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Inequity in Australian health care: how do we progress from here?

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Past experiences and current attitudes inhibit this society's ability to adopt a caring stance in allocating health care resources. Any health care system is first and foremost a social institution built on the cultural stance of the nation it serves. It is thus not happenstance that the US, with its emphasis on neo-liberal values, has a much larger private health sector than the Scandinavian countries, where social solidarity is important.

This paper examines various aspects of equity in health care in Australia, why such efforts have largely failed and what might be done to bring about a more equitable health care system. The focus is equity in health care and not in health as that would broaden the paper too much in the space available. As inequities are greatest in Aboriginal and Torres Strait Islander (hereafter Aboriginal) health, this is the focus of the next section. Then some issues in defining equity are highlighted briefly and some of the broader problems in pursuing equity in health care in Australia are discussed, with some implications and conclusions.

Aboriginal health funding and the distribution of power

Very real inequities exist in Aboriginal health care and in its funding1. This is exemplified using a case study of Derbarl Yerrigan, the Perth Aboriginal Medical Service.

There are three reasons why spending on Aboriginal people's health should be higher per capita than for non-Aboriginal people.

• The health problems of Aboriginal people are much greater.2

• There is some evidence3 that, as a form of positive discrimination in favour of Aboriginal people, health gains for Aboriginal people are valued more highly by the Australian community in general than health gains for non-Aboriginal people (i.e. vertical equity is considered appropriate).

• The problems of access – particularly with respect to cultural barriers – are greater for Aboriginal people. Services need to be made culturally secure.4

There are precedents in various health service jurisdictions for having a higher level of spending on Aboriginal health services because need is greater. A ratio of three was used in the resource allocation funding formula for Queensland.5 In General Practice Divisions, the ratio for Aboriginal people is

2.9. McDermott and Beaver,6 in the Northern Territory, on the basis of relative needs, suggested a ratio of four.

The 'standard' approach to equity – horizontal equity – argues that all health gains no matter to whom they accrue should be weighted equally (i.e. by one). Vertical equity suggests that there should be positive discrimination for the disadvantaged and that any benefits to them be weighted above one.

In the citizens' juries in Perth in 2001, the ratio proposed was 1.2.7 In the Resource Development Formula in NSW,8 it is 2.5.

To arrive at a composite figure for weighting Aboriginal people for the factors listed above, the three ratios (2.9, the lowest for relative need, 1.2 for positive discrimination, and 1.75 for cultural security from a study of Derbarl Yerrigan9) are multiplied together. This gives a factor of more than five.

Looking specifically at primary care in Perth, the level of spending in the general population on Medicare Community Doctor Services (i.e. those similar to the sorts of services that Derbarl Yerrigan provides) was $765 per capita. Multiplying by five would give a figure for funding per capita at Derbarl Yerrigan of more than $3,800. The level of expenditure at Derbarl Yerrigan at the time (2000/01) was $829, slightly higher than the Perth overall figure ($765) but well short of $3,800.

The actual level of *funding* of Derbarl Yerrigan was about 10% ($800,000) below their level of expenditure. As a result, in the wake of a management consultants' report, they were forced to close one of their successful branches that was providing services to clients in the Midland area on the outskirts of Perth. Yet it can be argued that it was a direct result of Midland's success that they had over spent. Midland had increased its client base from 400 to 2,100, at an extra cost that exceeded their overspend of $800,000.10

About the same time as these events were occurring at Derbarl Yerrigan, the Perth teaching hospitals were overspending by $100 million, about 12% of their budget and about 120 times the overspend at Derbarl Yerrigan.11 The Perth teaching hospitals did not have to close anything.

Not only does this say something about the inadequate funding of this Aboriginal Medical Service but about the inequitable distribution of power over resource allocation in health care. It is also an example of institutionalised racism. This has been defined as "the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin".12 (For more discussion of this phenomenon in health care see *The Lancet* editorial.13)

Defining health care equity

There is no agreed uniquely correct *definition* of equity in health care. Equity is inevitably a value-laden, social and cultural phenomenon.

The most common definitions are equal health, equal access (for equal need) and equal use (for equal need).

There are also different ways of *conceiving* of equity. For example, horizontal equity is about the equal treatment of equals, while vertical equity is about the unequal but equitable treatment of unequals. It is also possible to distinguish usefully between distributive justice and procedural justice, where the former is consequentialist and concerned only with outcomes; the latter with the fairness of procedures.

How to define equity is perhaps best decided on an informed basis by the Australian community i.e. Australian citizens as a whole. To date they have not been given the chance to do so. One example, that at least starts down this road, is the equity stance that citizens' juries adopted at a meeting organised under the auspices of the WA Medical Council.7 In summary this is:

Equal access for equal need, where equality of access means that two or more groups face barriers of the same height and where the judgement of the heights is made by each group for their own group; where need is defined as capacity to benefit; and where nominally equal benefits may be weighted according to social preferences such that the benefits to more disadvantaged groups may have a higher weight attached to them than those to the better off.

This does not, however, address certain other problems. First, it is implied that all groupings, social and cultural, have the same construct of health, a common presumption in definitions of equity.

Yet even within Australia, the construct of health is different for Aboriginal people from that of non-Aboriginal Australians.4,14

Distributive justice in health care however requires measured outcomes or consequences, involving health or health need. If there is no common outcome, operationalising distributive justice becomes problematical. (A way of overcoming this is proposed in the Implications and conclusions section.)

Some key inequity issues

Lack of political will and complacency

If progress is to be made in achieving more equitable health care in Australia, there needs first to be the political will to do so; second, reduced complacency surrounding the idea that Medicare, the publicly funded health insurance system,15 is already fair; and third, research to allow greater understanding of some of these issues.

With respect to lack of political will, the most glaring examples of late are the Government's schemes to promote greater uptake of private health insurance and subsequent use of the private sector. These are symptomatic of a desire to work against equity in health care. Second, on complacency, there is unfortunately a belief that we already have an equitable health care system.

With respect to Medicare, there is a perception that this is, first, universal16 and, second, fair (as in the Friends of Medicare slogan 'It works. It's fair. It's Medicare'17). Even if that were the original intent, Medicare today is, in reality, neither. The mistaken belief that it is fosters complacency with respect to equity in our health care system as a whole.

Let me exemplify this. Medicare has in principle universal coverage; it is fair. In practice, for primary care services, this turns out not to be true. On average, Australians use Medicare-funded primary health care to the extent of just over $530 per year.18 The people in Double Bay, a rich suburb in Sydney, use more than $900.

In the Kutjungka Region, in the Kimberley, the Aboriginal people are among the sickest in Australia. They use less than $80 in Medicare primary health care funds per year,18 largely because of the non-availability of GPs. In time, initiatives such as the Primary Health Care Access Program19 being trialed in the Northern Territory may help on this front.

Many of the inequities in Aboriginal health are recognised, have been investigated and brought to the attention of politicians and public in various reports. The problem beyond

that is the fact that so little action is taken to address these inequities. It is, for example, 24 years since the now Minister for Immigration and Multicultural and Indigenous Affairs, Philip Ruddock MP, argued:

"When innumerable reports on the poor state of Aboriginal health are released there are expressions of shock or surprise and outraged cries for immediate action. However ... the appalling state of Aboriginal health is soon forgotten until another report is released."

2 As a report into Indigenous health in 20002 went on:

"The continuing poor state of Indigenous health in Australia over the last twenty years ... has generated a continuous (sic) flow of further reports about the problem." There have been at least 20 further reports into Indigenous health since 1979.

Private funding

Australia has a large share of private spending on health care compared to most OECD countries. All private health care is inequitable.

The ability of the rich to pay is greater. Recent attempts by the Federal Government to cajole more people into private health insurance increase inequities across income groups in Australia.

20 Private health insurance has been taxpayer subsidised to the extent of an additional $2 billion a year.20

What is now in danger of happening in Australia is that as the private sector grows, Medicare will become more a safety net for the poor and, in reality and in perception, cease to be a universal system.

This is what Margolis's21 fair shares model would seem to predict. The 'participation utility' that individuals get through paying taxes for health care for all – a form of 'social solidarity' – will, if more and more people opt out to the private sector, not be stable. A key aspect of this model is that the individual is a member of the group and thus the concern for the group is not strictly altruism, not 'the rich paying for the poor'. When feelings of social solidarity are breached, however – '*we* are paying for *them*' – the decline in participation utility is likely to be rapid. It may well be that we are approaching that point in Australia.

Public funding does seem likely to lead to greater equity. We can learn about funding for equity from Scandinavia where, compared with Australia, public funding dominates and the tax-based system is much more progressive in allowing the redistribution of the burden of health care costs from the well to the sick and from the rich to the poor. Where ability to pay is a significant factor in access to health care, then the existence of a private sector creates barriers for the poor.

Private health care is internationally almost always concentrated in cities. It thus makes it more difficult to staff services in rural and remote areas as the incomes to be obtained in the private sector make working in the cities more attractive.

Community preferences for equity

At a WA Medical Council meeting in 2000, both a randomly selected group of Perth citizens and a group of senior health care professionals, including many clinicians, argued for greater investment in both public health and for greater equity.22 It is significant that the Perth citizens voted altruistically for more resources to be allocated outside of Perth.

In 2001,7 where the topic was narrowed to equity, citizens' juries argued for both horizontal and vertical equity. Of the three areas of inequity in WA with which they were

presented – Aboriginal health, rural and remote health and aged care – their greatest strength of preferences for spending more health service money was in Aboriginal health. In a mailed survey of the South Australian community23,24 respondents were asked about the principles (including equity) they wished to underpin their health services. One half were randomly given some basic information about Aboriginal health and the other no information. Both groups argued for vertical equity/ positive discrimination. Those given the information about Aboriginal health discriminated more positively although, in a small survey, the difference was not statistically significant. Clearly any attempt to elicit the preferences of the community needs to try to ensure that the community is adequately informed as well as being aware of the resource consequences if their preferences were to be used.

Thus it seems – but the evidence is tentative – that the public wants some greater degree of equity in health care, a point confirmed by other researchers.25 It is disturbing that so little research has been conducted on this issue.

There is additionally poor recognition of the need to allow articulation and elicitation of the values of the disadvantaged who are deemed to be being treated inequitably. In this context there is no single value system that extends all the way across advantaged and the various disadvantaged groups. It follows that we need to find a paradigm that does not rely on a single value system. One is proposed below.

Implications and conclusions

A number of changes are needed to pursue greater equity in Australian health care. First, it is less 'natural' in Australia (than in Denmark, for example) to have a social value structure that promotes compassion and concern for the less well off. We need a more compassionate society, an idea echoed by Sen26 when he writes in this context of the "overwhelming role for intelligent and equitable social policies" and "an appropriate social commitment".

To move to a more compassionate society and in turn a more equitable health care system will require strong political leadership. As Nussbaum27 argues: "We want leaders whose hearts and imaginations acknowledge the humanity in human beings."

There are thus severe limits to making progress with equity in health care in Australia without the appropriate political will. Second, neo-liberalism and market values dominate so much of the value system of Australian society (and not just the Australian economy). The standard health economics approaches will not get us an equitable health care system. That is why I have advocated elsewhere28 the adoption of a new paradigm. This is based on communitarianism, which involves *inter alia* a recognition that the community is something to be valued in and of itself. Crucial are two other factors: first, the recognition that the nature of autonomy is social; and second, an emphasis on freedom. A community-determined 'constitution' or set of principles is advocated as the vehicle for expressing this communitarianism29 based on Vanberg's30 'constitutional paradigm', which "draws attention to the procedural foundations that organizational action is *based upon*".

Leading into this may best be done through 'communitarian claims'. On the concept of claims, Broome31 has proposed that a claim to a good involves a duty that a candidate for that good should in fact have it. Communitarian claims, as I have proposed elsewhere, "recognise first that the duty is owed by the community of which the candidate is a

member and secondly that the carrying out of this duty is not just instrumental but is good in itself ".32

There is no need strictly for potential recipients to be active in 'claiming' goods or resources. Further, the idea avoids the need for a common construct of health or health needs and for different groups to have the same ability to manage to desire, one of the main criticisms that Sen33 makes of more conventional schools of economic thought.

Third, since equity lies at the heart of public health, there is a responsibility in public health to promote debate about issues that have a potential impact on the health of the public.

Fourth, research on equity has to date focused on use and too little on access.34 This needs to change. Research on Aboriginal health needs to support the call by Humphery35 "for a move beyond the project … seeing research … as a collective enterprise of the broad research community'. The recent initiative of the NHMRC Research Agenda Working Group36 to develop such a strategy is welcome.

Fifth, rural and remote health care services need to reflect better the preferences of rural and remote communities. There then needs to be consideration given to adequate funding to allow the pursuit of what 'claims', and relative strengths of claims, Australians see as relevant to these areas.

The key consideration in each instance, however, is to ask what Australian citizens want in terms of general practice, Aboriginal health services, rural health services, etc. What is essential is to get citizens to make informed, resource-constrained choices (thereby avoiding wish-listing). There is Australian evidence, tentative thus far,7,22,24,25 that this can be done. There is also wider and more substantial international evidence37 about the feasibility and potential usefulness of such an approach. It is *informed* community preferences that should be the driving force of policy for equity in Australian health care.

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In no sense, however, am I attempting to write on their behalf. In this context it was, in my view, unfortunate that no Aboriginal or Torres Strait Islander people were invited to the Round Table.

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