Chapter 4

Health Economics

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The recognition of health economics as a specialised area of study within economics is often dated to the late 1960s and early 1970s, a period that coincided with the rapid growth of health care expenditure in all developed economies (Culyer and Newhouse 2000). Much of the increasing budget was borne by governments as new social programs were initiated to provide access for the poor, the elderly and otherwise disadvantaged groups. Yet there was no obvious gain in population health, and mounting criticism of the futility of, if not harm due to, modern medicine. Nonetheless, public demand for medical care continued to grow exponentially.

Economists' attention was thus drawn to the health sector. The analysis of health care as a special commodity, often dated to Arrow (1963), laid the foundations for the economic analysis of the health sector. There is nothing special about the economic analysis applied to this sector; as Fuchs (1989) has pointed out, it draws from finance and insurance, industrial organisation, labour, public finance, and welfare, but it requires also a detailed knowledge of health technology and institutions.

The field has grown rapidly and become increasingly specialised – for a description of its history, see Culyer and Newhouse (2000). There are now four health economics journals, the *Journal of Health Economics* (established in 1982), *Health Economics* (1992), the *Journal of Health Care Financing* (2000) and, more recently, the *European Journal of Health Economics*. The *Journal of Mental Health Policy and Economics* and *Pharmacoeconomics* are aimed at a particular clinical/policy audience. *Social Science and Medicine* carries a substantial health economics content, as do several health policy and technology assessment journals. In addition to the general economics journals, much health economics can be found in medical, public health and other journals aimed at health professionals.

In Australia, the beginnings of health economics are inextricably linked with the names of Deeble and Scotton and their work on the financing and delivery of health care. The policy impact of this was immense, providing the basis for universal, publicly financed health care, first as Medibank in 1975, and then as Medicare in 1984. However, from the 1960s to the 1980s, an academic base for Australian health economics was slow to develop; what little work was done was often prompted by official inquiries and constrained by the lack of data (Richardson and Wallace 1982). There have been substantial developments since then. The Australian Health Economics Society, from its first meeting in 1979, has provided a focus for and publication of theoretical and applied research. Specialised university-based research centres have been established. Economists specialising in health are employed in economics and other departments in universities, in government and in the private sector.

Much Australian health economics research and analysis is also written for a health professional audience. Around 50 per cent of all articles are found in health (rather than economics) journals, but many of these are authored by clinical or health-services researchers. Therefore this does not adequately represent the output of economists whose research interests are focused on health, but it does illustrate that much of the work is applied rather than conceptual, theoretical or methodological. In the specialised health economics journals, which generally require conceptual, theoretical or methodological advances rather than non-innovative applications, the Australian contribution is around 1 per cent (a total of twenty-six papers) of the total.

These specialised journals do not reflect the contribution of health economics to policy development. The 'permeation of economic modes of thinking', as Culyer (1981:10) described this process, has been substantial, not just in universal insurance but also in the appraisal of new public health interventions, the evaluation of new hospital programs, the reimbursement of new pharmaceuticals and new medical procedures, hospital funding, the development of private health insurance incentives, and the limitations on medical care providers. The development of health economics and health policy have always been closely linked in Australia, and policy development and evaluation have been major stimuli for research. Hence, an understanding of the Australian health care system and recent policy development is necessary to place health economics research in its context.

The Australian health care system

The three major components of the Australian health care system are public and private hospitals; fee-for-service, private-practice medical care; and fee-per-item, subsidised prescription pharmaceuticals. Responsibility for policy and expenditure is divided between the Commonwealth government (medical benefits and pharmaceutical benefits) and the states and territories (public hospitals). There are substantial opportunities and incentives for cost-shifting, particularly but not only between the different levels of government (see Palmer and Short 2000; Senate Community Affairs References Committee 2000).

These arrangements, established after World War II, were not influenced by Australian economists and have remained unchanged by the introduction of universal, publicly financed health insurance (see Richardson and Wallace 1982). The new arrangements addressed universality (as there had always been at least 17 per cent of the population without insurance), fairness in financial contributions (the previous system of payment through tax-deductible insurance premiums was regressive), and the administrative costs of multiple insurers and insurance schemes (see Scotton 2001).

Private health insurance remained to cover in-hospital private treatment (although all Australian citizens are entitled to free public-hospital treatment) and ancillary services

(such as dental care and physiotherapy). It also remained highly regulated, with mandatory community rating (all purchasers paying the same premium irrespective of predicted claims). Health care financing remained the most significant difference in health policy between the two major political parties until recent years, when bipartisan support emerged for the continuation of a universal publicly financed scheme (1996) and for government support for private health insurance (1999). Recent measures have been introduced to encourage the purchase of private health insurance: first, a rebate on insurance premiums for the less well-off, and tax penalties for the wealthy; then a 30 per cent rebate on health insurance premiums; and, most recently, lifetime health cover, where the premium paid is related to the age at which the individual takes up health insurance. These are described in detail in Hall, De Abreu Lourenco and Viney (1999). While these measures constitute some move away from pure community rating, insurers cannot refuse insurance cover to any individual.

Hospitals are the most expensive component of the health system, with funding negotiated between Commonwealth and states every five years. Public-hospital budgets have been effectively capped, thus forcing hospitals to ration services by reducing services and/or costs. Access to and shortages in public hospitals – waiting lists and times for elective surgery, emergency departments being closed to new cases – remain a focus of public concern and political attention. The private-hospital system had grown in size and complexity before recent private-insurance initiatives. Within the public-hospital system, there is a complex interaction between private and public financing and provision. There have been substantial changes in the payment of hospitals, with some variation across the states and territories, in an attempt to improve efficiency.

Subsidised pharmaceuticals have been the major area of growth in health care expenditure over the past five years. The price is negotiated between the Commonwealth government and the manufacturer. Patients pay a fixed copayment. Formal economic evaluation, in addition to evidence on safety and clinical effectiveness, is required before new items are accepted on the subsidised list. Australia was the first country to require this.

For medical services, there is no control of the fee levels charged but there is a fixed rate of reimbursement from Medicare, thus effectively establishing a floor price. So for medical services and pharmaceuticals, although government has some influence on price, there are no substantive controls on quantity and thus there is no effective expenditure cap. The supply of doctors has increased significantly over the past fifteen years, accompanied by growing service utilisation and expenditure. General practitioners play an important gatekeeping role in the health care system in that their referral is essential to the use of specialist services, diagnostic services, pharmaceutical therapies and admission to hospital. Workforce growth has not corrected substantial imbalances in distribution favouring inner cities over rural, remote and outer-suburban areas. There is a significant shortage of trained nurses in the workforce, with most nurses leaving their field for other sectors.

The basic principle of the system is universal access to needed care irrespective of ability to pay. Although the structure of the system is designed to ensure that access is universal and not impeded by financial barriers, it is not clear that this has been

realised. The Pharmaceutical Benefits Scheme is limited to prescription drugs; the out-of-pocket cost of medical services varies with where people live; there is increasing reliance on private hospitals and private insurance; and the location of facilities and providers does not accord with the population distribution. There are population subgroups that appear to have substantially poorer access to health care in general, including those living in rural and remote Australia, the economically disadvantaged, and some immigrant groups (Duckett 2000).

Aboriginal and Torres Strait Islander peoples have the worst health of any Australian population group, with life expectancies some twenty years fewer than those of other Australians (AIHW 2001). Although stark health differences have been documented across many health indicators and over time, health care expenditure estimates were not produced until 1998. They showed that per capita spending on Aboriginal and Torres Strait Islander peoples was only 8 per cent higher than the national average and with different patterns of service use (Deeble 1998).

The international fashion for major health care reforms of the late 1980s and early 1990s, based on the ideas of Alain Enthoven (1978), was to separate purchaser and provider functions in health care delivery, and make greater use of competition to drive health care markets. In Australia, these found effect in a national plan for reform (National Health Strategy Australia 1991), but actual developments in the following fifteen years did not attempt anything so radical. Reforms, though often involving quite major reorganisations within state health services, were piecemeal at the national level; while these could be criticised as ad hoc and muddling through, they can also be seen, in retrospect, as an incremental approach to ensuring evolutionary rather than revolutionary reform (Hall 1999). The complexity of Australia's health system and frequent incremental policy changes provide many avenues for investigation and suggest a considerable research agenda for Australian health economics.

Insurance and financing

The value of private health insurance in a system with universal access to free hospital treatment is not immediately obvious and so there have been a number of papers modelling insurance purchase, either as individuals (Cameron et al. 1988; Cameron and Trivedi 1991; Hopkins and Kidd 1996; Ngui, Burrows and Brown 1989; Schofield 1997), or as household units (Wilson 1999). All of the studies included socioeconomic and health-related factors as explanatory variables. In general, the likelihood of having insurance was found to increase with age, being married, higher income and, to a lesser extent, poor health state.

Most commentators, including the Industry Commission (1997), have argued that adverse selection (and the consequent increase in premiums) was the major cause of falling insurance levels. Vaithianathan (2001) argued that the extent of adverse selection has been overstated, as the number of different insurance plans and extent of coverage suggests that insurers designed plans to discriminate across different risk groups. Cameron and McCallum (1996) argued that the reduced government subsidy to the

private funds and the increased size of the reinsurance pool may have contributed to the decline.

There has been limited empirical investigation of the impact of rising premiums, because the lack of data on these prices in the Australian Bureau of Statistics National Health Surveys has limited the extent to which this can be investigated. Butler (1999), by constructing a price variable from average premiums at the state level and expected benefits data by age, estimated a price elasticity of demand for hospital insurance of −0.5 and for ancillary insurance of −0.35, with income elasticities around 0.2.

A recommendation for lifetime health cover (the third stage of insurance incentives) came from the Productivity Commission review of the private health insurance industry. However, the proposals were not developed from any academic research but had been put forward by the insurance industry (Hall 2001a). The introduction of such proposals may have been subject to detailed and careful analysis, but if so this was not independent and not in the public domain. What analytical work there is has followed the policy implementation. It is still early to evaluate the effect of the various incentives, particularly lifetime health cover. Butler (2001) argued that the rebate (stage 2) was expensive (currently more than $2 billion per annum) but had little effect; while the least-cost strategy, age-related premiums, was the most effective. However, this strategy has had considerable cost implications due to increased rebates.

It is not clear that the recent rise in insurance coverage will be sustained over time. In the absence of studies investigating the determinants of the demand for private health insurance based in theories of behaviour, forecasts remain conjecture.

Part of the rationale for the insurance incentives was that higher private insurance would lead to higher use of private hospitals and hence reduce the pressure on public hospitals. There have been few empirical studies of the interaction between insurance and hospital use. Cameron et al. (1988) modelled insurance choice and health-service utilisation using 1977–78 data (restricted to single persons over the age of eighteen) and found that the insured used more health services. Savage and Wright (2001), modifying Cameron's approach and using 1989–90 data, also found higher utilisation associated with insurance, by a factor of up to three in private-hospital length of stay.

Further reforms to health care financing depend on the directions chosen for public and private financing and, within the latter, user payments and insurance. While there are strong advocates for more reliance on market forces, these arguments are more often found in the popular media than the academic press. Scotton's proposals for managed competition, that the health care purchasing role be taken by insurers who compete for customers, have been developing since the 1980s and are comparatively well-documented (Scotton 1999). The key features of his plan are that budget-holders, including private insurers and public agencies, be allowed to compete; that all public funds be incorporated into a single pool; that public funds be distributed to budget-holders as risk-adjusted capitation payments; and that additional copayments for service delivery and top-up of insurance premiums be allowed. The expectation of lower insurance costs depends on competitive purchasing of health care through some funds pooling (discussed further below). Whether these theoretical benefits could be realised depends on the extent of profit-driven cost-cutting rather than better purchasing of

care. There is little Australian empirical research on which to base the setting of the appropriate capitation levels. Important issues are yet to be determined: whether competition across budget-holders will be driven by consumer preferences, quality and efficiency, rather than insurers attempting to select low-risk customers (that is, cream-skimming); the extent to which adverse selection will occur; and the differential impact of incentives and motivation across private for-profit, private not-for-profit, and public budget-holders.

Funding health-service provision

Funds pooling can be advanced without managed competition. In Australia, it has been progressed since the mid-1990s through a series of demonstration projects, the Coordinated Care Trials, in which funds were combined from medical benefits (Commonwealth), pharmaceutical benefits (Commonwealth), public hospitals (state) and the community health program (state) (see Duckett 2000). The results of evaluation studies were equivocal, showing that better care, improved health outcomes and lower costs were not readily attainable. In fact, setting up the trials produced evidence of underprovided care as well as duplication of service provision. The evaluators concluded that few of the demonstration programs were likely to remain financially viable (DHAC 2001). It can be argued that the demonstration programs were inadequately planned with insufficient data on which to determine the level of funds to be pooled, with weak incentives, and a narrow framework for evaluation, and so the results are not conclusive evidence of no benefit from funds pooling. This strategy is, however, likely to remain on the reform agenda in Australia because it is the only substantial reform that is being considered and developed internationally (Hall 2002; Maynard 2002).

The most important question about funds pooling is who holds and manages the funds, effectively becoming the purchaser of care. What follows from this is what incentives the purchasing agency faces, whether purchasers can be profit-seeking, as with managed competition proposals, and what effect this will have on service volumes and quality of care. At a practical level, the substantial information infrastructure required – to set the appropriate capitation rates, monitor cream-skimming in risk selection, and assess quality of care – is currently lacking (van Gool et al. 2002).

Hospital productivity and payment mechanisms

Support for private health insurance has also been justified on the basis that it will increase the use of private hospitals, which are presumed to be more efficient. Although private insurance and use of privately provided services are usually considered as linked, this does not have to be the case, because private patients are treated in public hospitals and publicly funded care could be purchased from private providers. Therefore, the comparative efficiency of public-sector and private-sector provision is an important issue.

Butler (1995), reporting on a major study of hospital cost functions, found some evidence that private hospitals were less costly than public, after adjusting for casemix (differences in types and severity of patients treated), scale and occupancy levels – but the analysis was limited by the lack of individual hospital data, and the inadequate classification of private hospitals. Casemix classification has advanced substantially since then. US work on diagnosis related groups (DRGs) was translated to Australia in the mid-1980s, largely due to the research and advocacy of Palmer (Duckett 2000). Adaptation and implementation have required a major research effort in the development of classification systems, comparative weights for different types of cases, and monitoring classification, most of which involves cost accounting rather than economic analysis. The result is that much more disaggregated data are now available on hospital outputs.

More recent studies support the view that the private sector is at best no more efficient than the public sector. Using DRGs to weight cost per admission, Duckett and Jackson (2000) showed that public hospitals were no more expensive than private hospitals and possibly less. There are a number of studies that focus on particular case types rather than hospital-wide efficiency. For example, Robertson and Richardson (2000) showed that heart-attack patients in private hospitals had the highest rate of procedures, and private patients treated in public hospitals had a higher rate, compared to standard public treatment. However, these findings do not address which is the 'right' rate; it is as plausible that public patients were undertreated as private patients overtreated. However, other studies find similarities in treatment between the two sectors (for coronary disease, Harper et al. 2000; for affective disorders, Goldney, Elzinga and Kent 1996).

There are numerous applications of stochastic frontier analysis or data envelopment analysis to US and European hospitals – although there remain unresolved issues concerning the conceptual basis, methodological approach, and data quality and availability. These techniques can be used to compare efficiency between public and private sectors, or to benchmark performance within groups of similar hospitals. The few Australian studies in this vein tend to explore the techniques, rather than reach definitive conclusions, and are working papers rather than peer-reviewed publications (Webster, Kennedy and Johnson 1998; Yong and Harris 1999).

The major change in the funding of hospitals, also driven by developments in casemix measures, has been towards payment on a per-case-type treated. This has been adopted by all states except New South Wales, and endorsed by the Commonwealth (Stoelwinder and Viney 2000). It has been argued that casemix funding provides incentives to treat as many patients as possible at as low a cost as possible, promoting technical efficiency. There has been little debate or critique, even though the incentives also encourage admitting easier patients (cream-skimming), skimping on quality, maximising readmissions, and pushing cases into more complex (financially rewarding) classifications. Nor does this funding mechanism address the issue of what level and mix of services are provided (allocative efficiency). Yet the substantial variations in service utilisation account for more variation in expenditure levels than cost per case.

Consumer and provider behaviour

While there have been several studies of consumer behaviour in respect of the purchase of health insurance, there is little research into health care use. Yet understanding what influences service use is crucial to predicting the effect of rising copayments. Similarly, investigation of consumer behaviour can contribute to understanding lifestyle choices and the household production of health, and therefore the development of effective public health policies. Health care consumers, generally poorly informed about their health and the effectiveness of available treatments, rely on expert advice – so provider behaviour and the interaction of consumers and providers are also important areas for research. For instance, the existence of informational asymmetries gives rise to the supplier-inducement hypothesis; that is, that doctors can influence the demand for their services so that provider incomes can be maintained despite an increase in doctor supply.

Utilisation has certainly increased over time with the doctor supply, and rising service volume has been associated with growth in doctor numbers and lower prices (higher bulk-billing rates) (Hall and van Gool 2001). Richardson (1999) concluded from econometric modelling that supplier-induced demand was indeed demonstrated. While these, and similar findings from other countries, have convinced most health economists of the existence of supplier-induced demand (Richardson 2001), the underlying theory and the interpretation of the empirical evidence remain contentious (Borland 2002). However, if the policy goal is to constrain the use of medical services, then the existence of supplier-induced demand is less critical, as supply-side controls will reduce utilisation and hence expenditure.

Supply-side controls have been used in Australia in limiting provider numbers through medical-school entry, the number of new practitioners accredited for the purpose of Medicare reimbursement, and targets for specialty training positions (Hall and van Gool 2001). The Australian Medical Workforce Advisory Committee (AMWAC) undertakes medical workforce planning, although there are several ways in which this approach could be strengthened (Borland 2002). The geographic distribution of the medical workforce has not been addressed by AMWAC (although a number of policy initiatives have been aimed at improving doctor supply in rural areas), and increasing supply has not improved the imbalance – arguably it has exacerbated it. Despite acute shortages in the nursing workforce, due particularly to low retention rates, this area has not been subject to extensive research and investigation in Australia. Understanding entry, exit and location decisions could do much to inform policy development.

Welfare assessment and evaluation

The structure of Medicare was intended to ensure equity of access to health care and equity in paying for it, but few commentators believe that equity goals have been met satisfactorily (Duckett 2000). Empirical work tends to treat utilisation of health care as equivalent to access, even though conceptually and in policy terms access is concerned with barriers to use (Mooney et al. 1992). Nonetheless, studies of utilisation can be

useful in highlighting where barriers may exist. Low socioeconomic groups are high users of health services, so considering use without adjustment for health status provides limited insight into access and equity.

Comparison of use of services with tax and other payments by income groups demonstrates the progressivity/regressivity of the system. The only comprehensive Australian study showed that the privately insured higher-income groups were favoured (Lairson, Hindson and Hauquitz 1995). However, this study used 1988–89 data, and given the substantial changes in financing and delivery patterns over the past ten years, this can be expected to have changed. There has been no empirical analysis of the impact of the recent health-insurance subsidies on the distribution of financing, although van Gool et al. (2002) show that there has been a redistribution in favour of the upper-income groups.

Evaluation requires a normative judgement as to what constitutes an improvement in social welfare, and thus a definition of the goals of the health care system. Empirical research can, however, investigate individual attitudes to health-system goals. Richardson and colleagues demonstrated that the maximisation of health outcomes should not be unquestioningly accepted as the social objective of health care (Nord 1995).

There have been several criticisms of the individualistic base of conventional economic analysis, particularly as applied to health care, primarily advancing the argument that relationships between individuals and thence externalities are important sources of wellbeing (Hall 1996). While this is a move to expand the concept of utility beyond narrow self-interest, it can be accommodated within a conventional welfare framework. Others go further, arguing that community has value in its own right (Mooney 1998; Shiell and Hawe 1996).

This work, in Australia as elsewhere, has been largely motivated by the increasing use of economic evaluation and the debate about whether health outcomes are what should be maximised. Alternative approaches to exploring social welfare have been neglected (Savage 2001).

Economic evaluation

The application of economic evaluation gained great impetus from the 1993 requirement that such evaluation be included in submissions for inclusion on the Pharmaceutical Benefits Scheme (PBS). This requirement has led to the development of groups specialising in pharmaco-economics, commissioned both by the industry (to prepare Pharmaceutical Benefit Advisory Committee submissions) and by government (to check the quality of evaluations submitted), resulting in numerous papers providing an introduction and 'how to' guidance for clinical researchers.

The requirement that economic evaluation contribute to listing decisions was advocated by pharmacologists, rather than economists – but the latter have been involved in the development of the details of implementation. Although the rationale for the evaluation requirement has been cost control and efficiency (Salkeld, Mitchell and Hill 1999), the design of the scheme does not allow efficiency to be addressed

explicitly. While there is some descriptive work on the operation of the economic evaluation guidelines (Birkett, Mitchell and McManus 2001), there has been little critique of this aspect (Viney and Hall 1995).

It might be expected that the focus on and funding for economic evaluation would have led to some major methodological work. The major problem here is the measurement and valuation of the benefits of health programs. In a study of breast-cancer screening, Hall, Gerard, Salkeld and Richardson (1992) explored whether preferences for health states were independent of time. Also in the context of breast-cancer screening, Clarke (1998) applied the travel cost method (using time spent in travel as a measure of utility gained) to estimate welfare gains. Cook, Richardson and Street (1994) compared ex ante to ex post values of health states in a study of gall-stone treatment. Apart from these, the applied studies do not tackle methodological issues, and the quality and rigour of the methods used are highly variable (Gerard, Seymour and Smoker 2000).

Quality-of-life measurement is a major topic area in health services and clinical research, but few instruments have the required properties for estimating validly combined survival and quality measures (such as quality-adjusted life years, or QALYs). The Australian Quality of Life measure (AQoL) is a multi-attribute utility measure, with weights for the various health states derived from preference surveys of Australian communities (Hawthorne, Richardson and Osborne 1999; Hawthorne, Richardson and Day 2001). This work is the most comprehensive investigation of the properties of quality-of-life instruments. Other work on measuring health-related quality of life has included the most appropriate method of eliciting such weights (Richardson, 1994), the form of the utility function over health and survival (Bleichrodt and Quiggin 1999), and the stability of preferences over time (Shiell et al. 2000).

Policy guidelines for pharmaceutical and medical benefits have prescribed health as the appropriate objective to be maximised in economic evaluation. This is of questionable relevance for many health programs, particularly screening programs where the immediate product of the interventions is information (Hall, Viney and Haas 1998) and it does not clearly accord with community preferences (Richardson 1994). Allowing a broader range of benefits than only health gains has led to new interest, internationally, in contingent valuation and the use of stated preference methods. In particular, the elicitation of preferences and willingness-to-pay estimates, using choice experiments, is increasing. There is a significant Australian contribution to developing these approaches and extending their application to the prediction of program uptake (Hall, Kenny et al. 2002; Hall, Viney, Haas and Louviere forthcoming).

However, the process instituted by the PBS provides highly prescriptive guidelines for the methods that are acceptable in the economic submissions. This limits the development of new approaches, such as developments in stated preference methods and the use of cost-benefit analysis. This prescriptive approach influences review in other applications of economic evaluation, so that the guidelines become not just the standard for drug evaluations for reimbursement decisions, but are seen as the gold standard to be applied in assessing grant applications and journal articles.

Conclusion

The conceptual, theoretical and empirical challenges in health economics are wide-ranging. Health care decision-making is complex, there are multiple sources of market failure, and welfare assessment is by no means straightforward. While the various administrative and survey health databases are extensive, there are often significant deficiencies and gaps that have limited the scope of research. Health economics in Australia, since the pioneering work of Deeble and Scotton, has been inextricably tied to health policy. The Australian health care system is a complex mix of public-sector and private-sector involvement in financing and delivery of services, of substantial variations in the funding and organisation of services within a universal framework, and of frequent, incremental policy changes. As a recent Senate inquiry noted:

> [The] persistent problem with assessing proposals for reform is the lack of appropriate data to determine whether reforms are likely to achieve their objectives … it was only possible to make a broad qualitative judgement of whether reforms would enhance equity and efficiency. [Senate Community Affairs References Committee 2000:196]

To date, there have been significant Australian contributions to health economics research on the demand for private health insurance, comparative efficiency of private and public provision, welfare assessment, and economic evaluation. The academic base for health economics has grown strongly – currently about half of the members of the Australian Health Economics Society are working from academic institutions. Nonetheless, the existing health economics capacity is spread thinly. Several important topics, such as labour markets and workforce issues, or equity in financing and access to care, have received little or no attention. In other significant policy areas, such as private health insurance, and the relationship between insurance and utilisation, although there are some important contributions, there is not a sustained research program, and frequent changes in policy settings limit the policy usefulness of what research has been done. The low levels and short-term nature of research funding have made it almost impossible for a critical mass of researchers to focus on and develop a specific area. Although there have been repeated recommendations for a national investment in health services and health economics research, so far there has been little by way of implementation.

Economics ways of thinking have transferred to health policy, much more so than was the case in the 1980s. But these ideas have not been backed up by in-depth and rigorous analysis, either as a precursor to policy development or as an evaluation of its implementation. For this to be achieved means a wider and more ambitious research agenda, supported by long-term programmatic funding for Australian health economics.

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The Cambridge Handbook of Social Sciences in Australia

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Contents

Figures and Tables

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Preface and Acknowledgements

As the title makes clear, this is a book that examines the current state of social-science research about Australia. The aim of the book is to provide a comprehensive summary and evaluation of what we know about Australian society at the beginning of the twenty-first century. Most contemporary works dealing with the social sciences take an explicitly international perspective: for example, world summaries can be found in the *World Social Science Report* (UNESCO, 1999), the *Handbook of Social Science Research*, by Gary Bouma and G.B.J. Atkinson (Oxford, 1996), and the *Social Science Encyclopedia*, by Adam Kuper and Jessica Kuper (Routledge, 1989). Particular studies dealing with individual disciplines have also generally followed this international emphasis. Why, then, a book that examines Australia only?

While Australian social science – like that of its overseas counterparts of similar size – has been derivative of the international social sciences, the past half century has seen the emergence of a more independent, innovative research culture with specific contributions to make. In many important respects, this distinct contribution has been lost or ignored in international works of social-science scholarship, and often only those contributions by Australians that address international problems have warranted attention. Yet Australia has maintained a social-science research culture for at least as long as its international counterparts, with a research council being formed during World War II and a research-only faculty immediately afterwards. After the natural scientists, social scientists are the largest group of scholars working in Australian universities.

A second reason for examining social-science research about Australia is the international contribution social science has made in dealing with distinctively Australian problems. The relative newness of the country, the comparatively small size of the political and governmental elites, and a longstanding tradition of constructive interchange with government at all levels on matters of policy have all combined to make Australian social scientists more influential at a practical and policy level than many of their counterparts overseas. Distinctive Australian contributions, stemming from the analysis of local conditions and problems, have been particularly innovative. For example, Australia's academic contributions to social welfare, to the study of immigration and ethnicity, and to the design of electoral systems have all stemmed from our distinctive local conditions, and from a readiness on the part of government and the bureaucracy to formulate policy based on the results of this research.

Any overview of an area as diverse and complex as the social sciences is necessarily likely to be selective. When the overview is based on the social sciences within a single country, the selectivity is likely to be even more marked. The chapters that constitute this *Handbook* contain many insights and observations, but many other works are necessarily excluded, either because of space limitations or because of the structure of the chapters. We combine the contributions around the three core social sciences – economics, political science and sociology – and the introduction discusses why we have

followed this tripartite distinction. But throughout the *Handbook*, we treat these three fields as generic; each incorporates much overlap, between each of them, and also with other areas of scholarly research.

An intellectual endeavour as large and complex as the *Handbook* incurs many intellectual debts. First and foremost, we are grateful to Peter Debus, from Cambridge University Press, who offered both encouragement and patience as the project took shape. We are also grateful to three anonymous referees for the original proposal, who all provided important insights and constructive comments that were invaluable at the planning stage. Kate Hoffmann assisted in the preparation of the sociology section of the book. Most obviously, we are grateful to the forty-five contributors who provided the entries contained herein.

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