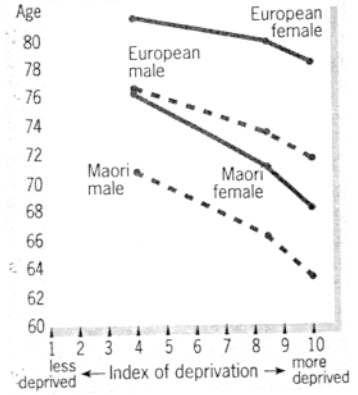
Tues, 9 March, 2004, Dom Post

Health system funding is already 'needs-based'

▶LIFE EXPECTANCY

Economic background and race are both important for life expectancy.



Peter Crampton, Tony Blakely and Philippa Howden-Chapman

NEED and ethnicity are already co-habiting in our health funding system. "Socioeconomic deprivation" and "ethnicity" are two of the five main factors that dictate need and how health dollars are spent.

Both matter, says the existing system — not as much as the fundamental measure, population size, nor age and gender — but they are important parts of the equation. That's the equation that is used when New Zealand calculates its needs-based health funding, the one we've run, in one form or another, for the past 10 years.

The previous funding system, based on the 19th-century location of hospitals, had evolved in a way that unfairly penalised fast-growing regions like Auckland.

Fundamentally, our health system is based on the principle that we spend most health dollars on the people who need most care. That allows for everyone to be looked after without bankrupting the nation.

To make that work, there need to be formulas. At present, the money flows this way: the Health Ministry funds district health boards using a population- and needs-based formula. They get a certain number of dollars a head, adjusted on a "needs basis".

The DHBs fund primary health organisations, like GPs and nurses, using more of the same kind of needs-based formulas. The main factors affecting money allocation are:

- Population size, which gives a baseline "per head" allowance.
- Age of the population — adjustments are made for the greater needs of the old and very young.
- Gender — adjustments are made for the greater needs of women in their child-bearing years.
- Socioeconomic deprivation — there are adjustments for the greater needs of people living in socioeconomically deprived areas.
- Ethnicity — adjustments are made for greater needs in Maori and Pacific populations.

Ideally it would be nice not to have to use such clunky things as formulas with complicated weightings of generalised factors like these, but in the absence of detailed accurate health data for every person in New Zealand, they are what we have to work with.

Some of the factors used to spread the money don't generally raise eyebrows. Who would object to the very old, babies and pregnant or new mothers getting more of the kitty.

Instead, the focus of recent debate has been on the relative importance of socioeconomic deprivation and ethnicity. The calls for the emphasis to be on socioeconomic factors is well-founded. For well over a century, researchers have demonstrated a strong link between poverty and poor health. This association is unlikely to go away in the foreseeable future, though needs-based funding should help reduce inequalities.

However, the recent public debate has tended to miss the fact that, in contemporary New Zealand, ethnicity is an important measure of need, even after socioeconomic deprivation is taken into account.

The accompanying graph measuring life expectancy by deprivation and ethnicity shows, as recently reported, that Maori people can expect to die earlier than European New Zealanders with similar levels of socioeconomic deprivation.

In future, we hope this will not be the case. Then, when the health status of all ethnic groups is similar, we can drop ethnicity from the formulas.

In the end, the health system can do only so much to change the extent of health needs. We rely on the economy, high employment rates, the education system, good housing and the myriad other factors that create healthy populations. But we do expect the health system to respond to our health needs. It is the ambulance at the bottom of the cliff ... and the ambulance needs to be funded to respond to the needs of everyone, and to respond to those who have the greatest levels of sickness.

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