SOCIAL CAPITAL AND PUBLIC EXPENDITURE IN AUSTRALIA

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This article describes the effect of changes in public expenditure on health and education services in Australia, and draws international comparisons.

The structure of developed economies has changed radically in recent decades. As late as the 1960s, it was reasonable to describe the economy in terms of three stages of production: primary production—of agricultural and mineral raw materials; secondary production—a manufacturing industry that transformed raw materials into items of final consumption; tertiary production—a sector that provided transport, distribution, retail, and financial services to the primary and secondary sectors. Services such as health and education did not fit into this model, but since they accounted for less than 20 per cent of employment, they were commonly regarded as a kind of 'overhead cost' for the economy as a whole.

Although this three-stage model continues to dominate national accounts, and to inform the economic worldview of many policymakers, it has long since ceased to be appropriate. The primary and secondary production sectors (agriculture, mining and manufacturing) now account for less than 20 per cent of total employment (down from 35 per cent in the 1960s); while education, health, and other community and personal services account for nearly 30 per cent of employment (up from 20 per cent in the 1960s). There has also been strong growth in property and business services employment, which now accounts for 10 per cent of all employment. The share of the traditional tertiary sector (wholesale and retail trade, construction and financial services) has remained static at around 40 per cent.[1]

This change in employment patterns reflects a more fundamental change, from an economy based on the use of physical capital to produce material goods to one based on the use of human and social capital to produce services. Three basic forces are at work here. First, rapid technological progress in agriculture and manufacturing has enabled a smaller number of workers to produce any given physical output. Second, the same technological progress has greatly reduced the demand for raw physical effort and increased the importance of skilled and motivated workers. Third, the resulting increase in income has enabled households to move up Maslow's 'hierarchy of needs'.[2] Consumption of material goods is crucial in meeting basic needs for food, clothing, and shelter. However, services are of greater importance in meeting higher-level needs for social interaction, self-actualisation, and fulfilment.[2] Economists have a relatively good understanding of the physical goods economy. By contrast many issues remain unresolved in our understanding of the role of human and social capital and the services they generate.

The links between the various forms of human and social capital are complex, but nonetheless are crucial. There is a well-established link between higher levels of education and better health status.[3] Higher levels of parental (particularly maternal) education also contribute positively to a range of measures of wellbeing. These links are strong even when the correlation between education and income levels is taken into account.[4]

Evidence on the consequences of improved health status is rather less satisfactory. In part, this reflects the fact that, whereas standardised measures of educational attainment are easily observable, measures of health status are still relatively crude and have not been standardised.

In this context, a notable development of the past two decades has been a dramatic increase in the proportion of the population, and particularly of men aged between 50 and 65, receiving various forms of invalidity benefits. There is no evidence to suggest that there has been an increase in morbidity among this group. Rather, the rise in official invalidity reflects the realities of the labour market. The probability of an unemployed male over 50 finding employment is small, even for the best-qualified. Health problems can reduce this probability to zero, even though they might not have been considered incapacitating in the past.

The direct effects of improvements in health and education status can be interpreted using the notion of human capital. The underlying metaphor is derived from the observation that improved health and education for an individual leads to a flow of benefits, including greater productivity capacity and improved wellbeing, in the same way as investment in an item of physical capital yields a flow of outputs over time.

More complex issues arise with the notion of social capital. The basic idea is to extend the metaphor of human capital to take account of the affect of the effects of social relationships and structures on productive capacity and wellbeing. Despite the difficulty of making this metaphor operational, there can be no doubt of the importance of these issues.

The response of Australian governments to the changing economic and social structure has been based on past experience rather than future needs. For the past two decades, the central focus of policy has been

'microeconomic reform', a policy agenda that begins with the perception that inappropriate policies and economic rigidities are imposing unnecessary costs on the primary and secondary sectors, which are seen as the engines of growth for the economy in general and exports in particular.[5]

The results of this agenda have been negative for human services. First, excessive veneration for the business methods of the private sector has led to the rise of 'managerialism'.[6,7] Second, there has been a misguided attempt to let market forces determine the appropriate level and form of health and educational services. Finally, there has been continuing pressure to reduce what is referred to as 'public consumption expenditure', including health and education (this classification encompasses publicly funded private health and education as well as public health and education). As public expenditure has been constrained in the 1990s, so has the growth in employment in the human services sector.[8]

In this article, attention is focused on the effect of changes in public expenditure on health and education services. Australia's total expenditure on health care has remained roughly constant at around 8 per cent of gross domestic product (GDP) for the past two decades, comparable to most other developed countries with the exception of the United States. The mixture of public and private contributions has also remained broadly constant. The pressure to cut expenditure has been offset by steadily increasing demand for health services, leading to a situation of chronic strain, manifested in waiting lists and public dissatisfaction.

INTERNATIONAL COMPARISONS

The example of the United States, where large proportions of the population are effectively excluded from access to all but emergency care indicates that higher levels of health expenditure do not necessarily imply improved access to health services or better health outcomes. On the other hand, as personal income levels rise, the share of income allocated to basic needs such as food declines, and the share of income allocated to health care should rise.

However, the unsatisfactory experience of the United Kingdom, by comparison with higher-spending European countries, indicates the dangers of taking cost containment too far. The government of the United Kingdom has promised to improve British health care standards to those prevailing in other leading European countries, but has conceded that this goal is unlikely to be achieved before 2010. Economic analysts sympathetic to the current government's approach to health care reform have argued that substantial increases in expenditure will be required.[9]

EDUCATION

The situation is even less satisfactory with respect to education. Despite the fact that Australia has a relatively young population, and could therefore be expected to spend more on education, the ratio of expenditure on education to gross domestic product in Australia is below the Organization for Economic Cooperation and Development average, and reliance on private expenditure is well above the average.

The quality of education services available to children from low-income families has deteriorated as a result of cuts in public expenditure. This has been reflected in declining rates of school completion, and more recently, in declining university enrolments. The experience of South Australia provides a particularly striking example. Until the early 1990s, South Australia's performance on this criterion was strong. South Australia had a higher apparent retention rate (an estimate of the proportion of Year 8 students continuing to Year 12) than any other Australian state. Expenditure cuts introduced in 1994 by the newly-elected Liberal government had a severe impact on educational services and an almost immediate impact on educational outcomes. From July 1994 to December 1995 teaching staff positions in public schools were reduced by 1100 and non-teaching positions by 110.[10] Over the same period, school retention rates dropped at a rate not equalled in any other Australian state, though the pattern elsewhere was broadly similar. In only two years, the school completion rate dropped by 10 percentage points, from 81.5 per cent to 71.6 per cent.[11] The completion rate for boys in South Australian government schools has fallen to 51 per cent, a return to the outcomes of the 1970s.

CONCLUSION

The recent federal election campaign represented a missed opportunity for Australia to address the issues raised by the transition to an economy based on human and social capital. The 'Knowledge Nation' report commissioned by the Labor Party raised some important questions,[12] but the Labor campaign platform offered only incremental changes in expenditure policy, while the government derided the report and offered no serious alternative. Issues relating to health and social capital were barely discussed. Despite this, the issue of social capital formation will dominate the political agenda of the 21st century.

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SOCIAL INCLUSION AND THE PUBLIC HEALTH: THE CASE FOR PARTNERSHIPS

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Governments of both the right and left espouse community participation as a means of engaging with their constituencies. Concepts such as social capital, social justice, social participation, social coalition,[1] equity, and communitarianism, are frames through which social policies are viewed. These directions in social policy ('whole of government') approaches in Australia; the 'third way' and 'joined-up communities' in the United Kingdom; and related concepts of 360° accountability,[2] are relevant to the way the health system will be organised in the future.

In the early 1980s, the commonwealth government established national health goals and targets.[3] States too, defined targets, goals, and outcomes for heath programs. These were managed approaches, suggesting that health improvement could be engineered. Tweak the knobs on the grand dial and health would then be distributed. Implicit in this thinking is the belief that the whole population is homogenous and that its health can be managed from the top down.

The community, however, is not so constructed. Rather, it is many communities—communities interacting with each other and within themselves—each with their own patterns of health. Inner-city communities are different from outer urban communities, and both of these are different from rural communities. There are the marked differences between Aboriginal and non-Aboriginal communities, and between migrant groups. There are also masked differences. For example, in the South West of Sydney the health of the population is about the same as the average for New South Wales, but the massed data belie the poor health of the Australian-born residents locked into poverty. Their predicament is diluted by the better health of migrant populations.[4]

By attending to the health needs of particular communities, overall population health can be improved. This is not to deny the importance of mass campaigns such as immunisation, which depend on reaching into communities for their effectiveness.

Community participation and social inclusion are now ideas of good currency. They are intuitive ideas for many and influence the way politicians think. Communities think this way as they search for quality in communal life. With this emphasis on community, there is a shift towards young people and their development as the pivot for local initiatives. This shift in concern for young people is a threshold test for the capacity of our communities to be nurturing and protective environments.