

Mutual obligation and Indigenous health: thinking through incentives and obligations

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As shared responsibility agreements between Indigenous communities and the Australian Government become more prevalent, where their goal is health improvement we need to consider whether the rewards and obligatory behaviours are acceptable, whether communities have real freedom of choice, whether the arrangements can be implemented and evaluated, and whether they will improve health. (MJA 2006; 184: 292-293)

The Howard Government's *New arrangements in Indigenous Affairs* have seen 76 shared responsibility agreements (SRAs) signed between leaders of 64 Indigenous communities and the Australian Government.¹ The first SRA publicised, in December 2004, entailed community leaders in Mulan in the East Kimberly ensuring that children were given showers daily in return for funding for a new petrol bowser and health programs. The main rationale for the agreement presented in the media was improving child health, particularly reducing the incidence of trachoma.²

The near-silence of health commentators on this issue was, thankfully, broken last year by Collard and colleagues in this Journal.³ These authors questioned the morality of the government in placing conditions on the provision of basic rights to Indigenous communities. However, behind both the government's enthusiasm and Collard et al's criticism lie enduring public health dilemmas. Below, I present five questions that may help readers consider these issues as they relate to the Mulan SRA in particular, and to incentives and obligations in general.

But first, we need a working definition. In the context of health, let us say that "mutual obligation" means *obligating people to adopt healthy behaviours in return for a reward*. While the Mulan agreement incorporated a number of obligations and rewards (see Box), here I focus on the obligation of parents and children to maintain hygienic behaviours and the reward of a petrol bowser.

The key questions presented here refer only to obligations placed on communities, rather than on governments. Furthermore, for the purposes of this discussion, it is assumed that community members are in a position to fulfil the obligations (for example, they have access to a functioning water supply).

Is the reward acceptable?

For many, this question hinges on the distinction between a right and a privilege. Is it the *right* of a small, isolated community to be provided with a petrol bowser by the government, or is it a *privilege*? Most would agree that it is unfair to offer something as a reward if it is a human or civil right, such as the provision of health care. If it is a privilege, however, it may be considered acceptable to use it as an incentive. This distinction is highlighted by "no school,

Draft agreement between the government and the residents of Mulan

Government

- The federal government will contribute \$172 000 for the installation of fuel bowsers at Mulan.
- The Government of Western Australia will undertake to "monitor and review" the adequacy of health services in an area where trachoma rates are "arguably the worst in the world".

Mulan Aboriginal Community

- The residents will:
 - Ensure children shower daily and wash their faces twice a day;
 - Ensure rubbish bins are at every house and are emptied twice weekly through the local work-for-the-dole scheme;
 - Undertake household pest control four times a year; and
 - Act to prevent petrol sniffing.
- Families and individuals will also make sure children attend school, crèche and the health clinic; and they will keep their homes clean and pay rents (to ensure the local council can afford pest control and repairs like plumbing).

Source: Collard, et al. *Med J Aust* 2005; 182: 502.³ ◆

no pool" programs (in which children who do not attend school may not use the community pool), which share features with mutual obligation arrangements, and also use improved child health as their rationale.⁴ There has been no prominent criticism of the government providing swimming pools to remote communities conditionally, perhaps because swimming pools are seen as a privilege, not a right.

In making these judgements, the special status of Indigenous peoples must be taken into account. Their historical status as Australia's first peoples, their current position of extreme social disadvantage, and their cultural distinctiveness all mean that the government has special responsibilities towards them.⁵ For instance, if it is shown that swimming pools hold long-term benefits for child health, it may be argued that they should be provided to remote communities as part of their right to health-promoting infrastructure.

Is the obligatory behaviour acceptable?

Is it acceptable to ask parents to ensure their children are clean? Some people would consider it an intrusion into the family unit, an affront to personal autonomy, or dangerously close to the paternalism of the assimilation era. Others would argue that the grave situation of child health means that we should explore any approach that can improve it, including addressing basic health behaviours such as hygiene.

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The issue of *who* is obliging the behaviour is clearly important. If it can be shown that the community itself wants to dictate the behaviour of community members, there may be less basis for concern. For instance, when community councils enact alcohol restrictions, obliging people not to drink, they are celebrated by many as effective public health interventions.⁶

Is it acceptable that people adopt the behaviour in order to obtain the reward?

Public health science has long wrestled with the problem of changing behaviour, including whether and when education, incentives or compulsion are the best strategies.⁷ Economic incentives and disincentives for healthy behaviour are generally acceptable in some forms, such as taxes on tobacco and alcohol, and health insurance rebates for spending on healthy activities such as gym membership and yoga classes.

The question is whether it is acceptable for people to adopt healthy behaviours *in order to* obtain the reward (a petrol bowser or saving money), or whether sustainable behaviour change must stem from genuine belief in the related health benefits. This question is partly one of effectiveness: some argue that once a behaviour is adopted it becomes habitual, regardless of why the behaviour was adopted, while others question this reasoning.⁸ But the question is also one of ethics: is the reward an inappropriate inducement, despite the “healthiness” of the obligation? This relates to the issue of autonomy I now turn to.

Do communities freely choose to participate?

This is the key issue for Collard and colleagues,³ and others for whom community autonomy and self-determination are central concerns. They suggest that the Mulan community was not “well placed to judge whether the benefit they will get from a petrol bowser will be worth the ‘price’ they have agreed to pay”,³ implying an element of exploitation or coercion in the government’s approach. The proponents of the agreements, however, argue they enhance community autonomy by allowing the community to deal directly with government, rather than through intermediaries in multiple bureaucracies.⁹

Some would consider that the substantial power difference between a small, isolated Aboriginal community and the Australian Government means that a community can *never* freely participate, even if community representatives truly believe they are making an autonomous choice. Others think that to dismiss the choices communities make as “false” is paternalistic.¹⁰

Can the arrangement be implemented?

It is concerning that there are no formal evaluative mechanisms built into SRAs, as there are numerous questions surrounding the implementation of these agreements. How would the cleanliness of children be assessed? Would the government take the bowser away if people stopped showering their children? If one family in the community didn’t comply, would they be barred from using the bowser? These are but a few of the immediate questions that would need to be addressed in the implementation of the Mulan SRA — questions that remain unanswered.

Will it improve health?

The public health literature indicates that incentives and obligations that promote healthy behaviours have a role in improving health.⁷ The lack of attention to the implementation and evaluation of these agreements on the government’s part suggests that they, at least, are not taking the potential health benefits seriously. A more serious approach to the potential health benefits of SRAs would employ public health expertise and an evidence-based approach. For instance, face-washing programs need to be integrated with screening and treatment programs and environmental health programs to have maximum impact on trachoma rates.¹¹

It is also difficult to judge how genuinely Indigenous communities themselves are engaging with the health-related obligations of SRAs. A pessimistic view might be that, to access much-needed resources, communities are agreeing to obligations they have no intention or ability to meet. This may have the inadvertent effect of focusing the public health gaze on individual behaviours and distracting us from necessary structural change. An optimistic view would welcome the opportunity for community leaders to voice their concerns about health and adopt novel health promotion approaches, in a similar vein to alcohol restrictions and “no school, no pool” policies. There may also be potential to use the agreements to hold the government accountable for the provision of basic infrastructure and services necessary for good health.

The political reality of SRAs is complex and fraught. However, the current focus on incentives and obligations provides an opportunity to reflect on the variety of methods available for practising public health, and the factors that may affect the application of SRAs in Indigenous contexts.

Competing interests

None identified.

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