Cost Control, Equity and Efficiency: Can We Have It All?[1]

EQUITY

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Introduction

On March 1, 2006, the Government of Ontario enacted the Local Health System Integration Act, which created 14 Local Health Integration Networks (LHINs) (2005, 2006). These organizations are charged with strategic purchasing; they will not directly provide services. Each LHIN is responsible for planning, integrating and funding healthcare services in its region. About two thirds of Ontario's healthcare budget is allocated to LHINs (Ministry of Health and Long-Term Care 2006a), which are required to achieve cost control and promote equity and efficiency (Canadian Health Care Manager 2005). LHINs must also respond to local needs and priorities and implement province-wide priorities (Ministry of Health and Long-Term Care 2006b). Ontario's Ministry of Health and Long-Term Care (MOHLTC) (2006c) emphasized that the goal of LHINs is to "restore equity to Ontario's health care system, ensuring quality care for every patient, in every community, in the province." The Ontario Hospital Association (2005), meanwhile, identified achieving efficiency and equity in hospital funding to be the crucial issue.

The health systems of Ontario and England are becoming increasingly similar in seeking cost control, equity and efficiency. The acts that created the National Health Service (NHS) in the United Kingdom (UK) in 1948 and medicare in Canada in 1966

aimed to provide equity of access to healthcare according to need through universal coverage that is financed by taxation and free at the point of delivery (Klein 2006; Tuohy 1999a; Marchildon 2005). There were, however, two key structural differences between the creation of the NHS in the UK and medicare in Canada. In the UK the government nationalized independent hospitals, brought local authority hospitals within a national system and revolutionized arrangements for paying hospital specialists by making them salaried employees of the NHS (but not direct employees of hospitals) (Klein 2006; Webster 1988; Forsyth 1975). In Canada the federal government limited its role to being an insurer. It also did not change hospitals' independent status nor did it alter arrangements governing the paying of hospital specialists on a fee-for-service basis (Tuohy 1999a). From 1991, however, the Thatcher government in the UK (Department of Health 1989) and – following devolution, which created a different NHS in each of the countries of the UK (Greer 2004) – the Blair government in England (Department of Health 2002a) have sought to move the NHS toward the Canadian model. Under this revised framework, ministers are responsible only for insurance by giving NHS hospitals greater independence from central controls and encouraging pluralism (Klein 2006; Department of Health 1989, 2002a). A report from the Ontario Hospital Association (2005: ii) recommended England's current regional form of regional health authority – Strategic Health Authorities (SHAs), which were created in 2002 – as a model for Ontario's LHINs.

In the next two sections of this paper I show that, although the English NHS has always achieved cost control by using a budgetary cap, there have been serious difficulties in the design and implementation of policy instruments intended to achieve two other desiderata: a more equitable distribution of resources and improved hospital performance. I conclude by raising questions about the current models of strategic purchasing in England and Ontario, questions that are intended to help policy-makers find ways to achieve these objectives.

The Search for Equity of Access

Although there is consensus that the underlying purpose of publicly financed healthcare is to improve equity, there is a lack of clarity over what kinds of equity ought to be sought (Mooney 1994). In practice, policies seek to correct identified inequities, beginning with the removal of the ability to pay as a barrier to access. In 1946, Aneurin Bevan (1991) identified two other inequities that characterized healthcare in the UK at the time: the inequitable distributions of general practitioners (GPs) and hospital services. The first was tackled from the start of the NHS by creating medical practice committees, which were given limited powers of "negative direction" – for example, the right to refuse to allow GPs to work in "over-doctored" areas (Webster 1988: 354–57). Nothing was done until 1976, however, to tackle the second problem (Rivett 1998: 26). Up to that point, NHS hospitals had been financed by a process of incremental budgeting and exceptional arrangements were made for England's élite teaching hospitals so that they remained outside the state hierarchy of regional hospital boards and hospital management committees. These arrangements undermined attempts to promote equity through the program of new capital development in the 1960s (Bevan et al. 1980: 22–24). Julian Hart (1971) observed that the NHS operated an "inverse care law," by which the availability of good medical care tended to vary inversely with the need for it in the population served. A study published

the same year by Cooper and Culyer (1971) provided empirical evidence of variations in ratios of supply to populations.

Two key developments provided the bases for correcting these inequalities. The first was the reorganization in 1974 of the NHS in England, a change that brought teaching hospitals into the regional structure and created new health authorities responsible for populations defined in terms of geographical areas. Fourteen regional health authorities were created, and they were responsible for planning and resource allocation. Ninety area health authorities were also launched; these were responsible for planning and running healthcare services for their areas (Bevan et al. 1980: 43–68). In 1979, the area health authorities were succeeded by 200 district health authorities (hereafter simply referred to as districts) (Department of Health and Social Security 1979). The second major development was spearheaded by the landmark *Report of the Resource Allocation Working Party (RAWP Report)* (Department of Health and Social Security 1976), which recommended a method for deriving a weighted capitation formula to develop equitable target allocations for each health authority, based on their unique population sizes, demographics and estimated additional needs. This report established the policy of allocating resources in England so as to move slowly toward equitable target allocations derived from a weighted capitation formula.

Since then, there have been various modifications of the formulas used in resource allocation. These changes have sought to derive estimates of additional need by conducting small-area analyses of variations in the utilization of hospital services and of unavoidable cost variations, which mainly involve staff, by undertaking analyses of general labour markets (Smith 2007: 92–99, 55–57). Despite developments in methods and data, these modifications remain contentious (Asthana et al. 2004; Stone and Galbraith 2006; Health Select Committee 1996, 2006).[2]

The *RAWP Report* interpreted the underlying objective of its terms of reference to be "to secure through resource allocation equal opportunity of access for people at equal risk" (Department of Health and Social Security 1976: 7). Although this objective has since been stated to be the bedrock principle on which all subsequent methods of developing capitation formulas were developed, all methods have sought to equalize resource use per capita. These methods have not, of themselves, corrected problems of access inequities caused by variations across groups by age, social class or ethnic group or discrimination by providers on grounds other than clinical need (Asthana et al. 2004). Hence there are two different kinds of access inequities, ones that both are and are not tackled by changes in the distribution of supply. In 1999, the UK government promulgated a new objective for resource allocation intended "to contribute to the reduction in avoidable health inequalities" (Hauck et al. 2002: 668). This initiative resulted, however, in just a small sum allocated as a health inequality adjustment for 2001/02 and 2002/03 only (Department of Health 2003a: 11).

The Search for Equity of Access and Efficiency

Although the *RAWP Report*'s terms of reference required its authors to recommend "a method of distribution to health authorities responsive objectively, equitably and efficiently to relative need," their methods were not designed to promote efficiency (Department of Health and Social Security 1976: 5). They recognized that achieving equity in terms of expenditure per capita, which took account only of variations in risk, would not achieve equity of access because of variations in costs

per unit of service. They also saw that, while formulas ought to account for unavoidable variations in costs, variations in efficiency required other policy instruments.

From 1977, the policy of achieving more equitable resource allocation was sought through a process of "levelling up." That is to say, the NHS's real growth money was directed at authorities with below-target allocations; with the rest – above target – experiencing no real growth. This phase began under a Labour government in 1977 and continued, following the election of a Conservative government in 1979, until 1982 (Bevan 1989). From 1982, the Thatcher government sought to achieve three objectives: cost control, efficiency and equitable allocations to health authorities. The government undertook the first two by applying fiscal constraint (from 1982 to 1988 there was no real growth in total NHS expenditure) (Webster 1998: 149–53; Klein 2006: 140–46). It sought to implement equitable allocations by moving these toward targets derived from a weighted capitation formula (see discussion of the *RAWP Report* above).

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The combination of these policies produced very different outcomes at the district level. The majority of districts were below target, experienced varying growth, and were under no financial pressure to achieve efficiency. The minority that were above target, which included London's teaching districts, experienced such severe budget reductions that they had to make cuts in services. The cuts in, and not developments of, services made the news, so that in the winter of 1987–88 it appeared that the NHS was in a financial crisis. The Thatcher government's response to that crisis was a wide-ranging review of the NHS, the outcome of which was the policy of reforming the NHS by introducing an "internal market" that aimed to introduce financial incentives to treat patients through a system in which "money would follow the patient" (Webster 1998: 182–205; Klein 2006: 146–52; Department of Health 1989).

The key structural change made in order to enable the internal market to function was the creation of two kinds of purchasers (Department of Health 1989). The dominant purchasers were districts, which were stripped of their provider functions. A radical innovation of the internal market was the creation of the scheme of GP fundholding for GPs who opted to act as small-scale purchasers of hospital services for their patients. GP fundholders became responsible for managing their costs of prescribing and referrals to hospitals for diagnoses and elective care (Glennerster et al. 1994). Providers became independent NHS trusts, which were required to compete for contracts from purchasers with each other and the private sector. The separation of purchasers from providers meant that, for the first time, the NHS had three policy instruments with which to pursue three policy objectives: cost control and equity by distributing a fixed budget for total NHS spending using a weighted capitation formula, and efficiency achieved through provider competition. The separation of purchasers from providers also meant that NHS trusts located within above-target districts could seek extra work from below-target districts (Bevan and Robinson 2005).

As Tuohy (1999a, 1999b) argued, however, the idea of provider competition was in conflict with the political logic of the NHS as a state hierarchical system, one in which decisions on patients were made collegially by GPs who acted as gatekeepers for hospital specialists and in which ministers were accountable for local failings. Contracts between districts as purchasers and trusts as providers had to be designed to capture, rather than determine, collegial decision-making on patient care by GPs and hospital specialists.

These contracts had all the characteristics Williamson (1975: 20–40, 1985: 43–67) identified as causing high transaction costs. Districts had become essentially pure insurers and were remote from the knowledge of hospital-based care. They had limited information on needs assessment (Hollinghurst et al. 2000) and were unable to develop "managed care" by integrating into the demand side (Robinson and Steiner 1998) because GPs contracted independently with a different body (family practitioner committees, which had been created in the 1974 reorganization to be coterminous with area health authorities). Ministerial accountability meant that the market had to be constrained so as to avoid hospitals being destabilized through loss of contractual income in the internal market.

A function of contracts is to share risk between purchasers and providers. In the internal market, however, purchasers had fixed budgets and they therefore could not afford the risk of providers increasing volumes and requiring payment at average costs. Providers, meanwhile, could not afford the risk of destabilization from losing contracted volumes of cases at average costs. As a result, contracts evolved into a system of block payments, with adjustments for volumes at marginal costs. This meant that not much money followed the patient and the market therefore lacked high-powered incentives for providers to compete for new business.

Following its election in 1997, the Labour government implemented three waves of system reform in England (Stevens 2004; Klein 2006: 187–208, 222–25, 232–38). From 1997 to 2000, the government sought a "third way" as an alternative to centralized command and control and the internal market (Department of Health 1997). From 2000 to 2005, it instituted a system of targets and terror through a system of "star rating" NHS organizations (Department of Health 2000; Bevan and Hood 2006). In 2006, the government introduced a second internal market (Department of Health 2002a). These reforms were accompanied by successive reorganizations from 1997 on (Klein 2006: 241–44). The key differences between the first and second internal markets are that in the second

- the emphasis is on patient choice (Department of Health 2003b);
- purchasers are primary care trusts (PCTs), which replaced districts and contracts with both GPs and providers of secondary care;
- providers are paid at a centrally determined standard tariff based on estimated national average costs using an English version of diagnosis-related groups (Department of Health 2002b); and
- providers with costs below the standard tariff are allowed to retain a financial surplus and trusts that fail are subject to measures to improve performance (with the ultimate threat of sacking the chief executive).

Discussion

In Canada regional health authorities have traditionally acted as both purchasers and providers (Marchildon 2005: 51). The experience in England of combining these roles was that the more urgent problems associated with running services took priority over strate-

gies for delivering healthcare to populations. The separation of purchasers from providers, however, offers a way of resolving this tension and supplies the policy instruments required for seeking efficiency and equity within a global budget. In light of these benefits, I wish now to raise a series of questions, the answers to which, I believe, have direct bearing on models of strategic purchasing in both England and Ontario.

In England two main sets of questions hover over the second internal market. First, given the emphasis on patient choice, who is supposed to manage initial demand: the GP, the practice or the PCT? And who is supposed to manage demand following referral to specialists: the trust, the GP or practice or the PCT? Second, to what extent is responsibility for managing local failures seen as a local matter? The tradition of ministerial accountability for resolving local failures fundamentally undermined the first internal market; as a result, it developed a payment system that lacked high-powered incentives. The second internal market can be seen as a technical fix, which imposes on the NHS a payment system that has high-powered incentives but that threatens to destabilize providers. It is difficult to see how ministers can be insulated from threats to services on which local populations depend. An interesting consideration for England is how hospital closures are managed in Ontario, which has always had a pluralistic hospital system independent of government. It would also be valuable to consider the case law that has emerged over the kinds of issues in which ministers are and are not expected to become involved.

In Ontario what policies are being developed to follow through on the MOHLTC's pledge to "restore equity to Ontario's health care system"? Birch et al. (1993) point out that, while the primary objectives of the Canada Health Act (1984) include facilitating reasonable access to health services without financial or other barriers, Canadian resource allocation methods have perpetuated historic inequalities. To solve this problem, Birch et al. recommend the use of a capitation formula as deployed in England. It is also important to consider whether the creation of LHINs will lead to the identification of inequities in the geographical distribution of resources within Ontario and policies to reduce them. If so, how would a funding formula be developed to account for differences in need and unavoidable variations in costs? If a formula were developed, how would it be used to move budgetary allocations toward the equitable distribution indicated by the formula? And how would LHINs manage demand and develop a fair system of funding hospitals for the work they do? Would LHINs also seek to correct other inequities in access (e.g., by social class, ethnicity or linguistic group), which can persist alongside an equitable geographical distribution of resources? Would LHINs seek to reduce inequities in outcomes?

In this paper I have tried to illuminate the main tensions between economic and political logics found in the healthcare systems under discussion. The systems currently found in the UK and Canada arose out of a desire to introduce universal coverage as a means of removing the ability to pay as a barrier to accessing care. Both countries are now seeking to develop systems that can control total costs as well as improve equity and efficiency. In the past, British governments have found it politically problematic to correct inequities in supply through limiting growth in total expenditure and imposing financial penalties on inefficient providers. Difficulties arose in large part because each tactic worsened access to healthcare for some local populations. Going forward, political logic suggests the realistic options for healthcare reform to be either incremental budgeting while ignoring

inequities and/or inefficiencies or implementation of policies designed to improve equity and efficiency in order to manage the pace of change so that local populations do not suffer.

Endnotes

1 I would like to acknowledge the help I have received from the thoughtful comments provided by an anonymous reviewer of an earlier draft of this paper.

2 For full documentation on official reports, accounts of developments and the current formula, see the Department of Health (n.d.) "Revenue Allocations" Web site.

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