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Staking a claim for claims: a case study of resource allocation in Australian Aboriginal health care

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Abstract

There have been numerous ways in which the notion of equity has been put forward in the literature. This reflects the fact that equity is essentially driven by values and is therefore subject to individual interpretation and preferences. Deciding between these various value judgements is however outside the scope of economic analysis, as conventionally defined. This poses a problem for the examination of issues of resource allocation in Aboriginal health services in Australia, where equity, very clearly, has a role to play. One possibility for moving forward on this issue is the adoption of a 'claims' approach where the emphasis is on the explicit recognition of the values to be employed in the 'equitable' allocation of resources. This involves teasing out the principles by which, under various approaches, resources are allocated differentially across groups (e.g. under resource allocation formulae, the criterion of 'need' as measured by SMRs can be viewed to be a basis for a 'claim' over resources). The commonly cited 'basic needs approach' is then used in the paper as a case in point to illustrate how such underlying principles may be identified and then assessed.

In relation to the issue of equity in Aboriginal health services, there are a number of possible standards for equity which seem to have a significant degree of community acceptance. The paper discusses ways in which they can be applied to the problem of deciding how to allocate resources in Aboriginal health. © 2002 Elsevier Science Ltd. All rights reserved.

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Introduction

The issue of equity as it relates to the allocation of resources across groups or individuals is very clearly one in which economists have much to contribute. The vast body of literature devoted to this topic not only in the health economics field but also in the economics literature more generally is testament to this. There are, however, many ways in which equity as a principle can be presented. This reflects the fact that equity is about values (Olsen, 1997). Choosing between various possible equity principles therefore necessarily involves value judgement.

Economists for the large part shy clear of making or being seen to be incorporating explicit value judgements of their own in their evaluations. This is perhaps a vain appeal to scientific rigour. Normative statements are generally formed on the basis of a priori value positions which are usually deemed to be uncontroversial, e.g. the Pareto criterion. Although this form of utilitarianism may be seen as entailing some form of equity, it is more normally seen as attempting to eschew such considerations. Its locus of value is in terms of individualism and individual interest. This, as a result, places limits on the extent to which the normative concerns of economists (as conventionally accepted) are able to deal with broader social concerns such as those about how individuals and groups are to be treated relative to one another.

Perhaps, as a result of this, the literature on equity relates mainly to alternatives to or additions to the

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conventional utilitarian perspective. Where economists have attempted to enter this debate, their approach has typically entailed a concern for some principle of fairness with respect to certain goods, resources, well-being or other such outcomes. Although the distribution of outcomes will be determined fundamentally by the values one imposes on the decision-making process, there has been little critical debate about which ones are the most appropriate. The prevailing sentiment seems to be that the process of deciding over values lies outside the domain of economics. Perhaps, not surprisingly therefore, much of the literature in this area has been at the interface between the disciplines of moral philosophy and economics (Hausman & McPherson, 1993, 1996; Hamlin, 1996; Olsen, 1997). There has, however, been some limited debate within the health economics literature which examines what notion of equity should be deployed in the allocation of health care resources (Mooney, Hall, Donaldson, & Gerard, 1991; Culyer, van Doorslaer, & Wagstaff, 1992).

Whatever theory is chosen and whatever measures of equity adopted, it is important to note, within the Australian health policy context, the vast differences in health between indigenous and non-indigenous Australians. For instance, Aboriginal and Torres Strait Islander people have an average life expectancy of 15–20 years less than that of Australians in general and infant mortality rates around 3–4 times greater than the general population. In some communities, diabetes rates are 15–20% in comparison to 2–3% in the general Australian population (Abraham, d'Espaignet, & Stevenson, 1995). Such levels of disadvantage are also present in other social indicators. Perhaps, most striking is the evidence that the differences in health status between indigenous and non-indigenous populations are greater in Australia than in the US, Canada or New Zealand (Kunitz, 1994).

Very clearly, given the significant disparities in health and health-related disadvantage between Aboriginal and non-Aboriginal Australians, the application of some notion of equity has a role to play in the formulation of policy with respect to Aboriginal health. This imperative can be read into virtually any policy statement relating to how health policy should deal with the concerns of the Aboriginal and Torres Strait Islander populations and, at least implicitly and increasingly explicitly, we can add 'vis-a-vis those of the non-Aboriginal and Torres Strait Islander population'. The problem then is to decide what is to be meant by equity in this context. Addressing this question is the aim of this paper. In the section, "Equity and the 'claims' approach", some of the ways in which the issue of equity has been approached in the literature will be reviewed. In particular, the focus will be on the underlying values embodied in alternative versions of equity. Reference will be made in the section 'Basic needs approach' to the 'claims' approach which

can be used to tease out some of the values embedded in notions of equity. The section, 'The bases for a claims approach to equity in Aboriginal and Torres Strait Islander health', contains an appraisal of one commonly cited approach to meeting the needs of the most disadvantaged groups in society, the basic needs approach. Specific reference is made to the values underlying this approach. This is followed in the next section, 'Where to go from here?', by an analysis of the claims approach as it relates to Aboriginal and Torres Strait Islander health. Finally, the section, 'Conclusion', provides a brief description of how such principles can be implemented in practice—drawing largely on as yet unpublished work undertaken by the authors.

Equity

Equity can be seen as synonymous with the notion of justice or fairness and is generally defined as equality in the distribution of some phenomena (e.g. goods, welfare, rights, etc.) but with some added qualification such as 'according to need'. Indeed, as highlighted by Sen (1980), the utilitarian imperative of maximising utility can be seen as being consistent with the objective of equality but only if viewed in terms of *marginal* utility.¹ Within the health economics literature, there has been limited discussion over the appropriate objective for equity policy. Some of the principles, which have been used, are 'equal access for equal need', 'equal health', 'equal resources for equal need' and 'equal use for equal need'. The debate over what forms an appropriate equity principle to a large extent mirrors a wider debate within moral philosophy over what the appropriate criterion for fairness is. This is not surprising given, as mentioned earlier, that the issue of equity is driven by values and that what is deemed fair or equitable by one person may not be seen as fair or equitable by another. In essence, these represent different moral positions.

The arguments in moral philosophy about the principles of equity can be classified in terms broadly of how the consequences which arise from the exercise of personal preferences are accounted for. It can be argued that these various principles differ inter alia in the degree of 'paternalism' they embody. At one end of the spectrum, typified by the 'equality of resources' argument, is the view that equity is achieved through equality in the distribution of *initial* resources available to an individual (or class of individuals). Inequalities in the distribution of what is then *achieved* with these resources are deemed irrelevant to the issue of equity. What one

¹ While not the focus of this paper, this observation from Sen has, we believe, considerable significance in the context not so much of supporting a utilitarian principle of equity but rather emphasising that such a principle *excludes other equalities*.

then makes of one's initial endowments, which is likely to be a product of individual abilities and preferences and in practice, *differing* individual abilities and preferences, is not relevant or is ignored. This is consistent with the view that individuals should have the opportunity to exercise their own preferences on their own behalf.

At the other end of the spectrum is the argument that equity is achieved only through equality of welfare. This is similar in many respects to how equity is presented by Culyer and colleagues (Culyer et al., 1992), i.e. equal health for all (although it could be argued that health is simply an instrumental goal in the achievement of wellbeing and thus the goal of equality of health is more about the equality of capabilities, as suggested by Sen (1980)—see below).

Two of the commonly supported positions lying between these extremes are the principles of 'equality of opportunity for welfare' as proposed by Arneson (1989) and 'equality of capabilities' as put forward by Sen (1980). There are broad similarities between these two views insofar as they both propose that individuals have the same *opportunities* for welfare gains and that differences in *realised* welfare are an individual rather than a social responsibility. In effect, they aim to compensate groups or individuals for certain disadvantages which create potential barriers to the achievement of wellbeing at the time that such disadvantages arise and which occur as a result of factors beyond the individual's control (e.g. through the lottery of birth). Of course, this begs the question as to the extent to which factors such as genetic predisposition and environment *determine* preferences and in turn whether it is right to hold people accountable for the exercise of these preferences if these factors do play a significant role in preference formation. This is first an empirical question to ascertain as to how preferences are formed; but second, it is a value question with respect to whether different preferences are to be respected irrespective of how they have been determined. Within the health economics literature, however, these views resemble most closely the principle of 'equal access for equal need'. The justification for this principle is that it entails the recognition that individuals may have varying preferences for health (and health care) and that social policy should not interfere with such preferences (more about this in the section, 'Where to go from here?').

It is suggested in this paper that the view of equity as simply being the equality of some phenomenon, while being attractive in the analysis of 'horizontal equity' ('the equal treatment of equals') poses difficulties when considering vertical equity ('unequal but fair treatment of unequals'). A danger lies in assuming that vertical equity involves achieving equality of some *dimension* (or phenomenon) across different groups. This is not necessarily the case. Egalitarianism of this type is but

one of a number of possible value positions (and indeed a particularly strong position) underlying a vertical equity stance. For instance, it would be considered, conventionally at least, an exaggeration to contend that underlying the progressive taxation system (where the application of vertical equity involves the imposition of different marginal tax rates), the ultimate aim is one of 'equal disposable income' across groups. Similarly, in the context of health, the application of vertical equity does not necessarily imply a policy objective of equalising health, wellbeing or any other phenomenon across groups or individuals. It entails the treatment of different groups differently yet equitably. How this is done on a 'fair' basis depends on the set of values adopted.

In terms of equity in health care resource allocation, Donaldson and Gerard (1993) have found in an international survey of policy documents, that 'equal access for equal need' seems to be the most commonly adopted (see also Mooney et al., 1991). In relation to Australian Aboriginal and Torres Strait Islander health, the National Aboriginal Health Strategy likewise adopted the criterion of equal access for equal need (National Aboriginal Health Strategy Working Party, 1989). Furthermore, this was more recently reaffirmed by the National Aboriginal Community Controlled Organisation (1999).

Equity and the 'claims' approach

In attempting to attain some degree of coherence and transparency in the assessment of equity from an economics perspective, we advocate the use of what we have termed 'communitarian claims' (Mooney & Jan, 1997; Mooney, 1998). This builds on the concept of claims put forward by John Broome (1989): 'To take account of fairness we must start by dividing the reasons why a person should get a good into two classes: 'claims' and other reasons. By a claim to the good I mean a duty owed to the candidate herself that she should have it.'

Claims are thus 'reasons', supported by a notion of duty, why one group should be allocated more resources than another. In the equity principles underlying population-based resource allocation formulae (such as the New South Wales Resource Distribution Formula (NSW Health Department, 1996) or the English RAWP (Resource Allocation Working Party RAWP, 1976)), for instance, need measured by variables such as SMRs and socioeconomic status form the basis for a claim. Everything else being equal, a population with a higher than average SMR is entitled to a greater than average share of resources. Under market-based health-care systems, willingness and ability to pay are seen as bases for claims over health care resources. Alternatively, under systems of historical funding, the level of funding

in one year is interpreted as a claim for resources in the next.

The prime rationale for putting these fairly basic ideas into the language of claims is that it allows the values embodied within various methods for allocating resources to be viewed explicitly. Set out in these terms, equity can be viewed as defined by, first, how claims are established and, second, how different claims are weighted. 'Claims' seen in this light, as asserted by Broome (1989), 'are the object of fairness'. (See also Broome, 1990–1.) Claims can be seen as being consistent with a social/community perspective (which is necessary in dealing with equity) because they deal explicitly with how groups/individuals within society should be treated *relative* to one another. Much of the utilitarianism inherent in the conventional economics perspective falls short in addressing this issue of equity because it focuses on the individual as the unit of analysis (Shiell & Hawe, 1996) and lacks a view from society qua society (as does, to a large extent, the basic needs approach—see later). Furthermore, this claims approach is not hamstrung by an adherence to some or other goal of equality and is thus open to a wider set of values, which may be deemed relevant to vertical equity.

Adopting a claims perspective, however, necessarily entails the recognition of two issues.

1. If policy on equity is ultimately to be directed to determining the allocation of resources, the relative claims of parties within society should be established with respect to the prevailing resource constraints. For economist readers, this is perhaps self-evident, but as discussed later, such considerations are not necessarily apparent in other more individual-orientated approaches to equity.
2. The basis for claims should be determined by community standards of fairness (which in turn may be determined by community preferences). This seems to be a reasonable stance given, as contended earlier, that equity is essentially about how individuals/groups within society are to be treated relative to one another.²

To operationalise this approach, it is necessary to establish on what basis claims are to be established. This involves the task of partitioning the population into groups, which are meaningful in relation to the objective of allocating resources fairly. For instance, it may be useful for the purposes of resource allocation to define the population in terms of age groups as suggested by Williams (1997). Alternatively, social class, existing

²One feature of the 'communitarian claims' approach is that they are not simply about channelling resources to the neediest groups. Since claims are established by the values of the entire community, the process of honouring them can be viewed as a source of value to that community (Mooney, 1998).

health status, capacity to benefit, age or indeed smoking status may be seen as forming bases for differential claims.

The second task in operationalism a 'claims' approach is to determine the relative weights attributable to these claims, e.g. what weight should programs to the young be given vis-à-vis those to the elderly. At each of these two levels, there are value judgements required in determining, respectively, the bases and weightings attached to these claims. In the limited amount of work which has been undertaken in the health economics literature examining possible weightings to be attached to different groups (although not necessarily in the language of 'claims'), some form of community deliberation has generally been used (Mooney, Jan, & Wiseman, 1995; Nord, Richardson, Street, Kuhse, & Singer, 1995; Cookson & Dolan, 1999; Dolan, Cookson, & Ferguson, 1999; Mooney, Jan, Ryan, Bruggemann, & Alexander, 1999). Indeed, it is difficult to see how such issues can legitimately be addressed without, in some way, consulting the community. In this sense, the claims approach can be seen as communitarian. It is also appropriate to call this communitarian in the sense that the community may well value its involvement in this process. A difficulty here lies to a large extent in addressing how such consultation is undertaken. Some of the methods used include surveys of individuals (Mooney et al., 1995, 1999; Nord et al., 1995), focus group deliberations (Cookson & Dolan, 1999; Dolan et al., 1999) and some form of citizens' jury (Lenaghan, New, & Mitchell, 1996).

Basic needs approach

As a way of illustrating this claims approach, it is instructive to examine the 'basic needs approach', where some of the above considerations are not fully accounted for. The 'basic needs approach' is frequently proposed as a means of addressing the issue of allocating resources, including health care resources, to disadvantaged groups (e.g. Stewart, 1985; Scrimgeour, 1997).

It requires the identification of a set of basic needs (also sometimes referred to as 'minimum' or 'core' needs), which typically comprise 'basic levels of health care' along with basic levels of food, clothing, shelter, housing and education. One of the most celebrated statements of such needs is the United Nations Universal Declaration of Human Rights which includes 'food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond [an individual's] control' (United Nations, 1949).

This approach is generally couched in terms of individual rights, i.e. the rights of the individual to draw

on certain benefits from the state, with for example a right to minimum health care, a right to minimum income, etc. (e.g. van Parijs, 1991; Hill, 1996). Such needs are considered to be universal. The application of the approach to policy has some appeal because it provides well-defined targets, progress towards which is relatively easy to measure (Stewart, 1985). Furthermore, it establishes an institutional/quasi-legal requirement on the state to deliver a minimum level of services. A significant dimension of any failure to meet such needs is that it is regarded as being not only an undesirable distributive outcome but also a denial of individual rights.

The basic needs approach is however *absolutist*, in the sense that each individual has a right to a particular set of goods *as defined by a third party* regardless of context. This can be seen to be problematical on a number of counts.

First, a set of goods, which might be considered to constitute the basic needs for one individual/group may not be adequate for other individuals/groups. Factors such as differences in culture, society, physical attributes and race can mean differences in the manner in which and the extent to which the consumption of certain goods is able to meet the requirements of daily living. For example, what is considered to be a 'basic' level of health care for mainstream Australia may not apply to remote Aboriginal and Torres Strait Islander communities—in terms of both level and type of services. In a somewhat similar vein, Sen (1984) has argued that the notion of poverty cannot be defined absolutely because the living requirements across societies will differ. The problem occurs largely when needs are defined by third parties without reference to the heterogeneity of the individuals and groups concerned.

Another potential problem with any basic needs approach lies in determining which commodities belong to the set of basic needs. It is assumed here that the commodity health care belongs to this basic set. One difficulty, however, is that the identified needs of any population may not reflect the culture and preferences of any subset within that population. Individuals may not attach the same value to those goods deemed by policy makers to be part of their basic needs. Stewart (1985, p. 4) observes that 'even people who are deprived of very basic physiological needs do consume non-basic goods or services'. There is then an onus on those who espouse this basic needs approach, when needs are defined by a third party, to justify the overriding of individual/community preferences particularly in relation to indigenous health care where the cultural appropriateness of services can determine the extent to which they are used. (While this is an especially difficult issue when needs are being assessed in a bi- or multi-cultural society such as Australia, it is an issue even within a more culturally homogeneous society where, for example,

there are social groupings such as socio-economic classes where relevant values may not be common. In dealing with these, it is all too easy to descend into paternalism and elitism.)

Inherent in these first two problems is the implication that there is a commonality or homogeneity present in a society *or* that differences, which do exist, can be ignored. A feature of the basic needs approach is the *universality* of the priorities which it puts forward.

It is possible, however, that basic needs can be seen not in terms of specific sets of goods or services, but of a general set of basic 'capabilities' (Sen, 1980). These could be seen as being similar to what Rawls (1972) refers to as 'primary goods' or Stewart (1985) calls the 'full-life' perspective. This would offer a greater degree of flexibility in the type of tangible goods and services available and possibly overcome some of the inflexibility associated with the 'universality' discussed above. It would allow for the fact that different people require different sets of goods to reach the same level of human capability. It thus offers a way forward from a basic needs approach by providing the situational flexibility necessary to account for differences in the requirements of day to day living across individuals and cultures.

Thirdly and perhaps most problematically, the needs approach fails to take into account the notion of marginal benefit. In principle, the approach involves allocating resources to meeting the basic needs regardless of the opportunity cost. This could easily lead to highly inefficient resource use since resources would be allocated to predetermined areas, regardless of the marginal benefit and the marginal cost involved. This problem stems from the lack of recognition of prevailing resource constraints, which in turn results again from the establishment of universal goals, independent of context.

Fourthly, at a pragmatic level, the basic needs approach may point to policies which simply fail to be implemented. This may be through lack of resources, lack of political will, the values of the dominant cultural group, etc. Certainly, these features are present in Australia in its policies for Aboriginal and Torres Strait Islander communities. This failure needs to be analysed and the claims approach may help in such analysis.

In summary, the key difficulties associated with the basic needs approach, as we interpret it, in its application to a notion of equity, are that it lacks first a concept of society and secondly, an adequate reflection of the scarcity of resources. The imperative under such an approach is to fulfil a uniform set of requirements at the level of the individual. As argued, this is problematical because, among other things, factors such as the capacity of a society to fulfil these needs across all individuals (e.g. in terms of resource constraints) and the relationship between these needs and the ultimate wellbeing of the individuals concerned is not necessarily

fixed and may well differ across communities and settings.

Despite these difficulties, such statements of basic need commonly form, ostensibly at least, the basis for policy statements. Against this background, the narrow basic needs approach (defined in terms of goods rather than capabilities), which entails the setting of minimum general standards of health care and other social services is unlikely to be adequate for Aboriginal and Torres Strait Islander populations. Factors, such as the need for cultural appropriateness of services and the environment of social and economic disadvantage faced by much of this population, inevitably impose additional resource requirements on the top of those necessary to maintain these bare minimum standards.

The bases for a claims approach to equity in Aboriginal and Torres Strait Islander health

In the application of equity to the allocation of resources for Aboriginal and Torres Strait Islander health, a claims approach entails firstly, a recognition of prevailing resource constraints and secondly, the identification of some sort of community standard for fairness or equity.

In determining the claims, some idea of the prevailing resource constraint needs to be established. Within the existing policy setting, one (but by no means the only) way of doing this is to recognise the resource constraints which exist, the decisions on which they are binding and in turn the choices which need to be made. In the context in which we are currently concerned, it is apparent that such constraints and thus choices regarding the allocation of resources occur at three levels: (i) between Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander populations; (ii) across Aboriginal and Torres Strait Islander communities; and (iii) within Aboriginal and Torres Strait Islander communities.

In relation to the community standards for equity, while there may not be universal endorsement of the value statements put forward below, they seem nevertheless to have strong community support.

1. Procedural vs. distributive justice: Since we are dealing with different cultures in which the constructs of health and health gain (and possibly also other benefits of health care) are likely to be different, we acknowledge that distributive justice may not be feasible and that we are forced to adopt a procedural justice account of equity in which the driving force is to get the procedures or processes fair. Distributive justice requires that some output or outcome be fairly distributed. In relation to health care, this is typically taken to mean the fair (often defined as equal) distribution of health. Where, however, there is no common construct of health, such a

requirement lacks sense whatever other conceptual merits there might be in choosing a distributive justice goal for equity in health care. (See Mooney & Jan, 1997.)

One feature associated with this emphasis on procedural rather than distributive justice is that it allows for the promotion of autonomy and self-determination in the decision-making process. The importance of these 'instrumental' goals cannot be underestimated as highlighted by Anderson (1994, p. 36).

'Poor health in Aboriginal communities can only partly be explained by the high levels of risk (such as dietary or environmental factors, or smoking) to which people are exposed. Well-being implies the act 'to be': if I am to be healthy I must actively engage in my world, make choices, and act on them.'

He continues, 'The concept of self-determination expresses the right of Aboriginal communities to improve the quality of their life through a process of empowerment... We believe such a principle to be fundamental to improvements in Aboriginal well-being.'

These sentiments are echoed by others, most notably by the National Aboriginal Health Strategy (1989). This reflects a greater recognition within policy debate that a condition for the achievement of equity is the engagement of individuals and groups within the process of decision making. Siggers and Gray (1991), Hunter (1993) and Palmer and Short (1994) characterise the current period in policy making in Aboriginal and Torres Strait Islander affairs as being represented by this greater emphasis on 'self determination'. Thus, there does seem to be some support from policy makers and communities themselves for the promotion of these procedural aspects and the process of resource allocation as being part of the overall program of achieving equity in Aboriginal health.

Accepting this notion of procedural justice, however, poses methodological problems since the tools of conventional welfare economic theory are inherently based on a consequentialist view of the world. Equity is generally interpreted in terms of distributive justice. Typically, within the health economics literature, the application of equity criteria involves some sort of social weighting attached to either health outcomes or the outcomes of health care programs (e.g. Gafni & Birch, 1991; Nord, 1994; Mooney, 1996; Williams, 1996, 1997; Dolan, 1998)—for examples within the more general economics literature, see Weisbrod (1968); and Harberger (1978). In examining procedural justice, greater attention is paid to 'instrumental' variables such as the methods chosen to pursue policy, the relative input of different parties in the decision-making process, the degree of community consultation, etc. It is not clear whether a reductionist approach characterised by the

‘weighting’ of outcomes is uniquely the most appropriate for examining these variables and thus other methodological traditions need to be considered (Jan, 1998). This also raises the question of precisely what it is that is incorporated within the term ‘outcomes’.

Although, in principle, there is a clear dichotomy between procedural and distributive justice, it is possible that in the formulation of public policy, this distinction may become blurred. The emphasis on procedural justice in this paper is based on securing some degree of indigenous community participation and control in decision making. It would, however, be fanciful to presume that, within such a policy framework, the significant shortfall (however measured) in health of the Aboriginal and Torres Strait Islander population and the persistence of such a shortfall over time could be overlooked regardless of what procedures were adopted in resource allocation.

Horizontal vs. vertical equity: The notion of horizontal equity (the equal treatment of equals) would seem to have limited application in the context of the very substantial differences in health status between indigenous and non-indigenous Australians (as outlined earlier). While one can debate whether there is evidence that Aboriginality itself is a risk factor for illness, we would contend that there is a moral argument for adopting it as such (especially, as indicated below, if one adopts a communitarian claims perspective).

We have argued elsewhere that vertical equity needs to be addressed when the relative needs of Aboriginal and Torres Strait Islander vs. non-Aboriginal and Torres Strait Islander people are examined (Mooney, 1996). One way this could be put into practice would be to establish a positive resource weighting for Aboriginality in resource allocation formulae. Indeed, this stance seems to have strong support, as reflected in the current policy highlighted in the NSW Health Department Economic Statement (NSW Health Department, 1996).

Equal access for equal need: The question of the dimension of equity that is most appropriate is quickly narrowed down to equal access when the choice is between equality of health, use and access. (Such a choice echoes earlier debates on this issue. See Mooney et al. (1991) and Culyer et al. (1992).) As it happens, equality of access is also the principle of equity that the National Aboriginal Health Strategy (1989) endorsed.

In defining access, we would suggest that this discussion go beyond the relatively common view of access measured in terms of the opportunity costs of use and take account additionally of the welfare loss of use. This notion of access recognises that two individuals faced with the same money charges and other resource costs of using health services may nevertheless have different access because they have different perceptions of other potential barriers such as language, health service staff attitudes, cultural appropriateness, etc.

Here equal access is defined as a situation in which two (or more) individuals perceive the barriers they face as being of the same height.

It is clear, however, that a concept of equity set in terms of equality of access needs some added dimension, both in principle and in practice, related in some way to a claim to health care which is likely to vary across individuals. Most commonly, this is defined as equal access for equal need.

There are two main ways in which need is normally defined. First, there is the extent of sickness in a population and secondly there is the notion of ‘capacity to benefit’. The latter notion is preferred as it can pay due account to the fact that not all health problems are amenable to health care interventions and, in so far as they are at all, will vary in the extent to which health services have the capacity to deal with them (Culyer, 1995). How one defines ‘benefit’ is an open question and is ultimately a value judgement especially where health as a construct is viewed differently by different groups.

It now seems clear that the Aboriginal and Torres Strait Islander concept of health embraces a broader set of factors, including autonomy and self-determination or community control, than conventional Western biomedical concepts and indeed has much in common with the WHO definition (Kunitz, 1994; Brady, 1995). Where health includes notions of autonomy and self-determination, the argument that the priority-setting focus should be simply to reduce disparities in health without necessarily involving communities in this decision making creates a potentially false separation between ‘health’ per se and participation (both individual and community) in health advancement (Hawe, 1994). This would suggest some role for community valuation of the benefit of various programs given that the output of such programs is likely to be viewed differently by different populations.

As touched upon earlier, one concern regarding this use of preferences from the community, however, is that they are likely to be shaped by the environment and social conditions in which they are formed. Therefore, asking a relatively sick community about both the extent of their health problems and what is needed to address them can be very different from asking the same questions to a healthier community. Essentially, the frames of reference will differ, as almost certainly will the answers.

This point is perhaps best illustrated by the apparent discrepancy between the clinical indicators of health (for instance, those reported in the introduction) and self-reported measures of health for the Aboriginal and Torres Strait Islander population. The National Aboriginal and Torres Strait Islander Survey (ABS, 1997) indicates that 88% of respondents reported that their health was ‘good’, ‘very good’ or ‘excellent’. Only 2% reported it as being ‘poor’. In comparison, in the 1989

National Health Survey (ABS, 1991) for the general population, the corresponding figures were 79% and 4.5%, respectively.

That self-assessed measures of health or well-being are relative rather than absolute concepts has some support in the psychology literature although typically the studies on which this evidence is based have focused on personality rather than social environment (Campbell, 1976; Brickman, Coates, & Janoff-Bulman, 1978; Diener, 1984; Allison, Locker, & Feine, 1997). Nevertheless, by recognising the influence of these expectations over preferences, potentially significant constraints are placed on how community self-assessment can be used in priority setting. Where communities differ in terms of their health 'environment', it seems that emphasis should also be placed on reducing the disparities across environments as opposed to simply addressing the self-perceived need.

What this section highlights therefore is the importance of community involvement in the decision-making process (in promoting access and meeting needs—as defined above), balanced with the recognition that such preferences may be greatly influenced by local norms and expectations. This is an important consideration although hardly surprising when comparing preferences across groups with relevant and significant inequalities.

Where to go from here?

What we have done in the preceding sections of this paper is to consider various bases on which health care resources can be equitably allocated. Because of cultural differences in health, etc., and the instrumental importance of acknowledging claims, the primary emphasis is on procedural rather than distributive justice.

The principles that we would then want to use in allocating health care resources are built on the notion of equal access for equal need, *but* only where the following applies:

1. Access relates to the height of the barriers, both opportunity cost barriers and welfare loss barriers.
2. Need is set in terms of vertical equity and of communitarian claims, i.e. the society as a whole determines first, what constitutes needs and secondly, the weights to be attached to the needs of different groups. It may then be that such need is based solely on health problems or on the capacity to benefit and that, thereby, little change occurs in how need is portrayed and incorporated in any allocation formula. But it may not be (see below).
3. Related to point 2, there is an acceptance that health and hence need for health care are not necessarily of the same construct across different cultures.

4. That the lack of a common construct of health and in turn need and the existence of different expectations for health arising in different health environments and social settings (or communities) create problems for the 'standard' approaches to resource allocation in health care. We propose the use of 'communitarian claims' linked to vertical equity to try to address these otherwise seemingly unresolvable problems.

First, in the allocation of resources *within indigenous communities*, we would argue quite explicitly that to achieve cultural appropriateness in services and in service delivery requires community input by way of community preferences. These preferences would then provide the *value* base to assist in determining priorities. We would argue just as explicitly that the *information* base on which priorities are to be set will require inputs, such as good epidemiological research, much wider than those to which the community would normally have access. Setting out options in terms of packages of possible interventions and/or redeployments of existing resources, which are costed and 'benefited', as well as existing epidemiological and other data will enable:

- (i) priorities to be set on the basis of communities' own values about capacity to benefit;
- (ii) issues of access to be addressed both explicitly within a priority-setting framework (by including them within the surveys of the preferences of communities) and through the *process* of consulting the communities about their needs; and
- (iii) the importance of community self-determination/control to be built into the options, thereby allowing the community to express its preferences about such matters as well.

Two examples where this approach has been employed in practice with the support of indigenous communities are found in Wiseman and Nona (1998) and Wiseman, Daley, Mooney, Williams and Williams (1999). In these studies, the issue of how most appropriately to determine community preferences was complicated by the existing social structures. The danger of initiatives of this kind is that various methods of community consultation, such as surveys and polling, impose a form of collective decision making which may be inappropriate to that setting. By misreading the preferences of the community in this way, the paternalism that has blighted past policies in indigenous health in Australia is continued in the present. In these particular studies, the process of consultation was importantly built into existing policy initiatives, had the support of local community controlled organisations and was undertaken largely by local health workers. The process itself entailed an initial household survey as a means of simply flagging health issues of concern, which

were to be brought up later at a series of public meetings. These meetings were open to all members of the community. Discussion and deliberation took place at these meetings over how health resources were to be allocated across health care priorities. (In one of these communities, since the initiative was run with the local council as well as the health service, various environmental, non-health service initiatives were also considered.) Although the inclusiveness of these priority-setting exercises may not have been consistent with the usual decision-making processes of these communities, the support gained from the peak decision-making bodies and individuals within these communities suggested that such a process and the data it provided were of value in decision making.

Second, the question of allocating resources *between* communities needs to be addressed, with some degree of community consultation to determine program areas in which there is the greatest capacity to benefit, barriers to services and community control. However, since we may be comparing across communities which have significantly different levels of health and health care provision, it is unlikely to be enough to rely solely on these preferences. As discussed above, preferences of individuals are generally shaped by expectations (which in turn are shaped *inter alia* by general community standards of health). It thus needs to be recognised that differences in access and in health problems will not necessarily be fully reflected in any comparisons of such preferences. Therefore, some more ‘objective’ measures will be required to augment the communities’ stated preferences. Relevant variables here will include:

- distances to various health and social services;
- availability of services;
- inventory of health problems;
- measures of self-assessed health; and
- demographic data.

Third, at the level of health-care resource allocations for Aboriginal and Torres Strait Islander people vs. other Australians, vertical equity concerns become more pronounced and the question to be addressed is primarily about guidelines or bases for various funding formulae based on population characteristics (e.g. Commonwealth Grants Commission, 1995; NSW Health Department, 1996). Here, the question of the relative weights to be attached to the claims of different populations moves to the centre stage. We favour the use of community-wide surveys as being the most legitimate way of determining these claims. It is in this context not just an epidemiological question as to whether or not Aboriginality is to be deemed a risk factor for poor health but a moral, social question, essentially: does Aboriginality constitute a claim over

scarce resources?—although the answer to the first question could strongly influence the second.

What we have done to date is to look at this issue using the preferences of public-sector health-service decision makers in two jurisdictions in Australia, and with weightings based on a claim restricted to health status.³ (See Mooney & Wiseman, 1998.) Beyond that, however, the notion of weighting according to community preferences is something of a departure from the more commonly advocated concept and measurement of need and as such we would want to adhere to the nomenclature of claims. It also means that something akin to the concept of marginal benefit can be incorporated but can be perceived in terms of the relative trade-off between differently weighted competing claims.

At all the three levels above, some concepts of equity, efficiency and community values apply but the nature of these and the relative weights are likely to be different. Where we see the greatest challenge is in making the concept of ‘communitarian claims’ work in practice. We believe that it is a fruitful way of addressing questions of resource allocation across different cultures where the construct of health may differ but where what the preferred outcomes are beyond that construct may also vary. The practical applications are under way and it will be here that the real test of the value of these ideas will occur.

Conclusion

One of the aims of this paper has been to promote a greater degree of transparency in the use of values in resource-allocation decisions, which we believe can be achieved through using a ‘claims’ approach. Although funding for programs which affect Aboriginal and Torres Strait Islander health comes from numerous agencies both within and outside the formal health sector (as well as from different levels of government), the focus of this paper is on the funding of health care programs. There is no reason, however, why the issues of equity discussed in this paper cannot be applied more broadly to achieving equity within other types of social programs (e.g. education, employment and housing) since the disadvantages in health faced by Aboriginal and Torres Strait Islander populations are paralleled in other aspects of day to day living.

³One of the things that a community survey needs to establish is not only what the weights are but also what constitute the claims to be weighted. If it were to transpire that the only basis for claims was health status, then claims and (at least one version of) needs might coincide. We are grateful to Jan Abel Olsen for making this point.

The existing boundaries for economic analysis, as conventionally defined, have limited, significantly, the extent to which economists have thus far contributed to the issue of how resources are to be equitably allocated. Making more explicit the values necessarily underpinning any stance on equity better enables economists and others involved in resource allocation decisions to engage in the assessment and debate over these issues. Ultimately, achieving this greater clarity and explicitness will also potentially enable resource-allocation decisions, both within and beyond the context of Aboriginal health, to be made more in line with broader policy objectives.

Health care provision for Aboriginal and Torres Strait Islander populations is characterised by a history of paternalism. Only since the 1970s has there been a significant move in Australia toward indigenous community control and the participation of indigenous people in health-care decision making. The claims approach presented in this paper is an attempt to establish, within this spirit, an economic framework for resource allocation.

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