

Globalism, social insecurity and health outcomes in Australia

James Goodman

Abstract

As the dominant ideology of the most recent wave of globalization, *globalism* promotes 'market-friendly' policy as a global panacea. Resulting social inequalities, both within and between countries, generate deeper health divides. Focusing on boom-time Australia from the mid-1990s to the mid-2000s, this chapter identifies a range of policy initiatives and structural shifts linked to globalist pressures. Policy measures include:

- Incentivising 'health consumers' to take-out private insurance;
- Creating internal quasi-markets in public healthcare;
- Reducing universal access with increased means-testing and user-pays;
- Imposing health conditionalities on Indigenous welfare recipients.

Shifts in socio-economic structure, and related health outcomes include:

- A 20% increase in real income with a marginal fall in income inequality;
- A significant increase in income insecurity, heavily stratified by social class;
- A substantial rise in health inequality between rich and poor neighbourhoods;
- Continuing inequality between Indigenous and non-Indigenous health.

As both diagnosis and prescription, globalism correlates its policy approach with the related structural shifts: health ceases to be a social priority, and becomes a market opportunity. In Australia, globalism has realigned policy, including health and welfare policy, further stratified income insecurity, and thereby widened health inequality.

Introduction

The ideology of market globalisation began to influence Australian politics in the mid-1980s. At that time a Labor administration re-orientated economic policy in a drive for global competitiveness, culminating in the 1986 proclamation of Treasurer Paul Keating that Australia would go the way of a 'banana republic' if it failed to undergo more extensive structural reform.

Through to the mid-1990s, with Keating as Prime Minister, reforms to enhance economic flexibility were introduced hand-in-hand with an improved social wage and safety net. From 1996, with the election of a more clearly neo-liberal Coalition Government, the marketisation process intensified and was extended across the board into social provisions, such as health services and welfare benefits.

The consequences, as outlined in this chapter, involve significantly heightened health inequalities, rising faster than income inequalities. These experiences offer teasing suggestions about the logic of neo-liberalism, as a process that generates new forms of non-income stratification – such as the stratification of income insecurity – that may have an important bearing on health outcomes.

The chapter traces links between globalism and health outcomes along two dimensions – one ideological, the other structural. *Globalism* re-stratifies society through a transnationalisation of material power. At the same time, as an ideology, it reshapes institutional practices and policy-making. Accordingly, the paper is organized into two main sections, the first discussing policy frameworks acting on health outcomes in Australia, the second addressing the re-stratification of social and health inequalities. Before exploring these local contexts it is important to address broader relations between socio-economic change, globalisation and health outcomes.

Rise in health inequalities

Under globalism, health inequalities tend to increase with rising national income levels. The apparent paradox is most easily explained in terms of the current growth model, which centres on the marketisation of social relations. The neo-liberal commodification drive privatises care and social reproduction, and thus greatly increases health risks (Coburn 2000). The process also entails growing social disaggregation, social intolerance and public authoritarianism, especially in relation to those who are not clear beneficiaries of globalism.

In this context non-income social inequality becomes a key determinant of health outcomes. In a survey of Organisation for Economic Co-operation and Development (OECD)¹ member countries' experiences, one observer found that 'what really affects national health outcomes is not the way national health care systems are organised, but rather social variables such as the level of socio-economic inequality' (Castillo 2004: 423, 426). Non-income inequalities appear to be central: a study that correlated inequality and health outcomes across 115 countries for the second half of the Twentieth Century, found that 'inequalities other than income inequality may impact health independently or as mediating factors' (Beckfield, 2004: 247).

Such non-income inequalities relate to qualitative factors of deprivation or exclusion, which may range from gender or ethnic division, to welfare exclusions, labour market contexts and environmental changes (Beckfield 2004). Well-being and health directly relate to these questions of relative deprivation and social exclusion: as Coburn argues, 'income inequality is itself the consequence of fundamental changes in class structure which

¹ The Organisation for Economic Co-operation and Development (OECD) is an international organisation composed of 30 high-income countries.

have produced not only income inequality but also numerous other health-relevant social inequalities' (Coburn 2004:43).

Stratification and child mortality rates

With globalism, health risks reflect global stratification. Moore et al, for instance, map world-systemic hierarchies along a scale from core to periphery against infant mortality rates, and find a remarkable degree of correlation. Australia and Canada are positioned in a group of 20 core countries, with relatively low trade dependency, high GDP and high political influence, and with an infant mortality rate below 10 per 1 000 births. The remaining countries all have a child mortality rate in excess of 15 per 1 000 births, rising to 68 per 1 000 for the most peripheral grouping. The authors conclude the capacity to deliver good health outcomes is constrained by global hierarchies of autonomy and dependence. Relatively peripheral countries are, the authors conclude, 'at a higher level of vulnerability to the negative effects of globalisation' (Moore et al 2006: 176).

If we turn from structural dynamics to neo-liberal ideology and health policy, we see a parallel process of internationalisation. National health policy is increasingly inseparable from global health policy debates between, for instance, World Health Organisation efforts at charting global health as a public good, and pressures for market 'harmonisation' through the regulation of intellectual property under free trade agreements (Kickbusch 2000).

Increased privatisation of pharmaceuticals

The changing regulatory model is perhaps most clearly demonstrated in the relationship between states and pharmaceutical corporations. Here, public monopsonies²

² A monopsony is when a single buyer effectively controls the purchase of goods or services from a number of providers. Monopsonies can be public (as in the drug

established to approve and purchase drugs for public health services have been progressively regeared to private corporate interests as against public health interests. Standardisation of approvals, through an international conference on regulatory harmonisation established in 1991, loosen requirements to report adverse drug reactions to the authorities, and make it easier to gain patent protection and approval for new drugs (Abraham 2004).

Overall, globalism clearly has an impact on health. The effects are multifaceted. One recent account undertaken for the Netherlands Environmental Assessment Agency argues that "globalisation affects the economic, ecological, social-cultural and institutional determinants of population health". A key factor is the privatisation and commercialisation of health services. As the authors note: "Health is increasingly perceived as a private good leaving the law of the market to determine whose health is profitable for investment and whose health is not." (Huynen et al, 2006: 45). The resulting privatisation of care is directly gendered, with unpaid women's labour in the domestic sphere directly replacing paid labour in the public sector (Spiegel and Andruske 2005). In this respect, healthcare reform in the era of globalism exacerbates what has been characterised worldwide as a feminisation of poverty (Doyal 2005).

Health and welfare policy in Australia

Australia's publicly-funded health care system, Medicare, was established in 1984. From its inception it was embedded in the growth of neo-liberalism in Australia. Essentially it was the product of 'the Accord', a social compromise between the labour movement and the Labor Government where wage growth was dampened in exchange for a rising social wage.

formulary example) or private (as in the role of Wal-Mart and its competing large retailers in setting the terms of purchase from multiple manufacturers located in low- and middle-income countries).

Medicare was established in parallel with private healthcare, and in many respects it has underpinned the private system (Bloom 2000). The Medicare system funds public hospitals, pays a proportion of fees for GPs through the Medical Benefits Scheme (MBS), and subsidises medicines through the Pharmaceutical Benefits Scheme (PBS). Access to hospitals is free, while access to medical general practitioners (GPs) and medicines is means-tested.

The system is mainly funded through a Commonwealth (Federal) Medicare levy: taxpayers above a certain income threshold pay 1.5% of their taxable income. Reflecting the success and popularity of Medicare, private health insurance has declined, from 50% to about 30% of the population. Take-up of private insurance has failed to increase despite a range of tax incentives for patients and extensive subsidies for the insurance industry (subsidies which, remarkably enough, amount to about a quarter of the cost of the MBS).

While promoting heightened privatisation of Medicare, the Coalition Government consistently claimed that it had no desire to dismantle the system as a whole, and that its primary concern was, as its policy claimed in 2003, to 'safeguard Medicare'. The Coalition Government's underlying position was made clear by the Secretary to the Department of Health and Aging, who strongly advocated "further deregulation of the industry and

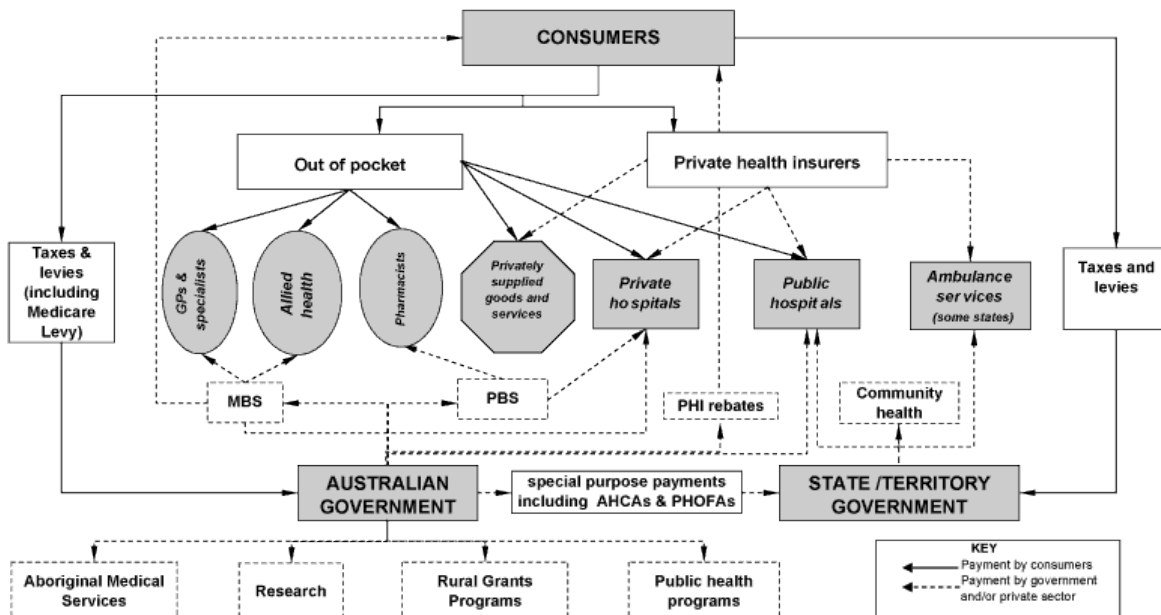
promotion of the principles of competition across the health sector as a whole" (Podger and Hagan 1999: 21).

Creating the 'health consumer'

In outlining how it understood the role of government in healthcare, the Department focused almost exclusively on the need to correct 'market failure'. Its agenda for health reform centred on delimiting government commitments, to create 'consumer democracy in health care', to get 'value for money' and to promote cost-effective quality improvements (Podger and Hagan 1999). Neither the patient, nor indeed the citizen, featured in the model: the 'consumer' was paramount (Eastwood 2002).

In 2006 the orthodoxy was outlined in the Department's *Health and Ageing Factbook* that sketched a diagram, reproduced below, of the Australian health system 'at a glance', placing the health consumer at the apex of the system (see Department of Health and Aged Care (DHA) 2006). The diagram highlights the absence of patients or citizens in this marketised schema. The focus of the entire model is "on the consumer who pays taxes, levies, out-of-pocket and other funds to government and non-government entities and receives health related goods and services in return." (DHA, 2006)

Figure 1: Health system at a glance (flow of funding)



Source: Department of Health and Aged Care, 2006.

Focus on outputs

Within this framework the policy mix encompasses managerialism, contractualisation, privatisation and the introduction of user fees, a focus on outputs rather than process, the reduction in public sector employment and an emphasis on market efficiency (Hancock 1999; Muetzelfeldt 1999). The main impact is that the Australia health care system has become much more clearly stratified, with the withdrawal of public services and their replacement by private paid and unpaid careers. The burden falls for the most part on women, both in terms of childcare and care of the sick and the elderly, with the rhetoric of community and family care signaling increased reliance on women's unpaid informal labour (Hancock 1999: 272).

Reflecting this, since 1996 the Medicare system has undergone some important changes that delimit its effectiveness. Two aspects are discussed here: primary care through the Medical Benefits Scheme (MBS) and access to medicines through the Pharmaceutical Benefits

Scheme (PBS). In terms of primary care, dentistry and eye-care has never been fully covered by Medicare, and from 1996 was more fully privatised with the removal of free visits for benefit recipients. GPs have been encouraged to charge patients for visits: from 1996 government payments for GP visits fell behind rising costs, and GPs were encouraged to charge patients their own top-up 'co-payment'.

As a result the proportion of free GP visits fell from 80% to 65% between 1996 and 2003 (Hopkins and Speed 2005). The decline in free GP visits attracted considerable negative publicity. In response, in 2004 the government increased the rebate for benefit recipients, while further strengthening incentives for others to be charged a 'co-payment'. This had the effect of increasing the proportion of free GP visits from 65% in 2003 to 75% in 2006 (DHA 2006), but at the same time has further entrenched the shift to a two-tiered health system (Hopkins and Speed 2005; Willis 2002).

Further limiting of public subsidies

There has also been a significant impact on the PBS. In the first instance there is pressure to constrain costs by limiting the range of drugs eligible for a PBS subsidy. There is also a consistent rise in both the general and the concessional prescription charge. Erosion of the safety net in part reflects the growing leverage of the pharmaceutical industry. The Australian PBS has operated since the 1950s as a public monopsony designed to minimize the cost of buying drugs for the public health system, and in the 1990s was securing medicines for the public health system at up to a third of the cost of equivalent medicines in the US (Lofgren 2004).

Not surprisingly the scheme has come under intense pressure from industry groups seeking to strengthen their market power, extending to legal challenges by companies against decisions made under the scheme (Willis 2002). As a result, successive governments in Australia have offered a range of incentives to persuade pharmaceuticals to remain operating in the country. The Pharmaceutical Industry Action Agenda and the Pharmaceutical Partnership Program, for instance, were geared to attracting drug research and development funds to Australia (Lofgren 2004).

Subsequently, in 2004 the PBS itself came under direct attack through Australia's free trade agreement (AUSFTA) which explicitly committed the Australian Government to raising the prices it paid for drugs in Australia (Australia Institute 2003). The issue of how the FTA affected the PBS became a key political issue as the Agreement came under review in the Federal Parliament. The main opposition party insisted on amendments to the FTA to provide greater protection for the PBS, and this was accepted (along with an amendment preserving the effectiveness of laws against media concentration) (Harvey 2004).

The reformed AUSFTA still created a

confrontation between a highly subsidised public healthcare system and strong patent-protected pharmaceutical companies. In a wide-ranging analysis of the politics of the FTA, Ranald demonstrates the importance of public support for the PBS, as played out in Federal Parliament and in the FTA negotiations (Ranald 2006).

But, as Ranald notes, the outcomes were mixed. The PBS 'reference' pricing system, which compares the price of new drugs with cheaper generic versions, was defended and maintained. But the FTA also created a right of review for companies seeking to overturn decisions not to list their medicines. While failing to enunciate principles of access and affordability, the Agreement created a joint 'Medicines Working Group' solely orientated to promoting commercial intellectual property rights. At the same time the Agreement made it harder to gain approvals for generic drug suppliers (Ranald 2006).

The eventual impact on the PBS still remains uncertain, but as a recent study argued, the implications are profound: "the potential exists for the AUSFTA to reshape the character of Australia's regulatory system concerning medicines – from a public good to a private rights-oriented system" (Fauce et al, 2006).

Increased means-testing

At the centre of this process of privatisation and burden-shifting is the neo-liberal ideology that healthcare is in the first instance a responsibility of individuals. There is acknowledgement that some are unable to provide for themselves, and limited provision is made for this grouping, but as a rule, responsibility rests with the individual. Free access to the system has become increasingly means-tested, foregrounding the process of deciding who is deserving of assistance. Free healthcare, with the exception of hospital care, is increasingly not available to those who cannot access state benefits, thus creating a

direct link between the benefits system and healthcare.

Access to benefits, and thus access to free healthcare, is increasingly restricted. Since the early 1990s a growing range of conditionalities have been imposed on people seeking access to benefits. First introduced under the Labor administration with the rhetoric of 'active citizenship' and 'mutual obligation', the conditionalities have been extended for 'job-seeker' benefits, for youth allowance, for disability benefits and most recently for single-parent benefits. The new dispensation is presented as a reciprocal arrangement, where the rhetoric of shared responsibility justifies the imposition of conditions on access to the basic means of subsistence.

Welfare conditionalities

The model is authoritarian and intrusive in imposing a range of compliance and surveillance measures. Most importantly, recipients are placed in a position of permanent income insecurity, an insecurity that leaves those deemed non-compliant to depend on charity. Not surprisingly, charities can be amongst the most vocal in condemning the policies: as the Australian chief executive of the St Vincent de Paul Society argued:

“The individual who stands accused of having failed to make it in the market is subjected not only to new heights of intrusive surveillance but also to a veritable theology of damnation” (Falzon, 2006: 1).

The health effects are both direct and indirect, and certainly none more so than for Indigenous communities. Conditionalities have been a recurrent feature of public service provision and welfare for Indigenous communities: one example is the Community Development Employment Program, effectively a 'work for the dole' program that was introduced for Indigenous 'job-seekers' several years before it

was developed for their non-Indigenous counterparts.

Indigenous welfare

From 2005, Indigenous communities were offered funding for health-related public services on condition they complied with current government policy priorities. These conditionalities, framed as 'Shared Responsibility Agreements', related to the care of children, where funding for public recreational facilities had been made conditional upon community sanitation. More recently, funding for basic services such as education and housing has been made dependent on long-term leasing of Indigenous landholdings to non-Indigenous land managers.

This 'blackmail' of Indigenous communities, as one Federal politician has called it, has become the model for Indigenous governance in Australia (Snowdon 2006). As Patrick Dodson, former Social Justice Commissioner put it:

“The welfare and patrol officers were replaced by another form of social manager that doled out largesse in quantum of appeasement determined by government whim...Today the bureaucrats charged with our management are known as contract managers and their task is to 'manage' the contracts of mutual obligation and regional partnership that are the latest manifestations of the unequal relationship between our peoples” (Dodson 2006: 3).

Discriminatory 'income management'

In 2007 obligations for Indigenous communities were directly imposed through the 'Northern Territory Intervention', which saw the Federal Government literally take control of Indigenous communities in the name of improving child health and welfare. Justified by revelations of child abuse in Indigenous communities, the

Intervention saw the unilateral suspension of local governance structures and Indigenous property rights to enable teams of health and welfare inspectors, backed by police and military, to assess children.

At the same time all Indigenous benefit recipients were forced onto a unique form of 'compulsory income management', a food stamp system proscribing expenditure on non-essential items. As the Intervention was imposed solely on the 45,000 Indigenous peoples living in the Northern Territory, it required suspension of the 1975 Racial Discrimination Act (see Altman and Hinkson 2007).

The Intervention was highly controversial but was supported by the Opposition and was kept in place with the change of Federal Government in late 2007. Following an independent review in late 2008 (heavily edited by the Government prior to publication), there have been some reforms to the scheme, although it remains in place for the duration (NTER Review Board 2008).

Welfare-health linkages

Overall, neo-liberalism has had an insidious effect on the health system and on related benefits systems in Australia. Rather than launching an all-out assault on Medicare, and indeed on the benefits system, there has been a process of erosion from within. Rather than being forced into the private sector, patients and practitioners are encouraged to see themselves as private players. In Australian parlance this may be termed a process of 'white-anting', with reforms deliberately designed to replace notions of rights and universality with notions of consumer choice and safety-net provision.

Meanwhile, those caught in the welfare 'net' face an increasing range of conditionalities, intensifying income insecurity. For Indigenous peoples in particular the conditionalities have

become a directly discriminatory tool of health policy.

Social and health inequalities in Australia

Between 1995 and 2007 the Australian economy was booming. The average growth in net disposable income between 1994 and 2004 was about 3% a year, raising average real income by about 20%. The increase was relatively evenly spread across the board, with working poor families compensated through increased family benefits (Wilson, Maegher and Breusch 2005). In 2008 the OECD found that falling income inequality between 2000 and 2005 had reversed the rise in the last half of the 1990s: by 2002 Australian income inequality had fallen below the OECD average (OECD 2008). One might expect that a one-fifth rise in income, spread relatively evenly, would have extensive health benefits. Yet in terms of self-reported health, from 1995 to 2005 there was only a small decline in those describing themselves as in fair or poor health (from 17.2 to 16.7% in 2005), and a small increase in those feeling in good or excellent health (from 54.7 to 56.4%) (ABS 2006b).

In terms of unhealthy practices in Australia there is little scope for complacency: in 2006, as many people smoked as in 1995 (at 23.3%), there has been a dramatic two-thirds increase in those consuming alcohol at risky levels (to 13.4%), along with a significant increase in obesity and overweight (from 40.6 to 49%) and an on-going rise in those experiencing psychological distress (ABS 2006b). To investigate this apparent paradox between income and health outcomes, there is discussion first of social inequalities and second of health inequalities.

Obscured within the Australian aggregate figures on prosperity is a more disturbing picture of deprivation and exclusion (Saunders, 2003). The OECD finds that the income poverty rate – the proportion of people living on less than half of median income – rose

between 1995 and 2005, and remained above the OECD average (OECD 2008). The income poverty rate in Australia is still about half that of the UK, but overall reported deprivation is about double the British rate: 16% reported difficulty in paying for utilities in Australia, for instance, as against 6.8% in the UK (Saunders and Adelman, 2005).

‘Working poor’ face risks

Social exclusion and deprivation in Australia is not concentrated in the poorest segment of the population but is reported at equivalent rates for at least the poorest 30% of the population. Thus roughly one-third of the population may be understood as Australia’s working poor – not on poverty-level incomes but facing poverty risks. In terms of household type, those who face greatest risk of poverty live in non-aged lone person households, lone parent households, or are couples with three or more children.

We may speculate that deprivation in Australia is more linked to income insecurity than to the experience of poverty. Work and welfare regimes in Australia contribute to this insecurity, with work increasingly casualised and welfare increasingly difficult to access. Casualisation rates have increased exponentially in Australia – from 16% of employment in 1985 to 27% of the workforce in 2000 – higher than that in any other OECD country (ABS 2008).

At the same time, rights at work are also constrained by an increasingly heavy-handed industrial relations system, somewhat ameliorated with the transfer to the Labor Government in 2007. Public services are increasingly provided as a safety-net for low income groups, with middle classes encouraged to buy private education, health, transport and social services, underpinned by subsidies and tax incentives.

Some of the impacts are highlighted in surveys that appear to suggest a high level of

unhappiness and dissatisfaction. One report has investigated the paradox that Australia almost tops the globe in terms of the United Nation’s Human Development Index (HDI), but in terms of happiness sits in the middle (Blanchflower and Oswald 2005).

Levels of happiness and job satisfaction

The International Social Survey Programme places Australia at about 12th out of 35 countries in terms of general happiness, satisfaction with family life, and job stress and job-related fatigue. In terms of job satisfaction, Australians are significantly less satisfied than Western European or North American counterparts, perhaps highlighting the issue of workplace insecurity (Blanchflower and Oswald 2005). These results are to some extent affirmed by the World Values Survey, which shows several countries at higher levels of both happiness and satisfaction than Australia, despite having significantly lower levels of GDP and HDI. Out of 78 countries surveyed in the 1980s, Australia is in 12th position in terms of happiness and 19th in terms of satisfaction (Canada is 10th and 12th respectively) (Leigh and Wolfers 2006).

The debate about Australian happiness reflects a broader discussion about how to characterise ‘progress’ in the country, in part stimulated in 2002 by the first annual ABS ‘Measuring Australia’s Progress’ report (ABS 2002). Skepticism at the standard measures of progress has centred not simply on measures of social but also environmental well-being. The Report, ‘How Australia Compares’, for instance, was deliberately designed to question the country’s HDI rating, and to extend comparison beyond the HDI focus on income, education and health to include measures of gender equity, use of technology, and environmental impacts (Tiffen and Gittins 2004). One observer quantified these elements into a league table that placed Australia behind much of Western Europe, and slightly ahead of the US (Horvath 2004).

'Affluenza' and over-work

Others have developed indices to measure 'genuine progress', arguing that Australia's materialistic lifestyle manifests as a form of 'affluenza', where unhappiness increases in direct proportion with material prosperity (Hamilton 2005).

In terms of the links with ill-health, there are the obvious dimensions of lifestyle excess which have, as noted, grown exponentially since the 1990s in Australia. In addition, there are dimensions of income insecurity and work intensification that focus attention on the more affective factors contributing to ill-health. Here, for instance, it may be the experience of income insecurity rather than low income per se that may be the most debilitating factor. For people dependent on benefits, insecurity can be directly related with ill health (see Rawsthorne 2006). Those working in the casualised sector of the workforce are also likely to experience high levels of income insecurity. Indeed, for people in continuing positions, the pressures may be no less intense in terms of the threat of outsourcing and flexibilisation, and also in terms of work intensification, including requirements to work longer hours.

While a generalised problem, income security is heavily stratified. The Australian Social Attitudes Survey, conducted in 2003 with over 4,000 respondents, found that only 40% of respondents in low-skill occupations did not fear losing their job and were confident of being able to find equivalent alternative employment should they require it, contrasting with about 70% for those in professional and managerial occupations (Martin and Pixley 2003).

Australians work longer hours than those in any other OECD country, and there is qualitative evidence of broader work-related stress and loss of leisure time, and of time for community, cultural and caring labour³, leading

³ Nancy Folbre, a feminist economist argues that only by working collectively to ensure a greater supply and

to a 'collision' between work and life (Pocock 2003). Most respondents in the social attitudes survey stated they would prefer reduced hours, suggesting a preference for a less intense working life (Martin and Pixley 2003).

Such experiences of work intensification, work casualisation and insecurity are masked in aggregate employment figures that appear to show, at least currently for Australia, a society experiencing a remarkably sustained period of close to full employment. Something of the scope of the problem is revealed in self-assessments of 'financial stress', which show that nearly 13% of all households had experienced financial stress in 2004, rising to 18% for lone persons aged between 35 and 64, and 40% for lone parents (ABS 2006: 71).

Growing social insecurity

Indeed, a broad sense of insecurity appears to be widespread. An important qualitative survey of 'middle Australia', comparing middle class concerns in 1996 and 2000, found a growing sense of unease. It finds that in 2000, at the height of the recent economic boom, a greater proportion of 'middle Australia' felt less secure than in 1996, at the tail-end of a recession (81% as against 76%) (Pusey 2003: 53).

The research suggested this was 'the only boom in living memory in which so little of the gains have been shared with the mass of the people', and in light of this found 'huge majorities of Australians want the gap between rich and poor to get smaller' (Pusey 2003: 38). The survey also found a growing sense of exclusion from the spoils of 'reform', and a resentment and growing prejudice against benefit recipients and migrants.

quality of care, independent of the market, can we ensure that the responsibility of care is equitably distributed and not disproportionately placed upon women (Folbre 2004).

These findings are confirmed by the much larger social attitudes survey which finds a strong and growing public concern about income differentials: in 1994 66% of respondents said the differences were too large, by 2003 this had risen to 84%. Yet there was little support for income redistribution to address this problem: only 46% agreed in 2003 that more income should be distributed (Pusey and Turnbull, 2005:174-5).

Support for somewhat higher taxes and government spending on services such as education and health is much stronger than support for benefits: 69% of respondents were willing to pay more tax for 'health and Medicare' while only 34% were willing to pay more taxes for welfare benefits (Wilson, Maegher, and Breusch, 2005: 109).

From social inequalities to health inequalities

There is strong evidence that the social insecurities of globalism translate into health inequalities. The links are most clearly revealed in research investigating self-reported levels of health and ill-health. The incidence of sickness, as against diagnosed illness is much more prevalent with lower socioeconomic status (Duckett 2004). If we take the World Health Organisation position that healthiness involves well-being, not simply absence from disease, then self-assessments of whether one feels healthy take on a central importance (the WHO position is cited in Rawsthorne, 2006:102).

In 2004 the ABS reported on its 'General Social Survey' of 2002, linking rates of reported ill-health with socio-economic disadvantage, and household type (ABS 2004). Overall it found that 16% of the population reported that their health is 'fair' or 'poor'. Within this aggregate the report found deep inequalities, with more than three times as many respondents in the lowest quintile reporting fair or poor health as in the highest quintile (17% as against 4.7% for

18-34 years; 36.2% as against 8.7% for the 35-64 range) (ABS 2004).

The results of the survey in terms of household type were also highly revealing. About a quarter of lone person households aged 35-65 reported fair or poor health. Interestingly, while lone parent households were most likely to be in the poorest 20% of the population, their reported incidence of fair or poor health was much the same as the national average. The ABS report also found a very strong link between reports of poor health and low income, and revealed household type as a related, contributing factor.

Rising inequity in cancer mortality cases

More broadly, health inequalities have widened considerably. The neo-liberal boom sharpened the social gradient in health while flattening the social gradient in income. In 2005 the Royal Australian College of Physicians found increasing health inequalities across the board: inequity in cancer mortality for women, for instance, was negligible in 1985, but by 1998 rich women were 30% less likely to die of cancer than their poorer counterparts (Royal Australian College of Physicians 2005).

In an earlier report the College had cited the prime cause as "economic rationalism and globalisation, which increase personal insecurities, overburdening relationships and an individual's sense of well-being, putting them at further risk", and called for policymakers to "ensure that social and health policy concerns inform all policy and program development across all of government" (Royal Australian College of Physicians, 1999: v). Likewise, in 2006, the Australian Institute of Health and Welfare reported that "although there have been significant health improvements for Australians in recent decades, these have not been distributed equally" (AIHW 2006: 232).

In 2006 Torrell et al reported that inequalities in health risk and outcomes had become more

statistically significant through the 1990s: those with low income, low education and less skilled occupations simply reported poorer health (this applied for men and women across all ages). The key explanation for Torrell et al was “differential exposure to adverse social, physical, economic and environmental circumstances, which are themselves influenced by factors such as the actions and decisions of governments, the economic market, civic society and broader global forces” (Torrell et al 2006:135).

Global forces, according to Torrell et al, act on economic, welfare, health, transport and taxation policies that directly affect the social determinants of health, including education, employment, occupation, income and housing or area of residence. Because of this, the authors called for a *whole of society* approach that addresses structural causes, arguing that initiatives focused on individual responsibilities have had the effect of widening inequalities.

Rising inequality in mortality

Spatial inequalities between the most disadvantaged and most advantaged neighbourhoods are particularly revealing. In terms of mortality rates there is an across-the-board improvement, but with this has come dramatic increases in inequality. Draper et al (2004) summarise the findings for mortality as follows:

“Between 1985 and 2000 mortality inequalities rose across virtually all ages for males. The rise in inequalities is greatest for males in the 15-24 age range, where inequality rose from 55% to 90% between 1985 and 2000; in the 0-14 age bracket the rise was from 20 to 78%; in the 25-64 brackets it was from 68 to 75%. For females there is a general rise in inequalities but much less marked. There is only an increased difference in absolute death rates for

males aged 15-24” (Draper et al, 2004: 91-4).

Overall, Draper et al estimate that in 1998–2000 about 16,752 male deaths and 6,485 female deaths would have been avoided among persons aged 0–64 years if the national mortality rate was that of the least disadvantaged quintile. While noting these patterns are broadly replicated in other high-income countries, the authors note a significant variation on the theme in the Australian context, namely that inequalities in health outcomes for females remained relatively static. Clearly this needs explanation and investigation – a task beyond the scope of this chapter.

Remoteness is not a factor

Importantly, though, the socio-economic health gradient does not appear to be a product of remoteness, as against socio-economic disadvantage. Mortality tends to be significantly higher in the more remote regions of the country but this largely reflects the distribution of the Indigenous population, rather than remoteness per se. The report notes:

“When Indigenous deaths were excluded, mortality rates in Remote or Very Remote areas were similar to those found in Highly Accessible areas.... what initially appeared to be mortality inequalities resulting from differences between urban and rural areas in terms of social and economic factors and access to services was largely due to the vastly different mortality experiences of Indigenous and non-Indigenous Australians” (Draper et al, 2004: 96).

Indeed, society-wide health inequalities pale into insignificance in the context of Indigenous health outcomes. Indigenous people in Australia account for 2.4% of the population, or about half a million people, with relatively large concentrations in rural and remote regions:

about a third of the population of the Northern Territory, for instance, is Indigenous. But remoteness, as noted, does not appear to be a serious factor in health outcomes. What seems much more central is the socioeconomic and cultural status of the Indigenous population, as a colonized people.

Ongoing Indigenous health crisis

Indigenous health outcomes are substantially below even the poorest fifth of the population (NSW Chief Health Officer 2006). In NSW in 2006 Indigenous infant mortality, at 8.5 per 1000 births, was twice that of the rest of the population. Low birth-weight in 2002 was about double for Indigenous newborns, at 13% as against 6% for the broader population (ABS 2006a: 229).

In NSW 12% of Indigenous deaths occurred at less than 25 years as against 2% for the rest of the population; about two fifths of Indigenous deaths were among people aged 65 years and over, while for the rest of the population the figure was double this. As a result the Aboriginal population is younger: just less than 3% of the Indigenous population is over 65, compared with over 13% for the rest of the population (NSW Chief Health Officer 2006). Average life expectancy across the country for Indigenous men is 59 years and for women 65, compared with the national average of 77 for men and 82 for women in 2001 (ABS 2006a: 222).

The upshot is that an Indigenous man is six times more likely to die before the age of 35 than his non-Indigenous counterpart (Duckett 2004).

Spending discriminates against Indigenous peoples

An important factor in these appalling health outcomes is discriminatory health spending. The Commonwealth defends its record presenting comparisons of aggregate health

expenditure that show Indigenous households attracting relatively more health expenditure than non-Indigenous households (DHA 2006). A more relevant comparison between spending on Indigenous and non-Indigenous households of similar socioeconomic status provides a very different picture. Here, non-hospital health expenditure is found to be about 90% lower per head for Indigenous people than for the equivalent non-Indigenous population (Gray et al 2002).

These findings demonstrate what has been called the 'inverse care law', that to those most in need the least is given (Deeble et al cited in Gray et al 2002). Gray et al argue that to address the health spending shortfall there has to be a clearer understanding of the health risks across the life course of Indigenous peoples – from early childhood development, to family separation, discrimination, and social fragmentation. Unless these risks of exclusion from mainstream society are addressed, they argue, Indigenous health outcomes are unlikely to improve (Gray et al 2002: 38).

A health disaster

The Indigenous experience, as a health disaster, is vitally important in itself. It is also important for what it reveals about the broader logic of stratification and health. Clearly Indigenous health outcomes cannot simply be correlated to income inequalities: health outcomes of Indigenous people far outstrip even the broadly comparable non-Indigenous population.

As with other sections of the population, non-income socio-economic and cultural inequalities figure prominently. Under neo-liberalism, as noted, these inequalities have widened dramatically, with what appear to be direct effects on health inequalities. We may, then, want to explore what light the Indigenous experience casts on the general question of non-income inequalities and health outcomes, as well as addressing the specific question of Australian Indigenous health.

Conclusions

The impact of globalism in Australia has been far-reaching in healthcare and health outcomes. Investigation of health policy and health outcomes offers important insights into the dynamics of globalism. We find a process that transforms the policy field and re-stratifies society to recast health outcomes. The impacts are felt most clearly through the non-income components of socio-economic stratification, which have come to the fore in the process of neo-liberal marketisation in Australia.

The result is a picture that appears on the surface to suggest growing prosperity, shared by most, producing improved health outcomes. Below the surface there are growing inequalities, especially in terms of income insecurity and work intensification. There are increased mortality inequalities between rich and poor regions, and a continuing health

disaster amongst Indigenous peoples. Policy responses that attribute blame to individuals and communities for poor health have attenuated the social divides.

What remains encouraging, though, is the public concern this creates, along with an on-going public commitment to universal public healthcare. At the most immediate level, as Duckett argues, health inequality violates a sense of fairness, challenging 'the conventional wisdom of Australia as an egalitarian society' (Duckett 2004: 25). In this context, even an electorally-popular conservative Coalition Government, in power from 1996 to 2007, had to position itself as 'safeguarding' the public healthcare system. That at least suggests some possibility for future transformations to address the continuing and in some respects deepening health inequalities that have prevailed in Australia's boom-times.

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James Goodman has edited or co-edited several books on globalization and social change. He was on the research team for the University of Alberta project, 'Neo-liberal globalism and its challengers', and is a member of the 'Cosmopolitan Civil Societies Research Centre' at the University of Technology in Sydney.