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Medicine and Health Care in Australia

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Australia is a wealthy, First World country of approximately 19 million people which was founded as a penal colony by the English in 1788. The states and territories of Australia were federated in 1901, and government operates at both the federal and the state/territory level. The British antecedents of the modern Australian state has had much influence upon contemporary Australian culture. Australia is still a member of the British Commonwealth and has the Queen of England as her head of state, although there are currently influential moves towards republicanism.

Well into the mid-twentieth century, Australian governments upheld the principles of the racist White Australia Policy, which sought to prevent non-white people from emigrating to and settling in Australia. As a result, the Australian population was dominated by people of Anglo-Celtic ethnicity with a very small minority of Aboriginal people and others of non-Anglo-Celtic ancestry. Over the past half century, however, this monocultural perspective has been challenged by a massive immigration program. Since the years following World War II, when large numbers of people emigrated to Australia from central and southern Europe, immigration programs have vastly expanded, with the most recent increase in people arriving from east and southeast Asia. By 1998, almost a quarter of the current Australian population were born overseas, of which only 7 percent were born in Britain, while 13 percent were born in Europe and 5 percent were born in east and southeast Asia. Approximately 15 percent of Australians over the age of five years speak a language other than English at home, with Italian, Greek, Cantonese, Arabic, and Vietnamese the most common languages (Australian Bureau of Statistics 1999).

Since 1996 Australia has been governed by a conservative Coalition Party, led by Prime Minister John Howard. Before Howard's party gained power, the other major party, the Australian Labor Party, had ruled for some 13 years. While the

Coalition Party can be characterized as right-wing, and the Labor Party as left-wing, in recent years both parties have developed attributes of neo-liberalism, albeit to varying degrees and with different emphases. Neo-liberalism is an approach to government which has been taken up in many western societies at the end of the twentieth century. It incorporates a focus on a relationship between citizens and the state that emphasizes the responsibility of the former to care for themselves, drawing attention away from the state acting to promote the welfare of citizens (Dean 1997).

According to the neo-liberal perspective, health care becomes seen as more of a privileged commodity than a universal right. As is discussed in greater detail below, although Australia currently has a public health insurance system, the Howard government has taken steps to protect the private health insurance industry with tax incentives rather than deciding to direct significant additional revenue to the public system. As such, it demonstrates a neo-liberal rather than welfare state approach to health care provision. Recently even some members of Labor governments, known in the past for their social welfare approach to health care provision and other public institutions, have proposed directing more resources to the private health insurance and private health provision sectors. No political party, however, has attempted to dismantle the current universal health care system, which is strongly supported by the electorate.

The health status of Australians in general rates well in comparison to other First World nations. For infants born in 1995, it has been calculated that female life expectancy is 81 years and male life expectancy 75 years. This compares favorably with the United Kingdom (79 years and 74 years respectively) and the United States (79 years and 72 years respectively). The Australian infant mortality rate also compares favorably with other western Anglophone nations. In 1994 the rate was 5.7 per 1,000 live births, compared with 6.1 for the United Kingdom and 7.5 for the United States. Like many other western nations, the Australian population is aging due to the sustained decline in fertility which followed the post-World War II baby boom (Australian Bureau of Statistics 1999).

MEDICAL SOCIOLOGY IN AUSTRALIA

Medical sociology is strong in Australian universities in terms of both teaching and research and scholarship, comprising the largest of the interest sections in the Australian Sociological Association. There are currently two dominant theoretical positions taken in Australian medical sociology: the political economy perspective and the poststructuralist perspective. The former perspective has been dominant since the 1970s, responding to a wider turn towards Marxist theory in sociology at that time. Writers in this area have focused their attentions on the ways in which health status and health care are structured via social class and other major social categories such as age, gender, and ethnicity (for book-length works, see, for example, Willis 1983; Davis and George 1988; Palmer and Short 1989; Reid and Trompf 1990, 1991; Broom 1991).

The poststructuralist perspective, which has a social constructionist orientation, is more recent, emerging in Australian sociology in the mid- to late 1980s. This perspective has now become predominant over the political economy critique in Australian research and scholarship on health and medicine. Poststructuralism in Australian medical sociology is influenced by the writings of Michel Foucault on medical power and the regulated body. Exponents focus their attention on the diffuse ways in which power operates via medicine and health care and on the importance of language in constructing notions of health and illness (for example books by Lawler 1991; Lupton 1994a, 1994b, 1995a; Petersen and Lupton 1996; Pringle 1998). Some recent textbooks on health and medicine in Australia have sought to combine both perspectives (Petersen and Waddell 1998; Germov 1999).

THE AUSTRALIAN HEALTH CARE SYSTEM

Health care in contemporary Australia is funded by a mixture of private and publicly funded insurance schemes regulated by the federal government in negotiation with state governments, who run the public hospitals. Funding for public care comes from general taxation revenue: the federal government provides funds to state governments to partially support hospital care and reimburses individuals in full or part for fees they pay to individual health care providers outside the public hospital system. State governments provide some additional funding for public hospitals and community health services through state taxation revenue. The Australian health care system can therefore be located somewhere between the universal health insurance system in Britain and the largely private health care system in the United States. This status is, to some extent, reflected in the expenditure on health services, which in Australia in 1997 was 8.3 percent of GDP compared with 6.7 percent in the United Kingdom and 14 percent in the United States (Australian Bureau of Statistics 1999).

The current Australian health care system has its antecedents in the early years of British settlement, in which public medical care was made available by the British government to convicts, the military, and free settlers. Following the cessation of the transportation of convicts in the mid-nineteenth century, the principles of laissez-faire government began to hold sway in the Australian colonies. Medical practitioners embraced these principles, dissociating themselves from government and seeking to set themselves up as entrepreneurial private practitioners. Then followed over half a century of medical entrepreneurialism largely unencumbered by state regulation.

It was not until the early twentieth century that state patronage of doctors, and with it, increased state intervention into the regulation and provision of medical care, began to emerge in Australia. As in other western countries, medical practitioners began successfully to differentiate themselves from other health care providers such as homoeopaths and to position themselves as the preeminent source of “scientific” health care. A series of licensing laws were enacted which enabled the medical profession to set itself apart legally from

other practitioners and to control entry into the profession (Davis and George 1988; Lloyd 1994). From World War II onwards, this position allowed doctors to begin to have a significant influence on government health care policy and to resist government attempts to regulate their work (Willis 1983). From the 1920s, medical specializations began to develop and the various specialist associations were established (Lloyd 1994). In Australia today, general practitioners offer routine, non- surgical health care, referring patients to specialists for more specific care or surgical procedures.

Due in part to the vociferous opposition of the medical profession, it was not until 1975 that the first universal health insurance scheme, Medibank, was introduced by the reformist Whitlam Labor government. This government, however, was voted out of power only a matter of months after Medibank had been set in place. Medibank was gradually dismantled by the incumbent conservative Fraser government, and was finally completely abandoned by 1981. Another change of government back to the Labor Party in 1983 saw the reintroduction of universal health insurance, this time under the name "Medicare." This is the system which remains in place today, albeit with some changes introduced by the Howard government.

The proportion of people privately insured has steadily dropped since the reintroduction of the national health insurance scheme. In 1997 less than a third of the population had private health insurance compared with almost half the population in 1987 (Australian Bureau of Statistics 1999). Since gaining office, the Howard government has attempted to encourage people to seek out private health care (particularly in hospitals), therefore reducing the financial burden on the public system, and to fund this through private insurance schemes.

While medical practitioners work within a system of national insurance for health care, they retain a high level of autonomy. The majority of medical care is provided as a fee-for-service, whether offered in public or private institutions or clinics. Doctors have the right to treat private patients in public hospitals and very few of them are employed exclusively by the state as salaried employees. The government reimburses patients a set amount for each procedure they pay for. Practitioners in private practice are free to set the fees they charge for their services while those treating public patients in public hospitals may only charge the Medicare scheduled fee. It is therefore more lucrative for doctors to treat private patients. The private patient must bear the cost of any extra over the scheduled fee that their doctor charges. There are no restrictions on which doctors people may choose to attend, although a referral from a GP is required for specialist care. Those who have private medical insurance may seek such coverage for procedures or commodities that are not covered by Medicare, such as spectacles or contact lenses and dental procedures, to have some degree of choice concerning the specialist who attends them in hospital (public patients in public hospitals do not have this choice) and to gain entry to a private rather than a public hospital should they require hospitalization.

The national association of medical practitioners, the Australian Medical Association (AMA), has a powerful voice in lobbying government on behalf of its members. As noted above, historically, Australian medical practitioners have sought to avoid becoming salaried employees of the state,

preferring instead to practice medicine as private entrepreneurs. The AMA, to which a majority of doctors belong, has traditionally opposed universal health insurance. This organization sees universal health insurance as a means of allowing government to have greater control over doctors' activities and incomes (Sax 1984).

The Australian health care system is controversial largely because of funding issues. Media coverage constantly warns of the results of underfunding of the public health care system, and the stresses placed on the system by an ageing population and increasing use of high-technology medicine, particularly in relation to hospital care. Long waiting lists and poor conditions in public hospitals are often emphasized in the mass media. For example, a study I conducted of health and medical news stories reported on the front page of a major Australian newspaper in the early 1990s (Lupton 1995b) found that issues concerning health service delivery was the most frequently reported topic. The news stories were highly political, describing disputes and controversies over policy decisions and the distribution of resources, particularly between leaders of the AMA and other medical spokespeople and government ministers and officials.

The Position of the Medical Profession

As noted above, organizations of Australian medical practitioners such as the AMA have wielded a great deal of power as a lobby group in the political arena, particularly in relation to issues around health care funding and provision. Some sociologists have argued that the medical profession in western countries such as Australia has been faced with threats to its power and dominance in matters medical over the past three decades, and thus has become "deprofessionalized." They claim that doctors' autonomy to practice medicine has been challenged by the state and that patients have become more cynical, ambivalent, and consumeristic in their attitudes towards members of the medical profession (Haug 1988; McKinlay and Stoeckle 1988).

It is certainly the case in Australia that the power of the medical profession has, to some extent, been challenged by the emergence of patient consumer groups and such state-funded organizations as health complaints commissions. Patients have been encouraged by such organizations as, on the one hand, the Consumers' Health Forum and the Australian Consumers' Association, and on the other hand, right-wing policy "think tanks" (Logan et al. 1989) to view themselves as consumers: that is, to challenge medical authority if they feel it to be negligent or inaccurate and to demand second opinions and "value for money." Despite this, research suggests that many Australians do not want to adopt the consumerist approach to health care, preferring to invest their faith and trust in their doctors. Even though they may have a more jaundiced and cynical view concerning doctors now than in the past, Australians still respect members of the medical profession, particularly their "own" doctors.

One study of Sydney patients, conducted by myself and colleagues, found that although they had chosen their general practitioner in a casual manner, only a small minority of the respondents reported ever changing to another GP or even considering such a move. While they may have occasionally sought help from other doctors or alternative practitioners, the majority of respondents adhered to a satellite rather than a pluralist model of health care, preferring to return to their regular GP for care whenever possible (Lupton et al. 1991). In another, more recent study, again of patients living in Sydney, I found that the participants expressed their belief in the power of biomedicine to cure illnesses and save lives, and were particularly impressed by the advances made in high-technology surgical procedures and drug therapies. The authority and expertise that attend biomedicine and those who are medically trained still carried much weight among these patients (Lupton 1996, 1997).

These findings would suggest that the Australian medical profession retains a significant degree of social and cultural status. While Medicare does incorporate some degree of structural control over doctors' professional activities, as most general practitioners and specialists are not salaried workers in public hospitals but rather are self-employed, they are under far less government control than are practitioners in such fully public systems as the British National Health Service. Further, medical practitioners in Australia, particularly AMA officials, still have a high profile in terms of acting as influential spokespeople on medical matters in the public domain. They are frequently reported as authoritative experts in the news media in reports on medical and health issues compared with other health care providers or consumer bodies (Lupton 1995b; Lupton and McLean 1998) and hold important roles in decision-making bodies in hospitals and government agencies (Willis 1993). Although news stories in the Australian press report cases of medical negligence or misconduct, they also frequently represent doctors as skilled, heroic, and fighting to maintain high standards of patient care in the face of funding pressures for health care delivery (Lupton and McLean 1998).

In recent years, challenges to the dominance of orthodox practitioners in Australia have come from practitioners of alternative therapies, who have sought to have their therapies legitimized. Universities now offer courses in such therapies as chiropractic, homoeopathy, and acupuncture, and chiropractors and osteopaths have achieved statutory registration as legitimate health care providers in Australia. Only acupuncture is officially recognized through attracting a Medicare rebate, however, and this is only the case if it is performed by a medical practitioner. The AMA has also played an important role in opposing the entry of alternative practitioners into orthodox health care system, arguing that alternative therapies are "unscientific" (Easthope 1993). The medical profession thus far has successfully prevented alternative therapists from practising in hospitals.

One study conducted in the state of South Australia in 1993 found that one in five of the respondents had ever sought treatment from alternative practitioners (MacLennan et al. 1996). But while alternative therapies continue to gain popularity among Australians, orthodox medicine remains far and away the first source of health care. Although more Australians are seeking care from alternat-

ive therapists, they have not rejected biomedicine, but rather tend to turn to alternative therapy when they find that orthodox medicine cannot provide a cure for a particular ailment (Lloyd et al. 1993; Lupton 1998). The 1989–90 National Health Survey found that fully 20 percent of respondents had consulted an orthodox medical practitioner during the two weeks prior to the survey, while only 1.3 percent had consulted a chiropractor, 0.2 percent an acupuncturist, and 0.3 percent a naturopath during that period (Australian Bureau of Statistics 1992).

In terms of reasons for seeking alternative therapies, it would appear that the nature of the doctor–patient encounter and disillusionment with what orthodox medicine can offer for a specific ailment are important factors. One study found that the patients greatly valued the time the practitioners spent with them, the personalized and individualized attention they received, the "natural" and "holistic" qualities of the therapy and the opportunity to seek help for conditions, particularly musculoskeletal, digestive, and emotional or nervous problems, that orthodox medicine had been unable to treat (Lloyd et al. 1993). Dissatisfaction with the medical encounter and doctor – patient relationship was found to be a major reason for seeking alternative therapies by Siahpush (1998) in his study of people living in a rural region of Australia. One response to the adoption of alternative medicine by patients is the decision by doctors to incorporate such therapies as acupuncture and chiropractic into their own practices. A recent study found that 15 percent of Australian GPs were offering acupuncture as part of their services to patients (Easthope et al. 1998).

Nurses in Australia have also attempted to gain greater professional power in relation to medical practitioners. Through the legitimization of nursing training via university courses and the introduction of the "nurse practitioner," a nurse who is qualified to independently perform procedures that were previously the preserve of medical practitioners only, nurses have sought greater autonomy and a higher professional status than they held in the past (Wicks 1999). Despite these moves, nurses still remain very much subordinate to medical practitioners in terms of status, power, and influence in health care provision decision-making.

Social Causes of Health and Illness

Social class is a factor in patterns of health and ill health in Australia as it is in other western societies. While it is often claimed that Australia is a "classless" society compared to Britain, there are distinct social groupings related to such aspects as income, education level, area of residence, and occupation that influence health outcomes. As in other western nations, people from lower socioeconomic classes have a higher mortality rate and a lower life expectancy than do the more advantaged, and suffer from some illnesses in greater numbers. For example, it has been reported by the Australian Bureau of Statistics (1999) that those people living in areas of greater socioeconomic disadvantage tend to rate their own health status more negatively and visit their doctors more often

than do those living in advantaged areas. Death rates from ischaemic heart disease, lung conditions such as bronchitis, emphysema, and lung cancer, diabetes, cerebrovascular disease (mostly strokes), suicide, and traffic accidents are higher for those living in the most disadvantaged areas. More men and women in disadvantaged areas are likely to smoke cigarettes and drink alcohol at a medium- or high-risk level, and more women from these areas are overweight or obese. People in these areas are less likely to engage in preventive health actions such as having their children immunized against infectious disease or taking part in cancer screening. There is also a social class difference in patients' perspectives on doctors. Patients who are more highly educated and who hold middle-class occupations are more likely to exhibit consumeristic attitudes toward their doctors, tending to challenge their authority to a greater extent (Lupton et al. 1991; Lupton 1997).

Ethnicity and race have an impact on health states for both better and worse among Australians. People from southern Europe who have emigrated to Australia have better health outcomes in relation to such diseases as heart disease than do Australians of British ethnicity. It has been speculated that their diet, which has less animal fat and more vegetables and grains than the standard British-style cuisine, is the reason for this. Their health risks may increase with length of residence in Australia, however, as immigrants may move towards a diet that is closer to the British style (Manderson and Reid 1994). Recent immigrants have better health than do the Australian born, most probably because they undergo stringent health checks before being granted immigrant status and are younger, on average, than the general Australian population. There is evidence to suggest that the health status of some immigrants worsens after their arrival in Australia. Immigrants may be prey to illness as a result of cultural dislocation, loneliness, and depression (Julian 1999). Men of Greek and Italian ethnicity, for example, are more at risk of coronary heart disease the longer they reside in Australia (Davis and George 1988). Refugees are more likely to suffer from psychiatric disorders than other Australians, often as a result of their enforced migration and traumatic experiences in their country of birth.

People from non-English-speaking backgrounds often find that health services available to them in Australia are culturally inappropriate or may have difficulties communicating with health workers because of poor English and a lack of available interpreters (Julian 1999). New immigrants are more likely to be employed in low-skilled, dangerous occupations and therefore to suffer from work-related injuries. Migrant women from non-English-speaking backgrounds, in particular, have a higher incidence of work-related injuries and illness and a greater incidence of mental health problems than do Australian women of English-speaking backgrounds. Their health often declines after their arrival in Australia due to problems of dislocation and social and cultural isolation, as well as poor working conditions (Alcorso and Schofield 1992).

Aboriginal people suffer the greatest socioeconomic disadvantage, and subsequently the worst health, of any other ethnic/racial group in Australia. The descendants of those Aboriginal people who survived the early decades of

colonization were subjected in the twentieth century to acts of rank racial discrimination. These included the forcible removal of infants and young children from their parents, a practice which continued until the 1960s in the attempt to "assimilate" Aboriginal people into white Australian cultural mores. Members of this "stolen generation" have suffered health and psychological problems as a result of their removal from their families and being brought up in missions, orphanages, or foster homes where some were subject to physical or sexual abuse (Human Rights and Equal Opportunity Commission 1997).

Aboriginal people currently have greater rates of unemployment than do non-Aboriginal Australians, have lower education levels, suffer from problems such as alcohol abuse, petrol sniffing, and violence in greater proportions, and are far more likely to be jailed than other Australians. They are more likely to smoke cigarettes, commit suicide, or inflict self-harm. Their socioeconomic and social disadvantage is mirrored in their health states. Aboriginal men and women have significantly lower life expectancies than do non-Aboriginals and the mortality rate of Aboriginal infants is far higher than for non-Aboriginals (Gray and Saggers 1994, 1999). Although successive Australian governments have recognized the plight of Aboriginal people, few attempts thus far have proved successful in ameliorating their poor health status. As with other "Fourth World" or indigenous populations in First World countries, such as the Native Americans and Maoris, Aboriginal people argue that their lack of access to traditional culture, customs, and rituals, their enforced dependence on the colonizing culture, and their lack of opportunity to engage in self-determination due to their dispossession from the land are major sources of cultural dislocation and ill health (Reid and Lupton 1991).

Conclusion

The nature of the health care system and the status of the medical profession in Australia demonstrate a number of features of the history, politics, and social structure of that country. In particular, white Australia's beginnings as a British penal colony, a subsequent change to laissez-faire government and then to increased government regulation of the medical profession followed by a move toward neo-liberalism have been important in the development of the current system. So too, the power of medical associations to disrupt government initiatives to introduce universal health care has been an important influence in Australian health care policy, particularly in the twentieth century. As in other western countries, the social power of the orthodox medical profession in Australia has been subject to some challenge in recent decades on the part of consumer bodies, practitioners of alternative therapies, and other health care professionals. Although its standing may have been somewhat eroded, particularly by negative media coverage, the Australian medical profession retains a significant degree of political, social, and cultural status. Its leaders continue to influence public policy, acting as influential spokespeople on health matters in decision-making bodies and media reports. For the most part, the medical

profession and the institution of scientific medicine are still held in high regard by patients in Australia.

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