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Health and Social Policy

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Problems in health care planning and delivery are part of the political economy of all modern industrial nations regardless of the financing mechanisms used, regardless of the degree of regulation attempted, regardless of the "health of the nation", regardless of consumer involvement and regardless of ideology. The allocactive system is under great pressure from rising demand for health care and rising costs. Together with rising demands, and cost, inequality of access to health care exists ; there is a maldistribution of health care personnel ; there is limited co-ordination and little incentive for co-ordination between health and social services ; and consumer activity in health care is not strong. Health of course, is something that affects all members of our society and substantial public, private and personal resources are expended in the health system.

Social Policy

Social policy is about interventionist activities which attempt to alter life chances. It is the operational resolution of value questions which relate to a theory of benefits and their distribution. In our society benefits are continually distributed, regulated and redistributed. The benefits consist both of services and cash allocations. Issues of why anything ought to be allocated, what it is which ought to be allocated, to whom should allocations be made, how it might happen, and how it might be financed

involve us in a host of value and strategic questions. We are dealing with the politics, the economics, the philosophy and the management of distribution as well as the specialist aspects of health care.

Let me illustrate with the obvious dilemmas in health care. When asking "why allocate ?" The choices include : to provide basic minima in health care facilities ; to compensate individuals or communities for environmental or societally induced malfunctions ; to treat injuries, disabilites and illnesses ; to rehabilitate those who have suffered in the past ; to protect society by public health services ; to invest for the future by way of preventive programs ; to redistribute facilities according to need or pressure. When asking "what is to be allocated ?" the choices include : nothing at all ; cash to individuals so that they might buy the expensive services they need, but which are beyond their means ; or perhaps to allocate the services themselves, on either a universal or means tested basis.

"To whom should allocations be made ?" involves the specification of targets. Is the focus to be individuals or communities ? Should allocation be made on the basis of need, or should they be made for all ? If on the basis of need, should it be financial need, need arising from medical conditions, or need arising from geographical or spatial location ? How are priorities to be determined among the young and the old, among those with chronic

conditions, and those likely to experience acute and episodic illness ? There are many political as well as medical issues which shape choices.

How the allocation is to be made focuses on strategies of implementation. Different delivery systems use different mixes of resources, personnel, equipment, education. It is important to note that the health field is no longer the monopoly of the medical professions and that a variety of community supports are part of any implementation strategy.

How to finance health care depends on decisions about who bears what costs. To what degree ought financing to be statutory or non-statutory — and within these two modes are numerous issues about free market activities, private insurance, broad scale contributions, public finance, tax deductions, tax rebates which are all part of the current debate.

I know the Chairman would never permit me time to try to answer all these questions. But it is important to note that rapidly changing political and economic conditions make answering the questions no easy matter. To start the ball rolling on the answers let me provide a bit of data of relevance.

Australia's Health

In the most recent Australian Health Survey conducted by the Australian Bureau of Statistics it was found that 65.3% of the population reported an illness in the two

weeks prior to interview. (The survey was carried out over a period of twelve months to diminish the effects of seasonality). The illnesses ranged from ailments such as colds, headaches and stomach upsets to more serious illnesses such as respiratory and circulatory diseases. 6.6% of persons aged two or more spent at least one day in bed due to sickness or injury in the two weeks before the survey and on average these people had 2.7 days off work. 17.6% of the population reported consulting a doctor in the previous two weeks.

45.1% of the total population reported suffering from some type of chronic condition and 9.9% of the population were limited in some way by their chronic illness. 54.6% of adults and 36.9% of children reported taking medications in the two days prior to the interview.

While 45% of the population experiences chronic illness it is of interest to note that for every 1000 persons there are 803 reported chronic conditions. They vary with age.

Number of Chronic Conditions Per 1000 population

Age	All Chronic Conditions
Under 15	318.8
15-44	657.0
45-64	1347.7
Over 65	1791.3
Total	
Males	742.0
Females	865.2
Persons	803.4

When broken down by condition, age, sex,and location, the data provide opportunities for detailed analysis and policy response. In social policy analysis there are two key variables upon which we must always focus, class and gender. Our health data in Australia tell us very little about class differences, but they do tell us about gender differences.

Most of the customers in both our social welfare and health systems are women. For every 1000 women there are 865 chronic conditions — for men the rate is 742. Women experience significantly more diseases of the circulatory system ; of the genito-urinary system ; of the musculoskeletal system and connective tissue, while men experience significantly more ~~mental disorders~~, diseases of the digestive system, and accidents, poisonings and violence. Leaving chronic conditions and turning to all conditions, 68% of females reported a recent illness while only 62.7% of males did. That is about 400,000 more females than males. 39% of females had recently consulted a doctor while for males it was only 30%.

The health services industry offers significant employment opportunities. In 1978 there were almost a quater of a million persons working in health services (223,635 to be precise). 64.5% (144,400) were nurses and 11.5% (25.810) were doctors. These were by far the largest two groups, while the remaining 53,000 employees were spread among thirty different occupation groups.

Health expenditure is around 8% of Gross Domestic Product. In 1978 60% of the $7.25 billion spent on health was borne by government and 40% came from private sources. Proportions fluctuate. This government, in constrast to its predecessor, tries to move more of the cost to the private sector. Federal/state politics also shifts the distribution of expenditure between levels of government.

Choices and Costs

Health care, which affects so many people in so many ways is an area which requires tremendous amounts of knowledge, skill and administration to make it all happen. It is also big business and big politics. When I talked about social policy a little earlier I mentioned all the whys and wherefores of allocation and used the term "choice" a lot. Social policy is basically about choices between conflicting political objectives and goals, about how they are formulated, implemented and evaluated ; choices between adequacy, equity and equality ; choices about basic standards ; choices between public and private allocations ; choices about who is going to be included and excluded ; choices about who is going to win and who is going to lose.

Over the last decade Commonwealth government expenditures on health have risen at an average annual rate of increase of 20.4%. Other government and private expenditures have

risen commensurately. It is no wonder that much of the contemporary literature is on cost effectiveness and cost control. Any social policy analyst dealing with health costs will be able to identify three sorts of costs — costs to individuals, costs to governments, costs to society. The difficult part involves measuring these costs, for the cash component is only part of the cost. Planning any policy in the human services involves a trade off between economic efficiency and broad social welfare coverage.

The data on chronic illness listed earlier indicate that a significant part of our health care system is, and must be devoted, not to curing illness, but to caring for people and providing ongoing support and reassurance. This is expensive, quite unglamorous, and not economically efficient. Many people are not able to bear the cash or emotional costs of illness. The development of structures to deal with personal costs is crucial. It is in this field that one would expect close integration of our health and welfare systems.

Better medical and surgical techniques are able to cure conditions which once were deemed incurable. These same techniques now keep alive large numbers of children who once died at an early age because of congenital disease or injury, but who now survive for long lifetimes of severe disability. Young people injured in sporting or motor accidents, elderly people who are recovering from

strokes or who have chronic conditions, people of all ages suffering from alcoholism, drug abuse and mental illness all require extended care for what may be basically incurable but improvable conditions.

Community support services such as sickness benefits, invalid pensions, compensation payments, rehabilitation services, job retraining, possible housing relocation, home help services, family counselling, day centres, to name a few, will be critical to the re-establishment of adequate social functioning. Dependency creates costs not only for the individual and for government, but also for the families of those who are ill or disabled. One crucial set of social policy decisions must determine which costs are to be borne by the individual (and/or his/her family) and which are to be borne collectively by the society as a whole.

Our social security system tries to respond to illness and disability. There is a strong link between poverty and illness. Establishing cause and effect is not easy. Overseas studies suggest that poor people suffer more illness and have shorter life expectancy than wealthier people. A recent British study showed how the relative fall in living standards which accompanies unemployment also contributes to many health problems. A strong correlation was found between increases in the unemployment rate and increases in indicators of ill-health.

There is Australian data which show the link between illness and poverty. If one loses one's earning capacity through illness, economic prospects are very bleak.

Illness among families with children is a strong predictor of poverty. In its 1973 survey, the Commission of Inquiry into Poverty found that 35.2% of families with children in which the head reported ongoing illness or disability fell below the austerely drawn poverty line. Households headed by people experiencing illness or disability had a heavy debt pattern and negligible liquid assets as a buffer against financial crisis. 53% of sickness beneficiaries and 40% of invalid pensioners had savings of less than $50. 75% of sickness beneficiaries and 59% of invalid pensioners had (non-housing) debts in excess of $50 while 44% and 30% respectively had non-housing) debts in excess of $500 (these are 1973 dollars — for today's values add 114%). Both cash and non-cash costs of illness weigh heavily on a large cross section of the community.

Government bears a wide range of costs for health care for all. In addition, special costs are borne for those with long-term illness or disability. The Commonwealth Government estimates that it will pay out $215 million on sickness benefits in 1981/2 and $990 million on invalid pensions. At June 30 1980 there were 39,361 people in receipt of sickness benefits. At June 30 1971

there were 10,632 recipients. There has been a rise of 270% through the decade. Despite the incidence of illness reported earlier, over three quarters of recipients are male. At June 30 1980 there were 229,219 persons in receipt of invalid pension, a rise of 71% since 1971. While the numbers of women receiving invalid pensions has been relatively stable over the decade (an exception is for women ahed 30-39 where there has been an increase of 74%) the number of men aged 60-64 in receipt of invalid pension has increased by 110% ; for those aged 50-59 by 170% ; for those aged 40-49 by 105% and for those 30-39 by 131%.

This is not the place to discuss the reasons or ramifications of these data. Very briefly I have tried to show that substantial costs are borne by individuals and by government. The community as a whole bears costs as well. With regard to one chronic condition, arthritis, a specialist in the field was reported (S.M.H. 14/9/81) as stating that the social and economic implications of arthritis, as well as having a disruptive effect on the harmony of family units, cost the community about $200 million per year in loss of productivity (about $50 million per head more than wage losses through industrial disputes). When we consider that arthritis and related conditions accounted for 16.8% of chronicity we can start to grapple with the magnitude of the problem of costs to the community.

In developing policy options we are faced with two sets of issues. Those relating to cure and those relating to care. Both areas are highly contentious. In the field of care we must remember that it is the family, and not the formal system which provides most of the home health services for incapacitated or housebound relatives. There are emerging doubts about the capacity of the family to provide appropriate care. Current official emphasis seems to be on reprivatization and on shifting the main task of caring onto families. This has implications for resource allocation.

The arguments about public versus private are the central arguments in social policy. Political and economic debates are intense on both the caring and curing fronts and are far from resolved. The Commission of Inquiry into Poverty stated that "private medicine, with its fee-for-service and curative philosophy remains dominant in Australia but is not well suited for dealing with the complex health/welfare problems which so often affect poor people". We have seen sections of the medical profession dispute this judgement. We have seen cost-escalations and cutbacks and an almost incomprehensible series of changes in health insurance. We have seen continual conflict about rights, shares and claims. With all of this, would you believe I once saw a bumper sticker which said "Health and Politics don't mix" ?

Social policy is about interventionist activities which attempt to alter life chances. Social and economic conditions in Australia suggest that a significant and growing number of people will be excluded from many of the outputs of our wealthy society. The future structure of our allocations will be determined by the action component of claims for inclusion, and the capacity and willingness of our institutions, including our health and welfare systems, to respond to these claims. The final outcomes in health care will be determined not technically, but politically.