Neoliberalism and the Australian Healthcare System (Factory)

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Abstract

This paper will examine the interrelationship between categorising the neo-liberal perspective and the term 'consumer.' My explicit concern is the likely intrusion of the neo-liberal mindset onto what is essentially the 'social nature of identity' (Billington, Hockey & Strawbridge 1998, p. 56). By locating the discourse of consumerism within the broader political framework, I am able to examine the neoliberalist view and its positioning of marginalised groups with the aim of attempting to focus attention to the potentially negative consequences of the consumer label.

Neoliberal Philosophy

Contemporary scholars continue to pay much attention to studying various aspects of the globalization phenomenon, including its origins. Although explanations which favor single seemingly evident factors, such as the growth of international trade or technological developments, still remain popular, there is a growing recognition that globalization has a complex multicausal nature with socio-political set of factors possibly playing more important role than many believe[1].

One popular view of globalization stresses the role of policy choices associated with a broader program of neoliberal reforms. This explanation implies that globalization must be perceived as the international manifestation of the general shift towards market-oriented neoliberalism. The new tendency has replaced the social-democratic paradigm, and produced the growth of unregulated international capital markets, which occurs in parallel with "….the shift to free-market domestic policies such as privatization, capital market deregulation and the abandonment of Keynesian macroeconomic management"[2].

The term 'neoliberalism' is comprised of two notions, namely neo meaning new and liberal meaning free from government intervention. Liberalism stems from the work of Adam Smith who, in the mid 1770s, advocated for a minimal role of government in economic matters so that trade could flourish. The mind set of liberal economics held sway for almost 200 years and was temporarily replaced in the 1930s by Keynesian economics which saw a place for government intervention. In the 1970s, liberalism, or the cry for deregulation, privatization and deletion of government intervention in the market economy, resurfaced with a vengeance; hence, the name renewed liberalism or neoliberalism[3].

Neoliberalism, which is also known as economic liberalism or economic rationalism, "…has an interest, like liberalism, to provide reason to limit government in relation to the market"[4]. This paradigm rests on the "…beliefs in the efficacy of the free market and the adoption of policies that prioritize deregulation, foreign debt reduction, privatization of the public sector...and a (new) orthodoxy of individual responsibility and the "emergency" safety net - thus replacing collective provision through a more residualist welfare state"[5]. Therefore, neoliberalism seeks its own ways to integrate self-conduct of the governed into the practices of their government and through the promotion of correspondingly appropriate techniques of self. It constructs ways in which individuals are required to assume the status of being the subjects of their own lives – the entrepreneurial self. Neoliberal philosophy has been used as a critique of State reason in an attempt to legitimate the minimalisation of the State in terms of its restructuring through corporatisation and privatisation.

Foucault suggests that it is important to understand neoliberalism as a form of governmental rationality because:

> it is a characteristic and troubling property of the development of the practice of government in Western societies that tend towards a form of political sovereignty whose concerns would be at once to 'totalise' and to 'individualise (Gordon, 1991a, p. 3).

Neoliberal thought relies on:

> ... a progressive enlargement of the territory of the theory by a series of redefinitions of its object, starting out from the neo-classical formula that economics concerns the study of all behaviours involving the allocation of scarce resources to alternative ends ... economics becomes an approach capable of explaining all human behaviour (Gordon, 1991b, p. 43).

Government impinges upon individuals in their individuality, in their practical relationships to themselves, in the conduct of their lives and at the very heart of themselves by making its rationality the condition of active freedom. It opens up a new uncertain, often critical and unstable domain of relationships between politics and ethics, between government of others and practice of self. From this perspective, society is merely the product of government's intervention and not the cultures of its various constituent groups[6]. [7]

Paradoxically, under neoliberalism, many western countries have been reformed through government intervention. The neo-liberal explanation for the impetus for state sector reform locates it in a need to improve a nation's international competitiveness by increasing the efficiency of all sectors of the economy. Through neoliberal philosophy the regulatory environment is designed to facilitate the development of a market that according to Peters has "paradoxically been established through State intervention".

Whereas under Keynesian welfarism the state provision of goods and services to a national population was understood as a means of ensuring social well-being; neoliberalism is associated with the preference for a minimalist state[8]. In an economy imbued with neo -liberal philosophy, managerialization of personal identity and personal relations accompanies the capitalisation of the meaning of life. (I should say 'The Life of Brian')

Neoliberalism in Australian Context

The neoliberal paradigm is believed to seriously affect absolute majority of contemporary reforms in Australia. According to Fairbrother, neo-liberal economic policies were adopted and implemented by Labor governments under the Hawke leadership between 1983-1991, continued by Keating from 1991-1996, and are evident in the present Howard led Coalition government's agenda. Design and implementation of the health care system reforms is also influenced significantly by the global neoliberal trend[9]. The ideology of neoliberalism has resulted in the notion that the state lacks efficiency while private markets are more cost-effective and consumer-friendly. Neoliberalism emphasizes the role of unregulated markets and a minimal welfare state with government being seriously limited in its attempts to intervene to mitigate the negative effects of market forces on health and social welfare[10].

Consequently, the essence of neoliberal health care reformation is cost cutting, "…decentralizing to the local or regional levels rather than the national levels and setting health care up as a private good for sale rather than a public good paid for with tax dollars"[11]. Neoliberal philosophy is illustrated by the terminology which nowadays prevails in discussions involving the Australian health care system: spending cuts, dismantling, deficit cutting, downsizing, declining welfare state, competitiveness, inefficiencies, inevitability, closures, chopping services, de-insured, user-pay fees, for-profit health care, escalating costs, free markets, erosion of health care, being forced to make difficult policy choices, unfortunate necessities and justifiable sacrifices[12].

Neoliberalism is reasonably perceived as a radical challenge to the philosophy underpinning the welfare state[13]. From the moment of its emergence and spread in the 1980s, neoliberalism has gradually moved the political debate in Australia toward the basic assumptions of its ideology, namely the concept of free market

without any constraints imposed by the state. Production and distribution of goods through such a market is viewed as the most ethical and honest alternative within the neoliberal philosophy which does not distinguish between ordinary consumer goods and public goods such as health care. Consequently, the Keynesian concepts of welfare state, socialism, and social justice are condemned as inefficient and unjust within the neoliberal paradigm[14].

Neoliberals view citizens primarily as rational consumers of public goods with health care being one of these goods. In other words, this philosophy places emphasis on the individual and mutual responsibilities rather than on rights, and therefore, fails to distinguish between our roles as consumers and citizens. Thus, Rian Voet even question[s] whether neoliberalism "… really has a concept of citizenship"[15].

On the one hand, this phenomenon of 'health consumerism' suggests a variety of strategies for participation at different levels such as decision making, defining needs and evaluating outcomes as well as being an open accountable system. However, the drawbacks are very essential too: thus, the patient-as-consumer may, in fact, be a myth because the '…consumer model [as such] does not fit well into health care'[16]. The term 'consumer' also fails to highlight inequalities between various social groups because patients, unlike consumers, do not have any significant power when it comes to influencing decisions made in relation to health care. In a similar vein, Rob Irvine asserts that the application of consumerism for those receiving health services is not appropriate 'because it fails to describe accurately the actual behavior of patients in the concrete setting of the hospital, the clinic or the practitioner's surgery'[17].

The idea of the consumer is crucial here. For neo-liberals the world in essence, is a vast supermarket. Consumer choice is a guarantor of democracy. The metaphor of the consumer and the supermarket are actually quite apposite here. For just as in life where there are individuals who can go into supermarkets and choose from a vast array of similar or other products, there are those who can only engage in what can be best called postmodern consumption. They stand outside the supermarket and look at the image. The entire project of neo-liberalism nationally and internationally is connected to a large process of exporting the blame from the decisions of the dominant groups onto the state, and onto poor people. Yet with their emphasis on the consumer rather than the producer, neo-liberal policies need also to be seen as part of a more extensive attack on government employees.

The discourse associated with neoliberalism, and in particular the word 'consumer', sets the scene for relationships between policy makers, healthcare employees, medical practitioners, and those receiving health services. The relationship is one of power – between the various participants of health care – based on individualistic policies[18]. (The power of the profession)

This approach to social policy formation is evidenced by the term 'consumer.' The term conjures up notions of using up and absorbing available resources. It seriously reflects the preoccupation of neoliberalism with consumerism and the acquisition of goods, and neglects to address society's caring role. In addition, neoliberalism fails to distinguish the differing interests amongst social groups, especially in relation to power. Instead of the original notion of the term 'consumer' (as a way of balancing power between the decision makers, health practitioners and those accessing services) hegemonic undertones are clearly evident. By adopting the language of those seeking health care services, power structures become blurred. In order to win ideological consent to rule, officials and political decision-makers take up the language of the governed and 'appropriate progressive political ideas, strategically manipulating or altering them in order to produce a "shared" framework that may be more apparent than real'[19].

Relations between social groups can be seen as relations of power[20]. Therefore, the dominant ideology can be seen to give only a partial view of society and serves to legitimate and justify the status quo. If the ruling class manages to maintain its control by gaining the approval and consent of members of society, then it has achieved hegemony. Hegemony refers to the achievement of political stability by persuading members of society to accept the political and moral values and beliefs of the ruling class:

> The capitalist class seeks to persuade society not only to accept the policies it advocates but also the ethos, the values and the goals which are its own, the economic system of which forms the central part, the 'way of life' which is the core of its being[21].

In regards to consumerism, the hegemonic acceptance of the term 'consumer' has enabled the government to impose its beliefs regarding consumerism on the majority by justifying and maintaining its dominant position with the consent of those being ruled. Therefore, it is important not to take the seemingly innocent acceptance of policy makers of an apparently inclusive and empowering term as 'consumer,' at face value. Issues of power are paramount here. In order to gain acceptance by the population, the beliefs of the powerful must be internalized by the majority of the population[22]. The acceptance of consumerism and user-pays has been achieved through neo-liberal policies of a more residualist approach to social services such as health and welfare. John Clarke claims that this approach 'aims not only to break up the old institutional attachments but also to create new forms of articulation between the citizen-as-consumer and the state'[23]. The government is prepared to spend more and more money on health and health-care facilities, but only if they meet the needs expressed by capital, thus resources are made available through reforms and policies that further connect the health-care system to the project of making our economy more competitive.

Consumerist policies have a particular impact on those who do not have adequate access to material goods, although many people with mental health issues see their problems as both financial and social. Factors include being poor, being unable to work or able to participate in other aspects of society[24]. Gwen Mulvany points out that the complexity and variety of the social limitations experienced by people with disabilities (and we are assuming this is broad enough to include persons with mental illness and the elderly) means the experience is often one of chronic economic hardship, unemployment, and relationship breakdown. This is compounded by the labeling of people with mental health problems as deviant, and the general classification of welfare recipients as undeserving. Both are reflective of a society that has become less compassionate towards those who are most disadvantaged and in need of our compassion[25].

Such situation not only requires that a critique of the health system be carried out, but also that the entire consumerist system based on the principles of neoliberalism be questioned through applying social justice principles. The needs of the disadvantaged must also be considered rather than concentrating solely on the needs of the ruling class. As Hogg notes, 'the myth of the health "consumer" diverts attention away from inequalities in health among different groups in the community'[26].

The increasing disparities in wealth and income have forced many researchers to rethink the role of social class as a primary determinant of health. Social and economic circumstances have been associated though not as heavily as these days, with health inequalities for many decades. Socio-economic status strongly influences people's physical and mental health, their use of health care, and mortality rates. Many recently published works on socio-economic determinants of health inequalities clearly demonstrate that these exist elsewhere in the world, even in the richest societies[27].

Within countries the inequalities can be seen throughout the whole social spectrum, suggesting "…there is not simply a threshold of absolute deprivation below which people are sicker, but a linear relationship between socio-economic circumstances and health even among the better off"[28]. For example, large inequalities in health between the most and least socially advantaged populations in the United Kingdom (UK), United States (US), Canada and New Zealand have been reported in every major report on public health.

Strange enough, despite the shift toward the economy of neoliberalism which started at approximately the same time as in the United Kingdom (UK) and United States (US), Australia stands apart from these countries in terms of inequality and population health. The increasing adoption of neoliberal principles and practices, an increased emphasis on transparency and accountability, and the introduction of managerial initiatives such as casemix-based hospital funding resulted in significant productivity, efficiency and

profitability gains[29]. These gains have been achieved at the cost of greater inequality in wealth, income and social power – the typical effect of neoliberal reformation.

However, the onset of neoliberalism in the social sphere has not seriously affected the population health outcomes up to now and it remains amongst the best in the world. Thus, Australia ranks third in the world on life expectancy at birth, third on survival to age 65 (male and female), fourth in infant mortality rates (IMR) and under-five mortality rates, sixth on male adult mortality rate, fifth on female adult mortality rate and fourth on the HALE[30]. As Boxall and Short observe, "[although] it is not possible to display data for other countries with liberal political economies … of all the countries with liberal political economies, Australia [has] the best population health indicators overall"[31].

At the first glance, these findings seriously undermine the seemingly reasonable assumption that the basic premises of neoliberalism deteriorate the system of health care. In reality, the current state of research does not allow for making any conclusions in this regard. Firstly, there is still insufficient research available to fully understand the relationship between health care and the type of economic system. Secondly, despite the established classification of the Australian economy as neoliberal some authors still express concerns that this classification may be incorrect:

> "[Australian] political economy may be similar to those of the US and UK, but crucial differences that account for the variation in population health outcomes may not have been considered. One difference may be in the operation of the welfare state. The 'wage earners' welfare state model used in Australia has been long regarded as unique. It differs from the typical democratic socialist models, like that of the UK, but also from liberal models, like that of the US. Australia's unique welfare state model may also partly account for its exceptionalism in terms of population health outcomes[32].

Thirdly, the neoliberal mindset is still a relatively new phenomenon and there is little understanding among the scholars as to how much time the neoliberal shift requires to fully reveal its impact on the health care system and population's health. Probably, the unique features of the political economy in Australia only extend the delay instead of mitigating the outcomes. Therefore, the situation in Australia deserves specific attention and represents probably the most interesting and challenging research problem in the field.

Evidently, modern policies in the realm of health care in developed countries are market driven and encourage private enterprise. Unfortunately, the need to improve the life chances of the least advantaged groups which are less able to compete in a capitalist society is often neglected. In a society overly concerned with the acquisition of wealth and where money and consumerism equates with independence and power, the 'health consumer' label effectively discriminates against a group whose spending power is, at worst, ineffectual.

Cultural imperialist groups impose that their values, experiences and perspectives are normal and universal thereby making the other group invisible as well as being stereotyped and marked as deviant in relation to the norm or dominant. The dominant group maybe oblivious to the existence as a group because they are unmarked and neutral and universal, however, the victims of cultural imperialism are always aware of their identity because of the behavior and reactions to them.

The notion of 'patient' is akin to passivity and raises issues of medical paternalism whilst 'client' is used to describe those seeking the services of professionals in a wide range of services. However, the currently used label 'health consumer' with its notion of 'empowerment' and focus on participation is misleading. The term 'consumer' has negative connotations when applied to those seeking the services of health professionals who are without the capacity to exercise spending power[33]. In addition, the term for example ignores the humanness of those with mental illness, the elderly and disabled and merely allocates them a role. The term 'consumer' impacts on all of us no matter what our position. The hegemonic overtones of the language of

capitalism alert us to what it means to be a 'consumer' rather than a 'citizen' within neoliberal ideology and it is my recommendation that a more appropriate term be sought. Neoliberalism then, as an artificial, governmentally induced game of entrepreneurial conduct, challenges traditional notions of professionalism under which nursing defines itself.

Conclusion

The ideology of neoliberalism is in conflict with the socially justified distribution of wealth and power. Policy-making power and money are redistributed upward in restoration. The conservative language for this reversal pits quality against equality. Since discourses shape and constrain what is sayable and do-able, as well as what is thinkable; the limits of the expressible and the permissible, it could be argued that the neoliberal conservative restoration has inserted new values into healthcare and has at the same time limited the space available for contestation of those values. Restoration policy promotes itself as the defender of excellence and high standards. It helps authority disguise the real intention of strengthening hierarchy. This conservative neoliberal discourse will not admit to questions about the rationality of its so-called 'new' values - the mere fact that they exist is taken as evidence of their positive value. However, the debate never allows the words 'hierarchy,' 'domination,' 'power,' to enter the discussion.

Recommendation

The specific position of Australia where neoliberal reforms in health care have not led to any observable decline in the population's health does not really challenge the current views on negative effects produced by the onset of neoliberal ideology in the field of health care. Nor does it challenge the relationship between the type of economic system and population health. Such specific results rather emphasize the need for further research in the field paying attention to other hidden factors. Research in this field is very important because although the link between inequality and population health does exist, many aspects of it still remain unclear, and Australia's case may clarify at least some of them. Ignoring this kind of explorations may be dangerous in the long term since no one really knows the reason's for the country's exceptional status among other neoliberal economies.[34]

Notes:

1 John Quiggin (1999) Globalisation, neoliberalism and inequality in Australia, *The Economic and Labour Relations Review*, 10:2, pp. 240-59.

2 Ibid., 248.

3 Elizabeth Martinez and Arnoldo Garcia, *Corporate watch - What is neoliberalism*, 2000 retrieved http://www.globalexchange.org/campaigns/econ101/neoliberalDefined.html (September 5, 2007).

4 Colin Gordon (1991) Governmental Rationality: An Introduction, in: Graham Burchell, Colin Gordon and Peter Miller (eds.) *The Foucault Effect. Studies in Governmentality* (Chicago: Chicago University Press) p. 6.

5 Linda Hancock, (1999) *Women, Public Policy and the State* (Macmillan: Melbourne) p. 5.

6 Gordon, pp. 1-52.

7 Foucault when writing about antiauthority struggles in Michel Foucault Beyond Structuralism and Hermeneutics states that they are struggles which question the status of the individual: on the one hand, they assert the right to be different and they underline everything which makes individuals truly individual. On the other hand they attack everything which separates the individual, breaks his links with others, splits up his community life, forces the individual back on himself and ties him to his own identity in a constraining way. These struggles are not exactly for or against the "individual" but rather they are struggles against the "government of individualisation."

8 Ibid.

9 Anne-Marie Boxall (2003) Navarro, neo-liberalism and the nation's health: A political economy perspective on population health in Australia, *Masters Treatise* (The University of Sydney: School of Public Health).

10 Ron Labonte (1998) Healthy public policy and the WTO, *Health Promotion International*, 13:3, pp. 245-256.

11 Sue L.T. McGregor (2001) Neoliberalism and health care, *International Journal of Consumer Studies - Special edition on 'Consumers and Health*, 25:2, p. 84.

12 McGregor, pp. 82-89.

13 Gordon, pp. 1-52.

14 Philip Mendes (2003) Australian Neoliberal Think Tanks and the Backlash Against the Welfare State, *Journal of Australian Political Economy*, 51, pp. 29-56.

15 Rian Voet (1998) *Feminism and Citizenship* (London: Sage) p. 10.

16 Christine Hogg (1999) *Patients, Power and Politics: From Patients to Citizens* (Sage: London) p. 169.

17 Irvine, p. 32.

18 Ibid.

19 Ibid., p. 36.

20 Margaret Sargent (1991) *Sociology for Australians* (Longman: Melbourne).

21 Michael Haralambos, Robert van Krieken, Philip Smith and Martin Holborn (1996) *Sociology: Themes and Perspectives, Australian edition* (Longman: Melbourne) p. 124.

22 Ibid.

23 John Clarke (1997) Public nightmares and communitarian dreams: the crisis of the social in social welfare, in: Stephen Edgell, Kevin Hetherington and Alan Warde (eds.), *Consumption Matters* (Blackwell Publishers: Oxford) p. 78.

24 Ron Bowl (2002) Psychiatric Survivors and Consumers in the UK – A Successful Social Movement?, *Ethical Human Sciences and Services: An International Journal of Critical Inquiry*, 4:2, p. 111.

25 Sherry, pp. 3-9.

26 Hogg, p. 174.

27 Nancy Krieger, David R. Williams, and Nancy E. Moss (1997) Measuring Social Class in U.S. Public Health; Research: Concepts, Methodologies, and Guidelines, *Annual Review of Public Health*, 18, pp. 341–378.

28 Sally Macintyre, (1994) Understanding the social patterning of health: The role of the social sciences, *Journal of Public Health Medicine*, 16, p. 54.

29 George R. Palmer and Stephanie D. Short (2000) *Health care and public policy: An Australian analysis* (MacMillan: Melbourne).

30 Colin D. Mathers, Christopher J.L. Murray, Ritu Sadana, Ajay Tandon, Joshua A. Salomon, T. Bedirhan Üstün, Alan D. Lopez and Somnath Chatterji (2003) Healthy life expectancy: comparison of OECD countries in 2001, *Australian and New Zealand Journal of Public Health*, 27:1, pp. 5-11.

31 Anne-Marie Boxall and Stephanie D. Short (2006) Political economy and population health: Is Australia exceptional?, *Australia and New Zealand Health Policy*, 3:6, p. 6.

32 Ibid, p. 6.

33 Irvine, p. 38.

34 Part of the reason for this is that the advocates of privatisation assume that there is 'a level playing field' i.e. that there are no differences in income, intelligence, age, gender, race/ethnicity, disability or geographical location. In other words individuals bring different levels of skills and abilities that assist or constrain their interactions in the marketplace. Participation varies according to those skills and abilities. Hence freedom of choice is not assured unless (and not always then) the individual is a member of the elite class. The same is true of equity - access to health care services will be limited if individuals do not have the ability to pay. Some sections of the community then may be worse off not better if services are privatised (Barker, 1996, pp. 155-159; Draper & Owen, 1996, pp. 195-209). The focus of community care in the health arena has been increasingly steered by the needs of acute institutional care. In particular community health services have had to change their focus from primary care to one that arises in response to early discharge, faster hospital throughput and increased day surgery (Smith, 1999, p. 173). Critics have argued that this move towards community care is "a pretext for reducing spending (and is) a form of social control, and a way of maintaining gender inequalities (Minichiello, 1995, pp. 455)". Presently the ideology of neo-liberalism expressed as economic rationalism with its emphasis on the autonomy of the individual and his/her right to make choices in the marketplace holds sway. Whilst this perspective does provide some useful insights and guidance its wholesale adoption leaves room for concern, most notably for the future of such areas as community health, health promotion and illness prevention.