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Position paper

Modern Monetary Theory and healthcare in Australia

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"Healthcare spending will soak up all of Australia's tax take well before the end of the century if it continues to grow at its current rate."[1]

Dr Stefan Hajkowicz, CSIRO

Long before the onset of the COVID-19 pandemic there was a sense that health care in many countries, including Australia, was becoming 'unaffordable' for governments. In the year before the pandemic first affected the United Kingdom (UK), for example, there was a broad media narrative that the National Health Service (NHS) was about to become, if not already, 'bankrupt.' Data from the UK King's Fund[2] revealed that in 2018/19, half of NHS trusts – including the providers of ambulance, mental health services, and community health care - were in deficit, with the total debt estimated at 13.4 billion GBP. An alarming BBC report published in September of 2019[3], only months before the COVID-19 pandemic reached British shores, quoted senior policy analysts expressing concern that hospitals were, "already unable to cover costs and were being forced to make further cuts in spending on patients to pay interest charges. Many hospitals can only survive by lurching from month to month with emergency bailouts from central government." She continued…"That leaves NHS trusts in the greatest financial difficulty unable to plan their future and make spending decisions that best suit their patients." The narrative is almost identical in the United States: Federal Reserve Chair Jerome Powell, testifying before the US Senate Banking Committee in February of 2019, warned that "the US Federal Government is on an unsustainable fiscal path. ... The thing that drives our single unsustainability is health care spending."[4]

Although 'bankruptcy' is not a danger in Australia, the long-term 'sustainability' of health expenditure has been a subject of deep concern for some time. In the financial year 2015/16, the amount of money spent on health in Australia exceeded 10% of our gross domestic product (GDP) for the first time. The fact that one dollar out of every ten dollars spent in this country went towards healthcare was a milestone that provoked strong reactions. University of Melbourne health economist Professor Philip Clarke told *The Guardian* newspaper[5] that state

[1] Australia's spending on healthcare unsustainable, CSIRO futurist says (smh.com.au)
[2] Financial debts and loans in the NHS | The King's Fund (kingsfund.org.uk)
[3] https://www.bbc.com/news/uk-england-49745970?intlink_from_url=&link_location=live-reporting-story
[4] America's 'inefficient' health care system is creating 'an unsustainable fiscal path' (yahoo.com)
[5] Australia's healthcare spending rises above 10% of GDP for first time | Health | The Guardian

and federal governments needed to act now to avoid a spending and funding crisis. "Inevitably this involves either spending less on other things and/or raising taxes," he warned. In the same article the head of health economics at the Grattan Institute, Dr Stephen Duckett, explained that, "breaching that 10% level is important, because … almost 70% of health spending is government spending."

Yet the amount of money spent on health goods and services continues to increase. The Australian Institute of Health and Welfare (AIHW) reported that during the financial year 2018-19, total annual spending on health goods and services had reached $185 billion.[6] The AIHW report revealed that between the years 2000 and 2018 Australia's total spending on health increased in real terms – that is, after adjusting for inflation - from $91 billion, by an average rate of 4.3% each year, until it reached the 'staggering' $185 billion figure.

Discussions of current and projected future health spending naturally take for granted the dominant narrative for public finance, which has been virtually unquestioned for decades. The modern form of this narrative goes under the name of New Keynesian economics, even though it has little in common with the work of the great economist J.M.Keynes (1883-1946). The New Keynesian recipe for economic management involves an independent central bank setting interest rates to stabilise the economy, with federal governments concentrating on balancing their budgets over time, or at least on avoiding increasing their debt as a proportion of GDP. This is virtually enshrined into Australian law, in the form of the Charter of Budget Honesty Act 1998[7], and it has been written into the Budget Papers as the Government's fiscal strategy for many years.[8]

The accepted narrative is that increases in public spending not matched by higher tax receipts add to the government's deficit and, depending on the rate of economic growth, may increase the debt-to-GDP ratio. This has the potential to trigger adverse consequences, such as downgrading from private credit-rating agencies with the inherent risk of driving up the cost of further government borrowing[9]. This leads eventually to enforced spending cuts or inflationary, and eventually counter-productive, 'money printing.' The only alternative, according to this

[6] Health expenditure - Australian Institute of Health and Welfare (aihw.gov.au)
[7] Charter of Budget Honesty Act 1998 | Australian Government
[8] Big budget spending isn't new: it's a return to what worked before | The Conversation
[9] Australia's credit rating is irrelevant. Ignore it. | The Conversation

narrative, is for the government to increase tax rates - which may be impractical politically – and, in any case, is assumed to damage incentives for private enterprise.

Given this narrative – so dominant that it seems like common sense – it is unsurprising to read of fears for the solvency of the British NHS, or for the sustainability of government spending on health in Australia in future decades. The scarcity of financial resources in an environment where there are so many other claims on the public purse seems obvious and intractable. The need to limit public provision and to privatise whatever can be located outside the public sector appears to be sound common sense. Certainly, this appears to be taken for granted by those on the government, opposition, and crossbench - and by many of their advisers. Yet, it may all be based on a misunderstanding of the mechanics of modern monetary systems, and of the appropriate role for the federal budget to play in the economy in countries like Australia, the UK, the United States, Japan, Canada and other nations with similar monetary systems to our own. As the famous institutional economist Hyman Minsky (1919-96) once said, "The game of policy making is rigged. The prince is constrained by the theory of his intellectuals."

A new approach to macroeconomics[10], which builds on the work of previous generations of economists from outside the mainstream, like Minsky, Wynne Godley (1926-2010), Abba Lerner (1903-83) and Keynes himself, suggests that the theory on which the dominant narrative is based is wrong in important ways, and that this biases policy making – including in the area of health spending. The prince has been constrained by a flawed and misleading theory.

The new approach is called Modern Monetary Theory (MMT), and although it does have theoretical elements, for our purposes its strength lies in its institutional realism, which undermines the dominant New Keynesian narrative. MMT was developed in the 1990s by the fund manager Warren Mosler and a small group of academic economists and has recently risen to prominence due to the work of Professor Stephanie Kelton, and notably her recent New York Times bestseller *The Deficit Myth: Modern Monetary Theory and How to Build a Better Economy* (2020). It represents the first serious challenger to economic orthodoxy since the 1930s.

Modern monetary theorists posit that orthodox economics has never accounted for the institutional details of monetary systems, and that consequently in important respects the New Keynesian narrative used in Canberra is now decades out of date. The most important flaw in the

[10] Explainer – What is Modern Monetary Theory? | The Conversation

standard narrative is that it ignores the distinction between currency users and currency issuers. Individuals, business and other private organisations and non-currency issuing governments are currency users. Before they can spend money, they need to find it. A state government needs grants from the federal government, tax receipts or borrowed funds in order to finance its spending. It is a currency user. In principle, it can become insolvent. When budgeting, this financial constraint must be taken into account.

The federal government is in a completely different position. It is the monopoly issuer of its currency. In the case of the Australian Government, every Australian dollar it ever spends is a new dollar. Every dollar of federal spending adds a dollar to every official monetary aggregate. This happens all the time, every day. Talking about 'printing money' is meaningless. All federal spending takes place the same way. Funds are created electronically in private bank accounts and added to the reserves of those banks at the Government's fiscal agent – the Reserve Bank of Australia (RBA).

Some of these dollars then are deleted from the banking system using federal taxes. According to MMT, the principal macroeconomic role of taxation is not to fund the government but to limit private spending power, to create room within the productive capacity of the economy for the government to make investments, without causing accelerating inflation. Taxes are vital – but they do not 'pay for' government spending. Not in the literal sense, in any case. This was explained very clearly, long ago, by the former Chair of the New York Federal Reserve, J. Beardsley Ruml (1894-1960)[11]. Indeed, the government spending must take place before taxes can be paid, logically, as the private sector cannot pay taxes with currency that has not previously been spent into existence by the government or lent into existence by its central bank.

The Australian Federal Government is a special type of currency issuer. The Australian dollar (AUD) is a freely floating currency, not tied to any commodity of foreign currency (it is a pure 'fiat' currency), and the Government has no significant foreign currency denominated liabilities. This makes the Australian Government a monetary sovereign, like the governments of the United States, Japan, the UK, Canada, and New Zealand, among others. Individual Eurozone countries are not monetary sovereigns, as they do not issue their own currencies, and neither are the governments of countries with fixed exchange rates or governments with significant foreign currency debts, like Argentina.

[11] Taxes for Revenue are Obsolete.| American Affairs

Monetary sovereign governments can never become insolvent - they face no purely financial constraints on spending. Their spending has economic consequences, obviously, but no purely financial limits. They do not need to raise taxes prior to engaging in additional spending. They choose to issue government securities, which play a variety of roles in monetary systems, but they are not forced to do so. Indeed, they cannot meaningfully borrow the currency they issue, and what is generally described as the national debt or government debt would be better described as the net money supply, as argued by David Andolfatto, senior economist at the US Federal Reserve, in December 2020[12].

Government deficits are non-government surpluses. A government deficit is a net financial contribution the government has made to the private sector. Historically, despite the lack of an accurate description of the mechanics of monetary systems in the dominant narrative, government deficits have been much more frequent than government surpluses, and much larger on average. Indeed, in an economy without a significant trade surplus, a government surplus weakens private sector balance sheets, and either forces the private sector into further debt to support the economy, or leads to a recession, which reduces tax payments, raises welfare payments, and drives the government balance back into deficit in any case. It turns out that it is not government deficits which are unsustainable, but government surpluses. A surplus, after all, just deletes dollars from the monetary system. It achieves nothing else than that.

MMT does *not* suggest that there are no limits on spending but, instead, argues that a concern for the projected fiscal balance taken out of context of the state of the economy generally is a form of focus illusion. The focus in public finance should be on inflation risk and not on a lack of dollars and the risk of insolvency. The currency issuer can never be forced into insolvency because it can never run out of dollars, as long as parliament authorises the spending of additional dollars into the system. Government spending is financed when it is authorised by parliament. Neither taxes nor bond sales fund government spending. As for the so-called ''debt,' it is just an accounting record of those dollars which have been spent into the system and not yet taxed back out of it.

If it is *inflation* risk - not solvency - which should be the focus when discussing public finance, then we need to replace a financial constraint with a real constraint. The real constraint is the productive capacity of the economy, which depends on available labour, skills, equipment,

[12] Does the National Debt Matter? | Federal Reserve Bank of St Louis

technology, natural resources, infrastructure, and institutional capacity. If the real resources exist to allow for additional spending without that spending driving up inflation, then the currency issuer is always in a position to carry out that spending. Getting this wrong can and has led to unnecessary austerity in the past, in the name of 'living within our means', when the consequence has been living *below* our means where public services are concerned.

It can also be argued that getting public finance wrong has led to unnecessary and counter-productive privatisations and cuts in a variety of areas, including health. The problem with the provision of health services has never been a lack of dollars. The problem is a shortage of real resources, and our current and potential levels of productivity – our ability to convert scarce real resources (inputs) into health sector goods and services (outputs). Where privatisation diverts real resources into unproductive uses, or contributes to private monopoly power and profit, it actually reduces what can be provided within the productive capacity of the economy, rather than enhancing it.

Moreover, there are no financial savings which can be made today which assist in the provision of health services in the future. What can be provided in the future will depend on the real resources which are available, and those depend on investments we make in increasing our capacity to supply those services today. Deficit spending, which is not inflationary, does not impose a burden on future generations – it supplies dollars to the present generation. It will be appropriate in an ageing society with access to more advanced medicine to ensure that appropriate real health resources are available. In practice, this will involve raising productivity in the healthcar sector by investing in both the education of the future healthcare workforce and through the provision of more effective medical technologies. The dollars in themselves are not the issue.

The pandemic effect

Estimates from the United Nations' Department of Economic and Social Affairs[13] suggest that the COVID-19 pandemic is likely to wipe USD 8.5 trillion from the global economy over 2021-22. This economic contraction is the worst since the Great Depression of the 1930s. With close to 90% of

[13] COVID-19 to slash global economic output by $8.5 trillion over next two years | UN DESA | United Nations Department of Economic and Social Affairs

the world economy under some form of lockdown there have been severe disruptions to global supply chains, accompanied by markedly reduced consumer demand. These economic changes are likely to send close to 35 million people into poverty.[14]

Early experience in China and elsewhere suggested that uncontrolled community spread of the virus led to health services being rapidly overwhelmed. In light of these observations, predictions were made that, within weeks, all of Australia's intensive care beds would be filled and the health system would be overwhelmed as was happening overseas.(Litton *et al*., 2020) In response to the rapidly evolving pandemic, Australian governments sought to limit effects by closing international borders and introducing restrictions – such as the closure of 'non-essential' businesses - designed to reduce community transmission of COVID-19. Since such measures were likely to have a severe effect on incomes and employment, a range of fiscal policies - notably the *JobKeeper* wage subsidy and the *JobSeeker* supplement schemes - were introduced. The hospitality sector was heavily affected, both from the loss of international tourism as well as domestic business, with more than 370000 people losing their jobs by May of 2020. GDP fell by 7% and the Australian economy went into recession – after 29 years of continuous growth – with consumption expenditure falling by 12.5% in the June quarter and unemployment reaching 7.4% in mid-2020.(Lim *et al*., 2021) It is very likely that the economic effects would have been considerably worse without the Federal Government's *JobKeeper* and *JobSeeker* schemes.(Borland & Charlton., 2020) All of these emergency budgetary measures have seen the amount of money spent by the Australian Commonwealth Government exceed its incomes. A report[15] published in the *Australian Financial Review* in December of 2020 sounded the alarm:

> "The annual budget deficit - where spending exceeds revenue - will record its longest stretch in the red in more than half a century and since World War II, with deficits expected from 2008-09 to at least 2030-31. The deficit at the start of next decade is projected to be $51 billion or 1.6 per cent of GDP because of the long-term economic consequences of the COVID-19 recession, the Parliamentary Budget Office [PBO] estimated. A primary mechanism for reducing debt in both cases was not paying back the

[14] Covid-19 Economic Impact And The Need To Do Better (forbes.com)
[15] The COVID-19 budget deficit will still be $51b in a decade (afr.com)

> debt, but allowing the economy, and hence government revenue streams, to grow naturally and reduce the relative value of the debt," the PBO said.

The PBO reports that Commonwealth Government debt must be 'repaid,' and explains[16] some of the ways that the Government has 'repaid' debt in the past:

> "During this time income taxes recovered well, first through bracket creep and later through the mining boom of the 2000s decade.
> "In addition, government sales of public assets, particularly Telstra, and cuts to government payments, resulted in debt being reduced more quickly than would have been possible otherwise."

The COVID-19 pandemic magnified other economic effects as well. Nobel Prizewinning economist Sir Angus Deaton, co-author with Dr Anne Case of the book *Deaths of despair and the future of capitalism*, giving evidence to the United States Congress in June of 2020, made the following comments[17]:

> "The pandemic is exposing and exaggerating longstanding inequalities in health and wealth. It will worsen the inequalities between black and white, between the more and the less educated, and between ordinary people and the well off. This pandemic, like other pandemics before it, lights up anew the fault lines in society. Inequalities that we knew about, like racial and ethnic inequalities, are more starkly visible. The pandemic may turn tolerable inequalities into intolerable inequalities."

Poverty, involuntary unemployment and underemployment, and inequality are known to impact wellbeing and both psychological and physical illness. Inequality has been rising in Australia since the mid-70s, which is when Australian governments abandoned the pursuit of genuine full employment. MMT suggests that the Government does not lack the financial resources to address these problems. In the middle of a pandemic, the Government raised *JobSeeker* to a

[16] Sustainable funding of health care: challenges ahead – Parliament of Australia (aph.gov.au)
[17] Deaton_Testimony.pdf (house.gov)

non-poverty level, albeit temporarily. This is something it would previously have viewed as unaffordable. The Government made it clear that it would engage in $200 billion of deficit spending, if necessary, to support the economy during the pandemic. There were fewer than $40 billion of bank reserves in existence in March 2020, so it was literally impossible to borrow this sum: the dollars had to be 'spent into existence.' The logical impossibility of taxes and bond sales literally 'paying for' government spending in the USA was explained in institutional detail by one of us more than 20 years ago.[18].

A government wishing to address underemployment and inequality can do so in the same way that a government which chooses to increase health funding can do so. To the extent that such investments make Australians healthier, they not only improve well-being but add to the productive capacity of the economy in the years to come. And healthier Australians, in the long run, impose less of a burden on the health system. The risk of making such investments is accelerating inflation in the short-run, but that is the only risk, and after all, central banks have been trying unsuccessfully to create more inflation for years. Furthermore, given that inflation is often the result of total private and public spending outstripping the economy's productive capacity, investments which increase productive capacity (such as better health outcomes) can ultimately be disinflationary in the long-run. Successive governments have chosen not to live up to our means, to under-invest in public services, and to leave people in unnecessary poverty, because they have been in vain pursuit of an inappropriate target – a fiscal surplus. A failure to make investments today is what will limit our ability to provide services in the future. A failure to make sufficient investments in the past is what limits our ability to provide those services today, not a lack of dollars.

Health in a post-pandemic world

The COVID-19 pandemic has brought concerns about spending on health into sharp focus. In a recent letter to the *Medical Journal of Australia*, public health experts Dr Shane Kavanagh et al (2021) from Deakin University wrote that:

[18] Can Taxes and Bonds Finance Government Spending? | Levy Economics Institute.

> "The COVID-19 pandemic has raised multiple health challenges for Australian society. In addition to the direct impacts of infection, there will be broader health impacts caused by physical and social distancing and the collapse in economic activity leading to the loss of employment and income. Interventions by the Federal Government, including *JobKeeper*, increased *JobSeeker* payments, the introduction of telehealth, and increased mental health spending, have made an important initial contribution to addressing the health impacts for individuals, families, and communities. The by-product of these interventions, however, has been a rapid increase in government debt. We are now seeing increased calls to enact austerity policies. Such policies prioritise rapid reductions in government debt, usually through cuts to health and social services."

Even looking at these effects from a purely economic perspective, the COVID-19 pandemic has shown us just how important community health is in allowing communities and countries to thrive, both economically and socially. The American Medical Association[19] puts it this way:

> "Health is the greatest social capital a nation can have. Without a healthy, productive citizenship, a country can't be economically stable. Addressing the social determinants of health is crucial to building a strong economic foundation, and eliminating health disparities is something… physicians should continue to work toward."

Similarly, the European Union publication, *The contribution of health to the economy in the European Union*[20]*,* states that:

> "There is a sound theoretical and empirical basis to the argument that human capital contributes to economic growth. Since human capital matters for economic outcomes and since health is an important component of human capital, health matters for economic outcomes. At the same time, economic outcomes also matter for health. A recurring theme throughout this book is the existence of feedback loops offering the scope for mutually reinforcing improvements in health and wealth."

[19] Healthy population equals healthy economy | American Medical Association (ama-assn.org)
[20] BW (europa.eu)

…and, again, similar sentiments have been published in the *British Medical Journal*[21]:

> "As well as being valued in their own right, health outcomes produced by the health sector contribute indirectly to other sectors, most notably but not exclusively, education and economic productivity. For example, by preventing and alleviating the consequences of disability, health systems can help people have longer, more productive working lives and reduce the fiscal and social costs of dependency in older age."

Even as the immediate effects of the COVID-19 pandemic pass, it seems certain that the requirement for health spending will only continue to increase year upon year. Australian Parliamentary research[22] tells us that as the 'baby boomer' generation ages, the number of people aged 85 years or older will increase to almost twomillion by 2050. To make matters worse, conditions that increase the risk of chronic diseases like diabetes – such as being overweight or not exercising – are becoming more common. Not only that, but community expectations of ever higher health standards seem to increase all the time: as medical research leads to better drugs, devices, and interventions to keep people healthier and living longer, subsidising these is increasingly expensive. The Parliamentary report concludes with a familiar warning: "There are concerns, therefore, that the level of funding for health care will soon become a significant burden for governments."

The Committee for Economic Development of Australia (CEDA) , in an article[23] worryingly titled '*Hard decisions needed to make health system sustainable*,' quotes then-Shadow Health Spokesperson Peter Dutton as saying, "There needs to be a comprehensive response to attempt to make our health system sustainable in the future. It is not sustainable for any country to spend beyond its means in the long term."

Dire warnings about the unsustainability of health spending by governments worry not only politicians and economists, but our community as a whole. Where will our government find the money needed to meet these obligations? Will we need to provide a greater and greater proportion of our incomes as tax to the government? How can the government possibly pay off its

[21] The economy of wellbeing: what is it and what are the implications for health? | The BMJ
[22] What are we doing to ensure the sustainability of the health system? – Parliament of Australia (aph.gov.au)
[23] CEDA - Hard decisions needed to make health system sustainable

ever-increasing deficits, balance its books, and still spend enough to ensure that Australians are healthy? Yet as the COVID-19 pandemic has revealed, a healthy economy is based on a healthy population. San Francisco-based economist Jaana Remes and her colleagues, writing for the *Brookings Institution* this year[24], state that "investment decisions around health have too often been evaluated purely as a cost, not as an investment with an economic return. This is a mistake because improving health is necessary for prosperity. Healthier people are more productive in their prime working years."

Health is not merely about treating disease or disability – the other dimension is in reducing the risk of ill health and disease in the first place. As the Australian Institute of Health and Welfare[25] puts it:

> "Evidence on the close relationship between living and working conditions and health outcomes has led to a renewed appreciation of how human health is sensitive to the social environment. Factors such as income, education, conditions of employment, power, and social support act to strengthen or undermine the health of individuals and communities. Because of their potent and underlying effects, these health-determining factors are known as the 'social determinants of health.' The World Health Organization (WHO) has described social determinants as: …the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social, and economic forces. According to the WHO, the social conditions in which people are born, live and work is the single most important determinant of good health or ill health."

Governments, then, face dual pressures: ensuring that adequate resources are available to treat established health conditions; and, trying to reduce the burden of disease in the community and thus reduce pressures on direct health spending. The latter priority – addressing the social determinants of disease – should not be an afterthought. There is good evidence that devoting resources to address the social determinants of health pays dividends. A recent systematic review of the available evidence (McCartney *et al*., 2019) concluded that:

[24] How investing in health has a significant economic payoff for developing economies (brookings.edu)
[25] 4.1 Social determinants of health (Australia's health 2016) (AIHW)

> "Politics, economics, and public policy are important determinants of population health. Countries with social democratic regimes, higher public spending, and lower income inequalities have populations with better health. This review is also consistent with the policy reviews that describe how the most effective means of reducing health inequalities is to decrease economic and social inequalities; use legislation, regulation, and taxation to restrict unhealthy consumption; and address the structural and financial barriers to access to services."

How can it be possible for governments like that of Australia to fund both direct health care costs and, at the same time, provide resources to overcome the social determinants of health in a post-pandemic era of unprecedented deficits with reduced tax receipts? MMT provides a powerful framework through which to reconsider the true capabilities of, and constraints upon, governments as we seek to improve the health of all in society and to ensure that all of us have access to the best health care achievable.

MMT, health and wellbeing

Once we start to consider macroeconomic and fiscal policy through the lens of MMT it quickly becomes clear that a much wider space for effective action on the social, environmental, and commercial determinants of health is really open to us compared to the self-imposed constraints of conventional New Keynesian or neoliberal policy thinking. Modern monetary theorists argue that, for decades, conventional macroeconomic policy has used unemployment as the real balancing variable to avoid inflation. People who wanted to work have been denied employment – either wholly (unemployment) or in part (underemployment) – through deeply ingrained but fallacious ideas of a 'natural' rate of unemployment. The result of failing to use macroeconomic policy to achieve genuinely 'full' employment has had profound impacts on health. The well-evidenced health harms of unemployment have been suffered by many more people than was necessary, and many more suffer the damaging health impacts of precarious and low-paid employment, which have been brough into such harsh relief during the pandemic. MMT scholars have largely avoided developing a set of 'MMT policies', for the good reason that their focus has been more on describing the mechanisms of money creation destruction; a wide range of policies

can be pursued within the monetary and economic system that MMT describes. One exception, however, lies in the championing by MMT theorists of proposals for national 'Job Guarantee' schemes. Detailed proposals for a Federal Job Guarantee have been developed in recent years in the USA[26], Australia[27] and elsewhere, and successful job guarantee-like initiatives have been introduced as a temporary, emergency measure in Argentina (2002-6)[28] and as an on-going program in India.[29] Job Guarantee proposals typically see the federal government funding a standing offer of work for anyone who wants it, to perform socially useful work at an equitable living wage, with reasonable conditions of employment (such as annual leave and sick leave for example). Job Guarantee proposals aim not only to tackle unemployment and underemployment, but also to be a profound agent for 'levelling up' casualised, low-paid and exploitative employment practices. Employers (or 'gig economy' platforms) who currently offer low pay and poor conditions would find themselves under market pressure to match the conditions of the Job Guarantee program if they do not wish to lose their workforce. Achieving true full employment in decent jobs for all who want them would be a transformative intervention to improve health for large numbers of Australians (Hensher, 2020a).

Another central argument within MMT is that the primary purpose of taxes is not, in fact, to raise revenue, but to achieve other socially and economically desirable aims. In the case of health, this insight is of great importance to widening the policy space for effective action on the 'commercial determinants of health' – the production, sale and consumption of goods and services which are damaging to health (Freudenberg, 2014). Great success was achieved in using taxation tools as an essential part of the fight to reduce rates of tobacco consumption across the developed world, and taxes on unhealthy foods increasingly show great promise.(Sacks et al., 2021) Yet, in many countries, efforts to effect behaviour change by consumers in a range of other health-damaging products (most notably sugar and sugar-sweetened beverages, and carbon taxes on greenhouse gas emissions) have been resisted by powerful industries with well-funded lobbyists (Oreskes and Conway, 2010). Accepting the MMT proposition that the proper use of taxes is to achieve socially desirable goals could allow a re-imagining and restructuring of the Australian tax

[26] Public Service Employment. A Path to Full Employment| Levy Economics Institute.
[27] Creating effective local labour markets: a new framework for regional employment policy.| Centre of Full Employment and Equity.
[28] Beyond Full Employment: The Employer of Last Resort as an Institution for Change. | Levy Economics Institute.
[29] National Rural Employment Guarantee.| Ministry of Rural Development.| Government of India.

system with greater focus on incentivising healthy behaviours, and on penalising unhealthy behaviours by industries and consumers alike, improving health through areas potentially as diverse as alcohol, air pollution, sugar, gambling, social media and internet addiction.

MMT allows us to better understand the real options available to a monetary sovereign government like Australia's and opens the door to far-reaching and ambitious investment by government in public, social, environmental and care infrastructure to meet the needs of coming decades. Climate change is increasingly recognised as the greatest avoidable long-term threat to the health of Australians and of all peoples around the world. Meeting the challenge of climate and environmental change offers the promise of realising the 'co-benefits' of improved economic, environmental and health outcomes in a virtuous cycle that not only improves health and wellbeing today but makes our society more resilient for the future. For example, accelerating the transition of our energy and transport infrastructure away from fossil fuels would deliver wide-ranging public benefits: reduced mortality and morbidity due to reduced air pollution immediately, and due to the reduced impacts of climate change in future, as well as improved health and social wellbeing through secure high-quality employment in the industries of the future. MMT shows that government has the space to support and facilitate a major restructuring of the economy that can leave workers better off and more secure than they are today.

MMT and healthcare

In the aftermath of the COVID-19 pandemic, debate on healthcare in Australia and around the world will likely focus on its 'affordability' – whether, in both the public and the private sectors – we, as a society, have the fiscal resources to sustain our healthcare system into the future. MMT suggests that important elements of that debate might be misplaced since the availability of funds to pay for public healthcare is not necessarily the real challenge. Indeed, fiscal austerity can have disastrous effects on healthcare access and outcomes (Stuckler and Basu, 2013). Yet healthcare is a sector in which many 'real' resources – for example skilled human professionals who may require many years of training and experience to be ready for practice – are in scarce supply. MMT theory suggests that the availability of real resources *can* constrain the capacity of an economy, and that letting demand outstrip supply for such real resources is highly likely to cause undesirable price inflation. It is important to note that healthcare prices have a long history of increasing at a faster

rate than general inflation in the economy, both in Australia and overseas[30], potentially making this sector an important test case for MMT and its implications for policy. The adoption of a MMT perspective allows us greater scope for action on many problems that have long influenced Australian healthcare. However, it is not a panacea that can solve all of the sector's problems, and the central importance of preventing unsustainable healthcare price increases and raising healthcare productivity under MMT will require particular attention.

Opportunities for healthcare

MMT does not offer us a blank cheque for unlimited health spending, but there are areas in which its acceptance has the potential to drive the most important benefits for healthcare in Australia. The first, and probably the most important, involves avoiding negative outcomes: MMT invalidates the arguments for austerity and fiscal rectitude that are routinely imposed on public healthcare systems, creating repeated cycles of public spending 'boom and bust' (Hensher et al, 2020b). All too frequently, public healthcare systems are forced to enact savings programs and crude cost controls, with predictable impacts on access to, and waiting times for, outpatient care, elective surgery, and emergency care. Prioritising financial cost minimisation ahead of maximising real resource efficiency and productivity can have perverse outcomes. Cost-cutting can see health providers foregoing or delaying investment in better equipment, more efficient systems, and more advanced technologies and practices, leading to lower productivity growth and less efficient use of scarce real resources. Paradoxically, efforts to address the non-existent financial constraint can end up exacerbating the real productive capacity constraint. MMT invalidates the accepted narrative of 'balancing the budget' – although it clearly needs careful planning to ensure that 'boom' periods do not cause overheating and unsustainable growth in real resource needs. Rather than simply using MMT as a cover for indiscriminate and ill-disciplined expenditure across the health sector, the following represent a few potential areas in which an MMT-based economic and fiscal policy could support well-planned but ambitious investments and structural improvements to realign Australian healthcare for the needs of Australians over the coming decades:

[30] Health Expenditure Australia 2018-19 - Australian Institute of Health and Welfare (aihw.gov.au)

- The introduction of universal dental healthcare access under the Medicare Benefits Schedule (MBS).
- A post-pandemic healthcare recovery program, that combines dealing with backlogs in planned care with investment in re-modelling the healthcare system to deal better with the changing burden of chronic disease in the population.
- The introduction of guaranteed access to an adequately funded, high quality, public option for aged care (both residential and home-based) able to care for all who need it, while driving uncompetitive, poor quality and low-wage private aged care operators out of the market and pushing up standards for those ethical, high-quality private operators who choose to remain.
- Urgent but sustained investment in domestic skills, education, research and development, design, and manufacturing capacity in essential pharmaceuticals, vaccines, medical devices and supplies, to build resilience and security of supply in the future for Australia and our wider region.
- Investment in the development and roll-out of more advanced health technologies and innovations, to increase the productivity of the healthcare sector.
- A recalibration of the balance between universal public care and the role of the private system.
- Sustained investment in the renewal of Australian healthcare's physical infrastructure, to equip the sector to play its part in achieving net zero greenhouse gas emissions (to which it currently contributes 7% of all Australian emissions) and to make it resilient against the future impacts of climate change and extreme weather events.

Real resources and constraints – What MMT cannot fix (by itself)

It seems self-evident that many of the deep and pervasive problems facing the Australian healthcare system are not directly or inherently linked to funding levels: a shift to a MMT-informed economic policy perspective could therefore not, in and of itself, be expected to have an impact on such problems. Yet these issues cannot be ignored by policy makers. The most important of these challenges include:

- Short-term skill shortages – MMT cannot create new health professionals overnight (indeed, this is a key area of price risk); however, MMT informed policy *can* support the long-term investments required to re-balance the Australian healthcare workforce with the appropriate mix of skills and specialties for the future.
- Regional and rural inequalities in access to healthcare – many years' accumulated evidence shows that rural and regional Australians typically have poorer access to healthcare and poorer health outcomes than urban Australians; yet many years' policy experimentation equally shows that funding is often only a small part of the challenge facing rural health services - recruitment, retention, and pressures on a small workforce are often far greater hurdles to sustainable rural healthcare.
- Aboriginal and Torres Strait Islander health inequalities – the persistence of shocking inequalities in health status and outcomes between Aboriginal and Torres Strait Islander peoples and other Australians are similarly driven by many factors beyond funding and will require renewed action across social and political, economic, justice, education and healthcare systems to be shifted. Yet an understanding of MMT once again removes any fiscal excuse for inaction, and potentially opens the door for new and more imaginative systemic efforts to address the national disgrace of poor indigenous health.
- Integration and care co-ordination – Australia, like all modern healthcare systems, struggles to offer patients with chronic conditions (especially the growing proportion of the population with multiple chronic conditions) effectively integrated, coordinated and personalised care to anticipate and meet their specific needs. This challenge probably has far less to do with overall funding levels than it does with professional cultures, organisational design and boundaries, technical and legal failures to achieve effective sharing of patient information between organisations, and the specific financial incentives facing individual providers as they interact with patients.
- Avoiding financial incentives for low value health care, especially where that care has the potential for harm rather than benefit, including the potential for harm to the environment.

MMT and healthcare financing in Australia

Central to MMT is the observation that the monetary sovereign currency issuer – the Australian Government – cannot 'run out of money', as long as it can pass a Budget through Parliament. The Australian Government does directly fund significant portions of the Australian healthcare system via the Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme, but it is the State and Territory governments which own, operate and fund the rest of Australia's public healthcare system, most notably the nation's public hospitals. Indeed, the response to the COVID-19 pandemic has demonstrated for us the greater capability for policy, planning, implementation and action that rests at State and Territory level. However, State and Territory Governments are currency users - not currency issuers - and their independent revenue raising powers are, under the Constitution, quite limited. As a result, this 'vertical fiscal imbalance' between the Commonwealth and the states has long been recognised, with a large majority of State and Territory expenditure (on health and their other key responsibilities) ultimately financed through a complex system of grants and transfers from the Australian Government. The system's current architecture involves the Commonwealth Grants Commission in the allocation of funding equal to the Goods and Services Tax to States and Territories, and a raft of National Health Agreements and National Health Reform Agreements signed over the years between the Australian and State / Territory Governments, incorporating various health-specific funding mechanisms. At one level, these existing arrangements already recognise the pre-eminence of the Australian Government as the ultimate source of most State and Territory revenues, although this is currently framed with reference to the Australian Government's superior taxation powers, rather than because it is the currency issuer. In practical terms, these arrangements might be adequate to support healthcare funding under a MMT-based fiscal policy regime. Equally, the time may soon be right for a deeper review of these arrangements. As the sovereign currency issuer, the Australian Government must necessarily be the ultimate funder of the public healthcare system. However, the potential benefits of achieving better integrated care for chronic conditions and aged care through pooling Federal and State funding may be significant enough to warrant a greater proportion of the national health budget flowing directly via States and Territories. This would require a new settlement between the two levels of government, which a decisive shift to MMT-informed fiscal policy could support

and justify. It would, however, also require the rebuilding and strengthening of policy making and implementation capabilities at both Federal and State/Territory levels.

A future perspective

A pivot towards austerity after this pandemic is unnecessary and would be damaging. The Australian Government has increased the net money supply in support of the economy during the pandemic, as was appropriate. The Government has not borrowed money which it ever needs to pay back, because the Government is the issuer of the currency and what people describe as its debt is not a debt in the conventional sense of the term[31]. As the economy recovers, the Government's deficit will automatically fall, but this should be an outcome and not a target.

The provision of adequate health services in the decades to come will depend on investments in those real resources which are inputs into those services, as well as a mission-approach to public policy (Mazzucato, 2021). We believe that, for Australia, the mission is to eliminate poverty and involuntary unemployment while making a rapid transition to a net zero emissions economy, making the necessary investments to build an equitable and sustainable economy, and in the real goods and services required to meet people's needs and to support excellent public services. The fiscal balance should be whatever is needed to implement the goals of this mission-approach. Federal budgets should be judged against their consistency with these goals and the feasibility of planned spending, given the available productive capacity in the economy, the realistic ability of policy reform to increase productive capacity over time, and the management of inflation risk. The role of the Australian Parliamentary Budget Office and US Congressional Budget Office should no longer be to assess spending plans for their impact on the fiscal balance, but instead to assess the inflation risks of budgetary decisions across the planning horizon[32]. Policy decisions should be rigorously assessed for their productivity implications and their effects on productive capacity – before they are made. In a post-pandemic environment, it will be vitally important to learn these lessons and to make the necessary changes to our political narrative and our institutional framework to shift towards this mission-approach to public investment.

[31] Please, no more questions about how we are going to pay off the COVID debt. | The Conversation.
[32] CBO—Still Out of Paradigm after All These Years. | New Economic Perspectives.

Healthcare is fundamental both to the social and the economic functioning of societies. This observation is central to the work of the new WHO *Council on the Economics of Health for All*, of which one of us is a member.[33] The accepted narrative – that the direct and indirect costs of healthcare are unsustainable in the long term – has constrained many governments' abilities to fund both the direct costs of providing equitable access to healthcare resources, and the costs of addressing the social determinants of our health. In the post-pandemic world, MMT allows us to reimagine healthcare and explore many ways in which we can promote health, wellbeing, and the productivity of our community. Let us not waste this opportunity.

[33] Global-experts-of-new-WHO-Council-on-the-Economics-of-Health-For-All-announced.

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