life. Health care is valued mostly because of the improvements in health which it provides but it is an unusual good in that processes and outcomes both matter: people attach value to delivery systems in a way that elsewhere would be thought of a means rather than ends.[14]

Underpinning the corpus of the charter documents is a horizontal approach, suggesting that public health is concerned with the organisation of society, its norms, and political, social and economic arrangements. In practice, however, public health activities are often organised along quite narrow lines, around particular diseases (heart disease, diabetes for cancer) or around *risk factors* (diet, exercise, stress – usually referred to as *lifestyle* factors). Occasionally it is organised around the perceived needs of a community (National Women's Health Program) but even these may focus on dis-ease states (cervical and breast cancer, reproduction) and result in medical care services and risk factor modification programs.

Thus, even though the ideals of public health are 'horizontal health care delivery systems as the basis of a mixed strategy of disease control/health promoting activity', the reality is that much activity is 'categorically specific, hierarchically

[14] Culyer, AJ, Wiseman, J and Walker, A (1977) *An annotated bibliography of health economics.* London: M. Robertson.

organised and discrete disease control programs'.[15] In addition, the programs are often focused on *lifestyle* change. This represents a dis-integration of the lifestyle approaches from those proposed by the WHO documents.

The definition of health that underpins public health also shapes the nature of public health programs and activities:

> If 'health' is equated with the absence of diseases, as it is in much of epidemiology, then disease prevention will receive more emphasis. If, on the other hand, 'health' is interpreted in a broad sense, involving the equitable distribution of the foundations for health, health promotion will be emphasised.[16]

While the objective is to create the conditions in which health is improved, it is not the only outcome that is important for my definition. Process also matters, in the delivery of services, in the decision-making and in the way that opportunities to be healthy are made available.

The WHO series of documents, and the early WHO definition of health, are a set of idealised statements about what could be. The difference between what is ideal in theory and what can be achieved in practice can be substantial. Beaglehole criticised *The Declarations*' goal of *Health for All by the year 2000* for being too ambitious, the WHO definition of health for being unattainable and the projects it generated for producing a series of local community experiments, which, unless they are translated into policies, are of only limited value in demonstrating possible approaches to health promotion.[17]

Public health, as defined by the WHO, is concerned with the health of groups or populations, as distinct from the health of individuals. However, this means more than recognising the importance of providing medical care on a mass basis (although this is one strategy of public health). The arrangements and processes by which such programs are possible are as much part of public health as are the programs that they produce. Health is affected by many activities that are not *organised* by society. The impact of the social, economic and political environment

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[15] Gish, O. (1992) Malaria eradication and the selective approach to health care: some lessons from Ethiopia. *International Journal of Health Services,* 22: 179-92
[16]Beaglehole and Bonita *Public Health at the Crossroads*. 124.
[17] Ibid. 215f.

as it evolves (without any consideration of the health effects) is likely to be as important an influence of health as those activities specifically intended to improve health. When I refer to public health I have in mind those organised efforts as well as the effects on health and the ability to organise for health, of the organisation of society, its norms, political, social and economic arrangements and responses to them.

There is a long history of debate and action to either expand or contract the boundaries of public health, including whether it should be concerned with prevention alone (often at the level of the individual), or also with cure, and whether it should extend to social welfare in a broad sense or adopt a narrower, technical view.[18] Australia has a firmly entrenched (in the public's mind, anyway) publicly funded health care system that takes some of the heat out of the prevention or cure question. However, it is increasingly clear that causes of poor health exist as much at the supra-individual level as they do with individuals and that, consequently, prevention should address those supra-individual factors that harm health. Therefore, a focus on social welfare and social reform is a necessary activity of public health.

Economics and public health

Just as the discourse of market liberalism has displaced social liberalism in the second half of the twentieth century, so the language of neo-classical economics has become increasingly apparent in the debate about health care and about public policy.[19] An examination of the health care literature demonstrates this. Of all articles listed on *Medline* prior to 1975, less than ten per thousand contained the word *economic* in the entire Medline entry. By 1996, the number had grown to more nearly 38 per thousand after which it increased more slowly to 45 per thousand. During the 21-year interval between 1975 and 1996, the number of indexed articles containing the word *economic* increased from 4,030 to over 16,800

[18] A short history of debate in the United States over these boundaries can be found in Starr, P (1982) *The social transformation of American Medicine.* New York: Basic Books.
[19] Sawer. The ethical state: Social liberalism and the critique of contract. ; Brett *Australian Liberals and the moral middle class : from Alfred Deakin to John Howard.*

per year. A similar pattern is found when examining the economics literature. A search of *Econlit* for articles containing the words *medicine, medical or health* reveals an increase from 50 per thousand in 1968 to 79 per thousand in 1997, a rate at which it has since been sitting steadily. The Australian literature, taken from *Australian Public Affairs Information Service* (APAIS) electronic database, shows a similar pattern of increase for articles containing the words *economic* and *social*, and for articles containing the words *economic and health.*

The number and proportion of papers that appear to deal with economic issues regarding health increased, and there has been a recent change in the literature in which they are concentrated. For Medline and APAIS, the rate per thousand of articles that appear to relate to health and economics has fallen since the mid 1990s, while it has continued to increase in Econlit. This suggests that writing on the economics of health and medical care has shifted from the periphery of economics and become more mainstream. It is also possible that the word *economic* is used less explicitly in the health literature as it is now an everyday part of health care management.

Additionally, Culyer et al (1977), Blades et al (1986), Backhouse et al (1992) and Elixhauser et al (1998) have described the growth in a health economics literature.[20]. Blades's update of Culyer's earlier work included a wide range of categories and listed a mere 57 entries prior to 1960, but over 1600 for the three years period between 1980 and 1982. Backhouse's bibliography of economic evaluation studies indicates that the number of publications roughly doubled in each five-year period from 1975-79 to 1985-89 and that trend looked set to continue into the 1990s. Elixhauser listed a cost-benefit and cost-effectiveness evaluation literature of 3500 items for 1991 to 1996. These works reflect growth in both size and scope of the literature dealing with economic aspects of health care and

[20] Backhouse, M, Backhouse, RE and Edey, S. (1992) Economic evaluation bibliography. *Health Economics,* 1: 1-236; Blades, C, Culyer, A, Wiseman, J and Walker, A (1986) *The international bibliography of health economics: a comprehensive annotated guide to English language sources since 1914. (Parts 1 and 2).* Brighton: Wheatsheaf Books; Culyer, Wiseman and Walker *An annotated bibliography of health economics.* ; Elixhauser, A, Halpern, M, Schmier, J and Luce, B. (1998) Health care CBA and CEA from 1991 to 1996: an updated bibliography. *Medical Care,* 36: MS1-MS9

medical care. This literature on the applied economics of health has drawn on the theories of resource use provided by neo-classical economics and has returned its insights back into those theories.[21] Thus it is important to understand how economic principles are used to consider policy questions in health care and in public health.

Sorkin [22] places health economics within the field of human resource economics, which has its origins in neo-classical economics (welfare economics). In 1958 Mushkin [23] identified two developments that had focused attention on health economics. The first was the development of new therapeutic products that altered both the pattern of disease and death and the patterns in the organisation of health services and intensified problems associated with the costs of medical care and stimulated prepayment arrangements for meeting these costs. The second development was the possibility of increasing life expectancy, which raised the prospect that gains in health would be 'dissipated by the pressures of increased population on low food supplies, with the consequent intensification of poverty'. These two issues required 'an analysis of the optimum use of resources for maintaining and improving the people's health and the quality of the population'[24].

These two broad approaches reflect the possibility of both an economics of health care markets and an economics of public health. However, Mushkin goes on to exclude food, housing, recreation and clothing because to include them would mean that the special problem of health economics would receive inadequate treatment! Thus, whilst not it's exclusive concern, the bulk of work in health economics has focused itself on the optimum use of resources within the formal health care sector.

Kenneth Arrow continued within Mushkin's parameters in a seminal paper where he claimed that

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[21] Blaug, M. (1998) Where are we now in British health economics? *Health Economics,* 7: S63-S78
[22] Sorkin, AL (1975) *Health Economics.* Lexington, Massachusetts: Lexington Books. xv.
[23] Mushkin, SJ. (1958) Toward a Definition of Health Economics. *Public Health Reports,* 73: 785-793
[24] Ibid. 968.

> the special economics problems of medical care can be explained as adaptations to the existence of uncertainty in the incidence of disease and in the efficacy of treatment [25].

That is, the economists' interest in health was in medical care as a result of its market failures, which arose from problems with information.

Although the nature and size of the problem in the two situations was quite distinctive, concern with rising health care costs in both the US and in the UK led to an intensified interest by economists in health care, reflected by a growth, particularly after the mid-1970s in a *health economics* literature. The health economists' activity has been concentrated in two areas; the evaluation of health care services (including, more recently, health promotion activities) against technical efficiency criteria, and the efficiency of alternative methods of financing and sources of funding for health care. Approaches in both areas have been based upon the foundation of welfare economics.

Welfare economics is founded on two postulates. First, the individual is the only legitimate judge of his or her wellbeing. Second, the welfare of society is influenced only by the welfare of each individual[26]. *Methodological individualism* is

> the doctrine that all social phenomena (their structure and change) are in principle explicable only in terms of individuals - their properties, goals, and beliefs[27].

This approach is based upon the application of the Pareto principle combined with a view that individuals are the only legitimate source of valuation. A conventional dictionary of modern economics does not mention *economic individualism* but a conventional dictionary of modern sociology does notice the underlying ideas, expressed in Gellner's unflattering judgement that, after circa 1950, 'a society emerged in which single individuals could apparently carry the entire culture within themselves, unaided'[28]. Perfectly competitive markets are Pareto optimal

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[25] Arrow, KJ. (1963) Uncertainty and the Economics of Medical Care. *The American Economic Review,* 53: 941-973. 401.
[26] Greenwald, D (Ed.) (1982) *Encyclopedia of economics,* McGraw-Hill, New York. 961.
[27] Elster 1982 p 453 quoted in Hodgson, GM. (1994b) Methodological individualism. In *Elgar Companion to Institutional and Evolutionary Economics L-Z.* (Ed, Hodgson GM) Edward Elgar Publishing Company: Aldershot. pp. 64-67
[28] Macfarlane, A. (1999) Individualism. In *The Social Science Encyclopedia.* (Eds, Kuper A and Kuper J) Routledge & Kegan Paul: London, Boston & Henley; Pearce, DW (1992) *Macmillan Dictionary of Modern Economics.* London: Macmillan.

because when they are operating it is not possible to make any individual better off without making someone else worse off. Situations in which markets fail are recognised by economists (especially in health care) and policy is socially optimal if it meets the potential Pareto criterion. However, economists generally shy away from the notion that a third person can judge what is best for another, or that it is possible to make valid interpersonal comparisons of utility,[29] because – they argue – it is not possible to say how much better or worse off individuals will be from a redistribution, even when the potential Pareto criterion is satisfied. Thus the role of collective activity, especially government activity for redistribution, should be minimal.

The limitations of economics for public health

The application of neo-classical economic principles to health care has been criticised by Rice, Evans, Culyer, and Sheill and Hawe[30] on several grounds. Rice[31] provides a general criticism of neo-classical assumptions on several bases. First, Pareto-optimality is concerned only with absolute well being, whereas there is sufficient evidence to conclude that individuals measure their happiness based on their relative well-being. This means that negative externalities of consumption exist: when my consumption of health care services makes me better off in *absolute* terms, others may consider themselves worse off as their *relative* standing falls. Frank has described this as the frame of reference and argues that it is a public good.[32] The consumption of health care services also has positive externalities. The clearest case of this is in relation to communicable disease control (we might all benefit, for example, from wearing masks as the H_5N_1 virus approached or

[29] Since Robbins, L (1935) *The nature and significance of economic science.* London: The Macmillan Press Ltd.
[30] Thomas Rice is a Professor and Chair of the UCLA Department of Health Services; Robert Evans is Professor in Economics and with the Centre for Health Services and Policy Research at the University of British Columbia; Tony Culyer holds a position as a Professor of Economics at the University of York in England, Alan Sheill. Professor Sheill is currently Professor of Economics at the Centre for Health and Policy Studies, Department of Community Health Sciences, University of Calgary in Canada and Penny Hawe is Professor and Markin Chair in Health and Society in the Department of Community Health Sciences at the University of Calgary, although both were at The University of Sydney when this piece was published.
[31] Rice, T (1998) *The Economics of Health Reconsidered.* Chicago, Illinois: Health Administration Press.
[32] Frank, RF. (1997) The frame of reference as a public good. *The Economic Journal,* 107: 1832-1847

from ensuring that emergency workers and nurses were immunized early and at public expense). Another example of a positive consumption externality recognised by health economists is what Culyer has called the *caring externality.* [33] In this case, third parties derive a benefit from knowing that people who need health care services can access them. Rice's second criticism is against the assumption that consumer tastes are predetermined. He argues that individual behaviour influences the community and is influenced by the community and by past behaviour. This is the case of people wanting what they get, rather than getting what they want. He uses the examples of addiction, habit and opportunities to demonstrate that people's choices are not free and constrained only by their income. Therefore, people's demand for goods and services might not reflect the things that would make them better off.

Evans's[34] criticism of neo-classical economics is more specific than Rice's and relates to current moves in the US health system to introduce and strengthen market mechanisms in health care. Market mechanisms for the allocation of resources in health care are promoted in spite of their association with inferior system performance, especially inequality, inefficiency, high cost and public dissatisfaction. This is despite the fact that theory that supports market mechanisms predicts the precise opposite outcomes. Evans argues that the push for market reforms continues because of two redistributive advantages it yields for particular influential groups. First, a more costly healthcare system yields higher prices and incomes for suppliers – physicians, drug companies, and private insurers. Second, private payment distributes overall system costs according to use (or expected use) of services, costing wealthier and healthier people less than finance from (income-related) taxation. Wealthy people who are unhealthy can purchase (real or perceived) better access or quality for themselves, without having to support a similar standard for others. Evans's argument echoes Joan

[33] Culyer, AJ. (1971) The nature of the commodity health care and its efficient allocation. *Economic Papers,* 23: 189-211

[34] Evans, RG. (1997) Going for the gold: The redistributive agenda behind market-based health care reform. *Journal of Health Politics, Policy and Law,* 22: 427-465

Robinson's assertion that economics has always been a vehicle for promoting particular political positions.[35]

While Rice's and Evans's criticisms have concentrated on health (mainly medical) care services, Sheill and Hawe[36] have explored the limitations of neo-classical economics in relation to evaluating health promotion. The basis of Sheill and Hawe's criticism is that while the techniques of microeconomics are well suited to the examination of individually-based behaviour change programs, those techniques deal poorly with goods such as community empowerment and the promotion of the community's capacity to deal with health issues, which exist beyond individuals.

As such, community empowerment is a public good. Public goods are another area in which individual demand for a good might not reflect the socially efficient level. These goods, in contrast to private goods are non-excludable and non-rivalrous. Non-excludability is the characteristic of the good that means that it is not possible for the owner of the good to prevent others from benefiting from her use of it. Non-rivalrous refers to the characteristic of the good that means that one person's use of or benefit from the good does not reduce the opportunity for others to access the same goods. Public health goods that are recognised as public goods include quarantine and clean air. However, other less tangible public goods may also be important for public health. These include, in addition to community empowerment, a healthy participatory democracy, social capital and, as discussed earlier, our frame of reference.[37]

Sheill and Hawe move the debate away from health-as-medical services, towards specific efforts to prevent poor health, extending the earlier demonstrations by McKeown and McKinlay[38] that most improvements in health status of

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[35] Robinson, J (1962) *Economic Philosophy*. London: Watts.
[36] Sheill, A and Hawe, P. (1996) Health promotion, community development and the tyranny of individualism. *Health Economics,* 5: 241-247
[37] Frank. The frame of reference as a public good.
[38] McKeown *The role of Medicine: Dream, mirage or nemesis?* ; McKinlay and McKinlay. The questionable contribution of medical measures to the decline of mortality in the US in the twentieth

populations, defined as a decline in mortality, in developed countries occurred as a result of factors other than specific medical interventions. McKeown and McKinlay revealed examples in infectious diseases in the 19th and early 20th century in England and Wales and in the United States, and in chronic (degenerative) diseases in the 20th century in the United States. Much debate surrounds the so-called McKeown thesis and centres on whether his explanation of improved nutrition as the primary cause of the 19th century decline in mortality is sufficient. On either side of this explanation sit two other explanations. The first broad thesis is that general improvements in living standards associated with increased economic productivity and higher national incomes produced improvements in health status. The policy implication of accepting this explanation is that the key to improving health is primarily to increase national income. The second thesis is that specific public health interventions, such as improved sanitation, water supply and housing were also important, with the implication that measures for the general welfare should continue to be a focus of attempts to improve health.

This does not imply that medical care has not played a role, or that it is unimportant. In particular, even at low levels of mortality, it does play a part in increasing life expectancy and inhibiting morbidity. Conversely, while health care is extremely important to individuals who receive it, and has a higher profile politically and is a strategy of public health, it has played a small part in the mortality decline beginning in the mid nineteenth century, which pre-dates most of modern medicine's major advances.

The situation differs in developing countries where specific medical interventions, particularly immunisation, antibiotics and simple measures such as oral rehydration have been instrumental in reducing infant mortality.[39] However, heavy reliance on health care services for individuals may not be a sustainable way of maintaining a minimal level of health status in the community particularly

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century. ; McKinlay, McKinlay and Beaglehole. A review of the evidence concerning the impact of medical measures on recent mortality and morbidity in the United States.

[39] Victora, C, Bryce, J, Fontaine, O and Monasch, R. (2000) Reducing deaths from diarrhoea through oral rehydration therapy. *Bulletin of the World Health Organization,* 78: 1246-1255

as the populations of developing countries age and experience similar health problems as populations of developed countries. Current strategies for dealing with the diseases that affect older populations rely substantially on health care services for individuals and it is unclear that the systems in developing countries will be able to expand to manage both.

An economic tool for the problem at hand

The fact that there has been relatively little attempt to apply neo-classical economic principles to public health may be explained in part by a mismatch in the assumptions about human behaviour and about the nature of society that underpin neo-classical economics and public health, respectively. Public health rarely satisfies the parameters set down by methodological individualism and does not fit the input-output model of production that is presumed by neo-classical economics. Therefore it is not a straightforward exercise to attribute the health status of a population to clear and discrete causes. Most medical care of individuals involves a one-to-one transaction in which it is possible to trace the transaction to some change in health status. Thus it fits the economists' model of behaviour and leads to a focus in health economics on the clinical care system rather than on public health.

The values and underlying assumptions of public health and of neo-classical economics are not always congruent. In neo-classical economics, the essential elements are individual action for utility maximization, and utilitarianism (sum of all individual welfare) as the measure of the health of the community. This conception of welfare denies the possibility of any good outside that experienced by individuals but reduces society/community to the simple sum of individuals' welfare.

In the kind of utilitarianism employed by economists, it is acceptable to have substantial inequalities in, for example, income and wealth, if their existence means that the total income or wealth is maximised as a result. The trade-off between efficiency and equity is an oft-mentioned concept, particularly in the health economics literature. However, the decision to trade-off efficiency for equity is seen as one for politics, rather than economics. In contrast, for public

health, inequalities in health status matter for the whole population. Refinement of rates and risks, and their comparison across population groups goes back at least to the time of William Farr, in the Registrar General's Office for England and Wales[40] and Edwin Chadwick as chief administrator of the Poor Laws[41] in Britain in the mid-19th Century. Reductions in inequality are an explicit goal of the *Declaration of Alma Ata*, which is the iconic statement of a public health position.

The indicators used to measure health status may or may not reflect concern about inequalities in health status. The problem of making inter-personal comparisons of utility is used by mainstream economists as a pretext for denying that there may be some goods which we can say with confidence will be more highly valued by individuals and are more valuable to the community irrespective of the ability or willingness of individuals to pay for those good. An example from health economics is measuring value in terms of quality-adjusted life years (QALYs) gained from different procedures, practices or health care arrangements. These QALYs have been developed as a measure of utility; they are calculated by counting the extra years of life gained from a health care intervention and then weighting them for quality of life experienced in those years. They are also useful when life is not extended by the intervention but quality of life is improved. In this case, the additional quality of life is measured and multiplied by the years of expected duration of the improvement. In either case, QALYs are considered to be of equal value no matter to whom they are applied and from what base they arise. It is possible, therefore, that a gain in QALYs of 1 percentage point improvement in quality of life at 90% for 100 people for one year will be treated as equivalent to a single person gaining one year of life at full health. However, there is evidence, including that from the *Oregon experiment*, indicating community concerns about distribution of health care benefits. In particular, there is a belief that health care should go to those at risk of dying (the rule of rescue [42]): in Australia, respondents

[40] Whitehead, M. (2000) William Farr's legacy to the study of inequalities in health. *Bulletin of the World Health Organisation,* 78: 86-89
[41] Ringen, K. (1979) Edwin Chadwick, the market ideology, and sanitary reform: On the nature of the 19th-century public health movement. *International Journal of Health Services,* 9: 107-120
[42] Hadorn. Setting health care priorities in Oregon. Cost-effectiveness meets the rule of rescue.

to one survey favoured weighting health gains for those in poor health more highly than health gains for those better off in health terms. [43]

Attempts at creating measures such as QALYs reflect continuing rationalisation of health care (in the Weberian sense of both promising liberation from the repression of tradition and producing the risk of more ordered control of the individual by bureaucracy)[44]. Calibrating the benefits of medical care in terms of a utilitarian calculation of (aggregated) individual improvements in health status shifts the focus away from broad interest in population health, with its accompanying interest in relieving individual suffering. Clearly, this calculus can only be partial if the benefits of health care extend beyond purely increasing the number and quality of years of life.

Jane Hall, who heads the main health economics group in Australia's biggest State, argues that economics and public health are not incompatible and have common ground in an interest in social phenomena. She holds that economics is concerned with 'how individuals and societies choose to use scarce resources; public health is characterised, inter alia, by a commitment to social action for social goods'[45]. That focus ignores the different conceptualisations that are available for defining what one means by social phenomena. In economics, social phenomena are corralled as aggregate phenomena, as they are in epidemiology, which is a central discipline in the study of public health. However, social phenomena may be thought of in other ways than just simply as aggregate phenomena. Social facts may be observed as sociological phenomena. A sociological approach considers relationships and dynamics beyond the simplified interaction between two individuals assumed in a market model. It recognises that a wide range of considerations influence human beings and that they rarely act in a way entirely independent of their structural,

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[43] Mooney, G. (1995) Efficiency in health care: just health gains? *Australian and New Zealand Journal of Public Health,* 19: 330-335

[44] Hillier, S. (1987) Rationalism, bureaucracy, and the organization of the health services: Max Weber's contribution to understanding modern health care systems. In *Sociological Theory and Medical Sociology*. (Ed, Scambler G) Tavistock Publications: London and New York. pp. 194-220

[45] Hall, J. (1993) In *Choice and change: Ethics, politics and economics of public health. Annual Conference of the PHA.*(Eds, Brown VA and Preston G).

cultural and historical circumstances.[46] Thus, a sociological approach may yield observations of outcomes quite different from those of a purely aggregate approach. This approach does not suggest that individuals' actions are merely a result of structure, culture and history, rather that only studying individuals is insufficient.

Public health and neo-classical economics have quite different views of the world on a number of matters that go to the core of beliefs about the nature of individuals, of human behaviour and of society. Little work has been undertaken by economists to consider the relationship more broadly between public health and economics. Neo-classical economics has been applied extensively to health care, which can be one strategy of public health, but the application has met considerable criticism. Traditionally, this criticism has come from non-economists. However, as Rice, Evans, and Sheill's works demonstrate, some economists have questioned the application of neo-classical economics to health care services and to health promotion activities.

Economics and public administration

Public health encompasses a range of social and governmental arrangements, which affect health. This is sufficient reason for examining the perspective of economics on the role of the public sector.

Particular sets of ideas and values from economics have become the dominant discourse in discussions about the role of the public sector. The growth in dominance of these ideas has followed the short period of prominence of Keynesian economic ideas as the guiding economic principles for the role of the public sector. Keynes was, without doubt, a liberal but he recognised that the capacity of market forces to resolve extremes in the (so-called) business cycle was limited. In particular, he recognised the need for governments to spend (engage in expansionary fiscal policy), incurring a budget deficit, in order to *kick start* an economy during economic downturns. The flipside of this was that income-linked

[46] Willis, E (1993) *The sociological quest: an introduction to the study of social life.* Crows Nest, N.S.W.: Allen & Unwin.

taxation and government budget surpluses would also assist in slowing down unsustainable economic growth.

Keynesianism became popular as a set of policy prescriptions in the period after World War II.[47] The development of his ideas, as well as the fact that they were adopted so readily, is a reflection of his particular time. Keynes studied mathematics and economics (under A.C. Pigou and Alfred Marshall) at Cambridge and rejected some of key tenets of economics in developing his theory. Keynes is by no means responsible for the expansion of the welfare state that is sometimes linked to his name. However, his theories placed increasing responsibility for economic performance on government shoulders, and his attacks on the priority that classical economics attached to a balanced budget helped to loosen a fiscal constraint that stood in the way of more generous social programs. [48]

The final chapter of Keynes' general theory did discuss the direction in which the general theory might lead social philosophy. In regard to inequality, he argued that economic growth was more likely to be hindered by disparities of wealth and income than increased by them. He believed that there was 'social and psychological justification for significant inequalities of incomes and wealth, but not for such large disparities as exist to-day'[49]. However, Keynesian social democracy, and Keynesian economics are not the same thing. The link between Keynes' economics and the rise of the welfare state is more that Keynes provided an economic entrée for social democratic political ideals. This does not mean that Keynes was opposed to collective action. However, he reserved a role for

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[47] A significant conduit for Keynes' ideas into Australian public administration was H.C. Coombs, who had written his PhD at the London School of Economics before going on to become Director-General of Post-War Reconstruction in Australia and then Governor of the Commonwealth Bank. Coombs was not a self-described Keynesian, however. See Rowse, T (2002) *Nugget Coombs: a reforming life.* Cambridge University Press..

[48] Skidelsky, R (1983/1992) *John Maynard Keynes (vol.1 Hopes Betrayed 1883-1920; vol.2 The Economist as Saviour 1920-1937).* London: Macmillan; Hall, PA (1989) *The political power of economic ideas: Keynesianism across nations.* Princeton University Press.

[49] Keynes, JM (2003) *The general theory of employment, interest and money [electronic resource].* The University of Adelaide Library eBooks @ Adelaide. eBooks @ Adelaide.

collective action to achieve goods that will not eventuate if the public sector does not make them.

The 1970s saw a revival of neo-classical economics - combined with a neo-conservative social movement. The shift away from the Keynesian welfare state has also seen a greater separation of *economic policy* from *social policy*. This has implications for public health. Much of the improvement in health (measured as a reduction in mortality) in developed countries has resulted from measures that can be included under the rubric of *social policy*. The separation of economic policy and social policy places economic objectives, narrowly defined as growth in GDP by the means of efficiently operating markets, at the forefront and assumes that the role of social policy is to deal with any residual social problems which arise. The market is assumed to be the best way of providing goods and services (note the absence of non-marketable goods), leaving social policy performing a safety net role through the provision of benefits and entitlements in what is referred to as the welfare state. The *Australian Settlement*[50] from 1903 and the post-WW2 period of Keynesian domination of Western policy-making represents the short period of history in which the economic and the social were seen as interlinked.

In Australia, this melding of the economic and the social was in the form of a social contract, which has been termed protectionism[51]. Protectionism had two strands. The first of these was industrial protection, which consisted of two elements. The first of these elements was protective tariffs that promoted the development of (usually) industrial sectors. The second was provisions to ensure that some sharing of the benefits of tariffs flows through to the whole community, not just capital. This took the form of minimum wages and working conditions embedded in industrial awards under an umbrella of a centralised wage-fixing system. The Harvester Judgment was the first of these, giving effect to an assumption that Australia was sufficiently wealthy to guarantee all families with a male breadwinner an income sufficient to keep them in decent comfort. Justice Higgins set the minimum weekly wage based on the normal needs of the average

[50] Kelly, P (1992) *The end of certainty: the story of the 1980s.* St Leonards, NSW: Allen & Unwin.
[51] Ibid.

employee, regarded as a human being living in a civilised society, which might encompass civilised habits, frugal comforts, decent shelter, decent partitioned rooms, fresh air, water to wash in, enough wholesome food and provision for rainy days. The Harvester judgement was based on a principle that every Australian was entitled to every single one of these standards, every day of their lives and that if the nation did not endorse this, it could not claim to be a civilised society. Thus, protectionism can also be considered as a response to the decimation of labour during the 1890s.

The second strand of protectionism was the program of pensions and benefits available to eligible persons. The first of these was the aged persons' pension in 1908 but in Australia the public sector had always been an important player in the provision of charity for relief from poverty. For a brief period this was private charitable subscription in the English manner, dispensed to the *deserving* poor, but as early as 1828, the New South Wales Benevolent Society derived almost three-quarters of its annual revenue from the colonial government, which had also provided the funds to build the Society's asylum in 1821.[52]

The social democratic principles that were reflected in State-supported benevolence, protectionism, aspects of the Australian Constitution and the Harvester judgement were not inconsistent with classical liberalism[53] but were inconsistent with neo-liberalism. Neo-liberalism is a combination of 18th century liberalism and social conservatism and is concerned mainly to preserve negative liberty – the freedom from unreasonable constraint to act as one would wish, consistent with not inhibiting the exercise of similar freedom by others. This is distinguished from positive liberty, which also stands up for the opportunity to exercise free will. Proponents of positive liberty would support the provision of goods such as education, health care and minimum income to ensure the possibility of a minimum level of autonomy for all. Whereas positive liberty

[52] Garton, S (1990) *Out of Luck: Poor Australians and Social Welfare.* "Allen & Unwin, North Sydney, Australia". 44.
[53] Sawer. The ethical state: Social liberalism and the critique of contract.

sustains the values underpinning the public health position negative liberty does not.

The dominance of negative liberty and of neoclassical economics in contemporary policy discourse about the role of the public sector, which marks the audit commission reports, is examined in detail in Chapters 5 & 6. In the context of this dominance, decisions about economic and social policy are seen to be a balancing act between *spending now* or *spending in the future* and *We are mortgaging our children's future* becomes an easy mantra. The response has manifested in a reluctance to use government intervention in the economy for economic stabilisation purposes, especially through fiscal policy. A second characteristic is the commitment to a *small government* rhetoric coincident with only a minimal decrease in the level of government spending as a proportion of GDP over this period. The third characteristic is a withdrawal of government support for the welfare state and the fourth has been the introduction of *market forces* into sectors previously dominated by government activity, especially in education, health and employment and, to some extent, aged care. Once seen as an investment, those goods are viewed, now, as consumption.

Conclusion

Neo-classical economics has emerged as the dominant economic paradigm of the late-20th century and health economics has developed as a branch of human resource economics, which has its roots in neo-classical economics (welfare economics). Public health has objectives that presume certain activities in pursuit of positive liberties and depend upon associated expenditures that fall outside the assumptions which neo-classical economics makes about the world. In particular, public health is concerned with collective actions to improve health and places significant importance not just on the level of health, but its distribution across the population as a normative matter. Most of the writing in health economics has concentrated on markets in health care. The application of economic ideas to health production and the non-market mechanisms upon which it depends as well as economic analysis of the collective problems of public health have received

much less attention. As it stands, neoclassical economics is not only inadequate for dealing with many public health questions; it is also potentially antithetical to it.

Chapter 3: Institutional Economics

Introduction

Mainstream economics has taken a narrow view of what constitutes *health economics* and has inherent features that limit its ability to deal with issues of importance in public health on their own terms. It is able to explain some aggregate behaviour, but its ability to theorise about collective matters that may be of concern to public health is limited so long as it is bound up with methodological individualism. In this chapter I describe the detail of institutional economic theories and discuss their potential usefulness for understanding issues that are relevant to public health from an economics perspective that is compatible with a public health perspective. Institutional economics, which rejects methodological individualism and subscribes to instrumental value theory, may provide an approach to economics questions in public health that is more compatible with a public health approach. Institutional economics encompasses a number of heterodox schools of economic thought and one that is more orthodox. This orthodox strand of institutionalism accepts those neo-classical assumptions about the world that were identified in Chapter 2 as being problematic for health care and public health. The heterodox and orthodox strands are referred to as Old Institutional Economics (OIE) and New Institutional Economics (NIE) respectively.

Institutional Economic Theories

The Audit Commission and the Reports on Ageing drew heavily upon neo-classical economics for their theoretical bases, but Chapter 2 identified a number of reasons why neo-classical economics may have limited saliency for considering health care and public health issues. These reasons included:

- the limitations of methodological individualism and the limited Pareto-optimality of markets,
- the importance in public health of collective considerations, actions and outcomes, compared with aggregate considerations, which predominate in neoclassical economics,
- the centrality in public health of distributive questions which are largely glossed over in neo-classical economics, and
- concern in public health with criteria other than efficiency in individual transactions.

In this chapter I argue that institutional economics is potentially more congruent than neo-classical economics with the worldview of public health. I explore the contribution that institutional economists have made to the understanding of the economy and economic problems; outline the major groupings of institutional economists; consider their potential for application to public health questions and then describe their limited application to date to problems in health care and public health. The potentially different contribution that an institutional perspective can make to the analysis of public health issues, including care for an ageing population, is then contrasted with the perspective of mainstream neo-classical economics.

The history and contribution of Institutional Economists

Work in economics that is recognised as being of the institutionalist school started with John Commons and Thorstein Veblen and Wesley Clair Mitchell. Veblen's work was later synthesised with that of John Dewey by Clarence Ayres. Critical ideas about four areas in particular underpinned the development and separation of institutional theory from mainstream theory: evolution, culture, cultural relativity and instrumental valuing.[1]

Institutional economics was at its height in the 1920s and 1930s and had a number of strands that emphasised:

- the role of technological change in transforming the institutional structure of the economy and the resistance of vested interests to the changing order (stressed by Clarence Edwin and the Texas school);
- the need to use government to meet the new social needs created by economic development and institutional change (emphasised by John Rogers Commons and the Wisconsin institutionalists);
- the concept of empirically based economic theory in which every step in the deductive logic required empirical verification (developed by Wesley Clair Mitchell and the Columbia school)[2]

Anne Mayhew[3] argues that both Veblen (b1857) and Commons (b1862) were heavily influenced by their experience of rapid industrialisation and urbanisation

[1] Mayhew, A. (1987a) The beginnings of institutionalism. *Journal of Economic Issues,* 21: 971-1000 Mayhew has written extensively on the history of institutional economic theory and the history of institutional thought. At the time of writing this piece, she was Professor and Chair of Department of Economics at the University of Tennessee.
[2] Fusfeld, DR. (2000) A manifesto for institutional economics. *Journal of Economic Issues,* 34: 257-265
[3] Mayhew. The beginnings of institutionalism.

in the US. This was accompanied by the rise of large corporations and commercialisation of the economy. They both relied more on the new social science that was emerging, than on earlier traditions of economic thought, or earlier justifications for economic reform. However, while they arrived at similar positions about the approach to inquiry and problem solving, Hodgson argues that Commons work differs from Veblen's in some important respects, not the least, his neglect of the habit-instinct psychology of William James and others; his failure to appreciate the philosophical and other insights of Darwinism; and his insufficient emphasis on extra-legal institutions and self-organisation, and spontaneous orders that do not involve legal rules. Nonetheless, his influence has been wide with Gunnar Myrdal and Herbert Simon, both Nobel Laureates, claiming to have been influenced significantly by him and JM Keynes being 'attracted to his ideas'[4]. Oliver Williamson has repeatedly singled him out on as an *old* institutionalist whose work is close to the *new* institutional economics. However, Anne Mayhew, who works within the *old* tradition, claims Commons as mentor and reported that it was he who encouraged her to study anthropology.[5]

Modern OIE has two research programs of major theoretical significance that are associated with the work of Veblen and Commons respectively. [6] The Veblenian strand gives attention to the concept of a dichotomy between ceremonial and instrumental thinking and behaviour. It focuses on the effects of new technology on institutions and on ways in which interests and social conventions resist change. Change and responses to it are evaluated according to their instrumental value: the extent to which they serve to meets the needs of the community.

The Commons strand concentrates on law, property rights and organisations. Institutions are seen as formal and informal outcomes of conflict resolution and

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[4] Hodgson, G. (2003) John Commons and the foundations of institutional economics. *Journal of Economic Issues,* 37: 547-576. 547.
[5] Kallen, HM. (1931) Functionalism. In *Encyclopaedia of the Social Sciences*. Vol. VI (Eds, Seligman ER and Johnson A) McMillan: New York
[6] Rutherford, M (1994) *Institutions in economics: the old and the new institutionalism.* Cambridge: Cambridge University Press.

the criterion is whether the institution has generated *reasonable value* or *workable mutuality* out of the conflict.[7]

The theme of evolution provided an early distinction between the institutional and mainstream economists. It was a central idea of Veblen's economics,[8] providing an alternative to the static reductionist methods of mainstream economics at the time.

Culture and cultural relativity feature in institutional economics, primarily through the link between culture and institutions, which are inextricably linked. Veblen defined institutions as 'habits of thought common to the generality of men'[9], they have also been defined as 'the regular, patterned behaviour of people in a society and for the ideas and values associated with these regularities'[10], 'socially prescribed patterns of correlated behaviour in which the standards for judging behaviour is set within the institutional framework'[11] and 'collective action in control of individual action; widely prevalent, highly standardized social habits; a way of thought or action embedded in the habits of a group or the customs of a people'[12]. Institutions are features of communities and cultures and the result of cultural evolution. Institutions, the way we think about the world are a matter of custom, and customs vary from culture to culture. The non-teleological stance of institutionalism along with this understanding of institutions as matters of cultural evolution leads to a cultural relativism. There is no a priori reason why one set of institutions should be seen as superior to another.

Not only is pragmatism the philosophical foundation of institutional economics, but also both the early institutionalists and pragmatists were 'strongly impressed

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[7] Ibid.
[8] Veblen, T. (1898) Why economics is not an evolutionary science. *The Quarterly Journal of Economics,* 12
[9] Ramstad, Y. (1994) Veblen, Thorstein. In *The Elgar Companion to Institutional and Evolutionary Economics L-Z.* (Eds, Hodgson GM, Samuels WJ and Tool MR) Edward Elgar: Aldershot. pp. 363-368
[10] Bush, PD. (1994b) Social change, Theory of. In *The Elgar Companion to Institutional and Evolutionary Economics. L-Z.* (Eds, Hodgson GM, Samuels WJ and Tool MR) Edward Elgar: Aldershot. pp. 291-295
[11] Neale, WC. (1994) Institutions. In *Elgar Companion to Institutional and Evolutionary Economics A-K.* (Ed, Hodgson GM) Edward Elgar: Aldershot. 402.
[12] Ibid.

by evolutionary ideas in general and Darwinism in particular'[13]. The link between pragmatism and institutionalism is through the Veblenian strand of institutionalism. Common's work centred on the integration of the law and the functioning of the public sector into economics. In particular, he worked on workplace safety and workers compensation, regulation of public utilities and public payments to the unemployed. His work on workplace safety and workers compensation and the regulation of public policies all resulted in the creation of administration commissions in Wisconsin under the governorship of Robert M. LaFollette Snr.[14]

Veblen was both taught and influenced by the pragmatist philosopher William Peirce, and was both a contemporary and a colleague of Dewey. Their tenures at the University of Chicago overlapped for 8 years between 1894 and 1906 and Veblen and Dewey both served on the Editorial Board and wrote for *The Dial* in New York for fourteen months during 1918 and 1919.[15] In particular, they formed, with Helen Marot, a *Reconstruction Project* – the development of planning for organising economic activity, to utilise the 'unified machinery the war had brought into action'.[16] However, Joost comments that 'two less likely confreres it would be hard to discover outside the environment of a large university'[17]. Veblen had a deeply ambiguous attitude towards pragmatism, even although he was careful to express respect for both Dewey and William James.[18] Clarence Ayres, who had studied both at Chicago, but not until after both Veblen and Dewey had departed, attended to the integration of Dewey's instrumentalism with Veblen's institutionalism.

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[13] Hodgson, GM (1993) *Economics and evolution: bringing life back into economics.* Ann Arbor: The University of Michigan Press. 11.
[14] Website of Thayer Watkins, Lecturer, Department of Economics, University of San Jose. www.sjsu.edu/faculty/watkins/commons.htm accessed on 25 January 2006.
[15] Joost, N (1967) *Years of Transition: The Dial 1912-1920.* Barre, Massachusetts: Barre Publishers. Joost is the author of two books on history of *The Dial*. The other book, published three years earlier, picks up the story after it was bought by Schofield Thayer:
[16] Ibid. 201.
[17] Ibid. 205.
[18] Diggins, JP (1999) *Thorstein Veblen: Theorist of the leisure class*. Princeton, New Jersey: Princeton University Press.

Dewey believed that all human behaviour is underpinned by an appraisal of values, which are themselves subject to appraisal.[19] For Dewey, valuations are social; 'habits of moral deliberation and action are learned behaviour'[20]. Values are the result of social relations, including schooling and social practice. This is in clear distinction to mainstream economics, which takes wants and preferences as given and puts them beyond inquiry.

The third of the founding fathers of institutional economics, Wesley Clair Mitchell, was a student of Veblen and Dewey's at The University of Chicago. He established the National Bureau for Economic Research in the United States and concentrated his theoretical and empirical work on money and the business cycle. His major methodological contribution was in establishing empirical methods for testing theories about business cycles. However, 'few if any present day leaders of institutional economics do or recommend the kind of work which Mitchell favoured'[21].

Institutional thinking in economics

There are two broad streams in modern institutional thinking in economics. One stream, known and the New Institutional Economics (NIE) tends to concentrate on formal institutions, especially those surrounding, for example, property rights or other legal frameworks that are deliberately developed, to deal with market failure. The other stream, known as the Old Institutional Economics (OIE) takes a broader view of what constitutes institutions. In his paper entitled *What is the essence of institutional economics?* Geoffrey Hodgson, who has been a leading scholar of the concept, argues that institutionalism is characterised by five propositions;

> 1. Although institutional economists are keen to give their theories practical relevance; institutionalism itself is not defined in terms of any policy proposals.

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[19] Festenstein, M. (2001) Inquiry as Critique: on the Legacy of Deweyan Pragmatism for Political Theory. *Political Studies,* 49: 730-478

[20] Gouinlock, J. (1992) Dewey, John. In *Encyclopedia of Ethics*. Vol. I (Eds, Becker LC and Becker CB) Garland Publishing, Inc.: New York & London. 260.

[21] Hirsch, A. (1994) Mitchell, Wesley Clair. In *The Elgar Companion to Institutional and Evolutionary Economics L-Z*. (Eds, Hodgson G, Samuels WJ and Tool MR) Edward Elgar: Aldershot. pp. 85-90. 88.

> 2. Institutionalism makes extensive use of ideas and data from other disciplines such as psychology, sociology and anthropology in order to develop a richer analysis of institutional and of human behaviour.
>
> 3. Institutions are the key elements of any economy, and thus a major task for economists is to study institutions and the processes of institutional conservation, innovation and change.
>
> 4. The economy is an open and evolving system, situated in a natural environment, effected by technological changes, and embedded in a broader set of social, cultural, political and power relationships.
>
> 5. The notion of individual agents as utility-maximising is regarded as inadequate or erroneous. Institutionalism does not take 'the individual' as given. Individuals are affected by their institutional and cultural situations. Hence, individuals do not simply (intentionally or unintentionally) create institutions. Through 'reconstructive downward causation' institutions affect individuals in fundamental ways. [22]

Hodgson argues that while propositions 1 to 4 are important in defining institutionalism, they are not sufficient and are also characteristic of other economic schools of thought, including some work done within the mainstream. It is the notion of the institutionalised individual, he argues, that distinguishes institutional economics most clearly from mainstream economics and which distinguishes between OIE and NIE. A major implication of institutional thinking is that it takes the focus away from a behaviourist view of individual people or firms engaged in individual transactions and focuses on the context in which those transactions occur at the same time considering the two-way interaction between individuals and their context, particularly institutions. Downward causation is evident on the effect that institutions have on individuals, in shaping them. Upward causation is evident in the impact that individuals have in creating and changing institutions. The notion of downward causation opens the possibility of the exercise of power not through violence or coercion, but more subtly, by orchestrating the thoughts and desires of others. Attempts by mainstream economists to incorporate culture usually result in culture being included as a term in a preference function, rather than culture being used to explain the shape of the preference function in the first place.[23]

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[22] Hodgson, GM. (2000) What is the essence of institutional economics? *Journal of Economic Issues,* 34: 317-329

[23] See for example Becker, GS (1996) *Accounting for tastes.* Cambridge, Massachusetts: Harvard University Press.

Evolutionary thinking in economics

The application of an evolutionary approach to economics seems to involve a number of advantages and improvements over the orthodox, mechanistic paradigm. According to Hodgson, it pays attention to

> irreversible and ongoing processes in time, with long-run development rather than short-run marginal adjustments, with qualitative as well as quantitative change, with variation and diversity, with non-equilibrium as well as equilibrium situations, and with the possibility of persistent and systematic error-making and thereby non-optimising behaviour[24]

Second, economic systems, like biological systems are highly complex, with intermeshed structures and causalities, which undergo continuous change and display huge variety. This raises the problem of degrees of inclusiveness and complexity and corresponding tiers of abstraction and units of analysis, which has been given some attention by biologists, but none by economists.

Hodgson argues that there has been evolutionary thinking in mainstream economics, but that it focuses the unfolding of genetically predetermined characteristics of individuals. Evolutionary thinking in mainstream economics has also tended to be progressive, assuming that there is a path of improvement upon which evolution travels. This contrasts to the evolutionary thinking of institutional economists that focuses on the non-teleological development of a variety of characteristics in a population (of institutions).

The implication of evolutionary thinking in institutional economics is that it takes the focus away from individual market transactions and looks at the evolution of economies in the context of historical, cultural and social forces. There, again there are two general approaches. One is to assume that evolution is progress towards an optimal situation, as has generally been the approach in mainstream economics. The second, more Darwinian approach, does not assume that evolution leads to superior arrangements, only to arrangements that are better adapted to their circumstances. One implication of this is recognition that arrangements that evolve in one set of circumstances may be inappropriate in

[24] Hodgson *Economics and evolution: bringing life back into economics.* 32. p32

another. In addition, those of a more Darwinian bent recognise that arrangements that evolve through natural selection in one set of circumstances will not be well *adapted* in a different set of circumstances, and will not develop to their potential.

The main schools of institutional economics

Having outlined the general features of institutionalism that seem relevant to the limitations of mainstream neo-classical economics in its application to problems in public health and health care, it is reasonable to examine in turn each of the two main groupings of institutional economists in order to estimate the extent to which they appear to address these shortcomings. Each of the so-called Old Institutional Economic (OIE) Theories and the New Institutional Economic (NIE) Theories are considered here in terms of their history, theory and methods, and potential for public health. Potential for public health is considered with reference to the extent to which the theories address the critique of the neo-classical approach that was outlined in Chapter 2.

Old Institutional Economic theories (OIE)

Whereas NIE is confined to microeconomic or market approaches to dealing with social and economic problems, OIE has strands of study across both microeconomics and macroeconomics. Institutional economics has its beginnings in the American Institutionalist School that emerged in the United States in the late 19th century. Its foundations lie in the work of Thorstein Veblen, Clarence Ayres, John Commons and Wesley Mitchell. A common link between these Old Institutionalists was that their work emerged out of a critique of orthodox conception of human nature and the presumption that individuals can be taken as given.[25] This orthodox conception treats human nature as fixed, and exemplified by *Homo Economicus*; rational economic man, who calculates the costs and benefits of all his options before making a choice that maximises the satisfaction of his preferences.

[25] Hodgson, GM. (1994a) Institutionalism, 'Old' and 'New'. In *Elgar Companion to Institutional and Evolutionary Economics A-K*. (Eds, Hodgson GM, Samuels WJ and Tool MR) Edward Elgar: Aldershot

The American Institutionalist School, typified by Thorstein Veblen, rejected universalist theories of the Classical and Neo-classical Schools, stressing the importance of historical, social and institutional factors upon which economic *laws* are contingent. Their main contribution was to use history and institutions to explain economic behaviour, structures and patterns. While active in the US into the 1930s, they were overtaken by the Keynesians in their role as heterodox critics of the neoclassical orthodoxy, partly because they retreated to empirical measurement of business cycles, rather than concentrating on theoretical and methodological development. More recently, their approach is embodied in the work of John Kenneth Galbraith and Robert L Heilbroner, both of whom accepted lifetime achievements awards from the peak body for institutional economics in the United States.

Economists who constitute the old school of institutional economists follow Veblen's lead in placing emphasis 'both on the processes of economic evolution and technological transformation, and on the manner in which action is moulded by circumstances'[26]. The Association for Evolutionary Economics has outlined what they describe as the *tenets of institutionalism*, which are outlined in Table 3.1

This approach clearly is more holistic than the neo-classical approach. In particular, it concentrates on social and cultural processes other than those that are proximal to individual market transactions, it is concerned with solving real-life policy problems, it considers the interaction that different parts have on each other and on the whole and it recognises issues of power and democracy in the analysis of economic problems.

Old institutional theories represent a relatively diverse group of theories that do not all share a common set of assumptions in the way that neo-classical economics can be considered to do so. What they do have in common is the choice of institutions rather than individuals as their unit of analysis, evolutionary approaches rather than equilibrium theorising and recognition of the importance

[26] Ibid.400.

of circumstances in shaping actions.27 An understanding of institutions makes it possible to understand some of what motivates individual behaviour by reference to the rules governing the particular institutional situation that is under study. This contrasts to the neo-classical approach that places human motivations squarely within the individual.

Table 3.1: The Tenets of Institutionalism[28]

NOTE: This table is included on page 49 of the print copy of the thesis held in the University of Adelaide Library.

OIE deals with collective phenomena chiefly by considering the use of institutions as the analytic unit. The various definitions of *institution* emphasise regularities or patterns that can be observed in human behaviour, which are governed by social rule. These social rules are underpinned by people's values and their systems of beliefs. The interrelationships between these institutions and the sum of the rules, values and beliefs that govern them are a culture.

Institutions vary between societies and over time and are specific to time and place. There is nothing *natural* about any particular institution. They evolve with

27 Ibid.; Rutherford *Institutions in economics: the old and the new institutionalism.*
28 Source is Association for Institutional Economics. Tenets of Institutionalism. Accessed at http://www.orgs.bucknell.edu/afee/afit/about_institutionalism.htm. Accessed on 15 March 2006

and are the product of societies. Once in existence, they, in turn, shape the future development of societies. Thus, institutions and the rules that govern them are the product of collective, ongoing activity in developing and defining rules. They also shape, to some extent (but do not determine), the rules that will be developed in the future. The existence of institutions is used by OIEs mainly to explain individual action but also suggests a field of inquiry as to the social processes from which they emerge. The NIEs explain the existence of institutions being the result of attempts to solve specific (especially market failure and information) problems. However, not all institutions are conducive to the smooth working of markets. Institutions clearly may serve a range of societies' objectives, but may also undermine them. Understanding the origins and operations of institutions may be useful in exploring questions of the workings and impact of collective mechanisms in a society.

Neo-classical economics has little to say about distributional arrangements, except to the extent that generally, the distribution of income that results from perfectly competitive markets in a freely operating economy generates a pareto-optimal distribution of resources. OIE theories, by contrast, consider the extent to which differentials in power can influence distributional arrangements. For OIEs, 'distributional arrangements are not primarily market phenomena, but are determined by the conscious decisions of persons with power to do so'[29].

Unlike neo-classical economics which treats inequalities as an outcome of the scarcity of natural and other resources, or essential to generate the savings needed for investment, OIEs consider resources and their distribution to be a cultural phenomenon, a function of both technical knowledge and of human wants.[30] OIEs reject the neoclassical explanation and justification for inequalities and argue that, from the perspective of instrumental value theory, inequality inhibits economic

[29] Peach, JT. (1994) Distribution Theory. In *The Elgar Companion to Institutional and Evolutionary Economics A-K*. (Eds, Hodgson GM, Samuels WJ and Tool MR). 167.
[30] Ibid.

progress because it causes deprivations of genuine economic choices and impairs the instrumental efficiency of significant portions of the community.[31]

As to distributional issues, OIE would appear to share some common ground with public health inasmuch as inequalities in health matter and can be detrimental overall. Following the work of Galbraith, one implication for the consideration of collective action could be the role of the public sector in forming institutions, in contrast to the presumption that rational individuals in aggregate spontaneously generate institutions.[32] In particular, it raises the question of what role the public sector might take in developing countervailing institutions against the power to influence to the distribution of resources, especially in view of the monopolising tendency which modern capitalism has shown in the post- WW2 period. OIE creates a window for collective action through interventionist policies, whereas NIE offers no new approaches to the issue, beyond those provided by neoclassical economics.

New Institutional Economics

The New Institutional Economics (NIE) school refers to the collection of schools of thought that seek to explain political, historical, economics and social institutions such as government, law, markets, firms, social conventions, the family, etc in terms on neoclassical economic theory.[33] Its predecessors are claimed to be the American Institutionalist School, the English Historical School and the Chicago School.

Typically, new institutional theories focus on the narrow role of institutions as a means to deal with market failure, for example, transaction costs. In this view, institutions are the result of purposeful decisions by rational actors. They exist because they allow the economic system to function more smoothly. Alternatively, these theories treat institutions only as a constraint on individual behaviour.

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[31] Tool, MR (2001) *The discretionary economy: A normative theory of political economy.* New Brunswick, N.J. and London: Transaction.
[32] Galbraith, JK. (1954) Countervailing Power. *American Economic Review,* 44: 1-6
[33] From *The New Institutionalist Schools* at http://homepage.newschool.edu/het/ accessed 28/8/01.

New institutional economics includes the work of Coase who argued that firms should be conceived as entities that are endogenous to the economic system and whose existence is justified only in the presence of transactions costs to production. Firms and other economic organisations and institutions, in effect, exist because agents find them a useful manner of minimizing transactions costs.[34] Another prominent NIE is Oliver Williamson who builds on Coase's theory and conceptualizes the firm as a governance structure that orders individual priorities into collective ones so that its hierarchy is a substitute for costly transactions of the market. In neither case are the basic propositions of mainstream economics substituted by those of institutional economics as outlined by Hodgson, especially his fifth proposition

New institutionalist economists accept the essential methodological individualism of neo-classical economics.[35] They see institutions as providing only external constraints, conventions or openings to individuals who are taken as given, atomistic entities. They do not consider the possibility that social institutions may actually shape individuals. For example, one prominent new institutionalist theme is 'to explain the existence of political, legal or more generally social, institutions by reference to a model of individual behaviour, tracing out its consequences in terms of human interactions'[36]. Some of these theorists have moved away from neo-classical assumptions, including recognition of information problems and avoiding equilibrating models. However, they maintain the same basic liberalism and determinism that characterises neo-classical economics. In the new institutionalism, individuals are regarded as being basically the same throughout time: while they respond to their circumstances, they are not shaped by them.

This element of institutional theory does not represent the alternative view of economic phenomena that is inherent in the old institutional theories. NIEs do not question, fundamentally, the pareto-optimality of markets. An example of this is Ronald Coase's work on pollution externalities and tradeable property rights on

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[34] Coase, RH. (1937) The Nature of the Firm. *Economica,* 4: 386-405
[35] Rutherford *Institutions in economics: the old and the new institutionalism.*
[36] Hodgson. Institutionalism, 'Old' and 'New'. 399.

scarce resources.[37] Where Pigou recommended pollution taxes to reduce the external costs of pollution to a socially efficient level, Coase proposed placing property rights on pollution and to allowing market mechanisms to decide how the right to pollute will be used, or withheld by its owner. Pigou's solution entailed information problems that would lead to potentially large transactions costs and Coase argued that his solution overcame these. Nonetheless, his is a market solution based on the values and assumptions of neo-classical economics.

The methodological individualism of NIE means that 'the individual, along with his or her assumed behavioural characteristics, is taken as the elemental building-block in the theory of the social or economic system'[38]. Thus, all phenomena can be studied in terms of individuals, rather than in terms of groups or communities. Even in the study of externalities, which can be considered as a collective problem, NIE is interested in how *rational individuals* will resolve the existence of an externality. This is in line with the general approach of neo-classical economics.

Coase's work on pollution externalities (described in the previous section) illustrates this. His preferred solution is one in which difficulties are resolved at an individual level. Coase's proposal takes the solution of social problems out of the public realm into the private, with the solution being their resolution by individuals acting rationally, rather than through collective resolution. The need to negotiate at a community level, proposed in Pigou's solution, is replaced by negotiation at an individual level. There is little evidence in their work that distributive issues concern NIEs: in Coase's work on pollution, for example, it matters not to whom the tradeable property rights are assigned, so long as such assignment of rights results in the socially efficient amount of pollution.

NIE does little to move beyond the basic assumptions of neo-classical economics. Its recognition of information problems and partial eschewing of equilibrium theories does not seem to alter its basic character as orthodox within the neo-classical tradition. NIE does not move away from methodological individualism, it

[37] Tradeable property rights are now a feature of the distribution of water in agriculture and horticulture in many of Australia's water catchments.
[38] Hodgson. Institutionalism, 'Old' and 'New'. 397.

accepts markets as the appropriate form of social interaction for dealing with the problems it has studied and does not recognise distributional questions as relevant ones for study.

Comparison of the Old and New Institutional Economics

The context in which individuals and institutions co-evolve can be cultural, social, political or historical. This is more congruent with the approach of public health, which, rather than concentrating on disease in individuals, asks questions about the extra-individual factors that affect the health of groups of people. Rutherford's dichotomous distinction between neo-classical and institutionalist approaches, outlined in Table 3.2 makes this clearer. His work refers to the charges leveled at each other by the New and Old Institutional Economists. The OIEs have their roots in Veblen and Ayres' notion of institutions as characteristics of societies. The NIEs study market failure and are interested in studying institutions by reference to a model of rational individual behaviour. Rutherford's point, here, was that the two broad groupings of institutionalists recognise their differences. The following table outlines the critical charges they make of each other but I will argue, later, the NIEs differ little from mainstream neo-classical economists.

The dichotomy is useful for contrasting the general approaches of the two groupings of economists and highlighting where traditional institutionalism may have methodological approaches that are both more congruent with public health approaches, and which may address some of the limitations identified in the mainstream economic thinking on public health and health care issues.

Table 3.2: Criticisms charged by Old and New Institutional Economists against each other. [39]

NOTE: This table is included on page 54 of the print copy of the thesis held in the University of Adelaide Library.

39 Adapted from Rutherford *Institutions in economics: the old and the new institutionalism.*

The first criticism of the OIE by the NIE probably arises from the focus on empirical measurement of business cycles by the early institutional economists. However, institutional economists do also work with formalist theories and models. In the early years of the twentieth century, the contribution of institutional economists was largely theoretical, was based on a conception of the economy and of economic behaviour different from that of mainstream economics at the time. In addition, OIE does not rely as heavily as mainstream economics does on the formal modelling, for which mainstream economics has become notorious. Formalism in NIE, as in mainstream economics, takes its shape in three elements. [40] The first is the wholesale use of mathematical symbolism to express the propositions of economic theory in what is alleged to be formally rigorous manner. However, the theory of measurement that underpins this mathematics was never intended to deal with the problem of translating scientific propositions into formal symbolisms. The second element is the application of the techniques of mathematical reasoning, valued for its explicitness, precision and rigour, to derive certain kinds of conclusions. However, the deductive validity of the formulae is questionable as many of the assumptions upon which the models turn lie outside the range of mathematical expression and deduction and thus receive no explicit expression within the models. The third element is the view that patterns of economic behaviour are inherently quantifiable and law-like in their uniformity. However, this presumption has been criticized widely for its characterisation of human nature as a purely calculating mechanism, to which economic reality is unlikely to conform. As OIEs are interested in understanding real economic systems, they see limited value in formal methods.

The second element of difference is linked to the first and involves the extent to which each takes a holist or a reductionist approach. A reductionist approach is that it allows a single attribute to be studied in isolation, permitting its specific characteristics or contribution to be identified. The difficulty with such an

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[40] Dennis, K. (1994) Formalism in Economics. In *The Elgar Companion to Institutional and Evolutionary Economics*. (Eds, Hodgson GM, Samuels WJ and Tool MR) Edward Elgar: Aldershot. pp. 251-256

approach comes when single attributes neither occur nor operate in isolation. When this happens, there can be some doubt as to the validity of any findings that do not take into account these interactions. NIE tends to be reductionist, whilst OIE tends to holism, it claims, because it is concerned with understanding how a system actually works, rather than prediction. It tends, therefore to concatenated models that link together the elements of a system and are more suited to describing actual economic systems.

The third level of difference involves the assumption that is made about the origins of human behaviour. NIE and mainstream neo-classical economists subscribe to the rational choice assumption that rational actors behave in ways that maximise the satisfaction of preferences and that this action follows rationally from the beliefs and desires of the actor concerned.[41] This approach goes on to assume that giving effect to these desires yields an optimal outcome in most situations. OIE does not deny that rationality exist but insists that matters other than their self-interest influence decisions by humans. One of Veblen's enduring ideas is that of institutions as 'habits of thought common to the generality of men' provide an alternative framework for understanding human behaviour. Institutions provide the basis for decision-making that does not need to assume rationality. People's decisions are also influenced by their understanding of matters of right and wrong and of how the world is or should be. Their decisions about behaviour reflect their institutionalised understanding of the world and of the range of choices that are legitimate.

The fourth criticism relates to the degree of individualism and collectivism evident in each strand. Collectivism in OIE refers to collective ownership of technology and to the processes of collective decision making, rather than individual economising. For Veblen 'technology, a product of the instinct of workmanship, forms the "joint-stock" of human knowledge and continually evolves as a "living structure" while it is passed down through the generations'[42], rather than the

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[41] Hindess, B. (1994) Rational Actor Models. In *The Elgar Companion to Institutional and Evolutionary Economics*. (Eds, Hodgson GM, Samuels WJ and Tool MR) Edward Elgar: Aldershot
[42] Eby, CV. (1998) Veblen's Assault on Time. *Journal of Economic Issues,* 32: 689-707. 690.

property of individuals. In NIE, individualism is evident in the application of methodological individualism and in economic individualism.

These differences in methodology between OIE and NIE are mirrored by the differences between OIE and mainstream economics. Mainstream economists use formal models and reductionism, and make assumptions about behaviour partly because it sustains their quest to make predictions. A standard element of undergraduate economics education is to read Friedman's paper which argues that economics should be judged by the accuracy of its prediction (rather than the realism of its assumptions), because prediction is what matters.[43] By doing so, individuals as buyers can be shown to behave *as if* they work on self-interest and indifference maps and firms can be shown to act *as if* they produce until marginal cost is equal to marginal revenue. However, both what goes on inside the head of an individual or of a firm, and the environment in which it happens, is largely a black box. Prediction is possible because the models are pared down to represent a single strand of behaviour, primarily the effect on quantity demanded of a change in price. This tells us nothing about what other stimuli are important in economic behaviour, or what other effects stimuli, including a change in price, have on behaviour outside that to be predicted by single formal model.

Old institutional economists are more concerned with developing understanding than prediction. Economic systems are seen as context-specific and unlikely to yield universal laws that allow global predictions. Mainstream economists assume away many of the elements of an economic system or situation that institutional economists are interested in understanding. In addition to using formal models, institutional economists also use participant observer methods to develop concatenated models based on pattern modelling techniques.[44]

Finally, mainstream economists tend to argue against government intervention on two grounds. First, they argue, markets work well to provide an efficient allocation of resources to produce the goods and services that individuals value

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[43] Friedman, M (1953) *Essays in positive economics.* Chicago University Press. 3-4
[44] Wilber, CK and Harrison, RS. (1978) The Methodological Basis of Institutional Economics: Pattern Model, Storytelling, and Holism. *Journal of Economic Issues,* 12: 61-90

most. Second, even when there is market failure, government is not infallible, and government failure is a likely outcome of government intervention. For OIEs, the market is but one institution that plays a part in provisioning. Government is not simply umpire and rule enforcer, but an integral player in the economy.

The problems presented to those working from a public health perspective that the formalist, reductionist, rationalist, individualist, anti-interventionist approach creates have been discussed in Chapter 2. Rutherford's comparison of NIE and OIE with respect to their methodology indicates that OIE is less constrained in both its theoretical framework and its methodology. This provides scope to consider a broader range of aspects of an economic (or public health) system in its modelling and to accept as legitimate a more diverse set of arrangements for delivering economic and public health goods.

Contemporary contributions in field relevant to public health

In order to consider the contributions of institutional and evolutionary economics that are relevant to thinking in public health, it is necessary to define the territory that is the legitimate purview of public health. In Chapter 2 I argued for a wide definition based on the elements of public health that are discernible from WHO publications on public health, including economic and social development, the distribution of wealth and income, provision of health care services and the role of government as the mediator of collective activity in these three activities. Veblen sought to explain social change as the evolutionary process of *cumulative causation*, which he described in terms of the impact of *technology* on institutions. He emphasised the difference between behaviour that was based on *invidious* distinctions, reflected in *ceremonial* behaviour (for example class and caste systems that provide differential advantages) from that which was not, reflected in behaviour that benefits the community at large without regard to status or differential advantage.[45] The impact of technology depends upon the impact it has upon institutions. However, the way in which institutions adapt is also a matter of human volition.

[45] Bush. Social change, Theory of.

The development of institutional thinking on social development has culminated in Tool's formulation of the *social value principle* in which 'progressive institutional change occurs when the instrumental use of knowledge provides for the continuity of human life and the non-invidious recreation of community'[46] This principle clearly has implications for economic as well as social change and is discussed in more detail in the later section on the role of government.

In relation to inequalities in income distribution, which is a relevant matter in current debates about the social gradient in health status, institutional economists argue that the instrumental view, that 'an effective income distribution is one that sustains continuity and restrains invidiousness'[47], is violated by income distributions which create social exclusion. Thus, effective economic policy begins with a recognition that the economy is an evolving set of institutions engaged in the process of providing for the material needs of its members and that the purpose of economic inquiry is to provide the tools to guide this process toward outcomes that promote the full participation of all individuals and the non-invidious re-creation of community.[48]

Provision of health care

Published work on health care provision that used an institutional framework comes mainly from the NIE tradition. Preker et al.[49] propose a conceptual framework in which a combination of institutional economics and organisational theory is used to examine the core production activities in the health sector, with a view to making recommendations about whether health care organisations should make or buy services. They argue that most inputs for the health sector, with the exception of human resources and knowledge, can be efficiently produced by and brought from the private sector, therefore, with a strong regulatory environment and skilled contracting mechanisms, governments can unbundled and outsource

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[46] Ibid.295.
[47] Stanfield, JR. (1984) Social Reform and Economic Policy. *Journal of Economic Issues,* 18: 19-44. 23.
[48] Peterson, J. (2001) The Policy Relevance of Institutional Economics. *Journal of Economic Issues,* 35: 173
[49] Preker, AS, Harding, A and Travis, P. (2000) "Make or buy" decisions in the production of health care goods and services: new insights from institutional economics and organizational theory. *Bulletin of the World Health Organization,* 78: 779-790790

subsidiary activities within the production process. Preker and Harding argue that the developments most relevant to understanding different arrangements for service delivery derive from principal/agent theory, transaction cost economics, property rights and public choice theory, all fields that they categorise as institutional economics. Each of these sits within the framework of mainstream economics in as much as they rest on rational actor models and are part of the NIE.[50]

Palmer et al[51] used an NIE framework to assess the likely success of contracting out arrangements in low and middle-income countries. They consider factors such as poorly developed institutional capacity, a shortage of administrative and contract writing skills and poorly developed markets.

Stephen Jan examined the implication that the NIE approach has for the evaluation of Programme Budgeting and Marginal Analysis (PBMA) in health care,[52] and discussed the importance of understanding the institutional context in which resource allocation decision making occurs, as this 'provides among other things, a broader appreciation of the incentive compatibility of various initiatives'[53].

Jan has also applied the OIE to the economic evaluation of health programs.[54] In this paper, he argued that the reductionism of conventional forms of economic evaluation, where value (or benefit) is seen in terms of either health consequences or individuals' utility, can cause aspects of such programs, such as health-enhancing changes to the socio-political environment, to be overlooked. In contrast, he argues, OIE theory, in common with the community development

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[50] Recent evidence suggests that, in the UK at least, the NHS has neither the regulatory environment nor the requisite contracting skills to do so without a health care cost blow-out.
[51] Palmer, N. (2000) The use of private-sector contracts for primary health care: theory, evidence and lessons for low-income and middle-income countries. *Bulletin of the World Health Organisation,* 78: 821-829
[52] Jan, S. (2000) Institutional considerations in priority setting: Transactions cost perspective on PBMA. *Health Economics,* 9: 631-641
[53] Jan, S, Dommers, E and Mooney, G. (2003) A politico-economic analysis of decision making in funding health service organisations. *Social Science & Medicine,* 57: 427-435
[54] Jan, S. (1998) A holistic approach to the economic evaluation of health programs using institutionalist methodology. *Social Science and Medicine,* 47: 1565-1572

approach to health promotion, is an area of research that acknowledges that change to the broader socio-political environment can be a source of value and that a greater receptiveness to broader sources of social value can help to improve the way evaluations are conducted.

Lawson, a bioethicist has argued that early writings in OIE have salience for modern bioethics in dealing with ethical dilemmas that have scope beyond individual patients. For example, questions of resource allocation to, and in, the health system are currently dealt with in terms of fairness and non-discrimination for patients, rather than an analysis of how health systems take the shape that they do.[55]

William Hildred, Professor of Economics at Northern Arizona University has co-authored two papers on economic evaluation in healthcare.[56] In these papers, Hildred and his co-authors argued that methods for economic evaluation in health care are contrary to Dewey's instrumentalism because they erect barriers to participation in democratic policy development, and because, due to their technical and conceptual shortcomings, they do not contribute warranted knowledge to the democratic dialogue.

The contributions by Jan and Hildred on economic evaluation, Jan on resource allocation decision-making, and Lawson come the closest to addressing the concerns of this thesis, but within a comparatively narrow perspective. Jan's and Hildred's discussions are limited to methods for economic evaluation, and Lawson confines her discussion to the health care system.

The role of the public sector

The old institutionalist view of the role of the public sector arises from the recognition that modern, large-scale production methods required by modern technology made the models of competitive markets and the assumptions

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[55] Lawson, CL. (1998) The second stage of bioethics and institutional economics. *Journal of Economic Issues,* 32: 985(1)

[56] Hildred, W and Beauvais, F. (1995) An Instrumentalist Critique of `Cost-Utility Analysis'. *Journal of Economic Issues,* 29: 1083-1096; Hildred, W and Watkins, L. (1996) The Nearly Good, the Bad, and the Ugly in Cost-Effectiveness Analysis of Health Care. *Journal of Economic Issues,* 30: 755-775

surrounding them untenable. In particular, the assumption of a large number of small competitors became shaky. In the absence of the conditions for *perfect competition*, critical monitoring of all market allocation would be required.

Conventional economics recognises a role for the public sector. The public finance stream of mainstream economics that deals with the public sector, maintains that the goal of pareto optimality obviates the need for a public sector, except in specified areas (maintenance of law and order, definition of property rights, modification of property rights and the rules of the economic game, adjudication in disputes about the interpretation of rules, enforcement of contracts, promotion of competition, provision of a monetary framework, engagement in activities to counter monopoly and overcome serious externalities, and supplementation of private charity in protecting the vulnerable).[57] Each of the items on this substantial list serves to support the smooth operation of markets. Mainstream economists recognise that individual economies may opt for additional public goods and services for reasons that either violate the rules of efficiency, based on notions of equity which defy *rational* analysis, or are otherwise defined to be outside the neo-classical analytical framework. Government failure, it is argued, is as likely to occur in the public sector as is market failure in the private, so the effort in the public sector is called into question before it has been put into operation.

In addition to the narrow, conventional criteria, institutional economists also recognise that the development of power throughout the economy is always a factor in the way resources are directed. Concentrated power has profound implications for *higher efficiency*. But technology-related departures from structurally pure competition, such a monopoly create a role for the public sector in monitoring of resource allocation. 'The public sector is defined by that optimal role the government can play in moving resource allocation along towards optimal fulfillment of all these criteria.'[58] That is, the traditional efficiency criteria

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[57] Friedman, M (1962) *Capitalism and freedom.* Chicago: University of Chicago Press.
[58] Klein, PA. (1994) Public Sector, Role of the. *The Elgar Companion to Institutional and Evolutionary Economics L-Z,* 2: 194-200. 196. At the time of writing this piece, Klein was Professor (now Emeritus) of Economics, Economic Cycle Research Institute at Pennsylvania State University. He has published widely on Institutional Economics and Business Cycles.

is not sufficient, and the public sector may have a role even if it does not explicitly improve efficiency, narrowly defined.

Institutional economists were part of the original move in the United States to regulate industry. They argued that monitoring is required to detect areas in which private resource allocation conflicts with evolving values of the community. Instrumental value theory suggests ways of judging whether market allocation needs regulation in order to be socially optimal.[59] Later institutional economics have drawn upon the work of John Dewey in developing their theory of valuation. Dewey believed that all human behaviour is underpinned by an appraisal of values. Valuations are social, involving interrelations among persons, and characterizing conditioning and patterning modes of behaviour. This is in clear distinction to mainstream economics, which takes wants and preferences as given and puts them beyond inquiry.

Provision of public goods

Both mainstream and institutional economists agree that there is a role for government in providing public goods, in promoting market efficiency (eg regulation of monopoly) and in dealing with problems of externality.[60] Institutionalists quest for higher efficiency may also involve the public sector in two further functions - making direct expenditures and acting as a guarantor of minimal societal welfare standards for all individuals. For mainstream economists, welfare standards involve non-economic criteria. For institutionalists, *social* indicators may be subsumed under economic indicators because they are part of what determines the character of the economy.[61] For institutionalists, the public sector plays a crucial role in transmitting emergent value to economic performance. Even Milton Friedman allowed that, as participant in public debates, the public sector plays rule maker and umpire but institutionalists would cast the public sector as player and manager as well.

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[59] Ibid.
[60] Tool, MR. (1994a) Dewey, John. In *The Elgar Companion to Institutional and Evolutionary Economics A-K*. (Eds, Hodgson GM, Samuels WJ and Tool MR) Edward Elgar: Aldershot. pp. 152-157
[61] Klein. Public Sector, Role of the.

> The public sector is a critical link between the economy as merely a market allocation mechanism and the economy as governing the total resource allocation in the services of the process of valuation, which is the ultimate task of the economy[62]

Conclusion

Institutional economics encompasses a growing group of economists with diverse approaches to questions that involve institutions. One group in particular, the new institutional economists, are unlikely to offer insights into economic problems in public health and health care that are different to those offered by mainstream neo-classical economists. Indeed, NIE turns institutionalism on its head by using 'Neoclassical economics to explain history, social relations and the formation of institutions rather than the other way around, as the old Institutionalists proposed, of using history and institutional concerns to explain economic behavior, structures and patterns'[63]. They do not really provide an alternative to neoclassical explanations as they use neoclassical explanations to explain history, social relations, and the formation of institutions, rather than giving institutions explanatory status. Thus, they do not offer any prospect for addressing the limitations of neoclassical theory with which this thesis is concerned and will not be pursued any further.

The OIE appears to work with theories and methods that provide new frameworks in which these problems might be more productively analysed. Some institutional economists have argued that the approach of the OIE and the notion of the institutionalised individual are not incompatible with mainstream economics and may be complementary to it. OIE appears to have the potential to address the concerns outlined in Chapter 2 about the application of mainstream economics to questions of public health. It is appropriate then, to examine the application of mainstream economics to population ageing and the role of government, as the questions of public health importance, in order to detail the specific shortcomings of the mainstream approach.

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[62] Ibid. 200.

[63] This neat description comes from the History of Economic Thought Website managed from the New School for Social Sciences: http://homepage.newschool.edu/het/ last accessed on 15 February 2006

Chapter 4: Mainstream economics and population ageing

Introduction

The previous chapter provided a systematic account of ideas in institutional economics as a counterpoint to the present prevalent system of neoclassical economics. That account was offered as part of a wider argument that public health activities, including the care of ageing and aged people, presumes a detailed, contextual account of the population involved and that evolutionary and institutional economics is more responsive to matters of context than are neoclassical approaches.

This chapter considers the current application of mainstream economic ideas to population ageing, using various audits by Australian public agencies as a museum of relevant specimens. The dominant school of economic thought is widely referred to as neoclassical economics. The ideas and approaches from this school prevail in economic research and policy on population ageing in Australia. An analysis of the products of the neoclassical approach suggests that there are inadequacies both in its basic approach and in its application to the specific issue of population ageing. A critical review of a broader range of evidence indicates that the results of this approach (including conclusions that have been drawn from first principles, rather than tested empirically) are potentially misleading and could prescribe policies that do little to address the real economic issues that population ageing may bring. A direct examination of these reports highlights a number of empirical shortcomings, while examination from a public health perspective highlights their underlying theoretical shortcomings.

Population ageing from a neo-classical perspective

The key elements of the neo-classical approach outlined in Chapter 2 are methodological individualism, an assumption of rational behaviour, market-clearing equilibrium and no informational problems. The limitations of the application of those elements to developing an understanding of the causes and effects of dependency in old age are evident from an examination of the literature in this area. In Australia, five *comprehensive summaries* of ageing viewed

neoclassically have appeared at shortish intervals every few years since the former Economic Planning Advisory Council's (EPAC) report, published in 1988, on the economic implications of ageing[1]. This was followed by a second, updated and extended, report from EPAC in 1994[2]. In 1996, the National Commission of Audit report included a chapter on the effects of demographic change on Commonwealth Government finances[3] and recommended the adoption of *Charter of Budget Honesty*. When the Charter of Budget Honesty Act was passed in 1998, it included a requirement for an intergenerational report to assess the long-term sustainability of government policies including the financial implications of demographic change to be produced within five years of the Act and every five years thereafter. The first *Intergenerational Report*[4] was published with the 2002/03 budget papers. Finally, in 2005, the Productivity Commission released a *Research Report on the Economic Implications of an Ageing Australia*[5] In each case, projections of the extent and effects of population ageing were made for at least 40 years into the future.

The initial EPAC report was the first Australian example of a comprehensive application of the neo-classical approach to ageing. Much of what has been contained in the reports published in Australia thereafter has debated the accuracy of the predictions and refined the models, rather than re-conceptualising the problem, nonetheless there have been changes in emphasis and tone in the reports. In a nutshell, EPAC said that Australia's population is becoming older and that older people experience more illness, use more health resources than younger people, are poor and consume an unequal proportion of welfare resources. In addition, population ageing represents a threat to productivity, economic growth

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[1] Cox, J, Dempster, P and Saunders, PG (1988) *Economic effects of an aging population.* Council paper (Economic Planning Advisory Council). Barton, A.C.T: Economic Planning Advisory Council.
[2] Clare, R and Tulpule, A (1994) *Australia's Ageing Society.* Background paper. Parkes, ACT: Economic Planning Advisory Council.
[3] National Commission of Audit (1996) *National Commission of Audit: Report to the Commonwealth Government.* Canberra: Australian Government Publishing Service.
[4] Commonwealth of Australia (2002) *Intergenerational Report.* Canberra: Commonwealth of Australia.
[5] Productivity Commission (2005a) *Economic Implications of an Ageing Australia.* Canberra: Productivity Commission.

and our capacity to provide a growing aged population with the resources they will expect. Therefore, the nation cannot afford to let things continue as they are.

However, the first two EPAC reports both concluded that the implications of ageing for levels of social spending are not unduly alarming, but could eventually require some policy change,[6] that the projections are not cause for immediate alarm and that do not threaten Australia with unmanageable costs of ageing[7]. The first EPAC report argued that potential social and political tensions between aged dependents and taxpayer could be avoided if the community were well-informed about issues arising from the ageing process. It also stated in the executive summary that this would involve an educational role for government in promoting a wider consensus on these issues.[8] By the second EPAC report[9] there was a noticeable change in tone. For example, the executive summary pointed out that the focus in most OECD countries was moving away from government as a provider of income, to government as a partner that supports or requires individuals to take initiatives on their own, whilst recognising that there are divergent views on this development. A particular focus of the report was on how the shift in responsibility is occurring in the fields of retirement incomes, home and community care, and health services. It also recognised that action is already being taken to meet the challenges of population ageing.

Another theme that appears in the reports on ageing relates to the question of equity. There is a gap of only two years between the second EPAC report and the National Commission of Audit report, so little should have changed. However, the National Commission of Audit's first recommendation in relation to population ageing is that there is 'need for urgent action'[10] and in this report the term intergenerational equity receives its own chapter sub-heading and almost four pages of discussion. The term first appeared in the second EPAC report, which

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[6] Cox, Dempster and Saunders *Economic effects of an aging population.*
[7] Clare and Tulpule *Australia's Ageing Society.*
[8] Cox, Dempster and Saunders *Economic effects of an aging population.*
[9] Clare and Tulpule *Australia's Ageing Society.*
[10] National Commission of Audit *National Commission of Audit: Report to the Commonwealth Government.*

noted that government should not work on the basis of each *individual* having an account with government, which determines eligibility for assistance on the basis of prior contributions.[11] Although the second EPAC report goes on to say that needs and eligibility for assistance must be determined in the context of the overall capacity of the economy and the relative needs of others, the notion of intergenerational equity and intergenerational accounting does imply that eligibility by a cohort for assistance should be contingent on previous (or future) contributions by the members of that cohort. The Audit Commission[12] spent almost four pages on the issue. It invokes 'concerns frequently expressed … that those alive today are not paying their way … leaving debt to be paid by their children' to justify the use of generational accounts to explore whether the 'present budgetary arrangements are fair to those living in the future and whether fiscal policy can be considered generationally neutral'[13].

Only six years later, in 2002, the *Intergenerational Repor*t did refer to the need for sustainable policies that promote intergenerational equity, defined as 'fairness in the distribution of public resources between generations of Australians', but without any discussion of what constitutes *fair*[14]. This relatively slim document was quickly superseded by the Productivity Commission's report of 2005, which updated and refined the analysis provided by the Intergenerational Report as well as extending it to include each of the States and Territories. It is by far the longest of the reports at 339 pages plus appendices (an additional 57 pages). A CD-ROM that contains an additional 130+ pages of technical reports accompanies the printed report. Whilst longer and more detailed, this report draws almost identical conclusions to the *Intergenerational Report*.

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[11] Clare and Tulpule *Australia's Ageing Society.*
[12] The National Commission of Audit and its contribution to the discussion on demographic change are discussed more extensively in Chapter 5 of this thesis. This short taste of its offerings appears here as it fits neatly into this discussion.
[13]National Commission of Audit *National Commission of Audit: Report to the Commonwealth Government.* 143.
[14] Commonwealth of Australia *Intergenerational Report.* 14.

The reports on ageing do recognise that the outcomes that they project will only occur if government policies and people's behaviour remain unchanged.[15] In addition, some possible mitigating factors are recognised. For example, the second EPAC report listed changes in administrative and funding arrangements, greater emphasis on informed consent (which includes information about costs), possible resort to euthanasia, policies already in place about right to refusal/withdrawal of treatment and about involving families in decisions about pain relief and withdrawal of treatment, limiting the availability of some lifesaving procedures (for example vascular surgery for smokers), promotion of good health for life rather than treatment and diagnosis near the end of life, and retirement incomes policy reform in the form of initiatives such as the superannuation guarantee charge (SGC).[16] Their inclusion in this report appears to be mainly speculative, as no discussion of the very real difficulties that each of these suggestions raises is discussed. All of these matters were already being discussed widely in the community, although there is no elaboration on them, or their consequences in the report.

Whist there is some discussion in the five reports of *non-demographic* factors that effect the projections that are made, little attention is paid to their detail, and no serious consideration is given to change in relevant factors However, the relevant factors are amenable to change, as Chapter 3 on Institutional Economics suggested, and since they are material to the issues raised in the reports, they are given further attention following a detailed examination of the reports.

Approach of the reports

The Productivity Commission report of 2005 focuses somewhat courageously on predicting the situation for 2043-44 by when, it calculates, the rate of growth in the Australian fiscal deficit will have tapered off. The most rapid rate of increase is anticipated in the period around 2018-19 until 2028-29, when more rapid change and demographic and fiscal pressures are likely to generate the greatest potential for intergenerational conflict. The choice of time frame presumably reflects a belief

[15] Productivity Commission *Economic Implications of an Ageing Australia.*
[16] Clare and Tulpule *Australia's Ageing Society.*

amongst economists that projections beyond 40 years are not reliable but the Demography chapter in the National Audit Commission report published one figure that estimated age pension outlays out to 2055. This indicates that outlays will peak around 2035 and then decline from 4.5 per cent of GDP to about 4 per cent of GDP by the mid-2050s. The rate of decline is reducing at the point, but it is unclear whether this level of expenditure is largely sustained or whether expenditure will decline even further in subsequent years. The Productivity Commission report has age and service pension expenditure increasing throughout the projection period and peaking at 4.5 per cent of GDP in 2044-45. The period of greatest change, and therefore, most rapid adjustment, occurs prior to the year 2030. This is the time period in which population ageing will be most threatening to the social fabric. In addition, the fact that the proportion of the population that is aged is predicted to fall after 2044-45 suggests that 2044-45 is a peak, rather than an indication of a long-term position. The appropriate policy responses for a temporary peak could differ from those for a long-term position.

If the anticipated position is a long-term one, then the intergenerational effects of an aged population for persons alive in 2044-45 is neutral. If the proportion of the population who are aged is stable, then each individual will contribute the same relative amount for the same relative benefits. The system will be in equilibrium. However, it is during times of population change, such as ageing, that working age individuals will pay less tax than future generations to support the dependent aged and the percentage of GDP needed to meet social expenditures will increase. If 2044-45 represents a peak, and the percentage of the population in the dependent aged category declines (even slightly) then the amount of taxes required to support them will also decline.

These reports presume a peak in spending but the amount of spending is likely to be declining by 2052. The dynamics for, and consequences of the change should be laid out in the Report because there are important implications for the equity of 2044-45 taxation arrangements. In addition, if the welfare expenditure burden is projected to fall over the following decade, then this should be factored in to both political and more narrowly economic discussions of intergenerational equity.

Dependency ratios

Dependency ratios reflect a presumption that dependency is primarily a function of age, plus often-tacit conceptions of economic welfare and of economic dependency. Either people are too young to be economically independent (generally thought to be up until age 15 or 20 years), or too old to be so (generally aged from 60 or 65) – although both age-groups were regarded as independent or dependent at different times in twentieth century Australia [17] and New Zealand[18]. In Australia, the *old age* dependency ratio - *at the ages specified* - will increase slightly until 2011 from about 18 per cent to 20 per cent, after which time it will increase steadily until 2051, when it will have reached 35 per cent.

In particular, two issues are pertinent. First, many other societies have much higher ageing populations and higher age based dependency ratios and have not self-destructed. Aged dependency ratios from other OECD countries are reproduced in a number of the reports and indicate both that Australia has lower dependency ratios than many OECD countries, and that they will have had many years of experience of high dependency ratios before Australia catches up to them.

Second, age as the basis for estimating the ratio of the dependent to the independent ignores important patterns that may affect overall dependency. Demographically derived notions of dependency are used in the report on ageing along with data on expenditures in dependent age groups to demonstrate the heavy burden of dependency associated with population ageing.

Dependency ratios derived demographically assume that the only valuable economic contribution that needs to be considered is that which is made by trading labour in a market. Thus, productive work not remunerated in the market, done by people at any age, is not counted as economically valuable. The kind of dependency that underpins this approach is financial dependency, rather than economic dependency, and it is assumed that financial dependency is primarily a

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[17] Davison, G. (1995) 'Our youth is spent and our backs are bent': the origins of Australian ageism. *Australian Cultural History,* 14: 40-62

[18] Thomson, D. (1998) *Cohort Fortunes and Demographic Change in the Twentieth Century*. Working Paper Series No. 6 Cambridge Group for History of Population and Social Structure.

function of age. Even if it is accepted that financial dependency is a sufficient approximate for economic dependency, the *engine of dependency* has at least two other cylinders - patterns of labour force participation across age and gender, and levels of unemployment. When historical dependency ratios for the UK from 1951 to 1981 are recalculated on the basis of whether people were economically active (that is, in the workforce), the dependency ratio increases by between 20 per cent and 40 per cent.[19] When Falkingham added dependency created by unemployment, the dependency ratio for 1981 increased by another 20 per cent on the age-based ratio.

Falkingham's work demonstrates that historically, dependency has been much more sensitive to changes other than demographic age changes. Two important lessons come from this observation. First, most of the historical increase in dependency does not arise from demographic change although the population has been ageing. Second, dependency, as measured by the proportion of the population who are either not in the workforce, or who are unemployed, has increased steadily in the UK example. Therefore, increases in dependency are neither a new phenomenon, nor associated only with population ageing.

The future effects of the phenomenon reported by Falkingham suggest that it is worth looking at similarly revised dependency ratio projections for Australia. Projections by the Retirement Incomes Modelling (RIM) Unit in the Australian Treasury[20], predict a future for dependency in Australia similar to what the UK has experienced historically. Financial dependency in Australia is projected to be far more heavily influenced by labour force participation and unemployment than it is by population ageing. The RIM Unit report estimated that between 1994-95 and 2059-60 the *aged* dependency ratio (Ratio of those aged 65+ to those aged 18-64) would increase from 0.19 to 0.39. The ratio of all adults who are not working, ie all *non-workers* aged 18 years or more to the ratio of workers, the dependency ratio

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[19] Falkingham, J. (1989) Dependency and Ageing in Britain: A Re-Examination of the Evidence. *Journal of Social Policy,* 18: 211-233

[20] Rothman, GP (1998) *Projections of key aggregates for Australia's aged - government outlays, financial assets and incomes.* Paper for the Sixth Colloquium of Superannuation Researchers, University of Melbourne, July 1998:

would increase from 0.77 to 0.95. The current burden of *non-age* adult dependency is far greater than even the future predicted *aged* dependency. There are far more people in the 18-64 age group, than in the 65+ age group who are dependent. The predicted change is greater in the older age group, but the bulk of dependency is in the younger age group. Two key differences shift the focus to the older age group. The first is that they are more likely to be dependent on public means, rather than private ones. The second is that the cost of their dependency is likely to be higher, given the interaction of age with the health care system.

Age by itself is not a good reflection of true overall dependency in the population. Not only do age-based dependency ratios fail to always reflect true overall dependency but they also avoid questions about the nature and causes of dependency, which they assume to be related to unalterable characteristics of human beings, such as their age, rather than the result of shifting political and social processes. The Falkingham example demonstrates that, at a population level, changes in adult dependency through changes in workforce participation and unemployment have been larger than those related to age and the Rothman data confirms this with Australian data. The focus on age dependency ratios, especially old age dependency ratios as used in the reports on ageing, place responsibility for the level of dependency with the aged and does not reflect changes in the broader community that influence the levels of employment and workforce participation.

Patterns of retirement

Retirement data for Australia suggest that there is an epidemic of retirement from economic activity. In 1961, 26.5 per cent of males age 65 and over, which we now accept as retirement age, were in the labour force, by 1986, this was down to 9.3 per cent; by 2006 it was back up to 12 per cent of 65-year-olds. The percentage of married women aged over 60 in the work force increased from 3.9 per cent to 7.8 per cent between 1961 and 1986, but a large part of this increase is probably due to the inclusion of part-time workers in the definition of labour force after 1961. The percentage of unmarried females in the work force also reduced from 9.2 per cent to 4.5 per cent over the same period. In 2006, less than five percent of females aged

65 or over remained in the labour force.[21] Similar figures for the UK indicate that the level of economic activity in males aged over 65 has fallen from 75 per cent in 1881 to 10 per cent in 1981 where it has remained.[22]

A neoclassical economic model would assume that retirement is a choice that is available by virtue of flexible working arrangements whereas choices-in-practice about work are constrained by both cultural factors, such as beliefs about retirement and the influence of close family[23] and structural ones such as politically-sanctioned compulsory retirement ages. The compulsion might be explained, on neoclassical principles, as the outcome of mutually beneficial interactions between individuals and firms or, less individualistically, state retirement policies can be seen as a means of regulating labour supply. Lack of institutional scope of choosing number of hours means that individual retirement decisions may be confined to a discrete choice between working a fixed number of hours and not working at all. The design of pension schemes, for example the inability to pay part-pension for part-retirement may exacerbate this.

There is empirical evidence of a positive relationship between pension levels and retirement decisions but the relationship is not constant between countries.[24] The meaning of the relationship is debatable and could reflect secular trends towards any of higher living standards, higher real pensions, shorter working hours and earlier retirement. All of these are social and cultural factors that go beyond the individual choice perceived through the rationalists' reversed telescope.

Australian aged pensions are not generous by international standards.[25] Modelling by the OECD of policies for Australia to make pension schemes more actuarially

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[21] Rowland, DT (1991) *Ageing in Australia.* Melbourne: Longman Cheshire. 131.; Australian Bureau of Statistics (2006) *Australian Labour Market Statistics. April 2006.* ABS Catalogue No. 6105. Canberra: ABS.
[22] Johnson, P. (1994) The employment and retirement of older men in England and Wales, 1881-1981. *Economic History Review,* 47: 106-128. Office of National Statistics (2006) *Labour Force Survey: Economic Inactivity Rates by Age (SA) 1971-2006.* Accessed at C:\My Documents\Documents\labour force statistics UK inactivity.xls. Accessed on 21 May 2006.
[23] Australian Bureau of Statistics (1997) *Retirement and retirement intentions, Australia.* ABS Catalogue No. 6238.0. Canberra: Australian Bureau of Statistics.
[24] Duval, R. (2003) Retirement behaviour in OECD countries: impact of old-age pension schemes and other social transfer programs. *OECD Economic Studies,* 37: 7-50
[25] Ibid.

fair (that is, in their definition, do not bias the retirement decision towards excessive leisure and insufficient consumption) and to increase the pension-eligibility age to 67 results in an increase of projected participation of males aged 55 to 65 from 48 per cent to between 51.2 and 54.5 per cent, and for males aged 65 and over from 7.4 per cent to between 11.2 and 12.4 per cent. The authors note that this small increase in projected participation in their model probably results because a number of influences on the retirement decision, including a range of country-specific institutional, cultural and historical factors were omitted from the analysis.[26]

Tied up in the use of dependency ratios are assumptions about patterns of workforce participation and retirement, in particular that women aged 60 and men aged 65 can be considered as dependent. There are some extra-individual issues that can affect the level and pattern of income dependency in older age groups that the reports on ageing do not consider which are relevant to thinking about this issue. The extra-individual factors that affect current patterns of retirement in Australia reflect some cohort and some time factors.[27] Cohort factors that Rowland considered important in 1991 included veterans from World War II reaching the age of eligibility for pensions (five years earlier than the *standard* age of eligibility for aged pensions, creating a wave of *early* retirement), increased superannuation cover, allowing higher levels of retirement; and earlier attainment of home ownership, which increases the probability of economic security after retirement.

Time factors include increasing numbers receiving invalid pensions, with a suggestion that age and lack of marketable work skills are being given greater weight in conjunction with medical impairment in determining eligibility for invalid pensions; attractiveness of early retirement schemes and a change in lifestyle that places more emphasis on leisure; economic recession causing unemployment because older workers are over-represented in industries which have reduced their workforces sharply during recession (and as a result of microeconomic reform in the manufacturing sector), and economic recession

[26] Ibid.
[27] Rowland *Ageing in Australia.* 132.

creating *discouraged workers*. Rowland suggests that the number of discouraged workers were considered to be many times more than the number recorded as unemployed. While the second EPAC report did describe some of these phenomena, it does not address the potential for their effects to be modified, except on the point of economic recession and early retirement. Even then, no movement of policy was canvassed: the report merely opined that

> As the economy comes out of recession, and as the restructuring of a number of traditional industries is completed, pressures for early retirement might decline. Both the availability and need for lump-sum inducements for older workers to leave firms can be expected to decrease.[28]

The second EPAC report's prediction that employment would increase as the economy came out of recession was not realised in a straightforward way. By the late 1990s Australia had experienced a *jobless* recovery, the rate of employment growth was much slower than the rate of GDP growth,[29] a trend that had been evident since the early- 1960s.[30] The assumption that the level of employment available is fixed in relation to the level of GDP did not hold. More recently, there has been recognition that the jobs being created are not the same kinds of jobs that were lost in the early- 1980s, either in terms of industry, tenure, working conditions or skills required. In addition, while unemployment has now decreased, in the restructured job market that emerged from that recession, fulltime, permanent jobs have been replaced by part-time and casual work. As a result, underemployment has increased and older workers who lose their jobs have a low probability of re-employment.[31 ,32]

This experience raises two cautions for considerations of dependency. First, the proportion of the population who are economically active may reduce in spite of

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[28] Clare and Tulpule *Australia's Ageing Society.* 46.
[29] Parham, D (2002) *Microeconomic reforms and the revival in Australia's growth in productivity and living standards.* Paper presented to the Conference of Economists, Adelaide, 1 October 2002. Session on Microeconomic Reform Revisited:
[30] O'Neill, S. (1996) *Redistributing work: Methods and possibilities.* Research Paper No. 26 1995-96 Parliament of Australia. Parliamentary Library.
[31] Barrett, S. (2004) In *Australian Political Studies Association Conference.* University of Adelaide, Australia.
[32] Ranzijn, R, Carson, E and Winefield, AH (2002) *On the scrap-heap at 45: Report of mature aged unemployment research 2000-2002.* Adelaide: SA: Department of Education, Arts, and Social Sciences, University of South Australia.

continued economic growth, which means that the political difficulties of raising taxes may be magnified, because a smaller proportion of the population are supporting pensioners. Second, the focus on dependency ratios may always be misleading because within each category (dependent age group and independent age group), the level of dependency may change. Changes in dependency reflect broader patterns in the way we organise our society and their impact on the capacity to be independent and on the timing and experience of retirement that have little to do with age directly.

The implications for dependency of these factors lies in the way that early retirement in particular, can mean that either savings (private or superannuation paid in a lump sum retrenchment package) are used as a main source of income in the early retirement years, leaving early retirees dependent on the publicly funded income support pension, which confines them to the lowest income group for those aged over 65, rather than having some private income to supplement their pension income. On a summary view, the reports on ageing, by focusing on patterns associated with age now, failed to consider seriously the future consequences of retirement. The time and cohort factors which Rowland identified as contributing to high levels of retirement now, may not apply in the future, especially for example, the cohort of World War II veterans, however, these will be replaced by new time and cohort factors as history unfolds.

Use of health services

Three points about the use of health services are made in the second EPAC report. The first is the high cost of health service usage in old age, the second is the poor health of the aged, and the third is the high cost of dying. The report takes the *high* cost of care for the aged as problematic, and assumes that the pattern of spending of health care for this age group is problematic. However, it fails to ask the same question of health care spending for the younger population as it asks of health care spending for the aged. That is, it assumes that the *problem* it observes is entirely due to or associated with ageing. Having limited its conception of the problem, the report's treatment of the *health* of the aged fails to consider variations that may have important implications for future policy.

Within the category *aged*, there are important variations in health status. Phillipson[33] identifies two sources of poor health status in elderly people. First, there are environmental factors that can cluster in old age, such as poverty, bereavement and reduced social status that can precipitate mental health problems. Second, there are important differences in health status within the elderly population. Phillipson cites evidence for a social gradient in physical fitness in the United Kingdom, but evidence for a social gradient of health that persists into old age also exists for Australia.[34]

Finally, the reports makes reference to the high costs of health service usage in the aged, particularly the over 85 group, and to the fact that these costs are concentrated into the last two years of life. In the second EPAC Report, the discussion that ensues assumes that this concentration is problematic, that it is somehow unjustified and that steps should be taken to reduce per capita spending on this age group. The report does reject simply cutting back available funds for the dying (p 39) as a possible solution, and suggests changes in administrative and funding arrangements, greater emphasis on informed consent (which includes information about costs) euthanasia, right to refusal/withdrawal of treatment, involving families in decisions about pain relief and withdrawal of treatment, limiting the availability of some lifesaving procedures (for example vascular surgery for smokers), and promotion of good health for life rather than treatment and diagnosis near end of life. This report does talk about the need for change in attitudes to the provision of health care around death and dying. However, there is no sense that the determinants of these decisions lay anywhere but with patients and possibly, their immediate family. In addition, it is assumed that the provision of information will change behaviour, reflecting rational decision-making. There is no consideration of the complex sociology and social psychology of the consent process.

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[33] Phillipson, C (1982) *Capitalism and the Construction of Old Age.* London: Macmillan.
[34] Mishra, G, Ball, K, Dobson, A and Byles, J. (2004) Do socioeconomic gradients in women's health widen over time and with age? *Social Science and Medicine,* 58: 1585-95

Scitovsky[35] and others found that spending on health care is higher in people who die compared to those who survive. The high costs of medical care in the aged have more to do with how far they are from death, rather than how far they are from birth. However, the cost of dying decreased with age. In Scitovsky's sample of patients attending the Palo Alto Medical Centre in 1983-84, less, not more, was spent in their last year of life on those aged 80 years or more than on those aged 65 to 79 years. In 1988, Medicare expenditures were 74 per cent higher for decedents aged 65 to 74 years than for decedents aged 90 years or more.

Although Scitovsky's sample was not random and may not have been representative, as all subjects were enrollees of a particular medical plan, it was the case for that sample that highest costs were associated with lower levels of functional impairment and, as functional impairment increased, a greater proportion of costs were associated with nursing home and domiciliary services, not high cost, high tech medical services. Daily hospital costs for those who died decreased with age, suggesting lower intensity of services when in hospital.

In 1988 the available evidence indicated that across the entire population of Medicare (US) recipients, there was no evidence of excessive spending on the very old in the last year of life, about 5 per cent of over 80 years old who died used more than $40,000 worth of services, a level at which the authors estimated that neither multiple hospitalisations or use of high technology services was likely to be occurring. This level of spending occurred for about 0.4 per cent of survivors. However, about the same number of survivors and decedents received this level of health care and whether anything could have been known about which half of this group were to survive and which were not is a matter of mere speculation. Overall, Scitovsky's own research and review of others' research does not support the assumption that older disabled patients receive expensive, high-technology care that could be considered wasteful or inappropriate.

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[35] Scitovsky, A. (1994) The high cost of dying revisited. *The Milbank Quarterly,* 72: 561-591; Scitovsky, A. (1988) Medical care in the last twelve months of life: The relation between age, functional status, and medical care expenditures. *The Milbank Quarterly,* 66: 641-660

More recent work in Australia indicates that population ageing has had a small effect on overall health care costs. For example, Richardson and Robertson first applied the *forward projections* methodology to historical data (1980-1994) and found a poor correlation between predicted and actual total expenditure and expenditure as a percentage of GDP. Second, they examined Australian cross-sectional expenditures and found that the explanatory power of age/sex changes is small, accounting for only 2-3 per cent of the total variance in expenditures. Third, they examined cross sectional cross national health expenditure data from OECD countries and found that none of the demographic variables helped to explain the variation between national health expenditures as a percentage of GDP. Finally, they used cross-national time series data to test whether idiosyncratic historical factors dominate the cross-sectional relationship between nations but over time demographic changes determine the relative growth of health expenditures in different countries, and found no relationship between changes in the demographic variable and increased health expenditures.

Health care costs in the elderly are concentrated in the last years of life and a growing body of evidence indicates that the cost of dying reduces with very old age. Brameld and colleagues examining health care costs for elderly Western Australians found that between 1985 and 1994 increasing proportions of all age groups (65 to 74, 75 to 84, and 85 years and over) were admitted to hospital at least once in the year before death, but the chance of admission decreased with age. Total bed days per person showed no significant increase with age, except at ages 65 to 74 years. Total inpatient resource utilisation during the last year of life was lowest and remained constant in those aged 85 years and over, while increasing gradually (3.7 per cent per annum) in the younger elderly. They concluded that recent gains in life expectancy and higher per capita health expenditure have not been accompanied by more time spent in hospital during the last year of life at ages 75 years and over.[36] British evidence also confirms that ageing has a small

[36] Brameld, K, Holman, C, Bass, A, Codde, J and Rouse, I. (1998) Hospitalisation of the elderly during the last year of life: an application of record linkage in Western Australia 1985-1994. *Journal of Epidemiology and Community Health,* 52: 740-744

effect on hospital costs, except in the last year of life when they triple.[37] Similar results have been reported for Germany,[38] Canada,[39] Taiwan[40], and Massachusetts (United States)[41] and medical care costs in the United States [42].

The Australian Productivity Commission report on ageing considers briefly and dismisses swiftly the claim that ageing may not affect health care costs significantly because most of a person's lifetime health costs are concentrated in the period before death, regardless of how long he or she lives. The Commission regards the claim as being flawed on two counts. First, health care costs in the last one or two years of life do not comprise the bulk of a person's lifetime costs. That is, ongoing costs for people who are not close to death still appear to account for most health spending and these costs increase with age. Second, the number of deaths per 1000 people will increase by around 40 per cent by 2044-45. The Commission provides no evidence for the first claim.

Further, it seems that the scope to make significant savings by reducing costs at the end of life seem limited.[43] This means that suggestions by the second EPAC report for reducing health care costs associated with age will have little impact and that ways may need to be found of living with the health care costs of old age.

Projections for growth in health care costs associated with population ageing that are given by the various reports suggest that health care costs as a percent of GDP

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[37] Seshamani, M and Gray, A. (2004) Ageing and health-care expenditure: the red herring argument revisited. *Health Economics,* 13: 303-314

[38] Brockman, H. (2002) Why is less money spent on health care for the elderly than for the rest of the population? Health care rationing in German hospitals. *Social Science and Medicine,* 55: 593-608

[39] Demers, M. (1998) Age differences in the rates and costs of medical procedures and hospitalization during the last year of life. *Canadian Journal on Aging-Revue Canadienne Du Vieillissement,* 17: 186-196; McGrail, K, Green, B, Barer, ML, Evans, RG, Hertzman, C and Normand, C. (2000) Age, costs of acute and long-term care and proximity to death: evidence for 1987-88 and 1994-95 in British Columbia. *Age and Ageing,* 29: 249-253

[40] Liu, CN and Yang, MC. (2002) National Health Insurance expenditure for adult beneficiaries in Taiwan in their last year of life. *Journal of the Formosan Medical Association,* 101: 552-559

[41] Perls, TT and Wood, ER. (1996) Acute care costs of the oldest old: they cost less, their care intensity is less, and they do to nonteaching hospitals. *Archives of Internal Medicine,* 156: 754,

[42] Spillman, BC and Lubitz, J. (2000) The effect of longevity on spending for acute and long-term care. *New England Journal of Medicine,* 342: 1409-1415

[43] Emanuel, EJ. (1996) Cost savings at the end of life - What do the data show? *Journal of the American Medical Association,* 275: 1907-1914 Stooker, T, van Acht, JW, van Barneveld, EM, van Vliet, R, van Hout, BA, Hessing, DJ and Busschbach, JJV. (2001) Costs in the last year of life in the Netherlands. *Inquiry-the Journal of Health Care Organization Provision and Financing,* 38: 73-80

will increase. Their conclusion is not the result of a straightforward decomposition of total expenditure as equal to the product of cost per person multiplied by the number of people. The discussion in the section accompanying these projections in the Productivity Commission Report suggests that this method would yield a relative modest increase in health care costs associated with ageing alone, that is, if the cost per person remains constant and the structure of the population ages. However, the projection also included amounts for increases in per-capita spending in excess of demographic change. In the health care spending projections, 0.6 per cent per year was used, except in the case of pharmaceuticals where 4 percentage points above growth in GDP per capita is used initially, after which this trends down to the growth rate for other components[44]. A simple decomposition of total expenditure as equal to the product of cost per person multiplied by the number of people, without per capita increases would result in the increase in health care costs that is attributable to demographic change, net of changes in technology and age-specific per capita use is about half the amount reported in the Productivity Commission's tables.

The questions of affordability and sustainability

Despite their claims to be about the economics of population ageing, the main concern of the reports on ageing is the level of public expenditure. This suggests that the concern is not simply the total amount of community resources consumed by the aged, but that worries about the level of taxation and government spending overall have crept in on the coat tails of prevailing economic theories and models of the macro economy that associate high levels of government consumption with the crowding out of investment and inhibition of private savings. The affordability question can take on many guises. All of the projections in the Australian reports on ageing indicate that the net effect for future generations will be a considerable increase in GDP per capita that remains after health and welfare costs are met. On this criterion of absolute financial well being, we can afford to grow old. This point was acknowledged in the early EPAC reports. However, the criteria for *affordability* have changed over the life of the reports on ageing.

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[44] Productivity Commission *Economic Implications of an Ageing Australia.* 374

The issue may not be one of whether Australia can *afford* to support the aged, but whether Australians are willing to share resources with those to whom they are unwilling or unable to offer remunerative employment. Other data provided in the second EPAC report indicate that, in fact, projected national income, even after the increased publicly funded social welfare costs associated with ageing have been met, is over $10,000 more per capita than in 1990. Similar conclusions can be drawn from later projections of social expenditures. Neither the Audit Commission, the *Intergenerational Report*, nor the Productivity Commission report published projections of tax revenue and expenditure in dollar amounts, choosing instead to use percentages of GDP. However, the Productivity Commission's projections indicate that between 2003-04 and 2044-45, GDP per capita will increase from $39,234 to at least $64,417, and a likely $72,708 in its own base-case projections. This is an increase in *real* GDP per capita of between $25,093 and $33,384. The base case scenario puts the fiscal gap at 6.5 per cent of GDP, or $4,726 per capita in additional tax burden. Consistent with the same analysis for each of the other reports on aging, this leaves workers $28,657 better off in 2044-45 than their counterparts on 2003-04.

The issue therefore, is not whether Australia can afford the expense of maintaining current levels of average benefits, but whether the electorate will be willing to do so. Only the first EPAC report, among all the reports on ageing, assumes a generous electorate. The treatment of affordability has changed with successive reports on ageing. In the first EPAC report, linking real benefits to productivity would result in the share of social expenditures increasing from 20.0 per cent of GDP in 1985 to 22.6 per cent in 2025.[45] The conclusion drawn then was that 'although aging may increase the share of social spending in GDP, particularly after 2010, there is time for Australia to plan a considered and equitable response'[46].

[45] Cox, Dempster and Saunders *Economic effects of an aging population.*
[46] Ibid. 7.

The second EPAC report also argued that although population ageing would be associated with increased costs for the Commonwealth government their projections were

> not cause of immediate alarm they do not show that Australia will be unable to cope with the costs of an ageing population structure ..(what).. is needed is an economic and social environment which provides incomes, incentives and economic growth sufficient to support the emerging needs of our population. Lifting levels of national savings and investment is likely to be a crucial part of such a process[47]

The Audit Commission introduced the notion of intergenerational equity. It did not define the notion, but stated that it asks what the implication of the future path of taxes is, given current levels of taxation and the net fiscal burden in the future. It does this by using generational accounts to explore whether present budgetary arrangements are fair to those living in the future and whether fiscal policy can be considered *generationally neutral*. Generational accounts are a tabulation of 'the net effect of future taxes paid and transfers received by future generations, assuming that current policy remains unchanged into the definite future'[48]. Using this framework, the tax and benefits system achieves generational equity if each successive generation has the same net discounted tax/benefits balance. Hence current policies are affordable only if they cost each successive generation the same real amount. The only generational accounts that were available for the Audit Commission to use (and none have been produced since) indicated that net of savings and consumption, the balance was in favour of future generations but that a 'major structural deficiency in saving' resulted in a 'strongly negative outcomes for future generations if current consumption levels are sustained'[49]. Generational accounts are designed to be consistent with the neoclassical life-cycle model and a present value, public sector budget constraint.[50] However, as Havemen points out, the method for producing Generational Accounts is complex and makes a number of controversial assumptions.

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[47] Ibid. 6.
[48] Haveman, R. (1994) Should generational accounts replace public budgets and deficits? *Journal of Economic Perspectives,* 8: 95-111. 98.
[49] National Commission of Audit *National Commission of Audit: Report to the Commonwealth Government.* 145.
[50] Haveman. Should generational accounts replace public budgets and deficits?

The *Intergenerational Report* defines intergenerational equity as 'fairness in the distribution of public resources between generations of Australians'[51] and links the notion of intergenerational equity to the notion of sustainability. It states that fiscal sustainability is one way of ensuring that the level of government debt passed on to future generations is appropriate. Appropriateness seems to be reflected in a balance between accumulated debt and the benefits of 'socially productive investments'[52]. The phrase *generational equity* appears in the Productivity Commission report three times, without either definition or explicit criteria. This report does acknowledge, however, that;

> There are assets and liabilities other than those held by the Government that are relevant to judgments about intergenerational equity, but which may not be captured in intergenerational accounting. For example, these include the stock of public knowledge and environmental amenity (or lack of it).[53]

The notion of sustainability, which the Intergenerational Report cites as key to intergenerational equity also plays an important role in the thinking behind the reports on ageing, which use *sustainability* to refer to ecological (un)sustainability associated with population growth and to fiscal sustainability. It is also referred to in relation to the methods by which pensions are indexed.

Fiscal sustainability refers to 'the government's ability to manage its finances so it can meet its spending commitments, both now and in the future'[54] and, says the *Intergenerational Report*, ensures future generations of taxpayers do not face an unmanageable bill for government services provided to the current generation. According to that report, the main source of *un*sustainability is the growing deficit between taxation revenues and expenditures if the taxation regime remains unchanged and the expenditure tax-income ratio rises. In later reports, the intergenerational conflicts that may arise as well as the disincentive effects of higher levels of taxation are raised as sustainability issues.

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[51] Commonwealth of Australia *Intergenerational Report.* 14.
[52] Ibid.
[53] Productivity Commission *Economic Implications of an Ageing Australia.* 328.
[54] Commonwealth of Australia *Intergenerational Report.* 2.

The references to ecological sustainability in the Productivity Commission report are all associated with the issue of whether increased migration or increased fertility can be targeted as means of slowing population ageing. In both cases, faster population growth than would otherwise occur is recognised as having the potential to increase pressure on the natural environment.

No clear definition of sustainability is provided in the Productivity Commission report. The Intergenerational Report states that sustainability 'requires the maintenance of appropriate economic, social, and environmental conditions through time to ensure the wellbeing of future generations is not compromised by the activities of the current generation'[55]. In both reports, it is mostly GDP and taxation effects that are subjected to the test of sustainability. However, in all of the Australian reports on ageing, residual GDP per capita (after taxation) is considerably higher for future generations than in the base year. By that definition, future generations can be expected to be better off than current generations.

The reports discount this promise by pointing to how much better off future generations would be if there was no population ageing, and to the potential for future generations to *feel* worse off because they pay more taxes than current generations. They also note the possibility of a brain drain associated with higher taxes. Finally, the use of the terms *appropriate* and *fairness* imply both inappropriateness and unfairness in the existing arrangements with absolutely no discussion of what might be a starting point for deciding what is either *appropriate* or *fair*. The discussion bears no necessary relation to any premise in economics.

The closest to a definition of fair that can be gleaned from reading the Productivity Commission report is implied in their acceptance of the notion of generational equity. For example, Ablett has constructed generational accounts for Australia[56] in which it is not clear that he expects that all generations have a neutral public

[55] Ibid. 13.
[56] Ablett, J. (1996a) Generational Accounting - an Australian perspective. *Review of Income & Wealth,* 42: 91-105; Ablett, J. (1996b) Intergenerational accounting and saving in Australia. *The Economic Record,* 72: 236-245; Ablett, J. (1997) A set of generational accounts for Australia: Base year 1994/95. *The Economic and Labour Relations Review,* 8: 90-109

account, rather he seems to imply that in a fair system, successive generations contribute (or receive) the same net amount to (or from) the system. However, if this is the case, no justification for it is provided and there are precedents in our taxation system for individuals in different circumstances contributing different amounts to the system. The most salient of these is the very taxation and social security benefits system that the reports are concerned about. Income taxes are progressive and the amount paid by an individual increases as income increases. Social security benefits are means tested and increase as need increases. These principles are firmly entrenched in our system for within generation decision-making. No argument has been put forward as to why they should not apply to different generations alive at the same time. The Ablett notion of generational equity is in fact one of actuarial fairness (an accounting notion), rather than of equity as equal treatment for equal need and differential treatment for differential need (a moral notion), which is based on social solidarity.

Generational equity

The National Audit Commission highlighted Ablett's generational accounts for Australia, based on the 1994/95 fiscal year.[57] The first of Ablett's papers produced generational accounts for tax and public spending in Australia for the year 1994/95. It found a moderate imbalance in favour of current generations, but that recent fiscal constraints should have been sufficient to correct the imbalance. His subsequent analysis included consumption and private intergenerational transfers. Ablett concluded that the accounts revealed 'significant imbalance to the detriment of future generations …(and) … current savings rates in Australia… inadequate to permit intergenerational balance'[58]. The Audit Commission concludes that 'The overwhelming message is one of major structural deficiency in national saving'[59]. However, one characteristic of generational accounts is that only future generations are subject to a requirement that governments meet a

[57] Ablett. A set of generational accounts for Australia: Base year 1994/95. ; Ablett, J. (1998) Intergenerational Redistribution and Fiscal Policy. *The Australian Economic Review,* 31: 73-79.
[58] Ablett. Intergenerational accounting and saving in Australia. 236.
[59] National Commission of Audit *National Commission of Audit: Report to the Commonwealth Government.* 145.

present value, public budget constraint, not current generations.[60] This means that Generational Accounting assumes that the current generation will continue to consume public resources at the current rate, making no adjustment, while future generations will need to both balance their current budget and pay off accumulated debt. This, in part, explains why Ablett estimates that a child born in 1994/95 will pay $22,000 more in taxes than he receives in government services, whereas one born a year later will pay $53,300 more in taxes than he receives in services. In addition, generational accounts do not impute to generations the value of government purchases to provide services such as education, highways and national defence, only the cost incurred at their initial purchase. Again, Generational Accounts focus on what goes into and out of the public purse, not what is left when the publicly provided goods have been paid for.

Using age as the focus of analysis

Only half of the projected increase in health care spending is actually due to population ageing. The remainder is due to changes in utilisation and technology.[61] However, whilst an entire chapter of 40 pages of the Productivity Commission's Report are devoted to a discussion of why the population is ageing, little more than one page is given to discussion of the reasons why utilisation and technology have advanced at such a pace.[62] This suggests that there is no real interest in promoting a better understanding of why health care costs are increasing, or in recommending a leadership role for government in addressing issues within the system of provision of health care that generates changes in utilisation and the demand for health care. An institutional economist would regard those issues as central to an economic understanding of the matter.

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[60] Haveman. Should generational accounts replace public budgets and deficits?
[61] Productivity Commission *Economic Implications of an Ageing Australia.*
[62] 'A report released by the Productivity Commission five months after the report on ageing explored the effects of advances in medical technology. Productivity Commission (2005b) *Impact of Advances in Medical Technology in Australia.* Canberra: Commonwealth of Australia. This report received neither the promotion by the PC, nor the media coverage enjoyed by the Report on Ageing

Life course matters

One source of growing sophistication of the reports on ageing has been the use of cohort analyses. This acknowledges that different cohorts have different workforce participation and health experiences and that these affect the state in which people arrive into older age. Again, each cohort is treated as a lump. This means that the average life experience of the cohort is used to project financial dependency and health care expenditure needs. No account is taken of the variety of experiences within a cohort. According to the second EPAC report, even with the Superannuation Guarantee Charge (SGC)[63], superannuation coverage will be patchy because 'life tends to be more complicated than the traditional model (of 40 years continuous paid employment)'[64]. However there is no suggestion in any of the reports on ageing that policies to address fluctuations in employment throughout the life course should be investigated.

The broader economic impact

In spite of their various titles, the main focus of the reports on ageing is the impact of population ageing on government finances. Much of the concern about government finances is ostensibly linked to the impact that increased government spending, leading to either higher taxes or budget deficits will have on the broader economy. The first EPAC Report (1988) did not consider wider economic effects in any detail, focusing instead on the public expenditure effects. The second EPAC Report (1994) projected GDP per capita out to 2051, but did not consider the effects of ageing on GDP growth. The *Intergenerational Report* concentrates on the damaging, intergenerational effect of higher marginal taxes on people's incentives to gain education, work and save and the prospect that this would dampen future productivity and economic growth. Higher marginal tax rates, it argued, could also result in difficulty in attracting skilled migrants from higher income, lower-taxing countries or to prevent brain-drain to them. This implies that population ageing is mainly a problem because governments pay for many of the costs associated with individual ageing (pensions and health care). All of the discussion

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[63] A compulsory employer contribution of 9 per cent of base earnings towards an approved superannuation fund.
[64] Clare and Tulpule *Australia's Ageing Society.* 56.

about broader economic effects of population ageing leads into projections of the impact on the economy via government budgets, rather than any direct concern about the overall economic impact, or the private impact.

The broadest parameter that is used is GDP per capita, as a measure of economic well-being. This is an important indicator of well-being. There has long been awareness in public health of a strong association between GDP per capita and a number of population health outcomes, especially the key indicators of infant mortality rates and life expectancy. However, at high-income levels, there ceases to be an association between GDP per capita and these indicators of health (Figure 4.1 and Figure 4.2).

Death rates are greatest and life expectancies lowest at the lowest levels of income. Mortality falls and life expectancy increases as per capita national income increases, but the rate of improvement decreases in the $10,000 to $15,000 range. This does not mean that further increases in GDP per capita will have no impact of health status, but it does mean that, at high levels of income, other factors may be important. Even at low levels of income this is the case. The examples of Costa Rica and the state of Kerala in India are two often cited examples of communities that have infant mortality rates that are low and life expectancy rates that are high for their low income because of the impact of re-distributive policies on health status, particularly through improving the health of the worst off. The explanation for the association between GDP per capita and health status is largely a materialist one. It fits with the longer-term decline in infectious diseases in the nineteenth century.[65] However, the relationship between GDP and health status is not a clean one and is mediated by the distribution of resources, and therefore, access to goods and services, in the community. [66]

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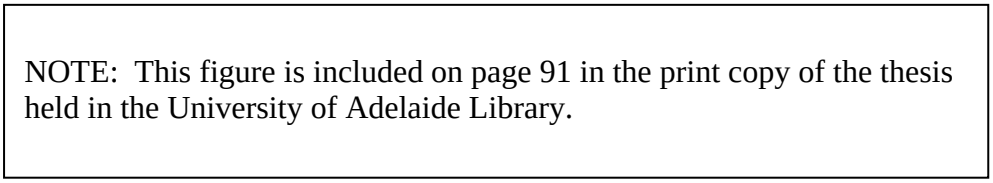
[65] See for example McKeown *The role of Medicine: Dream, mirage or nemesis?*

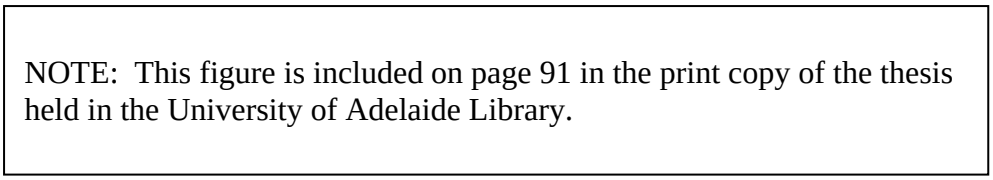
[66] There is a burgeoning literature on the effect of the level of socioeconomic inequality on health inequality and population health status. Current interest in the topic followed from the publication of the Black Report in the United Kingdom in 1984. This literature points to opportunities for and conditions of work, housing, transport, food, social support and social inclusion as important factors in the way that socioeconomic inequalities play out into health inequalities. See for

Figure 4.1 Life expectancy and Gross National Income at Purchasing Power Parity. Selected countries.



Source: World Bank (2004) World Development Report 2005 (Table 1: Key Indicators of development, p256-7). All countries for which complete data was reported are included

Figure 4.2 Under-5 mortality and Gross National Income at Purchasing Power Parity. Selected countries



Source: World Bank (2004) World Development Report 2005 (Table 1: Key Indicators of development, p256-7). All countries for which complete data was reported are included

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example: Marmot, M and Wilkinson, RG (Eds.) (1999) *Social Determinants of Health*, OUP, Oxford; New York

GDP measures were not designed as measures of national welfare, although they are often treated as just that.[67] Their original purpose was to provide an accurate measure of aggregate economic activity to assist in Keynesian macroeconomic stabilisation policy.[68] Consequently, GDP per capita is simply a very blunt measure of welfare and increasingly, expenditure that is included in it can reflect a worsening of well-being, rather than an improvement in it. Dowrick and Quiggan cite the inclusion of the costs of car crashes as an example of this. GDP includes the cost of car crashes[69], but does not include degradation of the natural environment or the value of unpaid domestic services produced and consumed within households or volunteer or community work.[70] While these may be estimated and recorded in satellite accounts to the National Accounts, they are not actually reflected in GDP. If a measure of welfare is meant to reflect the well-being of the community, then GDP cannot be said to be an accurate measure of well-being, in the way that it is assumed to be in the reports on ageing.

A more complete picture of what life might be like in 2044-45 might be needed to take into account the effects that population ageing will have on well-being and that completeness includes measures that are not counted in the GDP. Using GDP alone can only be sustained on the basis of only one of two assumptions. The first is that all other factors that contribute to well being remain constant in the face of population ageing. The second is that no other factors contribute to well being. The second assumption is easily refuted. The first is mentioned, but not taken seriously, in the reports on ageing.

One area that illustrates the importance of looking at all parts of the economy is illustrated by a closer examination of pharmaceutical drugs. Table 4.1 shows the components of increased Commonwealth spending on health care as reported by the Intergenerational Report and the Productivity Commission Report. Of the 4.17

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[67] Dowrick, S and Quiggan, J. (1998) Measures of Economic Activity and Welfare: The uses and abuses of GDP. In *Measuring progress.* (Ed, Eckersley R) CSIRO Publishing: Collingwood, Vic
[68] Ibid.
[69] Ibid.100.
[70] Australian Bureau of Statistics (2000) *Australian system of national accounts: Concepts, sources and methods.* ABS Catalogue no. 5216.0. Canberra: ABS.

percentage point increase in Commonwealth spending estimated in the Intergenerational Report, 2.65 percentage points are attributable to spending on the PBS. In the Productivity Commission Report, 1.91 of the 3.60 percentage point increase is attributed to the Pharmaceutical Benefits Scheme (PBS). In both cases, more than half of the percentage points of GDP increases in health expenditure are the result of increased spending on the PBS. Both the Intergenerational Report and the Productivity Commission Report indicate that a substantial proportion of the past and projected future increase in publicly funded health care costs is due to increased spending in the PBS. However, there is no discussion about what the impact of spending on pharmaceuticals would be without the PBS, either on individuals trying to meet pharmaceuticals costs out of pocket or on the economy, given the continuing rise, in excess of GDP growth in the total amount spent on pharmaceuticals. In addition, there is no attempt to look at the value that the PBS adds to pharmaceuticals expenditure by (i) keeping the cost of pharmaceuticals lower than they would be in a market un-moderated by the PBS, perhaps exemplified by the USA or by (ii) monitoring the effectiveness and cost-effectiveness of pharmaceuticals. Ironically, growing expenditure on pharmaceuticals and other health care will be reflected in a higher GDP if that health care is produced domestically.

That the greater share of growth in spending is concentrated in the PBS suggests that the increases are not purely age-related. If they were, then the increase in spending would be more even across expenditure areas. In a decomposition of the changes in health spending, the Productivity Commission report concluded that 39.1 per cent of the revenue shortfall for health expenditure that is predicted for 2041-42 is due to population ageing, while the majority, 60.6 per cent is due to real-age-specific per capita costs. That is, changes in spending that are not related to population ageing account for a larger share of increased health care costs than does population ageing. However, very little attention is given to the reasons for this or to policies to deal with it.

Table 4.1: Health expenditure projections from the Intergenerational Report and the Productivity Commission Report. Source: (Commonwealth of Australia, 2002) (Productivity Commission, 2005a)

	Intergenerational Report			Productivity Commission Report		
	2001-02	2041-42	Percentage point contribution to increase	2002-03	2044-45	Percentage point contribution to increase
Australian Government Hospital				1.40	2.25	0.75
Hospital and Health Services	1.16	1.63	0.47			
Medicare				1.23	1.80	0.57
MBS	1.09	1.78	0.69			
PBS	0.60	3.35	2.65	0.68	2.59	1.91
Australian Government other	1.12	1.37	0.25	0.60	0.86	0.26
Australian Government total	3.96	8.13	4.17	3.90	7.50	3.60

Policy prescriptions

Policy recommendations take up only a very small fraction of the reports on ageing. Neither of the EPAC Reports, nor the Intergenerational Report had published terms of reference and the terms of reference for the Productivity Commission Report did not include a requirement to make policy recommendations. Nevertheless, all have made suggestions about the broad policy directions that might be taken to address the fiscal shortfall that each of them identifies. While they are only a small fraction of the report, the recommendations matter because those reading the reports will inevitably want to know what should be done about the potential problems that the reports describe.

The policy suggestions of the EPAC report range over increasing individual savings for retirement, changing expectations about health care and improving productivity growth to increase future economic output. The Intergenerational Report argues that, by 2042, government will need to make a fiscal adjustment

equal to five per cent of GDP by either reducing spending growth through policy change, by imposing higher taxes on future generations of taxpayers, or by combining these approaches. The Productivity Commission states that 'the choices in financing the fiscal gap come down to increased debt, greater user contributions to service costs and higher taxes' (p 323). The first two options are dismissed in a matter of a few sentences. It rejects greater debt due to the high level of debt this would leave to future generations. Increased private contributions to health care are not considered as an option because one of the main areas of increased costs is public hospital services where governments in Australia are committed to free universal access, leaving little scope for user charges to eliminate the gap. The option of higher taxes is discussed at greater length but is also rejected because of the postulated effect on work incentives of having higher marginal tax rates. Using accumulated wealth of older people is also given short shrift. It is said to have intergenerational implications because it would reduce bequests. This is one of the few references to wealth, rather than income, made in the reports on ageing. The question of wealth is largely ignored, perhaps because it is seen as a private matter, whereas income is an issue for which a public role has status in the Australian Constitution.[71]

The policy directions that can be attended to, according to the Productivity Commission report, are those that deal with population directly through population policies, those that promote economic growth (through increased labour supply and productivity) and those that seek to increase the cost-effectiveness of government-provided services (particularly health and aged care).

With regard to population policy, the Productivity Commission rejects pro-fertility policies as they have a weak effect on fertility rates. Instead, it favours other government-influenced inducements to fertility. In particular, it cites broad policy settings aimed at prosperity, which reduce uncertainty and increase economic

[71] Section 51 of the Australian Constitution provides for powers for the Commonwealth Parliament to make laws in relation to invalid and aged pensions maternity allowances, widows' pensions, child endowment, unemployment and sickness benefits as well as benefits to students and family allowances.

stability.[72] It notes that migration policies have better prospects for partly reducing the fiscal pressures associated with ageing, and reducing some skill deficits.

Labour supply is discussed only in terms of persons aged under 24 years (who have relatively high labour force participation compared with OECD countries) and the 55 to 64 year age group (in which Australia is middle among OECD countries and significantly below the highest performers). It identifies the rapid growth of disability pensioners as a major source of lower participation amongst mature and older (especially male) Australians, reflecting injury rates in manual labour and low demand for unskilled (particularly male) workers.

For the health care system, the report highlights a number of imperatives, including:

- The need to increase coordination between different types of services, providers and all levels of government.
- The need for health care labour market reform to reduce inflexible professional demarcations that are inappropriate or redundant.
- The need to introduce only new technologies that are justified on evidence-based grounds.
- The need to increase health promotion to reduce preventable disease.
- The need to reduce adverse events in the hospital system.
- The need to change patient behaviours to improve effective management of chronic conditions. And
- The need to strengthen price signals in health care.

These are all well within the traditional focus of neoclassical economics, which is to introduce and strengthen unhampered operation of free markets wherever politically and practically possible. Where it is not possible to introduce a market, it establishes arrangements that would reflect the outcomes of a market if one were operating. However, it is necessary to examine the broader policy package to see how these general recommendations for policy directions translate into detailed policy.

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[72] Evidence that generous family policies have little effect on completed life-time fertility was also presented in the first EPAC report and is also a theme of Neville Hicks' work on the NSW Royal Commission on the Decline of the Birth Rate, completed in 1904. Similar recommendations were made to this Commission in relation to increasing prosperity to encourage fertility, by 'sweeping away restrictions on trade and enterprise', especially the arbitration system, although this did not become on of the recommendations of the Commission. Hicks, N (1978) *This sin and Scandal: Australia's population debate 1891-1911.* Canberra: ANU Press.

Level of focus of the reports

The reports on ageing focus on the fiscal rather than the economic effects and age rather than other causes of dependency and public burden. They have as their focus the fiscal, rather than the overall economic effects. They focus on monetary effects, rather than one of real resources and the largely political matter of how these will be distributed. [73] One of the limitations is their tight focus is on the effects of population ageing on government finances. The Intergenerational Report, for example, explicitly states that the report is to address the fiscal implications for the Commonwealth government. Although the Productivity Commission's terms of reference required attention to overall productivity and economic growth, as well as their fiscal impact, the ultimate focus of the Report is on the fiscal impact. This tight focus is particularly important when the effects on the private economy of many of the implied and stated policy responses are considered. There is no discussion of the effect on the broader economy of these. The private economic effects are not discussed.

Only half of the projected increase in health care spending is actually due to population ageing, the remainder is due to changes in utilisation and technology.[74] However, whilst an entire chapter of 40 pages of the Productivity Commission's report is devoted to a discussion of why the population is ageing, just over one page is given to discussion of the reasons why utilisation and technology have advanced at such a pace. This suggests that there is no real interest in suggesting a leadership role for government in addressing dynamics within the system of provision of health care that generate changes in utilisation and the demand for health care.

The reports on ageing either state or imply the need for privatisation of responsibility for retirement incomes and for health care expenditure. Privatisation of retirement incomes would be achieved by private retirement saving-funded superannuation supplanting taxation-funded pay-as-you-go

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[73] Mitchell, W and Mosler, W. (2003) *The Intergenerational Report - myths and solutions*. Working Paper No. 03-10 Newcastle: Centre of Full Employment and Equity.
[74] Productivity Commission *Economic Implications of an Ageing Australia.*

pension schemes as the main source of retirement incomes. The focus would also shift from an entitlement at retirement to an individual accumulation of funds. Privatisation of health care would be achieved by greater reliance on private health insurance and out-of-pocket funding of health care.

The push to increase private savings as the basis for retirement incomes assumes that by doing so, it will be possible to increase the overall income of older people, reducing their dependence on public sources of income. However, having a large number of people dependent on savings for income in the context of a shortage of labour is likely to result in inflation. In addition, it has been argued that the income generated by these savings will not be as great as it is now as there will be an oversupply of savings, lowering yields on bonds and shares. Finally, it is possible that rapid growth in savings in tandem with workforce shortages could reduce the earnings potential of savings.[75]

Population ageing as a public health issue and an economic issue

Population ageing has been selected as the first of two case studies for this thesis because it represents two important and inter-related issues. It is both an important public health issue and an important economic issue (and there are extensive literatures to draw upon in both domains).

The importance of population ageing as a public health issue arises from four of its characteristics. First, population ageing has implications for population health status. Older people are more likely to experience disability and disease, mainly chronic disease. This is the population health aspect of public health. If the chronic diseases which older people experience were purely a matter of genetics or individual failings or bad luck, the matter could rest there. However, the variations in disability and chronic disease evident in the older population are not simply a matter of genetics, resulting entirely from the failure of individuals to protect their health, but they occur in sufficiently patterned ways for even the

[75] Edey, M (2005) *The challenge of ageing populations.* Opening address to the Fifth APEC Future Economic Leaders Think-tank, Sydney 22 June 2005:

most careless of statisticians to rule out chance. Inequalities in mortality rates and disability by socioeconomic status that are evident in middle age persist into older age, even if in less pronounced form.[76] Reductions in inequality in older age, however, are not the result of improved fortunes for poorer old people, but reflect a survivor bias. [77]

The second element that makes population ageing a public health issue is that this systematic patterning of the experience of disability and disease suggests that there are forces that affect the health of individuals that are beyond individual control and require collective action to reduce their effects. The third element is that the ageing of the population changes the very nature of that experience for people in older age groups. Growing old in a population that is generally young is likely to be different from growing old in a population that is generally older. Fourth, population ageing has implications for people in younger age groups who may have no contact privately with ageing people because population ageing has the potential to change the nature of both the society and the economy. In economics this is known as an externality.

Ageing is also an important economic issue. Population ageing is the result of long-term movements in fertility and mortality. First, mortality rates fell during the nineteenth century. This was flowed by falling fertility rates in the late nineteenth century and throughout the twentieth century.[78] These movements almost certainly result from changes in economic conditions and themselves have economic implications.[79]

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[76] Cairney, J and Arnold, R. (1996) Social class, health and aging: Socioeconomic determinants of self-reported morbidity among the non-institutionalized elderly in Canada. *Canadian Journal of Public Health-Revue Canadienne De Sante Publique,* 87: 199-203; Melzer, D, McWilliams, B, Brayne, C, Johnson, T and Bond, J. (2000) Socioeconomic status and the expectation of disability in old age: estimates for England. *Journal of Epidemiology and Community Health,* 54: 286-292

[77] Ferraro, KF and Farmer, MM. (1996) Double jeopardy, aging as leveler, or persistent health inequality? A longitudinal analysis of White and Black Americans. *Journals of Gerontology Series B-Psychological Sciences and Social Sciences,* 51: S319-S328 Survivor bias occurs when those with the poorest health die earlier, leaving a population biased towards those who had the better health to start with.

[78] Rowland *Ageing in Australia.*

[79] Jackson, WA (1998) *The political economy of population ageing.* Cheltenham UK; Northampton MA USA: Edward Elgar. 10.

From the late eighteenth century, population ageing was modified substantially by the industrial revolution. Notestein's demographic transition model describes this transition, but offers no theories or causal mechanisms. It indicates the prominent role of economic development, but does not specify the precise relation between population and the economy. While the basic facts of the demographic transition are uncontroversial, their economic interpretation and future implications leave room for conflicting views[80]. Much the same can be said about modern population ageing, as I will demonstrate later.

Population growth is related to economic growth, but the causal mechanisms behind the relationship are uncertain. Lower mortality symbolises, and probably reflects, better health and higher living standards. Experience also suggests the value of improved nutrition and sanitation in combating infectious diseases, and these require that resources be widely distributed, often through 'public health measures'[81]. Rapid population growth initially followed a decline in mortality, the first change that led the modern demographic transition and instrumental in modern population ageing. Within the economics literature, discussion of the relationship between economic growth and population growth stretches between two extreme strands. The Malthusian strand argues that population growth is detrimental to economic growth as additional population produces less at the margin than existing population does, thus economic growth will slow. Malthus initially related this proposition to the limited availability of land, arguing that the expansion of land for cultivation could only be arithmetic, whereas population could grow exponentially. Malthus' original predictions were postponed by developments in agriculture but there are renewed suggestions that the earth's carrying capacity may be being exceeded, partly as a result of the technologies that allowed the productivity of land to increase by reducing land degradation and water pollution. In an economy that relies more heavily on goods that have been processed in some way, or are manufactured, and relies increasingly on services,

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[80] Ibid.

[81] Szreter, S. (1988a) The Importance of Social Intervention in Britain's Mortality Decline: Re-interpretation of the Role of Public Health. *Social History of Medicine,* 1: 1-39; Szreter. Rethinking McKeown: the relationship between public health and social change.

rather than natural capital, for much of its growth, Malthusian ideas seem less relevant. However, generally, Malthusians seem to assume that the capital needed to make labour valuable is limited in its capacity to grow and thus each additional worker will add less value to the economy than the one before her. In modern economics, the concern is with the rate of growth of the capital stock (investment) and the rate of growth of worker productivity, both of which Malthusians took to be fairly static, probably because they assumed that the capital needed to make labour valuable is limited in its capacity to grow and that each additional worker will add less value to the economy than the one before her.

At the other extreme is a more optimistic view that population growth is a motivating factor behind the introduction of markets, the discovery of new resources and the adoption of new technology. That is, entrepreneurs will respond to the change in prices that population growth generates by seeking (or investing in) novelty.

Between these two extreme strands are any number of positions about the likely effects of population growth, in particular, the Kuznets position that population growth is neither necessary for economic growth nor sufficient on its own to cause economic growth. Economic growth is a long-term rise in the 'capacity to supply an increasingly diverse range of goods … based on advancing technology and the institutional and ideological adjustments that it demands'[82]. It encompasses both an increase in GDP and a change in the character of the economy. Traditionally, the level of income, or GDP per capita has measured this. Economic development includes growth in income, but also expansion of the capabilities and entitlements of the population. Thus the United Nations Development Programme's Human Development Index (HDI) includes measures of health status (life expectancy) and education (literacy).

Population ageing is a late result of the changes that brought on the modern rise in population. The earliest modern concern with population ageing seems to have

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[82] Kuznets, S. (1973) Modern economic growth: Findings and reflections. *The American Economic Review,* 63: 247-258

been associated with the introduction of public pensions in Germany in the 1880s as part of a scheme of compulsory health and unemployment insurance payments from workers, employers and the state, in the face of increased insecurity associated with industrialisation[83] as a 'pre-emptive and protective measure by which the working classes might yet be silenced'[84]. However, the extent to which this reflected a concern for the social and economic effects of population ageing is called into question by one author who notes that according to the *lore of gerontology* Bismark chose 65 as the age for aged pension entitlements as this was an age beyond which, his advisers assured him, few people would live.[85]

Looking at population ageing from this perspective brings into sharp focus five main theoretical shortcomings of the reports on ageing that are intrinsic to mainstream economic analysis. These are methodological individualism, the assumption of rationality, market clearing equilibrium, maximisation and reductionism. A sixth theoretical shortcoming, demographic determinism, is not intrinsic to mainstream economic analysis, but is closely related to methodological individualism and so is quite at home in this style of analysis. In addition, the Productivity Commission Report advances a version of equity for which no justification is provided, and which is at odds with the notion of equity from a public health perspective.

Individualism

The interrelated Methodological, Abstract, and Economic forms of Individualism evident in the reports on ageing together form an analytically coherent and apparently impenetrable conception of individuals and of the economy. According to this conception, social arrangements are explicable only in terms of individuals (Methodological Individualism) and economic arrangements that are left to individuals to make are most likely to reflect what individuals want and to be efficient (Economic Individualism). What individuals want exists independently

[83] Studenski, P. (1933) Pensions. In *Encyclopaedia of the Social Sciences*. Vol. Eleven (Eds, Seligman ER and Johnson A) The Macmillan Company: New York. pp. 64-69
[84] Dickey, B (1987) *No Charity There: A Short History of Social Welfare in Australia.* Allen & Unwin Australia Pty Ltd. 83.
[85] Manton, K. (1982) Changing concepts of morbidity and mortality in the elderly population. *Millbank Memorial Fund Quarterly - Health and Society,* 60: 183-244

of the society in which they live (Abstract Individualism). Together the inter-related individualisms seek out instances where individuals might not be able to express their own desires and preferences, mostly because of government activity, and carry a normative prescription for withdrawal of government from economic activities. Except in the standard cases of market failure, this approach takes little account of other influences on what people want, or their behaviour.

Methodological Individualism seeks to explain all social phenomena only in terms of individuals. This has two important consequences for the representation of economics in the ageing documents. First, there is no scope for asking questions about the broader context and how this might affect outcomes in the future. Second, that lacuna, when combined with demographic determinism, can lead to a fallacy of composition.

Methodological Individualism and demographic determinism combined assume that because health care costs are higher for older people, and the population is ageing, then the bulk of increased health care costs can be attributed to ageing. However this is not borne out by the available evidence. Indeed the Productivity Commission Report reviews the macroeconomic studies of the effects of ageing, which conclude that there is little correlation between population ageing and increased health care spending. When they recognise that there is a mismatch between the microeconomic phenomenon and the macroeconomic studies, they simply assert that the previous macroeconomic studies can be ignored because none of them relate to times or places where the extent of population ageing has been as great as we can expect it to be in the future.[86] Even when the empirical evidence should lead them to question their assumptions, the Productivity Commission skips straight to an explanation that fits with their assumptions, without any serious consideration of alternative explanations. Looking beyond individual persons and examining the environment in which the twin phenomena of population ageing and increased health care costs have occurred might have generated more powerful explanations.

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[86] Productivity Commission *Economic Implications of an Ageing Australia.*

For some twenty years public health research has been generating evidence that the determinants of individual cases and the determinants of the incidence rate are not necessarily the same.[87] Assuming that events or causes common at an individual level are also the relevant matters for inquiry at the population level can result in a misleading epidemiological analysis. Like neoclassical economics, epidemiology tends to concentrate on causes that affect individuals, rather than causes that affect populations. Relative risk, which tells us how much more likely individuals exposed to a particular cause are to experience a particular outcome than non-exposed individuals, is less helpful to public health policy than attributable risk, which indicates how much of the outcome in the population is attributable to that cause.

The Intergenerational Report does acknowledge at least one of those environmental factors when it comments that 'Australians now expect to access more expensive diagnostic procedures and new (and more expensive) medications listed on the PBS'[88]. Thus, the available technology, the pattern of delivery of health services and the associated changes in expectations about what can be provided also drive increases in health care costs. Even when the available technology causes the cost of the treatment of a particular condition to fall, it may contribute to an overall increase in health care costs because it becomes more widely applied as it becomes cheaper. This is not simply the result of a new *equilibrium* being achieved when the market supply curve shifts to the left in the conventional, neoclassical diagram. It occurs largely because of active promotion of the technology or therapy by its makers and by health care providers. Promotion by makers is almost certainly profit-motivated. However, promotion by providers probably represents a mix of profit-motivation and Hippocratic obligation to the patient. Neoclassical analysis of this dynamic tends to focus on the profit-motive and imperfect agency in health care, whereas *Hippocratic* invokes a more sophisticated respect for the ethical obligations ascribed to clinicians. While the second EPAC Report offers suggestions for changes to practices relating

[87] Rose, G. (2001) Sick individuals and sick populations. *International Journal of Epidemiology,* 30: 427-32

[88] Commonwealth of Australia *Intergenerational Report.* 8-9.

to death and dying, including the possibility of euthanasia and withdrawal of life support but 'has no intention of entering that particular minefield' (p40) and instead discusses clinical rankings, patient charter and associated institutional arrangements for seeking consumer views[89]. Underlying these suggestions is an assumption that individual (ageing) patients make autonomous, rational choices about the health care they receive. The problem is that the ageing, *they,* are making choices that the middle-aged, *we* cannot afford because *they* do not face appropriate price signals or do not have sufficient information to make efficient choices. Consequently, each of the suggestions to address rising health care costs associated with population ageing directly targets behaviour changes on the demand side of the health-care transaction, but ignores commercial, institutional or governmental behaviours on the supply-side.

On the supply side of health care clinicians have a Hippocractic obligation to their patients – and, increasingly, various allegiances to organisations, companies and corporations that produce health care technologies and own or operate the organisations from which clinicians deliver health care services. The new technologies that drive health care costs do not appear from nowhere. Many are developed with the specific aim of making a profit. Much health care research and development is not aimed at improving population health status, which means that many new technologies target conditions for which there is likely to be effective future demand, rather than a widespread need. Hence their impact on overall health status is unlikely to be high, although their profitability may still be very healthy. This, it is argued, is one of the reasons why development of new anti-malarial drugs has been largely neglected since the 1970s.[90] People who are at highest risk of contracting malaria tend to be poorer people living in poor countries that do not have generous public funding of health care and pharmaceuticals. Pharmaceutical manufacturers' best chance of developing profitable drugs is to target conditions that affect people living in wealthy countries with more generous public funding of health care and pharmaceuticals.

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[89] Clare and Tulpule *Australia's Ageing Society.* 39-41.
[90] Weisner, J, Ortmann, R, Jomaa, H and Schilitzer, M. (2003) New Antimalarial Drugs. *Angewandte Chemie International Edition,* 42: 5274-5293

It is clear that the practitioner-and-products market does not necessarily produce what contributes the most to the health of the public, but neoclassical economic theory does not identify this as a source of market failure.

At a local level, technologies are developed and marketed if producers think they will sell. This means that treatments are offered that will either be funded by the public purse, or which individuals will purchase, are offered. In order for them to be taken up, health care professionals, usually medical practitioners, or individuals or politicians need to be convinced of their worth. Increasingly, advertising of pharmaceutical drugs and other medical and surgical technologies occurs either through paid advertising, or via journalistic coverage on current affairs television.[91] This reflects the capacity of manufacturers to create a demand in the general public for their technologies products and runs contrary to the neoclassical doctrine that the origins and evolution of consumers' wants and preferences are taken as given and are not the concern of economists.

If much of the demand for health care is generated by the activities of the manufacturers of the technologies, then any discussion of moderating expectations about health care and the demand for health care must recognise this dynamic. Health economists have recognised the possibility of supplier-induced demand in health care arising from imperfect agency on the part of health care providers. This is different to what is being argued here. The activities of the producers of the technologies constitute part of the context in which the imperfect relationship between doctor and patient occurs.

The Intergenerational Report recognized that there is not a significant relationship between population ageing and increased health care costs. The Report offers other possible explanations for increased health care costs suggesting, on the supply side, that health expenditures have been driven by increased unit costs driven, by increased provider incomes, by increased capacity to deliver services, and by new technologies and more intensive use of traditional therapies. On the

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[91] Moynihan, R, Heath, I and Henry, D. (2002) Selling sickness: the pharmaceutical industry and disease mongering. *British Medical Journal,* 324: 886-891

demand side, the Report cites growth in national income and supplier-induced demand. None of these is examined in any detail in any of the ageing reports as a possible explanation for increasing health care costs or as a possible target of policies to control the growth in health care costs.

The Productivity Commission argued that although ageing, itself, has been a relatively minor driver of health care costs, the fact that health care utilisation is higher at older ages means that new technologies will be applied more intensively at older ages and population ageing will amplify the costs of these new technologies. Most importantly, nowhere in any of the reports on ageing is consideration given to the forces that drive the availability of new technologies and pharmaceuticals in the first place.

Methodological Individualism looks to individuals to explain phenomena such as large-scale retirement (and early retirement). It assumes that decisions to retire reflect individuals' assessment of the costs and benefits of retirement and are a rational and autonomous choice, given the incentive set with which each individual is faced. If there is an unsustainable fiscal burden with too many people retiring or retiring too young, then Methodological Individualism holds that the problem lies with the incentives that individuals face, or with their autonomously derived wants and preferences for work versus leisure. The Australian reports pay little attention to the qualitative literature about why people retire compared with the quantitative, often abstractedly empiricist, literature about availability and significance of pensions.

Until the recent past, the opportunity for retirement for the bulk of the population came courtesy of the availability of public pensions. For many others, work-based pension/superannuation schemes (which also attracted a public tax benefit for individuals) created the possibility for early retirement. In Australia, aged pensions were first introduced in Victoria, New South Wales and Queensland, and then replaced by a national system of aged pensions in 1908. The history and evolution of Australian public pensions provides a useful illustration of how institutions that are an important part of the ageing landscape can change and

evolve, often more to address non-demographic concerns than with reference to the material needs of the ageing.[92]

Abstracted individualism

Abstracted Individualism assumes that individuals can be taken as given, independently of any social context.[93] That doctrine fails to recognise that individuals are, to some extent, a product of their environment. Economic Individualism is a belief in economic liberty. It amounts to the justification of certain culturally specific patterns of behaviour and a consequent presumption against economic regulation.[94] This belief asserts that

> a spontaneous economic system based on private property, the market and freedom on production, contract and exchange, and on the unfettered self-interest of individuals, tends to be more or less self-adjusting; and that it conduces to the maximum satisfaction of individuals and to progress.[95]

This has implications for thinking about both economic dependency in old age and the use of health services in old age. Individuals and the health care system are not independent entities, since the system exists both to address the wants of individuals and to address the wants of many players other than users of the services. In addition, the shape of the health care system and the presumptions and actions of the players within it are important influences in the development of individual's expectations of the health care system. This conclusion also applies to the retirement incomes system and decisions to retire. Nonetheless, the reports on ageing treat decisions by individuals in the community as independent from the development of the health system generally and from the behaviour of providers of health care. The reports ignore available evidence and argument that there are disadvantages in funding retirement income through private savings similar to those in funding retirement income through pay-as-you-go pension schemes. For example, Jackson argues that funding retirement through savings can be

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[92] Stone makes a similar argument about the definition of disability, especially for the purposes of accessing public income support payment. Stone, DA (1984) *The Disabled State.* Temple University Press, Philadelphia.
[93] Lukes, S. (1973) Types of individualism. In *Dictionary of the history of ideas: Studies of selected pivotal ideas*. Vol. II (Ed, Weiner PP) Charles Scribner's Sons: New York. pp. 594-604
[94] Ibid. 602.
[95] Ibid.

inflationary if there is insufficient excess productive capacity in the economy to absorb the demand for goods and services that is fueled by income from savings. If inflation occurs then both the old and the young feel the effect on real income. In addition, savings are vulnerable to erosion by inflation.[96] Savings is not as clearly the superior solution to the problem of intergenerational equity as the ageing reports suggest. However, it is the policy option that shifts focus and responsibility back to individuals.

Rationality

Rationality assumes that 'the greater part of social life can be explained as the outcomes of the rational choice of the individual actor'[97] and choice, manifest in action is assumed to follow rationally from the beliefs and desires of individuals. In economics, this usually involves the assumption that actors' preferences are articulated sufficiently for an optimal outcome to be defined in most situations.

Rationality is thus conceived in each of the Australian reports on ageing that consider demographic change. They assume that levels of savings and retirement decisions result from autonomous decisions by rational individuals, made in response to the prevailing set of incentives. From this, it follows logically that the way to change behaviour (increase savings, retire later, look after one's health better and not use health services unnecessarily) is to mandate a new set of incentives that promotes that behaviour. Rationality leading to an optimal outcome can be compromised by uncertainty, knowledge problems, capacity and power.

Simon recognised that rationality can be limited when he coined the term *bounded rationality*.[98] The term is used to denote the 'type of rationality that people (or organizations) resort to when the environment in which they operate is too complex relative to their limited mental capabilities'[99], according to Dequerch

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[96] Jackson *The political economy of population ageing.*
[97] Hindess. Rational Actor Models. 211.
[98] Simon, HA (1957) *Models of man social and rational: mathematical essays on rational human in a social setting.* New York: Wiley.
[99] Dequech, D. (2001) Bounded rationality, institutions and uncertainty. *Journal of Economic Issues,* 35: 911-929. 912-913.

(who might, also, have recognised that rationality can be bounded by the material circumstances of rational actors). For example, complexity is an issue for individuals planning for their retirement since there is a complex maze of rules governing the superannuation industry and the tax treatment of superannuation in Australia.

Market clearing equilibrium / price signals

The evident concern (of the Productivity Commission Report, in particular) about intergenerational equity, and the disincentive effect of higher taxes, suggests that a notion of equilibrium underpins the authors' thinking about this issue. Population ageing is treated as if it is a deviation from an ideal or equilibrium that currently exists. A number of figures and tables are presented to demonstrate a contrast between the with ageing and the without ageing scenarios that have been modelled for the report, giving the impression that the current level of old age in the community is normal, with the future a deviation from it.

For example, the Productivity Commission treats as disequilibrium caused by population ageing, the requirement that later generations contribute a greater part of their personal income in taxes than an earlier generation did. The Commission argued that higher marginal taxes will tip the balance away from increased work effort. A generational backlash could occur because marginal tax rates have increased to the point of being unacceptable. In each of these cases, the fairness or *equilibrium* of the outcome is a matter not of perception but of science. For example, the Productivity Commission's Table 2.3 provides data on the percentage of the population aged 65 and over and the aged dependency ratio for selected countries. Using data reported by the OECD for total taxation receipts for 2003, it is possible to test for a simple correlation between both percentage of population aged 65 and over and total taxation receipts, and between the aged dependency ratio and total taxation receipts. Limiting the analysis to high income countries, as defined by the World Bank, because of the relationship between GDP per capita and government spending, Figures 4.3 and 4.4 indicate that there is no significant correction between percentage of population aged 65 or over and total taxation receipts, and only a weak correlation between the aged dependency ratio and total

taxation receipts. These data include countries that have both contributory and PAYG pensions schemes, as well as large publicly funded health care systems.

In Figure 4.3, total taxation receipts as a per cent of GDP are charted against the per cent of the population aged 65 years and over. The shallow slope of the trend line and the low co-efficient of variation (R^2) confirm that, amongst these countries, there is no significant relationship between total tax receipts and the per cent of the population who are aged. In Figure 4.4, total tax receipts as a per cent of GDP are charter against the aged dependency ratio. While there appears to be some association between tax receipts, as indicated by the gentle upward slope of the trend line, the R^2 statistic for this dataset, at 0.2093 indicates that this is a weak association.

The Productivity Commission Report estimated a fiscal gap by 2044-45 of 6.4 percentage points[100]. This implies an increase in Australia's total tax receipts from 30.1 per cent (OECD 2005) to 36.5 per cent in 2044-45. The argument put forward (but not supported by any evidence) by the Productivity Commission is that this is unsustainable. However, it is not an unprecedented level of taxation. Table 4.2 below, shows total taxation receipts for the same countries for which data is presented in Figures 4.3 and 4.4. This table indicates that Australia is a low-taxed country by OECD standards. In addition, no less than twelve of the countries listed in the table currently have total taxation receipts in excess of 36.5 per cent of GDP. Despite taxation reform being a regular favourite of the mainstream press, there is little evidence of a groundswell of support for reduced taxes in Australia, especially if it is at the expense of health care.[101]

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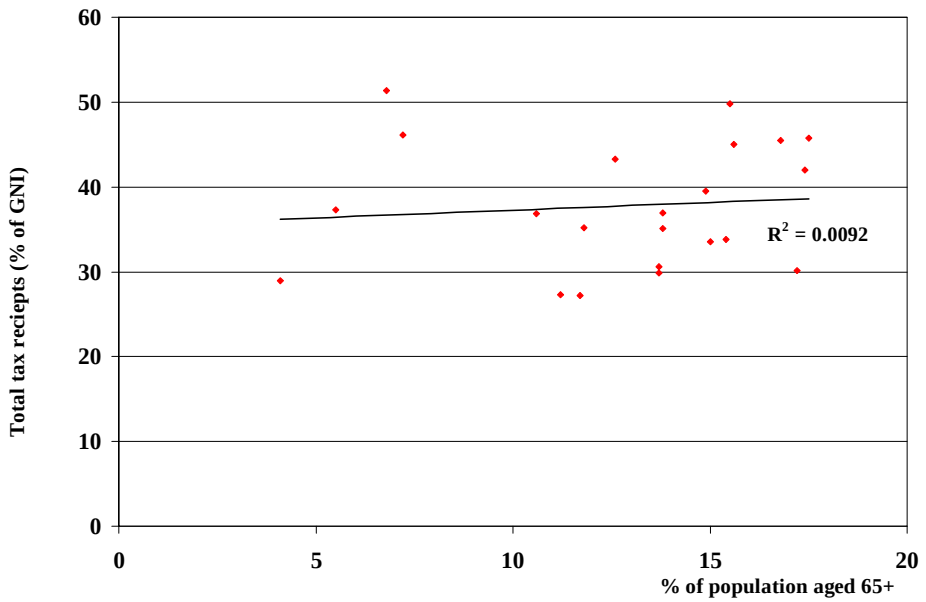
[100] Productivity Commission *Economic Implications of an Ageing Australia.*

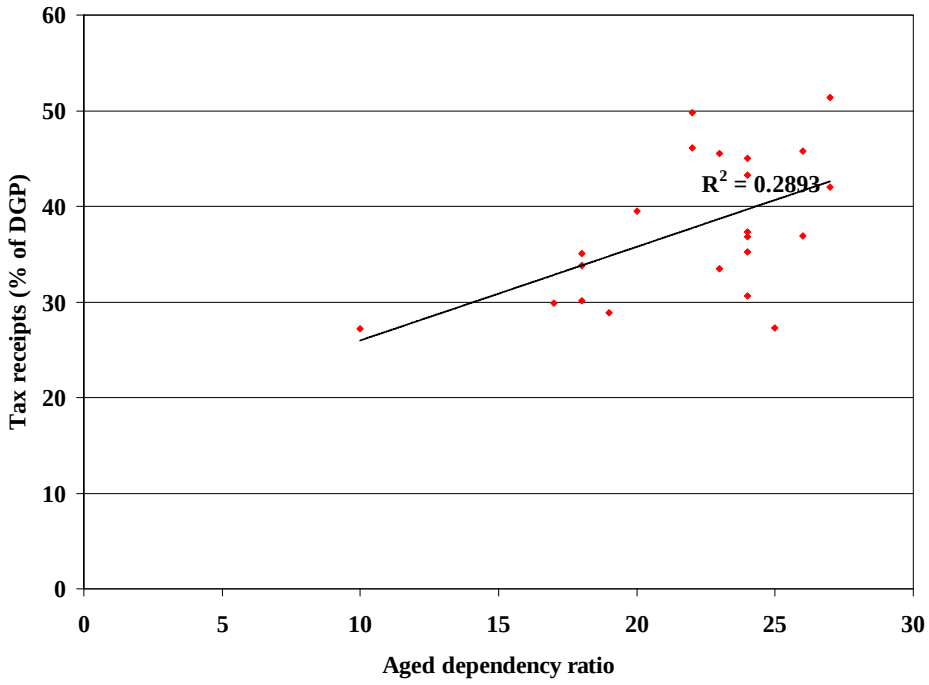
[101] Wilson, S and Breusch, T. (2004) After the tax revolt: Why Medicare matters more to middle Australia than lower taxes. *Australian Journal of Social Issues,* 39: 99-116; Wilson, S and Breusch, T. (2003) Taxes and social spending: the shifting demands of the Australian public. *Australian Journal of Social Issues,* 38; Australian Council of Social Services. (2003) *Taxation, Fairness and public opinion*. ACOSS Info No. 351 Sydney NSW: ACOSS.

Figure 4.3: Percent of population aged 65 and over and total taxation receipts. Selected countries.



Source: Productivity Commission Table 2.3: OECD 2005

Figure 4.4: Aged dependency ratio and total taxation receipts. Selected countries



Source: Productivity Commission Table 2.3: OECD 2005

Table 4.2 Total taxation receipts for selected countries, 2001

Country	Total tax receipts (%GDP)
Sweden	51.4
Denmark	49.8
Finland	46.1
Belgium	45.8
Austria	45.5
France	45
Norway	43.3
Italy	42
Netherlands	39.5
United Kingdom	37.3
Greece	36.9
Germany	36.8
Spain	35.2
Canada	35.1
New Zealand	33.8
Portugal	33.5
Switzerland	30.6
Australia	30.1
Ireland	29.9
United States	28.9
Japan	27.3
Republic of Korea	27.2

Source: Productivity Commission 2005 and OECD 2005

Reductionism

The chief evidence of reductionism comes from an examination of the scope of the reports themselves. Population ageing and its effect are treated as if they will occur somewhat independently of the economy. Policies to address the financial implications of population ageing are treated as if they need to operate apart from general economic and social policy directions. However, old age and dependency in old age are the accumulation of a lifetime of effects on health status and on economic status. There is some recognition of the need, for example, to increase

participation rates in the workforce to reduce the dependency ratio in the future. However, not much attention is given to increasing participation early in life, in order to improve their chances of economic independence in old age, of those who will be old in the future. A number of other issues are also treated in this reductionist manner, including sustainability and dependency. Reductionism is also evident in the reports' demographic determinism.

Sustainability is a recurring theme in the reports on ageing. It is mentioned in relation to maintaining differences in indexing of government benefits,[102] excess growth in law and order expenditure, further growth in local government fees and charges (being unsustainable), levels of health funding and levels of health expenditure. However, except for a passing reference, there is little consideration to the sustainability of population growth as a way of slowing population ageing or of the sustainability of projected continued growth in GDP. Continued population growth will result in a number of challenges, including expansion and increased congestion of cities and increased use of water. Unless there are significant changes in the relationship between the economy and the environment, both increased population and higher GDP will increase the rate of environmental degradation, the use of non-renewable resources and the need for energy. The model that underpins the reports on ageing, of the economy as a distinct and separate entity, reduces economic concerns to those of the man made economy, rather than the economy as encompassing the biosphere.

The reports on ageing are concerned primarily with dependency on the public purse in old age. There is little concern for the effects of private dependency. This reflects the tendency of the authors of the reports to conflate the economic effects and fiscal effects of ageing. However, old age has always been a time of some dependency on resources other than one's own labour, for financial support. This may have come from the proceeds of generated wealth, or from the assistance of family or friends. In the case of family, this support would often be part of the

[102] The unemployment benefit is indexed on CPI and Aged pension is indexed on Male take home average weekly earning (MTAWE).

intergenerational contract. Younger family members support older members in the understanding that the family property will be returned to them in future.[103]

Demographic determinism is also a form of reductionism. The focus of demographic characteristics and demographic change obscures a range of other factors that drive both dependency and health care costs. For example, health care expenditure varies with age. It is highest in the older age groups. Demographic determinists argue that an increasing proportion of older people in the population will necessarily drive health care costs up, clinging to this line of argument even in the presence of evidence that refutes it.[104]

Maximisation

Enthusiasm for intergenerational equity and the use of generational accounting is predicated on the need to maximise consumption possibilities of future generations. This is exemplified by Ablett, who writes 'one can argue that the government should try to avoid significant inter generational redistribution because it could result in the consumption possibilities of certain generations, in particular future generations, being unduly compromised'[105]. Advancing the goal of maximising future (or even present) consumption possibilities pays no attention to the quality or distribution of that consumption. One example where this is a particularly important issue is health care. First, health care markets are recognised as among the least perfect of markets. They are subject to problems with predictability of demand, information and agency. In addition, the benefits of health care are widely debated, both for individuals and for populations. Maximising the consumption of healthcare does not necessarily reflect individuals making good (that is, rational) choices in health care, nor does it necessarily reflect commensurate improvements in health status.

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[103] Thane, P (2005) *The long history of old age.* London: Thames & Sons.
[104] The Productivity Commission report is the best example of this. A myriad of longitudinal and cross-section evidence that refute the proposition that ageing drives up health care costs is dismissed with the assertion that all of the evidence so far relates to slower rates of ageing than we see in the future. Even if ageing doesn't drive costs now, it will in the future.
[105] Ablett. Intergenerational Redistribution and Fiscal Policy.76.

The distribution of goods also matters. Institutional economists recognise this in their definition of the economy as a provisioning process. Instrumentalism demands that the economy provide for the needs of all people. From a public health perspective, improving the health of the population as a whole usually requires attention first to those with the worst health as a practical matter, but also as a moral one. Maximisation does not pay explicit attention to the question of distribution and so fails to accommodate these matters that are of importance to public health.

Equity

The notion of generational equity advanced in the reports on ageing, but most clearly in the Productivity Commission Report rests on the benefit principle that taxpayers of each generation should (as a group) contribute to public expenditures from which they derive benefits in accordance with their share of those benefits. In other words, they should *pay their way*, without either subsidising, or being subsidised by taxpayers in other time periods'[106]. This provides for contemporaneous taxation for current expenditures. This has two implications.

The first is that the principle that applies to intergenerational equity is different from that which currently underpins intragenerational transfers through the taxation system. The principle of collective provision and that underpinning our welfare payments and publicly provided services provision has been loosely based on contribution according to ability to pay, and receipt according to need. That is, through a progressive taxation system, those who have higher incomes, and greater capacity to contribute, pay higher taxes. Need is defined differently depending on the program. Most income support programs are subject to various income and assets test to ensure that they benefit only those in need. The principle of generational equity argues that the sharing of resources based on ability to pay and need should only apply on a year-by-year basis, not over time.

[106] Coombs, G and Dollery, B. (2002) An analysis of the debate on intergenerational equity and fiscal sustainability in Australia. *Australian Journal of Social Issues,* 37: 363-381. 364.

If ability to pay was the principle, then the notion of equity would be quite different. It is forecast that future generations will be far richer than current generations, to the tune of two times GDP per capita by 2044-45, and will still be better off than the current generation even after increased welfare costs associated with ageing have been met. It should also be remembered that this higher GDP per capita has been built on the earlier work of the generation that will be retired in 2042.

The second implication of the *pay your own way* principle is that it hints at a definition of equity as not having to pay for the support of others. This is predicated on the belief that market allocation of income is morally superior to other forms of distribution and allows an analysis of the contribution that individuals make to the tax base and the benefits they received from publicly funded health services and income support. It reflects an individualist ethic that fails to recognise intergenerational interdependencies that are considered to be quite noble when they are expressed privately, rather than publicly.

Discussion

The reports on ageing reflect ambivalence about sharing resources with the non-working aged and exhibit a number of empirical shortcomings. However, this approach fails to adequately address the needs of an ageing population. It constructs old age as the primary cause of ill-health, poverty and dependency in old age, but fails to address to problems in the structure of the economy and society that also contribute to producing those problems.

It has been suggested that ambivalence regarding how far older people have the right to share and enjoy material resources without being engaged in (remunerative) work arises from two factors.[107] First, the elderly play no future role in production. They will consume with no prospect of producing. The fact that they have spent the bulk of their lives creating wealth is usually ignored. Second, in social policy terms, they are viewed as an economic burden that cannot be afforded. Therefore, they are a group for whom financial support must be

[107] Phillipson *Capitalism and the Construction of Old Age.*

strictly rationed and controlled. There is some sense of this in the reports on ageing, as the question of affordability is not fully supported by the evidence. One reason that the assumption of un-affordability is adopted so uncritically in the reports is that the balance of what older people continue to contribute is not considered sufficient in light of the cost of maintaining their income and health care.

Overall the empirical shortcomings fall into two categories. The first is demographic determinism, because it discounts cohort and period effects. Riley shows that accurate forecasts of mortality and disease are difficult to make, even when justified by current evidence.[108] Where the economy is concerned, even short terms predictions, for example, for the year ahead are often inaccurate.[109] The future is not determined entirely by the here and now and there is scope to shape the future in a positive, pro active way, rather than seeing the ageing of the population as a series of threats to which we (often negatively) respond.

Second, the reports fail to look beyond the characteristics, behaviours and circumstances of individuals to examine broader patterns of social organisation that influence or determine their level of wealth and health in old age. Embedded in the arguments surrounding the issue of aged-based entitlements is a broader debate about the nature of society and of human beings. Much of the legitimate subject matter for that debate is lost if age only is used as a criterion for evaluation. The debate about the problems of old age dependency brings to mind Sylvia Tesh's argument about the choices of disease theories. Her argument is that debates about causes are,

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[108] Riley, JC (1989) *Sickness, Recovery and Death: A History and Forecast of Ill Health.* Iowa City: University of Iowa Press.

[109] For example, in Newsweek magazine (26 January 2006) on the accuracy of the World Economic Forum's forecasts for 2005 Michael Meyer reported, 'The U.S. dollar would fall. (It rose.) Interest rates would rise. (They didn't.) Global bubbles from real estate to stocks were likely to burst. (They haven't, at least not yet.) As for oil and energy prices? "We didn't even talk about it!" exclaims Stephen Roach, chief economist of Morgan Stanley in New York and one of Davos's pre-eminent economic seers. A black mark on his prognosticatory scorecard? Nah. "That's just the way it goes in the forecasting business," he says with a shrug.'

> inextricably linked to … beliefs about the proper organisation of society, and more fundamentally, to convictions about the nature of human beings[110]

Once theories about the choice of explanation of causes of disease are in place, in this case the epidemic of old age dependency and disease, are in place, policies are generated which can exacerbate the very problems which they are meant to solve, commonly referred to a *cause-remedy mismatch*. The problem of dependency in old age is not fully explained by the attainment of a particular age. However, its explanation in these terms has led to policies that have promoted early retirement as a cure for other social ills such as unemployment, exacerbating the level of old age dependency. Thus Phillipson argues;

> The experience of growing old must be viewed as an event heavily influenced by class and gender relations. To view old age as a period where the biological process of ageing assumes a primary role is to ignore the cumulative power and significance of life in a class society. The form which experiences in retirement take are not a consequence of individual characteristics or the biological process of ageing, but reflect the influence of numerous forms of inequality within capitalism. Ideologies of retirement and the care of the elderly ... become examples of the way in which growing old is constructed through range of policies imposed upon the older population.[111]

The conventional argument about dependency in old age fails to address the situation of the aged head on, because to do so would challenge three underlying beliefs both about the proper organisation of society and about the nature of human beings. The first belief is that the proper order of society is found in the fulfillment of economic goals, of the type that appear in the national account; the second is that the presence of the old in the workplace is a hindrance to economic efficiency and therefore, to the achievement of those goals; the third is that when employment is scarce the old should make way for the young, and that when any resources are scarce, the old should make way for the young.

In many ways, the economic impact of an ageing society is treated in a fashion that draws the same criticism that Brian Dickey makes of the late 19th century Australian debates about social welfare:

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[110] Tesh *Hidden Arguments: Political Ideology and Disease*. 8.
[111] Phillipson *Capitalism and the Construction of Old Age*. 166-7.

> it confirms a categorical and selective approach to social welfare problems, modified by some acceptance of universalist doctrines of citizenship as the basis of entitlement to a share of community resources… (but makes no) major attempt to face up to the causes of those problems which produced social dependence in the structure of society[112].

As long as old age is constructed as the primary cause of ill-health, poverty and dependency rather than the result of social policies and processes, these issues will not be dealt with at their root cause. However, to see the economic implications of population ageing differently requires an economic analysis capable of addressing the interaction of the broader changes in the economy and the society with the fact of population ageing. Neoclassical approaches are unable to do this. The limitation of neoclassical economics does not lie only in the restrictions of its excessive reliance on formal models, but deeper still, in its methodological approach, the triad of individualism, the presumption of rational behaviour and the focus on market-clearing equilibrium as the benchmark for evaluating the outcomes of all methods for allocating resources.

[112] Dickey *No Charity There: A Short History of Social Welfare in Australia*. 75.

Chapter 5: The National Commission of Audit

Introduction

Audit Commissions were established by the newly elected Liberal governments in each State and the Commonwealth between 1988 and 1996. The first of the Audit Commissions to be considered is that commissioned by the Howard Coalition government, newly-elected in March 1996[1] following 13 years of Labor rule. This Commission reported in June 1996 in line with the timeframes prescribed in the Commission's Terms of Reference[2]. The Commission's Terms specified that it should

> investigate and report on the financial position of the Commonwealth Government, with a view to advising the Government on the future management of its finances consistent with a medium to long term goal of improving the Government's fiscal position [3].

However, the report goes beyond simple questions of financial management and looks at issues including the role of government, the objectives of government, intra and inter-governmental service delivery arrangements and the most appropriate measure for benchmarking the level of the aged pension.

The following account summarises the key approaches and findings of the Commonwealth Audit Commission in relation to the role of government in collective action and the economic consequences of ageing, in particular, their public health implications. Each Chapter of the report makes a number of assertions about the nature of *the problem*, which illustrate the neo-classical approach to these issues. Because the assertions that are made are interrelated in as much as they all emerge from similar theories, they will be dealt with in turn with a discussion after the initial description of each.

The National Commission of Audit was conducted as a consequence of an election promise made by the newly elected Howard Coalition government. Four Commissioners, including a chairman, were appointed to the membership of the

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[1] National Commission of Audit *National Commission of Audit: Report to the Commonwealth Government.*
[2] Ibid. 2.
[3] Ibid. 1.

National Commission of Audit. The Chairman, Robert Officer, was also the Chair of the Victorian Commission of Audit, conducted three years earlier. The other four Commissioners were Geoff Carmody, Maurice Newman, John Fraser and Elizabeth Alexander.

Robert Officer was Professor of Finance at the University of Melbourne when the Audit Commission sat. His doctoral thesis on the market factor in the New York Stock Exchange was completed at the University of Chicago Graduate School of Business. Along with his experience and background in corporate finance and investment he has served as a Director and Treasurer of the Institute of Public Affairs (IPA). Geoff Carmody was founding director of the economic consulting company Access Economics and former Commonwealth Treasury official, who had represented Australia at the IMF and the OECD. He has been a member of the Institute of Public Affairs, was involved in the preparation of an earlier Federal Liberal Party policy document *Fightback* and, in a publication of the HR Nicholls Society, described the Industrial Relations Commission in Australia as a cancer.[4] Maurice Newman was chairman of investment banking company Bain & Company at the time of the Commission and was an early board member of the Centre for Independent Studies. John Fraser was executive chairman and CEO of investment company SBC Brinson Ltd and a former Deputy Secretary of the Commonwealth Treasury, where he had been employed for 20 years up until 1993. Elizabeth Alexander was a partner at Price Waterhouse at the time of the Commission, and is a specialist in risk management and corporate governance who has since held many board positions.

The association of Officer, Carmody and Newman with the IPA, the CIS and the HR Nicholls Society suggest that the Commission was not as independent as it might have been. The CIS and the IPA were described by sociologist Michael Pusey as the 'largest' and 'second in the pecking order', respectively, of right wing think tanks in Australia and the HR Nicholls Society as having 'dedicated itself to

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[4] Carmody, G (1989) *The industrial relations commission in terminal decline.* `The Legacy of the Hungry Mile' The Proceedings of a Conference of the H.R Nicholls Society at The President Melbourne Saturday, August 19, 1989. Melbourne: The HR Nicholls Society.

the destruction of centralised wage fixing'.[5] Peter Costello, Commonwealth Treasurer to whom the National Commission of Audit reported, and John Stone, former National Party Senator and former Secretary of the Treasury, were instrumental in the establishment the Society in 1984. Stone had been a Treasury official from 1954, serving as head of Treasury between 1979 and 1984. Stone was Australia's executive director in the International Monetary Fund, and the World Bank in Washington. This close association of at least three of the commissioners with economically conservative think-tanks with which the Liberal Party has various ties, also suggests an existing implicit understanding of what was required and may explain in some part, why the report could be completed so quickly.

The document is 300 pages long, plus 106 pages of appendices and comprises eleven chapters, of which three are relevant for this thesis. Chapter Two outlines the principles guiding the Commission's analysis. Chapter Three discusses the objectives of government activity and the question 'should government get involved?'. Chapter Six discusses demographic change and Commonwealth finances. There are seven appendices. Two of these, one relating to health and health related services (Appendix C) and one dealing with recent superannuation reforms in Australia (Appendix D) are largely descriptive and are not discussed at any length in this thesis.

The National Commission of Audit's Principles

Chapter Two of the Commonwealth Audit Commission Report (1996) outlines the principles guiding the Commission's analysis. However, it first provides a justification for the kind of review that it was about to undertake. Drawing upon an OECD report on public sector reforms in OECD countries, it lists a number of factors that, it says, apply in Australia and come together to make reform a burning issue. First among these is 'the development of a global market-place

[5] Pusey, M (1991) *Economic rationalism in Canberra: a nation-building state changes its mind.* Cambridge, England; Melbourne: Cambridge University Press. 227

which highlighted the impact of government activities on national competitiveness[6]. Other factors include:

- the perception that the public sector was both inferior to, and squeezing out, the private sector;
- the limits to future growth of the public sector, given budget deficits and high levels of public debt;
- lower expectations about the government's ability to solve problems by traditional means;
- citizen's demand for better services and the demands of public sector staff.

No evidence is provided in support of these claims, nor are they analysed in any way. This suggests that both the phenomenon listed and their consequences are understood and uncontested.

The Report then presents three principles. The first is the justifications for government involvement, while the second and third are the principles of effectiveness and efficiency, which, it argues, should guide such involvement. To answer the question 'when should governments get involved in the community's activities?' two sets of justifications are provided. The first is the 'social' case; when the community demands that specific social objectives be addressed, such as a humane society, a more even distribution of income and the provision of assistance to those genuinely in need. The second is the economic case, when there is clear evidence of market failure. This second justification receives the most attention. In particular, whether the benefits of government intervention outweigh the costs and the need for regular review to ensure that the government's role remains justified and appropriate.

It is then argued that the principles of efficiency and effectiveness should guide such involvement. Effectiveness principles dictate that programs be characterised by client-focused objectives, objectives that are consistent within and between programs, design that minimises incentives and opportunities for overuse or abuse and minimal opportunities for cost shifting between program areas. Efficiency principles dictate that programs be characterised by best practice

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[6] National Commission of Audit *National Commission of Audit: Report to the Commonwealth Government.* 9.

delivery, transparency and accountability, accessibility and contestability, and, it is argued, are best achieved by a purchaser/provider split (PPS).

This organisation of the material is justified by an assertion that, in the private sector, competition forces service providers to concentrate on efficiency. PPS and contestability should empower some clients to take on the purchaser role. PPS, it is claimed, provides a number of benefits:

- Better and clearer specification of policy priorities leading to improvement of working relationships due to clearer expectations and responsibilities;
- Minimisation of conflict of interest when providers are not the sole source of advice on targets, evaluation and standards;
- Enhancement of contestability as potential providers are exposed to competition and heightened accountability because a purchaser may specify what performance information is required from a provider; and
- Increased managerial autonomy because relevant roles and structures can be clarified coupled with improved responsiveness to clients because purchase agreements require the provider to meet client needs.

Other mechanisms and measures for achieving greater efficiency that are recommended include benchmarking, contestability, reduction of duplication, cross program approaches, reduction in complexity, risk management, the use of new technology and cost recovery mechanisms. These measures, it is asserted by the Commission, will drive better performance and innovation in work practices, reduce costly duplication and cost-shifting, promote more coherent and efficient service delivery and use, reduce client confusion and improve access to services. The Commission asserts that application of these measures and mechanisms will improve efficiency in the interface between Commonwealth and State programs; the operations of Commonwealth departments and agencies; and infrastructure operations.[7]

The National Commission of Audit and the role of government

Chapter Three of the Commission's report discusses the objectives of government activity and asks: when should the government be involved? It answers that the

[7] Ibid.

first task is to ensure that governments are focusing on their core activities and business. This Chapter considers the case for the Government to maintain its own programs, taking into account the framework of principles established in Chapter Two of the Report, and addresses government assistance programs, government business enterprises and government service programs. The case and its implications are not so much derived from theory and defined as described or prescribed.

For example, the Report prescribes the conduct of reviews of government priorities, using a rigorous and consistent set of principles, to

> fundamentally change organisations to concentrate on their core activities, to withdraw from activities that do not add value, to clearly establish their goals and to maximise their effectiveness and efficiency.[8]

Urgent review of government assistance programs that provide assistance to business and higher incomes earners that would not meet the principles for government involvement is recommended. Its chosen examples include non-means-tested childcare cash rebate, non-means-tested tertiary education and export market development grants and related programs. Tax expenditures, including some R&D expenditures and the income tax exemption of the unrelated business income of tax-exempt organisations, which are less visible than outlays programs, the Commission claims, should also be reviewed and, if their objectives are considered appropriate, consideration should be given to converting them to outlay programs.

On the subject of Government Business Enterprises (GBE), the Commission states that the original justifications for them may no longer be appropriate and that governments should not own businesses that can be operated successfully by the private sector. The proffered justifications include a perception of failure by the private sector in delivering the required products or services, a community view that government should own a firm that operated as a natural monopoly, or the need to fulfill a community service obligation. According to the Commission,

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[8] Ibid. 21.

these commercial activities are a distraction from the government's core activities, do not compete on neutral terms with their private sector counterparts and can arbitrage off government guarantees to increase profit, can be subject to capture or influence by interest groups and can lead to conflicts of interest where a government both owns a corporation and regulates the activities of its industry. The Commission recommends that government shut down or sell public sector assets where there appears to be no public interest reason for continued government ownership. The question of what constitutes a public interest is important here and is addressed later in the Chapter.

Recently, the commercialisation of government services has been promoted in Australia, on the basis that it will (or should) increase the efficient utilisation of resources and the effectiveness and transparency of service delivery. Supporters of this policy claim that features of its operation have included the separation of regulatory and service delivery functions; the progressive introduction of contestable markets wherever appropriate and possible; increased use of contracting out where appropriate and concentration on core or specialist service provision; user pays; user choice; transfer of funds from the suppliers to the customers or the purchasing agencies; self funding of service providers; and full cost accrual accounting.

Where a commercial activity or service meets the public interest test and is retained, the Audit Commission asserted that it should be subject to principles of competitive neutrality, including paying all taxes and charges or the introduction of a tax equivalence scheme; paying debt guarantee fees where applicable; complying with regulations that apply to competitors; obtaining a commercial return on capital; undertaking, at the full cost of capital, provision of services in the public interest and community service obligations; prevention of unwarranted and non-transparent cross-subsidisation between commercial and non-commercial activities and services, including community service obligations; having transparency in costing and funding arrangements for community service obligations and incorporating the business or, as a minimum, operating through a

commercial trust account, rather than directly from the Commonwealth public account.

The Commission provided a list of entities to which these principles should be applied, including the Department of Administrative Services's commercial activities; Defence Housing Authority; Legal practice of the Attorney-General's Department; Australian Protective Service; Insolvency and Trustee Services Australia; Australian Hearing Services, Commonwealth Rehabilitation Service and the Australian Government Health Service.

The National Commission of Audit and demographic change

Chapter Six of the Report of the National Commission of Audit considers demographic change and Commonwealth finances. It begins by defining demographic change 'broadly' as social change as well as changes in the size and composition of the population. Population ageing is attributed to reduced fertility and falling age-specific mortality, brought on by advances in health care and improved living standards, all expressed most obviously in the ageing of the baby boomer population, which was a popular topic of the time. Likely future changes to family structure and workforce participation cited by the Commission, include smaller families, more part-time employment, a higher proportion of females to males in the paid workforce and an increase in the proportion of the population not working (presumably due to retirement) are all cited as likely influences on the burden of existing and new social security measures on future generations at the individual taxpayer level. The aspects, or implications of demographic change that attracted the Commission's comment, included an ageing society, family structure and support arrangements and labour force participation.

First, societal ageing will manifest in a substantial increase in the proportion of the population who are aged, increasing the aged dependency ratio and the dependency ratio overall, because small reductions in the numbers of very young do not offset the increase in the numbers of aged. This is seen as a problem because the aged will impose a larger burden on Commonwealth outlays than the young.

Second, family structure and support arrangements are expected to change, including both smaller household size and more (especially older) people living in private homes. The Commission foresees a higher rate of family breakdown, greater labour force participation among females and greater assertion of rights for independent living for people with disabilities, leading to greater demand for long term care. They then comment that there has been an increased use of formal child care, including for non-work related care, but do not link it back to the issue at hand.

Third, the Commission noted that labour force participation has fallen among all age groups of males, but especially 55-59 year old males, but made no attempt to explain these changes except that possibly the availability of superannuation promoted early retirement. The conclusion is drawn that this produces a direct loss to national welfare through lost production and also encourages dissipation of benefits prior to the individual reaching pensionable age. Increasing labour force participation rates are reported for women (Figure 6.3b) - but are not commented upon.

Fourth, the Commission presented aged/working age and aged and non-working adult/working population dependency ratios. While the aged/working age ratio was projected to increase from 0.28 in 1993 to 0.54 in 2059, the non-working/working ratio was projected to increase from 0.77 to 0.91 over the same period but the Commission made no comment on the significance of these numbers.

Fifth, the overall effect of these demographic changes on Commonwealth finances, the Commission reported, would be an increase in per capita spending for health and social security sufficient to outweigh declining average spending per capita on education and employment as younger age cohorts shrink in relative size, and an increase in per capita spending as the proportion of females in the population increases, as spending for females is higher in respect of health and social security, but similar to spending on males for education. There is no discussion of why women have higher health care costs (though the contribution of childbirth comes

to mind) and social security costs (though the biases in access to income and wealth that keep women poor come to mind).

The Audit Commission then questioned the conclusion by the 1994 Economic Planning Advisory Council (EPAC) report, that the ageing problem is manageable and that no specific policy response is required, on the grounds that 1994 estimates were optimistic on two counts:

> (i) Each new projection of Australia's population (and also for other countries) seems to show an increase in the proportion of aged people, and
>
> (ii) The underlying growth in health costs due to increased use and technology appeared to have been underestimated by EPAC.[9]

However, the Audit Commission did not actually produce costings demonstrating that the changes were not manageable, only new estimates of increases in costs to the year 2031 as a percentage of GDP. The question of what actually drives health care costs, and the assumption that population ageing is an important driver of these, as well as the scope for government to manage health care costs are not explored by the Commission.

The Commission also disagreed with EPAC's assessment that the increase in social expenditure could be matched by an increase in the share of GDP allocated to taxation. First, the increase in social expenditure would be closer to 9.7 per cent of GDP, rather than the 2.5 per cent projected by EPAC, and they did not 'agree with EPAC's optimistic appraisal of the feasibility or desirability of attempting to raise taxation in the future'[10], on the grounds that a greater proportion of older people (who pay less tax), an increased proportion of females in the labour force and more part-time employment, combined, suggest less income tax revenue relative to GDP. These changes might be offset to some extent by higher wage levels and tax-bracket creep. However, indirect tax collections, it is argued, are likely to fall as a proportion of GDP on the basis of current (pre-GST) taxation policy. The question of whether the assertions that the Audit Commission makes about the

[9] Ibid. 133.
[10] Ibid. 135.

future difficulties in raising taxation revenue is a sufficient basis to proceed on taxation policy is addressed later in this Chapter. Finally, the impact that existing government polices have on the labour market, for example, that result in increased part-time and precarious employment, that are actually driving these trends are not dealt with by the Commission.

The Audit Commission then turned to major areas of pressures on outlays such as health, family support payments (including childcare) and social security. Assuming 1.25 per cent growth in real per capita GDP and 2 per cent real growth in average health care costs in each age group, they expected health expenditures to be 17 per cent of GDP by 2041, with health expenditure on the aged accounting for 9.6 per cent of GDP. The Commission then did a quick switch from economic analysis to political prophecy, declaring it 'unlikely that governments and the community will allow health to become such a disproportionate burden on national income'[11]. Another political judgement followed, that if 3.9 per cent of GDP (out of the 9.6 per cent) was met by the Commonwealth, State governments would find it extremely difficult to meet their share of the growth in health expenditure, increasing financial pressure on the Commonwealth. The Audit Commission's first recommendation is headed *Need for urgent action*. Specifically, the Audit Commission recommends that health budget pressures be addressed by

- better targeting of nursing home benefits, including means testing;
- providing scope for government recovery of costs from the estates of income poor but asset rich clients; and
- development of long term care insurance products by private insurers.[12]

All suggestions but the last lean towards keeping the government in, rather than getting it out of, micro-management and there is no discussion of the well-rehearsed problems of market failure in insurance or any evidence as to the efficacy of long-term care insurance.

The Audit Commission identified the current income support environment as a cause for concern, in that it is likely to cultivate expectations as to the availability

[11] Ibid. 138.
[12] Ibid. 140.

and generosity of government support that might prove to be beyond the Government's capacity to meet. It claims that people perceive a right to 'claw back' in retirement taxes they have paid during their working lives and arrange their affairs so as to maintain eligibility for government support and avoid saving (although no evidence is provided to support this claim or the extent of the problem), and that any proposal to introduce or enhance a benefit should include confirmation of long term affordability, having regard to both behavioral responses from the community and impacts on long term expectations of support from government.[13] The report describes intergenerational accounting, which asks whether present budgetary arrangements are fair to those living in the future and whether fiscal policy can be considered generationally neutral. This, the report claims, is especially important in countries with pay-as you-go pension and health schemes and the Commission implicitly endorsed Intergenerational Equity as a criterion for judging expenditure.

The Audit Commission considers two examples of intergenerational accounting, prepared by Ablett. The first suggests that

> demographic change will not impose a public finance burden on future generations so large as to result in intergenerational inequities. In fact the results are marginally favourable to future generations.[14]

However, the second example, which extends the first to include private transfers and consumption, gives a strongly negative outcome for future generations in that it suggests that current consumption trends are sustainable only with a substantial private wealth transfer from future generations to those alive today, which 'appears only a hypothetical possibility'[15]. Thus, Ablett identified a major structural deficiency in national saving and a need to ensure that the private saving culture in not being undermined and distorted by present social security, superannuation and taxation regimes. This is consistent with the suggestion that compulsory superannuation schemes add little to overall household savings

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[13] Ibid. 142-3.
[14] Ablett (1994) cited by Ibid. 144. Ablett was the first to apply generational accounting to Australia and has produced the only sets of Intergenerational Account that are available for Australia
[15] Saltman, RB and von Otter, C. (1989) Public competition versus mixed markets: an analytic comparison. *Health Policy,* 11: 43-55. 154.

because they displace non-superannuation savings. In addition, the complex taxation system allows a variety of treatments for superannuation savings (which, in any case, are likely to be relatively diminished for individuals who experience lengthy periods of unemployment).

The Audit Commission concludes that both public and private savings need to be increased, in part because one takes the pressure off the other. However, saving offset effects can arise as people attempt to maximize pension eligibility and, at higher levels of income, run down superannuation savings to achieve pension eligibility.[16] They can effectively double-dip by taking advantage of both superannuation concessions and pension entitlements.

Broad features of a solution proposed by the Audit Commission include the promotion of a stronger private saving culture, which requires comprehensive reform of private saving arrangements, and the way they interact with government benefit programs (but no mention of an income level from which savings are feasible); ensuring publicly funded retirement income support is targeted tightly on those most in need; and action to minimise opportunities for double dipping. Further research by the Retirement Incomes Modeling Task Force in the Department of Treasury was also recommended.

More broadly, in relation to family support payments (including childcare), the Audit Commission links changes in the balance of roles between the family, society and government to the increased prevalence of two income families. The Audit Commission's report treats each of these issues as if they are related only by their impact on government finances. However, the relationship between family support payments, childcare subsidies and paid maternity leave, female workforce participation, demographic change and dependency in old age needs to be recognised because it has the potential to affect both fertility rates and labour force participation patterns.

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[16] A 'savings offset effect' occurs when individuals transfer existing saving to the new savings line, thus saving appears under this line, but they are not new savings. Apparently new savings are offset by reductions in existing savings elsewhere.

Issues raised by the National Commission of Audit

A number of issues that arise from this reading of selected Chapters of the Commonwealth Audit Commission Report, most pertinent to an ageing population, require future discussion as to their nature, significance or consequences. Seven important issues arising from the Audit Commission are discussed further in this Chapter. These issues are the role of government, public sector performance, privatisation and purchaser/provider split, the concept of the public interest. Moreover, these issues have their basis in public choice theory and mainstream economic theory of the market, the interrelatedness of policies at different stages of life and the problem of health care costs. A discussion of these issues demonstrates that the Commission's recommendations were based more on theory than empirical evidence and that the reductive nature of its analysis fails to recognise the contradictory nature of many of its policy recommendations.

Public sector performance

The underlying approach of the Audit Commission reflects the neo-classical view that markets are the optimal means of allocation and distributing resources and that government should only become involved when there is clear evidence of *market failure*, or possibly when there is a 'social' case. However, much of the argument in the Audit Commission Report assumes that the key issues are market failure and efficiency.

Issues of public health are a case in which market failure clearly exists. Examples include traditionally recognised problems such as negative externalities in infectious diseases, positive externalities in immunization programs and market failure in providing information. In the realm of health care services, such as medical services, market failure arises from a number of sources and is widely recognised by health economists as a reason for government intervention.

One of the problems facing the public sector is said to be difficulties in raising taxes. This is an allusion to apparent tax revolts. However, apart from sporadic campaigns by the business community, there is little evidence of a tax revolt by

the general population. [17] The Audit Commission report expressed concern about future difficulties in raising taxation revenue to fund existing and new expenditure. This concern arises as population ageing will resulting in a smaller percentage of the population being in the workforce, and thus the tax burden falling on each worker being larger. This is because ageing (older people pay less tax), an increased proportion of females in the labour force and more part-time employment, combined, reduces the amount of income tax revenue relative to GDP.

However, many of these trends have occurred because of government labour market policies or have negative consequences because of the policies. One of the ongoing reforms continued and accelerated by the Commonwealth government has been in the labour market, where policies designed to increase flexibility have resulted in an increase in the number of part-time and casual jobs and a relative reduction in the availability of full-time jobs. One objective of these policies has been to lower unemployment. In terms of the unemployment rate, the outcomes look fairly positive with unemployment falling to record low levels. However, the growth of part-time work means that many people who are not counted as unemployed are underemployed and the growth of casual work makes access to work precarious for many people. Both of these trends can erode the tax base in terms of how much tax each worker pays. In addition, the increased ratio of women to men in the workforce is an outcome of government policies. Women are more likely to take part-time and casual employment and, therefore, more likely to be locked into low paying or precarious employment that has limited opportunities for advancement. This also contributes to dependency in old age.

Privatisation and purchaser-provider models

Purchaser Provider models (otherwise known as Purchaser-Provider Split or PPS) is a means of structuring the public financing and provision of health care in a

[17] While the introduction of a consumption tax had been Liberal Party policy as part of the Fightback! package, the Howard Liberal Government was re-elected in October 1998 with a policy of not introducing a consumption tax. Despite this a 10 per cent Goods and Services Tax (GST) was introduced in July 2000. This government was subsequently re-elected in November 2001 and October 2004. While other factors played a role in the later elections, apparently the GST was not a big enough issue to prevent re-election.

way that is said to mimic the efficiency enhancing features of the market. Critiques of publicly funded and provided health care argue that the arrangements that are put in place do not provide incentives for providers of health care to behave efficiently and be responsive to patient needs. Subjecting them to market forces through PPS arrangements, it is argued, will impose discipline through competition and improve efficiency and responsiveness of health care services. Naturally, this discipline is most evident if contracts to provide care are contestable and the threat of switching providers is a credible one. The issue of privatisation is taken up in more detail in Chapter 7.

The concept of the 'public interest'

The question of what constitutes a public interest is important here. The Audit Commission states that:

> 'Public interest' largely implies that there is some market failure, for example, in areas such as quarantine and air safety. In general, if the private sector is adequately providing, or can provide, the service, there is unlikely to be a public interest reason for government to deliver the service.[18]

This reference to the public interest is made in the context of a discussion about Government service programs. It is the only attempt that is made by the National Audit Commission to define *public interest*[19] and the formulation reflects the view that interests are met through the consumption of goods and services and that markets will provide adequately unless there is a structural reason for market failure, such as an externality or a public good. The assertion that the public interest is unlikely to be met by market provision in the case of an externality or a public good is a valid view in relation to the provision of goods or services to individuals, that is meeting individual interests in aggregate, rather than a collective, public interest. However, people interested in public health development, as an obvious case in point, might also employ broader notions of public interest.

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[18] National Commission of Audit *National Commission of Audit: Report to the Commonwealth Government.* 26.

[19] Reference is made to public interest broadcasting in Chapter 5 of the report, but there is no discussion as to what constitutes this.

Public interest is a contested term, used on both the right and left of politics. Organisations with the term public interest in their title include those arguing for less government, for more work to protect the environment, greater transparency of information by product (especially pharmaceuticals) manufacturers, better public housing, education and healthcare, safe, affordable and reliable energy services, and stronger government efforts to fight abuse of charitable trust status. This is a diverse list of items, some of which there would probably command widespread consensus (for example, transparent information on the safety or otherwise of pharmaceuticals), but with parts that would be challenged if the views of the whole community were sought.

The notion of public interest can also reflect a view that society has an interest in an issue. In the case of public health, one definition of public health that is widely accepted is that 'the mission of public health is to fulfill society's interests in assuring conditions in which people can be healthy' [20] This is not to say that there is no self-interested behaviour in public health[21], but to recognise that public health, ideally, reflects a public interest in a healthy population, irrespective of whether threats to public health arise from market failure, or due to the workings of competitive markets that simply do not produce the health outcomes that the community expects. Often the threats to health arise from the distribution of goods, services and incomes in competitive markets and questions about what kinds of markets we should have are pertinent.

The interrelatedness of policies at different stages of life and demographic change

The Audit Commission Report treats each of the issues that contribute to demographic change as if related only by their impact on government finances. However, the relationship between family support payments, childcare subsidies and paid maternity leave, female workforce participation, demographic change and dependency in old age needs to be considered. The Report attributes the

[20] Beaglehole, R and Dal Poz, M. (2003) Public health workforce: challenges and policy issues. *Human Resources for Health,* 1: 4. 2.
[21] Tollison, RD and Wagner, RE. (1991) Self-interest, public interest, and public health. *Public Choice,* 69: 323-343

problem of population ageing to lower fertility rates and lower mortality rates, which can be influenced, indirectly, by a number of factors canvassed in the Report. The Report also discusses childcare rebate and health care spending policies that have the potential to directly impact on fertility and future population ageing.

There has been an ongoing debate about the adequacy of childcare rebates in Australia since this Report was released. There is argument in some circles that the availability of childcare reduces fertility rates by increasing the opportunities for women to participate in the workforce. When they do this, they forgo having children. This is seen as a choice between production and reproduction. Certainly there has been a relationship between female workforce participation and fertility, internationally but the causal relationship is not necessarily that workforce participation leads to fewer children. Much of the observed fertility reduction has been due to education for girls, an improved social status of women and the availability of acceptable and effective contraception.

When only developed countries are considered, those that have higher rates of female workforce participation also have higher fertility rates.[22] In addition, attempts in the US to increase fertility by lowering workforce participation through reduced childcare subsidies resulted in lower fertility rates, rather than lower workforce participation rates.[23] Finally, it is worth noting that lower rates of workforce participation among women are likely to increase their dependence on the state in old age.

Health care costs

Health care costs in Australia have certainly increased in real terms. However, as a proportion of GDP, the increase has been more modest, from 7.7 per cent of GDP in 1982/83, when Medicare was introduced, to 8.5 per cent of GDP in 1999-2000 following almost a decade of health expenditure growth that mirrored GDP

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[22] Coleman, DA (1998) *Reproduction and survival in an unknown world: what drives today's industrial populations and to what future?* NIDI Hofstee Lecture Series. The Hague: Netherlands Interdisciplinary Demographic Institute.
[23] Mencimer, S. (2001) The baby boycott. *The Washington Monthly,* June 2001: 14-19

growth.[24] Since 1999-2000, health care expenditure has increased to 9.7 per cent in 2003-04.[25] This is about 0.9 per cent of GDP higher than the OECD average, but by no means high up the OECD rankings.[26] While Australians do spend more each year on health care, considered on a *per capita* basis, the increase is not much greater than the increase in income. A review by Richardson, in 1999, of the considerable exploration of forces that drive the increase in health care costs found little evidence that demographic change had a significant impact on health care costs.[27] In the US, the proportion of health care spending on people aged 65 and over increased from 23.6 per cent to 32.7 per cent between 1965 and 1981 due both to the number of elderly growing more rapidly than the rest of the population and to *per capita* spending on the elderly increasing more rapidly than for the rest of the population.[28] This second factor suggests that concentrating on changing demography, rather than other dynamics fails to identify drivers that are amenable to change. Indeed, Richardson argues that 'it is possible that aggregate costs may be determined by factors that are independent of the demographic profile and that the age profile simply determines the distribution of the predetermined expenditures'[29]. Those factors include increased unit costs driven by the increase in provider incomes; the increased capacity to deliver services which have been determined by a diverse range of uncoordinated health and educational authorities and new technologies including the more intensive use of traditional therapies (probably the most important 'autonomous' variable in the equation and the most difficult for a small country to control), growth in national income and supplier-induced demand.

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[24] Australian Institute of Health and Welfare (1996a) *Health Expenditure Bulletin.* Information Bulletin No. 12. Canberra: AIHW; Australian Institute of Health and Welfare (2001) *Health Expenditure Bulletin No 17.* Canberra: AIHW.
[25] Australian Institute of Health and Welfare (AIHW) *Health Expenditure Australia 2003–04.*
[26] Ibid.
[27] Richardson, J and Robertson, I. (1999) Ageing and the cost of health services. In *Policy Implications of the Ageing of Australia's Population*. Productivity Commission and Melbourne Institute: Canberra
[28] Fuchs, VR. (1984) "Though Much is Taken": Reflections on Ageing, Health and Medical Care. *Milbank Memorial Fund Quarterly. Health and Society,* 62: 143-169
[29] Richardson and Robertson. Ageing and the cost of health services. 331.

Conclusion

The Commonwealth Audit Commission Report raises a number of issues that have implications for public health. The Commissioners take many of these on face value and assumptions are made, without critical analysis, about their problematic nature and consequences. In addition, different parts of the Report refer to issues that have a bearing on each other without recognising the linkages. As a result, some policy recommendations in one area may have a negative impact on another issue that the Report recommends action on. It is conceivable that detail would be omitted from the Report due to space constraints but failure to deal with many of these issues on more than face value results in a piecemeal approach and ill-connected proposals unlikely to deal effectively with many of the long-term consequences with which it is apparently concerned.

Chapter 6: The State Audit Commissions

Introduction

Australia is a federation of six States (New South Wales, Queensland, Victoria, South Australia, Western Australia and Tasmania) and two self-governing Territories. The 1901 Constitution transferred limited powers to the Commonwealth Government from the colonial governments, which retained their distinct political status, albeit with reduced residual powers. The States and Territories continue to have responsibility for providing many services, including health care, funded by both State and Commonwealth taxation revenue. The Commonwealth Government collects the bulk of taxation revenues, has responsibility for quarantine, money and banking and has a lead role in international issues including trade and treaties. In addition, the Australian Constitution allows the Commonwealth to make laws with respect to a number of payments to individuals including for medical and dental services and income support. The Commonwealth also makes payments to the States for the provision of services and other programs.

Audit Commissions were conducted in all States and the Commonwealth soon after the election of coalition governments, starting with New South Wales in 1988, and ending with Queensland in 1996.[1] Thus, most of the States' Audit Commissions predate the Commonwealth exercise, with the last one being delivered only eleven days after the Commonwealth report. They were established to provide advice to the various State governments on matters relating to the financial management of the States. Abridged versions of the terms of reference for each of the State Audit Commissions are contained in Appendix One.

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[1] *Coalition* is essentially shorthand for Liberal and Country Party political groupings, which have followed a career during the 20th century from 'social liberalism' to an embrace of 'market liberalism'. Non-coalition governments of Labor politicians also began as ethical liberals and have moved later, and a little less aggressively, towards market liberalism. See Sawer, M (2003) *The Ethical State? Social Liberalism in Australia.* Melbourne: Melbourne University Press; Sawer, M. (1983) From Ethical state to minimal state - state ideology in Australia. *Politics,* 18: 26-35

The Audit Commissions have not been without their critics. Broomhill, for example, had the following to say about the South Australian Commission of Audit:

- Firstly, the structure of the audit committee ensured that it could not provide an 'independent' review of the state's public sector. The composition of the committee was highly political and followed a pattern employed in other States.
- Secondly, the report was seen to be based on the principles of economic rationalism and as such was ideologically biased and extremist. It was dominated by the sort of economic rationalist assumptions which were tried and largely discarded in the 80s, such as: we are living beyond our means; government should have a minimalist role in the economy; the public sector is inherently inefficient; reducing the size of the public sector will benefit the overall economy (the crowding out theory); the market, unimpeded by the public sector, will maximise efficiency; and the 'user pays' principle should be applied wherever possible.
- Thirdly, the document was flawed in its methodology, assumptions and conclusions. The debt was grossly exaggerated … Its accounting methods were inappropriate for the public sector (and) The benefits from reducing debt faster were highly exaggerated. …
- Fourthly, the report was … fundamentally an accounting document … and did not consider the broader economic and social implications of its policy recommendations in terms of equity. There was a serious lack of consideration of the different impacts on different social groups even through the impact on existing disadvantaged groups was certain to be very negative … no recognition that unemployment would be worsened or the huge price rises for public services would be inevitable under the user pays principle. …
- Finally … 'the impact of this approach would inevitably choke economic recovery. There was no strategy for recovery and growth other than the usual economic rationalist faith in the role of the market. … The report showed no awareness of research which indicates that local and State governments can play a key role in economic development by promoting high quality social and economic infrastructure'[2].

Whilst I would concur, in the broad, with those general criticisms, this thesis is concerned more with the specific criticisms and issues that the audit commission approach and recommendations have for health care and public health. Therefore only some of Broomhill's themes are explored here.

This Chapter considers two areas of the State Audit Commission reports. The first is the framework sections or Chapters, which are important to this thesis because they outline the approach and methods used by the Audit Commissions. The approaches that the Commissions took reflect that neo-classical approach to economic problems which, as I have argued in Chapter Two, is inappropriate to

[2] Broomhill, R, Genoff, R, Juniper, J and Spoehr, J. (1995) The debt made us do it! In *Altered States*. (Eds, Broomhill R and Spoehr J) Centre for Labour Research and the Social Justice Research Foundation Inc: Adelaide. 216-217.

many aspects of health care and public health. The theory that the Audit Commission reports provides is an insufficient account of the role of government and the effects of their recommendations. A major reason for this is that the theoretical models lack sufficient detail about, and have an insufficient theory of, institutions and institutional change.

Specifically, I argued in Chapter Two that neo-classical economics has emerged as the dominant economic paradigm and that health economics has its roots in neo-classical economics. However, public health has objectives that assume certain activities that are not always compatible with the assumptions that neo-classical economics makes about the world. This has led (in addition to other factors) to a narrow focus in health economics on the marketable elements of health care systems. McKeown and McKinlay *et al*. demonstrate that most improvements in the health of the community occur as a result of factors other than specific medical interventions, including innovations in political economy and in public policy and this has been demonstrated both for infectious diseases in the nineteenth and early twentieth century in England and Wales and in the United States, and for chronic (degenerative) diseases in the twentieth century in the United States.[3]

The McKeown Thesis could be used in support of at least two arguments that are relevant to considering the content of the Audit Commission reports and the role of government in providing health care related public health goods. The first is that specific medical measures made only a limited contribution to the decline in mortality after the 1850s and that high levels of spending on health care probably do not contribute a great deal to low mortality rates. Thus, reducing spending on medical care services is justified on efficiency grounds. The second argument is that much of the decline in mortality occurred as a consequence of improved nutrition that resulted from economic growth. The corollary of this is that concentrating on economic growth is the best way to ensure that health improves. This could lead to support for a hands-off approach by government as unfettered

[3] McKeown *The role of Medicine: Dream, mirage or nemesis?* ; McKinlay and McKinlay. The questionable contribution of medical measures to the decline of mortality in the US in the twentieth century. ; McKinlay, McKinlay and Beaglehole. A review of the evidence concerning the impact of medical measures on recent mortality and morbidity in the United States.

markets and *trickle-down* appears to have worked in the nineteenth century when the mortality decline was most dramatic. As Szreter pointed out, later, McKeown ignored the importance of conventional public health work at the local level that resulted in cleaner water and separated sewerage, improved sanitation of the food chain and the home environment, which also made an important contribution to the decline of mortality in the nineteenth century.[4] More recently, the importance of environmental factors has been highlighted in the work of Barker and others on the foetal origins cardiovascular disease that points to the importance of the mother's environment during pregnancy and the child's early environment in the risk of both infant mortality and later death rates from cardiovascular disease.[5] This public health work did not occur as a natural outcome of market forces and went against many of the doctrines of market economics but was pushed forward by the hard political work of public health advocates.[6]

With that broader historical background in mind, this Chapter has two aims. The first is to consider the implications for public health of a focus on the microeconomics of markets in the Audit Commission reports similar to that evident in the nineteenth century prior to the impact of the sanitary reform. The second aim is to highlight an institutionalist approach that looks beyond specific technologies and individual behaviour in isolation that may provide an alternative economic paradigm from which questions of the role of government, as the major instrument of collective action in Australia, are approached.

The Chapter is organized as follows. I first review selected parts of the Audit Commission reports, concentrating on those sections and Chapters that relate specifically to approach and methodology and to health care. The second section

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[4] Szreter. The Importance of Social Intervention in Britain's Mortality Decline: Re-interpretation of the Role of Public Health.

[5] Barker, D (1994) *Mothers, Babies, and Disease in Later Life.* London: BMJ Publishing. Australian evidence in support of the Barker hypothesis has been presented by Moore. See: Moore, VM. (1997) *Fetal growth and cardiovascular risk factors in an Australian cohort*. PhD. Public Health. University of Adelaide. Adelaide.

[6] Whilst the McKeown thesis has been criticised, the importance of nutrition, especially in early life, is echoed in the *Barker Hypothesis*. Also known as the foetal origins hypothesis, it states that foetal under nutrition in middle to late gestation leads to disproportionate foetal growth and programs later coronary heart disease. See, for example Barker, DJ. (1995) Fetal origins of coronary heart disease. *British Medical Journal,* 311: 171-174

then considers a number of issues that are raised by this review, specifically, what the reports had to say about the role of government, then the repeated recommendations for various forms of privatisation that follow from that narrowly defined role. The third section reviews the Audit Commissions from within their own, neo-classical, paradigm. Finally, I discuss the importance of these issues for the themes of this thesis.

The State Audit Commission Reports

Audit Commissions were established by incoming Liberal and National Party Coalition governments in each of the States between 1988 and 1996. They shared a general theme of conducting a review into the finances of the State governments. However, as was the case with the Commonwealth Commission of Audit, they also considered matters such as the legitimate role of government and some were given terms of reference that allowed them to report on a wide range of matters that the Commissioners felt were relevant. Broomhill's criticisms of the Commissions have already been outlined. These observations point to the Commissions being highly political exercises and their reports being primarily political documents. This suggests that they would be open to a criticism of bias and are unlikely to take full account of all the factors that bear significantly on their subject material. The particular issue for this thesis is whether the neo-classical economics approach that they take fails to recognise important questions in public health and undermines the public health effort in the way that the review of neo-classical economics undertaken in Chapter Two suggests they might.

Framework

Three of the Audit Commission Reports devote entire Chapters to outlining the frameworks or approaches used in their assessments of government finances. In the case of the other two, the sections on the role of government or on strategies for reform are indicative some of the assumptions that are made by the Commissioners, or contain comments or recommendations from which such assumptions can be deduced. The Victorian report, for example, does not initially specify its approach or framework, but launches directly into its analysis of the State's finances. The discussion of principles is confined to three pages in the

introduction to the second volume. In Queensland, the Commission claimed that direction for reform recommended by the other State Commissions of Audit had drawn upon a powerful framework of principles for reform of public sector management and finances field-tested and refined in many jurisdictions around the world, over nearly two decades, The Queensland Report drew directly on the Framework of the UK Efficiency Unit which distinguished between the responsibility of ensuring the provision of services and actually providing them, using modern management practices for efficient delivery of services.[7]

In its second Chapter, entitled *Broad Principles: The role of Government in Service Delivery*, the Queensland report outlined the economic case for government intervention. It argued that regulation may be required for those exceptional situations of market failure in which taxes and subsidies can be used to correct spillovers. Hence public provision or regulation may be appropriate in the case of natural monopolies, while public goods are a case for public provision, although very few goods that are publicly provided are pure public goods. However, the Commissioners concluded that direct provision of services by government itself often has not engendered strong pressures for efficient resource use, but often has created strong incentives for departments to expand for the sake of expansion.

The NSW report argued that government has a role to play in regulating markets to ensure that consumers are not disadvantaged in cases of natural monopoly, externality, uncertainty and poor information, merit goods, inequity (mainly geographical) and public goods. However, it warns of government failure such as the pursuit of internal goals, the pursuit of unnecessarily high standards to the detriment of cost-effectiveness, regulatory capture and unanticipated side effects. While the NSW report also warns against being too idealistic about the private sector it accepts the presumption that the private sector has a number of advantages over the public sector, including responsiveness, independence, the discipline of competition, the ability to obtain equity and loan capital, simple performance measures such as profit, greater cost consciousness, full appraisal of

[7] FitzGerald, V (1996) *Report of the Queensland Commission of Audit. Volume 2.* Brisbane: Queensland Commission of Audit.

investment decisions, less bureaucratic restraints on use of resources and the ability to award performance according to merit. The report then expressed the view that 'competition was the best way to ensure that goods and services desired by the customer are provided at the lowest economic cost and that the State should move out of providing goods and services where there is a possibility of private sector providers'.[8]

In Western Australia, the framework Chapter noted that protected government monopolies are inherently inefficient: they have top-heavy structures and try to meet all their needs with in-house workers. Private business on the other hand have leaner, flatter administrative structures and contract out non-core activities to expose them to a level of competition. Competition is described as 'the force that generates growth in the economy and matches output to consumer requirements'[9]. That Chapter also claims that 'there is no economic advantage to be gained from the activity and the resulting employment being located in the public sector rather than in the private sector'[10]. Rather, government agencies and sectional interests are claimed to be inflexible and unresponsive to changes in society and have shown a reluctance to relinquish their perceived special role to the private sector when it has been demonstrated that the private sector has the capacity to provide these services.

The South Australian report has a section headed *The Role of Government in Service Provision*. Two roles in relation to service provision are identified. The first is to determine the level of services, which is influenced by many factors, some of which, the Commissioners report, go beyond the scope of the Commission's terms of reference. The second role concerns the method of service provision. This section is mainly a discussion of the pressures on government for greater spending and the economic and institutional factors that constrain the ability of government

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[8] New South Wales Commission of Audit (1988) *Focus on reform: report on the state's finances.* Sydney, New South Wales: Commission of Audit.70.
[9] Western Australia. Independent Commission to Review Public Sector Finances (1993b) *Agenda for reform: Report of the Independent Commission to Review Public Sector Finances. Volume 2.* The Commission. 4.
[10] Ibid. 1.

to defend itself against these pressures. That section concludes with the Commissioners' first recommendation that the State government 'fundamentally reassess its role in the economy in order to concentrate on its core functions and to promote efficiency and effectiveness in service provision'[11]. However, it does not state, anywhere, just what those core functions are.

The Tasmanian report states that the Tasmanian Government should ideally concentrate its resources on the provision of core public goods and services, that is to 'ensure that economic infrastructure is adequate to support economic activity, and that the social fabric is maintained'[12]. There is no discussion of approach but a short discussion of the roles that the State Government currently plays, plus comments that the *colonial socialism* that it reflects 'seems incongruous in a modern market'[13] and an expression of regret that that some of the functions continue to be delivered by government. The tone of the Report is one of regret that the net effect of these characteristics is to foreshadow a reduced role for the State government in the Tasmanian economy.

The Victorian report has no preliminary framework section to indicate to the reader the approach taken by the Commissioners. However, as the report moves from reporting on what it describes as the *macro-economic problem* in Volume One to the *micro-economic* in Volume Two issues, three *broad principles* are outlined. The first is that contracting for services should be separated from service delivery so that those responsible for contracting out services do not identify too closely with the provider of services or become susceptible to pressure from narrow sectional interests. The second is that funding should be for outputs to provide outcomes. The Commissioners would prefer contracts to specify outcomes, but these are often ill-defined and difficult to write into contracts. The third principle is that

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11 South Australian Commission of Audit (1994) *Charting the way forward: improving public sector performance: report of the South Australian Commission of Audit. Volume 1.* Adelaide: The Commission.28.
12 Tasmania. Independent Commission to Review Tasmania's Public Sector Finances. (1993) *Tasmania in the nineties: Government finances, economic performance, challenges and opportunities*. No. Hobart: The Commission. 46.
[13] Ibid.No. 45.

competitive tendering systems should be put in place so that there are no unwarranted profits or inefficiencies in the price of the successful tenderer.

The recommendations contained in these Chapters are variations on a theme of downsizing, out-sourcing and privatising services currently provided within the public sector. There is confidence that these reforms will result in cost saving (although the quanta are not always known) and a stated expectation that, although they will result in job losses in the public sector, the Commissioners expect them to be largely accommodated by retirements and voluntary redundancies. These reforms fall under two main areas of change in public sector management, administrative reforms that provide government trading enterprises and business units within departments with an increased commercial and competitive focus and the privatisation of service provision, including competitive tendering and corporatisation prior to sale.

These framework approaches all conform predictably with neo-classical theory on the economic role of government. This theory has two strands. The first states that, being protected from the pressure of competition and the goal of profit maximisation, government organisations do not operate in a technically efficient manner and they work to goals that are unlikely to coincide with the public interest. [14] The neo-classical remedy to this problem is to introduce competition, or the threat of it, to force public organisations to respond to market disciplines that will make them more efficient and responsive in service provision. If they fail to do so, they will be out-bid by their private sector competitors and *naturally* cease to be part of the service provision system. If they succeed, more efficient service provision will reduce waste, allow service provision to be expanded and result in welfare gains to the community.

The second strand, drawing upon public choice theory, focuses on whether or not government should even be engaged in those activities at all, irrespective of whether it can undertake them in a technically efficient manner. First, government

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[14] LeGrand, J. (1991) The Theory of Government Failure. *British Journal of Political Science,* 21: 423-442. These arguments, made by Wolf, are nicely summarised by LeGrand.

activities are subject to political processes that permit logrolling and special interest legislation, and thus favour inefficiently large public sectors because voters are *rationally ignorant*. Second, people in government become secondary to rules, processes and procedures as organisations become more complex, thus there is a loss on control over government activity. [15]

Chapters on health care

Chapters devoted to health services are contained in all but the NSW report, where there is only reference made to the contribution of demographic change and technology to increasing health care costs, and the Tasmanian report, where there is no specific mention of health services. The Chapters vary greatly in their length and detail and also in the methods they use to arrive at their conclusions. There is no reason, within the framework of the reports, why this should be so. The number of pages and recommendations of the health services Chapters is outlined in Table 6.1.

Table 6.1: State Audit Commission Reports Chapters on health care, number of pages and recommendations

State	Date	Pages	Recommendations
New South Wales	1988	-	-
Western Australia	April 1993	15	23
Victoria	August 1993	50	12
Tasmania	August 1993	-	-
South Australia	April 1994	63	77
Queensland	June 1996	42	2

The Queensland report made only two recommendations, first to establish an independent health service planning body and second, to establish a competitive framework within the hospital and ambulatory care sectors. At the other end of the spectrum, the South Australian report made 77 detailed recommendations under 23 sub-headings. Many relate to the transition from a Health Commission to a Health Department for administering public funding for health care, to

[15] Cullis, J and Jones, P (1992) *Public Finance and Public Choice.* Maidenhead, Berk.: McGraw-Hill. Cullis and Jones also list the extension of the franchise as a Public choice explanation for government failure. Fortunately, none of the audit commissions suggesting limiting this as a means to reduce government spending.

regionalisation and to other strategies to achieve operational efficiency.[16] Most of the recommendations, and their appearances in reports, are summarised in Appendix Three. There are fewer than 77 recommendations listed there for South Australia, as those recommendations regarding the details of proposals were not included in the table. All reports recommend some form of regional or area health authority structure for administering public hospitals and health care services. In the case of Western Australia and Queensland, this endorses existing plans to regionalise or changes to existing regional structures. The next most common recommendation is some form of privatisation or outsourcing of services. The Western Australian, Victoria and South Australian reports all recommended shifting hospital outpatient services to general practice providers, the outsourcing of what they described as either non-core or commercial services, and the introduction of purchaser provider split arrangements for funding and providing hospital services. Two reports (Western Australia and South Australia) recommended the introduction of private sector investment in the assets of public hospitals. South Australia and Queensland recommended funding private providers of services for public patients and Western Australia recommended privatisation or outsourcing of the management of public hospitals. One report (Western Australia) recommended the transfer of State Government nursing homes to private operators, another (Victoria) appears to endorse the existing commitment to move public sector beds under its control to the same funding system for private nursing homes. The Western Australian report also recommended privatising the care of long-term care patients through placement contracts with nursing homes and hostels. Finally, the Western Australia report recommended the introduction of user pays policies for appliances and aids on the grounds that user-pays principles applied in some other States.

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[16] At the time, South Australia's Health Commission was the last one of its type still standing. There has been a long history of reports that recommend restructuring of the health bureaucracy in South Australia. In 1974 a Committee of Enquiry into Health Services recommended that the separate Hospitals Department and Public Health Department be subsumed within a Health Commission. That was done in 1978 (though not in detailed conformity with the CEHS recommendations); the Commission was reformed in 1981 (in closer conformity with the CEHS prescription); but the practices of the *Commission* for some further years were not far distant from those of a conventional public service department.

The State Audit Commissions also made a range of recommendations on industrial, organisational and management matters. Recommendations on industrial issues included the elimination of restrictive work practices (Victoria and South Australia), reduce the nursing shift overlap (Western Australia and Victoria) and full implementation of the 38-hour week where it exists in awards. Organisational matters include rationalisation of bed numbers, space utilisation and facilities utilisation. Recommendations on management detail included the introduction of benchmarking, cost reviews and quality management mechanisms.

Methods of the Audit Commission Chapters on health care

In each of the State Audit Commission reports the Chapters on health began with a cherry-picking comparison of costs between States and concluded that their State had high costs on at least one comparator. Western Australia compares itself with Queensland as the State that spent the least *per capita* on health services and had a 15 per cent more efficient public health sector. In particular, it made the comparison with Queensland public hospitals that were 20 per cent cheaper to run than the Australian average, with 40 per cent less administrative costs. This is reported by the Western Australian report as being due to lower staffing levels, less emphasis on support services, lower salary rates and less up-to-date and sophisticated infrastructure. This is achieved with no clear evidence that the Queensland system had longer waiting lists or less adequate outcomes, although the Queensland system, necessarily more decentralized than that in Western Australia, had been regarded throughout Australia as the most under-funded system for half a century

Victoria chose New South Wales as its comparator State – without discussing or justifying the reason for this selection. The South Australian report relied on Commonwealth Grants Commission data for 1994 that indicated that New South Wales had the second lowest *per capita* expenditure on health in 1992-93 (just pipped by Queensland) and that Victoria was about par with the national average for total expenditure, although quite a bit higher than average for mental health and nursing homes. Nevertheless, the analysis undertaken by the private sector management consultants, KPMG, for the Victorian Audit Commission found that

while Victoria's teaching hospitals did well on comparison with New South Wales, all other categories of hospitals were less efficient than their New South Wales counterparts. Their source for comparisons was the Commonwealth Grants Commission report on general revenue relativities 1993 and their own survey of hospital costs that took costs for one unit in each of six groups; teaching and specialist hospitals, suburban/base/regional hospitals, district hospitals, extended care centres, large psychiatric facilities and small and other psychiatric centres. They used cost per adjusted bed-day as Australian Diagnosis Related Grouping (AN-DRGs) weights were not yet available. Hospitals were selected on the basis of being 'comparable and representative of their peer group', but the report did not specify the basis on which they were representative, and comparability information is incomplete. The Victorian Audit Commission did point out that, generally, the Victorian hospitals chosen represented the better performing health care facilities overall.

The South Australian public system was compared with most of the States and the national average, depending on the parameter. On all parameters that were reported, South Australia compared unfavourably to its interstate counterparts or the national average. South Australia, like Western Australia, cited Queensland as an efficient example. However, while Queenslanders were relatively healthy compared to the rest of Australia and other countries in the OECD, they were admitted to hospital 6 per cent more frequently than the Australian average admission rate. In addition, Queensland's hospitals provided a similar quality of service to other States for about 85 per cent of the Australian average cost. However the Queensland report attributed this to lower average cost to lower casemix complexity, in part because Queensland hospitals admitted a substantial number of people who might have been treated differently (for example, as outpatients) and the seductive 85 per cent shifts to 96 per cent when adjusted for casemix.[17] Indeed, the Queensland report concludes that 'Queensland's relatively

[17] FitzGerald *Report of the Queensland Commission of Audit. Volume 2.* Costs per separation for Queensland and Australia are reported in Table 9.3 on page 18. The unadjusted cost per separation for Queensland and Australia respectively are $2,010 and $2,368, adjusted for casemix, they are $2,234 and $2,327.

low health expenditure overall is largely explained by lower expenditure *per capita* on mental health (67 per cent of the national average) and community health services (53 per cent of the average)'[18]. Thus even the healthiest, lowest spending State found reasons to cite inefficiency as a justification for a revamp of the system.

While it is reasonable to make interstate comparisons in order to assess where one health system sits in relation to the others, it has some dangers. Each of the reports assumes that the State that has the lowest expenditure on a particular aspect of its health care system must be doing things right. While this may well be the case, every State was able to find parameters on which it compared unfavourably with at least one other State. In the case of South Australia, most of the other States were invoked as a benchmark at some time or another. This resulted in a very reductionist approach to the analysis in support of an untested inference that it might be possible to take all the efficiencies of all the States and combine them to achieve one singularly efficiency health care system. However, taking the performance level of one system and assuming that it can be achieved in other systems without having to change those systems to accommodate the achievement whilst maintaining existing efficiencies is misguided. First, the fact that we refer to health care systems indicates interdependency between the parts, allowing the implication that some efficiencies may be achieved at the expense of other parts of the system. Second, different patterns of apparent efficiencies and inefficiencies may reflect differences in the health care systems that reflect particular local conditions and needs. This leads to the temptation to take aspects of the system out of their context and assume that they can be replicated in any other context. This makes the exercise one of analysing separate technical efficiencies and putting them together, a bit like a taxidermy class not knowing what parts it is getting from the dissecting class next door. Parts of the system interact with each other in complex ways and failure to recognise that this risks simply shifting costs to other parts of the system or to the community if the parts of the system do not fit well together.

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[18] Ibid. 10.

Most of the reports did recognise the need to adjust the numbers that they used to take account of differences between States in age and sex distribution, but failed to do any in-depth analysis of the social and economic context of the health outcomes and health expenditure patterns that they reported. The South Australian report made reference to the fact that South Australia has high numbers of unemployed but drew no inference and did not even consider the possibility that Queensland may benefit from a *healthy migrant effect* of wealthier and healthier retirees from other parts of Australia retiring to Queensland. In addition, there is no attempt to understand why the health care systems in each of the States vary in the ways they do or the relationships between the health care system and other government and community institutions. Thus the reports are largely ahistorical and acontextual. In addition to this, despite their positivist focus, they were remarkably casual about the quality of their empirical data.

Issues arising from an examination of the State Audit Commission reports

Three main, interrelated issues that warrant further consideration arise from the examination the State Audit Commission reports. The first is the way that efficiency is treated. The second is the appropriate role for government as outlined by the reports. The third, which flows on from the other two, is the recurring theme of privatisation as a solution to the problems of government provision. A closer examination of these issues indicates that either the theory underpinning the analysis and recommendations or the implementation of the recommendations was, in many cases, inadequate.

Efficiency comparisons

A number of important issues arise from this review of the various Australian Audit Commissions. The first is the notion of efficiency used by the Commissions. Most economists, including neo-classical economists, would argue for allocative efficiency. This involves technical efficiency to achieve least-cost methods of production of goods and services. It also requires that the goods and services that are most highly valued be produced and distributed to where they are valued most highly. Neo-classical economists regard the perfectly competitive market as

the model that best achieves these two outcomes. Neo-classical economists recognise that there are circumstances under which markets fail (and they were outlined in the Queensland report). However, as the Queensland report indicates, neo-classical economists see these instances of market failure as exceptions, as in the case of most public goods. In addition, they often consider that the efficiency losses of these examples of market failure are smaller than those associated with government intervention, which should not be indulged.

Not all schools of economic thought agree on this point. For example, Keynesians see the market system as largely effective, but allow that when market failures do occur government intervention is necessary. At the opposite end of the spectrum to the neo-classical economists, Marxists argue that market failure is inherent, not exceptional, and that the welfare losses are substantial, not small. The Audit Commission reports, eschewing both Keynes and Marx, sit firmly in the neo-classical framework.

Effectiveness is an important element of efficiency. The health care Chapters of the Audit Commission reports concentrate on measurable outputs of healthcare such as weighted admissions. In addition they refer to population health status as an outcome of the healthcare system, although at least one report[19] recognised the limited role of secondary health care, such as hospital care, in improving health status that the McKeown thesis suggests. In most cases the Commissions fail to recognise the role that publicly provided health care plays as a social institution, as a symbol of social solidarity, for example, rather than simply an economic one. Failure to recognise this role understates the effectiveness of these institutions.

Role of government

The Audit Commission reports generally confine the role of government to intervening in market failures. The Commissions follow neo-classical economics in treating as a failure of the market the failure to provide the socially optimal level of output at the lowest possible opportunity cost, due to the absence of the conditions for perfect competition. Conversely, they regard it as the role of

[19] Ibid.

government to intervene to promote the efficient provision of goods and services in which there is market failure, assuming, that is, that government failure is not even more costly than market failure. The New South Wales report also acknowledges the possibility that a community might wish to provide some goods, known as merit goods, at a minimum level to everyone, even if market provision were efficient.

In line with their definitions of market failure and merit goods, the Audit Commissions point to a minimalist role for government in which it does only what it can do more efficiently than markets, or provides the conditions in which markets can function efficiently. For example, the influential free-market economist Milton Friedman has written that government has important functions to perform in maintaining law and order, defining property rights, providing a means by which property rights and other rules of the economic game can be modified, adjudicating disputes about the interpretation of rules, enforcing contracts, promoting competition, providing a monetary framework, engaging in activities to overcome important monopolies and externalities and supplementing private charities and families and in protecting the vulnerable such as madmen and children.[20]

The neo-classical definition of the role of government appears to assume that all that is required for efficient outcomes is market participation. Public health requires more than this, not only market participation but also democratic participation, is important. The *Declaration of Alma-Ata*[21] calls for an economic order that protects vulnerable communities from the vagaries of markets, especially trade by multinational companies[22], and promotes fuller and better use of the world's resources, participation by the community in planning their health services and provision of adequate health and social measures by governments,

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[20] Friedman *Capitalism and freedom.*
[21] World Health Organization *Primary Health Care (The Declaration of Alma-Ata).*
[22] The declaration calls for 'Economic and social development, based on a New International Economic Order' (p1). The New International Economic Order was adopted by the United Nations in response to attempts by countries of the South to correct perceived inequities in the trading and financial systems based on the Bretton Woods system, which, not surprisingly, favoured the countries that had designed it.

which have a responsibility for the health of their people. This suggests that goods other than straightforward market efficiency as being key economic roles of government.

Public health, at least in the terms of Alma Ata, requires that the economic system does not simply respond to the wishes of citizens but that it be shaped by them in advance. Public health calls for goods such as equity and social and economic security, because 'promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace'[23]. These are goods that are presumed, in the neo-classical framework, to be either the result of properly functioning markets, or outside of the purview of economics. This public health perspective would argue that such goods are fundamentally tied to the economic system, and therefore, should be part of the calculus of the system. Under a market prescription, the capacity to define the economic system is fundamentally undemocratic because it violates the maxim of *one vote one value*, because the votes of those with more money have a greater impact on the shape of the economy than the votes of those with less money, simply because their impact (even if relatively small for each individual) is greater.

The Australian Audit Commission reports did, in fact, define the role of government in terms of the neo-classical economic theory of market failure and they were quick to identify the range of ways that government intervention perversely serves a range of interests. However, they were virtually silent on the possibility that their own recommendations might serve a range of interests other than *the public good*. The extent to which the recommendations of the Audit Commission reports do serve the public good, or other interests can be explored using the Commissions' extensive recommendations on privatisation.

Privatisation

Privatisation is presented in the Audit Commission reports as a solution to many of the ills of the public sector. Specifically, the reports cite inefficiency, which they

[23] World Health Organization *Primary Health Care (The Declaration of Alma-Ata)*. 1.

attribute to the public sector's lack of competition and unresponsiveness to changing social needs. After this, however, the reports pay little attention to the question of social needs in defining what they mean by this term. The recommendations of the Audit Commission fall into two categories. The first is management and administrative reforms within departments, including an increased commercial and competitive focus. The second is privatisation of service provision, or of assets, or both. It is crucial to examine both the theory that underpins the recommendation for privatisation and also the empirical evidence as to the relative efficiency of provision by the private sector of services that were previously provided from within the government sector. A search of the academic literature generated a long list of both health and non-health sector privatisations that will be discussed in this Chapter. Many health economists argue that health care is a special case of market failure. I have argued in Chapter Two that public health is an even more exceptional case and that, thus, health care and public health need to be considered separately from the provision of other goods and services.

The most common justifications for public provision are natural monopoly, externality and public goods, each of which neoclassicists regard as a condition under which the market fails to provide an efficient level of output. The optimum level of output occurs where marginal social value of the output is equal to its marginal social opportunity cost. In the case of monopoly, a single seller has power to set restrict output and set the price. In the case of an externality, either benefits (positive externality), but more usually, costs (negative externality), fall on a third party who is neither the buyer nor the seller. It is possible to assign property rights to externalities. However, in the case of public good, it is not possible to exercise property rights over the good or service because people cannot be excluded from its use. Each condition of these examples results in a level of provision that is less than the socially efficient amount. Monopoly, positive externality and public goods tend to results in under-provision in a market. Negative externality tends to lead to overprovision

Public provision is not the only option and, in the United States, regulation had also been used widely as an instrument for reducing the social costs of these forms of market failure. However, the main response in Australia to these kinds of market failures has been public provision, usually through publicly-owned enterprises, in telecommunications, postal facilities, banking, airlines, ports, police, correctional services, research centres (CSIRO), gas, electricity, water and sewerage. Public provision has also been a way of managing risk, for example, in research (CSIRO), or in the production or processing of new commodities (Comalco). In these examples, private investment is likely to be less than the socially optimal level because investors are risk averse. However, there has been a massive shift to private provision of these services, both in Australia and internationally. This is referred to in at least one of the Audit Commission reports as if to give credibility to the movement.[24]

For many countries the impetus for widespread privatisations has come from external forces, rather than the result of democratic decision-making. In particular, fiscal austerity, privatisation and market liberalisation are the pillars of the policy prescription adopted by the International Monetary Fund (IMF) and imposed as part of the conditions of structural adjustment loans. They have also become part of the conditions of assistance from the World Bank and many developing countries have taken on these policies under duress because they were in dire need of external assistance.[25] A range of non-government, and some international, organisations often uses the country status reports produced by the World Bank to assess a country's macroeconomic situation and economic stability.

It is open to question as to whether these are appropriate criteria to apply across the board and whether they serve the interests of each country's citizens. The IMF policies were developed in response to fiscal crises in Latin America in the 1980s, when large government deficits and loose monetary policy led to inflation running out of control. However, these same criteria are now applied to every country

[24] Western Australia. Independent Commission to Review Public Sector Finances (1993a) *Agenda for reform: Report of the Independent Commission to Review Public Sector Finances. Volume 1.* The Commission. 5.
[25] Stiglitz, JE (2002) *Globalization and its discontents.* New York & London: W.W. Norton & Co.

irrespective of its macroeconomic situation. The State Audit Commission reports, written when public sector debts were high, but inflation was low, follow the same line, diligently seeking evidence for loose government spending and inefficient public organisations. State governments have fiscal powers, but not monetary ones. The is due to the fact that there is a higher (Commonwealth) level of government that can exercise monetary policy that can put a brake on the effects of the fiscal activities of the States. Monetary policy, being a Federal function, is not an issue at State Government level in Australia, but these same preoccupations are evident in the Commonwealth Commission of Audit's report.

Privatisation is a complex process and may not work well, even when the theoretical arguments for it are sound in a particular situation. First, privatisations of large government organisations require extensive and complex contracts. The detail required is such that no single person is likely to be fully familiar with all aspects of a contract. This means that there is scope for some details to be missed by government negotiators in the process of negotiating and preparing contracts. Second, contracts often need to be written to cover long periods of time. In sectors where there is rapid technological change, this can mean that governments are effectively locked into using current technologies until well after they are obsolete. An example of this is IT services, in which contracts might be written to reflect current technology and service levels. If technologies or the needs of the organisation change in ways not foreseen when the contract was written, it can be extremely expensive to vary a contract. It might be argued that these are simply foreseeable practical problems for which there is a solution. However, evidence about the quality of the privatisation processes undertaken across Australia indicates that many privatisations to date have been executed poorly, from the point of view of the wider community.[26]

[26] Walker, RG and Con Walker, B (2000) *Privatisation : sell off or sell out? : the Australian experience.* Sydney: ABC Books for the Australian Broadcasting Corporation. This evidence is discussed in more detail later in this Chapter.

Privatisation theory

New institutional economics, discussed in Chapter 3 of this thesis, underpins some of the current thinking in relation to whether to 'make or buy' within an organisation, that is whether goods and services should be produced internally within a firm, or should be sourced externally.[27] This strand of new institutional economics, known as transaction cost economics, can provide insights into questions about the organisation of firms in order to reduce transactions costs. Apart from recognising that firms are worthy of study, they make no shifts from the basic propositions of mainstream economics.

Recommendations for various forms of privatisation of public sector services in the Audit Commission Reports are based on two assumptions. The first is that the services public sector organisations provide are able to be provided equally well, or better, in the private sector. The second is that the pressure of competition on the private firm will push down costs, whereas, in the absence of competitive pressures, public sector organisations have no incentives to operate efficiently. Instead, public sector organisations take monopoly rents in the form of high salaries, oversized administrative structures and profligate spending on accommodation and consumables, for example. In addition they have no incentives to respond to the needs of users of services and the community, as there is no credible threat of users or the community going elsewhere for services.

To these standard arguments, Albon adds that private ownership is concentrated ownership and each individual has a larger interest or stake in the efficient running of the organisation and is more likely to become involved in monitoring its performance. If an existing operator is not performing, a privately-owned firm can be taken over by those who feel they can do better (share values can act as a yardstick, if an imperfect one, of the performance of the firm). A major problem with public enterprises has been the inability to develop appropriate performance

[27] Preker, Harding and Travis. "Make or buy" decisions in the production of health care goods and services: new insights from institutional economics and organizational theory. . Williamson, OE. (1996) Economics and Organization: A Primer. *California Management Review,* 38: 131-146

criteria.[28] Private firms, by comparison, will be less amenable to the demands of unions interested in enjoying *feather-bedding*, better conditions, job security and other benefits. Even if a private firm had to maintain public sector employment conditions it would tend to do better in this regard. Albon considers that private firms would feel far less obligation to practice politicised pricing or to perform other *social obligations* not justified by commercial criteria and would not voluntarily engage in cross-subsidy. Albon also argues that, to the extent that a privatised organisation did make above-normal profits, this would be *prima facie* evidence that it operated in an insufficiently competitive environment and that its degree of contestability required examination.[29]

The theory of privatisation of public services represents an unravelling of the original rationale for their provision by the public sector. Some services were publicly provided because their provision by an unregulated market would have evoked a level of provision that did not match the socially efficient amount. In the post war period there was an expansion of public funding and provision to meet a range of goods and social and/or economic objectives services for socially and economically significant purposes such as reconstruction, demobilisation, retraining and the education of a baby boom that private provision was unlikely to meet.

Privatisation theory in health care

Health care is a special case as, in Australia, government has not only been a major supplier of the service, through the activities of State governments, but also a major buyer/source of revenue through the Commonwealth-funded Medicare program. Public provision of health care services in Australia has its roots in philanthropy. Hospitals had their origins as charitable institutions that took care of the poor. Government funding of these institutions arose early in Australia's

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[28] Although the case has been made that it is possible for it to be done: see Stretton, H (2005) *Australia Fair*. Sydney: UNSW Press.

[29] Albon, R (1986) *The scope for privatisation in Australia.* Information Paper. Melbourne: Committee for Economic Development of Australia. Robert Albon has published widely in the area of industry regulation. He has held positions in the department of Economics at the Australian National University and as Senior Economic Advisor (Regulatory) at the Australian Competition and Consumer Commission.

white settlement history when these institutions ran chronic budget deficits in New South Wales.[30]

In Australia, there has always been a sizeable private provision of health and welfare services. Even under Medicare, most formal medical care was provided in the private sector by general practitioners and specialists funded on a fee-for-service basis through Commonwealth spending (although largest item of public expenditure was and continues to be for hospital care). In hospitals, most of the funding comes from government sources (93.9 per cent).[31] Again, while mainly government subsidised, most community care services and aged care residential services were provided either by charitable organisations or by for-profit operators.

Health economists have established a case for health care being *different* from other goods in that it exhibits multiple sources of market failure,[32] each requires a separate intervention and the transactions costs of multiple interventions are high. The sources of market failure in health care include monopoly; information asymmetry leading to imperfect agency and supplier induced demand; externality; barriers to entry for providers and (probably) barriers to exit for consumers where the consequences of non-participation can be catastrophic. An added dimension to market failure in health care is the unpredictable and sometimes catastrophic costs of health care. This has given rise to systems of health care insurance, which in turn have multiple sources of market failure including moral hazard, cream skimming and adverse selection.

Therefore, most developed countries lack extensive systems of regulation for both the delivery of health care and for the financing of health care. Many have direct government provision and or financing of health care that arose over the twentieth century, but have been under pressure, since the 1970s, from perceptions that publicly provided health care is wasteful, does not meet community needs, is no

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[30] See Garton *Out of Luck: Poor Australians and Social Welfare.* p43ff for details of attempts by Governor Macquarie to establish Poor Law relief schemes in NSW
[31] Australian Institute of Health and Welfare *Health Expenditure Bulletin No 17.*
[32] Blaug. Where are we now in British health economics?

longer affordable (especially in light of population ageing), and has failed to address inequalities in health status (especially under the United Kingdom's National Health Service). Proponents of privatisation of health care have argued that, within Australia, private provision is more efficient than public provision and that private provision can be more responsive to consumer needs and to changes in those needs.

The debates around privatisation of health care services have carried an extra dimension where economic theory carries no superior authority. Health care is more than a simple good or service. It has a moral dimension, because there is more at stake than simple preference satisfaction. At an everyday level, it deals with the integrity of the human body, which has significant symbolic importance.[33] When it comes to matters of life and death, for example, judgements about the technical efficiency of care run into the *rule of rescue*, which reflects an unwillingness to stand by and watch somebody die when treatment is possible, even although the cost-benefit analysis might not be favourable.[34]

Evaluation of Privatisations - empirical evidence

The volume of empirical evidence regarding private ownership and privatisation of public services has burgeoned over the 1990s. Prior to large-scale privatisation activity, much of the evidence relied on a comparison between publicly owned and privately owned enterprises operating in the same markets within a country, or between publicly owned enterprises in one country with privately owned enterprises in another.

Prior to Australian governments embarking on large-scale privatisations, Albon argued that there was empirical evidence that private ownership *per se* mattered and stated that most reviews of the literature present 'evidence that private

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[33] See, for example, Fox, R (1989) *The Sociology of Medicine: a participant observer's view.* Englewood Cliffs, NJ: Prentice Hall., with applications in Fox, R and Swazey, JP (1978) *The Courage to Fail: a social view of organ transplantion and dialysis.* Chicago: University of Chicago Press; Fox, R (1998) *Essays in Medical Sociology: journeys into the field.* New York: Wiley. On the differing moral representation of different diseases (CHD and cancer) see Edwards, JE. (2003) *Elementary forms of the Medical Life: sacred and profane in biomedical cosmology*. PhD Thesis. Public Health. University of Adelaide. Adelaide.

[34] Hadorn. Setting health care priorities in Oregon. Cost-effectiveness meets the rule of rescue.

enterprise performs better than government enterprise' (although he did not specify his criteria). His own investigations of relative efficiency, including that of the Australian domestic trunk airline duopoly, showed clear evidence of superior relative private sector efficiency. His econometric analysis indicated that the privately owned airline Ansett was about five per cent more cost-efficient than the government-owned TAA (now Qantas Domestic). However, a much larger difference was found between the operating efficiency of the regulated Australian duopoly and the unregulated airlines in the US, suggesting that competition was a more important influence on efficiency than ownership.[35] Albon also states that similar evidence can be found when comparing private and public mail services in Australia, although all his evidence is provided in another publication and none of it is recounted here. Finally, a comparison of Australian Telecom and Canadian Bell indicates that Telecom has standardised measures of performance that puts Telecom in a worse position than Bell in the US.[36]

Evidence from New Zealand suggests that there are both wins and losses associated with privatisations. Boston's 1998 review of New Zealand privatisations concluded that the initial wave of corporatisation in the late-1980s brought marked improvements in productive efficiency, as well as greater managerial and political accountability. There were also significant negative social impacts, most notably in the form of large-scale redundancies that have had serious and enduring consequences for many small forestry and mining towns. However, the second wave of privatisation in health care was less successful, with the efficiency gains from turning Area Health Boards into Crown Health Enterprises proving modest at best and not nearly as substantial as had been expected by the government's advisors. Moreover, both the restructuring costs and the ongoing transaction costs associated with the new structures had been substantial.[37]

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[35] After Qantas was privatised it fairly rapidly proved to be 'fitter' than Ansett, which called in the liquidators in 2001.
[36] Albon *The scope for privatisation in Australia.*
[37] Boston, J. (1998) Public sector management, electoral reform and the future of the contract state in New Zealand. *Australian Journal of Public Administration,* 57: 32-43

A review by Walker and Con Walker[38] found that privatisations in Australia had changed society in positive ways, through an extension of share ownership and the reduction of governments' costs in some areas. However, it had also drastically changed the social and political landscape by

- producing massive wealth transfers within the community; conferring privileges on insiders;
- often leading to loss of services from communities and loss of jobs in government; feeding spurious claims about savings to the taxpayer;
- risking the marginalisation of rural communities; bringing about the dismantling of some government-owned state-based monopolies;
- contributing to the formation of more powerful, national oligopolies;
- arguably contributing to environmental damage;
- slowing or reversing the trend a trend towards more open and accountable government;
- eroding institutional arrangements for public sector accountability;
- subverting the planning process; and
- significantly eroding regulatory protection for investors in the Australian securities market. [39]

These changes also represent a large-scale transfer of risk away from government and the collective, back towards individuals. The Walkers also found that privatisations were handled badly in a variety of industries, with intimidation to prevent public debate (in the case of the Commonwealth Housing Loan Insurance Corporation); an undermining of value in the case of the Australian National Line (coastal shipping); high transaction costs and erosion of investor protections (New South Wales Government Insurance Office); poorly designed sale arrangements (National Pipeline Authority) and sale at any price (State Bank of NSW).

The Walkers and Con Walker findings might have been predicted using fairly mainstream economic theory. In relation to the theory of privatisation, Boston[40] argues that relevant theory, such as agency theory and transaction cost analysis, suggests that contracting out is of questionable merits (in terms of productive efficiency, effectiveness and accountability) where there is limited contestability in

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[38] Walker and Con Walker *Privatisation : sell off or sell out? : the Australian experience.*

[39] Walker and Con Walker are an accountant and an economist respectively. Walker is a former chairman of the Australian Shareholders' Association. Con Walker has worked with a major corporation, within the public sector and as a consultant to business. They state in the introduction to their book that they are 'economic rationalists' and not ideologically opposed to privatisation.

[40] Boston. Public sector management, electoral reform and the future of the contract state in New Zealand.

the relevant market and where contract specification, monitoring and enforcement is difficult. This is particularly the case when the operating environment is characterised by high levels of uncertainly, significant risks of opportunism by agents, complex and frequent transactions, and small numbers bargaining. (Boston 1998). Beyond those failures of procedure, the Walkers argue that, more significantly, the *theory* of privatisation is ideologically driven:

> Many of the arguments of the style that 'public sector is bad' and 'private sector is good' are founded on ideology rather than evidence and analysis.[41]

Furthermore, there have been very few efforts to explore in a rigorous fashion important issues such as what a change in the method of service provision means for the clients and whether they get better service at the same (or reduced) cost. It is held against many advocates of privatisation that, while having knowledge and expertise to comment on these matters, they failed to ask the critical questions. Many of them also stood to gain if government pursued privatisation. In addition, much of the debate surrounding privatisation, particularly the arguments for its implementation, was imported from overseas, particularly the United Kingdom, with little regard for whether the overseas claims were relevant to Australia.

Two other observations have been made about the privatisation process in New Zealand. The first is that, in assessing the evidence for privatisation, it is important to distinguish between short-term and long-term successes. Many agencies that were privatised in the early phase of privatisation were chosen because they had characteristics that made them attractive to private buyers, and, therefore, more likely to be successful. Thus profitability might have been high in these early privatisations. More marginal agencies may be privatised next, bearing higher restructuring costs and substantial ongoing transaction costs associated with the new structures. The second observation is that New Zealand's reforms, notwithstanding their numerous strengths, left many of the fundamental problems of public sector management unresolved. In addition, sharp political divisions remained over the extent to which a more commercial and contractualist

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[41] Walker and Con Walker *Privatisation : sell off or sell out? : the Australian experience.* 2.

approach should be applied to the organisation and delivery of key social services, including health care and public housing.[42]

Privatisation evidence in relation to health care

In relation to any impact on health care, White and Collyer argue that there are at least four types of cost-efficiency responses that can be seen in the hospital sector, not all of which are equally desirable. The four types are reducing costs, shifting costs, delaying costs and enlarging the business.[43] Costs can be reduced by eliminating duplication, cutting practices that are wasteful of time or resources, increasing productivity through changing work practice, or introducing a new technology. However, they concluded:

> Unfortunately there is little evidence to suggest that cost reduction of this type has been achieved in the hospital sector without reducing either access to service, the number or type of services provided, the number of employees engaged to perform the work, the conditions of workers, or the quality of work performed.[44]

Second, costs for one particular player can be reduced by shifting them onto other players. In the United States, this typically means that the costs of health care services are transferred to the patients (and their employers) in the form of escalating insurance premiums. In New South Wales, the Port Macquarie Base Hospital was privatised with a significant transfer of funds from the public sector into the private sector (banks and the hospital corporation), without securing additional services. The transfer was accompanied by shifting of costs onto the health insurance companies (estimated to be $35-45 million over 20 years) which now paid more to the private hospital for the care of their members than was paid to comparable public hospitals for private patients.

Third, although delaying costs is a way of reducing them in the short term, the costs over the long term may be significantly higher. As White and Collyer state:

> Rather than constructing hospitals from public funds, governments have been entering into arrangements with the private sector to build public infrastructure. The

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[42] Boston. Public sector management, electoral reform and the future of the contract state in New Zealand.
[43] White, K and Collyer, F. (1997) To market, to market: Corporatisation, privatisation and hospital costs. *Australian Health Review,* 20: 13-25
[44] Ibid. 16

> government is then liable for future lease payments and operational funding. The cost of these periodic payments, over the total life of the contract, may, however, be significantly higher than it would have been if the hospital had been constructed with public funds. This is because the periodic payments include an amount on top of the patient cost to allow companies to recoup their capital investment in building construction and equipment. [45]

Examples included the Port Macquarie Base Hospital in NSW, and the regional hospitals in Mount Gambier and Port Augusta in South Australia. Finally, enlarging the business is a competitive strategy for increasing patient volume and stimulating the demand for services. It drives the development of increasingly complex and elaborate treatments, therapies and products. While the demand for more services continues to rise and services continued to be highly valued, less costly services are unlikely to emerge within a competitive market.

White & Collyer demonstrate that the relationship between competitive pressures and socially efficient production methods is not always straightforward and that there is plenty of scope for profit-maximising health care providers to be cost-efficient producers without being socially efficient producers, because all costs and benefits are not fully internalised, or because contracts are poorly specified or because there is scope for corporatised or privatised firms to exert market power. There is evidence of White & Collyer's three strategies resulting from recommendations in the Audit Commission reports. Cost reduction is recommended through eliminating restrictive work practices (Victoria and South Australia), reducing relatively high numbers of staff and multi-skilling (South Australia). Recommendations that would result in cost shifting pepper the Audit Commission reports. The most consistent of these is the recommendation to shift outpatient services from hospital clinics funded by the State Governments to general practice clinics funded by the Commonwealth. A second common theme was the transfer of nursing home beds from State funding to Commonwealth funding. In neither of these cases is there any suggestion that the users of these services will be any better off under the new arrangements. They are used simply as devices for shifting costs from the States to the Commonwealth. However, the

[45] Ibid.19.

shift from the outpatient clinic model to fee-for service general practice may have other costs that result in a net social loss from the move. Livingston argues that,

> The FFS model of care has deformed the system both in type and quality of care by paying doctors more to do tests and procedures than careful, lengthier office visits, and physical examinations, and encouraging the speedy movement of patients through the office. It creates incentives to over treat by financially rewarding doctors for follow-up visits when telephone follow-up would suffice, and perversely provides no incentive for preventive care and health education, particularly when these services are provided by non-physicians and are therefore not directly reimbursable in a private practice setting. It also contributes to fragmentation and duplication of services.[46]

A number of recommendations would also see costs shift to the community as care is moved out of hospitals. This would occur even if the costs of formal care were fully met. For example, early discharge from hospital usually relies more heavily on the availability of an informal carer, as does the increased use of day only procedures. Even although the new technologies mean that less intensive and expert care is required in the post-operative period, patients who undergo day surgery procedures still often require low level care at home that requires the presence of an informal carer.

At least two Audit Commission reports recommended the use of private capital in the provision of hospital infrastructure. It remains to be seen whether this will lead to a net decrease in costs over the life of the assets involved. However, the available evidence from the Port Macquarie Base Hospital suggests that the converse will be the case. In addition, the UK Private Finance Initiative has proved to be more expensive than the earlier system of capital charges and resulted in an unplanned contraction in services (bed numbers) where private finance is used.[47]

Assessing the evidence on privatisation

Much of the evidence on both sides of the privatisation debate has focused on technical efficiency. However, sound economics should assess allocative

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[46] Livingston, M. (1998) Update on Health Care in Canada: What's right, what's wrong, what's left. *Journal of Public Health Policy,* 19: 267-288. 270.

[47] Gaffney, D, Pollock, A, Price, D and Shaoul, J. (1999) NHS capital expenditure and the private finance initiative. *British Medical Journal,* 319: 48-51; Pollock, AM, Dunnigan, MG, Gaffney, D, Price, D and Shaoul, J. (1999) The private finance initiative: Planning the "new" NHS: downsizing for the 21st century. *British Medical Journal,* 319: 179-184

efficiency, which takes into account all of the relevant and material costs and benefits of different methods for production and distribution.

All of the Audit Commission reports with Chapters on health services recommend some form of privatisation of at least one aspect of hospital services provision. However, there is very little discussion of privatisation and virtually no justification for its application to publicly provided health care. For example, the Western Australian health services Chapter simply states that 'The Western Australian Commissioner for Health suggested that under the proposed purchaser/provider model there was no philosophical reason why services could not be undertaken by the private sector'[48]. While the Western Australian report does have separate Chapters on competitive tendering and privatisation, neither discusses their specific application to health services. The Victorian report simply states that the Commission believes that a major program of service transfers from the public hospital system to the private hospital system or the Commonwealth is essential to deliver recurrent budget reductions and to shift budget funding obligations away from direct State government responsibility.[49] The Queensland report discusses the objectives of competitive frameworks and describes how these have been implemented in a number of countries. However, no evaluation of these is attempted and there is no discussion or justification of privatisation *per se*. The South Australian report makes reference to privatisation in relation to assets. This is also discussed in a separate Chapter on asset management which states that a key goal should be to provide benchmark models of peak efficiency in each of the major service delivery areas of the public sector (including hospitals) and that 'this will almost certainly require the participation of the private sector'[50]. However no further justification is given for private sector involvement.

Privatisation is presented in the Audit Commission reports as an article of faith, rather than being demonstrated with evidence as a sound way forward for health

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[48] Western Australia. Independent Commission to Review Public Sector Finances *Agenda for reform: Report of the Independent Commission to Review Public Sector Finances. Volume 2.* 212.
[49] Victorian Commission of Audit (1993) *Report of the Victorian Commission of Audit.* 123.
[50] South Australian Commission of Audit *Charting the way forward: improving public sector performance: report of the South Australian Commission of Audit. Volume 1.* 233.

services. There is generally an underlying presumption that the private sector can probably do things more efficiently than the public sector, or that at the very least, the public sector needs the threat of private sector competition in order to perform efficiently. Where significant restructuring of systems has been evaluated, many of the evaluations have been open to criticism. For example, Vingilis and Burkell, reviewing the evaluation of hospital closures in Winnipeg, Canada found that the reports lacked a 'conceptual model to articulate the process of downsizing and the hypothesized (sic) systemic changes and related outcomes'[51]. In addition, the Winnipeg report failed to identify intended resource inputs, expected changes in hospital procedures, shifts in health care by both formal and informal caregivers, or expected changes in services provided. Finally, no logical links between changes in hospital services and the measured outcomes were proposed.

While it was not necessarily the job of the Audit Commissions in Australia to provide such a detailed framework for evaluating their recommendations, what they have done is the same kind of evaluation of the relationship between inputs and outputs as is reported for the Winnipeg evaluations. However, there is no indication of anywhere near this level of sophistication in their models of how what they recommend will impact on the system. Thus, they take the standard market model and assume that by forcing competition or funding restrictions, efficiencies will be made and there will be a net social gain. In addition to taking the relationship between changes in hospital services and the expected outcomes largely as an article of faith, the Audit Commission reports failed to pay any attention to the broader institutional context. This is a failure of both theory and of practice. Neo-classical economics has a very thin theory of institutions, as exemplified by comparison with the New Institutional Economics. The limited discussion of institutional issues in neo-classical economics considers only those institutions that are developed to improve the efficiency of markets, usually by reducing transactions costs. However, a broader institutional framework is needed that includes a wider definition of institutions that are important in the evolution

[51] Vingilis, E and Burkell, J. (1996) A critique of an evaluation of the impact of hospital bed closures in Winnipeg, Canada: Lessons to be learned from evaluation research methods. *Journal of Public Health Policy,* 17: 409-421. 413.

and maintenance of systems of resource allocation and in the decisions of participants in the economy.

Discussion

The general themes of the terms of reference for the Audit Commissions also point to a larger threat to public health. The Audit Commissions were clearly concerned primarily with the state of the finances of each of the State governments and three of the Commissions' terms of reference made explicit reference to the States' credit ratings. The reports also attempted to look like technical, rather than political, exercises. They present quite a lot of data comparing the performances of the States to each other. However, there is no consistency in the parameters used for comparison, or in the comparators. Sometimes that national average is used, sometimes it is all other States, at other times some or one other State is used selectively. Without sufficient rationale for choice of comparators, their appropriateness needs to be questioned and the possibility for a charge of bias in their choice remains open.

In relation to health care, which is the focus of this thesis, the Audit Commissions also assume that the delivery of publicly funded health care services is a largely technical exercise, and can be performed by the lowest bidder. The reports do not recommend the privatisation of the policy process; however, the privatisation of service delivery may mean that it is more difficult to implement policy as the service provider now has an additional goal of profit maximisation that might work in conflict with the government's and the community's broader policy objectives for health care. In the case of health care providers, the existence of market failure may mean that some of the conflicting goals that result in government failure may also be present in a private service provider.

The Audit Commissions did not ask one very important question, namely 'whose interests do the new arrangement serve?' The evidence from Walker and Con Walker suggests that the benefits to the wider community of privatisation may have been overstated and the benefits to some private individuals understated. However, there are larger interests than just who wins and loses from the sale of a particular government asset. The reports presented definitions of what the role of

government should be. These definitions reflected a particular ideology that is dominant in economics. Any bids for alternative roles for government are interpreted under this ideology as self-interested attempts at rent-seeking and are represented as attempts to undermine the rights, obligations and outcomes that are the natural consequences of the market system. The market system is assumed to be a politically neutral system of production and distribution. Only market power resulting from the absence of one of the conditions of perfect competition results in the exercise of power by one entity or group over another. It assumes that there are no concentrations of power within the economy that would allow some interests to benefit disproportionately from the new rights or rules that governments introduce. The Walker and Con Walker examples demonstrate that even in the privatisation process participants were able to extract rents.

This leads to questions about the independence of the Audit Commissions. The terms of reference were so prescriptive in some States that the methods of the reports were inevitable and the conclusions were known in advance. Some may argue that politicians are wise not to ask a question to which they do not already know the answer. However, the Audit Commissions were putatively established to provide an independent assessment of each of the State's finances, but, given their terms of reference and membership, were unlikely to come to any other conclusions about the State governments.

Finally, the process of the Audit Commission reports and their outcomes raise questions about the quality of democracy. While the Audit Commissions were instituted by democratically elected governments, they were a largely closed process and allowed minimal scope for public participation (or much input by people with extra-economic views). It is not clear that there were any opportunities for democratic input into their deliberations or their recommendations. In addition, the result of the privatisation process has been that in many areas, information about the provision of publicly funded or previously publicly provided services is the subject of commercial-in-confidence contracts. This effectively reduces the level of transparency in the provision of goods and

services. It is ironic that increased transparency was one of the supposed benefits of the reforms that the Audit Commissions recommended.

Conclusion

The State Audit Commissions took a particular view of the role of government, and its failings and made recommendations that were pretty much inevitable, given their terms of reference and membership. However, the implementation of their recommendations has not resulted in the clear substitution of the costs of government with the benefits of private sector ownership and provision. One important reason for this is the failure of the theoretical framework that they employed failed to predict sufficiently the effects of their recommendations. In addition, they did not take into account any effects of their recommendations other than those on technical efficiency. This lack of texture to their theoretical frameworks, which continues to be dominant in Australian public administration, means that their recommendations resulted in outcomes that did not necessarily serve the interests of the wider community. This has important implications for public health that are not confined to the relative efficiency of public hospital services. The wider needs of the community for goods other than technically efficient services are compromised when government loses control over important community resources and power shifts with those resources to private interests.

The following Chapters of this thesis consider how the application of the theoretical frameworks of institutional economics, which provide a more thickly-textured account of the economy and its processes, and which take into account broader institutional issues, provides a more satisfactory account of the matters considered in both the Commonwealth and State Audit Commission reports.

Chapter 7: Six Strands of Institutionalist Theory

Introduction

The previous three chapters have provided a detailed exposition of two sets of documents that exemplify the mainstream economics approach to the role of government, to population ageing and to the provision of health services. This approach is deficient, from a public health perspective, given a substantial body of evidence that suggests alternative interpretations of the phenomena, even from within its own paradigm.

The purpose of this thesis is not to address every shortcoming of the mainstream approach, but to concentrate on those shortcomings that have some significance from a public health perspective, as they are focused through the lens of institutional economics. These shortcomings are summarised in this chapter and six strands of institutional economic theory are described in detail that reflect these concerns. The three following chapters then revisit the case studies in light of these specific strands of institutionalist theory.

Issues arising from the case studies

In the first case study, on population ageing, I concluded that the approach of mainstream economics fails to adequately address the needs of an ageing population. It constructs age as the primary cause of ill-health, poverty and dependency in old age, but fails to address to problems in the structure of the economy and society that also contribute to producing those problems. Specifically, it ignores a range of reasons for retirement that are not specifically to do with age and it ignores wide variations in health status in old age. The reasons for these lacunae are embedded in its methods: mainstream analysis assumes abstracted individuals who behave rationally – which seems to mean, in the view of the reports, maximising their retirement income with minimum effort. The reports focus on maximization of national income and minimisation of future taxes. Discussion of equity is confined to intergenerational effects of public expenditure and private savings, rather than how well off future generations will be, overall, compared with the current generation. The failure to acknowledge equity, which is an important concern for public health, is echoed in the chapter

on demographic change contained in the Commonwealth's Audit Commission Report.

The second area about which public health is concerned is the role of government. Most of the Audit Commission Reports provide a rationale, from the mainstream economics point of view, in support of a role for government. This rationale is usually confined to instances of market failure, which is discussed extensively. The National Audit Commission does acknowledge a social case, when the community demands that specific social objectives be addressed, but does not provide any discussion of this case, perhaps because it assumes that the important consequences of these social policies can be evaluated using various forms of cost-benefit analyses. These reports presume, rather than demonstrate, the superiority of market provision in the absence of classical market failure and argue for privatisation and marketisation of provision where market failure does occur. They ignore evidence that suggests that these strategies will not necessarily improve the situation. They also ignore evidence of power in health care to shape consumer wants and doubts about whether markets can provide the health system that citizens want, as distinct from the quality and quantity that patients may want from specific services.

The third area of public health concern that has been highlighted by the Reports on Ageing and the Audit Commission Reports is the provision of health services, particularly the increasing cost of them, which is largely attributed to population ageing and to poor cost control, low provider responsiveness and inadequate consumer information (price signals). Low provider responsiveness and inadequate consumer information are said to result from the lack of market mechanisms that facilitate communication between providers and health service users and discipline their behaviour.

Institutional economics claims to offer an alternative view of economics that does not rely on value or price theory as its economic theory and replaces the reductionist methods of mainstream economics with more holistic approaches that serve to explain, rather than merely predict, economic behaviour and outcomes. There are seven strands of institutional economics that will be explored in relation

to these three themes. Six of these strands will be described in this chapter then applied to the themes in the following three chapters. The seventh will be dealt with in isolation in Chapter 9.

Six strands of institutionalism

Within Old Institutional Economics (hereafter referred to as institutional economics) there are a number of approaches. In the remainder of this thesis, I concentrate on six strands that appear to have considerable (but not unanimous) support within the institutional ecomonics community and which appear to be salient to the issues that have been identified in the examination of the case studies. The first is the instincts approach of Thorstein Veblen. The second is Veblen's theory of collective social wealth. The third is a social value strand, exemplified in the work of Marc Tool and developed further by Philip O'Hara. The fourth is the treatment of power by institutional economists. The fifth is the notion of the institutionalised individual, most clearly articulated by Geoffrey Hodgson, and the sixth is the institutionalist theory of social change.

Thorstein Veblen's instincts

Veblen argued that three major positive instincts are apparent in humans, namely workmanship, idle curiosity and parental bent. The instinct of workmanship is 'concerned with the ways and means of life'[1] and 'occupies the interest with practical expedients, ways and means, devices and contrivances of efficiency and economy, proficiency, creative work and technological mastery of facts'[2]. The instinct of workmanship makes the greatest contribution to the material well-being of the race[3]. Idle curiosity is a 'force of which men, more or less insistently, want to know things, when graver interests do not engross their attention'[4]. Idle curiosity results in 'systematised knowledge and quasi-knowledge of things'[5] and serves to 'accelerate the gain in technological insight by bringing in material

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[1] Veblen, T (1965 {1899}) *The theory of the leisure class. 1899.* With the addition of a review by William Dean Howells. New York: A. M. Kelley.
[2] Veblen, T (1964 {c1914}) *The instinct of workmanship and the state of the industrial arts.* New York: Kelley. 33.
[3] Veblen *The theory of the leisure class. 1899.*
[4] Veblen *The instinct of workmanship and the state of the industrial arts.* 45.
[5] Ibid. 87.

information that may be turned to account, as well as by persistently disturbing the habitual body of knowledge on which workmanship draws'[6]. Parental bent is 'an instinctive disposition of much larger scope than a mere proclivity to the achievement of children. (…) The parental solicitude in mankind has a much wider bearing than simply the welfare of one's own children'[7].

Veblen believed that concern for the well-being of at least the next generation was an instinctive bent that extended not only to the well-being of one's own children, but of that generation as a whole. He also believed that the instinct of parental bent was common to most people:

> So also, virtually all thoughtful persons, - that is to say all persons who hold an opinion in these premises, - will agree that it is a despicably inhuman thing for the current generation wilfully to make the way of life harder for the next generation, whether through neglect of due provision for their subsistence and proper training or through wasting their heritage of resources and opportunity by improvident greed and indolence.[8]

The instinct of parental bent also extends across the current generation as it 'greatly reinforces that sentimental approval of economy and efficiency for the common good'[9]. Finally, the instinct of workmanship is the most important for achieving the well-being of the race. However, the instinct of workmanship is 'strongly sustained at this point by a parental solicitude for the common good'[10]. The two are so closely entwined that discussion of one inevitably draws in the other, and these two instincts are the primary forces in human advancement. Veblen argued that while instincts are innate characteristics that have their foundations in the biology and psychology of humans, their expression depended upon the cultural environment.

Thorstein Veblen's theory of collective social wealth

Veblen's theory of social wealth is recognition that the economy functions in a community and the quality of that community is a fundamental influence of the nature of and direction of the economy. In Veblen's theory, collective social wealth

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[6] Ibid.87-8.
[7] Ibid. 26.
[8] Ibid.
[9] Ibid. 27.
[10] Ibid.

is simply the means of maintaining and promoting technological change, information flows, institutions and the like. O'Hara argues for a more specifically normative theory and defines collective social wealth as 'the extent to which there is an instrumental functioning of social relations'[11]. In doing so, he continues the Veblenian tradition of drawing upon Dewey's notion of instrumentalism.

O'Hara defines Veblen's social wealth as including 'the stock of human norms, mores and structures of 'truthfulness, peaceableness, good-will, and a non-emulative, non-invidious interest in people and things'[12], which are necessary for the positive reproduction of community, warranted knowledge and participation. Veblen differentiated the reproductive activities of material production, cooperation, love, care, idle curiosity and the growth of knowledge, from the un-reproductive activities, which reflect predatory, emulative and pecuniary tendencies within institutions, and which discriminate in order to promote the vested interests through control of institutions and material assets.[13]

O'Hara linked Veblen's notion of social wealth to the notion of social capital through their common important role in promoting economic well-being. Social wealth includes the stock of human norms, mores and structures of truthfulness, peaceableness, good-will, and a non-emulative, non-invidious interest in people and things. It is an idea that is much less widely explored than is the contemporary notion of social capital. In their review of social capital, written for a public health audience, Baum and Ziersch[14] identify two main schools of thought regarding the definition of social capital. The first is influenced by Putman, who conceived of social capital as a community level resource defined as 'features of social organisation such as networks, norms and social trust that facilitate coordination and cooperation for mutual benefit'[15]. The second main school of

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[11] O'Hara, PA (1995) *Thorstein Veblen's Theory of Collective Social Wealth.* Department of Economics Working Paper No. 94.19. Perth: Curtin University of Technology. 18.
[12] O'Hara, PA. (2002) The contemporary relevance of Thorstein Veblen's institutional-evolutionary political economy. *History of Economics Review,* 35: 78-103. 82.
[13] O'Hara *Thorstein Veblen's Theory of Collective Social Wealth.*
[14] Baum, F and Ziersch, A. (2003) Social Capital. *Journal of Epidemiology and Community Health,* 57: 320-323
[15] Putnam quoted in Ibid. 320.

thought identified by Baum and Ziersch draws on the work of Bordieu who defined social capital as 'the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalised relationships of mutual acquaintance and recognition'[16] The Putnam notion of social capital is described by Baum as both a public good and an ecological characteristic, while the Bordieu definition focuses on resources that accrue to an individual as a result of membership in social networks.[17] However, Putnam's social capital is aggregated from individuals and is not necessarily held as a collective good.

Veblen's discussion of social wealth indicates that he constitutes it as a community level resource, rather than the property of individuals. It does not rely on shared relationships but on shared values. Granted, sharing of values may be increased by involvement in networks, but is not dependent upon it. In addition, the paths by which collective social wealth and social capital contribute to economic well-being are different. In the case of collective social wealth, it is the dominance of reproductive values, such as workmanship, idle curiosity and the parental bent that move human development forward. In the social capital model, it is the direct benefit of having networks and the indirect benefits of the trust these networks generate that are important. In the economics literature, social capital has been integrated into economics analysis as a preference in utility functions, as a resource next to other capital, and as a mechanism to address market failures due to imperfect information and risk.[18]

Very little of the institutionalist economics literature deals explicitly with social capital. A search of the *Journal of Economic Issues* (the journal of The Association for Evolutionary Economics (AFEE), which cites the Original Institutional Economics as its intellectual heritage) using the search term *social capital* yielded only nine hits, of which one was a book review[19] and one included social capital as a throw

[16] Bordieu, quoted in Ibid.
[17] Ibid.
[18] van Staveren, I. (2003) Beyond Social Capital in Poverty Research. *Journal of Economic Issues,* 37: 415-423
[19] Schmid, AA. (2002a) Social Capital : Critical Perspectives. *Journal of Economic Issues,* 36: 824-6

away line in the conclusion[20]. In addition, O'Hara appears to refer to social capital in support of Veblen's 'collective social wealth' but Veblen does not actually use the term *social capital*.[21]

Carroll and Stanfield claim that social capital is better viewed as an indication of the economy's embeddedness in the community. In areas that enjoy high levels of social capital, the provisioning process is enmeshed in the social fabric of the community. In other words, there is no completely separated economic sphere with a distinct set of motives and function. In a market economy, this integration with the social fabric may not be possible to achieve, so it may be more useful to speak of the degree to which the local economy is embedded. Areas with a high degree of social capital have a higher degree of economic embeddedness.[22]

Van Staveren defines social capital as 'a shared commitment to social values as expressed in the quantity and quality of social relationships, which may enable or constrain dynamic efficiency'[23] However, this is not an *institutionalist* definition, but one gleaned from the use of social capital in *social capital and poverty* literature, and Van Staveren is highly critical of the denial of inequality that is evident in this body of research.

Rubio[24] uses the term social capital loosely, including in it families, friends, neighbours, contacts, and networks of these individuals that facilitates the transfer of values and the accumulation of productive social capital to cultural characteristics such as trust. He describes productive social capital as 'a "virtuous" circle in which the institutional framework, the culture and the rules of the game stimulate economic growth, and the organizations that are successful in this environment favour institutional change that, in turn, reinforces growth'. Conversely, in perverse social capital 'the networks, the contacts, the power

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[20] McDowell, G. (2004) The Market as Traffic -- An Economic Metaphor. *Economic Issues,* 38: 274-78
[21] O'Hara *Thorstein Veblen's Theory of Collective Social Wealth.*
[22] Carroll, M and Stanfield, JR. (2003) Social Capital, Karl Polanyi, and American Social and Institutional Economics. *Journal of Economic Issues,* 37: 397-404. 400.
[23] van Staveren. Beyond Social Capital in Poverty Research. 415.
[24] Rubio, M. (1997) Perverse social capital -- some evidence from Colombia. *Journal of Economic Issues,* 31: 805-816. 815.

relations, the legal system, the informal norms of behaviour, the political activities, and the reward systems rent-seeking, or criminal behaviour, to the detriment of productive activities and technological innovation'[25], a substantial variation on the Putnam idea of social capital.

The use of the term *social capital* in four other articles in the *Journal of Economic Issues* does not suggest that a link has been made between it and Veblen's notion of collective social wealth. Rosenbaum[26] draws on Putman in his definition of social capital as that which 'facilitates the solution of collective action problems since social capital denotes the ability to create and sustain voluntary associations and discusses the need to understand the reproduction and distribution of social capital'.[27] Schmid draws upon the definitions of social capital provided by Putnam and Fukyama to discuss the need for more work to make the term *social capital* operational and measurable.[28] Dolfsma and Dannreuther do not provide a definition of social capital, but are highly critical of the World Bank's use of social capital. They argue that it reflects the Bank's methodologically individualist view as well as its stance about information as objectively given. These are important institutionalist critiques, but do not provide a link between social capital and Veblen's Collective Social Wealth.

.[29] Stabile used the term social capital, but did not define it, but described it as 'for example, human talent or the environment'[30]. Published in March 1993, this paper does not cite any of the modern exponents of social capital. It is safe to conclude that this was a casual use of the phrase and that this does not sit within the modern social capital field.

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[25] Ibid.
[26] Rosenbaum, EF. (2001) Culture, Cognitive Models, and the Performance of Institutions in Transformation Countries. *Journal of Economic Issues,* 35: 889-909
[27] Ibid. 892.
[28] Schmid, AA. (2002b) Using Motive to Distinguish Social Capital from Its Outputs. *Journal of Economic Issues,* 36: 747-768
[29] Dolfsma, W and Dannreuther, C. (2003) Subjects and Boundaries: Contesting Social Capital-Based Policies. *Journal of Economic Issues,* 37: 405-413
[30] Stabile, DR. (1993) Accountants and the Price System: The Problem of Social Costs. *Journal of Economic Issues,* 27: 171-178. 172.

Apart from O'Hara, none of these authors even mentions Veblen, Fagg Foster, Junker, Tool or Bush. So O'Hara's conception of Veblen's collective social wealth as equivalent to social capital appears to be unique. This should not be surprising since the two concepts are quite different: social capital is inextricably linked to particular relationships, a function of interactions between individuals in the current time. Collective social wealth is a stock of values held by the community: they may be increased by the presence of social capital but their impact on economic behaviour is via a quite different path.

The institutionalised individual

The idea that the innate characteristics of humans can be expressed differently in different cultural environments gives rise to the notion of the institutionalised individual. Hodgson argues that the notion of the institutionalised individual is the characteristic of institutional economics that distinguishes it most clearly from mainstream economics. Because of their defining role in economic activity, recognition of the pliability of human preferences and purposes has two important implications. The first is that individual preferences and purposes are legitimate objects of inquiry. What people think and why and how these preferences and purposes develop and are patterned is as much a legitimate object of inquiry as is what diseases people have and why and how these diseases develop and are patterned. The second is that preferences and purposes may also be legitimate targets for social change if their expression is not in the interest of the community. This is already an underlying tenet of attempts to change beliefs and behavior through marketing activities, including the social marketing activities associated with health promotion. Lest these be labelled as social engineering, the notion of the institutionalised individual implies that human wants and preferences are already engineered to some extent.

The institutionalised individual is a distinct methodological feature of institutional economics, setting it apart from most other schools of economics. In essence, 'the individual is not given, but can be reconstituted by institutions'[31]. This version of

[31] Hodgson. What is the essence of institutional economics? 323.

individualism and of institutions sees institutions as not simply constraints on behaviour, but as influencing the very character or constitution of individuals.

The concept of the institutionalized individual has important implications for both explanation in economics and for policy development. First, the reasons why people behave in the way they do can be elucidated more clearly using the concept of the institutionalised individual. Neo-classical economics take the individual as given, able to learn – but to learn a set of established facts. Learning is treated as 'stimulus and response, or as the Bayesian updating of subjective probability estimates in the light of incoming data'[32]. In institutional economics, however, recognition of the institutionalised individual provides a framework for a more complete understanding of why people behave as they do. This shifts the study of human behaviour from description, based on assumption that individuals behave in the way they do because it maximizes the fulfillment of their preferences, to analysis, based upon the origins and social patterning of those preferences and to the factors that may drive behaviour in ways that appear neither rational nor maximizing.

In terms of policy development, understanding the institutional influences on individual behaviour provides the potential for a wider set of possibilities for policy formulation. Currently, mainstream economics primarily develops policies in terms of changing the price structure. While this can be effective in changing behaviour in a desired direction, it can also have undesirable consequences if the interaction of the change in price with prevailing institutions is not well understood.

Tool's Social Value Theory

Veblen's contribution was elaborated by Clarence Ayres, who combined Veblen's work with John Dewey's instrumental value theory; by J. Fagg Foster, who located both instrumental and ceremonial patterns of behaviour within the institutional structure of society; by Junker and Bush, who formulated the concept of ceremonial encapsulation and by Tool, whose restatement of this approach

[32] Ibid. 327.

culminated in the formation of the social value principle – that 'progressive institutional change occurs when the instrumental use of knowledge provides for the continuity of human life and the non-invidious re-creation of community'.[33]

As a criterion of judgment, the continuity of human life and the non-invidious re-creation of community first requires a social system that must permit at the very least, the physical survival of the society. The second element requires that the social system must be able to adapt and be reconstituted, to retain the 'stock of human wit and wisdom'[34] whilst recognizing the need to choose among institutional forms that remain instrumental in new circumstances.

Marc Tool's 1979 book *The Discretionary Economy* dismisses what he calls ism-ideologies, pure capitalism, Marxism and fascism as not providing a framework for a functioning, evolving economy. Tool argues that all knowledge is tentative and the explanations 'retain their explanatory significance only so long as that capacity to explain is not seriously eroded or faulted by new evidences or more adequate or inclusive formulation' [35] A key problem with the ism-ideologies is that, as belief system, they are largely finished and final in fundamental form and content. They represent terminal states, unresponsive to changes in knowledge. Tool argues, however, that belief systems are needed that arise from 'evidentially grounded, logically consistent social inquiry'[36]. Drawing upon the pragmatist tradition in Institutional Economics, Tool argues that social inquiry is initiated to remove doubt about existing patterns of thinking and acting in order to assist in the task of resolving social problems. The object of inquiry must be the existing social processes, including the ideas and institutions that govern the determination and administration of public policy, the resolution of conflict and the production and distribution of real income. The ism-ideologies, in contrast, serve to block inquiry. Capitalist inquiry tends to be overly rationalistic, episodic, rather than evolutionary, and positivistic, rather than normative, generally limited to market phenomena and concerned with approaches to or departures from a

[33] Tool *The discretionary economy: A normative theory of political economy*. 293.
[34] Ibid. 294.
[35] Ibid. 28.
[36] Ibid. 29.

natural order. Marxist inquiry, a 'rationalistic affirmation of conflict in phenomena which is imposed on data to account, allegedly, for occurrences'[37] is monistic and reductionist in as much as all phenomena can be accounted for by dialectical analysis of inherent contradictions. The dialectical model is both an article of faith and a teleologically-defined end. Finally, fascism 'means action government by sentiment and duty in the service of fascist ends (and) inquiry is converted into propagandist apologetics'[38]. While Tool revisits each of these ism-ideologies throughout the course of his book, I will only elaborate on his critique of capitalism, as neither Marxism nor fascism is being considered, within the context of this thesis, as a viable theoretical framework for policy development, neither by the case study documents that I have examined, nor by me.

Tool argues that, rather than being deterministic, that real economies are both mixed and discretionary. They are discretionary because they result from human choices and the exercise of human discretion. Interest rates, the level of employment, the creation of resources, and the distribution of income share etcetera are all the product of human agents' discretion. As resources and institutional structures are discretionary, so must be the operational mechanisms of the economy. According to Tool 'An evolving, functional economy is one which operates to give those who receive the incidence of economic policy discretion over that policy'[39]. Thus, the operational mechanisms must provide for the generation of and access to information about how well existing institutional structures provide for effective performance of economic functions; produce efficient ways for those significantly affected by economic policy to exercise discretion over such policy; prohibit the denial of discretionary participation to anyone on trivial or prejudicial grounds and assure that consequences of policy judgments are the subject of competent and continuing inquiry and that the results are fully communicated to the many who hold discretion. Individuals may participate through their market involvement, as consumers and sellers; through their job involvements as workers and foremen, through their organisational

[37] Ibid. 32.
[38] Ibid. 34.
[39] Ibid.140.

involvements and members and leaders and through their political involvement as voters and candidates.

In a synthesis of institutional thought spanning the work of Veblen, Ayres and Foster, Tool defines a social value principle and describes what he considers to be the features of actual economies. This approach recognises, in the pragmatic tradition, that all economic inquiry has a normative basis and that policy recommendations need to be based on defensible knowledge.[40] O'Hara's extension of Tools' social value principle, provides a set of criteria for evaluating the contribution that economic system makes to human progress. These also provide a framework for policy evaluation. The three criteria fall under the headings of community integration, warranted knowledge and participatory democracy.

Community and integration refer to the extent to which the economy exhibits community consciousness, cooperation and integration. It evaluates the extent to which community values such as cooperation dominate over greed, selfishness and individualism. Thus the dominance of these characteristics amongst the population will affect not only the behaviours of individuals in that context, but their very development. This criterion is based on a value judgment that

> socioeconomic progress is positively related to the degree of collective harmony, without the dominant presence of (1) coercive laws, police and armies; (2) powerful corporations which are not themselves controlled by the workers and/or the community; (3) market forces and technology encapsulating instrumental functions of institutions (..) and (4) the hatred associated with racism, sexism, extreme nationalism, ageism and speciesism.[41]

as these diminish collective harmony and promote contradictions that reduce effective coordination of the life process of the system.

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[40] In contrast, economic theory makes assumptions about human behaviour and outcomes that are not necessarily tested empirically. For example, oral health behaviours (diet and hygiene) and dental care visiting patterns are associated with oral health status, and oral health demonstrates an inverse social gradient. However, while oral health behaviours also exhibit a social gradient, they do not explain the inverse social gradient in oral health. Sanders, AE, Spencer, AJ and Slade, GD. (2006) Evaluating the role of dental behaviour in oral health inequalities. *Community Dentistry and Oral Epidemiology,* 34: 71-79

[41] O'Hara *Thorstein Veblen's Theory of Collective Social Wealth.* 18-19.

A co-requisite for proper participation is 'the working knowledge the population needs in order to comprehend the nature and complexity of the interlinkages between the socioeconomic and biospheric processes in active motion over time'[42] or warranted knowledge. Specifically, warranted knowledge is 'factual knowledge, continuously generated, publicly available, open to challenge'[43]. It necessitates a degree of education of the population in order for them to be able to understand and interact in society in a meaningful way.

This is a different treatment of information and knowledge to that by health economists who have recognised that information is a key problem in health care at a number of levels. First, health economists have argued that there is information asymmetry between providers and users of health care services. Users of health services are often poorly informed (in relation to the amount and complexity of information about their condition(s)) and unable to act as *rational* consumers. Second, there is uncertainty in timing and incidence of illness. One way of managing this uncertainty is insurance against health care costs. However, inability of providers to obtain sufficient information about the individual health risks for each buyer of insurance leads to poor risk-rating and adverse selection. One solution to the information problem that has been proposed by mainstream economists is commodification of information. However, informational commodities also have characteristics of a public good that are associated with market failure. First, they are non-rivalrous: once it has been produced, everyone can benefit from it without diminishing other's enjoyment. Second, it is non-excludable; it is difficult to control who has access to information once it has been created.

The notion of warranted knowledge also contrasts to the New Institutionalist Economics (NIE) treatment of information. The NIE approach retains most of the assumptions of mainstream economics. With its focus on transaction costs, NIEs

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[42] Ibid. 19.
[43] Tool, MR (1995) *A neoinstitutional theory of social change in Veblen's "Theory of the Leisure Class"*. Presented at Meetings of the European Association for Evolutionary Political Economy, Krakow, Poland, October 1995, and at meetings of the International Thorstein Veblen Association at Carleton College in Northfield MN May 1996.:

such as Coase, theorise the firm as arising to deliberately administer internal flows of resources and to suppress the market mechanism because there are two costs in using the market mechanism. The first is discovering what relevant prices are and the second is negotiating and concluding separate contracts for each transaction. For NIEs, then, formation of firms is a third means of resolving market failure caused by uncertainty. The institutionalist economists provide a critique of the NIE approach, and have developed three other approaches to information. They view firms, especially large ones, as centres of power rather than as economisers of information/transactions costs. Firms deliberately control information flows inwards and outwards in an attempt to weaken competitive markets. Further, informational institutions do not merely produce and sell informational commodities. They also produce and market consciousness and culture, for example the use of mass media for corporate marketing equates consumerism with democracy.[44]

O'Hara's third criterion, participatory democracy, 'relates to the population being included in the decision-making processes of the political economy: in production, distribution, finance, the world economy, the home, and the public sector' and 'operates to that all sections of the population have a high degree of potential access to education and decision-making processes'[45]. Freedom is the opportunity to make genuinely informed choices among genuine alternatives and participation provides the opportunity to decide how those choices will be constrained by rules, laws customs and accepted practices.

Power in Institutional Economics

In mainstream economics, power is recognised in the presence of monopoly, where a firm has the power to set the price in the market, rather than being a price-taker. However, the discipline pays little attention to the effect on the economy of other forms on power. In institutional economics, the three contexts of power explored most often are power exercised by market actors, power over non-

[44] Babe, RE. (1994) Information theory in economics. In *The Elgar Companion to Institutional and Evolutionary Economics A-K*. (Eds, Hodgson G, Samuels WJ and Tool MR) Edward Elgar: Aldershot.364.
[45] O'Hara *Thorstein Veblen's Theory of Collective Social Wealth*. 20.

market social choices, and power over the content of human values.[46] Institutional economists recognise that imperfect markets create *discretionary power*, however, this is broader than in mainstream economics and can also extend to latitude in investment choice, rates of technology adoption, or product mix, or ability to dictate terms and conditions of trade. Power is seen as grounded in control of scarce but essential inputs, with the corollary that technological and social evolution can shift the locus of this power. Discretionary power can be countered by modification in key institutions, for example, the growth of labour unions in reaction to growth in employers' power over terms of employment. Power in market transactions may also be seen in the ability of sellers in some markets to shape the preferences of their customers. Power may also be exerted over social choice. Economic structures such as property rights that carry with them rights to make investment, production and employment decisions that affect social performance confer power to influence social choices. Finally, institutional economists argue that social contexts do not merely constrain choices, but shape the values that persons pursue, their rights and power, to be accepted, and so on. Power to influence these things can be exercised with neither those exercising, nor those experiencing power being aware of it and power is entrenched most firmly when individuals *naturally* support local institutions.

Change

Mainstream economics does not have a theory of individual and social change that provides a framework for understanding how and why behaviour might be different by time and place. There are two reasons for the lacunae: mainstream economics deals poorly with the notion that *we* can have a social, collective meaning, rather than an abstracted individualist meaning, and its explanatory mechanisms deal poorly with the complexities that stand between stimulus and outcome. Mainstream development economics does have theories about economic growth, but these also assume away broadly defined institutional factors and thus do not deal with processes of social change (or, indeed, with the quality of

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[46] Bartlett, R. (1994) Power (I). In *The Elgar Companion to Institutional and Evolutionary Economics*. Vol. 2 (Eds, Hodgson G, Samuels WJ and Tool MR) Edward Elgar: Aldershot. pp. 169-173

economic growth, which is an element of social change). The main thing that mainstream economics does offer is a set of conditions under which it asserts that all economies work best. As Marc Tool has argued, capitalism as an organising system is an end state: in market economies, the state of an unfettered market economy has been achieved, there are no changes needed. In real economies, Tool, argues, change occurs that must be accommodated by mixed means, not simply by market adjustments.[47]

One intellectual characteristic that made Veblen a *Father of institutionalism* was his keen interest in social change and the way he linked change to technological innovation. He explained social change as an evolutionary process of cumulative causation that can be described as the impact of technology on institutions. Innovations create pressure for changes in habit of thought and behaviour in all employments. For Veblen, institutional change was a continuing process of adaptation to changing circumstances and the mode of adaptations a matter of human volition.[48] Human responses can be either predominantly instrumental or predominantly ceremonial. Instrumental responses value new technologies according to the consequences of their use. Ceremonial responses value new technologies according to invidious modes of valuation embedded in myths, rituals and ideology and seek to authenticate existing patterns of behaviour by claims to authority, and tradition.

Two important points emerge from Veblen's contribution. He focuses on the effects of technological innovation on institutions, but population ageing can also stimulate social change. Second, responses to this demographic change (it is not social change in the institutionalist sense, until it has influenced the operation of institutions) are not predetermined. How that change occurs, that is, how population ageing, for example, plays out as social and economic change is largely a matter of collective human choice, reflecting the relative influence of instrumental versus ceremonial values in the collective response.

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[47] Tool *The discretionary economy: A normative theory of political economy.*
[48] Bush. Social change, Theory of.

Institutional change occurs within the value structure of society, in two phases. The first phase involves ceremonial encapsulation, in which progress in knowledge is encapsulated within the existing value structure. Changes are incorporated into behaviour - Bush asserts - as long as they have no immediate impact in the value structure of the community. In time the change demonstrates new possibilities for behaviour outside traditional patterns.[49] This second phase may involve either regressive or progressive institutional change. Regressive change results when instrumentally justified patterns of behaviour are suppressed in favour of ceremonially warranted behaviour. Collective life processes are not enhanced by this response to change. Progressive change results when instrumentally justified patterns of behaviour replace ceremonially justified patterns of behaviour and collective life processes are enhanced.[50]

Institutional economics views the social order as continually renewed through the creation of new institutions and modification and abandonment of existing institutions in response to demands on the community as problems are identified and efforts at resolving them proceed. Renewal need not always be instrumental, just as evolutionary change need not be singularly progressive, 'moving from the inferior to the superior and towards the optimal'[51]. This implies the need for directed social change in order to meet the requirements for human survival in ways that are non-discriminatory, using knowledge that is warranted and reliable.[52]

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[49] A similar argument is made about the extension of influence in science by Bruno Latour: Latour, B (1988) *The pasteurisation of France.* Cambridge, Mass: Harvard University Press.
[50] Bush, PD. (1994a) The Pragmatic Instrumentalist Perspective on the Theory of Institutional Change. *Journal of Economic Issues,* 28: 647-657. 652. A similar argument is made later by Donald Schon about resistance to institutional change as the result of new technologies, which he terms 'Dynamic conservatism' Schon, DA (1971) *Beyond the stable state: Public and private learning in a changing society.* London: Temple Smith.
[51] Hodgson, G. (1994) Evolution and optimality. In *The Elgar Companion to Institutional and Evolutionary Economics A-K.* (Eds, Hodgson G, Samuels WJ and Tool MR) Edward Elgar: Aldershot. pp. 207-212.208.
[52] Tool, MR. (1994b) Instrumental value theory. In *The Elgar Companion to Institutional and Evolutionary Economics A-K.* (Eds, Hodgson GM, Samuels WJ and Tool MR) Edward Elgar: Aldershot. pp. 406-412

Conclusion

This overview of six particular strands of institutional economics provides a contrasting approach to important elements of the Australian case studies that has promise for a public health approach. Individually, each of these elements of the approach of institutional economics points to a different way of thinking about particular issues in the economy. Collectively, the six elements demand a different conceptualisation of economy and provide scope for normative questions to be dealt with explicitly. The three chapters that follow apply elements of these strands to population ageing, the provision of health services and the role of government.

Chapter 8: Ageing and Institutional Economics

Introduction

The claims of the preceding chapter may be tested against the five Australian reports into the economic effects of ageing described in Chapter 4. The five reports span the period from 1988 to 2005 and, collectively, they illustrate the broad application of mainstream economics within the Commonwealth Government, to studying the economics of population ageing. Their mainstream approach to the economics of population ageing is problematic at the theoretical, empirical and policy prescription levels. This Chapter summarises the shortcomings that have been identified in these five reports and explores the alternative approach of institutional economics to the aspects of ageing rehearsed in the reports.

The theoretical shortcomings identified in relation to the approach taken in the reports on ageing included their reliance on methodological individualism, and abstracted individualism, that resulted in a failure to look beyond aggregated individuals to publics and thus to recognise the broader cultural and economic influences on preparations for retirements and the decision to retire. The reports assume rational actors in these decisions, whereas evidence exists that a range of influences other than self-interest influence the decision to retire. In addition, individuals may find it difficult to process the information required to undertake *rational* retirement planning and retirement decisions. These difficulties arise from both stochastic and Keynesian uncertainty.

The reports on ageing identify population ageing as a problem for the Australian economy. They imply a difference between what will happen and what ought to happen. The reports, like much economics, are part of a process of policy formulation and advocacy aimed at resolving problems – in this case, those problems that an ageing population is thought to pose. They deal with change at two levels. The first is the recognition that population ageing will bring with it changes to the economy (although any broader social changes that may also have economic implications are glossed over). The second is that the problem status of population ageing implies the need for change in order to avert its undesirable effects.

The problem of population ageing is fundamentally a problem of dealing with the effects of change. The demography of ageing alters the needs and capabilities of the population, provokes changes in social arrangements and puts pressure on existing arrangements. The generation of new ideas on how to organise society in order to accommodate the change associated with population ageing can only come from a theory that accommodates change at its core, not one that treats change as endogenous to and occurring outside of and independent from the economic system. Institutional economics incorporates change as an essential and ever present element of an economy embedded in a society. Mainstream economics treats population ageing as exogenous to the economic system.

The first two Australian reports relevant to this argument were produced in 1988 and 1994 respectively by The Economic Planning and Advisory Committee (later subsumed into the Productivity Commission). They were followed by a chapter on demographic change in the report of the National Commission of Audit, by the Intergenerational Report which was tabled as part of the 2002-03 Commonwealth Budget, and finally, by the Productivity Commission's Report in 2005. At a theoretical level, they take as given or, at least, unproblematic standard approaches and assumptions from mainstream economics, including methodological individualism, rationality and market clearing equilibrium. In addition, they employ a demographic determinist assumption that population age and sex structure is the main driving force behind changes in dependency and health care costs. However, it has been demonstrated in Chapter Four that each of these *givens* limits the scope of analysis of the phenomenon of population ageing and risks giving an incomplete or inaccurate picture of the causes of dependency in old age. In addition, as a later section of this Chapter shows, the *givens* limit the scope of possible policy prescriptions.

These theoretical shortcomings flow through to the use of empirical evidence by defining narrowly which evidence will be used and how. The reports purport to examine the economic effects of ageing but their main focus is on the fiscal effects for government. The term *economic* implies a view of the issue from the whole of society, taking into account its costs and benefits. The *fiscal* focus of the reports

largely confines the perspective to considering the implications for government revenues and expenditure. Thus, the *fiscal* reports acknowledge little of the private or informal economic (let alone social) contribution of the aged. Also at an empirical level, the reports concentrate on what resources population ageing will absorb, not what will be left. In addition, there is some suggestion, for example, by Dowrick & McDonald, commenting on the Intergenerational Report that the assumptions used are likely to favour a pessimistic outcome[1]. There is also a great deal of uncertainty in their predictions, with small changes in government policy resulting in substantial changes in outcomes in future years. The shortcomings in policy prescription reflect the combination of theoretical and empirical failure. They are important because they lead to policy prescriptions that may not be particularly effective in reducing dependency in old age and may even be harmful from a public health perspective. The three main areas of policy prescription that are highlighted in the reports are welfare reform, increased productivity growth (recently, this has primarily meant *workplace relations reform*), and health service reform.

This Chapter reconsiders the economic implication of population ageing through the lens of institutionalist economics theory. The Chapter also draws upon research from disciplines other than mainstream economics that are relevant from an institutional perspective. The purpose is not to answer the questions that such an approach generates but to examine the extent to which it contributes to a more satisfying account of the impact of population ageing and to the development of policy prescriptions likely to ensure that the basic foundations of a public health approach remain intact.

Having provided a general introduction to the approach of institutional economics, I will now explore selected elements of the strands of specific institutional theory introduced in Chapter 7 and highlight the differences in focus and in definition of the issues that it provides in relation to the questions of population ageing and dependency in old age.

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[1] Dowrick, S and McDonald, P (2002) *Comments on the Intergenerational Report.* Canberra: Australian National University.

Ageing as a study of change

Part of the challenge for the community of population ageing is to engage population change and growth in a way that is environmentally, economically and socially sustainable. The reports on ageing focus on economic sustainability, although the Productivity Commission Report suggests that the level of migration and associated population growth required to stabilise the age structure is probably not viable on any parameter and that demographic change appears to be inevitable.[2] The Productivity Commission also suggests that a reasonable long-term perspective may be one of zero population growth. This implies a significant change to the traditional view of the age distribution of the population as a significant driver of economic growth but nowhere does the Commission's Report seriously consider the broader implications of this and it does nothing to change the fact of population ageing.

Population ageing is important in two stages. The first stage is a transition from a younger population structure to an older one. The second stage occurs when a steady state population age structure is achieved. The challenges at each stage are different and need to be treated separately. The first challenge focuses attention on how we make a transition. The second challenge focuses attention on what a good society would look like with a permanently aged population structure. During both stages, a public health perspective would focus attention on how, first, the period and process of change affect opportunities for good health and well-being and, how, second, the health and well-being of the public is best protected and advanced in the context of an aged population.

The first stage of population ageing is already with us. According to the Productivity Commission's projections, it will be most rapid between 2012 and the late 2020s when the growth rate in the proportion aged 65+ will be around 0.4 percent per year. By around 2030, the rate of growth of that proportion of the then ageing fraction of the population will have fallen to less than 0.1 percentage points

[2] Productivity Commission *Economic Implications of an Ageing Australia.* 41.

per year.[3] It is fairly obvious that during the transition stage dealing with change is a key issue. In some senses, it does not matter what the change is, it is the very fact that change is happening that is the challenge. Demographic change in which the population becomes rapidly younger could be just as challenging as is ageing if the existing institutions have been created for a steady-state older population and assume an older population.

The approach that is evident in the reports on ageing is that, somehow, the economic path that would be taken without population ageing is the natural one and population ageing diverts the economy from the currently accepted ideal. But population ageing will not only result in economic change, it also represents a social change and will have social ramifications and the social and the economic cannot be disentangled easily. Institutionalism, in contrast to the presumptions of the reports on ageing, examines the socio-economic system as a whole, rather than the economic and the social separately. Ideally, it also includes the biosphere so that the three are treated as an integrated system, rather than separately.

The institutional theory of change also indicates that the response to, not just the process of, ageing is important. The earliest modern response to population ageing (as distinct from 'the aged'), was the introduction of aged pensions in the late-nineteenth century. A first test of the institutional theory of change can be to apply it to this period and assess whether the pattern described in the theory 'fits' the facts. The first aged pensions in Australia were introduced by some States in the early 1900s, with a national scheme in 1908.[4] There was a demographic 'problem' at this time. For example, in New South Wales, the proportion of the population aged over 65 years increased from 1.4 per cent in 1861 to 2.5 per cent in 1891 and 3.4 per cent in 1901, an increase of 60 per cent between 1891 and 1901.[5] However, the question of relief of poverty in the aged also came to the fore during the depression of the 1890s. These circumstances are similar to the environment in which the first EPAC reports were produced. However, by the early twenty-first

[3] Ibid. 9.
[4] Dickey *No Charity There: A Short History of Social Welfare in Australia.*
[5] Ibid. 84. The change that Dickey notes was, itself, largely an artefact of the collapse of the birth rate (and some reduction of immigration) in NSW, Victoria and South Australia during the 1890s

century, Australia had experienced one of the best economic growth rates in the developed world for almost a decade. The earlier debates in the late-nineteenth and early-twentieth centuries around the introduction of an aged pension centred around two key issues. The first was whether the pension should be available on a universalist or a selectivist basis, a right or a privilege, The second centred on the effects of a pension on effort.

The five reports, a century later retraced the argument whether the aged pension should be a right or a privilege. The reports on ageing hint that they think that it should be a privilege. On one hand, poverty ought to be relieved, on the other hand, universal aged pensions lead to behaviours that are contrary to the public interest and future generations might object to sharing 'their' incomes with the aged. It is notable that all three of those propositions are predicated on political, rather than economic, theorems.

The response to the situation in the late-nineteenth century was the eventual introduction of a universal aged pension by the Commonwealth Government based on the most generous of the existing State models - a universal means-tested pension with a morals clause, mostly because it was not politically feasible to reduce the entitlements.[6] As in the previous paragraph, it is reasonable to note that there was a sophisticated contemporary debate about the political morality of the pension (as to its extent, coverage of women, compared with men, and so on).[7] The process of early debate, Royal Commissions and finally, introduction of the aged pension reflected a shift from selective, individualist criteria associated with charitable relief, to a definition of a set of categories of citizens who were entitled to a cash payment as a right, based on a fairly regressive taxation regime, largely as the result of political concession.[8] The strictures on eligibility were gradually relaxed through the course of the twentieth century and now are means-tested and funded through a largely progressive taxation regime.

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[6] Ibid. 90.
[7] See Sawer *The Ethical State? Social Liberalism in Australia.*
[8] Dickey *No Charity There: A Short History of Social Welfare in Australia.* 92.

The first phase of change in relation to aged pensions involved recognition, fuelled by a series of late nineteenth-century reports on neglect and abuse of elderly inmates of charitable asylums, that there was a problem with the existing system of charity for the poor aged. Debate centred on ensuring that only those who would always have been dependent on charity were eligible for an aged pension, lest others who were capable of work should also opt for public sector support. Once a pension was adopted, the number of eligible recipients far outnumbered the number who had applied for private charity. This reflected the 'respectability' associated with public pensions, as well as an aversion amongst the poor to the demeaning elements of private charity. The pensions that were adopted were hardly generous but did provide an alternative to grinding poverty or unsafe or unsatisfactory work for old people. They also became an accepted way of dealing with unemployment in old age, and provided a safety valve in the economy when employment became difficult.[9] Eventually, receipt of the aged pension in retirement became the norm for a large percentage of Australians. The reports on ageing, on the other hand, open the door for advocates of radical reform that reduces eligibility for publicly available aged pensions and increases self-provision for retirement.

Two sets of questions about change can be asked from an institutional perspective. The first relate to whether or not the introduction of aged pensions, and current proposals for reform, reflect regressive or progressive institutional change. What were the effects of the introduction of aged pensions as response to population ageing and dependency in old age? Did their introduction reflect the dominance of instrumentally justified patterns of behaviour over ceremonially warranted behaviour, leading to enhanced collective life processes? In addition, what will the effect of any proposed changes to the aged pension on the effectiveness of the economy in providing for the needs of the community? Evidence taken from the estimates of the reports themselves suggest that the worst case scenario is that Australia will be a much wealthier country, even after the financial costs of

[9] The broad results and resolution (if not the fine details) were similar to the contemporaneous move to pensions in the late nineteenth-century Germany. See: Stone *The Disabled State.*

pensions and greater health care spending are accounted for than it was when pensions were introduced a century ago. The problem does not seem to be one of affordability, but of adjustment. This begs a final question about the dominant patterns of behaviour at play in the current debate about continuation and change for aged pensions, which is explored further in Chapter 11. More important, from an institutionalist perspective, is the capacity of the economy in the future to meet the changed needs of the future population.

Veblen's instincts and collective social wealth

Veblen's theory of collective social wealth can be applied to the study of population ageing with regards to the nature of economic accounting, the question of intergenerational conflict, generativity, and the income distribution. Collective social wealth points to the need for a broader accounting framework that takes into account Social, Ecological, Human as well as Financial-wealth. The reports on ageing focus on the financial aspects of population ageing with some attention to human capital. However, they pay no attention to either ecological or social wealth, which underpin the economic growth, influence well-being independently of their effect on economic growth and are an important part of the stock of wealth that needs to be accounted for by the current generation to future generations.

Successive reports on ageing have increasingly emphasised the potential for intergenerational conflict associated with dependence of the elderly on the public purse for their health care. All of the evidence provided in the reports on ageing is that financial wealth will increase more than the costs of ageing will over the next 40 years. However, the reports express concern that the increased amount of tax that will be levied on future generations, compared to current generations, will be a source of intergenerational conflict. The reports do not consider that accounting social wealth/social capital as part of the economic pie could, potentially, both increase GDP and reduce the level of intergenerational conflict and economic conflict by increasing the size of the pie and reducing the proportion of their income that worker will have to pay in taxes.

According to Veblen, the instinct of workmanship is strongly sustained by a parental bent. His argument underpins the need to promote the instincts that can

work positively towards ensuring that current generations pay sufficient attention to the needs of the next and later generations. This is not a question of calling up a novel human tendency, but does consider the degree to which the social environment reinforces that tendency or minimises it. The flip side of the parental bent is concern for relics of previous generations. If these instrumental instincts dominate, then there is a greater likelihood of successive generations cooperating to ensure that each other's needs are met.

The extent to which instrumental instincts will dominate depends upon the extent to which alternative values are reinforced in the social environment. The trend that the reports on ageing emphasise for an increasing potential for intergenerational conflict are worrying. Combined with the individualist approach that these reports take, they serve as an endorsement of the dissatisfaction of younger generations about the burden caring for the aged. They do nothing to provide leadership toward a more harmonious transition to an aged society where generations care for each other mutually.

Veblen's theory of collective social wealth leads to a conclusion that there should be a more egalitarian distribution of income. Veblen did not believe that the economic surplus could be easily attributed to the traditional factors of production (land, labour and capital). According to Veblen's theory of collective social wealth, technical knowledge is not just a product of current contributions, but has evolved over a period of time. When Veblen was writing, in the late nineteenth and early twentieth century, he argued that each contribution to technical knowledge is small in comparison to the total stock of technical knowledge upon which it sits. Certainly the pace of technological change is rapid now, probably more so than in Veblen's day. However, most new technology continues to build on previous knowledge. As Veblen argues:

> Individual initiative has no chance except on the ground afforded by the common stock, and the achievements of such initiative are of no effect except as accretions on the common stock. And the invention or discovery so achieved always embodies so

> much of what is already given that the creative contribution of the inventor or discoverer is trivial by comparison.[10]

Veblen's collective social wealth provides the theoretical basis for exploring a more egalitarian distribution of income than that which is achieved among the traditional factors by markets. What is not immediately apparent from O'Hara's work is the extent to income should be redistributed to those who do not actively contribute to production at a point in time. This group falls into four categories in a modern market economy. The first is the unemployed, in the traditional sense - persons who are in the workforce but unable to find work. In most market economies, there are either publicly or privately funded schemes that ensure a basic level of income (sometimes time-limited) in the case of unemployment. The second is the group of those unable to work because they have an intellectual or physical disability that either necessarily precludes them from participating in paid employment, or does so because of inaccurate perceptions about their abilities. Most wealthy market economies recognise that their circumstances mean that employment is not an option that they are free to exercise and pay a disability pension of some kind. A third group of working age are employed in productive but non-remunerative work such as raising children or caring for sick or disabled persons, usually family members. This group is usually women, but male participation in these activities may have increased. Finally, there are retirees, a group no longer considered to be of working age and who were, for most of the twentieth century excused from participation in paid employment. They did and continue to make a substantial contribution to the economy through unpaid work in the form of physical labour or by their contribution to the requirements for the collective social wealth. In each of these cases, individuals in the group may have previously participated in the paid sector. They may or may not do so in the future, depending upon their circumstances such as their level of disability and the availability of paid employment locally.

Veblen's theory of collective social wealth seems to be the basis of an argument that those who contributed to the stock of knowledge in the past may have a claim

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[10] Veblen, T. (1908) On the Nature of Capital. *The Quarterly Journal of Economics,* 22: 517-542 p 521

on it now and into the future. The current stock of technology includes contributions made by previous cohorts. That stock of technology, including past contributions to its development and maintenance continue to generate income for those who are able to exercise property rights over parts of it, or to earn income by applying their labour to it. The fact that older people no longer work directly with that stock to produce goods and services for sale in markets does not mean that their previous contribution has no current value.

A similar case can be made about the conditions for collective social wealth. The extent to which a retired generation has contributed to maintaining peaceableness, language etcetera, also indicates to the extent to which they might have a claim on the material output supported by that collective social wealth. Collective social wealth is a public good in the mainstream economic sense of the word. It is both non-rivalrous, and non-excludable. It cannot be divided and privately owned. Once produced, everyone can benefit from it with diminishing others' enjoyment of it. On the contrary, it is likely to be increased and consolidated by its employment. A key issue for public goods is the unwillingness of any one member of the community to produce or pay for the good in total because any person can obtain the benefits without incurring the cost. Collective social wealth is slightly different from the usual examples of public goods as it is a stock. Investment in it has most occurred in the past, although it continues to develop. Thus, for current users of the stock, there is not a problem with free-riders versus payers. Everyone is a free-rider to the extent that the collective social wealth results from the efforts of past generations. The elements that support social wealth, for example, language and peaceability, are also public goods. These clearly cannot be created by individuals or firms in isolation and traded. They are non-rivalrous *and* non-excludable, collectively produced *and* collectively held. Indeed they have no value unless they are collectively held.[11]

[11] My argument here focuses on the notion of collective social wealth as undermining presumptions about ownership of the income and wealth generated by a population. It might also be argued that social wealth is not equally accessible by all and that it might also be a matter for public policy if access to the social wealth is a precondition for reasonable access to participation.

If it is the case that both the conditions for collective social wealth and that wealth, itself, are produced and/or held collectively, then the benefits derived from them are also, to some extent, collectively owned and should also be shared. A similar argument is made in bioethics by Jonsen.[12]

Tool's social value theory

The reports on ageing take a fairly narrow view of what constitutes economic wealth in their focus on GDP. While GDP is important, much that matters to well-being is not counted in GDP. In addition, the Australian reports on ageing presume that the key driver of economic well-being is increased productivity and, therefore, increased GDP, is investment financed through domestic savings. In addition, the Productivity Commission's Report projects lower rates of GDP growth associated with population ageing. However, it is likely that the average productivity of older workers will increase in the future.[13] All of this raises questions about how workers participate in the workforce as they age, and what effects this has on their productivity as they age.

Tool's social value theory and O'Hara's elaboration of the egalitarian criterion provide an expanded framework for assessing the performance of the economy. Tools' social value principle changes the focus from economic growth and efficiency, which are *assumed* to meet the needs of the community, to the actual ability of the economy to meet the needs of the community. The questions centre on what are the needs of the community and what is the scope for discretion to be exercised in the economy to enhance the ability of the economy to meet those needs. O'Hara's criteria help to make this more explicit.

The criterion of community and integration points to the need to minimise the effects of ageism, both on older people, and on the wider community. Ageism promotes behaviours that are contradictory to the common good. For example,

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[12] Jonsen, A. (1972) Principles for the ethics of health services. In *Social policy, social ethics and the ageing society*. (Eds, Neugarten B and Havighurst R) Government Printing Office: Washington, DC, US

[13] The reasons for this are discussed in detail by the Productivity Commission and include higher levels of education, better general health and higher workforce participation rates than the current cohort of aged persons.

while 36 per cent of all retirees in the 2004 Household Income and Labour Dynamics in Australia (HILDA)[14] survey reported that they did not retire voluntarily, the Australian economy is beset with skills shortages. There is almost certainly a mismatch between the skills of the retired workers and those required in the economy. However, neither the rate of retirement nor the skills shortage occurred overnight, and opportunities exist or could be created to match involuntary retirees to continued employment or training. An important contradiction in the current policy package has to do with the extent of withdrawal of the Australian government sector from the economic sphere. The problems of this approach become particularly acute when rapid change occurs, as economies do not seem to adjust quickly to foreseeable situations. Easing the adjustment cannot be undertaken by individual economic players but must be taken by government if at all. It is insufficient for the reports on ageing to urge employers to change their attitudes to older workers: a more pro-active approach to directly addressing the perceptions that prevent retention of older workers in the workforce is needed and this can only come from government.

The problem of older workers being excluded from training opportunities has already been highlighted as a barrier to positive functioning of the economy. It is suggested in the Productivity Commission Report that education depreciates with time. This implies a danger that older workers will have the lowest stock of relevant education of all workers. The effect of this will be particularly acute in a rapidly changing economy where the presumptions about how the world works change relatively quickly. O'Hara's second criterion, warranted knowledge, extends beyond the specific knowledge or skills for employment in the economy to a broader knowledge of the economy that facilitates participation.

The need for warranted knowledge applies to the whole population, including the knowledge of the young. This also requires an understanding on their part (as well as older workers) of how an economy and work places might operate differently, but effectively in the presence of greater numbers of older people.

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[14] Melbourne Institute of Applied Social and Economic Research (2005) *HILDA Survey Annual Report 2004.* Melbourne: Melbourne Institute of Applied Social and Economic Research.

O'Hara's third criterion, a robust participatory democracy is most crucial when community includes large numbers of vulnerable people, who are most likely to fare poorly from rule, laws, customs and accepted practices, especially if they are a newly arrived group. There has been some adjustment to anti-age-discrimination legislation in Australia but it is not clear that all the customs and accepted practices have adjusted to the realities of an aged population or will do so spontaneously. If the reports on ageing are correct in their suggestion of heightened intergenerational conflict arising from population ageing, then a robust participatory democracy becomes even more important. Since it offers a mechanism by which mutual understandings can be reached and arrangements negotiated that meet the needs of all generations in a balanced way, it seems to be the best opportunity for managing the potential conflict.

This is a particularly important challenge. Even although the Productivity Commission Report shied away from substantial policy suggestions, its Chairman, Gary Banks argued recently for the need to take action to deal with the effects of population ageing sooner rather than later:

> While the challenges are long term, the political window for change may not be as wide as we might like. The political power of the old will substantially increase in coming years, making it more difficult to put in place policies that re-distribute any of their future consumption to the young.[15]

This position also seems to presume that the appropriate structure for dealing with an aged population in the future is already known, because it is largely a technical matter. Democracy appears to be OK, but only if the majority votes for the technically correct policies. His view seems to be that individuals can only be trusted to vote in their current best interests, not to take a view about what is reasonable for the community as a whole, given its circumstances.

The institutionalised individual

The reports on ageing treat a number of phenomena as simply being the rational decisions of individuals given the prevailing set of rewards and sanctions. Any

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[15] Banks, G (2005) *Policy Implications of an ageing Australia: an illustrated guide.* Presentation to Financial Review Ageing Population Summit, Sydney. 27 September 2005. Productivity Commission. 52.

policy suggestions that are made relate to providing information and changing the existing set of rewards and sanctions. This is based on the presumption that *homo-economicus* gives a sufficient account of human behaviour. The *institutionalised individual*, by comparison, is a model of human behaviour that opens a door to a critical examination of behaviour within a social context. This model allows for the possibility that decisions about saving for retirement and if and when to retire have a complex etiology. Understanding that etiology may provide opportunities to develop a broader range of approaches to reducing dependency in old age. In Chapter 4, I summarised evidence that indicates that there are a range of structural and social influences on the decision to retire. The fact that retirement, preparation for retirement and dependency in old age occur in patterned ways indicates the need to examine the reasons for these patterns. The notion of the institutionalised individual provides a lens for such inquiry.

Conclusion

Institutional economics offers a framework for thinking about the issue raised by population ageing and retirement in a way that differs from mainstream economic approach that prevails in the reports on ageing. The institutionalist approach broadens the range of acceptable explanations for retirement behaviour and provides some insights into how the adjustment from a younger population age structure to an older one might be facilitated. These insights rely on shifting the focus of analysis and policy prescription away from individuals and individuals' behaviour towards the broader society in which the economy is embedded.

At this point, I return to the Tenets of Institutionalism, previously introduced in Chapter 3. The principles outlined in the tenets provide a framework for defining research questions about the economics of population ageing from an institutional perspective. They are useful because they provide a consistent framework on which to base a disciplined approach to defining potential research questions. These principles generate a number of questions that facilitate understanding of the effects of population ageing, viewed from the perspective of the population as the unit of analysis, rather than from aggregated individuals. These principles commend themselves to the following questions about population ageing.

The first tenet is that inquiry is addressed to the institutional process of providing the material means of life and to significant problems of institutional malfunction. The tenet suggests two questions each about the effect of population ageing on providing the material means of life and on institutional malfunction. In relation to providing the material means of life: How does population ageing affect the process of providing the material means of life? Does population ageing adversely affect our capacity to provide the material means of life? In relation to institutional malfunction: Is population ageing the result of significant institutional malfunctioning: Does population ageing lead to significant institutional malfunctioning? The third and probably most policy relevant question in relation to institutional malfunction, assuming an affirmative answer to either of the previous questions, is what institutional adjustments will population ageing require in order to maintain the integrity of the process that provides the material means of life?

The second tenet is that economics is a policy science: economic inquiry is significant only to the extent that it is relevant to problem solving through institutional reform. This principle suggests questions about the kinds of information, and therefore the kinds of research, that will be useful in resolving the problems associated with population ageing. This requires a clear description of the problems that population ageing will bring, including their institutional characteristics and the kinds of institutional adjustments that they will require. The reports on ageing go some way to describing the kinds of problems that population ageing may bring, such as the effects on GDP growth and government budgets. They also largely ignore some important problems, in particular our capacity to provide the goods and services that an ageing population will require, apparently assuming that if the sources of finance for those goods and services are in place, the market will follow.

The third tenet is that the method of inquiry is evolutionary; the object of inquiry is the social process; the search is for factual explanations and causal understandings. This tenet points to questions about both individuals and institutions. If the preference and purposes of the individual are taken as

endogenous to the economy, as the notion of the institutionalised individual implies, then, in relation to ageing and public dependency we can ask: what are the social processes that have resulted in such a wide apparent acceptance of public income support in retirement? The reports on ageing seem to presume – but do not demonstrate – that individual expectations have been shaped by the existence of the pension through unspecified social processes. The search for factual explanations and causal understanding would first examine the presence of an association between public income support and the phenomenon of mass retirement from paid work by people at older ages. Other explanations should also be explored. For example: Is there an association between national income and retirement? Are expectations about retirement and public support in retirement associated with the presence of public retirement income support? Can a direction for a causal relationship be established? Even if preferences for a public aged pension are a self-reinforcing circle: does this constitute a virtuous or a vicious cycle? That is, is it the case that 'civilised behaviour is both built up by, and contributes to, cohesive social norms' or is it the case that 'a shortage of solidarity and trust may accelerate a propensity for individuals to diminish further their tolerance of altruism, thus advancing the process of social decay'[16]. This later point distinguishes the application of evolutionary ideas in institutional economics from that in mainstream economics. In mainstream economics, evolution is teleological and associated with the survival of the fittest (firm). However, no mechanism for passing on information that programs survival (the genes of the successful firm) is specified. In institutional economics, evolution occurs through the agency of institutions that carry information that can be transmitted between other institutions and between individuals.

The fourth tenet is that social value judgments are a part of inquiry and must themselves be objects of analysis; the normative-positive dichotomy is rejected. Rather than assuming that value judgments are the province of individuals and can be expressed mostly adequately through markets, this requires some inquiry

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[16] Hodgson, GM (1988) *Economics and institutions*. Philadelphia: University of Pennsylvania Press.138.

about the values should underpin our economic planning. For example, the reports on ageing assume that rates of economic growth, inflation and taxation are the most important dynamics but a public health perspective would also ask questions about the distribution of income, the quality of work, etcetera. Inquiry here would also be explicitly informed by values. The reports on ageing appear to report the facts of population ageing *simpliciter*, but the choice of facts is clearly normative even if the values that underpin them are not expressed explicitly. More importantly, however, research into population ageing should reflect the economic goals of the community, identified by democratic deliberation.

The fifth tenet is that all political economies evolve and are embedded in social and cultural processes; individuals are both products and creators of these processes. This suggests questions about the relationship between dependency in old age and these cultural processes, in particular: how do cultural specifics contribute to dependency? Any inquiry about these processes should seek to identify both their instrumental aspects and their ceremonial aspects. To be specific: how have these processes evolved and what options are there for their reformation?

The sixth tenet is that institutions correlate and coordinate economic behavior in progressive and regressive ways; problems are resolved with progressive changes in structure. This suggests questions about the coordinating functions of institutions in relation to dependency in old age. In particular, which of the ways in which economic behaviour is coordinated in relation to retirement and in relation to maintaining health are progressive and which are regressive? A second question relates to how the institutional structure can be changed to resolve problems and requires a definition of the problems that are associated with population ageing. Once the problems that we need to address are agreed upon, the task is to define the progressive changes in structure that can resolve these problems, based on evidence of the effects of these changes.

The seventh tenet is that the growth of warranted knowledge and its application as technology are prime movers in social change; they are both sources and means of resolving problems through institutional adjustment. This tenet suggests two

questions about the impact of knowledge on the effects of population ageing: What changes in knowledge and its application as technology influences the effect of population ageing? And what kinds of warranted knowledge could generate the technologies that are needed to deal with population ageing, especially through social change?

The eighth tenet is that the biotic and social communities are coevolutionary and interdependent; sustainability of either is dependent on the other. This tenet also suggests two questions, about the impact of population ageing and proposed policies on the natural environment: Which interdependencies between the biotic and social communities are affected by population ageing? and What is the effect of proposed policies to deal with population ageing on these interdependencies?

The ninth and final tenet is that any political economy is a system of power; the locus, use, and democratic accountability of achieved power remain priorities in analysis and policy. Three questions about population ageing arising from this tenet: What are the implications of population ageing for the locus, use and accountability of power in the community? How do the loci, uses and accountabilities of power in the community influence the impact of population ageing? and What are the implications of the policies proposed to deal with population ageing for the locus, use and accountability of power in the community?

The shift in focus from individuals to the institutions of the society in which they are embedded shifts the focus on inquiry from individual behaviour to the influences on individual behaviour that populations share. These influences include beliefs, rules and customs, which can vary in populations in which there are *many* publics. These influences are important for understanding all of retirement behaviour, expectations about health and social care in old age and beliefs about the same at younger ages.

Institutionalism is concerned with how economies meet the needs of societies for real goods and services. In contrast the reports on ageing focus on the monetary effects of population ageing. An institutionalist research agenda would include

consideration of the impact that population ageing will have on the types of goods and services that are needed by the community and how these needs can be met.[17]

[17] Wray, LR. (2006) *The burden of aging: Much ado about nothing, or little to do about something?* Policy note No. 2006 / 5 The Levy Economics Institute of Bard College.

Chapter 9: Institutional economics and health care

Introduction

The reports on ageing and broader community discussion about both population ageing and the health care system, generally, make much of the growing pressure on health care costs. The reports on ageing demonstrate that the pressure on health care costs is concentrated in the Pharmaceutical Benefits Scheme (PBS), demanding specific attention to the structure of the PBS and to behaviour within it. Moynihan's study of the pharmaceutical industry indicates that there are distinct pressures on pharmaceutical spending that are not as cogent for other health services.[1] However, costs are still predicted to increase in the non-pharmaceutical sector of the health system, independently of population ageing, as they have been doing for much of the latter part of the twentieth century. Concentration on the aged and on the effects of ageing in discussions about the rising costs of health care misses opportunities to improve the efficiency, broadly defined, of the health care system and to maximise its impact on the health of the population.

Institutional economic theories provide some insight into how policy prescriptions for the health system made by the Audit Commission Reports and, to a lesser extent, the reports on ageing, could play out. These policy prescriptions reflect the reports' diagnoses of the problems with the health care system and the reasons for rising health care costs. The prescriptions that relate directly to the health care system are detailed most clearly in the Audit Commission Reports and fall into broad two categories. The first deals with management and administrative reforms within departments, including an increased commercial and competitive focus. The second deals with privatisation of service provision or of assets or both. Both presume the twin diagnoses of lack of efficiency in the provision of health care services and lack of responsiveness of health care services to the needs of users.

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[1] Moynihan, R and Cassels, A (2005) *Selling Sickness: How Drug Companies Are Turning Us All Into Patients.* Crows Nest NSW: Allen & Unwin.

In this Chapter I examine the likely effects of the recommendations from an institutional economics perspective, which does not place economic efficiency, achieved by perfectly competitive markets, at the centre of economic analysis. Markets are but one of many institutions that shape the provisioning of society so institutional economists are interested in how the institutional context in which markets work affects the extent to which they provide goods and services that actually meet the needs of the community. This interest can be exercised with a specific public health perspective on the provision of health care services in mind that always asks: how will this shape the opportunities for good health in the population? The opportunities may come from many quarters other than the health care system, but that system remains the focus of the current chapter because I aim to explore the extent to which an institutional economics perspective on the provision of health care contributes to an understanding of the economics of health that is more compatible with a public health perspective than is a mainstream economics perspective.

The problem of health care costs

The Australian Productivity Commission assumes that excessive increases in health care costs are a problem of population ageing. Even when the available evidence suggests that population ageing has only had a minor role in rising current health care costs there is a lurking suspicion that they will inflate future costs.[2] The Productivity Commission acknowledges that technology and changes in demand apart from ageing also drive rising health care spending, it devotes little more than one page to discussing them.

There is certainly a positive association between health care spending and age in Australia. Higher health care costs are associated with being very young (up to 4 years of age) or with being older (increasing steadily from middle age). However, it is not clear that increasing the proportion of people in older age groups is a significant contributor to increasing health care costs. The Productivity Commission dismisses evidence that historical increases in health care costs have

[2] Productivity Commission *Economic Implications of an Ageing Australia.*

not been due significantly to population ageing and argues, instead, that the effect will be greater in the future because the population will age faster. A more constructive approach would have been to examine changes in health care costs for evidence as to why those increases occurred in the past and what their impact might be in the future. A major problem with not doing so is that concentration on the use of health services by the aged in the past offers no logical guarantee of cost restraint in the future if the past increases have been due to factors independent of population ageing. In addition, the estimates of past growth appear inconsistent: the Intergenerational Report associates the largest contribution to increased health care costs with increased spending on pharmaceuticals through the Pharmaceutical Benefits Scheme (PBS); the Productivity Commission Report attributes less growth to the PBS because the Commission adjusted expenditure growth rates downwards to reflect the impact of pricing policies in the PBS that had been introduced after the Intergenerational Report was released. Nevertheless, pharmaceuticals remained the largest single area of spending increase (in terms of both size and rate of increase) attributed to ageing by the Productivity Commission.

The sophistication of the expenditure projections made by the successive reports on ageing did increase with time. The EPAC reports (from 1988 to 1994) undertook relatively crude calculations of future expenditures. More factors that affect age-specific per capita health care costs were recognised and accommodated in the Intergenerational and Productivity Commission Reports (2002 and 2005) than in earlier reports. The Productivity Commission examined, in particular, the contribution of non-demographic factors to the growth in health care costs but there is no suggestion throughout its reports that these factors could reasonably be the target of policy. Although the reports all spent considerable time discussing the dynamics of population aging, the contribution of population ageing to productivity growth (or its decline), and the contribution of non-demographic factors to growth in health care costs, the discussion was mostly descriptive and there was very little critical analysis of the phenomena that were described. This limitation in the mainstream analysis is due to a lack, in the mainstream tradition, of theory that can provoke examination of the broader context in which the health

care markets are operating, or stimulate review of a range of influences on behaviour that might affect the level of health care spending. Institutional economic theories, on paper at least, seem to hold promise for examining these problems from a perspective that shares concerns with the public health perspective.

Two areas of theory are applicable to the problem of health care costs. The first is a concept of *countervailing power* put forward by John Kenneth Galbraith,[3] which I will apply to pharmaceutical spending. The second is Tool's Social Value principle and its criteria, which can be used to judge whether economic systems are likely to be effective in meeting the social value principle, which is not likely to be realised in a privatised and marketised health care system.

Countervailing power

John Kenneth Galbraith has argued that the traditional antidotes to economic power have been competition and regulation by the public sector, but that more recently, a phenomenon he called *countervailing power*, a form of resistance by those who are 'subject to the aggressions of economic power' [4] had become evident. This resistance occurs through various forms of organisation in order to neutralise the power on the opposite side of the market, first to protect the subjects of that aggression but also to share the gains that might accrue from a more balanced market. Examples of countervailing power include labour unions organising in the face of monopsony employers, and mass buying by department store chains in the face of a monopoly seller.

The Australian reports on ageing acknowledge the effects of ageing on economic growth but their primary concern is with the fiscal, rather than the broad economic, effects of dependency in old age. Their focus on fiscal effects, such as increased spending on the PBS, obscures their view of the overall economic effects of pharmaceutical use in old age and of the economic institutions that both drive and inhibit economically efficient use of pharmaceuticals. The reports see the

[3] Galbraith. Countervailing Power.
[4] Ibid. 2.

Commonwealth Government's role in the Australian pharmaceutical market only in terms of the fiscal costs, rather than the (potential) economic benefits. The PBS plays two roles in making pharmaceuticals accessible and affordable, by subsidising the retail price of drugs and by acting as a monopsony buyer of pharmaceuticals on behalf of Australians. The PBS is conceived in the reports purely as a subsidy scheme but it also provides countervailing power against the pharmaceutical companies. The Productivity Commission Report states that Commonwealth Government subsidises pharmaceutical in order 'to provide timely, reliable and affordable access to prescribed drugs'[5]. It also recognises the role that the PBS plays in 'using an evidence based approach in making recommendations about the listing of drugs'[6] and in instituting risk-sharing arrangements with drug companies to minimise the expenditure implications of drugs being more widely prescribed than for their intended indication. However, the Productivity Commission Report mentions neither its own earlier finding that manufacturer prices for the 150 top-selling PBS-listed drugs are low compared to those in the US, Canada, the UK and Sweden nor its own earlier conclusion that 'Australia's subsidy and cost-containment arrangements have assisted in keeping prices relatively low'[7].

Granted, this is not countervailing power in the strict sense described by Galbraith, in whose model organisation for countervailing power is undertaken by those directly affected by the behaviours associated with power in a particular market, in the case of union organisation, or arise spontaneously as the result of a commercial opportunity in the case of department stores. The PBS is organised by government on behalf of buyers and runs in parallel to a separate, but related system of approvals for drug marketing that verifies the safety and efficacy of the drugs, rather than their pricing. There is no regulation of the pricing behaviours of pharmaceutical manufacturers/suppliers for drugs not listed on the PBS. Thus, the PBS is a system of moderation, not of regulation, since it is possible to market

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[5] Productivity Commission *Economic Implications of an Ageing Australia.* 144.
[6] Ibid. 337, 374.
[7] Productivity Commission (2001) *International Pharmaceutical Price Differences.* Research Report. Canberra: Ausinfo. 69.

pharmaceutical drugs in Australia outside of the PBS. However, non-PBS pharmaceuticals are a small proportion of prescription pharmaceutical drugs.

Social value principle and the health care system

As a system of provisioning, the health care system can be assessed as to the extent that its performance is likely to be primarily instrumental or primarily ceremonial. O'Hara contemplates evaluating the contribution that an economic system can make to human progress against three criteria, of community and integration, warranted knowledge and participatory democracy, which provide an indication of the extent to which instrumental values are likely to dominate ceremonial values.

Community and integration refers to the extent to which the economy exhibits community consciousness and cooperation. It evaluates the extent to which community values such as cooperation dominate over greed, selfishness, and individualism, presuming that the dominance of these characteristics amongst the population will affect not only the behaviours of individuals in that context but their very development. This criterion is based on a value judgment that

> socioeconomic progress is positively related to the degree of collective harmony, without the dominant presence of (1) coercive laws, police and armies; (2) powerful corporations which are not themselves controlled by the workers and/or the community; (3) market forces and technology encapsulating instrumental functions of institutions (..) and (4) the hatred associated with racism, sexism, extreme nationalism, ageism and speciesism[8]

and that the four dominators diminish collective harmony and promote contradictions that reduce effective coordination of the life process of the system.

This is almost the antithesis to mainstream economic thinking in relation to the health care system. Whilst characteristics (1) and (4) are not at the heart of a health care system, the recommendations of the Audit Commission Reports do not preclude, and make more likely, the presence of characteristics (2) and (3) through their promotion of privatisation and market forces. Indeed, much policy development in Australia in recent years has focused on strengthening market

[8] O'Hara *Thorstein Veblen's Theory of Collective Social Wealth*. 18-19.

forces. The reports argue that competitive markets will both increase technical efficiency and make the health care system more responsive to the needs of its users. Institutional theorists, on the other hand, argue that market forces and competition generate a series of activities that do not contribute to the *life process*. These activities include what institutionalists, following Veblen, refer to as business rather than industry. Business activities are methods of obtaining a share of the monetary gains, contrary to collective interests by, (a) slowing down production during recessions or depression, (b) reducing output through degrees of monopolization, (c) redistributing surplus from industry to banking or the sales effort, and (d) producing output which is utilized for luxury consumption.[9]

A more marketised version of the Australian health care system can be imagined by examining the United States (US) health care system. Whatever that system does offer, there is no evidence that a more privately provided and marketised system results in either a cheaper health care system or a higher population health status than does the Australian system. The World Health Report's convenient set of comparative statistics shows that the US system consumes almost 15 per cent of GDP, compared to almost ten per cent in Australia. Given the US's higher GDP per capita, this equates to almost twice as much per capita in real terms.[10] Australia outperforms the US on every health outcome parameter that is reported for both countries by the World Health Organization, except for the percentage of one-year-olds immunised with 3 doses of DTP (92 vs 96 per cent). [11] Up until the late 1990s, the US also outperformed Australia on life expectancy at age 80, but this is no longer the case.[12] Two characteristics of the US health care system that are evident and relevant for this framework are that the health care system in the

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[9] Ibid. 4.
[10] According to the World Bank and the WHO, in 2003 GNI at PPP was $37,500 for the US and $28,290 for Australia while health care spending was 15.9% of GDP for the US and 9.5% of GDP for Australia. That is $2690 *per capita* for Australia compared to $5700 for the US. World Health Organization (2005c) *World Health Report 2006: Working Together for Health.* Geneva: World Health Organization; World Bank (2004) *World Development Report 2005. A Better Investment Climate for Everyone.* Washington and New York: World Bank for Reconstruction and Development / World Bank and Oxford University Press.
[11] World Health Organization (2005b) *World Health Report 2005.* Geneva: WHO. 175-219.
[12] OECD (2005) *Health at a Glance: OECD Indicators 2005.* Paris. Data 1.6. Downloaded from dx.doi.org/10.1787/644400068823. Downloaded on 21 November 2006: OECD.

US has a far greater level of participation by powerful corporations which are not themselves controlled by the workers and/or the community. According to institutional economic theory, this creates greater scope for the ceremonial functions of institutions to dominate the market in health care.

Using this framework, institutional economic theories can start to explore the reasons why overall, there is not a clear pattern of correlation between health system performance and the level of public funding. An important mediator in the relationship between who pays and what is produced is the institutional environment that reflects social and cultural norms and values, and sanctions and proscribes various behaviours. The dominant values of the wider community should be reflected in the functioning of the health care system, but this is not inevitable. It could be said that the same individualism that dominates the US health care system reflects market values that are evident in the wider community, at the expense of civic values. Unfortunately, the nature of health care makes it quite likely that the negative outcomes of those market values will become evident. If the dominant values are ones that lead to predatory or emulatory behaviours then these behaviours will also dominate in the health care system. This has consequences for health care system performance in terms of health improvement and equity, which are primary goals of most public health care systems.[13]

A second consequence of a market-dominated health care system is a tendency towards monopoly. This is not a characteristic unique to health care, but is a fundamental consequence of capitalism. The more concentrated an industry becomes, the fewer options there are for users to select providers that behave instrumentally, rather than ceremonially, because concentration allows greater opportunity for non-price forms of competition that can serve to protect producer incomes at the expense of users. Non-price competition is most likely to manifest in attempts by producers to differentiate their product from that of other producers. This can occur in two broad forms. The first is that genuine

[13] Williams, A. (2005) Thinking about equity in health care. *Journal of Nursing Management,* 13: 397-402

improvements in quality occur as providers strive to distinguish themselves from the rest. To the extent that these improvements in quality translate into better outcomes of care, including satisfaction with care, they are desirable. However, non-price competition can also occur in the form of promotional activities such as advertising, market research and brand development. These kinds of non-price competition do not add to the quality of care, but can be effective in influencing the public's view of a service. Importantly, the opportunity for this behaviour is greatest among oligopolies. That is, providers in markets with a small number of providers, as is the case with hospitals, are able to exert market power. Combined with the apparently intractable problems of information asymmetry in health care, these behaviours are unlikely to contribute in proportion to their costs to improving the health of the community. Even genuine improvements in quality may result in improvements in outcomes that are small compared to the costs of achieving them.

One of the reasons that health care provision is likely to become more concentrated amongst a smaller number of larger providers is that one of the outcomes of market competition is the progressive use of technology to lower labour costs and maximise profits. Health care provision, traditionally a labour intensive enterprise, is increasingly technology-intensive. This could be a positive outcome for the community if that technology met pressing health care needs of the community and were applied with an ethic of cooperation dominant over greed, selfishness, and individualism. However if greed, selfishness and individualism dominate, technology can become encapsulated and not achieve its potential benefits to the community.

Encapsulation of technology occurs if its use is restricted when ceremonial values dominate instrumental values. These values can be evident in the way that the technology is made available to users and in the uses that are made of that technology. Instrumental uses of technology are, in Veblen's words, *matter-of-fact* uses, that are a straightforward application of the technology to the human life process. Instrumental uses imply that the technology is a stimulus for change. The kind of change that would be instrumental in this case is the straightforward use

of the technology to improve people's health in a non-discriminatory way. Ceremonial uses are evident when the application of a new technology reflects 'traditional forms of valuation'[14] and inhibit change. On the supply side, this could include behaviours such as restriction of its availability by manufacturers to maintain a higher price or unwarranted monopolization of the technology by *expert* providers of health care. On the demand side, where the market is the primary mechanism for the allocation of goods, demand side behaviours include use of the good by those with the ability to pay, rather than on the basis of need. This might result in technology being applied to milder disease in reasonably health individuals, and with a lower yield, measured in both health improvement and reduction in health inequalities.

Ceremonial and instrumental behaviours are neither universal nor mutually exclusive and both may be evident in the use of a particular technology. The key issue is which type of behaviour dominates and what impact that has on the potential for the technology to improve health and reduce inequalities.

Increased marketisation is also likely to result in greater commodification of health care with users of health services being cast merely as consumers. There are potential dangers in this. The first is that users of health services are not consumers in the classic sense because of the potential for market failure in health care. Information asymmetry leading to imperfect agency, uncertainty about the incidence of disease for an individual and about the efficacy of treatments for an individual, and monopoly provision of health care all limit the ability of many users of health services to assert *consumer sovereignty*. The second danger, which is already evident in the pharmaceutical industry and widespread in the modern market economy, lies in the tendency to see the buyer as simply part of the production cycle: someone who needs to be managed to understand that he or she needs what the corporations produce.[15] This phenomenon has already been discussed in relation to the pharmaceutical industry, which, even without the legal

[14] Waller, W. (1994) Veblenian Dichotomy and its critics. *The Elgar Companion to Institutional and Evolutionary Economics L-Z*: 368-372. 369.
[15] Parker, R (2005) *John Kenneth Galbraith: His life, his politics, his economics*. Background Briefing. ABC Radio National Broadcast on 31 July 2005.

opportunity to directly advertise a product in Australia, can still create through mass-media advertising a *consumer awareness* that one might exist.[16] If these behaviours become widespread in the health sector, then the potential for improvements in health overall and reductions in inequalities diminishes. These patterns will result in products and services that do little to improve health status, or which are at the very least costly options for doing so, being disproportionately purchased by those who can afford them, rather than those who have the greatest need (are the sickest or have the most to gain).

Critics of the pharmaceutical industry argue that its promotional activities have the effect of diverting resources away from sick people, who can demonstrably benefit from pharmaceutical drugs, to the worried well, for whom the benefit of using pharmaceutical products is uncertain and unproven.[17] Other examples of medical care where this is also possible include plastic and reconstructive surgical techniques that have both therapeutic *medical* and *cosmetic* application.

A small body of evidence suggests that direct-to-consumer marketing of prescription pharmaceuticals in the US occurs most commonly for high quality, new drugs, with few competitors, which have a large estimated potential market (untreated disease). This suggests that the main effect of direct-to-consumer marketing is to expand the actual market for a drug, rather than to affect prescription choice.[18] It has increased physician visits[19] and may indeed provide warranted knowledge to the community although this is not the prime motivation behind it and commercial advertising that is presented as information may result in creating confusion. However, physicians in the US have reported that the effects

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[16] The most obvious of these is a television advertisement by Roche for a 'weight loss solution', which refers viewers to the general medical practitioner for further advice, and television advertising by Impotence Australia (IA) encouraging men with erectile dysfunction to seek help, which was a thinly disguised advertisement for Viagra, a product of Pfizer, who funded IA to the tune of $200,000. Moynihan, R (2000) Taking the soft option. Australian Financial Review. 13/11/2000. 29.

[17] Moynihan and Cassels *Selling Sickness: How Drug Companies Are Turning Us All Into Patients.*

[18] Iizuka, T. (2004) What explains the use of direct-to-consumer advertising of prescription drugs? *Journal of Industrial Economics,* 52: 349-379

[19] Iizuka, T and Jin, GZ. (2005) The effect of prescription drug advertising on doctor visits. *Journal of Economics & Management Strategy,* 14: 701-727

of direct-to-consumer advertising have mostly been positive,[20] although no extensive welfare analysis of this activity is yet to be undertaken.[21]

An additional potential effect of advertising of drugs relates to the institutionalist idea of power over the content of human values. Advertising may not convince a particular citizen that a particular pharmaceutical drug is for them. It may, however, serve to increase the acceptance of pharmaceuticals as a response to a range of problems that have complex etiologies and at the expense of other non-pharmaceutical means of managing them.

Warranted knowledge, O'Hara's second criterion, highlights potential for the management of information and of perception by firms that can serve to limit or to *spin* information in the community. This has implications for the flow of *warranted knowledge* by limiting the availability of some information and by promoting specific ideological views through which much other information is filtered. In a marketised health care system, where health care and information are commodities, and where the potential for concentration to a smaller number of larger firms exists, there is a danger that information that enables widespread understanding of the health care system and provision of health care that is necessary for instrumental democratic participation will be more highly controlled than ever. Again, the consequence for the functioning of the health care system is less scope for democratic participation, more scope for market failures due to informational problems and higher health care costs without improved health outcomes.

O'Hara's third criterion, participatory democracy, 'relates to the population being included in the decision-making processes of the political economy: in production, distribution, finance, the world economy, the home, and the public sector' and 'operates so that all sections of the population have a high degree of potential access to education and decision-making processes'[22]. Participation in the design

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[20] Donohue, J. (2006) A history of drug advertising: The evolving roles of consumers and consumer protection. *Milbank Quarterly,* 84: 659-699
[21] Iizuka. What explains the use of direct-to-consumer advertising of prescription drugs?
[22] O'Hara *Thorstein Veblen's Theory of Collective Social Wealth.* 20.

of the system has a direct influence on the choices that will be available to individuals within the health care system, which is an important outcome. However, health itself is one outcome of the operation of the health care system. Health services, to the extent that they improve and maintain health, are collectively produced 'material goods necessary for sustaining life'[23]. Instrumental freedom requires an informed populace that continually seeks to engage in participatory management of these goods. Health services (along with education, in particular), to the extent that they are necessary for sustaining life are essential to instrumental freedom, and allow people to participate in the broader rule-making processes that define the extent of their freedom. For the purposes of this thesis, participation in the rule-making process can occur at the level of rules of the whole system, or more narrowly at the level of rules of the health system.

Participation can also spin off into information and education, which are also important in public health. Informative, open health services can be an important portal for their users to learn about a significant component of modern knowledge. One example of the open portal is the women's health movement, which has successfully combined the provision of information with grass roots advocacy.[24]

Participation in the health care system can be either as a consumer or as a citizen.[25] Participation as a citizen occurs at the political level where it can involve participation in the rule-making process. Participation as a consumer occurs at the individual level in the process of *transactions*. Privatisation and marketisation of the health care system, both of which the Audit Commissions and, to a lesser extent, the reports on ageing promoted as solutions to health care costs, have the potential to limit democratic participation in the health care system. A privatised system that is dominated by market values necessarily focuses on individual

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[23] Ibid. 21.

[24] The best-known example is The Boston Women's Health Book Collective, which alongside its advocacy activities has produced information materials generated by the women themselves. In Australia a history of the Women's Health Movement is found in Broom, DH (1991) *Damned if we do : contradictions in women's health care.* Sydney: Allen and Unwin.

[25] Klein, R. (1980) Models of man and models of policy: Reflections on *Exit, Voice, and Loyalty* ten years later. *Millbank Memorial Fund Quarterly - Health and Society,* 58: 416-429

transactions for individual services: patients are treated in isolation, except to the extent that they might be aggregated for statistical and reporting purposes according to their condition or the kind of treatment they receive.

If the system offers services and systems of service that maximise the contribution of the services to health gain and well-being, then participation may not be an issue. However, one does not need to look far to see that the health care system is Australia has a poor track record of catering well to people's needs. The women's health movement in Australia is testament to this and, pre-dating Medibank/Medicare, relates as much to privatised medicine as it does to publicly provided care. In Australia, the women's health movement argued that not only were women's health needs met poorly by existing medical services, but that the focus of the health care system on an expensive, medically dominated model blocked a desirable shift to a participatory model of health care based on consumer orientation.[26] The level of participation afforded by a market-dominated health care system is limited to exit, voice and loyalty.[27] The option of exit will be limited in the case of monopoly or when there is uncertainty that other providers will do any better or in the case of life-threatening emergency. Voice, or complaint requires that customers experience unsatisfactory or deteriorating service before any action is taken. It may be effective if the provider has reason to listen and accommodate the complaint. This is most likely if the firm is not attracting sufficient custom and can yet recover. Because exit may not be an option, users of the service may be more likely to complain and voice may be more effective. However, Australian evidence suggests that in health care, complaints mechanisms, where they are available, reduce complaints to individual instances of conflict, to the exclusion of potentially generalisable provocations to improve overall firm or system performance.[28] Some proponents of voice assume that it is and should be an individual venture. However, the most successful articulation of

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[26] Palmer, GR and Short, SD (1989) *Health Care and Public Policy*. Melbourne: Macmillan.
[27] Hirschman, AO (1970) *Exit, voice, and loyalty : responses to decline in firms, organizations, and states*. Cambridge, Mass: Harvard University Press.
[28] Patterson, J. (1996) *Consumers and complaints systems in health care*. PhD Thesis. Department of Public Health. University of Adelaide. Adelaide.

voice in Australia has been by the women's health movement, which lent collective support to individual voices and is credited with achieving significant change in the orientation of health policy in Australia.[29] Despite this, opportunities to participate in rule-making in the system through voice remain relatively limited. Loyalty occurs when users stay with a firm in the belief that things will improve. This may be self-deceptive behaviour, which is more likely to occur if either entry or exit costs (to a particular medical treatment or, even, self-help modality) are high. In the case of health care, uncertainty about alternatives and the personal nature of health care may also contribute to loyalty. Although they may be *freely* undertaken, none of these actions are particularly democratic and exit is decidedly non-participatory. In none of them is the user acting as citizen, rather than individual consumer.

It is also argued in the Audit Commission Reports that privatisation of health services will increase the responsiveness of services to users needs. This implies a greater capacity to respond constructively to exit and voice but there is no scope in the market model for non-participators to voice an input into the market or firm and little power in exit, given the power of provider colleges and corporatised facilities. This means that participation, as citizen and participation as potential user are limited.

A marketised, privatised system may result in greater technical efficiency for *individuals*, although this has yet to be demonstrated, but will not necessarily result in greater allocative efficiency if it is not directed to *population* needs. Given the scope for market failure in healthcare, democratic participation seems to be an important element of a well-functioning health care system. However, even in the absence of clear market failure, knowing ahead of service provision what it is that the community wants and needs from a health care system is important in ensuring that they do not end up wanting what they can get, rather then getting what they need and want.

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[29] Lumb, P. (2003) Why is men's health and well-being policy not implemented in Australia? *International Journal of Men's Health,* 2: 73-88; Palmer and Short *Health Care and Public Policy.*

Discussion of democracy in health care is not new. It arose mainly from the experience of publicly-provided health care systems, where concerns that the health care system did not meet the needs of users bolstered support for increasing community input into health services planning and provision. It is clear that there have been many failures of publicly-provided (and publicly-funded, but privately-provided) health care. A key difference between a system with significant public involvement in planning and/or provision and one that is based on private provision in a marketised health system is in the potential for a democratic health service. Public providers may have done a poor job of reflecting community and user expectations (whatever the degree of realism). However, they have done so within a political context offering at least the potential for recourse by the community and by health service users, rather than a within market one devoid of that potential.

Increasingly, the need to include citizens in both planning for and the design of health services is being realised by various means of drawing upon community and user opinion, albeit in a limited fashion. This potential may exist in a firm through community membership on the board. However, it is unlikely that any directions that undermine firm profitability will be taken. Alternatively, public and user surveys may be used (as they are in publicly provided services). These have a range of limitations, whatever environment they are used in, and represent a very *thin* type of participation.[30]

Impact on public health

The criteria of the social value theory and the Principle of the Instrumental and Ceremonial Functions of Institutions (PICFI) allow public purposes to be defined explicitly in the examination of economic systems and their social environment. Market systems assume a technical enterprise in which only private purposes matter. However, public health combines two terms that presume a normative

[30] Hicks, N and Harford, J (2000) *Summary report on consumer participation in resource allocation.* Melbourne: National Resource Centre for Consumer Participation in Health. Their particular limitation is that the answers they provoke are more likely to be uninformed and undeliberated in comparison to methods that provide information and the opportunity for discussion and reflection.

enterprise interested in creating opportunities for health through non-invidious means that serve both to protect and to improve health across the community and to reduce inequalities in health, as well. Social value theory and the PICFI allow these public purposes to be examined within the context of economic inquiry, not carved off as normative or political as they would be in the mainstream economics approach.

Conclusion

Galbraith's theory of countervailing power and Tool's Social Value Theory both warn that a privatised/marketised health care system is unlikely to address immediately the diagnoses of the problems in the health care system offered by the Audit Commission Reports. This is in direct opposition to the assumption in the Reports that increased privatisation and marketisation of health care would both improve the efficiency of health care, contributing to a lower rate of growth of health care costs, and better responsiveness of health care providers under the pressure of competition.

It is too simplistic to argue that the reason for the difference between mainstream and institutional economics in assessment of the effects of the policy prescriptions is because institutional economics is not concerned about efficiency. The social value principle may provoke concern about efficiency in markets but markets are embedded in communities and the balance of institutions in a community at a point in time may or may not be adequate for instrumental functioning of an economy. Problems are identified in terms of whether they reflect the criteria of the social value principle. These criteria are used to define public purposes,[31] not just private ones as in market criteria. The social value principle also allow the public purposes that are inherent in public health to be treated as a legitimate part of economic inquiry, which is not the case in mainstream economic theory.

Again, the tenets of institutionalism provide a framework for defining an institutionalist research agenda for the provision of health care. In this case, eight of the nine tenets are clearly relevant.

[31] Tool. Instrumental value theory.

The first tenet is that inquiry is addressed to the institutional process of providing the material means of life and to significant problems of institutional malfunction. This tenet suggests two questions each about the role of health care in provisioning and the nature and extent of institutional malfunction in health care provision. In relation to provisioning, we need to ask: What is the role of health care in providing the material means of life? and How does the organisation of health care affect our capacity to provide the material means of life? and What evidence is there, for example of the advantages of private or marketised provision, over public provision?

In relation to institutional malfunction we need to ask: Are rising health care costs the result of significant institutional malfunctioning? and Is health care provision inherently likely to be associated with significant institutional malfunctioning? If the answer to either of the latter two questions in the affirmative, then further inquiry is needed to establish just what institutional adjustments are required in order to maintain the integrity of the process that contribute to sustaining the life of the community through health care.

The second tenet is that economics is a policy science; economic inquiry is significant only to the extent that it is relevant to problem solving through institutional reform. This principle suggests that we need to ask questions about what information we need to resolve, especially through institutional reform, problems associated with providing health care to all. The first requirement is an understanding of how the health care system actually works, including its institutional characteristics, and how these may promote or retard efforts to improve health.

An important task, linked to the first tenet, is to define what the community expects from the health care system and to examine alternative means for achieving those ends, allowing what is to be compared with what ought to be. One of the difficulties with the account of health care in the Audit Commission Reports is that it only skirts the task of examining what ought to be, except to the extent that it endorses marketisation and privatisation of health care. Very little evidence of inquiry is offered as to the efficacy of these proposals in improving

health care system performance. In addition, there is virtually no discussion of any undesirable consequences of the proposed changes. There is a need to explore what works in health care and what does not, without preconceived views about the appropriate setting for provision.

The third tenet is that the appropriate method of inquiry is evolutionary: the object of inquiry is the social process; the search is for factual explanations and causal understandings. Evolutionary inquiry asks questions about both individuals and institutions and understands each to be, in part, a product of the other. It would ask questions about the relationship between the preferences and purposes of the individual within the health care system, and the healthcare system itself. More broadly, this is the question to be answered: how are individual preferences and purposes within the healthcare system constituted by their social context? The answer to this provides information about the social processes that contribute to, for example, dependence on the health care system when the relevant problems are primarily social, rather than medical, in nature. It requires more than an assertion that the problem of over-use of health services reveals a lack of information about the full cost of health care. Certainly, increasing the cost of health care will reduce unnecessary use, but it is a blunt instrument and it does not address the needs of over users who have legitimate needs that are not merely medical needs.

The fourth tenet is that social value judgments are an integral part of inquiry and must themselves be objects of analysis: the normative-positive dichotomy is rejected. The authors of the Audit Commission Reports appear to think that they simply describe a situation but do not acknowledge the value judgments they make. These value judgments relate to the standards of performance for health care systems, to the proper location for the production of health care and to the proper system for delivering health care. An institutional research agenda calls for examination of these value judgments: do they reflect instrumental or ceremonial concerns? what values are not reflected? is there any evidence that this choice on inquiry reflects the concerns of the broader community?

The fifth tenet is that all political economies evolve and are embedded in social and cultural processes; individuals are both products and creators of these processes. Health care systems differ because they are embedded in differing social and cultural milieux. Likewise, institutional economics views individuals, in part, as products of their social and cultural environment. The importance of embeddedness for understanding health care systems is well understood by sociologists:

> The healthcare system of any society can only be understood within the sociocultural context of that society. No two healthcare delivery systems are exactly alike, with the differences primarily a function of the contexts within which they exist. The social structure of a society, along with its cultural values, defines the healthcare system. Thus, the form and function of the healthcare system reflect the form and function of the society in which it resides.[32]

Understanding these two points helps to understand why both health care systems and individuals within health care systems behave in particular ways. Both points have the potential to provide some insight into the effects of policy changes. The marketisation of health services that were previously provided as a social good provides an example. Attaching prices to health services in order to signal to patients the opportunity cost of care does nothing to address the cultural processes that affect health care use and may not change behaviour in ways that are allocatively efficient (direct care to those with the greatest clinical need) if these cultural factors have a strong influence.

An underlying assumption of the Audit Commission reports (and the Reports on Ageing where they specifically discuss health care) is that health services are over-used. The policy recommendations that are made aim to reduce (unnecessary) use. A key reason why they are concerned with health care usage is its importance in budgetary terms. This, in turn, reflects its importance as an institution in terms of the community. The problem of the high level of health care spending does not exist just because we have public funding and provision of health care. The US, where the proportion of public financing and provision is much less, spends a

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[32] Thomas, RK (2003) *Society and Health: Sociology for Health Professionals.* New York: Kluwer Academic Publishers.

larger share of GDP on health care than does Australia.[33] Issues other than the absence or presence of market mechanisms are clearly at play in the growth of health care spending. The importance of health care is also reflected in our preference for technology-intensive responses to health problems and the medicalisation of a range of what were previously considered normal biological processes, such as childbirth and menopause, or problems that were previously considered social in nature, such as obesity or hyperactivity in children.

The sixth tenet is that institutions correlate and coordinate economic behaviour in progressive and regressive ways; problems are resolved with progressive changes in structure. This suggests questions about the coordinating functions of institutions in relation to the provision of health care. In particular: what are the progressive and regressive ways in which economic behaviour is coordinated in health care? A second question, which is tackled by the audit commissions, without really establishing that the case for their answer is based on sound evidence, is about how the institutional structure can be changed to resolve problems. This requires a redefinition of the problems of the current provision of health care, based on sound inquiry. The problems that are assumed, but not demonstrated, by the audit commissions need to be tested against community views about the health care system. Naturally, these views should also be the subject of inquiry, as the fifth tenet would indicate. Proposed solutions to the identified problem need to be assessed against the criteria of instrumentality. For example: what evidence is there that the proposed solutions can actually achieve a health care system that meets the needs of the community better?

The seventh tenet is that the growth of warranted knowledge and its application as technology are prime movers in social change; they are both sources and means of resolving problems through institutional adjustment. A concern that is expressed generally and is evident in the reports on ageing, is that health care costs are unnecessarily high due to misuse of health care services, although it is

[33] Australia spends about 9.5% of GDP and the US about 15% of GDP on health care. The amount that is publicly funded accounts for about 6.4 % GDP in Australia and 6.8% of GDP in the US., according to data provided in World Health Organization *World Health Report 2006: Working Together for Health.*

important to be careful of the tendency to focus blame on individuals as the generators of both disease and health resource consumption. Warranted knowledge in this regard would serve to understand better the reasons why health services are used in apparently inappropriate ways and to generate acceptable and viable alternatives to current patterns of use. For example, inappropriate use of medical care could be due to lack of information, which is assumed in the audit commission reports, or it could reflect culture-related patient values and preferences.[34] In addition, it would make available to citizens current understandings of the various factors beyond individual behaviour that contribute to poor health. It is important for participation that citizens are in a position to recognise the limitations of a disease treatment system and to have reliable knowledge about alternatives to it for maintaining health.

The ninth tenet is that any economy is a system of power; the locus, use, and democratic accountability of achieved power remain priorities in analysis and policy. Mainstream economics seeks to instill greater accountability in health care by delivering the goods of health care through strong market mechanisms in its delivery. The institutionalist view is that this strengthens accountability only for what people can get, not for what they want from the system. Accountability through markets is focused on users of the service at a given point in time. There is no accountability to other citizens or to potential users. Power to shape the system resides with those who fund and provide care, although the extent to which they choose to exercise that power may vary. Users may have power to shape the system if it needs to respond to them for the needs of providers and funders to be met. Given the extent of market failure in health care,[35] there is considerable room for doubt as to the whether the actions of users have much impact on the institutional structure that shapes their transactions. However, these are matters

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[34] Marks, MK, Steinfort, D and Barnett, PL. (2003) Inappropriate use of hospital emergency departments. *Medical Journal of Australia,* 178: 187-188. Marks etal report a study in which they tried to reduce inappropriate use of emergency department medical care by providing information to recurrent inappropriate users of emergency department medical care, but achieved no decrease in attendance.

[35] Blaug. Where are we now in British health economics? Blaug argues that the market for health care can be distinguished from most other markets because it is a constellation of so many forms of market failure in one market.

that can be tested empirically. If, as an institutionalist perspective suggests, democratic accountability is needed, research might address the forms that it could take, examining and comparing different systems for democratic accountability.

Chapter 10: Institutional Economics and the role of the Public Sector

Introduction

The Audit Commission Reports span the years 1988 to 1996. Collectively, they illustrate the broad approach taken by mainstream economics to the role of the public sector and to the health care system, particularly as a publicly funded and/or provided system. Incidentally, they offer one history of trends in thinking that occurred over the decade that they cover.

That history is capable of creating a suspicion that the approach of mainstream economics to the role of the public sector and to the provision of health care is problematic at the levels of theory and of policy prescription. This chapter reviews the earlier account of shortcomings in these reports and re-considers each in the light of an institutional economics approach. Shortcomings in the economics of Audit Commission Reports, collectively, can be grouped as theoretical, empirical and political (see Chapter 6). These shortcomings limit the scope for analysis of the role of a public sector and of health care provision and may, therefore, yield incomplete policy prescriptions for both. Very little empirical work was used to support the case for the reforms proposed. The two main areas of policy prescription highlighted in the reports, corporatisation and privatisation of service provision presume that the main goals of policy should be to reform the health care system to one that most closely resembles the form of a perfectly competitive market, which is the benchmark against which all economic systems are evaluated in mainstream economics. In doing so, they give little consideration for either the broader effects of this, or the legitimacy of the *social* goals that they recognised governments might wish to pursue, but ignored largely because these goals are considered in their framework as being *non-economic*.

Reviewing the shortcomings of the reports from the perspective of Old Institutionalist Economics raises questions about an appropriate role for a public sector and about what constitutes appropriate/effective/acceptable provision of health care. To answer those questions it is necessary to draw upon research from disciplines other than economics; to focus on the institutions that affect the health

of the public and efforts to organise for better health, and to examine the characteristics of health care that become evident from an institutional economics perspective. This organisation of the argument concentrates on the extent to which the institutional perspective might offer a more satisfying account of the role of the public sector in public health and in the provision of health care, and might help to develop policy prescriptions to sustain the foundations of a public health approach.

Last's definition of public health, referring to collective and social actions and discussed in Chapter Two, provides a positive statement about public health; what it does and how.[1] The *Declaration of Alma-Ata*[2] provides a statement of values that underpin the public health project. Both point to a crucial role for the public sector in public health. The *Declaration of Alma-Ata* declares health to be a fundamental right, emphasises the need for collective efforts to produce goods that individuals cannot and affirms that governments have a responsibility for the health of their people that can be fulfilled only by the provision of adequate health and social measures. Both Last and the *Declaration* assert a definite role for the public sector in the name of public health different from the role outlined for the public sector by mainstream economics.

The National Commission of Audit identifies two justifications for public sector involvement in public health. The first is a social justification: when the community demands that specific social objectives be addressed, the public sector should act. The second justification is economic: when there is clear evidence of market failure, the public sector should intervene.[3] This second justification receives the most attention in the National Commission's report, which pays particular attention to the questions whether the benefits of public sector

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[1] Last *A Dictionary of Epidemiology*. He defines public health as; 'one of the efforts organised by society to protect, promote and restore the people's health. It is the combination of sciences, skills, and beliefs that is directed to the maintenance and improvement of health of all the people through collective or social actions. The programs, services, and institutions involved emphasise the prevention of disease and the health needs of the population as a whole.' p145

[2] World Health Organization *Primary Health Care (The Declaration of Alma-Ata).*

[3] National Commission of Audit *National Commission of Audit: Report to the Commonwealth Government.*

intervention outweigh the costs and whether the need for regular review to ensure that the public sector's role remains justified and appropriate. The State Audit Commission Reports generally confine the role of the public sector to intervening in market failures in the absence of conditions of perfect competition and the second EPAC report on ageing comments on the growing questioning of public sector involvement in a range of areas.[4]

The language of the Audit Commissions sets up a fundamental conflict between the rationale for a public sector involvement that emerges from the public health perspective and the rationale that comes from mainstream economics. Public health is fundamentally and unashamedly a normative project, avowedly striving to provide the best opportunity for good health across the population; asserting that health is achieved and held collectively; derived from social policy that recognises that the achievement and maintenance of good health is a complex matter; insisting that public sectors have a role in developing and implementing policies that recognize the complex interactions that shape health, increasing the opportunities for access to good health for those in the population who have least opportunity now. Public health's concern for the least well off reflects a concern for fairness or justice and an informed belief that individuals do not always have access to the means for maintaining good health and are not in a position to achieve them as individuals. The data of public health indicate that poor health is often a function of birth or location, rather than the result of a series of rational decisions made by individuals. The conditions for good health cannot always be purchased in a market, because they exist for communities, rather than individuals. In the language of mainstream economics they are a public good.

Mainstream economics, on the other hand, sees the role of the public sector primarily as a facilitator of markets. Even when social goals are defined, they are judged primarily in terms of their effects on markets, rather than on the well-being of the least well off in the community. The economic rationale for a role for the public sector is a narrow one. It assumes that markets can deliver what people

[4] Clare and Tulpule *Australia's Ageing Society.* ii.

want and that their wants, satisfied through the market, also satisfy their needs. The focus of its analysis is the efficiency with which markets meet the conditions for perfect competition. The mainstream economic approach to the public sector falls within the philosophy of *classic liberalism*.

Liberalism and the role of the public sector

The conflict between mainstream economic doctrine and the existing arrangements for providing health care generally and income and health care security in old age is, fundamentally, a conflict about the meaning and benefits of two types of freedom. The competing conceptions of liberty come from *classical liberalism* and *social liberalism*. Marian Sawer provides a detailed account of the influence of social liberalism in the development of the Australian Constitution in the late 19th century and in the development of the welfare state in Australia in the 20th century. The welfare state in Australia, including Old Age Pensions, was based on a commitment to the ideals of social liberalism, which grew from a critique of classical liberalism.[5]

Classical liberalism presumed that individuals' interests were served best if they go about making their own arrangements to meet their needs (and consistent with economic individualism). The Public sector was regarded as the main impediment to individuals doing this and classic liberalism informed the struggle to reduce the arbitrary power of an un-elected public sector. Social liberalism on the other hand, reflects some confidence in a democratically elected government presiding over a Public sector and an economy for the benefit of the majority of citizens. The doctrine offers an account of the links between development of the community and development of human potential through government action. 'Individuals only developed their full potential in relationship with the community, and required the means, education and access to culture to participate fully in community life.' [6]

[5] Sawer. The ethical state: Social liberalism and the critique of contract. See also: Sawer *The Ethical State? Social Liberalism in Australia.*
[6] Sawer. The ethical state: Social liberalism and the critique of contract. 69.

This notion of positive liberty leads to the conclusion that individuals need to be supported in achieving individual development, rather than not prevented from doing so. In particular, social liberalism is characterised by critique of the contract, belief in positive liberty and public sector interference, commitment to equal opportunity and active citizenship. According to Sawer, the early British social liberals, whose influence had significant conduits into Australia from the 1890s, rejected atomistic individualism and stressed the interdependence of individual and community. They adopted a *thick* view of citizenship as contrasted with the limited citizenship role of the rights-bearing or utility-maximising individual in earlier liberalisms; shared a Hegelian view about the evolution of liberalism and believed they represented a new stage of liberalism that had developed logically out of the old and was appropriate to the new era.[7]

Public health and the role of the public sector

The scope of interest in the broad public health community stretches from full individual responsibility for health to extensive public sector responsibility for health.[8] This reflects both notions about the significance of individuals and ideas about what it means to be free. As I have elected to locate my approach to public health within the frameworks provided by the WHO documents and the International Epidemiological Association (IEA) definition, outlined in Chapter Two, I will concentrate my discussions on the part of the spectrum implied by these documents. The WHO documents make clear that while individual behaviour is important, it occurs in social context. They take the position that individuals have limited control over that context and that 'governments have a responsibility for health which can be fulfilled only by the provision of adequate health and social measures'[9]. The IEA definition refers to public health as 'one of the efforts organised by society to protect, promote and restore the people's health'.[10] Public health work, as an *organised effort* is undertaken by public sector

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[7] Ibid.
[8] Each year, a broad range of perspectives is evident in presentations to the Public Health Association of Australia's annual conference.
[9] World Health Organization *Primary Health Care (The Declaration of Alma-Ata)*. 1.
[10] Last *A Dictionary of Epidemiology*. 145.

organisations and by civil society. The Centre for Civil Society at the London School of Economics defines civil society thus:

> Civil society refers to the arena of uncoerced collective action around shared interests, purposes and values. In theory, its institutional forms are distinct from those of the state, family and market, though in practice, the boundaries between state, civil society, family and market are often complex, blurred and negotiated. Civil society commonly embraces a diversity of spaces, actors and institutional forms, varying in their degree of formality, autonomy and power. Civil societies are often populated by organisations such as registered charities, development non-governmental organisations, community groups, women's organisations, faith-based organisations, professional associations, trades unions, self-help groups, social movements, business associations, coalitions and advocacy group.[11]

Some type of public health activity is undertaken in one form or another by most of the types of groups that are listed in this definition of civil society. In Australia, these organisations tend to provide services to individuals or distinct groups such as aged citizens or people with a disability. The bulk of classical public health activity is either undertaken directly by government or undertaken by organisations sanctioned by government through incorporation and/or registration of charitable status and/or receipt of funding from government. Public sector action is currently essential to public health activity in Australia.

In addition to activity that is readily recognisable as public health activity, myriad actions by the public sector have the capacity to affect the health of the public. Governments and public sector agencies fund and/or provide health services, broadly defined. They legislate for traditional public health activities such as pollution control and communicable diseases control, and exercise powers over the physical environments in which people live, the types of work that are available and the conditions of that work, the standard and accessibility of education, and access to non-market incomes. Since public health deals with threats to health that individuals will not, usually, have the capacity to address, it is largely a public sector responsibility backed with the capacity to exert considerable influence over people's life opportunities.

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[11] Centre for Civil Society (2004) *Centre for Civil Society.* Pamphlet. London: Centre for Civil Society, London School of Economics.

The WHO documents calls for an *upstream* approach to protecting health and to creating settings that are conducive to healthy behaviours and to good health. The proper extent of public sector intervention to change upstream influences is contentious and the further upstream the influence, the greater the controversy. For example, there is little debate about whether public sectors should provide information about the health effects of foods. This extends to advice to avoid some foods because of their health effects. However, there is great resistance from sectors of the wider community to restricting the availability of those foods. Nonetheless, viewed from this perspective, public health is consistent with social liberalism. Indeed, Sawer argues that much of what is recognised as public health activity at the level of the national public sector is a legacy of social liberal contributions to the Australian Constitution and to early Commonwealth legislation[12]. Similarly, Dickey argues that the Public sector has always been a major player in the provision of health and welfare services in Australia.[13]

Public health asserts the need for public sectors to create conditions in which enhance individuals' opportunities to be healthy rather than just not unreasonably restrict them. Mainstream economics, by contrast, is consistent with classic economic liberalism in asserting the need for public sectors to leave individuals to enter freely into market contracts for health or whatever other goods they estimate to be in their own best interests. However, at the same time, governments are expected to provide legislative and judicial frameworks for individuals to do this.

Mainstream economics and the role of the public sector

Mainstream economics purports to be a *positive* science that simply describes what is, rather than prescribing what should be. It claims to be value free. At best, this is a naïve portrait by economists of their own work. Mainstream economics starts with value judgments about *what is* by accepting the existing distribution of income, and about *what should be*, by defining *efficiency* as the criterion for evaluation.

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[12] Sawer. The ethical state: Social liberalism and the critique of contract.
[13] Dickey, B. (1966) Charity in New South Wales, 1850-1914. *Journal of the Royal Australian Historical Society,* 52: 1-32

The reports on ageing, by raising the spectre of intergenerational conflict, with an implicit endorsement of the response of younger generations, continue this tradition of unquestioned value judgments. They also discount goods not valued monetarily by their focus on the effects of ageing on the monetised economy, rather than on the capacity of the community to meet the needs of its members. Finally, the reports on ageing implicitly endorse a view that, while there might have been a need for public support in old age when incomes were lower, there is no need for public dependency in old age in a country that has such a high level of income. Therefore the dependency in old age is represented as a problem of foresight and thrift, in individuals, rather than having broader causes that should be addressed collectively.

This leads to a political agenda that defines the answer as increasing the incentives to save (positively, by subsidising retirement savings, and negatively, by withdrawing alternatives to private savings) and either increasing incentives to defer retirement (positively by providing tax incentives to defer retirement beyond age 65, or negatively by withdrawing alternatives to remaining in the workforce). The focus of this agenda is withdrawal of the Public sector from old age security and an expectation that the breach will be filled by individuals responding to the new incentives. The Public sector will be a backstop against extreme poverty, but will have a minimal role otherwise.

The reports on ageing also limit to changes in administrative and funding arrangements their discussion of what can be done to reduce health care costs. They emphasise individualist solutions to what they see as the rising cost of ageing (such as greater emphasis on informed consent including information about costs for items of service), reducing restraints on euthanasia and right to refusal/withdrawal of treatment; and locate responsibilities beyond the sphere of the public sector by involving families in decisions about pain relief and withdrawal of treatment or by limiting the availability of some lifesaving procedures, such as vascular surgery for smokers. In relation to improving the

health of the population the only possibility canvassed is 'promotion of good health for life rather than treatment and diagnosis near end of life'[14].

The Audit Commission reports are, in the main, quite explicit about what role they would set for the public sector. They begin by listing the concerns that have been expressed about the role of the public sector, such as a perception that government performance is inferior to that of the private sector; concern that the public sector is squeezing out the private sector; limits to future growth of the public sector, given high budget deficits and levels of government debt; a lowering of expectations about government's ability to solve economic and societal problems by traditional remedies; citizens' demands for improved responsiveness, choice and quality of service; and the (negative effects of) demands from public sector staff. By listing these concerns without discussion or criticism, the National Audit Commission implicitly endorses them. The National Audit Commission lists only two justifications for government activity. The social case for government action, which is acknowledged, but not elaborated by the National Audit Commission, is limited to generalised objectives such as a humane society, a more even distribution of income and the provision of assistance to those genuinely in need. Social equity outcomes that elected governments may be mandated to achieve 'are usually related to welfare issues involving the general standard of community health, education and standards of living'[15]. The second justification relies on the economic case. This involves instances of 'clear evidence of market failure', discussed in some detail, including the need for regular review to ensure that the government's role remains justified and appropriate. The discussion immediately focuses on programs that should be judged according to their effectiveness and their efficiency. This presumes a vision of a public sector that fixes discrete problems, trouble-shooting instances of 'market failure' as they arise. The good society is one in which providing for the community is the role of the market. The role of government is to ensure that the market remains untainted. It does not

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[14] Clare and Tulpule *Australia's Ageing Society.* It would be consistent with the rest of the documents if the authors intend this to mean health promotion, rather than health information.
[15] National Commission of Audit *National Commission of Audit: Report to the Commonwealth Government.* 7.

include the kinds of coordinating oversight and management of power that both public health and institutional economics might envisage.

The issues in the reports that require further consideration in this thesis can be grouped as theoretical, empirical and policy issues. At a theoretical level, the reports (especially the National Audit Commission) explicitly accept the mainstream economic theory that the role of the public sector is to address market failure. They define market failure as a situation in which 'private provision of the goods and services in question would be substantially inadequate or excessive'[16] absent government involvement and include examples such as information asymmetry, externalities and public goods, as well as protection of property rights. This definition is based on a narrow version of efficiency.

At an empirical level, no attention is paid to the actual experience of privatisation of the provision of either public sector services, generally or in health care in particular. Assertions made about the failings of public sector, such as

> a perception that public sector performance was inferior to that of the private sector; concern that the public sector was squeezing out the private sector; limits to future growth of the public sector, given budget deficits and high levels of public debt; a lowering of expectations about government's ability to solve economic and societal problems by traditional remedies [17]

are taken as proven, without evidence.

At a policy level, the reports lead to the only conclusion possible, given their theoretical presumptions and empirical shortcomings: Governments should stick to their core economic activities – essentially by ensuring freedom of markets – and, wherever possible, government activities to achieve social equity outcomes should be marketised, or preferably, privatised. These policy prescriptions are based on the (largely unexamined) prescriptions that emanate from mainstream economics.

Institutional economics replaces the somewhat narrow view of efficiency used by mainstream economics with the broader *higher efficiency*, which includes security,

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[16] Ibid. 10.
[17] Ibid. 13.

equity, freedom and compassion. This view of efficiency is not unconcerned about whether production occurs in a technically efficient manner, or whether the goods and services that are produced are distributed to where they are most valuable. The definition is extended to ask questions about the 'degree to which the economy structures the choices open to its participants so as to accurately and sensitively reflect their informed judgement about total resource allocation'[18]. This returns us to the question that was touched on in Chapter 7 about the extent to which health care providers, rather than health care consumers or the community more broadly define what choices about health care are available.

This is not just a question of market power to decide what will be available. It is also an issue of path dependence. For example, there is no question that health care in Australia has problems. It is heavily focused on cure, rather than prevention, of disease and where prevention does occur it is mainly secondary or tertiary prevention, either about minimising the effects of disease processes that are in train, or about rehabilitation. Spending on health care in Australia is dominated by hospital, medical and pharmaceutical spending and high-end aged care, which, together, have consistently accounted for around 71 per cent of health care expenditure in Australia since 1989-90. Some pharmaceutical expenditure will be for secondary preventive care, but most will treat established conditions. Some medical expenditure will also be preventive, even primary preventive, care. However, hospitals and high-dependency nursing-homes provide care to well-established disease and/or disability. The proportion of health care expenditure that went to hospitals fall about 10 percent from 37.7 percent in 1989-90 to 33.7 in 2003-04. This represents an annual average change of only 0.08 percent and has been more than offset by increases in pharmaceutical spending. Spending on medical care services as a proportion of health care spending also fell slightly from 17.1 per cent to 16.4 percent. It is interesting to note that high-end nursing home care, which is likely to be the most demographically specific of these categories, actually fell from 7.7 per cent to 6.3 per cent of health care spending during the

[18] Klein, PA. (1984) Institutionalist Reflections on the Role of the Public Sector. *Journal of Economic Issues,* 18: 45-68. 60-61.

fourteen years. (Table 10.1) Part of the reason that so little change has occurred in the percentages in each category is because the system is somewhat *locked-in* to using existing technologies and capital to continue to provide care, and because he development of new capital and new technologies builds on existing knowledge and technologies. This means that new ways of doing things often will e relatively small changes to existing ways of doing things.

Table 10.1: Percent contribution of selected areas of health expenditure to total health expenditure 1989-90 and 2003-04

NOTE: This table is included on page 252 the print copy of the thesis held in the University of Adelaide Library.

Source: Calculated from (Australian Institute of Health and Welfare, 1996b, Australian Institute of Health and Welfare (AIHW), 2005)

Ways of changing path can be expensive and, often, not profitable for suppliers of technology and capital or for providers of care who have invested in a particular skill set. Even a decision on the part of government to alter the skill set will be limited by the availability of potential educators with the desired skill set.

However, it is unlikely that either a shift to prevention or a change in the focus of health care spending to primary care will occur in the absence of a community consensus and a mechanism to act on this. A desire to change the overall shape of available health services will be realised only through the market if the sum of provider interests and public sector interventions system is geared heavily to a particular way of doing things – unless activities undertaken outside the health care system are geared towards changing the pattern of investment in technology and workers and which services will be purchased. Price signals are probably quite good at telling producers what consumers do not want and reinforcing production of existing goods they do want – but they provide no useful information as to what they do want if those goods do not already exist.

Withdrawal of the public sector from all but law and order, market maintenance and residual support for charity is the mainstream economic agenda for the public

sector articulated by Friedman. Friedman's discussion of the role of governments as rule makers recognises that the 'general conditions are the unintended outcome of custom, accepted unthinkingly'[19]. His discussion is limited to rules to resolve conflicting freedoms and his examples relate to freedom to set up new enterprises and freedom to combine and freedom to compete among labourers; and property rights.[20] There is no discussion about efforts to shape an economy that reflects collective, rather than individual goods.

This approach reflects the philosophy of classic liberalism. That Liberalism prescribes a minimal role for the public sector, preferably limited to the enforcement of contracts, implying dismantling of the welfare state and withdrawal of government from *interference* in contracts, including those in the labour market and the health care market. Individual freedom is the key to individuals taking responsibility for their own support and health care in old age, and freedom from interference by government will encourage individuals to plan for retirement and to look after their own health and their healthcare.

Institutional economics and the role of the public sector

Two sets of considerations arise: first, what are the implications of the social value principle for the role of the public sector, and second, is there a theory of the role of the public sector in institutional economics that sits independently of the social value principle. I argue here that the evaluative criteria set down by the social value principle point to a role for the public sector in community integration, warranted knowledge and participatory democracy. Markets will meet few of these criteria very well and markets offer only a limited role to civil society. This points to a role for a public sector. Secondly, there exists within institutionalism a stream of thought particularly relevant to a discussion of the role of government. Klein uses the notions of emergent values, value floor and higher efficiency to argue for a role for the public sector beyond the minimal role espoused by mainstream economics. I will argue that, while these two bodies of theory are

[19] Friedman *Capitalism and freedom*. 25.
[20] Ibid. 25-27.

theoretically related, each has something different to offer and together they provide both a rationale for a public sector and a set of criteria by which it can operate.

Implications of the Social Value Principle for the role of the public sector

The Social Value Principle calls for ways in the community by which community and integration, warranted knowledge and participatory democracy can be sustained. The three most probable ways this can occur are through the market, through the institutions of civil society and through the public sector or government. In order to conclude whether the Social Value Principle has anything clear to say about a role for the public sector, it is necessary to ascertain the extent to which community and integration, warranted knowledge and participatory democracy can be sustained by the market and civil society without any support or direct activity from the public sector, particularly in the context of the health care system and an ageing society.

The prospects for the Social Value Principle to be sustained through markets have been discussed in relation to ageing in Chapter 8, and health care in Chapter 9, where I showed that they are an inappropriate mechanism for sustaining community and integration, warranted knowledge and democracy because the market operates on discrete transactions between individuals and can only deliver the socially efficient amount of goods when they are rivalrous, excludable, and, therefore private goods, rather than public goods. The other alternative to markets and the public sector is civil society.

Civil society, which has already been defined, can act by organising for local non-market activities of production (usually to build or maintain public goods); by organising to produce goods or services that are also produced in the market; by organising the distribution of goods or services either produced by them or purchased from other producers; or by working to maintain or change the rules under which production and distribution occur.

Civil society is active in public health and in ageing in Australia. In public health, civil society includes organisation along disease lines, (for example, Diabetes

Australia, the State-based Cancer Councils and their peak body the Australian Cancer Council) or around body-systems (such as the National Heart Foundation). These organisations tend to provide services directly to people with their umbrella condition, to sponsor research and contribute to public education and to lobby the public sector to fund or provide services for people with the relevant conditions and programs for their prevention.

More broadly, organisations such as the Public Health Association, the Doctors' Reform Society and the Australian Medical Association (in addition to functioning on behalf of the personal interests of its members) act to influence the rules of the health care system, specifically, as well as the more general rules that influence health and access to and the provision of health care. In the case of ageing, specific groups such as the State-based Councils on Ageing and their national peak body provide services to older people and lobby for funding and for specific rules on matters that are usually related fairly directly to the current concerns of the aged, including income, services and housing.

In the aged care sector, civil society provides an alternative to profit-driven care. Non-profit but State-subsidised providers of aged care services have been the mainstay of both residential and the home-based service provision. Argument about the difference between their work and that of the for-profits providers swings around two poles. The first is the fact that non-profit providers do not need to generate a surplus to return to shareholders, thus freeing resources that may be used to provide a better quality of care than would be possible, all else being equal, in the hands of providers-for-profit. Of course, there is no guarantee that the potential surplus would be returned to expenditure that primarily benefits recipients of care. It may be absorbed by inefficiencies in the organisation. The second pole of argument is the ethos of non-profit provision, which claims, and probably is widely thought to be, focused more exclusively on the general welfare of the recipients of care than is the case with for-profit provision. The test question is 'would the organisation continue to exist if it did not return a surplus?' If the answer is 'no', then the benefit to the recipients of care is not the primary motive. However, non-profit provision does not automatically result in the provision of

care where the health care benefit to the recipients is the primary motivation. The motives of the organisation can be many and varied and can include religious conversion or religious service, for example.

So, there is a prima facie case that because non-profit organisations exist to do a service, rather than to make a profit, they might be a suitable channel for sustaining community and integration, warranted knowledge and participatory democracy. However, they may do this at the expense of technical efficiency. To conclude that civil society is either necessary or sufficient requires further evidence. I have already concluded that something other than markets is necessary. Now I shall argue that while civil society is necessary, it is not sufficient, from an institutional perspective.

Examples of not-for-profit provision of services demonstrate the existence of active civil society in Australia that is directly relevant to questions of public health, health care and ageing. The services undertake activities and represent perspectives on problems that would not necessarily be a chief concern of, or even evident in, the market or the public sector, without their presence. Even allowing for a role for the public sector, civil society is a necessary complement to democratically elected government.

Institutional economic theory would examine the extent to which ceremonial or instrumental values and behaviours dominate in the economic system.[21] Ceremonial values reflect traditional beliefs about status hierarchies and invidious distinctions about the worth of individuals and reinforce power relationships embedded in the status quo. Ceremonial behaviours are justified by invidious distinctions and status relationships and reflect the use of power and coercion. Instrumental values underpin the use of knowledge that provides for the 'continuity of human life and the noninvidious re-creation of community'[22]. Instrumental patterns of behavior make knowledge available to the community 'for use in the problem-solving activities that sustain the life processes of the

[21] Also known as the Veblenian Dichotomy, ceremonial and instrumental values and behaviours are discussed in more detail in Chapters 3 and 7.
[22] Tool. Instrumental value theory. 408-9.

community'[23]. A key question, for this chapter, is whether or not civil society, in this context, works to support community and integration, warranted knowledge and participatory democracy through primarily instrumental behaviours.

Community and integration 'seeks to appraise the extent to which the economic system relates to the degree of community consciousness, cooperation, and integration'. It requires evaluation of the extent to which 'community values such as cooperation, dominate over greed, selfishness and individualism'. In order to advance community and integration, civil society should contribute to reduced prejudice, coercion and large inequalities in knowledge and power, as these promote 'contradictions that reduce the effective coordination of the life process of the system'[24].

Civil society encompasses a very broad range of interests and activities. In the health and ageing fields these include professional organisations and user/patient organisations; they include activities such as providing care, redistributing resources and lobbying government for rule changes. There is nothing either inherently ceremonial or inherently instrumental about their values or their activities. The fact that they could exhibit ceremonial behaviour leads to the conclusion that they would not be sufficient from an institutional perspective, because of the variety of values and behaviours that are possible.

Civil society can contribute to warranted knowledge. The activity of the Workers Education Association (WEA) in Australia over many decades provides an illustrative example of the potential for an organisation built on the values of social liberalism to promote positive liberty and active citizenship (both of which are compatible with the Social Value Principle) by 'developing the capabilities of the individual (…) preparing him for the society in which he lives (…), and giving

[23] Bush, PD. (1983) An Exploration of the Structural Characteristics of a Veblen-Ayres-Foster Defined Institutional Domain. *Journal of Economic Issues,* 17: 35-66.38..
[24] O'Hara, PA. (1997) A New Measure of Macroeconomic Performance and Institutional Change: The Index of Community, Warranted Knowledge, and Participation. *Journal of Economic Issues,* 31: 103-131. 105.

him the will and, if he can, the power to modify that society where change is necessary to secure the proper development of the individuals who live in it' [25].

Warranted knowledge in relation to population ageing includes knowledge about the patterns of opportunity by age and gender; the labour market and the barriers to equal participation that is not hindered by ageism, sexism, rules about access to work and the workplace that reflects unequal power in the community and in the workplace. These are all matters that affect the capacity of individuals to reach retirement in good health and to make financial provision for their retirement. Civil society can facilitate the achievement of this capacity to some extent but is limited by its own resources and by the capacity of individuals to participate in its activities. In addition, there may be as many organisations in civil society that work to disseminate information that leads away from warranted knowledge as those working to promote it.

Scholte defines *civil society* as 'a political space where voluntary associations explicitly seek to shape the rules (in terms of specific policies, wider norms and deeper social structures) that govern one or the other aspect of social life'[26]. The elements of civil society can be radical, reformist or conformist/conservative. Civil society can contribute to participatory democracy only if it contributes to population involvement in decision-making and this population involvement enhances the non-invidious functioning of the community. Again, there is no *a priori* reason to conclude that civil society as a whole *will* achieve this, since its constituent organisations represent a range of interests and perspectives spanning the spectrum from radical to conservative. There is no *a priori* reason why either *radical* or *conservative* represents inherently instrumental, as distinct from ceremonial, values. Finally, civil society can discuss and educate extensively, but make little impact on behavior, even if the instrumental values become widely accepted as a result of its activities, because it has no direct power to change the formal rules in which institutions are embedded.

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[25] Sawer. The ethical state: Social liberalism and the critique of contract.47.
[26] Scholte, JA. (2001) *Civil Society and Democracy in Global Governance*. Working Paper No. 65/01 Warwick: Centre for the Study of Globalisation and Regionalisation, University of Warwick. 6.

Examining civil society through the criteria of the Social Value Principle provides no reason to conclude that its existence will automatically drive the promotion of community and integration, warranted knowledge or participatory democracy. In addition, elements of civil society do not have the power to change the formal rules on their own. While elements of civil society have a role to play in progressive institutional change, they are not a sufficient force for such change.

Emergent values and the role of the public sector

Tool's social value principle points to the need for a public sector to play a role in sustaining community and integration, warranted knowledge and participatory democracy. However, Klein, who draws upon a body of work similar to that which informed the theory espoused by O'Hara and was applied in Chapters 6 and 7, above, has also argued the case for a role for the public sector within the institutional paradigm. In particular, Klein draws on Clarence Ayres's development of John Dewey's instrumental theory of value and Marc Tool's extension of this. Klein argues that there are a range of *emergent values* that must be met within the context of the economy. Emergent values are 'the changing "collective ought"'[27]. Emergent values exist because of the fact of change and are underpinned by a value floor, giving rise to the need for a broader definition of efficiency. In Klein's view the public sector plays a crucial role in transmitting emergent value to economic performance. As a participant in public debates, the public sector plays rule-maker and umpire (as argued by Friedman 1962) – but institutionalists claim that the public sector behaves as player and manager as well. [28]

Klein argues that there is a value floor above which the economy must operate. He defines the value floor as 'the life process itself and, specifically an affirmation of the life process' [29]. There are values that are immutable within the community at a given time. What that value floor is will depend upon the circumstances of the community and may include the sanctity of human life or equality of opportunity

[27] Klein. Institutionalist Reflections on the Role of the Public Sector. 54.
[28] Klein. Public Sector, Role of the.
[29] Klein. Institutionalist Reflections on the Role of the Public Sector. 58.

(however defined) or human dignity or autonomy. Left on its own, the economy cannot guarantee that its operation will uphold these values. This means that full-on laissez-faire is not an acceptable model for the economy if the value floor is to be accommodated. Again, a public sector is the place where the community can work collectively to enforce those values within the economy.

If the economy exists to meet the needs of individuals and the community, then there is a need for a definition of efficiency broader than the market definition. That broader definition would have to accommodate 'the degree to which the economy structures the choices open to its participants so as to accurately and sensitively reflect their informed judgement about total resource allocation'[30]. The concept of efficiency in mainstream economics cannot achieve this higher efficiency because it does not account for judgments about resource allocation outside those reflected in individual exchanges in given circumstances.

An example that is particularly pertinent to health economics is the co-called *equity-efficiency trade-off*. Mainstream economists working in health care argue that improvements in equity in the provision of health care can only be gained at the price of efficiency.[31] This reflects economics presumption of the goal of maximisation. While many government forays into health care were based on a desire to achieve more equitable health care systems, during the 1990s, governments increasingly pronounced that the role of the health care system was to maximise the gains in health to the community. Maximising health gains is a matter of technical provision medical care to people whose health status can increase the most from receiving it. Equity is more concerned with ensuring that those who have the worst health or the worst access to health care benefit the most from the health care system. However, a notion of higher efficiency would include equity, to the extent that it is a community goal, as one of the economic goals of the system. The case has been made by Vagero that the idea of an equity-efficiency trade-off does not stand up to critical examination because it confuses the strategic

[30] Ibid. 61.
[31] Maynard, A. (1999) Rationing health care: an exploration. *Health Policy,* 49: 5-11. From outside the health care arena: Okun, AM (1975) *Equality and efficiency : the big tradeoff.* Washington, DC: The Brookings Institution.

goal of equity with the need to implement those goals efficiently.[32] The conflict here seems to be whether the strategic goal is equity or maximisation. Under the mainstream notion of efficiency, maximisation of health gains is an economic goal, but equity is not. The notion of higher efficiency brings equity into the economic realm because it is part of the character of the economy. For institutional economists, then, the extent to which it should play a part is a matter for democratic deliberation to clarify the *collective ought* so that this can then be transmitted to the health care sector.

In institutional economic theory, the kind of change most-often considered is technological change.[33] I argue that social change, in the form of demographic change can also be examined through the lens of emergent value. Population ageing is, in part, the result of technological changes that facilitated both reduced birth rates and greater life expectancy. The reduced birth rate is the result of technological change in the form of improvements in contraceptive technology but was facilitated, also, by earlier social change that increased access to education for women and reduced barriers to their greater participation in the workforce and improving rates of infant mortality. Increased life expectancy across the population is a long-term trend that has its roots in greater economic productivity and incomes, efforts to redistribute income through public health infrastructure, education, labour market policies and progressive taxation regimes.

This kind of change can impact on emergent values directly by creating new problems or indirectly by solving old problems. Changing technology impacts directly by affecting the kinds of work available and the kinds of products available. This creates the potential for new social problems as a result changing threats to health and safety in the workplace brought on by new technology, or from new products that are hazardous or create externalities, or bring some moral question into sharper focus. Changing technology impacts indirectly by solving some problems, which brings other problems into focus. For example, reducing

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[32] Vagero, D. (1994) Equity and efficiency in health reform. A European view. *Social Science & Medicine,* 39: 1203-1210

[33] Klein. Institutionalist Reflections on the Role of the Public Sector.

mortality rates across the population have brought into focus problems of morbidity and quality of life.[34] The emergent values that Klein argues are exhibited to some degree by all economies are efficiency, equity, freedom, security and compassion. However, the varying degree to which they might be reflected in an unregulated economy will not necessary reflect the community's judgments about the extent to which these values should be reflected.

What do people want the economy to provide is largely an empirical question. A more difficult question is how to discover what are the values of the community, which, according to some theorists, may differ from the aggregated values of individuals.[35] Individual values can be aggregated from *votes* in elections or in markets but it is also important to distinguish what individuals would want for themselves, or think are important personally, from what individuals believe should be available to others, or what is important socially.[36] Votes in markets tell us what individuals want for themselves. Votes in elections tell us some thing about what individuals want for themselves *and* what they want for others. Both sets of information are incomplete: individuals vote in elections for a bundle of goods, not necessarily endorsing all the proffered goods, and votes in elections tell us nothing about the intensity of valuation. In both markets and elections, votes are constrained to the choices offered by producers and politicians. Neither mechanism automatically provides an opportunity for individuals to say what choices they would like to be able to vote amongst nor how intensely they value those choices.[37] In order to reflect emergent value, a democracy that promotes participation, other than in elections is, therefore, essential.

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[34] Johansson, SR. (1991) The health transition: the cultural inflation of morbidity during the decline of mortality. *Health Transition Review,* 1: 39-65

[35] Mooney, G. (2001) Communitarianism and health economics. In *The social economics of health care*. (Ed, Davis JB) Routledge: London and New York. pp. 40-60

[36] Baily, MA. (1994) The democracy problem. *Hastings Centre Report,* 24: 39-42

[37] Mullen, P. (2000) Public involvement in health care priority setting: are the methods appropriate and valid? In *The global challenge of health care rationing*. (Eds, Coulter A and Ham C) Open Univerity Press: Buckingham

Institutional economics and public health

The previous discussion confirms that institutional economics would take a position on the matters covered by the Audit Commission Reports and the Reports on Ageing quite different from those taken by the Reports' mainstream economist authors. In particular, replacing the mainstream definition of efficiency with the institutional definition of *higher efficiency* indicates a role for the public sector in shaping the structure of the choices open to its participants so as to accurately and sensitively reflect their informed judgment about total resource allocation. Without this role for the public sector, the community is left to want the health care they can get, rather than get the health care they want. The Social Value Principle provides the criteria by which the processes for this role in maintaining the value floor through the health care system are weighed. Markets cannot be relied upon to deliver community and integration, warranted knowledge and participatory democracy. There is some prospect of them being supported by civil society, particularly if there is participatory democracy, but civil society represents incomplete interests of the community. While public sectors cannot provide these three goods alone, they are an essential element in supporting these processes. The key question for public health is: Does this provide for a role of the public sector and the organisation of societal processes that is more compatible with public health objectives? In particular, does the different prescription of institutional economics for the role of the public sector viewed through the lens the provision of health care take us closer to a public health approach than the mainstream economics approach does?

Health care provision in the form of clinical services has a number of features that constitute *a priori* evidence, from an institutional economics perspective, of failure to provide *higher efficiency*. Health care markets, especially in pharmaceuticals, are subject to considerable power exercised by producers in the form of monopoly.[38] In addition as Chapter 8 demonstrated in relation to pharmaceuticals, providers have power to shape what individuals want in terms of health care. What

[38] Monopoly in medical care arises from regulation, which restricts entry to the profession. Monopoly in pharmaceuticals arises from patent protection new drugs.

individuals end up wanting under monopoly conditions is what maximizes producers' profits, rather than what maximizes the health of the population.

While the Audit Commissions discuss health care in terms of improving consumer choice and responsiveness of services, they presume that there is overall consensus about how health care expenditure is distributed, both across services and across the population. The choice that needs to be expanded is for individuals within a given service system. Present market forms and practices offer no suggestion of the possibility of improving health by means other than clinical services, or even allow that this might be a priority for the community.

To achieve *higher efficiency* it would be necessary first to ascertain what the public think should be the priorities for public health, not just priorities amongst competing services or competing individuals. That particular judgment would then need to be placed in the context of the community's overall judgment about total resource allocation. *Total resource allocation* could mean the *guns or butter* example beloved of undergraduate textbooks but the adage *prevention is better than cure*, which seems to have widespread support in the community, is a more immediate example for this study. Proclaiming that prevention *is* better than cure is empirically implausible given the mobilisation of bias that sustains a regime of health goods in Australia heavily geared to *cure* by clinical services. Public health expenditure in Australia hovered around 1.4 to 1.7 percent of health care spending between 1990-2000 and 2003-04. Prior to this, published health expenditure data combined community health and public health expenditure. Between 1989-90 and 1998-99, the total thus described hovered around 5 percent of total health expenditure. Prevention may have been a priority in the mind of the public that was not reflected by the priority accorded to cure in the overall allocation of resources for health.

As part of promoting *higher efficiency* government should also be concerned about emergent values in public health and health care. Expectations of the community about health care services are likely to change over time in the face of new threats to health and new technologies for delivering clinical services. However, in light of earlier discussion about the ability of health care providers to influence

expectations about health and health care, it is likely that emergent value does not occur untainted by the activities of health care providers.

The fact that the preceding cavils prevail in a country such as Australia, where the public sector is active in health care and public health, might lead one to conclude that public sector involvement does not work anyway, but perhaps it is the way that public sector is involved that matters. In health care, much of what the public sector does is subsidise clinical services, chiefly to ensure that inability to pay is not a widespread barrier to accessing clinical services. This is partly predicated on the social role of governments referred to in some of the reports surveyed for this thesis. In addition to this, the mechanism of subsidy gives the public sector potential leverage over how health services are provided and what services are available. However, this leverage in the context of health care turns out to mean the tweaking of a series of interactions between providers and patients in a health care market. It is assumed that, subject to constraints of information and ability to understand, individuals only need to make choices between options that are available in the health system and that the ways in which health is protected and promoted in the community are not a matter of choice for the populace. Both the provision of clinical services and decisions about public health priorities are exercised chiefly within the bureaucracy with little reference to what the community wants in the context of the overall resource allocation. [39]

It is important to recognise that public sectors also have a role to play in balancing the power of health care providers with countervailing power. This is particularly important in relation to emergent values, since the power to influence expectations about what a health care system should deliver and what people can expect from it as individuals, affects both their votes for the rules or rulers of the system and their behaviours as users of health services. The information provided by producers does not reflect the broader needs and values of the community, but those of providers. Thus, this countervailing power would serve to promote warranted knowledge.

[39] It is not pertinent to this thesis to debate the possibility that subsidies are also a legitimate form of political patronage.

Finally, the values in the community that underpin the provision of health care can be dominated by either ceremonial or instrumental values and behaviours. The Social Value Principle criterion of community and integration is concerned with the extent to which the economy exhibits community consciousness, cooperation and integration. It evaluates the extent to which community values such as cooperation dominate over greed, selfishness, and individualism. One, perhaps unintended, consequence of the Audit Commission Reports (and the Reports on Ageing) is that, without question, they hold market values up as those values that should be shared and sustained. In addition, the repeated references to intergenerational conflict endorse individual values over communal values. They risk promoting greed and selfishness through their near obsession with GDP (their preferred measure of well-being) and their endorsement of a small public sector and low taxes. The reports on ageing and the audit commissions actually are examples of the public sector promoting these values, as government departments or statutory bodies produced them. The extent to which governments promote values of community consciousness and cooperation over individualism and selfishness will have an impact on how these values are balanced in the community and how well the health economy works to provide for the health needs of the population in a non-invidious way.

Achievement of *higher efficiency* and a balance between ceremonial and instrumental values and behaviours would require a commitment on the part of the public sector to increasing the level of community and integration and warranted knowledge and encouraging and supporting the activities of civil society in a robust participatory democracy.

Conclusion

At both a theoretical level and in the example provided here of health care, the approach of institutional economics though the Social Value Principle and the notion of higher efficiency highlights a broader and deeper role for the public sector in protecting and promoting public health. The activities implied in such a role would include strengthening participatory democracy by promoting civil society and also by democratising its own operations; funding and promoting

education that increases the understanding of the community of the broader processes of provisioning and not simply of the market mechanism for understanding economic problems.

Some of the criteria that flow from the social value principle are similar to those that flow from a social democratic tradition that was influential in early Australian national politics. This does not mean that the form or processes that participatory democracy under and institutional justification will be the same as that under a social democratic justification. This flows from the fact that there is a differing rationale for the two. They arise from different philosophical traditions and identify different problems to be addressed. The social democratic tradition flows from political philosophy and beliefs about the value of individuals. Social democracy is 'concerned with the achievement of greater social justice and fairer distribution of economic reward in order to secure greater freedom, understood in a positive and not just a negative sense (through) state intervention in the economy'[40]. The criteria of institutional economics, on the other hand, arise from an understanding of the economy and individuals as being embedded in society. Markets are just one of many institutional processes that could be used to meet the needs of the community and capitalist economies allow for discretion to be exercised. Participatory democracy is important because there are choices to be made about what kinds of institutional processes should be used to realise the values that the community want expressed in the economy. Participatory democracy allows for discretion in the economy to spread to those who are affected by the institutional arrangements that prevail.

Once again, I return to the Tenets of Institutionalism, previously introduced in Chapter 3. Seven of these nine principles suggest themselves to the following questions that are distinct from those canvassed in the previous two chapters about the role of the public sector in matters of public health significance.

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[40] Plant, R. (1987) Social Democracy. In *The Blackwell Encyclopaedia of Political Thought*. (Eds, Coleman J, Connolly W and Ryan A) Blackwell Reference: Oxford and New York. pp. 481-485. 483.

The first tenet is that inquiry is addressed to the institutional process of providing the material means of life and to significant problems of institutional malfunction. Two sets of questions that arise from this tenet relate to the presence of significant institutional malfunctioning and to a role for the public sector in addressing that problem. In relation to the presence of significant institutional malfunctioning: Is significant institutional malfunctioning the result of the presence or activities of the public sector? To what extent do the existence and activities of the public sector adversely affect our capacity to provide the material means of life? What significant institutional malfunctioning can be resolved by the removal of the public sector from a particular sphere? What alternative institutional forms, which can function more instrumentally, will be possible without a public sector?

In relation to institutional malfunctioning that does not already involve the public sector: Is there a role for a public sector in the process of providing the material means of life in the presence of significant institutional malfunction? If there is a prima facie case, the previous questions ought then to be applied to assess whether, on balance, the degree of institutional malfunctioning and its consequences are likely to be more instrumental than the current arrangements.

The second tenet is that economics is a policy science; economic inquiry is significant only to the extent that it is relevant to problem solving through institutional reform. The main question arising from this tenet is: what information do we need to clarify the extent and limits of an institutional role for a public sector through institutional reform? Underlying this question is a need to articulate both a values framework and criteria for deciding which phenomena constitute problems. This is an institutional question in itself, the answer to which must be underpinned by both warranted knowledge and participatory decision-making.

The third tenet is that the method of inquiry is evolutionary; the object of inquiry is the social process; the search is for factual explanations and causal understandings. This tenet points to questions about both individuals and institutions and the impact that the public sector has on each. If the preferences and purposes of the individual are taken as endogenous, which is what is implied

by the notion of the institutionalised individual, then, in relation to ageing and public dependency we could ask: what roles the public sector has played in the social processes that have resulted in such a wide apparent acceptance of public income support in retirement and public funding of health care in Australia? What has been the effect of the public sector activity on the evolution of values, norms and structures within health care provision? Have these been more or less instrumental than the ones they replaced? Institutional economists are also centrally concerned with the exercise of forms of social power. Questions about the exercise of power (discretionary behaviour) in health care provision and its effects of the performance of the system for meeting the health care needs of the community are also important. If these sources of power are evident: Have the existence and activities of the public sector influenced the development? Does the public sector play a role redistributing discretionary power?

The fourth tenet is that social value judgments are a part of inquiry and must themselves be objects of analysis; the normative-positive dichotomy is rejected. Rather than assuming that value judgments are the province of individuals and can be expressed mostly adequately through markets, this requires some inquiry about what values should underpin our economic planning. At least one of the reports on ageing makes the point that there is a general shift away from a public sector involvement in a range of activities. It is not clear in the areas of health care provision and retirement income support, in Australia at least, that this reflects the wishes of the community. The proposition that markets do it better is a judgment about social value (what constitutes better, for example) that is largely untested.

The fifth tenet is that all political economies evolve and are embedded in social and cultural processes; individuals are both products and creators of these processes. This suggests questions about the relationship between the accepted roles for a public sector and these cultural processes, in particular how they contribute to dependency. Any inquiry about these processes should seek to identify both their instrumental aspects and their ceremonial aspects. In addition, there are questions about origins. How have these processes evolved and what options are there for their reformation?

The seventh tenet is that the growth of warranted knowledge and its application as technology are prime movers in social change being both sources and means of resolving problems through institutional adjustment. Information is recognised as a problem in mainstream, as well as institutional economics. In both types of economics, information is a public good and subject to market failure. Warranted knowledge has similar characteristics: provision of adequate warranted knowledge almost certainly requires collective activity and research that assists in understanding how that collective activity does and could occur, including a role for the public sector is essential to participatory democracy.

The ninth and final tenet is that any political economy is a system of power; the locus, use, and democratic accountability of achieved power remain priorities in analysis and policy. Building on the answers to those questions generated in chapters 8 and 9 in reference to this tenet are questions that need to be explored about whether the public sector does and can play a role in defining the locus, use and accountability for power, including the kinds of institutions, other than a public sector can play these roles. The shift in focus from individuals to the institutions of the society in which they are embedded shifts the focus on inquiry from the role of the public sector in relation to individual behaviour to its role in in shaping influences on individual behaviour that populations share.

Chapter 11: Discussion

Introduction

The method of this thesis has been to construct a review of various Australian reports on ageing and Audit Commission Reports that were written in line with the presumptions of neo-classical, or mainstream economics and then to test the strength of those presumptions by comparison with the perspectives of institutional economics, which, are, incidentally, more congenial to the goods of public health, such as equity and participation. This examination has highlighted a number of points of difference between the mainstream economics approach to the questions of the role of government, the provision of health services and population ageing and an approach that might flow from different perspectives on them. This involves more than a *compare and contrast* canter around the separate encampments of the mainstream economic approach and the institutional approach, in that it goes part of the way to answering the question as to why the various reports relied upon the mainstream approach to the exclusion of others. The Veblenian dichotomy, which has been described in Chapter 3 and Chapter 7, provides a framework for assessing these reports by examining them in their context, as patterns of behaviour, which can, themselves, be assayed by applying an instrumental value principle to them.

That method has prepared the ground for two approaches to a judgment of the relative usefulness for public health of institutional economics, compared with mainstream economics. First, I ask how my earlier, specific discussion of what is revealed and what is hidden about ageing by the contending economic perspectives might play if extended to public health activities, more generally; secondly, I notice a body of writing in social history and political science that is not inconsistent with the policy implications for public health and ageing that I have reached from an economics perspective not constrained by neoclassicism.

The reports as instrumental or ceremonial behaviours

A discussion of the Veblenian dichotomy compels the question of whether the reports on ageing and the Audit Commission exercises are examples of instrumental behaviour, as they would claim, or ceremonial behaviour, or a

combination of the two. Whether the reports (both ageing and audit commission) are ceremonial or instrumental depends upon the behavioural pattern of which they are a part, and the values that correlate the elements of that behavioural pattern. The reports may be both ceremonial and instrumental, and it is necessary to examine their content, context and the values to determine which type of values dominate. That requires a step back from the reports to see them as part of a pattern of behaviours. Each group of reports (ageing and audit commissions) can be viewed as a pattern of behaviour on its own. In addition, within each of the seven Australian jurisdictions (six States and the Commonwealth), the several Audit Commissions were part of a pattern of behaviour that occurred within each jurisdiction. An examination of the broader pattern of behaviour and the values within which each report sits provides another test of the question of whether the reports represent ceremonial or instrumental behaviour.

If the values that correlate those patterns of behaviour with each other are ceremonial values, then the reports may be thought of as an expression of ceremonial behaviour. Alternatively, if the values that correlate those patterns of behaviour with each other are instrumental values, then the reports may be thought of as instrumental behaviour. Ceremonial behaviour is underpinned by standards of judgement for invidious distinction. Standards of that kind prescribe status, differential privileges, and master-servant relationships and justify the exercise of power by one social class over another.[1] The ceremonial values underlying these judgements are justified by appeal to tradition and in the formulation of ideologies that mystify the origin and legitimacy of their existence and put them largely beyond critical scrutiny. They are judged within the community on the basis of their *ceremonial adequacy* and their logic is *sufficient reason*.[2]

Instrumental values correlate behaviour by providing standards of judgment by which knowledge that is sustained by evidence is applied to solve the problems of the community. The logic of the instrumental value system is *efficient cause*.

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[1] Bush. The Theory of Institutional Change. 1079.
[2] Ibid.

Patterns of behaviour correlated by instrumental values are referred to as *instrumentally warranted* patterns of behaviour. What is instrumentally warranted changes because the problem-solving processes of the community are inherently dynamic. It changes with the process of inquiry and technological change, requiring changes in habits of thought and behaviour. As new patterns of behaviour are required to accommodate the absorption and diffusion of new technology, instrumentally warranted patterns of behaviour must change accordingly; requiring, in turn, changes in the instrumental values that correlate such behaviour.[3] Ceremonial and instrumental values affect both how problems are defined in the first place and the direction of efforts to understand problems and resolve them.

Reports on ageing

Three characteristics of the reports on ageing, discussed in this thesis, point to a ceremonial purpose. First, while the reports purport to be about the economics of ageing, they are primarily about its fiscal effects. Second, they attribute virtually the entire problem of the increase in health care spending to population ageing, even although (as material presented by the Productivity Commission confirms) only about one-third of the increase can be attributed to ageing. Third, they focus on the pressure that these increased costs will create for an increase in taxes in the future, not because increased taxes are unaffordable, but because they are presumed to be unacceptable.

There has been a shift in tone of the reports on ageing since the first EPAC report in 1988. That report mentioned at one point the possibility that higher future taxes might be needed to meet the pressure of population ageing. By the time of the Productivity Commission Report in 2005, increasing taxes was deemed to be unacceptable and the emphasis had shifted to encouraging the ageing (and their supporters) to expect less support from the community.

The first EPAC report argued that the higher rates of public spending associated with population ageing were feasible and higher taxes might be accepted by the

[3] Ibid.

public if it were well informed about the issues arising from an ageing population. This suggests a role for government in forming and changing community values and attitudes towards the aged and towards government spending. The second EPAC report refers to the possible need to develop a sense of mutual obligations and entitlements, including a move to greater intergenerational solidarity. This prognostication followed a discussion about the shift in emphasis from institutional to community care for the elderly, but made no reference to how that might happen or who should take responsibility for it.[4]

By 1996, the Audit Commission Report's chapter on demographic change warned that:

> To address emerging social and budgetary pressures, urgent action is needed to moderate community expectations of government assistance, increase incentives for self reliance in old age and more equitably share the cost of age related services funded by government. Unless present expectations are moderated, they will weaken individual perceptions of the need to provide for their own retirement[5],

then proclaimed that

> The Government should take action now to change expectations of reliance on government assistance, by reducing aged and health related outlays.[6]

In 2002 The *Intergenerational Report* argued for the need to promote fairness in distributing public resources between generations of Australians (generational equity), by ensuring that the level of government debt passed onto future generations is *appropriate*. Inappropriate debt is that which 'transfer(s) the cost of paying for the lifestyle of the current generation to future generations'[7].

Only two years later, in 2004, The Productivity Commission argued that tax increases would be counter to Government commitments to not increase the ratio of Australian Government taxation to GDP and to ensure that at least 80 per cent of taxpayers would face no higher tax rate than 30 per cent.[8] The Report gave

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[4] Cox, Dempster and Saunders *Economic effects of an aging population.* 87.
[5] National Commission of Audit *National Commission of Audit: Report to the Commonwealth Government.* 121.
[6] Ibid. 122.
[7] Commonwealth of Australia *Intergenerational Report.* 14.
[8] Productivity Commission *Economic Implications of an Ageing Australia.* 326.

precedence to existing government policy in its deliberations on what future policy, for changed circumstances, should be. The fact that it is *government policy* seems to be taken as sufficient reason to accept it. There is no discussion in the report as to whether this is also an appropriate goal. The same easy acceptance of other aspects of existing programs is not apparent in this report. While the question of expectations about spending on health and welfare services is not addressed directly, it is implied that this matter has already been settled within the community.

There is a danger that, rather than reflect community values about the level of government spending and population ageing, these reports will serve to drive community values. There is an important role for government in informing the community about the long-term effects of policies and in asking the community to consider a range of ways of thinking about the issues it faces. However, these reports present a particular, contestable, restricted view of older people and their contribution to the community. They also may sow the seeds of increased intergenerational conflict by their suggestion that such conflict is a reasonable outcome, rather than focusing, as the earlier EPAC report did, on the aged as part of the community whose needs can be accommodated by a change in thinking by the rest of the community.[9]

Ceremonial behaviour surrounding the Reports on Ageing

The reports on ageing are presented as purely instrumental documents, informed by *objective* statistical evidence of the problems that future ageing will bring. They link the ageing of the population to reduced economic growth (although not to worsened economic circumstances) and express concern for the well-being of future generations of younger workers. By both act and omission they also present an image of the aged as a homogenous, affluent, unproductive, and dependent population, which is a characterisation that de-legitimises the struggle of the aged

[9] And there are indications that the reports are widely reported in the media. For example see: Roffey, M. (1995) *Older people in print media: Myth versus reality*. BHSci Hons Thesis. Department of Community Medicine. University of Adelaide. Adelaide.

for social benefits.[10] The reports thus act to circumvent democratic debate about population ageing and how to respond to it by defining the only legitimate responses as those that are compatible with mainstream economic theory and the goal of maximising GDP. Other values that are considered *non-economic*, such as security, equity, freedom and compassion are largely ignored. Some institutionalists, by comparison, have argued that those four goods must be considered as *economic* goals because they form part of the character of the economy. Specifically, they influence the way that resources are distributed[11] and, therefore, the extent to which society is provisioned.

Gary Banks, Chairman of the Productivity Commission, has argued that we need to do something about ageing before the population ages too much and old people have a larger say in policy.[12] This implies that future older people will resist attempts to change eligibility criteria for pensions and reduce the level of benefits for health care and pharmaceuticals. Two observations can be made about this. First, one reason Australia 'has a problem' with older people not working is that there is not the will in the community to see them continue in the workforce. A change of policy may be possible only while older people are less of a minority. Second, Banks' formulation has – at least – the tendency to circumvent democratic discussion by locking in policies that fit with the concerns of the Commission that he has led. [13] Aside from tending to inhibit older people from influencing the role of government in the future, it assumes that individuals cannot think about the implications of policy for people other than themselves, makes no allowance for the possibility of an intergenerational social contract that takes account of people's needs across the lifespan, and offers no suggestion that individuals in the future will be concerned about the well-being of their children and grandchildren.[14]

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[10] Katz, S. (1992) Alarmist Demography - Power, Knowledge, and the Elderly Population. *Journal of Aging Studies,* 6: 203-225

[11] Klein. Public Sector, Role of the.

[12] Banks *Policy Implications of an ageing Australia: an illustrated guide.*

[13] The Chairman of the Productivity Commission has a five-year, renewable appointment at the pleasure of the Governor General Commonwealth of Australia (1988) *Productivity Commission Act (Commonwealth) (Revised to 2001).*

[14] These solidarity matters are rehearsed at length in Matthews & Russell: Matthews, E and Russell, E (2005) *Rationing Medical Care on the Basis of Age: the moral dimensions.* Abingdon, Oxon: Radcliffe

Further, even if all people only vote self-interestedly, this assumes that individuals will vote for policies that suit the immediate needs and not their future ones. All people who will be aged between 65 and 95 in 2045 are currently voters aged between 25 and 55. While some younger people probably are more focused on immediate concerns, Banks presumes that they will not regard existing arrangements as being in their future best interests. Future old people are not a separate species: they are the currently young and may have an interest in maintaining, not undermining, current arrangements.

The welfare state, which is a primary target of the reports on ageing, is one attempt to redistribute resources to improve *provisioning*. Mainstream economists, and the reports on ageing, argue that there are better ways of doing this. The key debates centre around whether it is more important to redistribute what we do have, to improve the lot of the worst off, or to maximise GDP growth to lift all incomes, including those of the worst off. The mainstream economic approach, reflected in the reports on ageing, assumes that markets are the most appropriate way to decide what goods will be produced, who will use those goods and how income will be distributed. This can entail significant inequality in the distribution of both income and goods. The literature on inequalities in health, which shows health status to be correlated inversely with command over resources, in almost all societies, creates concern about them in health care and public health circles.[15]

One example of the overall pattern of behaviour in relation to the Commonwealth Government and health care is its promotion of privately provided health care through a 30% subsidy on Private Health Insurance (PHI). This represents a subsidy on care for people who can afford private health insurance, irrespective of need or income. The subsidy was introduced on the premise that increasing PHI coverage would reduce pressure on public hospitals, freeing resources for those who cannot afford PHI to increase access and allow for improved quality. It was likely, on its own terms, that if the theory that informed this policy had any effect,

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Publishing Ltd., for the Nuffield Trust., which became available in the late-editing phase of this thesis. See, in particular, at pp.1-19, 53-61, 121-134.

[15] Rice, T. (1997) Can markets give us the health system we want? *Journal of Health Politics, Policy and Law,* 22: 383-426

it would at least result in a shift in productive resources, as patients moved from the public to the private sector.[16] If the subsidy resulted in an overall increase in the demand for hospital care with no commensurate increase in capacity including personnel, it would probably be inflationary. In addition, a shift to care provided under private insurance could cause a decline in the equity of care.[17] The evidence so far indicates that this initiative is unlikely to have a positive impact on health status through better provision of health care. If it does increase the share of health care that is provided in private hospitals, it has the potential to undermine public commitment to publicly funded services.

There is evidence that, while waiting lists in Victoria are probably smaller than they would have been otherwise,[18] the increase in private hospital admissions has been mainly for elective, short-stay treatments for patients with uncomplicated conditions. At the same time, admissions for emergency procedures for patients with significant co-morbidities and complications have increased as a proportion of all admissions, increasing bed load and complexity of cases in the public hospital system.[19] A more general review, by Hindle and McAuley, of the literature on private health insurance in Australia indicates that greater reliance on private health insurance will result in an overall increase in health care costs without a commensurate increase in throughput, that those with the poorest health who cannot afford PHI will be crowded out of health care, and that this is a regressive form of health care financing. [20] These conclusions about Australia are consistent with both the general international evidence and the conclusion in 1997 by Bob Evans, a leading Canadian health economist that '… greater reliance on the

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[16] So, Vaithianathan, R. (2002) Will Subsidising Private Health Insurance Help the Public Health System? *The Economic Record,* 78: 277-283 doi: 10.1111/1475-4932.00057 who acknowledged that the subsidy argued that it will mainly be taken up by people who had previously self-insured for health care

[17] Butler, J. (2002) Policy change and private health insurance: did the cheapest policy do the trick? *Australian Health Review,* 25: 33-4

[18] Hanning, B. (2002) Has the increase in private health insurance uptake affected the Victorian public hospital Surgical waiting list? *Australian Health Review,* 26: 6-10

[19] Sundararajan, V, Brown, K, Toni, H and Hindle, D. (2004) Effects of increased private health insurance on hospital utilisation in Victoria. *Australian Health Review,* 28: 320-329

[20] Hindle, D and McAuley, I. (2004) The effects of increased private health insurance: a review of the evidence. *Australian Health Review,* 28: 119-138 See also Evans. Going for the gold: The redistributive agenda behind market-based health care reform.

market is associated with inferior system performance - inequity, inefficiency, high cost, and public dissatisfaction'[21].

The Hindle review, and the evidence contained in it, was published prior to the final Productivity Commission report, which, nonetheless, focused only on the publicly funded health care costs of ageing, not the total health care costs, and barely acknowledged the effect of activity in the private health care market. While the terms of reference for the Commission required particular attention to fiscal issues, they also require attention to economic effects overall. However, the Commission did not consider private hospital care, which constitutes almost one-third of the hospital sector, and the possible policy directions that are discussed in the Commission's Report relate only to publicly provided and provided care.

The instrumental value principle requires that the efficient cause, rather than sufficient reason, be used as the criterion for judging whether behaviour is justified on instrumental, rather than ceremonial grounds. Given the lack of sound evidence to support the theory that private financing and provision are more efficient than public, recommendations for privatisation and marketisation of health care appear to be based on sufficient reason, rather than efficient cause.

If refocusing the health care system to increase the private share of financing and provision continues, then total health care costs can be expected, on past evidence, to increase without a commensurate improvement in health status. This has potentially important implications for future generations. First, the level of private saving available for inheritence will be reduced. In addition, a high-cost health care system will be created in place of the previous moderate-cost health system in Australia. This, if unchecked, will flow to the future generations in higher direct health care costs, and to higher levels of taxation to finance government spending for more expensive than anticipated publicly funded health care (or, in the absence of higher taxes, to higher debt). Alternatively, continuing growth in costs could be used as justification for reducing the share of health care that is financed and provided publicly, further undermining the integrity of the public system.

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[21] Evans. Going for the gold: The redistributive agenda behind market-based health care reform.

It is not too long a bow to draw to conclude that the efficacy of the market in financing and providing health care constitutes an enabling myth in this case. That 'Markets will do it better' is not just assumed to be the case, but is put forward as the rationale for shifting away from existing arrangements. The presumption that they *will* do so is beyond critical scrutiny.

Another enabling myth that supports the approach and general tenor of the reports on ageing is that 'nobody wants to raise taxes'. In a speech to the Queensland Press Forum the Australian Treasurer, Peter Costello, simply stated that raising taxes to cover the projected fiscal deficit (as reported in the Intergenerational Report) was simply 'not an option'[22] and in an interview with a high-profile Sydney radio announcer Alan Jones, in which Jones made the observation that in relation to ageing we could raise taxes, Costello replied 'Yes, that's not palatable no one wants to do that'[23]. No doubt there are many people who do not want to pay more in taxes, but the story is not a simple one. In an AC Neilson opinion poll taken shortly after the May 2004 Commonwealth Budget, 77 per cent of people thought the tax cuts announced in the budget should have been spent on health and education[24] This is consistent with a longer term trend towards Australians being less concerned about taxation, but more concerned for issues such as health and education and more prepared for taxes to rise to fund services.[25]

Despite the growing commitment in the community to funding social services, the Australian Federal government appears determined to use the current debate about ageing to drive its broader welfare reform agenda (which both supporters and opponents would describe as radical). For example, the government links policies to increase labour force participation and raise productivity with the need to avoid fiscal pressures and maintain living standards in the context of an ageing

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[22] Costello, P (2003a) *Address by the Hon Peter Costello MP, Treasurer to Queensland Press Forum Lunch, Carlton Crest Hotel, King George Square, Brisbane.* 12 September 2003:
[23] Costello, P (2004b) *Transcript. The Hon Peter Costello MP, Treasurer. Interview with Alan Jones, 2GB. Thursday 26 February 2004.* Sydney NSW.
[24] Reported in Gray, G (2004) *The politics of Medicare: Who gets what, when and how.* Sydney: UNSW Press. 12.
[25] Australian Council of Social Services. *Taxation, Fairness and public opinion*. No.

population[26] and runs a similar justification for a raft of labour reform legislation.[27] The Treasurer is particularly pleased that the Productivity Commission Report on Ageing 'endorses the Australian Government's emphasis on increasing participation and productivity to address the economic implications of an ageing Australia'[28].

Costello's first statement perpetuates the myth that Australians will be worse off than we are now if we do not act to arrest the costs of population ageing. On the contrary, all of the reports on ageing indicate that GDP per capita in future decades will be considerably greater than at present, even after paying any increased health and welfare costs associated with ageing. Second, efforts to increase participation have been particularly focused on recipients of the Disability Support Pension (DSP) and the Single Parenting Payment (SPP) but the focus on these groups as a means of decreasing dependency in old age is misplaced because many of those on DSP and SPP have been out of the workforce for a period of time and do not have either the skills or experience to address the current skills shortage. More importantly, because these welfare recipients are members of a very disadvantaged group, their participation in the workforce is unlikely to have much impact on dependency in the future because they will always be so close to the bottom of the heap that lifting their incomes will not substantially affect their ability to save for retirement and their future eligibility for an aged pension. If the goal is to reduce the percentage of people who qualify for the old age pension, the most effective strategy will be to target people who are the closest to not qualifying for the pension, that is, those people whose assets are valued at just below the cut-off for eligibility. Even if the policy brought about

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[26] Costello, P. (2003b) *Statement by the Hon. Peter Costello MP, Governor of the Bank and the Fund for Australia, at the Joint Annual Discussion*. Press Release No. 14 Dubai, United Arab Emirates: World Bank Group and International Monetary Fund. Costello has been Treasurer in the Australian Government since 1996.

[27] to 'reform of unfair dismissal laws (…); simplification of procedures for agreement making; improvements to the remedies and sanctions against unprotected (industrial) action; improvements to bargaining processes, and improvements to the process for union right of entry to the workplace' Costello, P (2004a) *Australia's demographic challenges.* Speech: The Hon. Peter Costello, MP. Treasurer. Downloaded from http://www.treasurer.gov.au/tsr/content/speeches/2004/003.asp on 1 December 2005

[28] Costello, P (2005) *Productivity Commission Report on economics implications of an ageing Australia (Press release).* No 2005/030.

marginal improvement in the employment prospects of those currently on SPP and DSP, they would be poor targets if old age dependency were the real problem. They would be on quite low an income, which means that they would accrue very small amounts of superannuation; their low incomes would render them unlikely to undertake any other savings. If poorly skilled, they would be on the margins of the labour market, in jobs that do not have strong worker protections, are less likely to be unionized and more prepared to accept unsafe (illegal) working conditions because they have no alternative. This means they are also less likely to remain off benefits of some kind.

There has also been a change in tone in the reports on ageing with regard to the attitudes of the community towards population ageing and towards taxation and government spending on health care and income support. Specifically, there has been a shift in emphasis from changing the general population's attitude to accommodate the effects of population ageing, to changing the expectations of individuals about what their community will provide for them in old age. The first EPAC (1988) report argued that the higher rates of public spending associated with population ageing were feasible and that it could be the case that the public might accept higher taxes if the community were well informed about the issues arising from an ageing population, with a role for 'governments and community groups to promote wide community understanding of the long term consequences of present demographic trends'[29]. The second EPAC (1994) report refers to the possible need for the development of a sense of mutual obligations and entitlements, including a move to greater intergenerational solidarity, but it does not discuss where responsibility for this should sit. Further, it rejects the notion of Intergenerational Accounting:

> That individuals receive more from government than they have contributed to taxes in the early part of their life can be entirely justifiable. Government does not and

[29] Cox, Dempster and Saunders *Economic effects of an aging population*. 35. The report's authors did, in fact, envisage a role for government in forming and changing community values and attitudes towards the aged and towards government spending.

> should not work on the basis of each individual having an account with government which determines eligibility for assistance on the basis of prior contributions'[30]

However, the later reports on ageing take as given community resistance to the increased public costs of ageing and shifting expectations away from public solutions. The National Audit Commission Report's chapter on demographic change (1996) opens with the claim that:

> To address emerging social and budgetary pressures, urgent action is needed to moderate community expectations of government assistance, increase incentives for self reliance in old age and more equitably share the cost of age related services funded by government. Unless present expectations are moderated, they will weaken individual perceptions of the need to provide for their own retirement[31]

and recommends that

> The Government should take action now to change expectations of reliance on government assistance, by reducing aged and health related outlays[32]

The Intergenerational Report (2002) argues that action is needed, but does not specify by whom, to respond to the community's expectations of accessing the latest health treatments[33] and the need to promote fairness in distributing public resources between generations of Australians, by ensuring that the level of government debt passed onto future generations is appropriate.[34]

While the Productivity Commission report does not refer specifically to reducing the expectations of the elderly, it makes many references to past, and likely future, increases in expectations about what health care should be available. It also noticed the Liberal-National government's budget commitment to not increase the ratio of Australian Government taxation to GDP, and to ensure that at least 80 per cent of taxpayers will face no higher personal tax rate than 30 per cent.[35] This *independent* report used current government policy on the levels of government taxation and expenditure to specify what policies should apply in a changed future. When it comes to the judgments of what levels of services or income

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[30] Clare and Tulpule *Australia's Ageing Society.* 6.
[31] National Commission of Audit *National Commission of Audit: Report to the Commonwealth Government.* 121.
[32] Ibid. 122.
[33] Commonwealth of Australia *Intergenerational Report.* 1.
[34] Ibid. 14.
[35] Productivity Commission *Economic Implications of an Ageing Australia.* 326.

support it is reasonable to set as a benchmark, current programs are ignored. Current policy on taxation and the level of government spending is endorsed, but there is no such notion in relation to the current and future level of care.

The successive reports on ageing give increasing emphasis to problems of intergenerational conflict associated with population ageing. In particular, there is an underlying message that paying for population ageing will take needed resources away from young people. This immediately sets up the old and the young as distinct groups with only conflicting interests, who have little concern for each other. The underlying message is that the needs of the young should be placed ahead of the needs of the old. In some quarters, but not in the Australian reports on ageing, this message has even extended to link the efforts to meet the health care and income demands of the aged to poverty in children[36]. The aged-based distinction between the young and the old is an invidious distinction.[37]

One effect of the reports on ageing is to suggest to the community what their expectations should be. Even if one believes strongly that there is a role for government in offering the community a range of perspectives to consider when confronted with a potential social problem, the prolonged discussion about generational equity essentially serves to *educate* the current young in a belief that paying for future generations is inherently unfair. It tells the younger generations what their values should be, rather than asking them what they are. It does not ask whether they think it is fair, or debate whether there are conditions under which it could be fair. Rather it starts with the assumption that it is unfair. Apart from the first EPAC report, the focus on changing individuals' expectations away from accommodating ageing through public means essentially closes off the alternatives as other options for policy.

The use of dependency ratios in the reports on ageing reflects another invidious distinction between the aged and the non-aged. The reports on ageing focus on the

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[36] Minkler, M and Robertson, A. (1991) Generational equity and public health policy: A critique of "Age/Race War" thinking. *Journal of Public Health Policy,* 12: 324-343

[37] Jecker, NS. (1990) Appeals to nature in theories of age-group justice. *Perspectives in Biology and Medicine,* 33: 517-527

aged dependency ratio, and do not consider non-age related dependency. They do recognise that some dependency related to old age will be offset for a short period of time by a reduction in the proportion of people aged 0-15. However, other forms of dependency, which are not strictly age-related, but are amenable to policy are not considered. For example, while the effects of unemployment on the Commonwealth government budget are modelled, there is no discussion about the overall dependency effects of the current level of unemployment. In addition, while the reports acknowledge that people aged over 65 may not be dependent, they do not recognise forms of dependency in the 16-64 age group that might be amenable to policy. Falkingham has demonstrated how important these groups are in the overall picture of dependency in the population. [38]

Finally, the Reports on ageing highlight just how different the policy response to a similar situation can be at two different points in time. *Population ageing in the '90s"* could be the title for either of two stories. Population ageing in the 1890s was a story of rapid population ageing at a time of high unemployment. The response, grounded in social liberal thinking, was to introduce aged pensions. These were not universal, in the sense they are now, but citizens of good character who met the income test associated with the aged pension were eligible to receive it. The rationale was that 'the past services performed by citizens, whether in war or peace, entitled them to help from the state during their declining years'. [39] Their introduction was equal for men and women, and women were paid their own pension directly, even if they were married, in recognition of the unpaid social contribution that women made.

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[38] Falkingham. Dependency and Ageing in Britain: A Re-Examination of the Evidence. See also Walker, A. (1982) Dependency and Old Age. *Social Policy and Administration,* 16:2: 114-135; Townsend, P. (1981) The Structured Dependency of the Elderly: Creation of Social Policy in the Twentieth Century. *Advancement of Science,* C:1: 5-28 for earlier discussion in the United Kingdom about the notion of dependency and its relationship to older age. In the United States context, Myles, Achenbaum and Estes have also written extensively on this issue; see, for example Estes, CL, Zones, GJ and Swan, J (1984) *Political Economy, Health, and Aging*. Little, Brown & Co Boston; Myles, J (1984) *Old Age in the Welfare State: the political economy of pensions*. Little, Brown Boston; Achenbaum, WA (1983) *Shades of Gray. Old age, American values and Federal policies since 1920.* Little, Brown Boston..

[39] Sawer. The ethical state: Social liberalism and the critique of contract.

Population ageing in the 1990s was another story of rapid population ageing in a time of high unemployment (and again, falling birth rates) but the response was to treat ageing as part of the *fiscal crisis of the state* that became an ongoing narrative during the stagflation of the 1970s. Prior responses to population ageing, such as the introduction of the aged pension, came to be constructed as part of the problem. Rather than being recognised for their past contributions, old people are now being chastised for not foreseeing their old age and making sufficient preparation for it.[40]

If the demographic events of the late-19th and early-20th centuries were similar, why were the responses different? This question is particularly important in light of the fact that, even after paying for the cost of securing a minimum income and access to health care for the aged, Australians in the 1990s remain better off, measured in real GDP per capita, than they were in the 1890s. The same is likely to be the case between now and the medium-future according to the projections in all of the reports on ageing. The crisis is certainly not an economic one. GDP growth will continue to outstrip population growth, so that real incomes will increase. The growth will not be as high as it would be with no further population ageing but that focus misses the big picture. Government spending as a percentage of GDP will certainly increase if there is no change to policy, but the amount of GDP per capita remaining after accounting for increased health and welfare expenditure still will be considerably higher than is the residual of GDP per capita now. The two key differences seem to be in the perception of the aged and of spending

First, the differing responses appear to reflect a change in the way we think about the aged and about their place in our society or, more accurately, in our economy. The dominant language of neo-classical economics allows the impression that we are no longer interested in recognising what cohorts have contributed in the past, only in what they can contribute in the future. Even then, we value only a future contribution that can be traded in markets to provide cash income, and/or taxed to pay for aged pensions and health care.

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[40] Hicks, N. (1991) Ageing, Well-Being & Research. *Australian Society,* 10: (Supplement); Davison. 'Our youth is spent and our backs are bent': the origins of Australian ageism.

The second differences seem to lie in the perception of this spending. If people perceive that spending is too high they may revolt, but perception is a product of attitudes and beliefs that are socially generated. Talking up a crisis in spending encourages perceptions that spending is too high and increases the likelihood that a revolt will occur. To the extent that the reports on ageing talk up crisis, they will have the effect of lowering support for income distribution to the aged, and for public funding of health services. Both effects place at risk the capacity of people to participate both socially and economically and for their material and social needs to be met. By this measure, provisioning for the aged will be compromised.

Audit Commission Reports

Like the reports on ageing, the audit commission reports are presented as purely instrumental documents. They purport to provide objective statistical evidence of the existing levels of government debt and the need to make significant changes to government activity in order to reduce debt. As conservative (Liberal-National Party coalition) governments were elected in each state and federally, the commissioned successive *independent* inquiries that found 'that state's finances (particularly the debt) were in a far worse state than predicted; harsh cutbacks were then introduced, together with privatisation and contracting out of state assets and services'.[41] What the inquiries did was largely reiterate the policy agenda that the Liberal parties had been working on for some years. This *Commonwealth* policy agenda had already been outlined in detail in the *Fightback*![42] document, published prior to the 1993 Federal election, which the Liberal party subsequently lost. The main thrusts of the Audit Commission Report were also evident in the 1993 platform in South Australia. [43]

Whether these documents represent primarily instrumental or primarily ceremonial behaviour depends, in part, upon whether they are part of a pattern of

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[41] Broomhill, Genoff, Juniper and Spoehr. The debt made us do it! 215.
[42] Liberal Party of Australia (1991) *Fightback! : the Liberal and National Parties' plan to rebuild and reward Australia.* Canberra: The Parties.
[43] Liberal Part of Australia. South Australian Division (1993) *Make a change for the better - the Liberal call to South Australians: freedom to grow - the Liberal vision for South Australia.* Adelaide: Liberal Party of Australia. South Australian Division.

behaviour that is primarily instrumental or primarily ceremonial and on whether they, themselves, contribute to providing for 'the continuity of human life and the non-invidious recreation of community'[44]. As a collection the Audit Commission Reports do form a pattern of behaviour. They were commissioned by Liberal-National Party coalition governments, have similar terms of reference and some overlap in membership and are based on the same assumptions about the role of government and its relationship with the population. Documents that were produced separately from the Audit Commission reports, for example, the *Fightback!* document and the Liberal Party platform for South Australia, as well as longstanding opposition by the Liberal Party to public funding of health care through Medicare[45] form a further element in the pattern of behaviour within which these reports sit comfortably.

Instrumental value theory provides criteria with which to choose among alternative economic futures, to distinguish between what is going on and what ought to go on, to determine where and how to revise problematic institutional structure. The Audit Commission reports do represent an attempt to lay out a problem and explore options for addressing it. However, their similarity to Liberal Party policy on health care suggests that their findings and outcomes were predetermined. While it is possible that these findings and predictions of the reports will result in the continuity of human life and non-invidious recreation of community, this is not their primary aim. As Chapter Five demonstrated, the empirical evidence on the provision of health services and privatisation of government activity indicates that the policy is unlikely to achieve the improvements in responsiveness and efficiency that the economic theory predicts. The reports have used knowledge selectively, emphasising a particular set of

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[44] Tool. Instrumental value theory. 408.

[45] A previous Liberal Government in the mid-1970s dismantled an earlier version of Medicare, *Medibank* and the Party maintained opposition to Medicare from its inception in the mid 1980s until their election to Federal Parliament in 1996 when 'it promised to maintain Medicare while strengthening private insurance' Hall, J and Maynard, A. (2005) Healthcare lessons from Australia: what can Michael Howard learn from John Howard? *British Medical Journal,* 330: 357-359. 357. The Liberal Party's public opposition to proposals for national health insurance schemes and Medicare up until 1996 is chronicled by Gray *The politics of Medicare: Who gets what, when and how*. 26-33.

theories and ignoring empirical evidence, in order to advance their position, but also have distorted it.

Ceremonial behaviour is past-binding and its usual defence is grounded in myths, legends and other uncritically examined beliefs. It reflects invidious judgments that discriminate and denigrate on the basis of observed or attributed differences among people and results, for example, in 'systems of caste and class, in the emergence and power of vested interests, in slavish observance of customary practices and in hierarchical and non-accountable arrangements for policy determination'.[46]

The Audit Commission Reports are based on assumptions and beliefs that are not examined critically, particularly the twin assumptions that markets provide the most efficient health care and that efficiency is what we most want from our health services. The beliefs were taken as read and the theoretical and empirical grounds for questioning the efficacy of markets in delivering the health services communities want was largely ignored. The policy recommendations were a predictable consequence of the *enabling myths* upon which the Audit Commissions relied. A myth is considered enabling 'if it promotes ceremonial at the expense of instrumental social choices'[47].

In addition to the enabling myths of the market as a natural and superior phenomenon, the Audit Commission reports relied significantly upon the enabling myth of government debt. The South Australian report (and those from other States), has been criticized for taking a pessimistic view of state economic figures, reporting that the state's debt was far worse than predicted and recommending harsh cutbacks and privatisation or contacting out of state assets and services.[48] Government debt was declared to be a problem because it affects the state's credit rating, and the interest rate on its loans, but the level of debt that government would need to service from taxes exaggerated, public assets

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[46] Tool. Instrumental value theory. 409.
[47] Peach, JT and Adkisson, RV. (1997) Enabling Myths and Mexico's Economic Crises (1976-1996). *Journal of Economic Issues,* 31: 567-574. 567.
[48] Broomhill, Genoff, Juniper and Spoehr. The debt made us do it!214-215.

undervalued and, in the South Australian case, the estimated benefit of achieving the level of debt reduction recommended by the report was less than $1million per year in interest payments.[49] Both beliefs, about the efficacy of the market and the problem of public debt are unquestioned in the reports, which do not canvass alternative views on either issue.

Like the reports on ageing, the Audit Commission reports act to circumvent democratic debate about the role of government, government debt and how to respond to it by presuming what the policy responses should be. They limit the debate about the role of government and debt to the framework within which the reports operate. The only legitimate responses are those that are compatible with mainstream economic theory and with the goal of minimising public debt and thus maximising GDP, each of which is espoused prior to the inquiry. Other values that are considered *non-economic*, such as solidarity, equity and compassion, are largely ignored. However, they can be regarded as being *economic* goals because they form part of the character of the economy. Specifically, they influence the way that resources are distributed and, therefore, the extent to which society is provisioned.[50]

A democratically informed report would include the opportunity for citizens to make submissions and provide opportunity for comment on a draft report. In South Australia, the report took 8 months to write, but only 3 weeks were allowed for community responses.[51] The Queensland report was produced within four months of the date of the terms of reference and makes no mention to any submissions or period of consultation on a draft report.[52] The Victorian Report took longer to produce (almost seven months), but neither sought submissions nor allowed for a consultation period.[53] The Western Australian Report took a similar

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[49] Independent Audit Commission Response Group (1994) *Charting the way forward ... or backward?: a critique of the Report of the South Australian Commission of Audit.* Adelaide, S. Aust.: The Authors.
[50] Klein. Public Sector, Role of the.
[51] South Australian Commission of Audit *Charting the way forward: improving public sector performance: report of the South Australian Commission of Audit. Volume 1.*
[52] FitzGerald *Report of the Queensland Commission of Audit. Volume 2.*
[53] Victorian Commission of Audit *Report of the Victorian Commission of Audit.*

time to prepare, and sought neither submissions nor comment.[54] The Commonwealth report was commissioned in March and produced in June. It did receive submissions, but did not allow for a consultation period.[55] By removing these processes from participatory processes and imposing hierarchical and non-accountable arrangements for policy determination[56], these reports reflect invidious judgments.

On this account, the Audit Commissions should be seen as primarily ceremonial exercises. They are past-binding in the sense that they seek to roll back the role of the state, they do not engage in instrumental use of knowledge and they work to circumvent democratic participation in decisions about the role of government and the provision of health services.

While the Audit Commissions were indeed political exercises they were also very influential in setting cost cutting and privatisation agendas in all jurisdictions in which they were commissioned.[57] However, they did draw on readily identifiable precepts from neoclassical economics and their approach and the conclusions they drew about the subject matter that they examined are consistent with other work in neo-classical economics on the same subject matter.

The reports on ageing and the audit commission report chapters on health care each have instrumental elements. However, on balance, they represent ceremonial behaviour. First, they rely heavily on theory that is both contested and contradicted by the available evidence. In the case of the audit commissions, the main issues are privatisation and marketisation of health services. While the economists who wrote these reports assume that the market will do better than the current system, the evidence, and even the theory, in health economics indicates

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[54] Western Australia. Independent Commission to Review Public Sector Finances *Agenda for reform: Report of the Independent Commission to Review Public Sector Finances. Volume 1.* ; Western Australia. Independent Commission to Review Public Sector Finances *Agenda for reform: Report of the Independent Commission to Review Public Sector Finances. Volume 2.*

[55] National Commission of Audit *National Commission of Audit: Report to the Commonwealth Government.*

[56] Tool. Instrumental value theory.

[57] Spoehr, J and Broomhill, R (Eds.) (1995) *Altered States: The impact of free market policies on the Australian states,* Centre of Labour Studies and the Social Justice Research Foundation, Adelaide

that this is not necessarily the case. The enabling *myth of the market* creates a precedent upon which the commissions could fall back, irrespective of the empirical evidence. In the case of the reports on ageing, invidious distinctions between the aged and the non-aged are evident and create a largely unexamined rationale for treating the aged differently from the rest.

Instrumental value theory and public health

The value stance of public health literature and workers includes presumptions that health is a human right, that gross inequality in health status is unacceptable, that promotion and protection of health is essential to sustained development and that better quality of life is an important accompaniment of health. The key processes by which health is achieved are held to include economic and social development, individual and collective participation, all sustained by active government responsibility for health in implementing public policies and enabling patterns of life, work and leisure that support good health.[58] Mainstream economic theory does not readily accommodate many of these values and processes into its thinking. For example, the mainstream theory usually casts government activity in a negative light, limiting the role of government to dealing with direct market power in the form of monopoly or controlling mainly negative externalities and providing pure public goods. In institutional economic theory government activity is also warranted in cases of social power. I have argued (Chapter 8) that government activity has been and remains fundamental to collective activity for public health in Australia. Institutional theory allows what mainstream theory precludes by giving government a role in achieving a *higher efficiency* to ensure that 'resources are totally utilized so as to enhance the life process optimally'[59]. This involves the activities of regulation, to ensure that private resource allocation does not conflict with the evolving values of the community; provision of public goods to guarantee minimal societal welfare standards for all; providing infrastructure and directly creating some resources and setting and enforcing

[58] World Health Organization *Primary Health Care (The Declaration of Alma-Ata).* ; World Health Organization *Ottawa Charter for Health Promotion.*
[59] Klein. Public Sector, Role of the. 196.

societal welfare standards since economic indicators of the degree of compassion exhibited by an economy are part of the character of the economy.[60]

That value floor sustains processes that have been integral to achieving improvements in public health in the past. These processes have included increasing income and also changing its distribution, first by the implementation of engineering solutions to public health problems, then by labour laws and the provision of state funded education, and finally, by state-managed redistribution of cash and funding of health and welfare services. As the politically easier gains associated with a rising tide of increased income and engineering solutions to public health problems are achieved, the processes that sustain the value floor are likely to become even more integral in solving problems that either reflect, or require changes in, social and economic organisation.

Tool argues that the social value principle is the product of inquiry and is subject to revision by inquiry and that its standing is as a 'construct for inquiry and as a tool for analysis and judgement'[61]. Therefore it is essential that researchers articulate their choices about 'assumptions, directive hypotheses, evidential sources, inquiry tools and inferences to be drawn'[62]. Researchers must be clear about means-consequences connections because they intend their inquiry to contribute to changing the situation from a lack of knowledge, understanding and ability to explain, to one where 'consequences are observed, unknowns become known and greater congruency between expectations and outcomes is achieved'[63]. The value position of the institutionalist is a choice to 'do or choose that which provides for the continuity of human life and the non-invidious recreation of community through the instrumental use of knowledge'[64]. In the main, human choices determine the paths of the social processes that support the continuation of human life, which is a basic precondition for the pursuit of all other human

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[60] Ibid.
[61] Tool, MR. (1990) Instrumental value theory an eternal verity? A reply to Wendell Gordon. *Journal of Economic Issues,* 24: 1109-1122. 1100.
[62] Tool. Instrumental value theory. 407.
[63] Ibid. 408.
[64] Ibid.

concerns – but those concerns change so the social order of the community is in continuing change. As part of the process of change, invidious considerations generate distinctions of class, race, status, income discretion and participation within and between communities, which feed ceremonially-warranted behaviours that inhibit provisioning for the communal good. As problems of social process are identified and efforts to resolve them proceed, there is a continuing demand for creation of new institutions and adjustment or abandonment of old ones. At that point, clarity about means and ends is a necessity for both the substantive goal (the continuity of human life and the noninvidious recreation of community) and the procedural criterion of approaching that end-in-view through the instrumental use of knowledge.

There has been some debate within the community of Institutional Economists regarding Tool's account of Instrumental Value Theory and Social Value Theory. Two writers, in particular, have been critical of the development of Social Value Theory, Anne Mayhew[65] and Wendall Gordon[66]. They have argued that Tool's use of Social Value Theory promotes an *eternal verity* that runs in direct conflict with the philosophy and approach of instrumental value theory (Gordon) and that it attempts to interpret the universality and centrality of instrumental reasoning as the universality and centrality of a rational strategy of human behaviour that comes to be seen as the important task of social science (Mayhew). In both cases, the charge is that Social Value Theory is an attempt to impose the researcher's values on the inquiry process, which is counter to Instrumental value theory.

Mayhew argues that, by applying 'instrumental use of knowledge' as a criterion, the cultural focus of institutional economics will be lost. Gordon argues that the notion of 'the continuity of human life and the non-invidious re-creation of community' is presumptuous, setting out prior to inquiry the values that should be pursued and thus undermining the open search for understanding of means-consequences relationships that exemplifies instrumental value theory. Tool's response is that any inquiry must be value-laden if it is to be purposeful and that,

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[65] Mayhew, A. (1987b) Culture: Core concept under attack. *Journal of Economic Issues,* 21: 587-603
[66] Gordon, W. (1990) The role of Tool's social value principle. *Journal of Economic Issues,* 24: 879-886

with some rare exceptions, *the continuity of human life* is a chief human purpose, anyway.

At its most basic, public health is concerned with the continuation of human life, as is health care (and post-Hippocratic medicine). Modern public health also has a tradition of being concerned with the unequal distribution of death and disease that goes back to William Farr's work in the General Register Office[67] and that of Edwin Chadwick as chief administrator of the Poor Laws[68] in mid-nineteenth century Britain. However, as mortality rates have fallen, particularly in developed countries, public health has added a rhetoric of *adding health to life*. In the three modes of *patient-centred medicine* [69], public intervention to inhibit inequalities in health and health development, the public health movement has generally been committed to the notion that the movement and the populations in which it is interested are legitimate contributors to the democratic debate about health issues and the role of the state. The institutional capacity of the movement has also reinforced the capacity of populations desiring health to bend the institutions of the State to that end.[70]

Value theory in mainstream economics.

Mainstream economics purports to be value free. Therefore it does not presume to set any kind of value floor that the community might wish to attain. Inquiry in mainstream economics is guided, however, by a model of what the world is said to look like. The statement that individuals meet in markets to make mutually beneficial trades and that this maximises utility is not just an observation of what is, in mainstream economic inquiry, it is a statement of what should be and it guides inquiry. Underpinning it is a commitment to methodological individualism, economic individualism, abstracted individualism and the Pareto

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[67] Whitehead. William Farr's legacy to the study of inequalities in health.
[68] Ringen. Edwin Chadwick, the market ideology, and sanitary reform: On the nature of the 19th-century public health movement.
[69] That is a marginally tendentious rendering of the Hippocratic tradition but does capture his commitment to modest intervention in well-ordered lives.
[70] See Mahmood, MA. (1999) *Local organisational and socio-political characteristics in urban community health system development.* PhD Thesis. Department of Public Health. The University of Adelaide. Adelaide.

principle. These are the values that guide inquiry in mainstream economics and both the values and the direction in which they point inquiry operate on a plane different from that of institutional economics. I have also argued, in Chapter 2, that the mainstream economics perspective presumes a worldview different from the public health worldview articulated in the publications of the World Health Organization. The approach of mainstream economics reduces community to aggregated individuals. Rather than maximising health and minimising inequities in health across the population, mainstream economics constrains its inquiry within any limitations set by existing inequalities in the distribution of income, wealth and health status.

Where the maximisation of health is considered, mainstream economics presumes that it is achieved by individuals making rational, self-interested decisions, rather than by collective action to provide the best possible conditions for good health for the whole community. Mainstream economics straitjackets public health into viewing health problems largely as problems of individuals and a presumption that the market distribution of goods reflects socially desirable (efficient), as well as an individually desirable, distribution of goods.[71] Does instrumental value theory, as outlined by Tool, provide an approach to inquiry that is more compatible with a public health approach? To what extent does the 'continuity of human life and the non-invidious recreation of community through instrumental use of knowledge' reflect a public health view of the world?

For instrumental value theory to be compatible with a public health view, both the substantive and the procedural elements must also be compatible with public health's substantive and procedural elements. First, the substantive element 'the continuity of human life and the noninividious recreation of community' should reflect public health's values of health as a human right; rejection of gross inequality in health status; promotion and protection of health as essential to

[71] In the field of health economics, a tendency to redefine problems of health care to fit mainstream economic theory has also been observed. See Ashmore, Mulkay and Pinch *Health and efficiency: a sociology of health economics.*

sustained development; and better quality of life as an important part of health, as outlined in the Declaration of Alma-Ata[72].

Second, the procedural element, 'the instrumental use of knowledge', should reflect public's health's processes of economic and social development, individual and collective participation and active government responsibility for health[73]. The consequent questions are: To what extent do the two sets of processes correlate? And is this a better correlation than between public health and mainstream economics? Evidence presented here indicates that the audit commission reports and the reports on ageing construe development, participation and responsibility largely in terms of individuals in market transactions. Problem solving is presumed to result from the instrumental use of knowledge, however, I have shown that this will not necessarily be the case if health care is privatised and marketised, and there is little scope for markets to positively influence the broader conditions for good health, other than the size of the GDP. Processes of democratic deliberation have some prospect of resulting in the instrumental use of knowledge to promote economic and social development, rather than simply growth in GDP and to underpin improvements in public health, in the view of the WHO presented here.

Fundament issue of dependency in old age remains unresolved

Unlike the *Intergenerational Report*, which acknowledges that ageing contributes in only a small way to health care costs, the Productivity Commission report dismissed all evidence pointing to this conclusion on the grounds that previous ageing was small compared to future ageing. However, a large chunk of the blow-out in costs associated with *ageing* is attributable to increases in spending on the Pharmaceutical Benefits Scheme (PBS). PBS spending has increased, and will continue to, at a rate greatly disproportionate to the rate of increase in the aged population because it is being driven by a technological-professional-corporate

[72] World Health Organization *Primary Health Care (The Declaration of Alma-Ata)*.
[73] Ibid.

dynamic more powerful than the demographic dynamic of population ageing.[74] The Productivity Commission report factors in lower growth in the PBS than has been experienced recently but compounds expected per-capita increases in PBS spending with population ageing.

The way in which ageing has been constructed as the primary cause of increases in health care costs is an example of ceremonial justification. Given a lack of *efficient cause* to conclude that there is a cause-effect relationship between population ageing and health care expenditure to account for recent and projected increases in health care spending, *ageing* is adopted as a sufficient reason. Even if the presumed dynamics do not produce the feared outcome, real problems of dependency and relative poverty in old age remain to be addressed. Solutions that reduce dependency on the public purse, but not poverty, are morally unacceptable when retaining the level of dependency on the public purse can be achieved without making future generations worse off than present generations. The fact that the growth in GDP per capita is projected to be greater than the growth in costs associated with ageing means that this is achievable.

The institutional alternative

To answer the question as to what extent institutionalism is more satisfactory, from a public health perspective, than mainstream economics, it is necessary to recall the identified shortcomings of the mainstream approach and examine the extent to which institutional economics offers an alternative approach that does not also carry these shortcomings, or introduce any new ones.

The contribution of the mainstream economists can help to answer these questions since the accounting exercises of their reports on ageing tell us what health and welfare expenditure will cost if the population ages as projected and if trends in age-specific per capita spending continue. They also attempt to accommodate changes in workforce participation and health care expenditure. However, they

[74] Moynihan, Heath and Henry. Selling sickness: the pharmaceutical industry and disease mongering. Moynihan reports that much of the increase in PBS spending is driven by the activities of pharmaceutical companies.

are very limited in their scope. First, they approach the task of planning for an ageing population as a technical exercise, rather than a political one. Instead of asking what kind of a society the public want to be in the future when a much larger proportion of us are old, they tell the public what it can or, rather, cannot afford. The information is useful but limited.

Second, mainstream economics' unit of analysis is individuals. Certainly, the analysis of these individuals is in aggregate. A public health approach may also be interested in understanding characteristics of societies, such as social and economic arrangements, and customs and norms within individuals and markets operate. In sociological theory, from which Veblen and other institutional economists have drawn their ideas, society, viewed as above and beyond the aggregation of individuals is a valid object of study.

In Chapter 2 I identified a number of generic issues that are raised by the application of the mainstream economics perspective to public health. These include the use of absolute, rather than relative, well-being whereas both individuals and public health are also interested in relative well-being.[75] Where mainstream economics assumes that consumer tastes are predetermined, public health and some health economists recognise that individual behaviour both influences the community and is influenced by income, addiction, habit and opportunity. [76] The use of market mechanisms for the allocation of resources in health care espoused by mainstream economics is associated with inferior system performance, inequality, inefficiency, high cost and public dissatisfaction[77]. It also results in redistributive changes that yield high prices and incomes for suppliers and distribute overall system cost according to individual use of services, costing wealthier and healthier people less than health care financed from taxation. The techniques of mainstream economics are well-suited to the examination of individually-based behaviour change programs but cannot deal with goods such as the promotion of the community's capacity to deal with health issues that exist

[75] Rice *The Economics of Health Reconsidered.*
[76] Ibid.
[77] Evans. Going for the gold: The redistributive agenda behind market-based health care reform.

beyond the individual.[78] Finally, mainstream economics is premised on values and assumptions that are not always congruent with those of public health as outlined by the World Health Organization. In particular, mainstream economics is not concerned with the unequal distribution of goods, including health, and assumes that capturing aggregated individual data is sufficient, whereas public health is also concerned with the experiences of communities.

In Chapter 4 I identified a number of shortcomings of applying the mainstream economic approach to the phenomenon of population ageing. Those shortcomings include heavy reliance on demographic projections – which historical demographers would say 'run the risk of demographic determinism'; the use of age as the primary explanation of dependency in old age and subsequent failure to look beyond the characteristics, behaviours and circumstances of individuals to examine broader patterns of social organisation that influence or determine the diverse levels of wealth and health in old age.

In Chapter 5 I explored a number of issues related to the application of the mainstream economic perspective to the question of the role of government. The Audit Commissions restrict the role of government to intervening in market failure in the absence of perfect competition. One report did recognise that the community may wish to provide some goods at a minimum level to everyone, even if market provision was efficient.[79]

The main recommendations of the chapters on health care in the audit commissions' reports related to marketisation and privatisation of publicly funded or provided health care services. They were based primarily on theoretical models and were interested chiefly in the achievement of technical efficiency but failed to recognise the flaws in their chosen theory and ignored both alternative theories and empirical evidence that cast doubt on their preferred theoretical foundations. Each of these issues has implications for public health. Those raised in Chapter 2 arise from a direct comparison of mainstream economics with public health. The

[78] Sheill and Hawe. Health promotion, community development and the tyranny of individualism.
[79] New South Wales Commission of Audit *Focus on reform: report on the state's finances.*

others arise from an examination of the practice of mainstream economists within domains that are important to public health. Demographic determinism appears to be concerned with populations but examines the experiences of individuals, based primarily on their age, and aggregates the data to a population estimate. The technique ignores the wide variations of experience that exist within age groups and can tend to minimise the likely differences in experience between cohorts. At its worst, it fails to ask what kinds of differences there have been between cohorts in the past that can already be described and may need to be accounted for in the future. The exercise is predicated on what has been, rather than what could be.

The audit commission reports consider the roles of government and of markets in providing health care but their considerations are limited to individual transactions and how to provide incentives to make these more efficient. This approach discounts the longer chain of causation by which people's work and living environments influence their health. Those environments include physical factors such as air quality and the safety of the road transport system, but also range from less tangible elements such as the levels of inequality in the community, to the amount of control that people have over their daily lives and the quality of their relationships. From a public health perspective, these are important matters over which individuals cannot necessarily be expected to exert control. They are not clear examples of market failure in the absence of perfect competition, but consequences of the health effects of our living arrangements that can be demonstrated to have an impact on the health of groups in the population and of the population overall. By definition, if the market rules, government involvement in reducing the ill-effects of air pollution or road hazards can not presume market levers but must include legislative fiat, administrative oversight or engagement with affected constituencies.

Discussion about policy choices in mainstream economics centre on whether it would be sufficient for governments to apply further embellishments to markets in order for these decisions to reflect a socially efficient outcome and satisfy the concerns of a public health approach, as defined in the thesis. On of the one hand,

neo-classical economics does have some means to deal with market failure. Some of these means are exemplified in the works of the new institutional economists, who argue that 'when markets fail, government has a role in creating a clear and stable environment of property rights, competition policy and the like (or) should create markets when do these do not emerge and design transparent information structures'[80]. However, as this dissertation also argues, there are many potential solutions for public health problems that are simply not 'on the table', because markets have not produced them in the past and economies are to an extent, path dependent. An evolutionary view of the economy, then argues that the government should not simply correct market failures, but 'should play a role that facilitates guides and sometimes directs the process into socially desirable directions'[81]. The reason for this is that market failure is caused by and/or accompanied by bounded rationality and often radical uncertainty. These cannot be dealt with within the market.

One example given by institutional economists is the difference between uncertainty caused by complexity and implicit in Herbert Simon's notion of bounded rationality and fundamental uncertainty which exists because of the possibility of creativity and unpredictable structural change in social reality.[82] 'Complexity' is a problem of information that may be amenable to the development of markets for information and its analysis. Fundamental uncertainty carries a risk, not only for individuals, but for the existing social and economic fabric. In this case, institutional economists argue, the state should 'foster learning, enhance human capabilities, systematically incorporate growing knowledge and adapt to changing circumstances'[83] In relation to the case study of population ageing, in particular, this is an insight that cannot be gleaned from an examination of the problem from a neo-classical perspective, and certainly does not come through as a theme on the reports on ageing. In light of this institutional

[80]Groenewegen, J and Van der Steen, M. (2007) The Evolutionary Policy Maker. *Journal of Economic Issues,* 41: 351-358 352
[81] Ibid. 352.
[82] Dequech. Bounded rationality, institutions and uncertainty.
[83] Groenewegen and Van der Steen. The Evolutionary Policy Maker. Quoting Hodgson, G (1990) *Economics and Utopia.* London: Routledge.

economics does provide additional insights over and above a properly functioning neo-classical economics.

The reports reflect mainstream economics' definition of the central problem as the analysis of the operation of the market and its price mechanisms, to the exclusion of other possible central problems. When markets and prices are seen as the central problem, to the exclusion of all others, only solutions that involve the operation of the market and the price mechanism are explored.[84]

One of the institutional critiques of neo-classical economics is that it treats utility functions as independent and that the behaviour of individuals is unaffected by social rules and norms and responds in a passive way to market forces,[85] however, the critique extends beyond this to the shape of the economy, or the choice sets that are available to individuals, as well as to the effects of instrumental, versus ceremonial influences on the economy.

I do not argue that insights that can be gained from a neo-classical perspective are of no use and should be discarded; instead my critique refers to shortcomings and inadequacies, rather than to fatal flaws. Institutional economists have argued that in some areas of economic analysis the tools of neo-classical economics are inapplicable due to the indivisible, discrete, path-dependent or non-quantifiable nature of the economic phenomena, but that institutional economics and neo-classical economics are complements.[86] However, this position is not universally held, for example, Hodgson[87] argues that neo-classical and heterodox approaches like institutional economics cannot easily be synthesised. First, because neo-classical economics is defined by a set of assumptions and tools, whereas the

[84] Samuels, WJ. (2000) Institutional Economics after One Century. *Journal of Economic Issues,* 34: 305-315
[85] Kaufman, BE. (2007) The institutional economics of John R. Commons: complement and substitute for neoclassical economic theory. *Socioecon Rev,* 5: 3-45
[86] Ibid.
[87] Hodgson, GM. (1992) The Reconstruction of Economics - Is There Still a Place for Neoclassical Theory. *Journal of Economic Issues,* 26: 749-767

heterodox approach defines economics in terms of the study of the economy. Second, because neo-classical theory is not just inadequate, but flawed.

My argument is that the nature of neo-classical analysis is such that it is inapplicable to many questions from a public health perspective, for the very same reason that the public health perspective may be interested in these phenomena, particularly when they are indivisible or non-quantifiable. In these cases, neo-classical economics may tell us much about how an individual will behave in a given situation, but not a lot about the societal influences on patterns of behaviour across the population, ie why many individuals in one time and place act differently to the many individuals in another time and place given exactly the same 'situation'. In particular it tells us little about why the preferences that those individuals carry vary in systematic ways across social classes and groups. Left to neo-classical economics, the solutions to changing patterns of behaviour across the population rest largely with manipulating price or some other 'within situation' variable. The institutional approach suggests that it is important to understand the differences in time and place and that these may also be variables that can be useful for understanding behaviours and for developing policies to change them, if that is desirable. For example Kaufman[88] quotes Commons;

> The law of supply and demand is inevitable . . . and, like death or the law of gravity, cannot be avoided. Yet the job of institutional economics is to 'analyze the forces and personifications [i.e., institutions and human beings] behind supply and demand.

One solution to the recognition of external influences on preferences might be to re-specify the utility function to recognise interdependence in preferences. This would only address one of several critiques of neo-classical economics by institutional economists and accepts the legitimacy of all of the external influences. It also risks treating shared influences as characteristics of individuals, rather than as sociologically relevant factors (as often do treatments of sex, ethnicity, income, indigenous status etc).

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[88] Kaufman. The institutional economics of John R. Commons: complement and substitute for neoclassical economic theory. 11

The legislative, administrative and constituency options are all available within the alternative approach to inquiry offered by institutional economics. Institutional economists, touting their holism and evolutionism, argue that mainstream economists have failed to understand the substantive and epistemological limitations of their work, and exclude ways of doing economics that lie outside the self-ordained mainstream framework. The broader orientation of institutional economics should, in theory, allow for the central problem(s) to be defined more broadly than does the mainstream approach, opening the possibility that central problems with economic consequences can be defined in terms other than markets and the price mechanism, in ways that can accommodate a public health perspective.

The role of the state prescribed by the economics of the audit commissions is limited to provision of national defence, protection of property rights, and intervention where there is 'clear evidence of market failure' [89]. The National Commission of Audit did recognise a social case when the community demands specific social objectives that warrant government action, citing some law and order activities, social welfare assistance to individuals in genuine need, and some education and health services as examples.[90] Working from the market model, which The Commission assumed to be valid unless proven otherwise, the burden of proof lies with those who want to argue for alternatives to the market. Because the market is an abstracted model, that assumes away a range of important social factors, including social power and culture, it is understood to be appropriate to all circumstances. The legitimate arenas for government intervention to reduce the effects of market failure are restricted to circumstances in which the internal workings of the market, for example, information about the good or service or power to influence price because of size, might be affected. This approach excludes circumstances where the whole position of the market and the good or service being produced and traded is affected by social, rather than market,

[89] National Commission of Audit *National Commission of Audit: Report to the Commonwealth Government.* 10.
[90] Ibid.

power, or where cultural values influence market behaviour such that outcomes do not reflect an improvement for the community.

In addition to being concerned about externalities, monopoly and information problems as defined within the mainstream economic framework, institutional economics also seeks to understand how social power and culture influence the development of economies and the operation of markets. This leads to an additional set of possible questions about both ageing and the role of government in provision of health care services and in protecting and improving the health of the public. Some of these questions are outlined in the institutional critique of the Reports on Ageing and the Audit Commission Reports contained in Chapters 8, 9 and 10 of this thesis.

In relation to ageing, mainstream economics has focused on the financial incentives that individuals face and how these might be changed to encourage private savings for retirement and delayed retirement. When the issue of people's expectations is raised, it is mainly to question their realism and point to the need for them to change expectations. Any clear policy suggestions, though, are framed in terms of financial incentives: if the price of retiring is low, people will retire in high numbers; if the price of retiring is high, individuals will defer retirement. The key, according to the reports on ageing, is to tweak the costs of retirement in order to achieve a fiscally sustainable level of retirement – and no other dynamics of retirement are examined.

A similar single-mindedness exists in relation to health care. Most discussion in the Audit Commission and Ageing Reports of behaviour related to health care costs focuses on the demand for health care. According to the Audit Commission Reports, imposition of *market disciplines* through privatisation of the provision of health care, if not its financing, is the way to minimise costs on the supply side of health care. However, this addresses only the technical efficiency of provision, and might achieve a one-off reduction in costs (if the theory is correct). There is little discussion how behaviours of the suppliers of health care can drive health care spending, except to note that technology is a driver of health care costs. The concept of *supplier induced demand* (SID) that is at issue here is widely debated in

health economics. The SID concept tends to be focused on the interaction between an individual provider, usually a medical general practitioner or specialist, and a patient. The problem arises because the provider knows more about the patient's condition and the options for care than the patient does. The end result is that the practitioner encourages the patient to have treatment that, if she had full information, she would not accept. This focuses on the effect of individual supplier behaviour within individual courses of care or transactions and raises the question about whether that supplier behaviour is open to market discipline.

The mainstream approach to SID confines analysis to 'within market transaction' phenomena and ignores effects outside of the immediate transaction that can influence how that transaction proceeds. Institutional economists have a somewhat different concern, related particularly to how the tastes and preferences that mainstream economists take as given are formed and change. Their approach shifts attention away from provider behaviour within individual transactions towards provider behaviour in the wider arena, and they ask how it affects tastes and preferences in relation to specific conditions and treatment, and even expectations about what health services can achieve (Fashions in diagnoses, enthusiasm for particular technologies, presumptions about how people value a good {longevity versus novelty} all suggest themselves as meriting inspection). Institutional economics allows for such influences on tastes and preferences, other than provider behaviour, to be studied. The broader culture and changes in the social and political landscape all affect people's tastes and preferences, and interact with and influence their values. As has been demonstrated in relation to pharmaceutical drugs[91], providers carefully craft expectations about what ills should be fixed by the health system, and what remedies are available long before patients enter medical consulting rooms.

The difference of emphasis around SID is part of a more substantial difference of theory and method. The detailed account of institutionalism, in earlier chapters, indicated the attention that the institutional economics perspective gives to

[91] Moynihan and Cassels *Selling Sickness: How Drug Companies Are Turning Us All Into Patients.*

contextual dynamics, ranging from forms of professional organisation to beliefs about the causes of illness and the potency of remedies.[92] Those upstream activities, influences and beliefs can encourage individuals to hope or believe that all manner of ills should be addressed by medical care. However, the thrust of contemporary rationalist discussion is that, while all options should be available, older people should not presume access to them, since access is a function of ability to pay, whereas access on the basis of need in relation to age is a category of social welfare, not of the market. The scope of the reports on ageing is *fiscal* rather than *economic* when it comes to health care. Thus, changing individuals' attitudes to health care is restricted to changing their attitudes to publicly funded health care, not health care paid for privately. Changing individuals' expectations is about changing expectations about who will pay for their health care, rather than changing expectations about health care generally.

The institutional alternative, as applied to the main directions of the reports on ageing and the audit commission Reports, looks beyond the behaviours of individuals to ask what drivers, apart from the self-interest of patients, affect the ways in which a society uses resources for the improvement of the health of the public. The perspective and the questions provoke a deeper look at the tastes and preferences of individuals and additional questions about the powers that form them. Deliberations about means for achieving a consensus on issues such as the desirable shape of the health care system, reasonable expectations for retirement and what individuals will expect from their own interactions with the health care system can be aided if they are informed by an understanding of peoples' values and expectations about these matters.

The shift of perspective and additional questions provoked by institutional economics open the debate about population ageing and the provision of health

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[92] For a short introduction to the former see the corpus of Eliot Friedson, especially Friedson, E (1986) *Professional Powers. A study of the institutionalization of formal knowledge.* Chicago: University of Chicago Press. and Friedson, E (1975) *Doctoring Together. A Study of Professional Social Control.* New York: Elsevier. For the latter, see Tesh *Hidden Arguments: Political Ideology and Disease.* for the long history Aronowitz, RA (1998) *Making Sense of Illness: science, society and disease.* Cambridge UK and New York NY: Cambridge University Press. for more recent examples.

care to matters that require an understanding of the broad range of experiences of health, health care and retirement. *That* shift makes the debate explicitly political. Instrumental value theory calls for participatory democracy as a key process for economic decision-making, which mirrors the Alma-Ata declaration that 'The people have the right and duty to participate individually and collectively in the planning and implementation of their health care'[93].

Public health significance

The aim of the thesis (as stated on p5) is to test the extent to which institutional economics provides approaches to problems in public health and avenues for inquiry that reflect a worldview similar to that of public health. This is relevant to public health, because there are a number of levels, established in chapter 2 of the thesis, at which a public health perspective, as defined by the thesis, and that of neo-classical economics, are at odds with each other.

Thus, this thesis is primarily concerned with two broad issues. The first is a challenge that exists for public health: Mainstream economics makes presumptions about the world that differ from those presumptions that underlie public health, however, questions of economics are also important in public health. The second issue is the extent to which the application of institutional economic theory to problems of pubic health significance provides an entrée into questions that are of both economic and public health significance, in a way that can accommodate the presumptions of public health.

The implications for public health arise from the recognition of a fault line which provoked this study. Mainstream economics had an increasing influence on public policy generally and health policy in particular, in the last quarter of the twentieth century. Contrary to much of its rhetoric, neither the policy nor the mainstream economics was value-free. Much of the rhetoric of public health policy, by comparison emphasised values: policy reflects the outcome of negotiation, compromise and the relative power of various groups that have an interest in each public health issue. The causal theories that each group of public health actors

[93] World Health Organization *Primary Health Care (The Declaration of Alma-Ata)*. 1.

promotes and the policy outcomes that each argues for reflects an amalgam of individual values and concerns.[94]

The introduction and growing influence of mainstream economic ideas in public health policy-making involved an implicit introduction of values (notwithstanding the rhetoric of value-free rationalism). The set of public health values has been negotiated through the work of the World Health Organization and reviewed from time to time.[95] Proponents of public health might feel justified in asserting that the implicit values in the mainstream economics critique should be subjected to a similar critique. Moreover, if an understanding of economic behaviour *would* enhance our understanding of issues of public health relevance, then economic inquiry *should* be undertaken within a framework that is value-compatible with a public health perspective. If this is not the case, there is a risk that the public health perspective will be lost in the push for *economic* analysis.

There are two other sources of public health significance in this thesis. They arise from the specific case studies that have been undertaken. The first case study (in Chapters 4, 5 and 8) considers population ageing as an example of an important public health issue, for three reasons. Population ageing is a form of demographic change in which the age structure of the population becomes more skewed to older ages. The mean and median ages of the population increase and there is a greater concentration of population in older age groups. The fact that many threats to health are age-related means that population ageing changes the profile of health and disease in the population. In addition, population ageing threatens the social fabric. Old ways of doing some things will become unsustainable in a more elderly population, new ways of achieving individual and community goals will need to be found, but there is the comfort that the change can be expected to be fairly slow and sustained. There is a danger that the 'problem of population *ageing*' will become the 'problem of *the aged*' and that responsibility for the costs of population ageing will be pushed onto individual older people, making the

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[94] Tesh *Hidden Arguments: Political Ideology and Disease.*
[95] For example World Health Organization *Primary Health Care (The Declaration of Alma-Ata).* ; World Health Organization (1981) *Global strategy for health for all by the year 2000.* Geneva: World Health Organization; World Health Organization *Ottawa Charter for Health Promotion.*

problem a private, rather than a public one. Therein lays a third problem: population ageing happens to the whole population and has implications for young and old; therefore a collective, rather than an individual, response is required.

A second case study (Chapters 4, 5, 6 and 9) examines the provision of health care. The provision of health care is one strategy that may be engaged in to achieve better health in the community. The reports on ageing and the audit commissions diagnose the problems of the health care system as being too much public involvement and the solution as privatisation and marketisation. In doing so, it takes health care out of the realm of public health that is Last's 'organised efforts of society' to the private realm. This in itself is not problematic, if it is based on sound evidence. However, this is not the case, as the reports neither present their own evidence that this is the case, nor recognise that which suggests that it will not be so. Two ideas from institutional economics make the case for society to organise for the provision of health care. Galbraith's notion of *countervailing power* and Tools' social value theory both recognise potential limitations of relying on individual efforts in providing and using health care, and outline activities for which organised efforts must play a role.

The third case study, in Chapters 5, 6 and 10, examines the role of government. Public health is a collective enterprise. In ideal circumstances it operates on a primary care model that entails public health activity as close as possible to where people live and work. In Australia, much public health activity is mediated by Commonwealth, State and Local governments, often with thin lines of contact to primary care. The association of economic rationalism with *statism* means that the ideas that prevail about the role of the public sector and their impact on public sector activity in public health have important implications for public health but limited constituency amongst the public. Not only are the lines of contact to

primary care thin but the commitment of Treasury funds or Public Service effort to an extra-individualist conception of health will be thought questionable. [96]

This thesis began by identifying the increasing application of mainstream economic ideas to questions of public health significance, then demonstrated that the value bases and the perspectives of public health, as defined by Last and the WHO, differ in important ways from the economic ideas. The key points of difference are the focus of public health on population, whereas mainstream economics focuses on individuals and their aggregation; concern about distribution as matter of justice and as a practical matter in public health, whereas mainstream economics views distributive justice as largely a normative matter about which economic theory is essentially indifferent; and the fact that public health allows for a myriad of ways of achieving good health, whereas mainstream economics endorses the use of unfettered markets and market-like activities as the primary mechanism for distributing all goods - provided that is close to the conditions of a perfectly competitive market, by comparison with which other methods are considered to be inherently inefficient.[97] These differences share the common feature that mainstream economics focuses on the ability of individuals to make decisions about what is in their best interests and to carry them out. The mainstream theory does not consider seriously whether such decisions result in any greater aggregate good, since the market's *invisible hand* ensures the greater good by underpinning economic growth.

There are two problems with these features of mainstream theory, from a public health perspective. The first is that public health history is littered with examples of external effects of markets that have a negative impact on the health of the public. Some of these arise from consumption decisions (externalities of use), others from production decisions (externalities of production). The second is that

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[96] For background, see Pusey *Economic rationalism in Canberra: a nation-building state changes its mind.* Pusey reports a detailed survey of the backgrounds and political, economic and administrative attitudes of 215 members of the Senior Executive Service (SES) in Canberra in the late-1980s and discusses, in its second half, the displacement of interest in civic society, by a reified Economy.
[97] The allowable exceptions are public goods, monopolies and goods that exhibit significant externalities.

public health is not something that markets automatically deliver, according to the theory, because that would mean choosing and delivering goods that protect and promote good health, rather than not delivering negative externalities.

Mainstream economics offers three solutions to these two problems.

i. Subsidise or tax, in the case of externalities

ii. Public provision, in the case of public goods

iii. Regulation of industries in which externalities, monopoly or public good are evident.

This is a very limited arsenal and it does not recognise community and integration, warranted knowledge and participatory democracy as public goods that have economic significance. These are elements of community that, according to institutional theory, underpin an instrumentally functioning economy. In particular, they work to ensure that the collective value floor of the community is reflected in the economy. One element that is part of the value floor is the level and distribution of health across the population. The overall level of health and the degree of inequality, especially inequitable differences, is a matter for community consensus.

Conclusion

An examination of the reports on ageing and the audit commission report chapters on health care, though the lens of the Veblenian dichotomy, indicates that the reports are primarily ceremonial behaviours. In the case of the audit commission reports, where the main recommendations centre on privatisation and marketisation of health care, the enabling myth of the market creates a precedent upon which the reports rely. The market theory that underpins these recommendations ignores both theory from health economics that questions the effectiveness of markets in providing efficient outcomes in health care and the empirical evidence of privatisations. It largely ignores values other than those that can be accounted for in a cost-benefit analysis. The reports on ageing rely on an invidious distinction between the old and the non-old to justify the possibility that the old can be treated differently from the non-old. This possibility is suggested in

terms of access to health care and access to income support. In both cases, the reports are part of a pattern of behaviour that is based on largely ceremonial values.

Appendix One: Terms of Reference for State Audit Commissions

Queensland

1. Review and report on the current and prospective state of Queensland's public finances, taking account of the service delivery performance of Queensland's public agencies and government owned corporations, and the adequacy of the State's public infrastructure;

2. Report on and recommend strategic priorities, policies and measure to enable existing and emerging service delivery requirements and infrastructure needs to be met, and services to be enhanced to best-practice standards while safeguarding Queensland's financial position, low tax status and AAA credit rating; Making appropriate comparisons with other State and/or Australia as a whole.

South Australia

1. Investigate the finances of the state.

2.1. Investigate the assets of the state (…) report on the value of those assets, their state of repair and the extent to which such assets are mortgaged or encumbered.

2.2 Ascertain the cost of rectifying deferred maintenance and identifying the major priorities for such maintenance within each department and authority.

3. Report on the adequacy of financial information presented by the state government with particular reference to the accuracy and usefulness of such information and the desirable level of disclosure.

4. Examine the standard of financial management, performance measurement, reporting and accountability and make such recommendations for changes as may be desirable.

5. Compare the financial performance and financial position of South Australia's public sector with that of other states.

6. Generally review the operational efficiency of all areas of government.

7. Make such recommendations on these and other matters related to the financial health of the South Australian public sector as the Commission deems appropriate.

Western Australia

Without limiting the scope of the Commission's review, it shall investigate and report of the following:

1. Budget sector transactions and outcomes for 1991-92 projects for 1992-93 and trends in recent years with regard to the Consolidated Revenue Fund, and General Loan and Capital Works Fund and relevant accounts in the Trust Fund.

2. The outcome in each year if the State Budget had been constructed according to accepted national accounting principles with a single Consolidated Fund.

3. The Government's cash position and the trend over recent years, including the application of interest earned on short term investments.

4. Review the several assessments of State debt, advise the most appropriate measure of debt, the position at June 30, 1992 and the estimate for June 30, 1993 for: 4.1 The Budget Sector 4.2 Public Sector Trading Enterprises 4.3 The Public Sector as a whole.

5. Borrowing and debt redemption policies and practices for general government and government agencies with recommendations for greater scrutiny and control by parliament.

6. Interest commitments identifying accrued, unpaid or deferred interest.

7. Contingent and other liabilities of a non-debt nature which could impact on the State's finances including superannuation commitments.

8. The assets and liabilities of the State public sector and the measures required to enable the publication of a comprehensive balance sheet.

9. Recommend changes to the presentation of the State Budget and accounts required to better inform Parliament and the public as to the ongoing financial position of the State Government including the true budgetary position, changes in accrued liabilities and public sector debt.

10. Provide forward estimates to 1997-98 of budget sector revenue and expenditure and the budget outcome based on the 1992-93 budget estimates drawing attention to any significant contingencies which could impact on the budget.

11. Review the operations of the Treasurer's Advance Accounts.

12. Conduct an examination of the finances and operations of major departments, government agencies, statutory trading authorities and others as may be referred to the Commission.

13. Recommendations on the future departmental structure of government.

14. Recommendations to government on future ownership of assets for reduction of debt.

15. The Western Australian Commission may issue one or more interim reports and the Premier may extend the terms of reference and request advice from the Commission at any time.

Victoria

The Commission shall review and report upon Victorian state public finances generally and make recommendations on the future management of the State's finances with particular reference to significant financial performance indicators, The review and report should cover the Budget sector and Victorian public agencies outside the Budget sector (with particular reference to the major statutory authorities and major asset-owning agencies).

The Commission shall review and report on the following:

1. Preparation of a broad and comprehensive statement of the assets and liabilities of the Victorian public sector as at 30 June 1992 with comment upon the previously published balance sheet.

2. A statement of the full extent of the debt and liabilities including unfunded liabilities, contingent liabilities and other future obligations of the Victorian public sector.

3. That State's public sector budgetary and financial trends for each of the three years ended June 1992 in relation to:

(a) the revenue and expenditure of both the Budget and non-Budget sectors;

(b) the Budget deficit and the total public sector deficit;

(c) public debt and other liabilities (use may be made of the concept of "State indebtedness" applied by the Victorian Auditor-General);

(d) interest commitment, identifying accrued and unpaid interest and interest deferred to future years

(e) the extent to which published figures accurately reflect the true underlying position.

4. Forward projections of the expenditure, revenues and the financial position (assuming unchanged policies from the Budget published on 12 August 1992) for

(a) the Victorian budget

(b) the Victorian public sector.

5. Any significant changes or movements which seem likely to occur (assuming unchanged policies from the budget published on 12 August 1992) in Victoria's public sector and other liabilities including unfunded liabilities, future commitments and contingent liabilities.

6. A review in broad terms of the financial position of other Australian States (with special reference to New South Wales and Queensland, where appropriate,

contrasting Victoria's position with those of other States, and/or Australia as a whole.

7. Recommendations in relation to major strategic priorities in the future management of Victorian public finances and the Victorian public sector generally, including the most effective service-delivery to the Victorian community.

8. Recommendations as to a course of action to reduce Victorian public indebtedness, to improve the management of borrowings, debt, risk and financial flows and to secure restoration of Victoria's AAA credit rating.

9. Recommendations to improve the efficiency, financial and other performance and accountability of Victoria's major statutory corporations and other major asset-owning entities and/or the industries in which they operate. The Commission may identify opportunities for contracting out, corporatisation, privatisation and other actions to secure the public benefit.

10. Any other matter which the Commission considers relevant to the management of Victorian public sector finances.

The Commission may issue one or more interim reports and the Premier may request advice from the Commission at any time.

New South Wales

1. Preparation of State Macro Financial study

1.1 Prepare a macro view of NSW financial accounts combining inner and outer budget sectors in terms of revenues, recurrent and capital expenditure, so as to determine the true deficit of the total NSW public sector. Such data should be prepared to 1986-87, with historical data over the last five years. The data should highlight the impact of debt charges, revenue sources (including state taxes) and employment.

1.2 Advise on the overall cost impact facing Government funded programmes arising from demographic and other economic trends.

1.3 Determine the full extent of NSW public sector actual and contingent liabilities, including but not limited to, unprovided for superannuation and other employment benefits, and foreign exchange exposures. Examine this against estimates in NSW budget papers.

1.4 Using the above data and other sources of information prepare a Balance Sheet for the State as at 30 June 1987.

1.5 The NSW accounts as reconstructed should be reconciled with the Australian Statistician's estimates of the NSW position in the publication "Government Financial Estimates Australia 1986-87 and similarly reconciled with statistics in Grants Commission reports.

1.6 Review progress for the establishment of a proposed set of financial performance targets for NSW public sector trading enterprises. Examine differing methods of financial performance targeting by the Victorian and New Zealand Governments. Prepare recommendation on action to be followed in NSW tighter with recommendations on public authority dividend policy as a commitment to improving financial performance targets.

1.7 To advise on total assets of State Departments and the major authorities and the liabilities to be faced in providing for their replacement and maintenance, including major overhauls and renovation.

1.8 To advise on the impact of, and procedures involved in, applying full accrual accounting to all public sector bodies.

1.9 To advise on the State's revenue sources and their likely long term prospects.

2. Specific review of Public Sector Bodies.

To report on:

2.1 the financial structure of selected Authorities to determine the total liabilities, assets, revenues and expenditures if commercial principles were fully applied;

2.2 the property holdings of Government Departments and Authorities, their valuation, purpose and management;

2.3 the use of, and stewardship of, any public funds paid to community bodies directly or through the Community Welfare Fund;

2.4 any other matter relevant to State finances and management.

Tasmania

The commission will examine the financial position of the State Government of Tasmania with a view to advising Government on the management of its finances in the future with a medium term goal of improving the State's credit rating.

The review will be a macro view of both the Inner-Budget sector and Statutory Authorities (mainly comprising commercial and semi-commercial agencies such as HEC, TT-Line, Metro etc).

It will report on the following:

1. Growth and changes in the composition of revenues and expenditures.

2. The management of assets and liabilities and the proportion of debt held between the Inner-Budget Sector and Statutory Authorities.

The State's capital works program

4. The Government's actual and contingent liabilities including superannuation, other employment benefits, guarantees and financial leases and foreign currency exposures.

5. Assess financial management, performance management, reporting and accountability and advise any proposed changes.

6. Examine the report on the extent to which full or partial privatisation of State-owned enterprises can be employed to improve the State's overall long-term financial position.

7. Any other matters relevant to the management of the State's finances.

Appendix Two: Summary of recommendations for the State Audit Commissions

	NSW	WA	Vic	SA	QLD
Regionalisation / Area health authorities / Regional health authorities		✓*	✓	✓	✓*
Public hospital service transfers through cost-shifting of non-emergency outpatient services		✓	✓	✓	
Outsource non-core and commercial services		✓	✓	✓	
Benchmark hospital / health service performance		✓	✓	✓	
Purchaser-provider split		✓	✓	✓	
Privatise assets of hospitals		✓		✓	
Review head office costs and administrative framework as part of implementation of regionalisation		✓		✓	
Analyse costs of teaching and research at tertiary hospitals to enhance accountability and clarify PPS		✓		✓	
Establish an independent health service planning (Qld) or advisory (SA) body				✓	✓
Binding service agreements (output/results based in SA)				✓	✓
Fund privates to provide for public patients/outsource/joint or network arrangements				✓	✓
Eliminate restrictive work practices			✓	✓	
Hospital and/or health services rationalisation			✓	✓	
Reduce nursing shift overlap		✓	✓		
Privatise/outsource management of hospitals /health services		✓			
Deregulation of public hospital fees control for compensable agencies and private insurers			✓		
Casemix funding					✓
Benchmark efficiency improvement targets			✓		
Review/rationalise hospital floor space utilisation			✓		
Strengthen ward utilisation			✓		
Review development/planned bed number increases		✓			
Implement 38 hour week where it is in the award		✓			
Promote increased private health insurance by prioritising on financial status		✓			
Close or downgrade country hospitals as previously recommended		✓			
Reorganise structure of tertiary hospitals along functional lines		✓			

User pays policies for appliances and aids		✓			
Recover monies for DVA patients from Commonwealth		✓			
Transfer state nursing home beds to private or not-for-profit operators		✓			
Relinquish overlapping nursing home licensing and inspectoral provisions to the Commonwealth		✓			
Assess non acute programs to identify non-essential expenditure and administrative inefficiencies		✓			
Enterprise bargaining with administrators especially medical administrators and AMA to increase productivity		✓			
Benchmark work practices for domestic and support services that are not to be privatised		✓			
Reduce cost of long-term care patients through placement contracts with nursing homes/hostels		✓			
Resolve future of RGH Daw Park				✓	
Introduce quality management approach to hospital services				✓	
Redistribute resources from institutional facilities to community care				✓	

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