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Comprehensive primary health care under neo-liberalism in Australia

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ABSTRACT

This paper applies a critical analysis of the impact of neo-liberal driven management reform to examine changes in Australian primary health care (PHC) services over five years. The implementation of comprehensive approaches to primary health care (PHC) in seven services: five state-managed and two non-government organisations (NGOs) was tracked from 2009 to 2014. Two questions are addressed: 1) How did the ability of Australian PHC services to implement comprehensive PHC change over the period 2009–2014? 2) To what extent is the ability of the PHC services to implement comprehensive PHC shaped by neo-liberal health sector reform processes? The study reports on detailed tracking and observations of the changes and in-depth interviews with 63 health service managers and practitioners, and regional and central health executives. The documented changes were: in the state-managed services (although not the NGOs) less comprehensive service coverage and more focus on clinical services and integration with hospitals and much less development activity including community development, advocacy, intersectoral collaboration and attention to the social determinants. These changes were found to be associated with practices typical of neo-liberal health sector reform: considerable uncertainty, more directive managerial control, budget reductions and competitive tendering and an emphasis on outputs rather than health outcomes. We conclude that a focus on clinical service provision, while highly compatible with neo-liberal reforms, will not on its own produce the shifts in population disease patterns that would be required to reduce demand for health services and promote health. Comprehensive PHC is much better suited to that task.

1. Introduction

In 1978 the World Health Organisation (WHO) endorsed a visionary approach to Primary Health Care (PHC). The vision for PHC was comprehensive in that it related health services to the broader organisation of society, calling for a new international economic order that would benefit developing nations, empowering democratic participation in health, and greater attention to social and environmental contexts that increased disease risks. Health services were to be multi-disciplinary, attuned to local need, and emphasise disease prevention and health promotion. This vision was developed during a period of decolonisation in the global south and the rise of progressive social movements in the global north, both of which embodied optimism for a less exploitative future and challenged established power bases. Re-reading the Alma Ata Declaration one is struck by its essential idealism and also by its recognition that resistance to the changes was likely.

The resistance was indeed swift, with a call for a more 'selective' PHC approach published just one year later (Walsh and Warren, 1979). Wary of costs and political opposition to the Declaration's assertions, the article envisioned a 'selective' implementation as an 'interim' measure. Broader global transitions in political economy, however, made this temporary 'selective' approach a permanent feature.

1.1. Theoretical framework

The period immediately following the Alma Ata Declaration has

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been characterised in the political science literature as the rise and global dominance of a neo-liberal economic discourse and its subsequent shaping of public policy choices, which forms the basis of the theoretical framework that guided analysis of our study findings. Neo-liberal economic theory was developed in the 1940s and 1950s from a distrust of the potential of state-planned economies, which were perceived as autocratic and repressive of individual liberties (Hendrikse and Sidaway, 2010; Labonté, 2012). A principal axiom of neo-liberal economic theory is that economies are too complex for governments to manage, and that free markets, sovereign individuals, free trade, strong property rights and minimal government interference will yield the best outcomes (Hayek, 1944). When first propounded, this theory gained ground in some economic departments, notably at the University of Chicago, but was marginalized by a dominant post-war Keynesian economic model, Keynesian economics, which emphasised, in part, the importance of government interventions in market economies to support full employment, provide for social protection programs, use taxation to reduce market-based income inequalities and engage in counter-cyclical spending during economic downturns.

Neo-liberalism eventually gained prominence following the elections of conservative governments in the UK (Thatcher), USA (Reagan) and Germany (Kohl). These elections corresponded with declining profit margins and sluggish growth in 'advanced' economies, and coincided with oil price shocks and worsening developing country foreign debts, risking massive sovereign defaults and imposing painful structural adjustment programmes on indebted countries (Cornia et al., 1988). Although initially directed to facilitating the maximum freedom of movement for finance capital, goods and services in the commercial sector, neo-liberalism came to promote a market economy in public health care, education, and social security sectors. Neo-liberal policies were manifest in public spending cuts, privatised public services, and adoption of private sector modes of operation (Osborne and Gaebler, 1992). The opening of global markets through trade and investment liberalisation accelerated these processes, partly through reductions in marginal and corporate taxation rates as part of a (now) global competition to attract foreign direct investment. In parallel, there was widespread de-regulation (or re-regulation) of financial markets over the 1990s and early 2000s, which led to a series of regional financial crises that culminated in the 2008 global financial crisis. This crisis and its subsequent recession became the rationale for a more globalised 'austerity' response by most of the world's countries (Labonté & Stuckler, 2016). Thus, there has been a gradual global roll-out of neo-liberal economic policies which, although not dramatically affecting high-income countries such as Australia until roughly the period when our study began, has shifted fundamentally the political economy from when vision of a comprehensive PHC was first promulgated.

This global shift represented a headwind for WHO's PHC program, and since the early 1980s fuller implementation of the Alma Ata vision has been infrequent. Selective PHC, with its 'vertical' emphasis on treating or preventing certain high-burden diseases rather than a 'horizontal' effort to build public health systems, became more entrenched with health reform initiatives of the 1990s and 2000s that were consistent with the core elements of neo-liberalism: cost-containment and efficiency, result-based financing, user fees, managed competition amongst service providers, increased contracting out to private providers, and an emphasis on individual responsibility for maintaining good health.

There have been instances of more comprehensive PHC practices which have strived to fulfil the original Alma Ata vision and aimed to:

- increase equity in access to health care and other services essential to health
- promote community empowerment to reduce vulnerabilities
- address social and environmental health determinants
- improve community participation in health services and the political capabilities of marginalized groups and
- increase intersectoral policy actions on social and economic health determinants (Labonté et al., 2014).

In OECD countries, the best examples have been community health centres in Canada (http://www.cachc.ca/) the USA (Lefkowitz, 2007), and Australia (Baum, 2013). Despite different histories, these centres share: a multi-disciplinary practice, a social health vision, participatory management practices and comprehensive work embracing the Alma Ata continuum of rehabilitation, treatment, prevention and promotion. Often marginal within the health systems of their countries these centres sometimes faced powerful opposition from mainstream medicine and have rarely been the subject of systematic national programs. This study examined how neo-liberal policies affected the ability of Australian PHC services to implement a comprehensive vision of PHC.

1.2. Background to Australian comprehensive PHC study

The Whitlam Australian Government instituted a National Community Health Program in 1973. This program created one of the isolated examples of comprehensive PHC and resulted in many multi-disciplinary community health centres being established in every state and territory. Although the program was defunded after three years, two states – Victoria and South Australia - maintained program funding over the ensuing three decades. Australia also saw the development of comprehensive PHC in Aboriginal Community Controlled Health Services (Bartlett and Boffa, 2001; Wakerman et al., 2008). That these services have represented the best examples of comprehensive PHC in Australia made them the focus of our study to examine what makes for effective comprehensive PHC. An earlier international study (Labonte et al., 2008) found that most of the empirical PHC literature focused on "slices" or particular programs, and only rarely study the overall service in a systematic way. Our interest was to demonstrate the effectiveness of comprehensive PHC by studying the totality of the service in a way not previously reported in the literature (Labonté et al., 2014).

Over 5 years (2009–2014) we witnessed a steady imposition of health sector reforms which undermined the comprehensiveness of most of the services. These reforms reflected neo-liberal precepts emanating from a post global financial crisis austerity agenda that had rapidly globalised, even amongst countries that were not in any fiscally constrained situation, such as Australia. Hence our study created an unforeseen opportunity to study the impact of the imposition of these reforms on comprehensive PHC services.

The impact of neo-liberalism on public sectors in general and health sectors in particular have been extensively studied over the past three decades (Cornia et al., 2008; Mooney, 2012). Some of these impacts have been documented in Australia, such as the introduction of 'new public management' techniques derived from the private sector (Pusey, 2010). Despite variation in the implementation of these neo-liberal reforms across Australian jurisdictions (O'Donnell et al., 2011) there is a discernible movement in public sectors towards a market-oriented discourse of program and service management, a "hyper-rationality" (Germov, 2005) in which health care is seen as a commodity rather than a collective good or human right (Pellegrino, 1999). Payne and Leiter (2013) note that while health managers are able to exert some agency in opposition to this powerful new rationality, the new managerial logic is often at odds with professional and social values relating to