# The Next Step on the Road to High Efficiency: Finding Common Ground between Equity and Performance

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## Introduction

The mixture of strategic purchasing and equity as themes for this volume may seem to be an uncomfortable or forced meeting between unrelated issues or, at best, a reunion of distant relatives. Historically in Canada, policies and laws directed toward equity – for example, the national Canada Health Act in 1984 or Ontario's Commitment to the Future of Medicare Act in 2005 – have tended to be quiet on the subject of strategic purchasing and the wider range of tools that can help promote health system performance. Similarly, policies directed toward increased efficiency or quality have tended to neglect equity as one of their central or explicit goals.

From a policy perspective, the apparent divide between strategic purchasing and equity might not be all that surprising. Scholars have long noted a trade-off between policies designed to improve a health system's fairness and those designed to improve its overall performance. Okun's *Efficiency and Equality: The Big Tradeoff* (1975) is the most powerful description of the tension between the two goals. Others, such as Ringen (1987), have observed that government intervention aimed at improving equity can actually reduce the legitimacy of government and perceptions of its performance. Thus, a collection of papers that includes discussions of equity and strategic purchasing – a key lever for improving efficiency and performance – might be more than an uncomfortable mixture; it might actually reflect an insoluble tension between competing policy goals.

Not surprisingly, we argue that this tension should be resolved in order to ensure the creation of a high-performing health system. Further, we believe there are several reasons to be optimistic that this tension can be resolved. Ontario's health system presents a situation in which

- the elements required to improve strategic purchasing and equity are in place;
- achieving the goals of purchasing and equity depends on similar policy tools;
- strategic purchasing may, eventually, be used to pursue equity as a goal; and
- equity concerns can help shape the environment for strategic purchasing.

However, before wading too deeply into a consideration of these potential outcomes, it is important to define strategic purchasing and equity. For the purposes of this paper, we follow the definition of strategic purchasing put forth by the World Health Organization (WHO) (2000: xix): "strategic purchasing means ensuring a coherent set of incentives for providers, whether public or private, to encourage them to offer priority interventions efficiently … for better responsiveness and improved health outcomes." Again following the WHO's lead (2001), a definition of healthcare equity can be drawn from its definition of gender equity; thus, we take equity in healthcare to mean fairness and justice in the distribution of benefits and responsibilities. It can include notions of horizontal equity (similar needs treated similarly) as well as vertical equity (different needs treated differently).

## Policy Tools Common to Strategic Purchasing and Equity

Both strategic purchasing and equity require a similar set of policy tools. These tools should answer two related and critical sets of questions. Strategic purchasing policies typically have to answer (1) what areas of performance are important? and (2) who will make the purchases and for what groups of people? Similarly, equity policies should answer (1) what areas of equity are important? and (2) what comparisons (horizontal and vertical) are important to our notions of equity?

In their responses to the first question in both sets, policy-makers usually develop groups of tools. Among the most familiar are quality councils, which report to the public on health system performance; report cards or scorecards; and performance-management instruments such as accountability agreements and commissioning or performance-management cycles. Ontario has a long tradition of publicly available reports and scorecards, which include those produced by the Canadian Institute for Health Information, the hospital report cards that were jointly sponsored by the Government of Ontario and the Ontario Hospital Association and a wide range of clinical atlases produced by the Institute for Clinical Evaluative Sciences.

In some cases, these reports and scorecards include consideration of both overall health system performance and equity. In Ontario, the Ontario Health Quality Council has adopted the Institute of Medicine (2001) definition of a high-performing health system, a definition that includes both equity and efficiency. The scorecard developed and used by Ontario's Ministry of Health and Long-Term Care (MOHLTC) includes health status, productivity and equity as health system goals. Further afield, one of the recent reports from the European Union (EU) (Judge et al. 2006) describes performance measurement around equity as one of three common policy approaches across the EU to promoting equity. However, as Anthony Culyer notes in this volume, there is not yet an agreed-on set of methodological approaches to measuring equity nor has there been an explicit consideration of which aspects of performance are critical to strategic purchasing and to defining equity.

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As performance measurement in health systems evolves from a focus on healthcare utilization and cost toward healthcare quality and health outcomes, the question of what to measure for purchasing and equity will become more difficult. In his paper, Culyer argues for an approach to equity that emphasizes equity of health as opposed to equity of healthcare use. This approach would require the development or adaptation of technologies and processes to ensure appropriate reflection of societal values.

This sort of deliberative process aimed at defining equity dimensions and targets takes us to the second set of questions common to strategic purchasing and equity. These questions stress the locus at which purchasing decisions are made or across which equity comparisons are conducted. Strategic purchasing almost always involves some form of decentralization so that purchasing decisions for particular communities can be more closely directed by those communities' needs. In this collection, Ida Goodreau emphasizes the importance of a regional structure to equity. Regional structures have on-the-ground perspectives that enable them to relate need to demand more accurately than a central planner can. This is particularly true in the situation Goodreau describes in which rich and poor communities sit side by side and are served by the same providers but where the aggregate number of such complex and different needs and the varying ability to meet them across an entire province would overwhelm a central planning authority.

At the same time, equity is always defined in a relative fashion. Access or outcome targets for one group are fair or equitable because they reflect a just distribution of or benefit from resources compared to those received by one or more other groups. Again, regional structures are important to the definition of equity because they provide the framework for one of those sets of comparisons. As Gwyn Bevan notes in his contribution, the goal of equity is actually embedded in the creation of some regional structures. In keeping with this perspective, the Government of

Ontario (2006) considers that Local Health Integration Networks (LHINs) can "restore equity to Ontario's health care system, ensuring quality care for every patient, in every community, in the province."

The establishment of local purchasing agencies is only one part of the answer to questions concerning which comparisons are important to notions of equity. Equity across the populations represented by a local agency is one notion of equity; however, differences within each population, such as those between rich and poor, are also important. These other sorts of comparisons typically involve some form of balancing between locally driven decision-making and central control.

A number of health services are sufficiently rare that they do not lend themselves to local decision-making, particularly when those services are costly and a small number of them could substantially affect a local agency's financial well-being. The high cost of such services could lead to a situation in which access would be limited to the largest local agencies, ones that are better able to manage the risk of rare events, that can rely on local support for specialized services or that benefit from having access to highly specialized care at (largely urban) academic health science centres. In response to these concerns, decision-making for such rare services is typically maintained at a central level – as with provincial programs in Ontario or strategic health authorities in England (on the latter, see Gwyn Bevan and Gerry McSorley in this collection) – so as to ensure both critical mass for good performance and some degree of equitable access across the entire jurisdiction.

Likewise, there are a number of populations that face specific needs, historical biases or patterns of delivery, and for which, for a number of reasons, policy-makers do not believe that local decision-making will entirely eliminate those biases or patterns. Although local agencies may be able to reduce variations at the geographical level, they do not necessarily reduce variations across their population groups (e.g., women vs men or Aboriginals vs non-Aboriginals). Again, central planners typically maintain some form of oversight, advice or decision-making in order to counteract these historical patterns. In Ontario, these efforts can encompass a wide range of vehicles, including a women's health institute that will provide advice, best practices and new evidence to improve the quality of women's health services across the province; provincial advisory councils on Aboriginal and francophone health services that report directly to the minister of health and long-term care; and planning entities for these same populations for each LHIN. In other jurisdictions they include strategic purchasing and planning authorities for women's and perinatal care, as in British Columbia, or specific report cards on minority populations, as in the United States (US).

Finally, strategic purchasing and equity converge strongly through resource allocation mechanisms that seek to assign resources in a fair way across local or regional bodies. These mechanisms can be described as population-based or needs-based, and they reflect values relating to horizontal and vertical equity as well as to overall health system performance. Each of these mechanisms or formulae includes assumptions about what an average person should be expected to consume (horizontal equity) and adjustments to this average for a number of characteristics, such as age, health status and income, that contribute to differences in need (vertical equity). Resource allocation mechanisms can also include assumptions around expected levels of performance and re-enforce continuing central involvement in strategic purchasing

through adjustments for quality (e.g., readmission rates), appropriateness of management practices (e.g., requirements for supply-chain management or levels of administrative costs) and other factors.

Strategic purchasing and equity policies are thus linked by their mutual dependence on a set of similar policy tools that define the aspects of performance deemed to be important, the local communities that will be measured and compared according to those aspects of performance and the balance of responsibilities between central and local agencies. Furthermore, the success of policy tools designed to meet the goals of strategic purchasing and equity will likely depend on similar types of processes – whether described as some form of deliberative discourse or democratic renewal and public engagement – that include expert and lay opinion and ensure the wide communication of goals and strategies.

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Ontario has developed many of these policy tools and some of them, such as LHINs and provincial and local councils, offer techniques that can help ensure the acceptability of targets for purchasing and equity. However, without some form of explicit balancing between overall performance and equitable performance, strategic purchasing and equity still might collide. These policy goals will also help the government to frame some of the most important questions around the appropriate scope and direction for strategic purchasing.

## Strategic Purchasing as a Way to Promote Equity

As Raisa Deber and Steven Lewis suggest in their contribution to this collection, strategic purchasing is nothing more than the prudent expenditure of public resources. If one of the goals of a health system is to promote health equity, then there is little to stop the establishment of equity targets within local agencies. In essence, this would involve putting constraints on the way that overall performance within each local agency may be achieved.

One of the challenges confronting this sort of target-setting will, however, be to coordinate local targets across multiple agencies in a way that balances provincial priorities that might focus on large population groups (e.g., francophones vs anglophones) and local priorities that are critical within specific areas but that have little relevance outside of specific geographical communities. In order to address this concern, central planners could adopt a staged set of policies that require attending to both provincial priorities that are set centrally and some local priorities that are set locally. In each case, this sort of balance between regional and local priorities would require a sufficiently light touch so that they did not substantially reduce efficiency or the perception of the legitimacy of government intervention. These sorts of policies could include explicit equity targets as measured by some form of Lorenz curve or other instrument, or they could include standards for health status, care availability or the perception of met healthcare need that could be captured and measured as part of regular census or vital-statistics surveying.

At the same time, so that strategic purchasing itself could be evaluated these sorts of local targets would need to be made part of an overall strategy that sets equity targets. These sorts of overall equity targets are perhaps even more important for equity than

for other areas of health system performance. Each local agency could pursue improvements in aspects of performance (e.g., efficiency) that represent the individual agencies' starting positions and some measurable and agreed-on level of performance. This approach to strategic purchasing has been used by employer and business coalitions in the US for years and reflects the different starting position of each insurer or agency (Schauffler et al. 1999).

The measurement of equity within and across local agencies depends, however, on levels of performance that are concurrently changing within and across each agency. The relative amount of inequity within an agency could, therefore, improve at the same time that the position of that agency became less equitable compared to other agencies. Equity targets therefore should be buttressed by an explicit approach to improving equity, whether by increasing the performance floor (standards), creating a performance ceiling (limits) or reducing overall variation. Given the complex and dynamic nature of health system performance, the importance of approaches such as benchmarking to ensuring overall system performance (discussed below) and the value of a light touch in regulation to promote legitimacy, the most appropriate form of targets for equity likely include some form of standards and a reduction in variation based on the pursuit of benchmarks.

If the goal of equity policy is to promote health equity, then the scope of strategic purchasing should also be considered. The importance of public health interventions and health promotion to health status is inarguable. Strategic purchasing at the local level should therefore acknowledge – and might even support – some attention to health promotion. In Ontario, LHINs' first round of integrated health service plans included substantial attention to chronic disease prevention and promotion (CDPM), even though primary care, public health and public education campaigns were (and remain) outside their funding authority. The prominent inclusion of CDPM emphasizes the importance of coordinated health system planning that extends beyond funding authority. The Quebec example described in this collection by David Levine offers insight into how such coordination can occur.

Likewise, efficiency in health system management depends on ensuring the right level of care for each individual. This sort of coordination entails moving patients in and out of the health system with its hospitals, chronic care facilities and long-term care homes, and in and out of the broader system of social supports, including housing, community services and the education system. In Ontario, LHINs' first round of plans involved paying attention to these broader social services, including transport and housing. Without some form of joined-up planning and purchasing, strategic purchasing might not be able to pursue lofty goals such as health equity and might be limited to equity of healthcare access.

### Benchmarking

Finally, one of the goals of measuring variation is to show that someone, somewhere, is doing things better. Comparison of performance across local agencies can be a powerful stimulus to change and an important source of information on how to improve. This is not surprising; leading organizations inside and outside of healthcare have used benchmarking and comparative performance reporting for a long time.

Benchmarking's value depends, however, on an organization's ability to innovate and pursue higher levels of performance. As governments increase their work with strategic purchasers it will be important for them to support a consistent approach to perform-

ance management that ensures performance within communities and sectors that supports the achievement of system-level goals such as equity. At the same time, policies that promote equity by setting limits on performance will actually run counter to the chief goal of strategic purchasing. In contrast, a few years ago Brown et al. (2003) experimented with applying Achievable Benchmarks of Care techniques to equity measurement. Results indicated that equity itself may be amenable to benchmarking.

It is safe to conclude that the absence of mechanisms that support benchmarking and comparative performance reporting limit a system's ability to support benchmarking activities and to measure equity. This means that, in the balance between central and local control, central agencies should focus on establishing standards, supporting the creation and use of benchmarks and defining the most critical aspects of performance. Conversely, they should shy away from setting limits on performance or from regulations that limit innovation. Likewise, local agencies may concentrate on how best to meet targets and should avoid agency-specific sets of targets that do not support measurement across all agencies.

## Conclusions

Equity and strategic purchasing rely on a similar set of policy levers; the application of those levers must take into account both goals. As a number of contributors to this collection argue, achieving equity is not inimical to attaining strategic purchasing's overall performance goals. To realize both will require a conscious and regular rebalancing of central and local control as performance and equity issues change, as technologies develop and diffuse and as priorities for health system performance change. However, as strategic purchasing evolves and begins to include equity in an explicit fashion, central or government control should focus on the goals of performance and equity. Local control, meanwhile, should focus on how best to meet those goals in a way that reflects local conditions and allows the balancing of local needs against jurisdictional priorities.

In every country currently experimenting with strategic purchasing and equity policies, none of this balancing will occur without regular measurement and evaluation of health system performance. Success will also depend on developing strategies that make targets explicit and on constantly reviewing – at both the local and central levels – progress on equity and other performance issues.

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