

## **What's fair in funding indigenous health care? We don't know, but isn't it time we did?**

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### **ABSTRACT**

There are various different ways of looking at equity in the context of the funding of indigenous health care. This paper argues for adopting an approach which incorporates notions of capacity to benefit, vertical equity and communitarian claims. Whatever decision is eventually reached on what is fair in such funding, it is suggested that there are enough indications that what is currently the case is unfair. While the question of what the ultimate goal of fairness might be is being sorted out, it is suggested that spending on indigenous health care be increased by 50%. Such a move is clearly justified as a short term policy objective.

### **Keywords**

Capacity to Benefit, Communitarian Claims, Indigenous Health, Vertical Equity

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## Introduction

This paper was written against a background where Australians have just had a very successful Olympics, successful in terms at least of Aboriginal reconciliation. Yet within days of the closing ceremony Philip Ruddock, the Minister for Aboriginal Reconciliation, was reported as having made announcements to the foreign press (Chandrasekaran, 2000) about the lack of development of indigenous people in Australia. He put this down in part to their lack of adoption of technology such as the wheel. Despite the support that the Prime Minister gave to his minister, there was considerable condemnation from the public of this statement.

While this appears as yet another example of the mean spiritedness of this government, the Australian people, at least some of them and maybe even a majority, do seem more caring about the state of health and wellbeing of our indigenous peoples. Why however should ordinary non-indigenous Australians be concerned about such a matter? Answering this question may well provide a clue as to how to address that of what would be equitable in indigenous health care.

It is important to open a debate about the extent to which the poor state of indigenous health affects not only indigenous people but non-indigenous Australians as well. It can readily be argued that it is not just indigenous health per se that affects non-indigenous Australians but the national neglect of their health, where one aspect of this neglect may be the relatively poor access of indigenous people to health care. If non-indigenous Australians felt that they were “doing their bit” or, along the lines of the US economist Howard Margolis (1982), “doing their fair share”, *even if this were unsuccessful in terms of improving indigenous health status*, might not Australian people in general, as a result, feel better and feel less shame?

To some that might seem an inappropriate or simply wrong argument. Consequentialists might struggle to agree to allow utility from a variable which looks more process orientated than outcome or consequence related. This paper however does not hang on that issue. This is used simply to exemplify the idea that what is fair is complex.

It is undoubtedly much easier to identify what is *unfair* than what is fair. This is in part simply because many situations can be deemed unfair but according to whatever school of thought one adopts there is a “point” at which fairness is achieved. Pinning that point down precisely is hard. It is thus often difficult to know or to judge the destination of any policy on fairness. It is easier to recognise that where things currently stand is unfair. In the context of indigenous health care and spending thereon, up until recently, even that judgment has been difficult to make, largely because there has been little concrete information on the level of expenditure on

health services for Aboriginal and Torres Strait Islander people. It has been quite widely believed to be very much higher than for the rest of the population.

Against this background, a study by John Deeble and colleagues was commissioned by the Commonwealth Department of Health and Family Services (Deeble et al, 1998), with the support and cooperation of all the State and Territory health authorities. It was undertaken by the National Centre for Epidemiology and Population Health and the Australian Institute of Health and Welfare.

One of the key findings of this study was that all the expenditure ratios of indigenous to non-indigenous were lower than had previously been assumed. For all services and all sources of funds, recurrent expenditures for and by Aboriginal and Torres Strait Islander people were estimated at \$853 million. This was 2.19% of all recurrent health expenditure in 1995/96. Per person, total spending for and by Aboriginal and Torres Strait Islander people was \$2,320, only about 8% higher than that for and by other Australians. It was also revealed that the pattern of service use by indigenous people is quite different from that for other Australians. The former rely much more heavily on publicly provided hospital and community health services and spend much less on private doctors, private hospital care, dentistry, medicines and ancillary services. The authors speculated that cultural differences, isolation and the structure of services in areas where many Aboriginal and Torres Strait Islander people live may all have contributed to this outcome.

The Deeble study was not required to make recommendations on funding criteria or policy. However, comparing expenditure on Aboriginal and Torres Strait Islander people with indicators of their health status raises unavoidable normative questions of what the resource allocation should be. For example, how can a relative expenditure ratio of 1.08:1 be reconciled with death rates for Aboriginal and Torres Strait Islander people of about three times the national average? If they cannot be, what criteria might be adopted to determine what a fair distribution of funds might be?

The current situation is manifestly unfair. Unless one were to ignore totally the much higher health problems of indigenous people then it is simply not possible to argue that what is, is fair. Equal expenditure per capita on all health care spending is equality; it is not equity.

So what should be spent? If non-indigenous Australians were to pay 1% more per capita for health care, it would be possible to spend 50% more on indigenous health care (Mooney et al 1998). This is simple arithmetic given what is currently spent and the small proportion of the population who are indigenous. It is not being argued that such increased spending would be enough but rather than delay yet further in addressing the problems of indigenous health, let us agree to that increase as a first step on two grounds. It would provide better access and perhaps better health for

indigenous Australians; second it might make non-indigenous Australians feel better and less ashamed.

### **A way forward**

A way forward involves combining the following.

1. the notion of “capacity to benefit” as a definition of need;
2. the operationalisation of vertical equity (i.e. the unequal but equitable treatment of unequals); and
3. communitarian claims.

This approach is favoured over the more conventional basis of resource allocation where the greater the amount of sickness in a population, the greater is deemed to be the need and the greater are judged the resources to be allocated. Frequently too, whatever measure of differential need is used, the resources to be allocated are determined pro rata with this. Thus if “need” is 10% above the average, 10% more resources are to be allocated.

The concept of need as capacity to benefit is almost self-explanatory and recognises that health services have varying capacities to benefit in terms of both the population receiving the care and the impact that health services as opposed to other services can have. This “capacity to benefit” notion of need is often seen to be more difficult to measure than the conventional “sickness” view of need. This is however something of a myth. This is because such need is often measured badly and inappropriately.

Marginal capacity to benefit (in essence what we can hope to achieve with additional resources) is what ought to be the major focus for the future in moving policy forward on equity issues in indigenous health services.

As an example of some of the problems of using degrees of sickness as measures of need, let us take the use of Standardised Mortality Ratios (SMRs) in resource allocation formulae. In several of these e.g. in the original RAWP formula in the U.K. (Resource Allocation Working Party, 1976) which was the very start of this type of approach and in the Resource Distribution Formula in NSW (NSW Health, 1996), SMRs were and are used to reflect the degree of sickness in different regions or areas. The implication of this is that an SMR of 110 translates into an additional 10% of resources to be allocated to that region. Now there are three reasons why this sort of measure might be problematical. First (and one that has been heavily debated) the fact that death rates are 10% higher does not mean that any sickness arising will also be 10% higher. Second, even if it did, there is no reason why a higher sickness rate of

10% should translate into 10% more resources. Third, even if that were the case, it is not immediately clear to me that that would result in an equitable outcome. There are no simple arithmetic guiding rules here; rather there are several value judgements needed to translate any differential sickness to differential resource allocation. The task only seems easy because such mechanical interpretations are in practice used to operationalise the measurement process. What are we trying to achieve with such a process? What is the impact of differential resource allocations? And what is fair with respect to process or outcome? Thus not only is it argued that marginal capacity to benefit is a useful measure of need; there is also an argument for opposing the use of the extent-of-sickness basis of need *in this context of resource allocation mechanisms*. It is seriously flawed in principle and, as indicated, even its seeming virtue in terms of its measurability is questionable.

In operationalising the concept of capacity to benefit, there is a need to try to respect community preferences. These *informed* preferences as far as possible should determine priorities for resource allocation. Certainly there will be a need to give the community or communities relevant cost and benefit information so that their choice of priorities is informed.

There is also a need to try to ensure that the setting of priorities and the establishment of equity rules should as far as possible be linked together and whenever practical be built from the bottom up. Thus the priorities of local communities can be used to assist in setting priorities in equitable resource allocation across indigenous communities. These in turn can be used when looking at the allocation of resources between indigenous and non-indigenous communities. The driving force is investment in capacity to benefit. At the level of indigenous versus non-indigenous resource allocation, given the differences that exist in health status and other factors, there is a need to establish differential weightings for health gains (and possibly for other benefits) for the different populations.

To this end it is proposed that the concept of vertical equity as embodied in the idea of weighting “claims” (Broome 1989) for indigenous versus non-indigenous people be endorsed. Claims — strictly “communitarian claims” (Mooney 1998) — represent a basis for a society deciding on what terms resources should be allocated to different groups. This task as indicated above is frequently done on the basis of health (or sickness) needs in public sector services or willingness to pay in market based systems. The idea of “communitarian claims” is to allow through this mechanism for society to have a say on what this basis ought to be and to determine the relative weights to be attached to different attributes of individuals or groups in allocating health service resources. It is possible to hypothesise in this context two things. First there will be more to such claims than the health status of the individual or group involved. Second the weight to be attached to health gains (and perhaps other benefits as well) will not always be one and may vary across different groups. Thus

one might hypothesise that for Aboriginal and Torres Strait Islanders this weight will be above 1. (For more discussion of communitarianism see Aveneri and de Shalit, 1992.)

This would mean assessing what the marginal benefits would be of additional spending in the two populations — indigenous and non-indigenous — and forming judgements about the relativities of benefits of such marginal spends. This is primarily an efficiency criterion where additionally and importantly there are weights attached to health gains (and other deemed-to-be-relevant benefits) which reflect a higher preference or greater importance being attached to them as a result of a greater strength of “social” or “communitarian” claims. In essence it is argued that the way to determine the optimal mix or balance of spending between indigenous and non-indigenous is through assessing the marginal benefit to cost ratios for the two populations and attaching a higher weight (determined by the community at large) to benefits to indigenous populations. This would reflect the higher claim that society attaches to benefits to the indigenous population.

If such a process were adopted, then the probability would be high — especially given the findings of the Deeble report (Deeble et al, 1998) — that this would lead to a substantial increase in spending on indigenous health care. At this point it is not possible to say how much.

There is a need for a survey of the population to determine the relative weights to be attached to health gains (and possibly other benefits) to indigenous versus non-indigenous Australians. An appraisal of the costs of reducing the access barriers and an assessment of the relativities thereafter of capacity to benefit in the two groups could then be made. An initial estimate could then be reached, at least in the short term, of equitable funding to indigenous health services. The fact that it may transpire to be difficult to pin down precisely what to spend as a fair allocation is hardly surprising given the multi faceted nature of equity and the inevitable measurement problems in assessing and quantifying capacity to benefit.

What is clear is that given the currently very small differential per capita spend on indigenous people, and the very large differential in health status (however this is measured) between indigenous and non-indigenous people, raising existing spending considerably, by say 50% in the short run, can be justified. Beyond that any weighting of indigenous claims above 1 and tentatively from various small surveys that have been undertaken by the author and colleagues (e.g. Mooney et al 1999), this figure may be above 2, would suggest possibly doubling in the longer run. Additionally the higher costs of remoteness and other barriers (including racist and cultural barriers) would justify a higher spend still. The greater marginal capacity to benefit of most indigenous communities would push the ratio yet higher.

It is very doubtful in any case whether any increase greater than 50% could reasonably be absorbed in the short run. Rather than devoting more energies to trying to pin any desirable or justifiable level of increased spending down yet further, it is advocated that we move in the right direction with the spending levels. At the same time as this move is taking place there is a need to ensure that adequate effort and resources are devoted to evaluating any changes in service provision. There is currently a desperate lack of information on the effectiveness and cost effectiveness of health service interventions among indigenous peoples. Trying to assess through the capacity to benefit notion of need what the optimal level of spending on indigenous health versus non-indigenous health is seriously hampered by this lack of information.

In recent years much of the debate around equity in health care (and beyond) has centred on the work of John Rawls (1972). It is thus apposite to consider whether an alternative approach to resource allocation can be built up from a liberal Rawlsian stance. This involves *inter alia* placing individuals behind a veil of ignorance so that they do not know what their own (individual) position is in a society and then asking them to form a judgement about what sort of rules of equity they would wish observed in that society. Rawls (1972) argues that this will lead to a “maximin” position, i.e. essentially that society will attempt to maximise the position of the least well off, the prime focus of any distributional policies then being on the most disadvantaged.

There are a number of problems, both in principle and in practice, with this approach. In principle it does not allow for “interdependencies” across different individuals or groups in society. The individual is asked to act in what is his or her best interests and independently of not only what his or her position is in any society but also independently of any knowledge of what others’ positions might be. For example, there is no scope for appealing to an individual’s altruism since those to whom the individual might be altruistic are unknown as to their relative positions in the society.

Individuals carry into any society not only themselves as individuals but also much baggage accumulated from being in a society. They know their position in that society and are aware of the relationships that they have with others and to some extent that others have in that society with yet others. There is no conception of a “good society” in Rawls’ theory; indeed it might be argued that there is no concept of society at all in the theory. Placing people behind the veil of ignorance does perform the potentially useful role of allowing individuals to be impartial but it also leads in essence to selfish attitudes — “what is *your* concern about *your* position?” is the force of the argument here. It is clearly a matter of judgement at the level of principle as to whether this impartiality argument is sufficient to outweigh any disadvantage created by the selfish thrust of the Rawlsian original position.

At a more practical level there are two major problems with Rawls. First, work by Miller (1992) suggests that however individuals perceive equity, it is not in Rawlsian terms. Second, while it might be possible to place individuals behind a veil of ignorance and ask them to obliterate from their minds that they as individuals are indigenous or non-indigenous, this does seem difficult to achieve. There have to be grave doubts about the capacity of individuals to do this successfully. (This is separate from the question of whether, even if this were possible, it would be appropriate to use the answers.) This would seem difficult conceptually for individuals to handle. Given the ignorance of many non-indigenous Australians about the position of indigenous Australians, then this would make the task even more difficult and the answers even less reliable.

The liberal position on equity, which requires, according to Rawls, the placing of individuals behind a veil of ignorance, is rejected. Partiality (which Rawls does avoid) does create its own problems in any discussion of equity; but to achieve this at the expense of recognising the interactions, interdependencies and mutuality of individuals living together in a society is unlikely to be worth the cost. That is why a communitarian basis for examining equity is proposed in the specific context of vertical equity especially and yet more specifically in relation to indigenous versus non-indigenous health.

## Research

It is clear from what has been written above that there is a need for much more research on indigenous health services. There is currently no national strategy for research on indigenous health. This at best is surprising. A major initiative is needed with emphasis very much on what interventions should be implemented, on evaluating such interventions, on learning about what works and what doesn't work. The problems are great. It can also be argued that the heterogeneity of the problems and of indigenous communities is such that there are few simple solutions. There is however a need to begin to identify *some* solutions, to monitor, to evaluate, to reflect on community preferences and their potential role and to drop the elitist stance of the past.

There is a need for a well funded research program, directed largely by indigenous thinking to allow us, beyond an immediate and sizeable injection of funds, to be able to say, within say two years, what is fair in indigenous health care funding.

The components of such a research program are many and for debate. The following are proposed as starting points.

1. More, and more genuine, participation of indigenous people in the process of planning and evaluating health services is a priority. This must begin with clarification of the Aboriginal construct of health, for to establish the principles



that indigenous people want to drive their health services and debate in the indigenous community more generally about how they want their resources allocated and not just with regard to the outcomes but the processes incorporated in such allocation. (The author has recently been privileged to be involved in such debate which has been a very positive experience in terms of both the process and the outcomes.)

2. There is a need to rethink in indigenous terms (and also probably non-indigenous terms) the current obsession with narrowly founded health outcomes and narrowly-based evidence-based health care. Of course good evidence matters but there is a risk that we prioritise what has good evidence about narrowly defined outcomes above what are probably (but not certainly) good buys. Let me give one personal example. In June this year the author attended a basket ball festival for Aboriginal youth in the Pilbara. It was to promote Safe Sex. The public health unit raised the money and Aboriginal Health Workers organised the event. It attracted 17 teams from around Western Australia and 500 Aboriginal people attended as spectators on each of the three days of the tournament. Measurable, evidence-based health outcomes were negative: two broken legs...
3. All too little is known about the costs of delivering services in remote areas and in particular the appropriate basis for such costings, especially of staff. Efforts are needed to develop the notion of "equally productive, equally attractive" (EPEA) positions. What does it cost to get the same amount of nursing output in remote North Queensland and create equally attractive nursing positions there as compared with the cost of one nurse in Brisbane or Perth? It is not enough to ask what a nurse costs in the Pilbara as compared with Perth.
4. There is a need for much better understanding of the barriers that indigenous people face. The paucity of information on this issue is striking (Ivers et al 1997). There is then need related, but clearly subsequent, research to establish how most efficiently to reduce such barriers.
5. Management of resources is a major issue and while progress has been made in self-determination and community control and some (even if limited) evidence exists that this "works" (see for example McDermott et al 1998), there is a need to understand better what constitutes good management in indigenous communities and what sort and size of investment are needed to bring this about.
6. The notion of vertical equity as a base, in part at least, for determining the funding for indigenous health may be crucial. It requires more investigation, including more community surveys.

## Conclusion

There is obviously a need to think of the opportunity cost involved in any increased spending on indigenous health services. One measure of such a cost which comes to mind is foregoing a part of the 30% rebate the federal government introduced last year for private health insurance. If the government now reduced that rebate to about 22%, Instead of 30%, then the monies saved could be used to increase spending in health care for indigenous people by 50%.

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