

Healthcare*Papers*

New Models for the New Healthcare

Strategic Levers *for a* High-Performing Health System

Commentary from

Gwyn Bevan, Adalsteinn D. Brown, Reinhard Busse, Anthony J. Culyer,
Raisa Deber, Josep Figueras, Richard H. Glazier, Ida Goodreau, Elke Jakubowski,
Louise Lemieux-Charles, David Levine, Steven Lewis, Gerry McSorley,
Joe Murphy, Richard Prial, Ray Robinson, Jeremy Veillard, A. Paul Williams

112 p





IN THIS ISSUE

INTRODUCTION

6 Strategic Levers for a High-Performing Health System

Louise Lemieux-Charles

EQUITY

12 Equity of What in Healthcare? Why the Traditional Answers Don't Help Policy – and What to Do in the Future

Anthony J. Culyer

27 Cost Control, Equity and Efficiency: Can We Have It All?

Gwyn Bevan

35 Balancing Equity Issues in Health Systems: Perspectives of Primary Healthcare

Richard H. Glazier

46 The Reform of Health and Social Services in Quebec

David Levine

55 Balancing Equity Issues in Health Systems: The Example of Vancouver Coastal Health

Ida Goodreau

STRATEGIC PURCHASING

62 Strategic Purchasing to Improve Health System Performance: Key Issues and International Trends

Reinhard Busse, Josep Figueras, Ray Robinson, Elke Jakubowski

77 Strategic Purchasing: The Experience in England

Gerry McSorley

93 Strategic Purchasing in Home and Community Care across Canada: Coming to Grips with “What” to Purchase

A. Paul Williams

104 Strategic Outsourcing by a Regional Health Authority: The Experience of the Vancouver Island Health Authority

Joe Murphy

ALL THINGS CONSIDERED

- 114 **Thoughts on the Day: Strategic Purchasing and Equity**
Raisa Deber and Steven Lewis
- 124 **The Next Step on the Road to High Efficiency: Finding Common Ground between Equity and Performance**
Adalsteinn D. Brown, Jeremy Veillard, Richard Prial

About the cover:

Photo collage of DaVinci sketches. Illustration by Santiago Ku.

Physician Leadership

Program

Visit www.hpme.utoronto.ca

The Physician Leadership Program focuses on developing the knowledge and skills that are required by today's physician leaders. It builds their understanding of the fundamentals of health leadership and management in order to effect change. Drawing from leading research and educational practices, the program will explore emerging leadership strategies and apply them to the health context.



The Department of Health Policy, Management and Evaluation gratefully acknowledges the contribution of Sunnybrook Health Sciences Centre and the Toronto Academic Health Sciences Network in the development of this program.

Visit our online archive
www.healthcarepapers.com

Vol. 7 No. 4 2007 | Chronic Disease Prevention and Management
Vol. 7 No. 3 2007 | The Public Health Enterprise
Vol. 7 No. 2 2006 | Using Networks to Enhance Health Services Delivery
Vol. 7 No. 1 2006 | Ontario's Wait Time Strategy
Vol. 6 No. 4 2006 | Pay-4-Performance
Vol. 6 No. 3 2006 | Quality Councils
Vol. 6 No. 2 2005 | Performance Reports
Vol. 6 No. 1 2005 | Diagnostic Imaging
Vol. 5 No. 4 2005 | Veterans Health Administration
Vol. 5 No. 3 2004 | Safe Healthcare
Vol. 5 No. 2 2004 | Mental Health in the Workplace
Vol. 5 No. 1 2004 | Regionalization
Vol. 4 No. 4 2004 | Public/Private Debate
Vol. 4 No. 3 2004 | Post-Romanow Pharmacare
Vol. 4 No. 2 2003 | Globalized Healthcare
Vol. 4 No. 1 2003 | Leadership Development
Vol. 3 No. 5 2003 | Complementary & Alternative Medicine
Vol. 3 No. 4 2003 | Post-Romanow Healthcare
Vol. 3 No. 3 2003 | Evidence-Based Practice
Vol. 3 No. 2 2002 | Health Workforce
Vol. 3 No. 1 2002 | Drug Policy
Vol. 2 No. 4 2002 | Reform Framework
Vol. 2 No. 3 2002 | Academic Health Centres
Vol. 2 No. 2 2001 | Physician Rationing
Vol. 2 No. 1 2001 | Patient Safety
Vol. 1 No. 4 2000 | Home Care
Vol. 1 No. 3 2000 | Rethinking Medicare
Vol. 1 No. 2 2000 | Integrated Healthcare
Vol. 1 No. 1 1999 | Primary Care

HealthcarePapers

New Models for the New Healthcare



HealthcarePapers

Volume 8 • Special Issue

Editor-in-Chief *Peggy Leatt*

Editorial Advisor *Rick Roger*

Editorial Director *Dianne Foster Kent*

Copy Editors *Morgan Holmes, Wayne Herrington*

Publisher *Anton Hart*

Associate Publisher/Administration *Barbara Marshall*

Associate Publisher/Media *Susan Hale*

Director, Design and Production *Yvonne Koo*

Graphic Designer *Jonathan Whitehead*

HOW TO REACH THE EDITORS AND PUBLISHER

Telephone: 416-864-9667

Fax: 416-368-4443

ADDRESSES

All mail should go to: Longwoods Publishing Corporation, 260 Adelaide Street East, No. 8, Toronto, Ontario M5A 1N1, Canada.

For deliveries to our studio: 54 Berkeley St., Suite 305, Toronto, Ontario M5A 2W4, Canada

SUBSCRIPTIONS

Individual subscription rates for one year are [C] \$100 for online only and [C] \$140 for print + online.

For individual subscriptions contact Barbara Marshall at telephone 416-864-9667, ext. 100 or by e-mail at bmarshall@longwoods.com.

Institutional subscription rates are [C] \$420 for online only and [C] \$520 for print + online.

For institutional subscriptions, please contact Rebecca Hart at telephone 416-864-9667, ext. 105 or by e-mail at rhart@longwoods.com.

Subscriptions must be paid in advance. An additional 6% Goods and Services Tax (GST) is payable on all Canadian transactions. Rates outside of Canada are in US dollars. Our GST number is R138513668.

SUBSCRIBE ONLINE

Go to www.healthcarepapers.com and click on "Subscribe now."

REPRINTS/SINGLE ISSUES

Single issues are available at \$40. Includes shipping and handling. Reprints can be ordered in lots of 100 or more. For reprint information call Barbara Marshall at 416-864-9667 or fax 416-368-4443, or e-mail to bmarshall@longwoods.com.

Return undeliverable Canadian addresses to: Circulation Department, Longwoods Publishing Corporation, 260 Adelaide Street East, No. 8, Toronto, Ontario M5A 1N1, Canada

EDITORIAL

To talk to our editors please contact Dianne Foster-Kent at 416-864-9667, ext. 106 or by e-mail at dkent@longwoods.com. Author guidelines are available online at <http://www.longwoods.com/pages.php?pageid=18&cat=250>

ADVERTISING

For advertising rates and inquiries, please contact Susan Hale at 416-864-9667, ext. 104 or by e-mail at shale@longwoods.com.

PUBLISHING

To discuss supplements or other publishing issues contact Anton Hart at 416-864-9667, ext. 109 or by e-mail at ahart@longwoods.com.

Healthcare Papers is published four times per year by Longwoods Publishing Corp., 260 Adelaide St. East, No. 8, Toronto, ON M5A 1N1, Canada. The views and opinions expressed are those of the individual contributors and do not necessarily represent an official opinion of Healthcare Papers or Longwoods Publishing Corporation. Readers are urged to consult their professional advisers prior to acting on the basis of material in this journal.

Healthcare Papers is indexed in the following: Pubmed/Medline, CINAHL, and Ulrich's.

No liability for this journal's content shall be incurred by Longwoods Publishing Corporation, the editors, the editorial advisory board or any contributors.

ISSN No. 1488-917X.

Publications Mail Agreement No. 40069375.

Printed by Harmony Printing © September 2007



Longwoods Publishing
Enabling Excellence



INTRODUCTION

Healthcare*Papers*

Strategic Levers for a High-Performing Health System



Louise Lemieux-Charles, PhD

Chair and Professor, Department of Health Policy, Management and Evaluation,
University of Toronto



Origin of this Collection

Over the past four years the Ontario Ministry of Health and Long-Term Care (MOHLTC) has been engaged in transforming the province's health system, a process that includes decentralizing decisions pertaining to the delivery of services. This decentralization is occurring through the devolution of decision-making to the newly created Local Health Integration Networks (LHINs). The LHINs' mandate is described in the Local Health System Integration Act (Government of Ontario 2006) and includes the following key elements:

- Provision or change of funding to health service providers
- Facilitating and negotiating health services integration
- Issuing integration decisions

Ontario's LHINs have embarked on their strategic planning journeys; however, the extent to which decisions will be decentralized is still under discussion.

Acknowledging the need to explore challenges arising from such a fundamental transformation, MOHLTC policy-makers, members of the University of Toronto's

Department of Health Policy, Management and Evaluation (HPME) and senior-level health system decision-makers developed a conference program that would showcase national and international experiences in decentralizing decision-making as it pertains to *equity* and *strategic purchasing*, two areas that are especially challenging from a policy perspective. The symposium that resulted – Strategic Levers for a High-Performing Health System – was held in Toronto on November 20 and 21, 2006.¹ It afforded a wide-ranging opportunity for the airing of many perspectives on these topics, including the views and experiences of practitioners from various Canadian and international jurisdictions who have encountered challenges in providing an equitable approach to healthcare while seeking efficiencies in care delivery.

This special issue of *Healthcare Papers* brings together most of the Strategic Levers symposium proceedings. We believe that the concepts, approaches and solutions explored and analyzed in this collection will serve as valuable references and models for people engaged in policy-making and service delivery decision-making as they relate to equity and strategic purchasing.

Collection Outline

The papers in this collection are grouped together in three sections: the first is dedicated to a discussion of equity, the second addresses strategic purchasing and the third offers a synthesis of the concepts and reflections on the challenges policy-makers and practitioners face and lessons that can be gleaned from diverse jurisdictions.

Equity

Leading off the section on equity, Anthony Culyer challenges the following ubiquitous propositions: healthcare ought to be allocated in proportion to a person's need; geographi-

cal allocation of healthcare resources ought to be allocated in proportion to the population's need in each area; access/utilization of healthcare ought to be equal for all members of society; and equity and efficiency in health and healthcare usually conflict and, when they do, equity trumps efficiency. Culyer argues that

“... showcase national and international experiences in decentralizing decision-making as it pertains to *equity* and *strategic purchasing*, two areas that are especially challenging from a policy perspective.

these propositions are impractical because it is unclear what policy steps follow for those who wish to embody them. He presents an alternative set of principles for equity in health and healthcare, together with some of the steps required to address them that are in tune with contemporary moves toward greater transparency and participative policy decision-making.

Moving from the theoretical to the practical, Gwyn Bevan describes the search for equity of access and efficiency by England's National Health Service (NHS). Although the 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 a more equitable distribution of resources and improved hospital performance. Extending his gaze beyond equity, Bevan raises probing questions about the current models of strategic purchasing in England and Ontario, questions that are intended to help policy-makers find ways to achieve equitable resource distribution.

The next three papers turn our attention to equity as it is experienced in Canada. Richard Glazier argues that even though primary healthcare is associated with better population health at lower cost and should be considered the cornerstone of Canada's health system, serious challenges remain. He is particularly concerned that there is no coordinated national plan for evaluating primary care reform and that most primary care efforts do not address the needs of disadvantaged and vulnerable populations.

From a regional system perspective, David Levine describes how Quebec's recent healthcare reforms – which are aimed at improving the population's health and well-being, distributing services equitably,

“... seeking and attaining system-wide improvement depends on the goals that are set and the methods employed to achieve them given local conditions.”

facilitating the use of services and managing vulnerable patients' care – are being implemented. Levine's analysis focuses in particular on Montreal's criteria for a high-performing healthcare system. The strategic levers being used to accomplish these goals include managed care (with its constituent elements) and performance measurement. Ida Goodreau next presents the challenges faced by Vancouver Coastal Health, whose region includes both Canada's highest per-capita income postal code and the country's lowest per-capita income postal code. Goodreau argues that while the regional structure is

an important component in addressing the imbalance between demand and supply in healthcare delivery, it is not, in itself, the solution. In Goodreau's analysis, equitable healthcare delivery entails a quest to define the need for healthcare services and a rigorous improvement of the efficiency of how those services are delivered.

Strategic Purchasing

Strategic purchasing goes beyond the mere contracting of providers by emphasizing the active involvement of funders and consumers in decision-making around healthcare planning, funding and delivery. In their paper, Reinhard Busse, Josep Figueras, Ray Robinson and Elke Jakubowski support this definition and note that the various approaches undertaken across Europe reveal that reform efforts must focus on strengthening purchasers' ability to respond to consumer needs and to establish more cost-effective contracts with providers. Concurrently, they argue, strategic purchasing is destined to fail in the absence of capable government stewardship. Busse et al. also show that the high complexity of strategic purchasing requires putting in place a comprehensive regulatory framework that integrates and coordinates purchasing's various components. This framework must achieve a fine balance between regulations that favour and limit entrepreneurial behaviour, so as to ensure the attainment of health system objectives.

The next three papers shed valuable light on the application of strategic purchasing approaches in the healthcare sector. Dovetailing with Bevan's discussion, Gerry McSorley describes the new commissioning approach implemented by England's NHS. The Organising Framework for NHS Reforms is based on the devolution of political power and the introduction of market-style incentives. In order to provide a better balance

of commissioning skills, the Department of Health committed itself to passing 75% of the NHS budget directly to primary care trusts, with a further level of devolution to individual practices in the form of practice-based commissioning. As McSorley contends, the success of these innovations depends on the full development of requisite leadership skills and the integration of clinical and public participation in decision-making.

Based on his review of practices in the home care and community care sector across Canada, A. Paul Williams argues that no single approach to funding and purchasing fits all and that a mix of approaches is now being used at the regional level throughout the country to fund and purchase services. Challenges arise in particular because services are located outside the medicare mainstream of medically necessary hospital and physician care and encompass a wide range of professional and non-professional health and social services. Joe Murphy next describes the experience and results of the Vancouver Island Health Authority's outsourcing initiatives for select support services as well as residential care and assisted living. He has also provided an addendum addressing the recent Supreme Court decision upholding the right to collective bargaining in the workplace.

All Things Considered

In the collection's final section, Raisa Deber and Steven Lewis draw the connection between what, at the outset of the symposium, some might have regarded as disparate concepts. They synthesize the main ideas presented throughout the two days and discuss the many links between equity and strategic purchasing. In the final paper, Adalsteinn Brown, Jeremy Veillard and Richard Prial bring an applied policy-making perspective on the road to high efficiency. Focusing on the Ontario scene, they differen-

tiate between the roles of the MOHLTC and the LHINs and ponder whether the tension that exists between what might appear to be competing policy goals can be resolved. Brown et al. conclude that attaining equity and fulfilling strategic purchasing require conscious and regular rebalancing of central and local control as performance and equity issues change. This conclusion coincides with the observation made by Lewis and Deber that seeking and attaining system-wide improvement depends on the goals that are set and the methods employed to achieve them given local conditions.

Strategic Levers for a High-Performing Health System was designed as a unique opportunity for "cross-learning" between academic researchers and on-the-ground policy- and decision-makers. I believe that the symposium achieved our goal of interdisciplinary knowledge exchange that was far richer than it would have been had it been restricted simply to one of those two groups. I know that my co-organizers share my hope that this collection will be a valuable resource of ideas and examples during the momentous transformations now unfolding here in Ontario's health system and many other locales around the country and throughout the world.

Endnote

1 Strategic Levers for a High-Performing Health System was funded by the MOHLTC and organized by members of the University of Toronto's Department of Health Policy, Management and Evaluation in collaboration with senior health system managers.

Reference

Government of Ontario. 2006. *Local Health System Integration Act, 2006*. Toronto: The Queen's Printer. Retrieved June 25, 2007. <<http://www.e-laws.gov.on.ca:81/ISYSQuery/IRLAA3C.tmp/9/doc>>

EQUITY
Healthcare*Papers*

Equity of What in Healthcare? Why the Traditional Answers Don't Help Policy – and What to Do in the Future



EQUITY

Anthony J. Culyer

Visiting Professor, Department of Health Policy,
Management and Evaluation, University of Toronto
Professor Economics, University of York, UK



Introduction

There are many deep philosophical issues regarding equity that I will slide over in order to address some practicalities of equity policy (see, for deeper material, Olsen 1997; Wikler and Murray forthcoming). However, I do want to try to link theory and policy rather than keep them in their usual silos. This is a dangerous plan. My amateur ethics will strike serious philosophers as gravely deficient, while my amateur policy strategizing will strike decision-makers as distantly up in the clouds. However, in the spirit of “nothing ventured ...” I am going to try to link the two more directly than is usual. One reason for doing this is that, if we cannot discuss ethics

explicitly as a foundation of policies for equity in health and healthcare policy, then I doubt we can do it anywhere else. A second reason is that I think there is a chance, if we can be more explicit about our ethics, that we might manage to translate them into policy action in reasonable and doable ways. Another reason is that I am fairly confident that the reasonable and doable ways will be different from the current ways. A fourth is that leaving the ethics largely implicit means that the huge differences between us that might otherwise remain submerged could become underwater reefs with the potential to rip the bottoms out of well-meaning policies for equity in practice – as soon as it becomes clear that one person’s

notion of equity is not also another's. We need to be clearer about what we mean and where we might differ in what we mean. So I shall say what I mean and what I think we all ought to agree to mean and then, from that, say what follows for policy.

In this paper I assume that we are discussing equity at the highest level of policy – distributive fairness in healthcare, its financing and the terms of access to it. I am also assuming that we care about distributive fairness in terms both of the outcomes of our decision-making processes and of the processes themselves.

I chose my title in order to provoke rethinking of some conventional ethical platitudes. I am not against platitudes in general – just these ones – and, indeed, I'll be offering some of my own shortly. The “answers” I am describing as “traditional,” at least among health service researchers, are these:

Healthcare ought to be allocated in proportion to a person's need

together with its group or regional geographic companion:

Geographical allocation of healthcare resources (generally, purchasing budgets) ought to be allocated in proportion to the population's need in each area

and this:

Access/utilization of healthcare ought to be equal for all members of society

and this:

Equity and efficiency in health and healthcare usually conflict and, when they do, equity trumps efficiency.

These slogans do not help policy for four main reasons:

- They are not good ethics.
- Even if they were better ethics, they would still be confused and confusing.
- Following these precepts can easily generate situations that we would all agree are more inequitable than what we have now.
- The principles are not practical – it is unclear what policy steps follow for those who wish to embody them in practical actions such as measuring the size of a problem, the outcomes of doing something about it or managing a process intended to deliver a solution.

I have already argued against the bogus claim that there is conflict between equity and efficiency (Culyer 2006) and therefore I do not propose to discuss that topic here. However, there *does* exist a big conflict – or rather a whole suite of conflicts – between rival notions of equity. These rival notions hardly ever receive explicit discussion in policy frameworks. The common presupposition that equity in general trumps efficiency is a considerable irritant and dealing with it distracts attention from the more important trade-offs. Of course, outrageous inequity might rightly dominate any concern we may have about mild inefficiency; however, I do not think that concern about mild inequity ought to dominate over outrageous inefficiency. To try to convince you that I am right about the status of the other slogans, let us go back to first principles.

Equity as Fairness

It seems attractive to treat equity as a matter of fairness.¹ It pervades all aspects of health and healthcare. It is significant at a high level of resource allocation (what is a fair distribution of money to Local Health Integration Networks [LHINs]?) and at the individual

level (is it fair that Canadians Phyllis Thomas and Gladys Lawless have each lived with rheumatoid arthritis for more than 20 years and reside only two kilometres apart, divided by a provincial border, yet Gladys receives etanercept [Enbrel] via medicare virtually free while Phyllis would have had to find around \$20,000 a year from her own pocket and so has gone without? [Abraham 2004]). Is it fair that Dr. Putter has closed his office this afternoon to play golf (it was all right for those who could easily get there in mornings but no good for me who could get there

“The common presupposition that equity in general trumps efficiency is a considerable irritant and dealing with it distracts attention from the more important trade-offs.

only in the afternoon)? It applies not only to individuals like Phyllis and Gladys but also to groups of individuals (is it fair that the infant mortality rate in Nunavut in 2004 was 16.1 per 1,000 live births compared with 4.3 in the two best Canadian provinces: New Brunswick and Prince Edward Island? [Statistics Canada 2007]). It applies to the outcomes of processes and also to the processes themselves (is it fair that the well-to-do on average have longer general practitioner [GP] interviews under medicare than poorer, less-well-educated people?). It applies to healthcare financing as well as healthcare delivery (is it fair that many employed Canadians get subsidized insurance for drug bills but other citizens, similar in all other respects, do not?). It applies in not-so-obvious policy choices (should the benefit

accruing to people with chronic, disabling and painful conditions be valued the same as a similar benefit accruing to someone without those disadvantages when making formulary decisions or, more generally, deciding what services shall be available?). It applies at the margin of what is available as well as at the totality (should people who are willing to pay be able to purchase drugs that are judged to be insufficiently effective to be made available in public programs?). It raises questions about the similarities and differences between people having different ethnic, religious and linguistic characteristics or living at different levels of prosperity and in different locations (which similarities and differences matter and which do not?). Health equity is also everyone's business, not just that of the Ministry of Health and Long-Term Care (MOHLTC). After all, many of the key determinants of health lie well outside the MOHLTC's remit.

Health or Healthcare?

Underlying all issues regarding equity in health are a distinction and a concern. The distinction is between health and healthcare: they are not the same and, in general, the latter is there to improve the former. Healthcare is not an end in itself; health is. In particular, there is no reason to expect that equality in healthcare will generate equality in health. The concern arises from the fact that wealth and health are inversely related. As we all know, there is a social-class gradient: in the case of almost every disease, the higher the socio-economic group to which you belong, the longer your life expectancy and the better your health state at each stage of life.² This generally means that those who are most in need of healthcare are also those who are worst placed to buy it in the marketplace either directly or through insurance. To all the other concerns about equity, therefore, we need to add a concern that the

financing of healthcare is fair; unfair financing both enhances any existing unfairness in the distribution of health and compounds it by making the poor multiply deprived. However, it is not just a question of rich vs poor. The gradient implies that at every socio-economic level those further down the ladder die sooner and suffer more ill health than those immediately above them. Although this argument suggests strongly that the distribution of the costs of healthcare financing interacts with the distribution of health, I shall set aside issues of financial equity here (a good empirical discussion of the subject can be found in van Doorslaer et al. 1999).

Efficiency and Equity

Why don't we come clean about the reasons why equity in health – and healthcare – is of deep ethical concern? At root, I suggest that there are two principal aspects that demand our attention. They are sometimes incorrectly seen as being in conflict and they both have a common grounding in ethical importance. One is the principle that says, "more health is a good thing, ethically speaking." The other is the principle that says, "fairly distributed health is a good thing." Ethically speaking, the first underlies the rationale for evidence-informed practice. It is an efficiency argument: we should get the most we can out of our limited healthcare resources. The second underlies, ethically speaking, most issues in decisions about the allocation of resources to defined groups: classically regions, although territorial distributive fairness is far from being the only dimension that challenges us here. Suppose that a given expenditure could generate a gain in health for downtown dropouts equal to that generated for prosperous dwellers in leafy suburbs. Who ought to get it? Many (though not all) would say the downtown street people. And many would go further and say that the issue of justice

trumps the issue of fairness so that the street people still ought to get the resource even if it would generate more health gain for the suburbanites. I suggest that this is, as a general presumption, wrong.

My argument is necessarily abstract. Consider the proposition that "more health is a good thing, ethically speaking." The primitive ethical proposition is the Aristotelian one that the ultimate human goal for which our society might aim is to be a society of flourishing individuals.³ I will not define "flourishing"; however, I mean it to imply something more than the enjoyment of mere goods and services or the economic-cum-utilitarian satisfaction of "preferences" often termed "welfarism" (e.g., Sen 1977; Boadway and Bruce 1984). I also do not wish flourishing to be restricted to the Aristotelian notion of an active life ruled by reason. This flourishing postulate is plainly a social value judgement, and if you and I differ fundamentally on it we are unlikely to agree on what is to follow. The next proposition is not a value judgement; it is factual. There is a range of concepts of "flourishing," all of which have in common that (a) they are ethically compelling and (b) they require – or usually require – good health for their full realization. Note the two factual and empirically rebuttable statements here: an assertion about there being a range of persuasive meanings for flourishing and an assertion that good health is a necessary condition for having a flourishing life. Now add a third factual assertion: healthcare is one of the means through which health is promoted.

So the extended syllogism goes like this: Flourishing lives are the ultimate good (a social value judgement). Good health is necessary for one to have a flourishing life (an empirically rebuttable statement, given an acceptable concept of flourishing). This factual proposition is true for a range of concepts of flourishing (another empirically rebuttable

statement, because we can ask people what they have in mind by flourishing). Healthcare is often a necessary condition for health (yet another empirically rebuttable statement). From this combination of ethical and factual

Resources devoted to morally compelling causes ought to be used so as to have maximum impact on the cause served – in this case, health.

propositions comes the deep ethical significance of arrangements for the finance and delivery of healthcare (see, e.g., Culyer 1997, 2001). In general, if it is ethically good to flourish, it becomes good to have the things, such as health, that contribute to flourishing. And if it is ethically good to have health, it is good to have healthcare. And if, moreover, so fundamental a characteristic as health ought in principle to be equally experienced, then ought not healthcare to be distributed so as to bring this about? Enter the “fairly distributed health is a good thing” proposition.

From here it takes but two further steps to get closer to the policy issues that motivate this discussion. First, if it is good to encourage flourishing it is also good to be efficient at it. For example, if we were using more healthcare resources than were necessary to achieve a given health gain, that would be inefficient. Resources devoted to morally compelling causes ought to be used so as to have maximum impact on the cause served – in this case, health (Culyer 1992). Second, the burden of proof lies with those who would depart from equality regarding opportunities to flourish. Because health is necessary for

flourishing, the burden of proof lies with those who wish to depart from a presumption that so necessary a human characteristic ought to be equally distributed.

A powerful implication of this line of thought on the efficiency side is that healthcare that does not contribute to health has no place in the system. It also implies that cost-ineffective healthcare has no place in such a system – even if it is effective – because providing cost-ineffective care would imply that resources that could be put to achieving better health for at least one person were in fact being put to no apparent use at all. In short, the ethical reasons for caring about the distribution of health are also reasons for caring about the efficient production of health. It is insufficiently recognized that the case for cost-effectiveness is, at root, an ethical case.

Another implication, this time on the distributional side, is that inequalities in health ought not to be manufactured without compelling reasons and ought not to be allowed to continue if they can be removed using reasonable means. By “compelling reasons” I mean countervailing ethical arguments that carry moral weight. By “reasonable means” I mean actions and policies that do not have costs or undesirable downstream consequences that might outweigh their equitable gain. Pursuing greater equality of health does not always imply, however, that we must pursue greater equality of healthcare or access to it, or that we should match it to need.

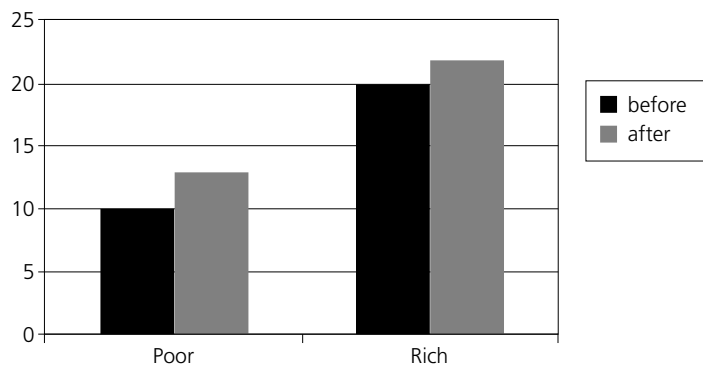
Let me give an illustration. Figure 1 shows the quality-adjusted life years (QALYs) to be had from spending a given sum on healthcare for the poor and the rich in a given community. The light-shaded bars indicate the existing expectation of QALYs for an average person, aged 50, in each of these equal-sized groups. For the rich, QALYs are twice that of the poor. The best estimates indicate that, if the given sum were spent entirely on the poor,

their expected health gain (in QALYs) would be 3 while the gain to the rich, if the sum were spent on them, would be 2. Supposing one were forced to choose which is the better way of spending the sum? You might say funds would be better spent on the poor because the gain would be 3 compared to 2, and this approach is therefore more efficient. However, that conclusion would be wrong because it entails an assumption that a QALY gain for the poor counts the same as a QALY gain for the rich. In fact, both dark bars indicate efficiency because we assume that maximum health gain is to be had for each group from spending the sum on them. Both are efficient.

To answer the fair distribution question one needs to make explicit interpersonal

received by people who have low expectations of future QALYs (for whatever reason, including that they are poor) are to be more highly valued than those going to others. In that case, the argument for spending the sum on the poor is even stronger. Third, one could say that the fair distribution is a more equal one. In that case, spending the money on the poor generates a 13:20 distribution, which is plainly more equal than 10:20 (let alone 10:22). In this example, all three distributional arguments go in favour of the poor. But both of the possible new distributions (13:20 or 10:22) are efficient and the test of fairness is not the relative sizes of potential health gain or the initial distribution of health, but the final (expected) distribution of health.

Figure 1. Quality-adjusted life years in relation to healthcare expenditures for poor and rich people



comparisons. There are three obvious ways of doing this in the above example. One could say that a health gain is of equal value to whomever gets it (in effect, we do not care if the recipient is either poor or rich). In that case, 3 outweighs 2 and the resource goes to the poor. This is straightforward QALY maximization coupled with the distributional value judgement that all QALYs are equal. Another possibility would be to say that QALYs

Equity vs Equality

Equity is not the same as equality, although they are often carelessly taken to be the same. However, they are connected. Equity often involves the equality of something. The critical question is “equality of what?” But sometimes equity also deals with just inequalities, and the question then is “what is the criterion for deciding which inequalities are fair or unfair?” Equity means treating likes alike and unlikes appropriately differently. Equity requires not only that relevantly similar cases be treated in similar

ways but also that relevantly different cases be treated in different ways. These two concepts are as old as Aristotle and are known as horizontal and vertical equity:

- Horizontal equity: The equal treatment of people who are equal in a relevant respect
- Vertical equity: The unequal treatment of people who are unequal in a relevant respect

By “treatment” I shall follow the convention of talking about healthcare resources generally denominated in terms of dollars. But what might be the “relevant” respects? There are seven commonly adopted ones. I shall state each respect and the principle to which it seems to be connected, and then make some comments on it.

Rival Relevant Respects

- *Need: Populations with equal needs should receive equal treatment and populations with greater needs should receive more favourable treatment.*
A disadvantage of this principle is that it is far from clear what “need” means. It might mean one or more of the “respects” that follow.
- *Ill health: Populations that are equally ill ought to be treated the same; those that are sickest ought to get more.*
A disadvantage of this principle is that it seems to assume what might not be the case – that the conditions in question are effectively treatable by healthcare and that all conditions are equally costly to treat. Unfortunately, the effectiveness of healthcare can vary widely (in cases of iatrogenesis, for example, it is negative⁴). It surely cannot make much sense to require a population to have the same amount regardless of their morbidity characteristics, the effectiveness of relevant preventive and restorative medical care and the cost, whether high or low, of delivering that care.
- *Desert: Populations of equal desert ought to be treated the same and those of greater desert ought to receive more.*
Common elements that advocates of this view have in mind are lifestyle choices (e.g., smoking, drug abuse, poor diet, dangerous sports, careless and promiscuous sex) that increase the chances that some-

one will need healthcare and, moreover, that might reduce the chances that the care will be effective. These are mutually reinforcing grounds for giving such individuals and groups a low priority. This view suffers from the problem that it is virtually impossible empirically to distinguish lifestyle effects from other effects, that it assumes that lifestyle differences are avoidable, not socially conditioned and, if deleterious to health, that the patients in question are culpable. Another, more positive, argument holds that groups with higher productivity (e.g., people with higher earnings or more dependent children or who do more public service work) deserve a higher priority. This argument suffers from the problem that the claim of desert rests heavily on a claimed contribution to the welfare of other people, which is hard to measure without arbitrariness and is, at best, a partial measure of deservingness.

- *Resources themselves: This is usually presented as a purely horizontal equity argument – since all people are fundamentally to be regarded as equal, each ought to have equally available resources; the per capita distribution ought to be everywhere the same in a jurisdiction.*
A disadvantage of this principle is that, like the previous one, it ignores the productivity of resources. It is difficult to see why, for example, there should be any concern for the equitable distribution of ineffective care or why people whose needs are different ought to have the same care.
- *Capacity to benefit⁵: People with equal ability to benefit from healthcare ought to be treated the same and those with high capacities to benefit ought to receive more.*
This principle addresses the productivity issue. However, if it turns out that populations with the greatest ability to benefit are normally also initially relatively healthy then the application of the principle will

lead to greater health inequalities and, because such people are also likely to be relatively wealthy, they will be made still healthier as well.

- *Health: This principle aims at greater equality of health not, usually, through reducing anyone's health but by giving priority to those with relatively low health or who are furthest from the average.*

A disadvantage of this principle is that it might imply the use of enormous amounts of resources for the very sick (but for whom medical care is not at all effective), resources that would generate much greater health gains if others were to receive them.

- *Equality of access: This principle is perhaps the most frequently encountered type of equity in healthcare.*

A disadvantage of this principle is that it can be satisfied at very high levels of cost of accessing – just so long as they are equal (e.g., an equal \$1,000 co-payment each per GP visit).

Things a priori and Algorithmic

I prefer “health” as the distribuendum compared to any of the other candidates for being a relevant respect. One – and only one – of seven candidates really addresses the heart of the ethical problem. None of the others is even a reliable tracker of health and it is easy to conceive of occasions when there might be a considerable divergence between them. For example, to use current ill health as a driver (inverse, of course) for healthcare resource allocation will, in situations where healthcare is of no avail, cause an unambiguous waste of resources – resources that could have been used to improve the health of those with poorest health whose condition can be improved through healthcare. The principle leads to both inefficiency and increased inequity. Despite this, current morbidity and

mortality are two of the most frequently met arguments of resource allocation formulae in all jurisdictions. For much the same reason, the so-called “burden of disease” is a poor indicator of the likely productivity of research (Mooney and Wiseman 2000).

It is health inequality that is inequitable, not inequality of healthcare. We therefore need quantitative and qualitative measures of health outcomes to determine the fair distribution of purchasing budgets and the extent to which the current distribution falls short of the ideal, just as we need them to make comparisons among interventions in health technology assessment (HTA). In HTA, a generic outcome measure is needed so that

“It is health inequality that is inequitable, not inequality of healthcare.”

one can make comparisons across technologies of different types (e.g., drugs, imaging and other diagnostic aids, devices, surgical procedures). In equity policy, one likewise needs to make systematic comparisons – in this case, not between technologies but across population groups.

It must be recognized that the selection of the dimensions of any generic measure entails social value judgements, as do their scaling and combining. It is natural to reach for a formula, and there are lots of candidates. Formulaic or algorithmic approaches to health outcome measurement have many advantages, *provided the variables embodied in them have sufficient construct validity and provided they are applied in an appropriate context.* These advantages include their transparency, the fact that once their construction has been completed

the business of using them is relatively straightforward and low cost and the fact that, used in appropriate contexts, they usually deliver precise solutions (e.g., a specific incremental [or average] cost-effectiveness ratio or a given budget allocation to a given LHIN). Until one of these constructs, or a satisfactory

“Judging the impact that a changing resource pattern has on health requires multiple skills and the exercise of judgement.”

substitute, is chosen, “health” ought always to be surrounded by scare quotes.⁶ However, once selected and despite their virtues, these algorithmic approaches are not enough.

Things Deliberative

Judging the impact that a changing resource pattern has on health requires multiple skills and the exercise of judgement. A scientific clinical epidemiological knowledge base will sometimes be available. If it is, this is what Lomas et al. (2005) have called “context-free scientific evidence.” But its use requires interpretation and judgement – practical clinical voices capable of expressing professional opinions about the applicability of the scientific knowledge in the social and professional contexts to hand – together with any available context-sensitive scientific research. One also needs economic estimates of what health outcomes might be achievable from different levels of resourcing, as well as the evidence and experience of social scientists that relate to the possibly distinctive cultural and ethnic circumstances that might affect the productivity of various ways of deploying resources.

The thoughtful integration of this knowledge also requires social value judgements to be made and, to give the process credibility in the public imagination, probably some lay participation too.

The decision-making process will almost certainly also involve what Lomas et al. (2005) have called “colloquial” evidence: evidence that is not scientific at all, but professional recollections, experience, case studies and other knowledge that, although scientifically weak, might be all there is on a particular aspect of a problem. Sifting this evidence cannot be done using only an algorithmic approach. Here the essence of the problem is that the knowledge needed to determine equitable distribution is incomplete and fragmented across disciplines, medical specialties and professions. It is also (probably) controversial and it cannot escape being intimately interwoven with values and the making of interpersonal comparisons of benefit and cost. It therefore requires synthesis, quality assessment, discussion of its relevance and applicability in the context of proposed application, the calling and interrogation of experts, the explicit confronting of possible trade-offs, the possibility of decision-makers changing their minds during the course of the deliberations as new knowledge is acquired and the making of an overall judgement informed, but not determined solely, by the evidence.

This is what I call a *deliberative* process. It is founded on the propositions that the facts do not speak for themselves, that decisions can never be solely evidence-based and the (un-evidenced) belief that evidence-informed decisions – using whatever is available – are better decisions.⁷

Health

It is not possible to have a practical policy about equity in health without a measure of

it. It is ludicrous that we are celebrating 50+ years of equitable medicare in Canada and most of the developed world and we still have no proper measure. Mortality data will not do: they tell us about the numbers of dead people but nothing of the quality of life of the living. In the United Kingdom, National Health Service (NHS) hospital data used to include a throughput measure called “deaths and discharges” – as though the difference did not matter. Choosing an appropriate measure of health is not, however, a matter requiring us to strain at gnats while swallowing camels. The literature on health measurement has attention-riveting properties for health service researchers delving into the minutiae of measurement methodology. These experts have developed a welter of candidates for the role of health-as-an-outcomes measure (e.g., Assessment Quality of Life; DALYs; DASH; EuroQol [EQ-5D], Health Utilities Index; Healthy Year Equivalents; QALYs; short-form health surveys such as SF-6D, SF-8, SF-12, SF-36).

The need in empirical equity policy is for a practical, low-cost instrument that has reasonable construct validity – i.e., one that takes account of the most important dimensions of population-level health – and is as sensitive as it needs to be (and no more). My own inclination is to select the EQ-5D, using Canadian weights, on grounds of simplicity, ease of use and its having well-understood virtues and vices – so that, should the latter prove to be important in any particular context, the need for a considered judgement that goes beyond the QALY becomes clear. The EQ-5D essentially interprets health in terms of five dimensions: mobility, ability to self-care, ability to perform usual activities of daily living, level of pain/discomfort and level of anxiety/depression. These are scored and combined using weights derived from the

populations whose health is being measured. So that is an algorithm we need – or at least something like it.

Combining an Algorithm and Other Elements in Deliberative Processes

The act of using an algorithm requires two important further steps that are not themselves well suited to algorithmic solution. The first addresses the way in which algorithmic measures are to be combined, not across *attributes of health* as discussed before but across *groups of people*: young or old, male or female, different ethnicities, different geographical locations, different histories of chronic or congenital disease and disability and so on. How health is combined across people amounts to determining the weights attaching to those with disadvantages or other vertical equity claims for favourable treatment compared with others. Only if there are no ethically relevant differences between people can we assume that the issue is one of horizontal equity and that a QALY=QALY=QALY, whoever gets it.

Making interpersonal comparisons also crops up in less conspicuous ways. For example, the seemingly technical field of HTA is loaded with interpersonal value judgements, as are all decision processes that involve the measurement of individuals' health and their adding up across individuals. So is the prioritization of people's claims (e.g., on waiting lists, for treatment in a treatment room, for research into new treatments). Typical equity-related questions raised by outcome measures in HTA include the following:

- Ought the fact that older people have shorter life expectancies than the young, and hence on average a shorter period of time in which to enjoy any benefits of healthcare, be reflected in benefit calcula-

tions? If so, how?

- Ought the fact that some people have lived extremely painful and restricted lives for many years or have had multiple handicaps than others affect the social valuation of their respective future health benefits? If so, how?
- Should the fact that some people might stand to make major gains in health benefits while others might gain only some reduction in the speed of their health deterioration affect the relative valuation of any additional future health benefit? If so, how?

The same issues crop up in making judgments about distributions of healthcare resources across social groups and between Ontario regions. In England and Wales, questions such as these have been put to a Citizens' Council (University of Toronto Priority Setting in Health Care Research Group 2006).

The second step is even less well suited to an algorithmic approach. This is the determination of the kinds of health-affecting interventions that would promote greater equality in the distribution of health. It would be highly desirable for the set of interventions to be taken as broader than those under the control of the MOHLTC and, in any event, to include public health interventions. Experience with attempts to develop evidence-informed formulary decisions teaches that the formal scientific knowledge base is commonly fairly unsatisfactory – the research might simply not have been done, the technologies investigated might have had policy-irrelevant comparators, the published work might be of poor general quality, it might be of high quality but unknown generalizability, it might be incomplete (e.g., with respect to long-term consequences or economic consequences of any kind) and it

might be scientifically controversial. These elements are likely to be even more prominent in public health research and research on the impact of healthcare on the distribution of health. If similar resource allocations seem to produce different outcomes in different locations and between different cultural groups, then we had better understand the reasons why – and even involve those who understand the local or ethnic cultures in the decision-making process – at least as commentators or consultees⁸ and, possibly, as participants in the decisions themselves. Both of these issues (making appropriate interpersonal comparisons and judging the cost-effectiveness of interventions) involve the use of both algorithmic and deliberative methods. Decisions about equitable resource allocation seem to meet most of the conditions conjectured to characterize the appropriate use of deliberative methods and decisions that are “accountable for reasonableness” (Daniels 2000a, 2000b).

As reported in Culyer and Lomas (2006), a deliberative process is more likely

- to generate guidance that is consistent with the context-free scientific evidence set in a relevant context;
- to identify relevant clinical, social and political contexts for interpreting context-free scientific evidence;
- to command wide credibility in professional circles and beyond;
- to generate recommendations whose implementation will be speedy; and
- to identify impediments to the implementation of guidance and to propose solutions.

One might also expect that the reasonableness of a process will depend upon the following:

- The quality of chairperson
- The clarity and openness of process

- The reasonableness of timelines for evidence submission and consideration
- The use of colloquial evidence to challenge context-free evidence, set contexts and plug gaps in science (but not to supplant scientific evidence of either kind)
- The possibility of interaction between decision-makers and non-participant stakeholders through consultation and commentary
- The availability of time for study, discussion and reflection before, during and after meetings
- The scope for decision-makers to request further information and take face-to-face oral evidence
- The opportunity to appeal a decision not because an appellant disagrees with the decision but on the following grounds:
 - Decision-makers failed to act fairly and in accordance with their published procedures.
 - Their decision was perverse in the light of the evidence submitted.
 - They exceeded their powers.
- Taking a policy decision regarding the entity whose equitable distribution is the focus of concern (this distribuendum is conjectured here to be health)
- Setting up a mechanism to select a pragmatic empirical measure (the algorithm) of health (suggested here to be EQ-5D with Canadian weights)
- Setting up a province-wide deliberative process (e.g., a healthcare distribution commission) whose tasks would be as follows:
 - Annually to determine the allocation of non-tertiary and non-experimental personal healthcare and public healthcare resources (and, preferably, other resources affecting health) to the regional commissioners (LHINs) with as wide a range of commissioning power as possible
 - To give advice to LHINs on the intra-LHIN distribution of resources for equity between social groups
 - Setting quantitative and qualitative annual targets for the commission and the LHINs for greater equality in the distribution of health (not healthcare)

In essence, I am recommending the creation of a new institution tasked with the blending of an algorithmic approach (the health measure) with a deliberative approach (determining the patterns of resource distribution to deliver changes in the outcome health indicator of choice and thereby to move the overall allocation of health in a more equal direction). The contribution of non-healthcare determinants of population health is also best considered in a deliberative process, one that requires the consent and collaboration of ministries other than the MOHLTC.

Need for New Mechanisms

The implementation of the policy for equity implied by the foregoing entails the following necessary key steps for the MOHLTC:

Slogans for Health Equity in Ontario

Having frowned on some common slogans purporting to be guides for policy, it is incumbent on me to suggest replacements:

All needed healthcare ought to be provided free. Healthcare that is not needed must be paid for privately.

Equity is a factor in determining resource allocation decisions only in respect of healthcare that is needed; i.e., of the healthcare that it would be technically possible to provide, only that which is (a) necessary for a person's timely health improvement and (b) cost effective may be said to be needed.

Access should be as cheap as is necessary to enable utilization of needed healthcare.

Equality of access is not specifically equitable but policies should seek to ensure that access is cheap by lowering barriers – whether financial, geographic, ethnic, cultural, linguistic or social – to service use. This is because diagnosis is a necessary condition for establishing whether there is a need for healthcare. The greater the barriers to the receipt of care, the more likely it is that genuine healthcare needs will go undetected and untreated, to the detriment of both efficiency and equity. Without *cheap* access, the community's need for healthcare goes unassessed. *How* cheap access ought to be will depend on the elasticity of demand for care and the impact of healthcare co-payments and other costs of access and use on a person's overall purchasing power (this is required if other forms of inequity are not to be generated by healthcare policy).

The main inequity is inequality of health.

Addressing other inequalities (e.g., of resources per head) is a distraction and can lead to greater health inequality.

Equity in health is impossible without an empirical measure of health.

The measure required does not have to be perfect nor suited for all decision contexts. It must, however, have construct validity and enable the making of politically acceptable comparisons between differing population groups.

Avoidable gross inequalities in health are intolerable moral outrages.

Good health is normally necessary for people to flourish as human beings. Gross inequalities in health imply gross inequalities in people's flourishing. Policy targets for reducing health inequalities should be set by the MOHLTC.

Let the largest differentials between persons and groups command the highest priority.

In seeking to promote the health of all Ontarians through cost-effective healthcare, policy should address the biggest disparities in people's lifetime experiences of health through selective resource allocation and specific policies aimed at having maximum impact on the health of the least healthy.

Unavoidable gross inequalities ought to be accompanied by generous palliative provisions and other compensating variations.

Avoidable gross inequities ought to be avoided. Although unavoidable inequalities may not be fully compensable through other policies, other policy opportunities for promoting more equal flourishing ought to be considered. This is but one policy element requiring inter-ministry collaboration.

Achieving equity in health requires a policy implementation process that is deliberative.

Achieving the equitable allocation of resources requires a combination of judgements about social values and judgements about the contribution that various interventions and types of care are likely to have on population health. Interventions ought ideally to include public health interventions and other non-healthcare determinants of population health. A deliberative process is more likely to deliver well-informed and politically acceptable decisions than other methods.

Equity in health is impossible without an information database.

A policy for the thoughtful distribution of health-affecting resources routinely requires the following:

- Information about the current distribution of resources
- Information about the current distribution of health across relevant social groups

- Information about the technical potential of health and other services to improve health – incremental impact ratios of resources on health

From Talk to Action

For the past 75 years healthcare policy has rarely been discussed without reference to equity and it is undoubtedly equity that drives four of the principles of the Canada Health Act (comprehensiveness, universality, portability and accessibility). Despite this long-standing concern, Canada, both federally and provincially, along with most other jurisdictions, has failed to develop

- clear definitions of terms such as equity and inequity;
- routine databases for measuring inequity or inequality;
- policy targets for achieving equity; and
- mechanisms, beyond the health system's broad structural characteristics, for promoting greater equity.

In my contribution to this collection I have tried to present a coherent set of principles for equity in health and healthcare, together with some of the steps required to address what has hitherto been lacking. I believe these actions are in broad sympathy with the historic roots of Ontario's healthcare policy and are in tune with contemporary moves toward greater transparency and more participative policy decision-making.

Endnotes

1 An idea most recently introduced and developed in Rawls (1971).

2 For a modern review of the evidence, see Ross et al. (2006).

3 The Greek concept of *eudaimonia* is often translated as "happiness," which seems to me somewhat to trivialize it. I prefer "flourishing."

4 The famous Dr. Spock advised countless thousands

of mothers thus: "There are two disadvantages to a baby's sleeping on his back. If he vomits, he's more likely to choke on the vomitus. Also he tends to keep his head turned towards the same side, this may flatten the side of his head ... I think it is preferable to accustom a baby to sleeping on his stomach from the start" (cited in Chalmers 2003: 23). Millions of Spock's readers followed this apparently rational, theory-based and authoritative advice. "We now know from the dramatic effects of the 'Back to Sleep' campaigns in several countries that the practice promulgated by well-intentioned experts like Spock led to tens of thousands of avoidable sudden infant deaths" (Chalmers 2005: 229).

5 Capacity to benefit is similar to Sen's (1980) idea of capabilities.

6 For the sake of readability, however, I have resisted the temptation to pepper my article with such devices.

7 An example of the sort of process I have in mind is Program Budgeting and Marginal Analysis (PBMA); see Ruta et al. (2007).

8 The difference in the practice of the National Institute for Health and Clinical Excellence (NICE) in England and Wales is that commentators are not those invited to make explicit submissions in connection with a technology appraisal: manufacturers of comparator technologies, specific agencies such as the NHS Quality Improvement Scotland, the relevant NICE National Collaborating Centre, other related research groups and "other groups where appropriate." Consultees, by contrast, can participate in the consultation on the draft scope and the other documents used in the appraisals process. Consultee organizations representing patient/carers and healthcare professionals may nominate clinical specialists and patient experts to present their personal views to the appraisal committee. All consultees are given the opportunity to appeal against the NICE conclusions before they are published.

References

Abraham, C. 2004, September 18. "Health Talks Offer No Remedy for Disparities in Drug Policies." *Globe and Mail* A4.

Boadway, R. and N. Bruce. 1984. *Welfare Economics*. Oxford: Basil Blackwell.

Chalmers, I. 2003. "Trying to Do More Good in Policy and Practice: The Role of Rigorous, Transparent, Up-to-Date Evaluations." *Annals of the American Academy of Political and Social Science* 589: 22–40.

Chalmers, I. 2005. "If Evidence-Informed Policy Works in Practice, Does it Matter if it Doesn't Work in Theory?" *Evidence & Policy* 1: 227–42.

- Culyer, A.J. 1992. "The Morality of Efficiency in Health Care – Some Uncomfortable Implications." *Health Economics* 1: 7–18. Rpt. in A. King, T. Hyclak, S. McMahon and R. Thornton, eds., *North American Health Care Policy in the 1990s*. Chichester: Wiley, 1993. 1–24.
- Culyer, A.J. 1997. "The Principal Objective of the NHS Ought to Be to Maximise the Aggregate Improvement in the Health Status of the Whole Community." *BMJ* 314: 667–69. Rpt. in B. New, ed., *Rationing: Talk and Action*. London: King's Fund and *BMJ*, 1997. 95–100.
- Culyer, A.J. 2001. "Equity – Some Theory and Its Policy Implications." *Journal of Medical Ethics* 27: 275–83.
- Culyer, A.J. 2006. "The Bogus Conflict between Efficiency and Equity." *Health Economics* 14: 1155–58.
- Culyer, A.J. and J. Lomas. 2006. "Deliberative Processes and Evidence-Informed Decision-Making in Health Care: Do They Work and How Might We Know?" *Evidence and Policy* 2: 357–71.
- Daniels, N. 2000a. "Accountability for Reasonableness in Private and Public Health Insurance." In A. Coulter and C. Ham, eds., *The Global Challenge of Health Care Rationing*. Buckingham: Open University Press. 89–106.
- Daniels, N. 2000b. "Accountability for Reasonableness." *BMJ* 321: 1300–01.
- Lomas, J., A.J. Culyer, C. McCutcheon, L. McAuley and S. Law. 2005. *Conceptualizing and Combining Evidence for Health System Guidance*. Ottawa: Canadian Health Services Research Foundation.
- Mooney, G. and V. Wiseman. 2000. "Burden of Disease and Priority Setting." *Health Economics* 9: 369–72.
- Olsen, J.A. 1997. "Theories of Justice and Their Implications for Priority Setting in Health Care." *Journal of Health Economics* 16: 625–39.
- Rawls, J. 1971. *Justice as Fairness*. Cambridge: Harvard University Press.
- Ross, N., N. Wolfson, G.A. Kaplan, J.R. Dunn, J. Lynch and C. Sanmartin. 2006. "Income Inequality as a Determinant of Health." In J. Heymann, C. Hertzman, M.L. Barer and R.G. Evans, eds., *Healthier Societies: From Analysis to Action*. Oxford: Oxford University Press. 202–36.
- Ruta, D., C. Mitton, A. Bate and C. Donaldson. 2007. "Programme Budgeting and Marginal Analysis: Bridging the Divide between Doctors and Managers." *BMJ* 330: 1501–03.
- Sen, A.K. 1977. "Social Choice Theory: A Re-examination." *Econometrica* 45: 53–89.
- Sen, A.K. 1980. "Equality of What?" In S. McMurrin, ed., *The Tanner Lectures on Human Values*. Cambridge: Cambridge University Press. 197–220.
- Statistics Canada. 2007. "Infant Mortality Rates by Province and Territory (Both Sexes)." Ottawa: Author. Retrieved April 3, 2007. <<http://www40.statcan.ca/101/cst01/health21a.htm>>
- University of Toronto Priority Setting in Health Care Research Group. 2006. *Review of Citizen's Councils and Recommendations for the Creation of a Citizens' Council in Ontario as Mandated under the Transparent Drug System for Patients Act*. Toronto: University of Toronto Department of Health Policy, Management and Evaluation.
- van Doorslaer, E., A. Wagstaff, H. van der Burg, T. Christiansen, G. Citoni, R. Di Biase, U.-G. Gerdtham, M. Gerfin, L. Gross, U. Häkkinen, J. John, P. Johnson, J. Klavus, C. Lachaud, J. Lauritsen, R. Leu, B. Nolan, J. Pereira, C. Propper, F. Puffer, L. Rochaix, M. Schellhorn, G. Sundberg and O. Winkelhake. 1999. "The Redistributive Effect of Health Care Finance in Twelve OECD Countries." *Journal of Health Economics* 18: 291–313.
- Wikler, D. and C.J.L. Murray, eds. Forthcoming. "Goodness" and "Fairness": *Ethical Issues in Health Resource Allocation*. Geneva: World Health Organization.

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



EQUITY

Gwyn Bevan

Professor of Management Science, Department of Management and LSE Health
and Social Care, London School of Economics and Political Science



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 elite 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

“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 ...

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).

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 (Glennister 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.

References

Asthana, S., A. Gibson, G. Moon, J. Dicker and P. Brigham 2004. "The Pursuit of Equity in NHS Resource Allocation: Should Morbidity Replace Utilisation as the Basis for Setting Health Care Capitations?" *Social Science & Medicine* 58: 539–51.

Bevan, A. 1991. "House of Commons, 30 April, 1946." In C. Webster, ed., *Aneurin Bevan on the National Health Service*. Oxford: Wellcome Unit for the History of Medicine.

Bevan, G. 1989. "Financing UK Hospital and Community Health Services." *Oxford Review of Economic Policy* 5: 124–35.

Bevan, G., H. Copeman, J. Perrin and R. Rosser. 1980. *Health Care: Priorities and Management*. London: Croom Helm.

Bevan, G. and C. Hood 2006. "What's Measured is What Matters: Targets and Gaming in the English Public Health Care System." *Public Administration* 84(3): 517–38.

Bevan, G. and R. Robinson. 2005. "The Interplay between Economic and Political Logics: Path Dependency in Health Care in England." *Journal of Health Politics, Policy and Law* 30(1): 53–78.

Birch, S., J. Eyles, J. Hurley, B. Hutchison and S. Chambers. 1993. "A Needs-Based Approach to Resource Allocation in Health Care." *Canadian Public Policy* 19(1): 68–85.

Canadian Health Care Manager. 2005. *Special Report, April 2005. Ontario's Local Health Integration Networks (LHINs)*. Retrieved March 30, 2007. <<http://www.chmonline.ca/images/LHINS/LHINsApril2005.pdf>>

Cooper, M.H. and A.J. Culyer. 1971. "An Economic Survey of the Nature and Intent of the British National Health Service." *Social Science and Medicine* 5(1): 1–13.

Department of Health. n.d. *Revenue Allocations*. Retrieved March 30, 2007. <http://www.dh.gov.uk/en/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/Allocations/DH_4108515>

Department of Health. 1989. *Working for Patients*. Cm 555. London: HMSO.

Department of Health. 1997. *The New NHS: Modern, Dependable*. Cm 3807. London: The Stationery Office. Retrieved March 30, 2007. <http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4008869&chk=VT3hrh>

Department of Health. 2000. *The NHS Plan*. Cm 4818-I. London: The Stationery Office. Retrieved March 30, 2007. <http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4008869&chk=VT3hrh>

Department of Health. 2002a. *Delivering the NHS Plan*. Cm 5503. London: The Stationery Office. Retrieved March 30, 2007. <http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4005818>

Department of Health. 2002b. *Reforming NHS Financial Flows. Introducing Payment by Results*. London: Author. Retrieved March 30, 2007. <http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4005300&chk=gWPrpL>

Department of Health. 2003a. *Resource Allocation: Weighted Capitation Formula*. 4th ed. Leeds: Author. Retrieved March 30, 2007. <http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4069186>

Department of Health. 2003b. *Choice of Hospitals. Guidance for PCTs, NHS Trusts and SHAs on Offering Patients Choice of Where They are Treated*. London: Author. Retrieved March 30, 2007. <http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4006060&chk=Uv6IsU>

Department of Health and Social Security. 1976. *Sharing Resources for Health in England. Report of the Resource Allocation Working Party (RAWP Report)*. London: HMSO. Retrieved March 30, 2007. <http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/Allocations/AllocationsArticle/fs/en?CONTENT_ID=4108515&chk=t1hmGo>

- Department of Health and Social Security. 1979. *Patients First*. London: HMSO.
- Forsyth, G. 1975. *Doctors and State Medicine*. London: Pitman.
- Glennister, H., M. Matsaganis, P. Owens and S. Hancock. 1994. *Implementing GP Fundholding*. Buckingham: Open University Press.
- Government of Ontario. 2005. *Compendium Local Health System Integration Act, 2005*. Toronto: The Queen's Printer. Retrieved March 30, 2007. <http://www.health.gov.on.ca/english/public/legislation/lhins/lhin_compendium.pdf>
- Government of Ontario. 2006. *Local Health System Integration Act, 2006*. Toronto: The Queen's Printer. Retrieved March 30, 2007. <http://www.e-laws.gov.on.ca/DBLaws/Statutes/English/06l04_e.htm#BK21>
- Greer, S.L. 2004. *Four Way Bet: How Devolution Has Led to Four Different Models for the NHS*. London: The Constitution Unit, School of Public Policy, UCL.
- Hart, J.T. 1971. "The Inverse Care Law." *Lancet* 1: 405-12.
- Hauck, K., R. Shaw and P.C. Smith. 2002. "Reducing Avoidable Inequalities in Health: A New Criterion for Setting Health Care Capitation Payments." *Health Economics* 11(8): 667-77.
- Health Select Committee. 1996. *Allocation of Resources to Health Authorities. Report, Volume 1 (Session 1995-96, HC4771)*. London: HMSO.
- Health Select Committee. 2006. NHS Deficits. *First Report of Session 2006-07, Volume 1*. London: The Stationery Office. Retrieved March 30, 2007. <<http://www.publications.parliament.uk/pa/cm200607/cmselect/cmhealth/73/73i.pdf>>
- Hollinghurst S., G. Bevan and C. Bowie. 2000. "Estimating the 'Avoidable' Burden of Disease by Disability Adjusted Life Years (DALYs)." *Health Care Management Science* 3(1): 9-21.
- Klein, R.E. 2006. *The New Politics of the National Health Service*. 5th ed. Oxford: Radcliffe Press.
- Marchildon, G.P. 2005. *Health Systems in Transition: Canada*. Copenhagen: WHO Regional Office for Europe on Behalf of the European Observatory on Health Systems and Priorities.
- Ministry of Health and Long-Term Care. 2006a. *Local Health Integration Networks*. Toronto: Author. Retrieved March 30, 2007. <<http://www.lhins.on.ca/english/main/aboutLHINs.asp>>
- Ministry of Health and Long-Term Care. 2006b. *The Plan for Health Care*. Toronto: Author. Retrieved March 30, 2007. <<http://www.health.gov.on.ca/transformation/index.html#1>>
- Ministry of Health and Long-Term Care. 2006c. *How LHINs Are Good For Your Health. Building a True System - Delivering Better Care*. Toronto: Author. Retrieved March 30, 2007. <http://www.health.gov.on.ca/transformation/lhin/lhins_goodhealth.pdf>
- Mooney, G. 1994. *Key Issues in Health Economics*. Hemel Hempstead: Harvester Wheatsheaf.
- Ontario Hospital Association. 2005. *Collaborating for Change: Optimizing the Effectiveness of Local Health Integration Networks in Ontario*. Toronto: Author. Retrieved March 30, 2007. <[http://www.oha.com/Client/OHA/OHA_LP4W_LND_WebStation.nsf/resources/LHINsPaper/\\$file/OHALHINPolicyPaper.pdf](http://www.oha.com/Client/OHA/OHA_LP4W_LND_WebStation.nsf/resources/LHINsPaper/$file/OHALHINPolicyPaper.pdf)>
- Rivett, G. 1998. *From Cradle to the Grave. Fifty Years of the NHS*. London: King's Fund.
- Robinson, R. and A. Steiner. 1998. *Managed Health Care: US Evidence and Lessons for the National Health Service*. Buckingham: Open University Press.
- Smith, P.C. 2007. *Formula Funding of Public Services*. Abingdon: Routledge.
- Stevens, S. 2004. "Reform Strategies for the English NHS." *Health Affairs* 23(3): 41-44.
- Stone, M. and J. Galbraith. 2006. "How Not to Fund Hospital and Community Health Services in England." *Journal of the Royal Statistical Society A* 169(1): 143-64.
- Tuohy, C. 1999a. *Accidental Logics. The Dynamics of Change in the Health Care Arena in the United States, Britain and Canada*. New York: Oxford University Press.
- Tuohy, C. 1999b. "Dynamics of a Changing Health Sphere: The United States, Britain and Canada." *Health Affairs* 18(3): 114-34.
- Webster, C. 1988. *The Health Services since the War, Volume 1. Problems of the National Health Service before 1957*. London: HMSO.
- Webster, C. 1998. *The National Health Service: A Political History*. Oxford: Oxford University Press.
- Williamson, O.E. 1975. *Markets and Hierarchies*. New York: The Free Press.
- Williamson, O.E. 1985. *The Economic Institutions of Capitalism: Firms, Markets and Relational Contracting*. New York: The Free Press.

Balancing Equity Issues in Health Systems: Perspectives of Primary Healthcare



EQUITY

Richard H. Glazier, MD, MPH, CCFP, FCFP
Senior Scientist and Leader, Primary Care and Population Health Program,
Institute for Clinical Evaluative Sciences, Toronto



Importance and Impact of Primary Healthcare

Primary healthcare is usually considered the first level of contact with the health system. In Organisation for Economic Co-operation and Development (OECD) countries, strong primary healthcare system and practice characteristics are associated with improved population health. The strength of a country's primary healthcare system has been shown to be negatively associated with all-cause mortality, all-cause premature mortality and cause-specific premature mortality from asthma and bronchitis, emphysema and pneumonia, cardiovascular disease and heart disease (Macinko et al. 2003). Starfield (1991) demonstrated that there was strong concord-

ance in 10 industrialized countries between the extent of primary health service, health indicators (including life expectancy and infant mortality) and the satisfaction of their populations in relation to the systems' overall costs. A systematic review found evidence that increased accessibility to physicians working in primary healthcare contributes to better health and lower total healthcare-system costs (Engstrom et al. 2001). Primary healthcare has also been shown to be associated with reduced socio-economic disparities in overall mortality, infant mortality and low birth weight, stroke mortality, self-reported health and avoidable hospitalizations (Starfield, Shi and Macinko 2005).

Studies of individual access to care provide

evidence supporting the effectiveness of primary healthcare at the country or regional level. Lack of access to a regular source of care has been associated with excess emergency department visits (Oster and Bindman 2003), while having a regular source of care has been associated with increased preventive healthcare (Bindman et al. 1996) and improved glycemic control for people with diabetes (O'Connor et al. 1998). Continuity of primary healthcare has been associated with increased preventive care (Gill et al. 2003), decreased hospitalization (Saultz and Lochner 2005), improved glycemic control for people with diabetes (Gill and Mainous 1998) and decreased rates of emergency department visits (Gill et al. 2000) and hospitalization (Gill and Mainous 1998).

The evidence for primary healthcare's positive contributions to population health is observational in nature (and therefore not necessarily causal) and there are minor inconsistencies about specific outcomes. Nonetheless, the overall findings are strong and consistent across ecological and individual-level studies, they appear to have dose-response relationships and they are specific to primary healthcare (Starfield, Shi, Grover and Macinko 2005). Experimental evidence will always be lacking about the organization of healthcare at the national or regional levels; therefore, the current evidence should be considered consistent and moderately strong within the realm of feasibility.

Health Provider Roles

Among health providers, family physicians (FPs) and general practitioners (GPs) are the health professionals most often contacted at least once by Canadians (80% in 2003), followed by dentists (64%) (Canadian Institute for Health Information 2005). A large majority of Canadians (85%) have a regular medical doctor, most commonly an

FP/GP (Statistics Canada 2003). Among physicians, FPs/GPs play the largest role in the care of children, adults and seniors and of people with respiratory conditions, heart failure, mental health problems and cancer (Jaakkimainen et al. 2006).

Compared with physicians, less is known about the supply or practice patterns of other primary healthcare professionals. Although the supply of nurses in Canada has been extensively documented, with almost 250,000 in total, the number working in primary healthcare and their roles are not well understood. The majority of nurses (76%) work in hospitals or long-term care settings and less than 10% work in industry, private agencies, self-employment and physicians' offices combined. While many work in primary care settings, Canada has fewer than 1,000 nurse practitioners. The majority of Canada's 28,000 pharmacists are employed in retail settings, where they provide first-contact care; however, coordination with other primary care providers is limited in many of these environments. Canada has over 28,000 social workers but their roles and interactions with other primary care providers are not well documented. Primary healthcare reform efforts in Canada are attempting to bridge gaps between providers in order to expand access to care and to improve the comprehensiveness and quality of care. As these efforts move forward, all providers can expect changes in their current roles and interactions as members of teams (Canadian Institute for Health Information 2006).

Declining Access to Primary Healthcare

Canada's physician workforce declined during the 1990s, with a large decrease in the availability of FPs/GPs. Provider factors related to these declines include a decrease in the proportion of FP/GP physicians, a decrease in the average hours worked (attributed to

the profession's changing demographics), an increase in time spent in training, a decrease in foreign-trained doctors, more physicians retiring and medical school enrolment cuts. Patient factors include an aging population that uses healthcare more intensively. In 2003, 5% (1.2 million) of Canadians age 12 and over were unable to find a regular doctor and an additional 9% (2.4 million) had not looked for one (Statistics Canada 2003). Across the country, only about 20% of FPs/GPs were accepting new patients, and this proportion declined between 2001 and 2004. In many communities, walk-in and special clinics staffed on a rotating basis are the only source of care for thousands of people. These clinics cannot provide care continuity and are not geared to provide ongoing chronic disease management or preventive healthcare. Lack of interest in family medicine among new medical school graduates, low professional satisfaction and rapid aging of the current workforce in the face of a growing and aging population generate a worsening crisis in access to basic healthcare in Canada.

The overall supply of FPs/GPs is not the only concern. Uneven distribution and reduced care comprehensiveness also greatly compromise the availability of primary care. There were 96 FPs/GPs per 100,000 people in Canada in 2002, with large variations – ranging from 35 (Nunavut) to 172 (Vancouver) – among the country's health regions. Even these variations do not fully account for severe shortages within certain sub-regions, part-time practices and limited and changing scope of practice over time. From 1989 to 1999, there were significant decreases in hospital in-patient care, surgical assistance, surgery, obstetrics and anaesthesia by Canadian FPs/GPs. There is evidence that this decline in the comprehensiveness of care offered by FP/GPs has occurred across all physician age groups for males and females, and that it is happen-

ing in rural areas as well as in cities with and without medical schools (Chan 2002). Along with a widespread withdrawal from hospital-based care, many FPs/GPs have developed

“There is also remarkably little evidence or consensus about whether patient outcomes are improved under any particular system of reimbursement.

specialty areas of practice, such as psychotherapy, sports medicine and palliative care. While these services are needed, and often fill serious gaps in care, such specialization further decreases the availability of comprehensive primary care services at the community level.

The Policy Response: Primary Healthcare Reform in Canada's Provinces

Access to care has been an important focus of primary healthcare policy-making in Canada. The 2003 First Ministers' Accord on Health Care Renewal committed federal and provincial governments to accelerating primary healthcare renewal so that citizens routinely receive needed healthcare from an appropriate provider. This accord set a goal that by 2011 “at least 50 per cent of their residents have access to an appropriate health care provider, 24 hours a day, seven days a week” (Health Canada 2003). In 2004's 10-Year Plan to Strengthen Health Care, this target was described as “50 per cent of Canadians having 24/7 access to multidisciplinary teams by 2011.” The 2004 plan also committed governments to continue to work with Health Canada's Infoway to realize the vision of an electronic health record

(Health Canada 2004).

According to a 2006 report (Health Council of Canada 2006), nine Canadian jurisdictions now provide access to a province- or territory-wide telephone service. Only five of those jurisdictions have a mechanism to inform a patient's primary care provider about telephone encounters. Interprofessional teams, another main policy response to improve access to primary healthcare, vary a great deal in composition and are not rolling out as quickly as expected. The same report also gives information about team care for several provinces in 2005:

- British Columbia had more than 1,000 clinicians providing team care; Saskatchewan had 34 primary care teams covering approximately 23% of the population.
- Ontario had 75 interdisciplinary teams, was adding community health centres and had plans to establish 150 family health teams by 2007.
- Quebec had an estimated 104 family medicine groups providing services to 1.55 million people.
- New Brunswick had eight community health centres and one collaborative practice model.
- Prince Edward Island had established five family health centres.
- Newfoundland and Labrador had eight teams in various stages of implementation.

Several other aspects of primary healthcare policy are relevant to improving access and quality. Rostering of patients with primary healthcare providers or teams has been promoted as a way to define practice populations, to increase accountability, to reduce duplication and to implement blended, capitated and other non-fee-for-service reimbursement models. Rostering has been criti-

cized as potentially difficult and disruptive to implement on a population-wide level given the current dispersion of care, especially in urban areas. The majority of Canadian FPs/GPs favour blended payment reimbursement over straight fee-for-service. Nonetheless, the large-scale implementation of capitation-based blended models has also been criticized and has generated a high degree of controversy among Canadian FPs/GPs. A chief concern raised about capitation models is their inherent incentive to underprovide services. Few Canadian capitation models have incorporated adjustment for patient characteristics beyond age and sex, raising concerns about preferential selection (aka "cream skimming") of the least complex and least demanding patients. The main concern is that, without adjustment for morbidity, physicians might continue to care for a range of patients but selectively enrol only the healthiest onto their capitation rosters.

There is also remarkably little evidence or consensus about whether patient outcomes are improved under any particular system of reimbursement. A 2001 systematic review concluded that, while the funding method in place influenced some aspects of physician behaviour, the authors were "unable to make conclusions as to whether these changes are beneficial to patients" (Gosden et al. 2001: 53). Even less evidence is available from Canadian settings where reimbursement and system issues are different from settings in the United States (US). Attention to care quality in primary healthcare reform is critical because funding appears to influence service delivery and there are concerns over the ability of primary healthcare providers to deliver evidence-based preventive care and chronic disease-management care as well as to communicate effectively with patients.

Dimensions of performance that have been proposed for primary healthcare reform

include effectiveness, continuity, quality, cost reduction, decline in total use, responsiveness, accessibility and equal access (Canadian Health Services Research Foundation 2003). No single model of care was found to approach optimal performance in all these dimensions; two models, however, were closest: the integrated community model and the professional coordination model. The former is most characteristic of community health centres (CHCs) and Quebec's centres locaux des services communautaires (CLSC) and centres de santé et des services sociaux (CSSS), with good performance reported in all dimensions except accessibility and responsiveness. The latter is best represented by Ontario's health service organizations (HSOs) and by managed care models such as health maintenance organizations (HMOs) in the US, which receive better ratings for accessibility and responsiveness than the integrated community model but worse ones in other dimensions. The professional contact model, which is most characteristic of fee-for-service care, also has strengths in accessibility and responsiveness but was not found to perform well in other dimensions. A commentary in the same report noted that the evidence on these issues is not strong and that funding and payment – two related but separate issues – need to be considered separately. A US analysis of domains of primary healthcare quality came to similar conclusions, based on the finding that CHC users are more likely than HMO users to rate their primary healthcare providers highly, except in the area of ease of first contact (Shi et al. 2003). Most Canadian jurisdictions have a mix of these models. In Canada, there is a current policy shift away from fee-for-service (professional contact model) and toward other organizational and payment arrangements, with most resembling the professional coordination model. In areas where CHCs are being expanded, this entails a move toward the

integrated community model.

Electronic health records (EHRs) are another policy response, one aimed more at quality of care and coordination than at access. An international comparison found that Canada lagged well behind many other nations in the uptake of EHRs in primary care, with only 20% of providers using computers for clinical purposes, compared with over 90% in 10 other countries (Protti 2005). Most Canadian FPs/GPs had some computer familiarity and already had computer systems in their offices for billing purposes – these were seen as positive steps toward clinical use. The most common functions in primary care offices internationally were prescription writing and accessing laboratory results. Both of these applications have been associated with practice benefits. Use of EHRs has also been associated with improved preventive care. A policy conference sponsored by Canada Health Infoway and the Health Council of Canada in June 2006 reported on evidence of positive impacts of EHRs on patient care in Canada and internationally. It also reported on financial benefits from e-health generally, but the return on investment of the EHR specifically remains to be determined (Canada Health Infoway and Health Council of Canada 2006). EHRs are increasingly being used in research and evaluation because they have numerous advantages over review of paper-based charts.

Policy Response: Ontario

Along with other Canadian jurisdictions, Ontario is struggling with the increasing challenges facing access to and quality of primary healthcare. The 2005 Canadian Community Health Survey (CCHS) (Statistics Canada 2005) indicates that more than 900,000 people in Ontario aged 12 and over (8.8%) did not have a regular medical doctor, ranging – by Local Health Integration Network

(LHIN) – from 6.4% in Hamilton Niagara Haldimand Brant to 15.4% in the Northwest. The proportion of FPs/GPs accepting new patients in Ontario is only 11%, with levels as low as 5% in Eastern Ontario and Southwest Ontario. The province is pursuing policy initiatives on several fronts, including increased medical school enrolment, increased licensure of international medical graduates, telehealth and enhanced incentives for physicians to work in under-serviced areas.

A key strategy to overcome shortfalls in primary medical care is primary healthcare reform. In Ontario these efforts include re-organization of payment mechanisms and financial incentives to reward comprehensive care, continuity of care and delivery of preventive services; increased access to after-hours care; payments to subsidize EHR implementation and payments to add non-medical health personnel to healthcare teams, especially nurses, nurse practitioners, pharmacists and social workers. New models have become available at different times and, due to the voluntary nature of the rollout and historical patterns of care, the uptake has not been uniform in all areas of the province.

Ontario’s new care models all involve patient enrolment, so that most people in the province are becoming associated with primary healthcare providers or teams. There is, however, considerable variation in mechanisms of physician compensation (see Figure 1). Straight fee-for-service remains a common method but there has been a rapid increase in a blended fee-for-service model, the Family Health Group (FHG), with more than 4,000 physicians representing more than 4 million patients enrolled from July 2003 to January 2006. That model includes higher fees for comprehensive care claims (comprising a large proportion of most physicians’ practices), has incentives for reaching preventive care targets

and requires expanded after-hours coverage. An earlier version, the Comprehensive Care Model (CCM), involved a small number of practices. Blended capitation is the dominant reimbursement mechanism for two older models: HSOs, which had 145 physicians in January 2006, and Group Health Centres (GHCs), which had 38 physicians in January 2006. It is also the dominant reimbursement mechanism for three newer models: Family Health Networks (FHNs), which had 648 physicians in January 2006; Primary Care Networks (PCNs), which had 1,919 physicians in January 2006; and Family Health Teams (FHTs). The major distinction between the newer blended capitation models is that FHTs support interprofessional team members. An initial round of 31 FHTs was announced in December 2005, along with an application process for 50 more FHTs and a plan to establish 150 in total by 2007. All of the newer patient-enrolment models (CCM, FHG, FHN, PCN, FHT) require after-hours coverage, provide financial support for EHRs and have incentives for preventive healthcare and diabetes comprehensive care.

Figure 1. Ontario’s patient enrolment models with types of physician compensation

Patient Enrolment Model	Physician Compensation
Comprehensive Care Model (CCM)	Blended fee-for-service
Family Health Group (FHG)	
Family Health Network (FHN)	Blended capitation
Family Health Team (FHT)	
Primary Care Network (PCN)	
Health Service Organization (HSO)	
Group Health Centre (CHG)	

Figure 2. Ontario's salaried models of primary healthcare showing physician-compensation types

Model	Physician-Compensation Types
Rural and Northern Physicians Group (RNPG)	Blended complement (payments to a group based upon the number of designated physicians)
Community Health Centre (CHC)	Blended salary
Aboriginal Health Access Centre (AHAC)	
Various specific organizations	Specialized models

Ontario has salaried models in primary healthcare (see Figure 2), including CHCs (54 in January 2006) and Aboriginal Health Access Centres (AHACs) (10 in January 2006). It also has alternative payment plans as the major form of payment in rural and northern areas (49 physicians in January 2006), at Queen's University and at Toronto's Hospital for Sick Children, as well as in many hospital emergency departments. The variety of models being implemented in Ontario, with rollout occurring at different times and places, provides a unique opportunity to study the effects of primary healthcare reform in Canada, one that is applicable across the country.

Equity Considerations in Primary Care

The population burden of illness is not shared equally among all people, even within the same age and sex groups. People with lower educational attainment, less income, unemployment and food insecurity report more fair and poor health, disability, depression and chronic diseases than more advantaged populations (Glazier et al. 2006). For example, three times as many low-income men and women aged 45–64 report poor and fair health compared to those with high income. Despite greater healthcare needs, disadvantaged populations do not make greater use of primary care or specialist care and have much lower levels of preventive healthcare, including Pap smears, mammograms, influenza

immunizations, blood pressure checks and dental visits.

Equity in primary care can be considered in terms of the Equity Effectiveness Loop framework (Tugwell 2006). In that framework, community effectiveness of care is seen as the product of efficacy, access, diagnostic accuracy, provider compliance and consumer adherence. With the possible exception of efficacy, disadvantaged populations might do worse than more advantaged ones at every step. Access to care and consumer adherence are particular concerns for disadvantaged populations that may experience barriers to scheduling appointments, obtaining transportation and affording medications and devices. Lower levels of health literacy have also been linked to lower levels of disease control (Schillinger et al. 2002).

Attending to Equity

Health system innovation that is meant to improve access to care has the potential to improve equity. That outcome is not certain, however, because more advantaged populations are often adept at learning about and using innovations. To be sure that primary healthcare reform does not worsen equity, equity will need to be articulated as a goal that is attended to during implementation and measured during evaluation.

Measurement of primary healthcare provision is challenging, however, due to incomplete

and fragmentary datasets and poor data quality. For example, data about the care provided at CHCs in Ontario are not available for evaluation and have not been linked to other aspects of primary healthcare utilization. Part of the CHC mandate is to look after underserved populations; therefore, this evidentiary gap is especially problematic for understanding equity. Residential addresses in Ontario are up to 15 years out of date in Ontario's healthcare registry, a shortcoming that greatly reduces the validity of data pertaining to geographical rates of primary healthcare.

“... there is no pan-Canadian approach to understanding which innovations are successful; nor is there a way to compare the impact of reform models across different provinces.”

As new models of interprofessional care are rapidly adopted in Ontario, ways to track the care provided by non-physicians will be increasingly needed. Currently, it is impossible to measure the care provided by nurses, nurse practitioners, social workers, pharmacists, psychologists, dieticians and others working on primary healthcare teams. Available data also lack measures of socio-economic or immigration status. Adding these measures to routinely collected data will greatly enable the measurement of equity in primary healthcare utilization.

Capitation rates in Ontario are based on age and sex and do not take morbidity or comorbidity into consideration. Without adjust-

ment for these factors, providers who care for disadvantaged populations under capitation will be under-paid due to the higher burden of illness in these populations. This constitutes a moral hazard for physicians who face financial penalties for looking after disadvantaged groups.

Evaluation of Primary Healthcare

The current level of innovations being introduced into Canada's health system at the provider level is virtually unprecedented. The degree to which these reforms will successfully address access and quality challenges, however, remains unclear. Each province is developing its own approaches to research and evaluation but there is no pan-Canadian approach to understanding which innovations are successful; nor is there a way to compare the impact of reform models across different provinces. Without a coordinated national approach to evaluating primary healthcare per se, there will be no cross-jurisdictional lessons learned and no external information available to policy-makers concerning the need for mid-course corrections or guiding the adoption of the most promising innovations.

At the national level, support for and organization of primary healthcare research has been fragmentary and uncoordinated. Researchers from different health disciplines have no common research community within which to network and no formal mechanism through which to interact. Some national research-funding agencies, including Health Canada and the Canadian Health Services Research Foundation, have had major primary healthcare initiatives; other key health research funders, however, have had none. The large initiatives have now ended, leaving the future direction of primary healthcare research unclear. Canada's national research-funding agencies have no history of collaborative

initiatives or strategies in primary healthcare research. The Canadian situation contrasts starkly with those found in the United Kingdom, Australia, New Zealand, the US and other countries that have established major national primary healthcare research initiatives, including appropriately focused research funding.

A national, coordinated plan to evaluate innovation in primary healthcare is essential. The first step must involve inter-agency agreement that primary healthcare is a shared research priority. Second, inter-agency action must be taken to develop a national primary healthcare research strategy. Elements of such a national strategy could include the following elements:

Building Research Capacity

While Canada has successful primary healthcare researchers, research is underdeveloped in relation to service provision. Targeted support for research training and ongoing career support are needed. Alternative models of outreach and mentorship, later career re-entry positions, support for teams and networks and attention to the needs of clinician scientists are especially needed in primary healthcare research.

Developing and Supporting an Interdisciplinary Research Community

Family medicine, nursing, pharmacy, social work, psychology and other disciplines are working together in new models of primary healthcare and should be conducting research together as well. Methodologists in biostatistics, qualitative methods, program evaluation, epidemiology, health services and systems research, health economics and policy analysis are also needed. National structures that foster interdisciplinary research and interaction are required to create a cohesive research community.

Fostering a Set of Interdisciplinary Teams and Centres

Research foci for primary healthcare studies should include the following:

- Access to care
- Quality of care
- Interdisciplinary practice
- Application of information technology
- Health human resources
- Organization of care
- Health economics and policy analysis

A network of interdisciplinary teams and centres, each focused on one or more of these topics, is one potential model for addressing national research needs in these critical areas.

Data Initiatives to Facilitate Cross-Model, Cross-Provincial and International Comparisons

Data sources for primary healthcare research are incomplete, fragmented and split across jurisdictions. While a set of performance measures for primary healthcare has been proposed, current data systems are entirely inadequate for measuring most of the proposed indicators within and across jurisdictions. Investments in harmonizing, linking and continually updating datasets are needed.

Supporting Practice-Based Research Networks

The most valuable data for primary healthcare research arise in the clinical setting, including clinical-encounter data, the functioning of interdisciplinary teams and the satisfaction of those using the health system. Canada already has a number of functioning, practice-based research networks; however, these networks work mostly in isolation from one another and lack interdisciplinarity, the ability to network with each other and, in many cases, the resources for long-term sustainability.

Such networks are an essential laboratory for primary healthcare research, have worked extremely well internationally and are ideally suited for research comparing models of healthcare.

Building Capacity to Link and Use EHRs for Research

EHRs are a feature of most primary healthcare reform efforts. They are usually introduced to enhance information coordination and to improve the delivery of clinical care. Unfortunately, many EHR systems are not designed to facilitate research; however, they have the potential to become rich data sources for comparative and longitudinal primary healthcare studies. EHRs can also be linked with provincial and national data and can facilitate data collection in practice-based research networks.

Conclusions

Primary healthcare is associated with better population health at lower cost and should be considered the cornerstone of Canada's health system. Serious challenges facing access to care, quality of care, uptake of information technologies, integration with other health sectors and attracting new trainees have become apparent. Policy initiatives to address these concerns include expansion of after-hours office care, telehealth, EHRs, new reimbursement models and new interprofessional team models of care.

Despite this high level of innovation in every province and territory, there is no coordinated national plan for evaluation. Innovations often attract those most able to learn about them and experience their benefits and there are concerns that the needs of disadvantaged and vulnerable populations are not being specifically addressed in most primary care reform efforts. Nationally coordinated strategies are needed to ensure that

primary care reform is appropriately evaluated and that mid-course corrections can be made to ensure effectiveness and equity.

References

- Bindman, A.B., K. Grumbach, D. Osmond, K. Vranizan and A.L. Stewart. 1996. "Primary Care and Receipt of Preventive Services." *Journal of General Internal Medicine* 11: 269-76.
- Canada Health Infoway and Health Council of Canada. 2006. *Beyond Good Intentions: Accelerating the Electronic Health Record in Canada. A Policy Conference Held on June 11-13, 2006. Montebello, QC. Summary of Main Themes and Insights.* Toronto: Author. Retrieved September 4, 2006. <http://www.infoway-inforoute.ca/Admin/Upload/Dev/Document/Conference%20Executive%20Summary_EN.pdf>
- Canadian Health Services Research Foundation. 2003. *Choices for Change: The Path for Restructuring Primary Healthcare Services in Canada.* Ottawa: Author. Retrieved September 4, 2006. <http://www.chsrf.ca/final_research/commissioned_research/policy_synthesis/pdf/choices_for_change_e.pdf>
- Canadian Institute for Health Information. 2005. *Canada's Health Care Providers: 2005 Chartbook.* Ottawa: Author. Retrieved September 4, 2006. <http://secure.cihi.ca/cihiweb/disPage.jsp?cw_page=PG_409_E&cw_topic=409&cw_rel=AR_35_E>
- Canadian Institute for Health Information. 2006. *Health Personnel Trends in Canada, 1995 to 2004 (Revised July 2006).* Ottawa: Author. Retrieved September 4, 2006. <http://secure.cihi.ca/cihiweb/products/Health_Personnel_Trend_1995-2004_e.pdf>
- Chan, B.T. 2002. "The Declining Comprehensiveness of Primary Care." *Canadian Medical Association Journal* 166: 429-34.
- Engstrom, S., M. Foldevi and L. Borquist. 2001. "Is General Practice Effective? A Systematic Literature Review." *Scandinavian Journal of Primary Care* 19: 131-44.
- Gill, J.M. and A.G. Mainous 3rd. 1998. "The Role of Provider Continuity in Preventing Hospitalizations." *Archives of Family Medicine* 7: 352-57.
- Gill, J.M., A.G. Mainous 3rd, J.J. Diamond and M.J. Lenhard. 2003. "Impact of Provider Continuity on Quality of Care for Persons with Diabetes Mellitus." *Annals of Family Medicine* 1: 162-70.
- Gill, J.M., A.G. Mainous 3rd and M. Nsereko. 2000. "The Effect of Continuity of Care on Emergency

- Department Use." *Archives of Family Medicine* 9: 333–38.
- Glazier, R., J. Tepper, M.M. Agha and R. Moineddin. 2006. "Primary Care in Disadvantaged Populations." In L. Jaakkimainen, R. Upshur, J. Klein-Geltink, A. Leong, S. Maaten, S. Schultz and L. Wang, eds., *Primary Care: A Practice Atlas*. Toronto: Institute for Clinical Evaluative Sciences.
- Gosden, T., F. Forland, I.S. Kristiansen, M. Sutton, B. Leese, A. Giuffrida, M. Sergison and L. Pedersen. 2001. "Impact of Payment Method on Behaviour of Primary Care Physicians: A Systematic Review." *Journal of Health Services Research and Policy* 6: 44–55.
- Health Canada. 2003. *2003 First Ministers' Accord on Health Care Renewal*. Ottawa: Author. Retrieved September 4, 2006. <http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2003accord/index_e.html>
- Health Canada. 2004. *First Minister's Meeting on the Future of Health Care 2004. A 10-Year Plan to Strengthen Health Care*. Ottawa: Author. Retrieved September 4, 2006. <http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index_e.html>
- Health Council of Canada. February 2006. *Primary Health Care. Health Care Renewal in Canada: Clearing the Road to Quality*. Ottawa: Author. Retrieved September 4, 2006. <http://www.healthcouncilcanada.ca/docs/rpts/2006/EX_PrimaryCare_EN.pdf>
- Jaakkimainen, L., R. Upshur, J. Klein-Geltink, A. Leong, S. Maaten, S. Schultz and L. Wang. 2006. *Primary Care: A Practice Atlas*. Toronto: Institute for Clinical Evaluative Sciences.
- Macinko, J., B. Starfield and L. Shi. 2003. "The Contribution of Primary Care Systems to Health Outcomes within Organization for Economic Cooperation and Development (OECD) Countries, 1970–1998." *Health Services Research* 38: 831–65.
- O'Connor, P.J., J. Desai, W.A. Rush, L.M. Cherney, L.I. Solberg and D.B. Bishop. 1998. "Is Having a Regular Provider of Diabetes Care Related to Intensity of Care and Glycemic Control?" *Journal of Family Practice* 47: 290–97.
- Oster, A. and A.B. Bindman. 2003. "Emergency Department Visits for Ambulatory Care Sensitive Conditions: Insights into Preventable Hospitalizations." *Medical Care* 41: 198–207.
- Protti, D. 2005. *IT in General Practice: A 10-Country Comparison*. Ottawa: Canada Health Infoway. Retrieved September 4, 2006. <http://www.cma.ca/index.cfm/ci_id/49047/la_id/1.htm>
- Saultz, J.W. and J. Lochner. 2005. "Interpersonal Continuity of Care and Care Outcomes: A Critical Review." *Annals of Family Medicine* 3: 159–66.
- Schillinger, D., K. Grumbach, J. Piette, F. Wang, D. Osmond, C. Daher, J. Palacios, G.D. Sullivan and A.B. Bindman. 2002. "Association of Health Literacy with Diabetes Outcomes." *Journal of the American Medical Association* 88: 475–82.
- Shi, L., B. Starfield, J. Xu, R. Politzer and J. Regan. 2003. "Primary Care Quality: Community Health Center and Health Maintenance Organization." *Southern Medical Journal* 96: 787–95.
- Starfield, B. 1991. "Primary Care and Health: A Cross-National Comparison." *Journal of the American Medical Association* 266: 2268–71.
- Starfield, B., L. Shi, A. Grover and J. Macinko. 2005. "The Effects of Specialist Supply on Populations' Health: Assessing the Evidence." *Health Affairs* Suppl Web Exclusives: W5-97–W5-107.
- Starfield, B., L. Shi and J. Macinko. 2005. "Contribution of Primary Care to Health Systems and Health." *Milbank Quarterly* 83: 457–502.
- Statistics Canada. 2003. *Canadian Community Health Survey 2.1*. Ottawa: Author. Retrieved September 4, 2006. <<http://www.statcan.ca/Daily/English/040615/d040615b.htm>>
- Statistics Canada. 2005. *Canadian Community Health Survey 3.1*. Ottawa: Author. Retrieved September 4, 2006. <http://cansim2.statcan.ca/cgi-win/CNSMCGI.EXE?&Lang=E&ArrayId=105-0458&Array_Pick=1&Detail=1&ResultTemplate=CII/CII___&RootDir=CII/>>
- Tugwell, P., D. de Savigny, G. Hawker and V. Robinson. 2006. "Applying Clinical Epidemiological Methods to Health Equity: The Equity Effectiveness Loop." *BMJ* 332: 358–61.

The Reform of Health and Social Services in Quebec



EQUITY

David Levine, BENG, MPhil, MAS
President and Chief Executive,
Agence de la santé et des services sociaux de Montréal
≈

Introduction

Quebec is undergoing a healthcare revolution (Levine 2005). With the passage of Bill 25 in 2003 and Bill 83 in 2005, the Government of Quebec introduced potentially profound reforms to the province's healthcare system. In this paper I examine these changes and identify some of the strategic levers that support them and increase the probability of their success.

The Reforms

Quebec's healthcare reform has four main objectives:

- Improving the population's health and well-being
- Distributing services equitably

- Facilitating the use of services
- Managing vulnerable patients' care

Two principles guide the reforms: population-based responsibility and the hierarchical provision of services.

Population-Based Responsibility

Quebec is divided into 17 healthcare regions. Each one has an agency responsible for ensuring the health and well-being of its population and for managing the primary and secondary health and social services delivered in its jurisdiction (regional or national organizations provide tertiary care and specialized services). Each regional agency is also responsible for ensuring patient access to care, no matter where that care is delivered.

Hierarchical Provision of Services

The Quebec system distinguishes between primary and secondary care services and the more specialized services offered in regional or tertiary care centres. This distinction is essential for determining which services will be provided close to the population being served and which will be provided in more resource-intensive specialized centres. It also underlies the concept of corridors of service, which are defined so that local, region-based centres can directly access more complex services without the random shopping around by physicians that presently occurs.

Structural Changes

Adhering to the principles of population-based responsibility and the hierarchical provision of services, the Quebec government created a new organizational form: the Health and Social Services Centre (HSSC). While variations exist, especially in Montreal, the basic HSSC structure entails the merger of one or more local community service centres, long-term care facilities and an acute care hospital. Across the province there are 95 HSSCs, each responsible for a specific territory and population (there are 12 centres on the island of Montreal – see <http://www.cmis.mtl.rtss.qc.ca>).

Bill 25 changed the mandate of regional health boards from being planning organizations to assuming responsibility for managing, coordinating and delivering healthcare in their regions. Each new regional health agency (e.g., Montreal Health and Social Service Agency) has a board nominated by the provincial minister of health and a president and chief executive officer (CEO) appointed by an order in council. The first mandate of these agencies was to determine the HSSCs that were needed in their regions and to make recommendations to the minister of health.

The mandate of each HSSC reflected their new responsibilities:

- To evaluate the health and well-being of their populations and determine their healthcare service needs
- To coordinate the use of healthcare services by their populations
- To manage the healthcare services they offered
- To develop integrated local care networks

Figure 1 illustrates the local care network form (Ministère de la santé et des services sociaux 2004). These networks connect care providers as well as other health and social service partners (e.g., local pharmacies, schools, community groups and social clubs). They are the cornerstone of efforts to ensure access to, and continuity of, services.

Strategic Levers

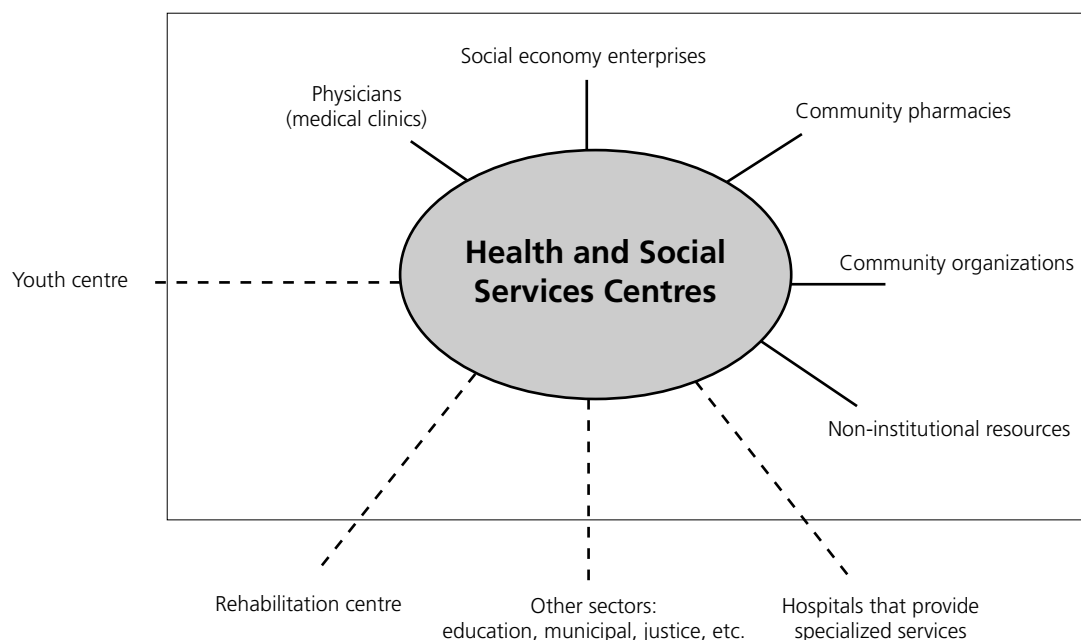
Between 2004 and 2006, Quebec's HSSCs established a new organizational structure by integrating activities and developing an appropriate management model. In Montreal, we designated the following criteria as essential for a high-performing healthcare system:

- Timely access to the different levels of care required
- Continuity in the provision of services
- Optimal use of available human, technological and financial resources
- Application of evidence-based practices, both clinical and managerial

Managed care (with its constituent elements) and performance measurement are our main strategic levers necessary for accomplishing these goals.

Managed Care

Montreal's approach to managed care was informed by models from Kaiser Permanente (2005); the United States Veterans Health Administration (Petzel 2006; Jha et al.,

Figure 1. Integrated local care networks

2003); the Puget Sound Project (Davis 2006, 2007; The Commonwealth Fund 2006; Puget Sound Center); primary care trusts in England (British Medical Association 2006; Roland et al. 2005; National Health Service); and primary care teams in Barcelona, Spain (Deuxième Colloque 2006). It has three major components:

- A population-based model
- A chronic care model
- Service management redeployment

Population-Based Model

Knowing the state of health of a given population is an essential part of a population-based model. Significant effort was therefore made to help each of Montreal's HSSCs learn about their populations. Using Statistics Canada census data as well as information obtained through local sources (e.g., <http://www.cmis.mtl.rtss.qc.ca>), the agency's public health team prepared a portrait of each HSSC population in the region. These portraits provide data on

socio-economic status, education level, and service consumption, as well as information on housing, immigration, and community organizations. Lifestyle data are also available for each area, including, for example, tobacco consumption, levels of physical activity and obesity rates. The data also define at-risk populations and highlight critical social issues such as homelessness and prostitution. These data are updated every two years and health-improvement targets are set for each HSSC and the Montreal agency as a whole. This information is also used to ensure equitable funding according to the specific needs of each population.

Chronic Care Model

Ed Wagner's Chronic Care Model (Wagner 1995, 1998; Wagner et al. 1996a, 1996b; Wagner et al. 1999) was adopted in order to manage the care of chronically ill patients and those at risk of developing a chronic illness. This model comprises four main components:

1. Chronic care protocols for each disease and involvement of family physicians in their application and follow-up
2. Patient self-management through education and support networks necessary to accomplish that goal
3. Multidisciplinary primary care teams or access to such teams by family physicians, including seamless access to secondary and tertiary services as well as all corridors of service for diagnosis and treatment
4. Information systems that support electronic medical records, chronic disease registers and diagnostic and treatment decision-support tools

The Montreal agency also established a close working relationship with the research team at the University of Montreal involved in chronic disease treatment. The agency also created a consortium that includes the CEOs of the 12 HSSCs and the agency's public health team. Four projects are now being examined for possible implementation.

Service Management Redeployment

Under the new integrated approach, it is necessary to ensure that the management of primary- and secondary-level services falls as much as possible under each HSSC's jurisdiction and that each centre also coordinates access to tertiary and other specialized services.

In this respect, the first major reorganization of services undertaken by the Montreal agency dealt with the provision of primary mental health services (Trépannier 2006). Almost 95% of the \$325 million spent annually on mental health in Montreal is managed by five psychiatric hospitals and four psychiatry departments based in teaching hospitals. The plan currently being executed involves the transfer of \$48 million worth of mental health services to the city's 12 HSSCs. Primary mental health services will thereupon

be offered in collaboration with primary care physicians in each territory. Similar reorganizations are being implemented for long-term care admissions, rehabilitation and subacute care services, public health programs and services for the intellectually handicapped.

Montreal's regional agency has also joined with its hospitals to study whether the implementation of a citywide laboratory service with a single dedicated specimen transport system and a single information system would improve accessibility and lower costs. Under such an arrangement, specialized analyses would be regrouped while ensuring hospitals' capacity to undertake immediate diagnostic work.

Performance Measurement

Performance measurement, which includes the ability to adjust practices when targets are not reached, is a second critical strategic lever for developing and maintaining a high-performing health system. This is true at the levels of both population health and professional activity. An example of the latter is the Quality and Outcomes Framework used by the United Kingdom's (UK's) health system and the British Medical Association to measure and pay physicians for the work they do (Department of Health 2004). Under this system, physicians are awarded points for achieving clinical and operational targets and are then remunerated for the points accumulated. These measurements help to orient the model of managed care in the UK and to maintain a certain uniformity of practice.

In addition to clinical performance measurements, there are the administrative measurements designed to ensure, for example, timely access, appropriate surgical wait times and emergency room efficiency. These measurements allow for better allocation of resources to services that require more support. Likewise, quality measurements – at both the clinical and administrative levels

– must also become part of an organization’s culture. Such measurements, which include patient satisfaction, are critical for ensuring standards are met and that feedback information can be integrated into reform initiatives.

The Montreal agency signs performance contracts with its regional HSSCs. These contracts are monitored throughout the year to ensure compliance.

Primary Care

Montreal has over 2,000 general practitioners (GPs) operating out of 400 private offices. As increasing numbers of walk-in clinics appeared, many physicians decided to work one or more shifts in these clin-

“... measurements, which include patient satisfaction, are critical for ensuring standards are met and that feedback information can be integrated into reform initiatives.

ics, which provide little or no follow-up care to the patients they see. As a result, many Montrealers report they do not have a family physician; indeed, it is almost impossible today to find a GP willing to accept new patients. Compounding this problem, GPs’ difficulty accessing timely diagnostic services for their patients or obtaining specialist consultations for them has also led to high degrees of dissatisfaction among both patients and physicians.

In a comparison with Kaiser Permanente, Montreal was found to have twice the number of emergency room visits per capita. To correct this situation and provide the medical support and coverage needed to manage Montrealers’

healthcare needs, a new primary care model was proposed. The Quebec government offered financial incentives to physicians who were willing to create new family medicine groups (FMGs), new organizational forms that exemplify the government’s integrative approach to health services. FMGs register 1,500 patients per full-time equivalent (FTE) physician (between 8 and 12 physicians belong to each one). FMG physicians commit to providing a full array of medical case management services to clients who have chosen to register with them. Services are provided with or without an appointment, seven days a week. FMGs also include extended nursing services totalling 70 hours of availability a week (Émond et al. 2005).

In Montreal, network clinics were also supported by the Montreal agency, which provided financial support to physicians who formed FMGs, agreed to provide services seven days a week and offered as many hours of services for patients with appointments as for those without (Agence de Santé de Montréal 2006).

To date, 33 new FMGs have been established in Montreal, and it is now necessary to move to the next stage in the development of primary care. This involves creating primary care multidisciplinary teams – or integrated network clinics – that will be capable of registering 2,000 patients per FTE physician and ensuring availability of a team of professionals and support staff to manage each patient’s healthcare needs (Jodoin 2007). Within 10 years, it is anticipated that Montreal will have developed 60 such multidisciplinary teams, each covering the healthcare needs of 30,000 people. These teams will sign funding contracts with their local HSSCs. The contracts will also encompass guaranteed access to diagnostic services, specialist consultation, subacute care and rehabilitation services, access to home care and treatments

Figure 2. The programs through which funding is provided

Program Types	Programs
Population programs	Public health
Service programs	General (clinical and assistance) and front-line medical services
Programs designed to address specific problems	<ul style="list-style-type: none"> • Loss of autonomy due to aging • Physical impairment • Intellectual impairment and pervasive developmental disorders • Troubled youth • Addiction • Mental health • Physical health
Support programs	<ul style="list-style-type: none"> • Administration and support for services • Building and equipment management

required by patients that the teams themselves are unable to provide.

Management Contracts

One of the most important elements of healthcare reform in Quebec has been the introduction of management contracts (i.e., accountability agreements) between the health ministry and the province’s regional agencies and the contracts signed between each agency and the organizations providing services in their jurisdictions. This contractualization has legitimized the regional agencies’ authority and has defined the management responsibilities of the partner organizations in terms of clear objectives. Indeed, these mandatory agency–organization contracts, which enable the regional agencies to honour their own management contracts with the provincial government, are the most important health system management tools in Quebec.

Contracts provide a formal method to monitor development on an annual basis and to measure the performance of regional services. In addition, they serve as an agreed-upon checklist of objectives, and it is hoped they eventually will include population-health outcomes. Contracts also provide a more uniform and equitable way for regional authorities to manage provider organiza-

tions, and they can be used to track production levels as well as the extent to which new orientations and policies are implemented.

Contracts can also be used as platforms for discussion between a regional agency and the organizations providing services to it. A contract allows each organization to identify the projects and programs that an agency agrees to support, while allowing an agency to define performance measures.

To succeed, Quebec’s health system reformation – including the development of population-based responsibility – requires a shared and sustained effort. Management contracts, for example, must be regarded as genuinely two-party agreements that benefit both sides. Equal partners make the best agreements and, while the situation does not allow for absolute equality, the contract negotiation process must attempt to provide all opportunities possible for objective exchange and discussion.

Conditions for Success

Equity Funding

Ensuring equitable resource allocation or equity funding requires a population-based funding formula. Each of Quebec’s 17 regions is evaluated using population-based criteria to determine its particular health needs. Funding

is provided through 11 programs (Figure 2) and resource allocation is determined according to each region's population; the services provided to people from outside a region are also considered. Data include socio-economic statistics and historical consumption patterns.

The provincial government's introduction of a new funding formula in 2003 proposed a reduction in funding of \$221 million for Montreal. Other regions, mainly urban areas, likewise saw their funding decrease, while in more rural areas funding increased. In order to implement this new formula gradually, it was decided that all transfers would be made exclusively from new development money and that any regions transferring funds outside of their jurisdictions would have to achieve greater productivity in order to ensure their own development. Given that the long-term collection of population-health data is needed to guarantee equitable funding among a region's HSSCs, all parties agree that it will be a number of years before the formula will be finalized.

Purchasing Access

Access has become one of the most visible measures of a high-performing healthcare system and the one that is most talked about in the media and by government. Wait times for surgery, emergency room consultation, diagnostic tests, specialist consultation and radiation therapy are just some of the issues making the headlines. The Supreme Court of Canada recently ruled that Quebec could not prevent private insurers from offering healthcare services if public institutions were unable to provide timely care in response to medically necessary services. This ruling has led Quebec to offer wait time guarantees and to allow the private purchase of medical services if wait times are not respected.

The most important, yet often least mentioned, form of access is the ability to see a family physician. While one might wait up

to five hours to see a GP for a five-minute consultation, access to one's family physician is frequently much more limited and often requires setting an appointment months in advance. The Kaiser Permanente model ensures a scheduled visit within 48 hours and an urgent scheduled visit the same day. This is achieved through the use of a multi-disciplinary team responsible for a group of patients (although each patient has his or her own family physician on the team). Access to diagnostic services is arranged by the team through a central booking system.

In Montreal, access to family physicians is being addressed by financially supporting the development of the FMGs I discussed earlier. The number of admissions to medical schools has also been increased and new curricula based on a team approach are in development. Recently, negotiated fee-for-service formulas have included bonuses for registering patients, registering and treating vulnerable patients, taking on management tasks and spending time discussing cases with other professionals.

Access to timely surgical intervention is receiving a lot of public and government attention, and the government made new money available to reduce wait times using a two-pronged approach. The first method involved designing a wait list system that ensures such lists are appropriate and centralized. Each hospital named a person responsible for managing its wait list and contacting patients and, when the guaranteed wait time could not be met, helping patients find alternatives. The wait time management program is administered by each regional agency with the support of the hospitals' information systems. The second step involves increasing the number of surgical interventions in those areas where wait times are beyond the norm. Regional agencies are responsible for this initiative. In Montreal, we issued a request for proposals and awarded new surgical volumes

to those hospitals that offered the highest quality, lowest-cost service. We encouraged high volumes and regrouped services such as cataract surgery and hip and knee replacement into high-volume services. These endeavours have proven successful: in some cases wait times have been cut in half, while costs have dropped significantly.

Family physicians frequently complain of lack of access to diagnostic services, a problem that is frustrating for patients as well. Important investments have recently been made in increasing the system's capacity, especially for MRI and CT scans; however,

In an effort to create more efficient, easily accessible, and comfortable healthcare environments, Quebec passed a new law that would allow the creation of private affiliated medical centres

there are many other areas, such as ultrasound, that are not easily accessible. Establishing a strong link between GPs and access to diagnostic services is key to successful healthcare management. As FMGs are established, they are linked to diagnostic centres that must ensure services in a timely manner.

In an effort to create more efficient, easily accessible, and comfortable healthcare environments, Quebec passed a new law that would allow the creation of private affiliated medical centres (Government of Quebec 2006). These are affiliated with hospitals in which the medical centres' physicians are members of the hospitals' medical advisory councils. Each centre will be permitted to

provide services that, under the Canada Health Act, are not allowed outside the organized care system. These private centres will not be allowed to charge patients for interventions but must negotiate a volume of activity from their local HSSCs. Each centre will need to be accredited by its regional agency and its affiliated hospital(s) will be responsible for quality of care.

Conclusion – The Key Ingredients of Success

I have attempted to illuminate some of the levers that the Quebec government and the Montreal Health and Social Service Agency are using to develop a high-performing healthcare system. The reform process began with a system-wide set of changes that reorganized services on a population basis. This step was followed by an integration of services aimed at providing more efficient care delivery. Last, steps were taken to focus on the health and well-being of individuals and communities by giving specific mandates to HSSCs across the province.

The success of these reforms depends upon physicians and other healthcare professionals making a significant cultural shift. It also requires strong health system leadership to promote the vision of this widespread transformation and to guide its implementation.

References

- Agence de Santé de Montréal. 2006. *Cadre de Référence pour l'Implantation des Cliniques-Réseaux*. Retrieved February 28, 2007. <http://www.santemontreal.qc.ca/pdf/cma_cadre.pdf>
- British Medical Association. 2006. *Revision to the GMS Contract 2006/2007: Delivering Investment in General Practice*. London: NHS Employers.
- Commonwealth Fund. 2006. "The Puget Sound Health Alliance: Bringing Together Purchasers, Payers, Providers, and Consumers to Change the System." *States in Action: A Quarterly Look at Innovations in Health Policy*. New York: Author. Retrieved February 28, 2007. <<http://www.cmwf>>

- org/publications/publications_show.htm?doc_id=410531#puget>
- Davis, K. 2006. "President's Message: The Best Health System in the World." *2006 Annual Report of The Commonwealth Fund*. New York: The Commonwealth Fund. Retrieved February 28, 2007. <http://www.cmwf.org/usr_doc/Pres_Message_2006_FINAL_small_file.pdf>
- Davis, K. 2007. "Models for Achieving the Best Health System in the World." Retrieved February 28, 2007. <http://www.cmwf.org/aboutus/aboutus_show.htm?doc_id=444193>
- Department of Health. 2004. *Quality and Outcomes Framework*. London: Author. Retrieved February 28, 2007. <<http://www.dh.gov.uk/assetRoot/04/08/86/93/04088693.pdf>>
- Deuxième Colloque sur le Modèle Montréalais de Prise en Charge de la Population. November 30–December 1, 2006. Retrieved February 28, 2007. <<http://www.santemontreal.qc.ca/fr/documentation/colloque.html>>
- Émond, J.-G., J. Pettigrew, C. Côté, J. Lalancette, D.L. Sasseville, A. Mageau, A. Munger, C. Plourde and L. Racette. 2005. *Devenir un GMF: Guide d'Accompagnement*. Rev. ed. Quebec: Ministère de la Santé et de Services Sociaux.
- Government of Quebec. 2006. *Projet de Loi no 33: Loi Modifiant la Loi sur les Services de Santé et les Services Sociaux et d'Autres Dispositions Législatives*. Quebec: Éditeur Officiel du Québec. Retrieved February 28, 2007. <<http://www2.publications-duquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=5&file=2006C43F.PDF>>
- Jha, A.K., J.B. Perlin, K.W. Kizer and R.A. Dudley. 2003. "Effect of the Transformation of the Veterans Affairs Health Care System on the Quality of Care." *New England Journal of Medicine* 348(22): 2218–27.
- Jodoin, Y. 2007. *Cadre de Référence de la Clinique Réseau Intégrée et Relatif au Modèle Montréalais de Prise en Charge – Document de Travail*. Montreal: Agence de Santé de Montréal.
- Kaiser Permanente. November 28, 2005. Papers presented at the conference La Prise en Charge de la Population: Quel Modèle pour Montréal? In *Les Actes: La Prise en Charge de la Population: Quel Modèle pour Montréal? Journée de Réflexion sur la Prise en Charge de la Population Montréalaise, 28 novembre 2005*. Retrieved February 28, 2007. <<http://www.bibliotheque.assnat.qc.ca/01/mono/2006/04/900545.pdf>>
- Levine, D. 2005. "A Healthcare Revolution: Quebec's New Model of Healthcare." *Healthcare Quarterly* 8(4): 38–46.
- Ministère de la santé et des services sociaux. 2004. *L'Intégration des Services de Santé et des Sociaux: Le Projet Organisationnel et Clinique et les Balises Associées à la Mise en Oeuvre des Réseaux Locaux des Services de Santé et de Services Sociaux*. Quebec: Author.
- National Health Service. "Primary Care Trusts." Retrieved February 28, 2007. <<http://www.nhs.uk/England/AuthoritiesTrusts/Pct/Default.aspx>>
- Petzel, D. October 5, 2006. "Health System Transformation." Paper presented at the GRÉAS conference, Montreal. Retrieved February 28, 2007. <<http://www.greas.ca/publication/pdf/robertpetzel.pdf>>
- Puget Sound Center. Retrieved February 28, 2007. <<http://www.pugetsoundcenter.org>>
- Puget Sound Health Alliance. Retrieved February 28, 2007. <<http://www.pugetsoundhealthalliance.org/index.html>>
- Roland, M., R. McDonald and B. Sibbald. 2005. *Outpatient Services and Primary Care: A Scooping Review of Research into Strategies for Improving Outpatient Effectiveness and Efficiency*. Manchester: National Primary Care Research and Development Centre and Centre for Public Policy and Management of the University of Manchester.
- Trépannier, J. 2006. *Cadre de Référence: Mise en place des Équipes de Santé Mentale de 1re Ligne dans les CSSS – Plan de Mise en Oeuvre à Montréal, Phase 1*. Montreal: Agence de Santé de Montréal. Retrieved February 28, 2007. <<http://www.santemontreal.qc.ca/fr/documentation/nouveaute.asp>>
- Wagner, E.H. 1995. "Population-Based Management of Diabetes Care." *Patient Education and Counseling*. 26(1–3): 225–30.
- Wagner, E.H. 1998. "Chronic Disease Management: What Will It Take to Improve Care for Chronic Illness?" *Effective Clinical Practice* 1(1): 2–4.
- Wagner, E.H., B.T. Austin and M. Von Korff. 1996a. "Improving Outcomes in Chronic Illness." *Managed Care Quarterly* 4(2): 12–25.
- Wagner, E.H., B.T. Austin and M. Von Korff. 1996b. "Organizing Care for Patients with Chronic Illness." *Milbank Quarterly* 74(4): 511–44.
- Wagner, E.H., C. Davis, J. Schaefer, M. Von Korff and B. Austin. 1999. "A Survey of Leading Chronic Disease Management Programs: Are They Consistent with the Literature?" *Managed Care Quarterly* 7(3): 56–66.

Balancing Equity Issues in Health Systems: The Example of Vancouver Coastal Health



EQUITY

Ida Goodreau

President and Chief Executive Officer, Vancouver Coastal Health



Introduction

Canada's public health system is committed to providing necessary healthcare services to all Canadians. This principle is so simple – as well as morally and practically appealing – that it has become embedded as a fundamental part of what it means to be Canadian. It is, of course, much more complex to follow through on the principle than to support its philosophy.

An ideal world would be one in which the need or demand for health services were fully matched by resources and the system's capacity to deliver desired activities. However, as we all know this ideal state does not exist in any public healthcare system in the developed world. This gap between ideals and reality gives rise to the challenge of allocating scarce resources so as to fulfill “most-needed” services.

At the health system delivery level, this

drama is played out every day – nowhere more so than in the territory overseen by Vancouver Coastal Health (VCH). In this region, Canada's highest per-capita income postal code lies within a few kilometres of the Downtown Eastside, the country's lowest per-capita income postal code. VCH staff decisions about who receives care and how much, and – perhaps more importantly – who does not, are in constant and stark relief.

British Columbia's Health Authorities

In 2001, the British Columbia (BC) government created a regional healthcare delivery structure by forming six health authorities across the province. This restructuring was motivated by the belief that integrating public healthcare services would result in improved quality outcomes and greater efficiencies.

Rather than focusing on just hospitals, residential care beds or community clinics, policy-makers argued that a regional system would break down silos and allow a continuum-of-care approach. Under this new system, early detection, treatment and ongoing disease management would be coordinated across

VCH staff decisions about who receives care and how much, and – perhaps more importantly – who does not, are in constant and stark relief.

a continuum supported by evidence-based practices, accepted protocols and pathways and multidisciplinary teams. The intent was to bring a more holistic approach focusing on the “whole” human being rather than fragmented care characterized by redundancy and the hand-off of patients between practitioners.

As one of BC’s health authorities, VCH’s mandate is “To improve health outcomes for the people we serve through appropriate care, education and research.” Particular emphasis is placed on three objectives:

- Increasing quality of life and longevity through high-quality medical and clinical care
- Improving the patient experience through increased access, responsiveness and support
- Promoting informed choice, self-care and self-responsibility

Demand and Supply

The regional structure is an important component in addressing the imbalance

between demand and supply in healthcare delivery. In itself, however, it clearly is not the solution. Given that there are two elements to the equity challenge (i.e., too much demand and/or too little supply), finding a balance implies adjusting or rationing one or the other element – or, more usually, both. The strategy for on-the-ground healthcare deliverers, then, involves both a quest to define and optimize the need for healthcare services and a rigorous improving of the efficiency of how those services are delivered.

The demand for healthcare services continues to grow at a rate that exceeds the expectations of Canadian governments and the public. Wait lists, delays and access issues are symptomatic of demand not being fully met, despite growth in funding levels in excess of 6% per annum in most jurisdictions. The following factors influence demand for services:

- Population growth
- Population aging
- New treatments and technologies
- The health status of the populations served
- Other non-medical factors:
 - Economy
 - Employment
 - Housing
 - Education
 - Culture

Across Canada the expanding and aging population can be predicted with relative accuracy and represents an annual growth factor of between approximately 1.5% and 2.5%. It has proven much more difficult to make accurate forecasts for new treatments and technologies – areas that have seen much greater increases. In BC, for example, the number of hip and knee replacements rose from 2,430 procedures in 1991 to 4,775 in 2005. Less than 15% of that increase can be

attributed directly to population growth and aging. Improvements in outcomes, length of stay, technology/treatment and surgeon proficiency were the biggest growth drivers (Ministry of Health, Health Economics and Analysis, Information and Modernization Branch 2007).

In a system in which demand exceeds supply, rationing becomes a time-honoured and sometimes desperate response. All health authorities and healthcare providers put enormous effort into initiatives that will avoid the need to ration services. On the demand side, strategies include the following:

- Continuum-of-care design, including chronic disease management, prevention, early detection, appropriate primary care and community-based care, including rehabilitation and home support
- Evidence-based practices guided by outcomes
- Adoption of new discoveries, therapies and treatments
- Individual self-care and self-responsibility
- Initiatives to reduce hospital admissions and re-admissions
- Timely access to diagnosis and assessment
- Streamlined navigation through the healthcare system
- Partnerships with other organizations that entail housing, income assistance and education

These strategies must accompany improved efficiencies and optimization of the supply or delivery side of the healthcare system.

Resource Allocation

Over the past decade, a concerted effort has been made across Canada to create a public healthcare system that is more efficient, costs less and is more effective. To achieve these goals, many public health providers have

adopted private sector best practices aimed at delivering more services for the funding provided. Among the most important and frequent measures undertaken, hospitals and health authorities have consolidated sites and activities, altered supply-chain logistics, adopted “lean” and “quality” redesign techniques, introduced patient-flow modelling and scenarios, outsourced to the private sector and improved costing and performance systems.

Despite these efforts, the reality for most public health providers is that the demand for services still outstrips the capacity to deliver. Therefore, decisions must be made regarding how and where to allocate funds and resources more effectively.

Resource Allocation Decision-Making

Resource allocation decisions are usually made at two levels. The first is at the level of government policy, where regulations, legislation and political directives determine public priorities and, frequently, where funds are directed. Federal-provincial agreements on waitlist times for selected surgeries and other procedures, and decisions regarding approvals of – and funding for – new, experimental and often high-cost drugs are recent high-profile examples of such resource allocation decisions.

From a broader perspective, healthcare provider structures and governance systems constitute the second level at which resource allocation decisions are made. In BC, funding for health authorities is largely based on a population needs-based funding (PNBF) formula. The strategic intent of this type of funding, as opposed to activity-based funding, is to create incentives for health authorities to provide the most appropriate and cost-effective services. The PNBF formula incorporates a per-capita dollar amount, with adjustments for age and socio-economic status. In many cases, it promotes greater investment in prevention, chronic disease management

and community-based services. The formula fosters a continuum-of-care approach and penalizes higher per-capita hospitalizations, re-admissions as well as in-patient and in-hospital procedures.

PNBF challenges policy-makers to find ways to generate incentives and discipline in order to bring about more efficient and lower-cost procedures. For example, it raises the issue of whether it is even possible to foster competition between hospitals and clinics that are likely to be awarded larger volumes of surgeries or diagnostic procedures on the basis of lower costs and greater productivity.

Performance Measurement

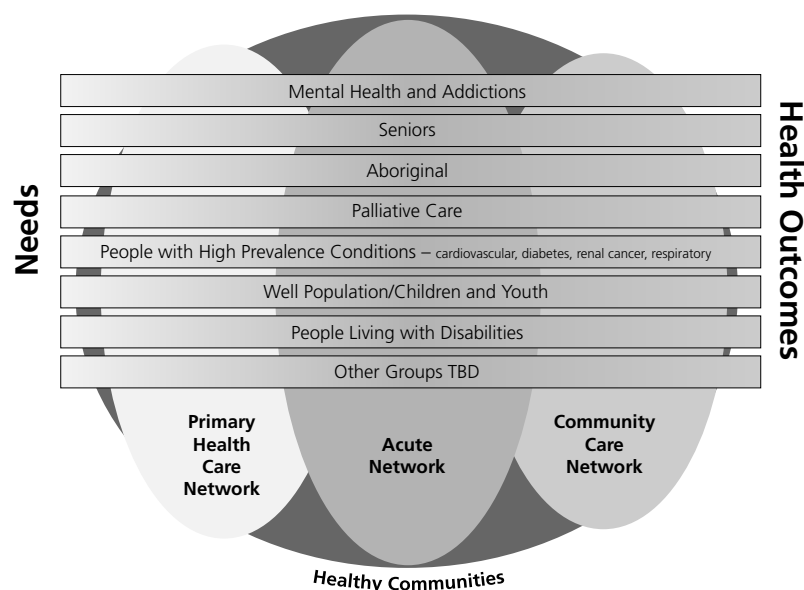
The other side of the funding picture is deciding which services or outcomes will be delivered. In BC, the Ministry of Health and health authorities are governed by a structure of contracts and agreements that spell out the provincial government's expectations for the performance to be delivered. The agreements include performance metrics that address quality, access, outcomes and improvement targets as well as a requirement for balanced budgets. Within these parameters, health authorities must develop strategies and plans that encompass health outcomes for the populations they serve and efficiencies that optimize available resources.

Benchmarks and comparative standards are important tools for making resource allocation decisions. These instruments help health system planners decide where resources should be focused and support healthcare

organizations in a process of continuous improvement. Figure 1 shows that at VCH a continuum-of-care strategy has guided planning and investment since its creation in 2001. The main elements of this strategy are:

- A focus on health outcomes by providing the most appropriate services/treatments designed to ensure optimal quality of life and longevity
- Optimal healthcare delivery that crosses traditional boundaries

Figure 1. VCH continuum of care



- Timely evidence-based care and best practices
- Focus on the health of whole population groups
- A multidisciplinary team approach
- Patient involvement in care and prevention

Performance indicators and measures that provide discipline and rigour across the organization support VCH's plans and initiatives related to the continuum of care. These

indicators and measures are captured in a balanced scorecard system that is reviewed at all levels, including VCH's board and senior executive team. They are presented at quarterly public board meetings and posted on our

“... it raises the issue of whether it is even possible to foster competition between hospitals and clinics that are likely to be awarded larger volumes of surgeries or diagnostic procedures on the basis of lower costs and greater productivity.”

Web site (www.vch.ca). Most importantly, they are used to provide direction and support for prioritization and improvement across the care continuum.

Given that the impact of interventions on outcomes often occurs years or even decades after an investment has been made, measures that focus on outcomes are the most challenging. Outcome measures considered by VCH include the following:

- Potential years of life lost for target populations
- Post-neonatal mortality rate
- Re-admissions for target populations (e.g., mental health, congestive heart failure)

Other indicators and measures focus on efficiencies and resource utilization. They include comparative measures designed to identify opportunities to exchange best practices among health providers in other parts of BC, Canada or the world. These include:

- Acute beds per capita
- Number of surgical cases per capita
- Residential care days per capita
- Alternate level of care days in hospitals
- Average length of stay (acute and rehabilitation)
- Number of cancellations
- Operating room and post-anaesthetic recovery productivity
- Cost per case/activity

Access is another key issue that can negatively impact health outcomes, workflow and costs. Waittime measures include the following:

- Emergency department measures, including the Canadian Triage and Acuity Scale (CTAS) measures and decision to admit
- Wait times for key surgical procedures, including hips, knees, oncology and cardiac care
- Wait times for diagnostic procedures
- Community care placements in residential care facilities
- Mental-health clients receiving follow-up within 30 days of discharge

Indicators also encompass the following public health and primary care effectiveness measures:

- The proportion of people experiencing difficulties in obtaining care
- The proportion of chronic diabetes patients receiving appropriate care (e.g., diabetes patients with HbA1C <7.0)
- The percentage of the population that is overweight or obese
- The percentage of the population that smokes

These indicators and measures help VCH to determine priorities, which then drive

resource allocation decisions. Within our health authority, a population health approach supports the goal of equity. Appropriate indicators and measures provide guidance and direction to support investments in services and activities. They also highlight areas of opportunity for improved efficiency and best-practice transfer.

Sustainability

While supply and demand pressures in the public health system are well recognized and much work is underway to find a balance

“Public debate and policy development are required to define what the public healthcare system can – and will – provide, as well as how services will be funded.

between the needs of the population and the system’s capacity to meet them, a third – equally critical – element must also be addressed. That element is sustainability. The demands on the healthcare system in the future – driven primarily by an aging population and new technologies and treatments – will outstrip the potential for efficiencies and improvements to absorb these additional requirements. Public debate and policy devel-

opment are required to define what the public healthcare system can – and will – provide, as well as how services will be funded. The dual questions of “what will be provided?” and “who will pay?” must be addressed in the coming new world of geriatric baby boomers.

Even in the shorter term, critical issues pertaining to sustainability require higher priority than they currently receive in most Canadian jurisdictions. Human resource shortages and lack of investment in information technology and infrastructure threaten the future viability of our health system. More and more frequently, particularly in larger centres, key issues are a lack of beds and surgical capacity. These issues are driven not by a shortage of funds but by a shortage of nurses and other healthcare professionals.

As we look toward the decades ahead, there appear to be many opportunities for vastly improved health outcomes. It behooves us to ensure that the policy and strategy decisions we make today will not only create a health system that will provide Canadians with the best healthcare possible but also create a system in which we will want to work.

Reference

Ministry of Health, Health Economics and Analysis, Information and Modernization Branch. *Discharge Abstract Database (DAD)*. Victoria: Author. Consulted April 2007.

STRATEGIC PURCHASING

Healthcare*Papers*

Strategic Purchasing to Improve Health System Performance: Key Issues and International Trends¹



PURCHASING

Reinhard Busse, MD, MPH

Professor and Chair, Department of Health Care Management,
Berlin University of Technology
Associate Head for Research, European Observatory on Health Systems and Policies

Josep Figueras, MD, MSc

Director, European Observatory on Health Systems and Policies

Ray Robinson, PhD

Professor of Health Policy, London School of Economics and Political Science

Elke Jakubowski, MD, MSc

World Health Organization – Regional Office for Europe



Introduction

All health systems exercise some form of purchasing, which, in its most basic form, constitutes the allocation of funds to provider organizations. When purchasing goes beyond the simple reimbursement of products and services and is aligned to societal healthcare needs and wishes, it has the potential to play a key role in determining a health system's over-

all performance. However, no single organizational model of purchasing can, or should, be applied to all health systems. Purchasing arrangements must be determined chiefly by each country's main form of healthcare funding and provision.

Purchasing goes well beyond the mere contracting of providers. It includes the central role played by citizens and their

governments as well as by providers' organizational forms. A central lesson derived from our analysis is that if policy-makers are to achieve their desired results, they need to take a broad systems approach to purchasing and act upon all the various components of the purchasing function. If purchasing is narrowly focused on individual elements such as contracts, payment systems or provider competition, it will not reach its full potential. For instance, the introduction of a new case mix-based payment system to improve efficiency will succeed only if providers can count on the managerial and organizational ability to respond to these new financial incentives and if the health interventions financed through the new payment system are informed by cost and effectiveness evidence and respond to the health needs and priorities of the specific population being served.

A definition of strategic purchasing should reflect this systemic approach. Strategic purchasing aims to increase health system performance through the effective allocation of financial resources to providers. This process involves three sets of explicit decisions:

- Which interventions should be purchased in response to population needs and wishes, taking into account national health priorities and evidence on cost-effectiveness
- How they should be purchased, including contractual mechanisms and payment systems
- From whom they ought to be purchased in light of providers' relative levels of quality and efficiency²

Strategic purchasing should lead to a maximization of overall health gain from available resources (i.e., increased allocative efficiency). It addresses one of the main problems traditionally encountered by health

planners: bridging the gap between plans and the budgetary allocation of resources. For instance, in many tax-funded systems of the national-health-service (NHS) type, separate departments carry out these functions, with national health plans having little influence over the historical and incremental budgetary processes.³ Purchasing theory thus underlies the potential of this function when it is closely linked to the planning process.

This was one of the most important considerations when, in the United Kingdom (UK), Spain, Sweden and other tax-funded systems, the purchaser-provider split was developed and introduced in the early 1990s. Until then, these systems were regarded as integrated systems in which a single organization filled both the third-party payer and provider roles (e.g., the NHS in the UK). If organized at the national level (rather than at the regional level as, for example, in Sweden), these two functions were also intertwined with the ministry of health's regulatory role. Financial resources were typically allocated down the health service hierarchy and providers were under NHS command and control. The purchaser-provider split not only separated the two functions but also made both sides independent of direct (national) government control. The purchasing role was given to regional governments (e.g., in Spain and Italy) or to separate institutions (e.g., in the UK), while providers were transformed into autonomous public entities ("trusts" in the UK). Somewhat later in most of these countries, purchasers also entered into purchasing relationships with other providers, both private not-for-profit and for-profit ones.

The basic NHS relationship between purchasers, providers and the government as steward and regulator has thus become similar to the traditional arrangement of actors in countries with a social health insurance (SHI) system, often termed Bismarckian after the

German chancellor at the time when the first SHI system was introduced by law in 1883. In SHI countries, the role of third-party payers has been delegated to “sickness funds,” which are separate from providers – be they public (typically owned by regional or local governments), private not-for-profit or for-profit. To a varying degree, national (and partly regional) governments regulate and supervise sickness funds and providers, both of which are organizationally separate from the regulating level government (Busse et al. 2004).

As to the question of whether the separation of purchasing and providing will bring net gains, at least in terms of economic efficiency, organization theory highlights a number of important factors. Markets appear to perform well when there is a potential for high competition, when investments do not tie providers to specific purchasers, when complexity and uncertainty are relatively low and when few scale economies apply. The absence of these conditions in healthcare, however, has led attention to shift toward network models. These can involve partnership models, which retain purchaser-provider separation but encourage long-term relationships and integrated decision-making. The relational contracts that are used in most network models rely on trust in order to economize on transaction costs. Network models resonate closely with the political ideas of the “third way,” which has been described as an explicit rejection of both the old centralized command-and-control systems and of divisive market systems. The third way seeks to find a middle path that combines a commitment to social values with some of the benefits believed to flow from an entrepreneurial approach. The obvious question arising from third-way approaches in the healthcare arena is whether the practice of purchasing meets these theoretical expectations.

Citizen Empowerment

A central element in purchasing theory is that a purchaser agent represents the wishes and needs of its citizenry. Strategies for citizen empowerment in purchasing can be grouped under the following four strategies:

- Assessing population health needs
- Ascertaining citizens’ views and values
- Enforcing purchasers’ accountability
- Increasing citizens’ choices

It should be noted at the outset that these strategies are aimed primarily at increasing health systems’ responsiveness but also, to the extent they reflect population health needs, at improving health, equity and allocative efficiency. However, as we note below, this is not always the case and trade-offs between these objectives are usually necessary. One other preliminary consideration here is that, in addition to these mechanisms that strengthen downward accountability to the population, patient empowerment is also achieved through upward accountability of purchasers and providers to health systems’ stewards (i.e., democratically elected governments).

Assessing Population Health Needs

In spite of its widely recognized importance, health needs assessment is not routinely carried out in many health systems; when it exists, it is not always incorporated into purchasing decisions. These shortcomings are due to a variety of reasons, including the general deficiency of the public health function in many countries, the non-geographically delimited coverage of many purchasers (e.g., sickness funds in many SHI countries) and the scarcity of public health skills in purchasing organizations, particularly those with small population coverage. Above all, they reflect the lack of structural or functional

integration of the public health function within purchasing. This function seems to work better in NHS systems in which coordination or integration between public health and purchasing is more straightforward; however, in some NHS countries there is still a virtual absence of health needs assessment. In spite of the inherent difficulties in SHI systems that, for instance, compartmentalize preventive and curative activities, the introduction of some innovative structures (e.g., in France) allowing for formal coordination between actors has met with positive results (Sandier et al. 2004).

Ascertaining Citizens' Views and Values

Purchasers' decisions often do not reflect their societies' values. There are, however, a number of innovative experiences in Norway, Sweden, the Netherlands and the UK on which one can draw in order to include citizens' views when deciding which services to provide (Mossialos and Maynard 1999). These examples are not exempt from complexity. For instance, citizens' participation in determining packages of care has proven to be problematic. Citizens are frequently averse to reducing care priorities and their views often lack consistency. In addition, we should take into account the fact that the influence of social values on purchasing priorities does not necessarily increase equity and allocative efficiency; as a consequence, trade-offs are at times necessary.⁴

Enforcing Purchasers' Accountability

There are four ways in which purchasers can be made accountable to their populations:

- Formal representation
- Statutory establishment of packages of care
- Patients' rights legislation
- Complaint mechanisms

The formal representation of consumers in purchasing organizations is commonplace in many European countries. The challenge lies in determining which group best represents consumers on purchasing boards. Another major strategy for enforcing purchasers' accountability is the statutory establishment of packages of care with formal coverage guarantees. This is very much the practice in most Western European SHI systems (Gibis et al. 2004) but less so in the more recently developed SHI systems in Eastern Europe and in many of the NHS systems in northern and southern Europe. A key means of enhancing the role of consumers in purchasers' decision-making and ensuring accountability is to stipulate purchasers' rights and responsibilities. In recent years there has been a flurry of national and international patients' rights conventions and declarations. Most countries have also developed patients' rights legislation, while others have developed patients' charters or ethical codes. One last mechanism to enforce purchasers' accountability and responsiveness to consumers is the use of complaint mechanisms to influence individual purchaser decisions. This is particularly so in many SHI systems where, due to the contractual relationships involved, complaints are raised before civil or administrative courts or made to quasi-judicial bodies. Most NHS systems have also put in place complaint systems; however, the absence of legally enforceable entitlements in many of them reduces the scope for consumers to assert whether the provision – or, more likely, the non-provision – of a particular service was appropriate.

Increasing Citizens' Choice

The strategies for citizen empowerment outlined above correspond, in Hirschman's (1970) terminology, to "voice" mechanisms. Health systems also increasingly rely on exit

mechanisms, notably the choice of purchaser and/or provider, as the ultimate strategy to empower individuals. Consumers in most countries have the right to choose their primary care providers. In SHI systems, consumers may also choose ambulatory specialists and hospitals (albeit in some countries – such as the Netherlands – through a gate-keeper). Choices are more restricted in NHS systems; however, this is rapidly changing in many countries. Swedish and Norwegian patients, for example, are allowed to choose any hospital outside their county of residence. Patients under the jurisdiction of the English NHS have also seen their hospital choices increased. While increased consumer choice of providers clearly increases responsiveness, there is debate over its negative impact on other social objectives, notably equity, cost containment and allocative efficiency. There is evidence that choice tends to benefit the higher (and usually better-informed) social classes and thus may lead to increasing health inequalities. The policy response, however, should not necessarily be to reduce choice in line with the “equity in poverty” argument but, rather, to focus efforts to ensure wider access to information and to support choice among the underprivileged.

Strengthening Government Stewardship

There is broad consensus among analysts and policy-makers about the central role of government stewardship in ensuring health system effectiveness. Stewardship’s main functions include formulating strategic policy directions, generating intelligence, exerting influence through regulation and ensuring accountability (Saltman and Ferroussier-Davis 2000; Travis et al. 2003).

The central question for policy-makers is no longer whether strengthening stewardship

of purchasing is necessary but how to put it in place. A preliminary consideration is the level of government at which purchasing stewardship should occur (i.e., central government’s role vis-à-vis regional or local levels and accountability mechanisms). On the whole, devolution to lower levels of government tends to increase responsiveness to local needs. It can, however, decrease equity of access – especially for some minority groups – and efficiency due to lack of economies of scale and duplication of facilities.

Translating Health Policy into Purchasing Decisions

Formulating health policy is a key function of government stewardship but one that is either absent or poorly carried out in many countries. As a result, it has tended to have minimal influence over purchasing decisions. The following five policy lessons can be drawn from the analysis of the failures, as well as successes, in implementing health targets:

- Targets should be realistic but challenging (not the mere projection of trends), transparent, technically and politically plausible, evidence-based, selective and reflective both of health needs and priorities.
- Key stakeholders, particularly the professionals involved in implementation, should be included in setting targets.
- Targets should be supported with evidence for effective implementation policies.
- Sub-national development of targets in combination with national formulation increases the likelihood of their implementation.
- Building targets into performance-management systems, including financial incentives and performance reviews, also facilitates their implementation.

Establishing an Integrated Regulatory Framework

Regulation takes centre stage in health systems' adoption of purchasing structures. These structures typically involve the substitution of hierarchical managerial relationships with contracts, management decentralization and a plurality of public and private providers, all of which require increased regulation. There is a wide array of regulatory mechanisms available to decision-makers to ensure purchasing's effective functioning.

The first lesson for policy-makers is to achieve an appropriate balance between pro-entrepreneurial regulation and regulation that sets boundaries to individual entrepreneurial behaviour. Sometimes the development of purchasing is stifled by a host of constraining regulations that lack mechanisms to facilitate entrepreneurship (e.g., enabling independent purchasing organizations and self-governance of public providers or introducing performance-based payment systems). The opposite has also been true in countries where command-and-control mechanisms have quickly been dismantled without an appropriate regulatory framework in place. This has caused opportunistic behaviour by both providers and purchasers, to the detriment of social objectives. A complementary policy lesson is, therefore, that deregulation should not occur without simultaneous re-regulation (Saltman and Busse 2002).

Purchasing's intricate components require a multi-level effort to achieve policy objectives. Perverse consequences result from narrow regulatory efforts focused on single purchasing components (e.g., payment systems) or on economic concerns (e.g., cost control). Another general lesson is, therefore, that one ought to be able to regulate complexity by setting out a broad framework of regulations that integrates and coordinates the

various aspects of cost-effective purchasing and deals with multiple objectives.

The main regulatory mechanisms that should be part of such a framework are grouped into four main categories. First, there are regulations to ensure citizens' participation and purchasers' accountability. Such regulations provide for the availability of information from purchasers about access to health services, formal participation of citizen representatives on purchasing boards, patients' rights legislation stipulating what citizens can expect from purchasers and complaint mechanisms, including an ombudsperson (den Exter 2005; Hunter et al. 2005).

Second, certain regulatory mechanisms are aimed at monitoring purchasers' performance. One set of regulations focuses on their insurance role, guaranteeing equitable and efficient behaviour and including mandatory insurance with open enrolment, income-related contributions or community-rated premiums and the transfer of funds between purchasers (applying redistribution formulae to compensate for differences in the risk structure) (Rice and Smith 2002). Another set of regulations relates to purchasing and aims to ensure operation within a fixed budget, a standardized package of benefits and government participation on purchasing boards.

The third type of regulation addresses the contractual relationships between providers and purchasers. This entails setting up a framework and rules for collective contracting; specifying the roles of the various partners, including purchasers, associations of providers, professional organizations and the government; and establishing the details of the contracting process, including negotiation and litigation rules. Specific rules and procedures for contracting include requirements for access to information for purchasers and providers as well as the right of purchasers to

evaluate the implementation of contractual provisions, quality standards, payment-system requirements and price regulation via national tariffs by unit of output, such as a diagnosis-related group (DRG), or by requiring specific costing and pricing procedures.

A fourth set of regulatory mechanisms is directed mainly at providers. It includes measures affecting strategic planning, technology and licensing, certification and accreditation.

Strengthening Government's Capacity and Credibility

Governments face a series of technical, economic, political and cultural barriers that impinge on their ability and credibility to carry out effective purchasing stewardship (Hunter et al. 2005). First of all, the technical and administrative abilities required are lacking, particularly in some of the countries in Central and Eastern Europe (CCEE). When regulatory departments exist, they are often understaffed and have poor information about the behaviour of purchasers and providers. Moreover, there are substantial transaction costs involved in formulating health policies and, particularly, in setting a regulatory framework, collecting information and monitoring purchasers. Although these costs should be offset by the efficiency gains derived from a well-functioning purchasing system, they still pose an economic obstacle for some governments.

The gap between the public guarantees of healthcare delivery and the public funding available poses a larger economic and political obstacle. For instance, the violation by governments of their own obligations to finance healthcare services weakens their control over purchasers. Political obstacles are further increased by the inability of some governments to enforce statutes and by the divergence of policies among different government bodies.

Many countries also face cultural and organizational difficulties in realizing purchas-

ing stewardship. Among these are the existence of closed social networks between government officials, purchasers and providers, alliances that might prevent the enforcement of legal agreements. Moreover, in some countries the former management culture of officials accustomed to command-and-control functions might prevent them from adapting to their new stewardship role.

Ensuring Cost-Effective Contracting

Contracts are the main vehicle by which purchasers translate their populations' health needs and desires into the provision of health services.

Linking Contracting with Planning

Establishing a purchasing strategy is the starting point of the contracting process (Duran et al. 2005). More emphasis should be paid to requiring purchasers to develop strategic (long-term) and operational (annual) purchasing plans. These will signal purchasers' intentions by setting out service requirements, budget constraints and performance targets. They will also enable providers to produce their own business plans. The contracting cycle continues with purchasers identifying and selecting providers, followed by negotiating contracts, reaching agreement and then managing and monitoring those contracts. The way this process is conducted depends on the degree of competition involved.

An appropriate balance must also be maintained between government stewardship and the roles of purchasers and providers in negotiating contracts' main parameters, such as activities (e.g., number of patients treated, surgeries performed), payment methods and selection of providers. In some countries government determines these parameters. As a result, the contracting parties are left with a merely symbolic role, making contracting a bureaucratic process.

Ensuring Evidence-Based Contracts

Part of the rationale for introducing contracts is to implement evidence-based healthcare by incorporating best-practice guidelines. In reality, however, this potential is far from realized and contracts often make little or no reference to evidence-based practices.

The first step in evidence-based contracting is to ensure that the actual evidence is available to purchasers. Most Western European governments have some form of health technology assessment (HTA) in the form of national agencies, although this is less the case in the CCEE, where HTA is less common (Borowitz et al. 2004). These initiatives have yielded many valuable insights; however, they often focus on individual technologies and interventions rather than on the overall organizational framework of care within which the interventions are used. Overall, there is still little research that can provide the information purchasers need, despite its availability and good quality (McKee and Brand 2005).

The second step is to incorporate evidence on interventions and methods of service delivery into workable contracts for specific disease and client groups. This step entails developing treatment guidelines that account for existing practices, the potential for change and the resources required and a broad view of health improvement, including both prevention and treatment options. This is an area of major potential but it is manifestly underdeveloped in most countries. One exception is the UK's NHS frameworks, which provide a comprehensive approach to building health strategy, priority interventions, treatment guidelines and performance targets into contracts.

Moving toward Cost-and-Volume Contracts

Decision-makers often face the question of what type of contract is the most appropriate. Issues of capacity and feasibility are

paramount in their decisions. On the whole, however, there seems to be a common trend toward service (cost-and-volume) and performance-based contracts. SHI countries in Western Europe are increasingly adopting more complex forms of cost-and-volume contracts, particularly ones that define products and include performance indicators. European NHS systems, at the start of the purchaser-provider split reforms, adopted block contracts that have become progressively sophisticated by incorporating better definitions of volume and product. Many of the CCEE, when they introduced SHI based on contracts, began with retrospective forms of cost-per-case contracts aimed at increasing activity; given upward cost pressures, however, they have also been increasingly moving toward cost-and-volume contracting. Such contracts seem to have the most potential for signalling the appropriate incentives to providers because they allow purchasers to decide the volume of care required, to define the product and to determine cost-effective forms of intervention. At present, however, most of these contracts are still relatively unsophisticated.

Paying for Performance

A system of payment, with its built-in financial incentives, is the main mechanism for contract implementation, to the extent that often there is little difference between a contract and the payment system it involves. An optimal payment system should induce providers to deliver top-quality treatments that respond to patients' needs with a high degree of technical efficiency. However, no single payment system seems to achieve all of them and trade-offs frequently become necessary. Retrospective methods of reimbursing providers by fee-for-service and/or per diems increase service productivity as well as responsiveness but can have a negative impact

on cost containment and efficiency. When providers are reimbursed for finished cases through some case-mix measure, the incentive is to treat cases more efficiently; however, problems with allocative efficiency and cost containment remain. This is not to say, however, that the answer lies simply in introducing prospective global budgets.

Many Western European countries have adopted a form of global budget based on prospective levels of activity and adjusted for severity through some case-mix measure such as DRG or one of its variants. Most countries

“Policy-makers, therefore, might prefer to opt for more transparent and easy-to-implement systems rather than more sophisticated systems that have greater potential but that face greater implementation and monitoring challenges.

also have an additional payment component based on retrospective cost-per-case reimbursement, usually for particularly expensive treatments or for cases handled by providers that lack contractual agreements with their purchasers.

Within this broad convergence in payment models, there is still much diversity involving aspects such as the choice of case-mix measure to adjust for severity and the use of financial incentives to reach target levels of efficiency and quality. Many methodological aspects also remain unresolved. A main methodological debate concerns the definition and measurement of the healthcare product, which has led to the development of a host of case-mix

measures such as DRGs, patient-management categories (PMCs) and disease staging. A more complex methodological challenge is how to pay for the treatment of diseases that require various episodes of care at different levels.

Another area that requires further emphasis and methodological innovation is linking payment incentives to quality indicators set out in contracts; for instance, providers' adherence to standards of care or fulfilling a series of health outcome and responsiveness targets.

In sum, there is broad convergence toward global budgets based on activity levels, which are adjusted by the severity of patients' health status, and on performance targets. In other words, such budgets incorporate inputs (severity), processes (activity) and outcomes (performance). However, a number of unresolved methodological issues require further innovation and development. A note of caution about the limits of payment systems is also pertinent here. Incentives often act as a double-edged sword: they can be easily “gamed” by providers who invariably have better information than purchasers (Rochaix et al. 1998). In addition, excessive reliance on payment systems can detract from investing efforts in other possibly effective strategies. Moreover, there are important trade-offs in terms of the transaction costs and management skills required to implement complex payment systems. Policy-makers, therefore, might prefer to opt for more transparent and easy-to-implement systems rather than more sophisticated systems that have greater potential but that face greater implementation and monitoring challenges.

Promoting Quality through Contracts

Quality strategies can be examined in relation to the stages in the contracting process, including negotiating (specifying appropriate quality requirements); monitoring (requiring and checking provider quality reports or

getting feedback from the public); and reviewing (agreeing on changes to improve quality via the contract) (Velasco-Garrido et al. 2005).

Prior to entering into a contract, a purchaser can establish a series of quality requirements and pre-select only those providers who fulfill them. At a minimum, purchasers should contract only with licensed facilities and personnel; purchasers might also set higher standards and contract only with certified personnel and accredited providers.

Accreditation measures have been developed mostly in the United States (US) and, although they have attracted interest in Europe, have been implemented there on a relatively small scale and with limited impact. In the CCEE, requiring provider accreditation and certification as preconditions for contracts has resulted in significant improvements in the quality of hospital infrastructure and care.

A more effective approach is to specify a series of quality requirements in contracts. These can be enforced through regulations, sanctions and/or payment incentives. There are three main types of quality requirements (Velasco-Garrido et al. 2005):

- Standards of care: These (e.g., mandating providers to use a particular set of clinical guidelines) are particularly useful in cases where evidence is sound and uncontroversial (e.g., adherence to diabetes care guidelines).
- Quality assurance initiatives: Clinical governance in the UK is an example.
- Quality targets (process and outcome): Process targets can entail levels of provision or wait times for certain interventions. Outcome targets can use surrogate measures such as blood pressure levels (if clearly correlated with patient-relevant outcomes) or patient-relevant outcome targets such as mortality from certain conditions (e.g., myocardial infarction).

In addition to specifying quality requirements in contracts, performance monitoring is central to achieving improved quality. There is a need for regionally or nationally coordinated schemes, particularly when there is competition between purchasers and providers and a provider is likely to contract with several purchasers at the same time.

With or without Provider Competition?

Most countries that discussed or introduced new forms of purchaser-provider separation during the 1990s did so on the basis that there would be supply-side competition. Competition was to be the market-based lever for improved performance. In practice, however, competition did not always materialize as theorists and policy-makers intended. In some ways this was entirely predictable. For one thing, healthcare markets are characterized by strong elements of spatial monopoly (resulting from patients' inability or unwillingness to travel), making competition difficult to achieve. In addition, it became clear (e.g., with the advent of the internal market in the UK in 1991) that the political consequences of market failure – resulting from supply-side competition – would be unacceptable.

It also became clear that transaction costs could make supply-side competition expensive; ways of economizing on these were, therefore, often sought. As a result, a number of countries attempted to encourage longer-term collaborative arrangements between purchasers and providers. This raises the question of whether contracting can operate effectively when purchasers do not have a choice of providers. On one hand, the contracting process in itself is a mechanism for purchasers and providers to be more explicit about mutual expectations than would otherwise be the case. On the other hand, if a purchaser cannot, in a case of unsatisfactory service from an existing provider, move to an alternative

provider, the stimulus for provider efficiency is seriously compromised.

One possible way out of this conundrum is to rely on proxy competition. Regulators can benchmark provider performance and require change in the case of persistent failure. Additionally, it is possible to draw on the concept of contestability; that is, new entrants to a market (e.g., through franchising arrangements) might pose a threat to existing providers even if actual competition does not exist.

Implementing Contracting

A common set of political, financial, managerial and organizational obstacles can hinder contracting implementation. The first major obstacle is the high complexity of most contracting mechanisms. The major complexities are the design of contracts, the development of appropriate payment systems, the specification of quality requirements and the monitoring of performance. All of these require a high level of managerial and technical skill, together with wide-ranging information systems that are not available to some purchaser organizations in several Western European countries, let alone in less developed Eastern European countries. Moreover, these mechanisms are very resource intensive, a factor that can pose an economic barrier to their implementation. The establishment of a contracting system, therefore, needs to be preceded by an assessment of purchasing organizations' capacities and, when required, by investing in appropriate training programs and information systems.

In some countries, the organizational design and roles of purchasers and providers might also pose major obstacles to implementation. These include fragmentation of purchasing, poor complementarity of design among strategies, inappropriate organizational definitions of purchaser and provider roles and institutional (legal and administrative) imped-

iments (Duran et al. 2005; Langenbrunner et al. 2005).

Issues also arise involving design complementarity among different strategies that provide incongruent incentives (e.g., financial ones) that are inconsistent with the quality indicators specified in a contract. Sometimes these problems apply to specific strategies (e.g., the adoption of payment mechanisms across settings) that do not complement one another and, therefore, undermine allocative efficiency.

Inappropriate definition of purchasers' functions is also likely to hinder contract implementation. In particular, there is much uncertainty about the roles of purchasers in the implementation of strategies such as health needs assessment, health strategy development, provider accreditation and development of specification guidelines for quality indicators in contracts.

Issues germane to organizational coherence also apply to provider organizations involved in contracts. For contracting to function properly, providers must have sufficient managerial and financial flexibility in order to respond to a contract's demands and incentives (discussed in the section on providers below). Further organizational reform of purchasers and providers is often blocked by institutional – legal or administrative – impediments. Many new models of purchasing organizations (both for purchasers and providers) have no chance of taking root unless they are preceded by a broader reform of the civil service and the public sector in which they are to be based.

Political and cultural issues comprise the third category of implementation obstacles. For instance, ministries of health often have vested political interests in not delegating decision-making to purchaser organizations, particularly in areas such as the selection and contracting of providers.

Developing Appropriate Purchasing Organizations

Finding the Right Purchaser

An important distinguishing feature of the range of purchaser organizations found in different European countries is the nature of their vertical organization (Robinson et al. 2005). This can involve macro, meso or micro levels of purchasing. Given this variety, the obvious question is what level of purchasing is likely to be most effective? Methodological difficulties in tracing causes and effects, coupled with the weakness of empirical evidence, make it difficult to offer an unambiguous answer. Moreover, the history of the health service organizations in a given country and their current institutional structures act as powerful constraints on feasible purchasing models. Clearly, a one-size-fits-all recommendation is untenable.

It is possible, however, to make some observations that policy-makers should take into account, albeit with a clear eye to their own national and/or regional and local situations. One is that devolution of decision-making seems to be associated with a number of advantages. Macro-level purchasing rarely offers the managerial autonomy necessary to improve local decision-making. The new public management seeks to give managers the opportunity to manage rather than to act as inflexible bureaucrats. This is far easier to achieve within lower-level organizations, where entrepreneurship and innovation can be expected to flourish. Similarly, responsiveness to patients and the public is likely to increase as purchasing decisions are taken closer to users. Contracting also becomes a more effective mechanism because negotiations take place between local decision-makers. Nonetheless, it must be recognized that some functions require a strong national focus (e.g., public health goals and the pursuit of equity targets).

Choosing between Multiple Purchasers

One of the most powerful ideas to influence public policy during the 1980s and 1990s was the belief that markets and competition have the capacity to improve efficiency. In Europe, proposals to extend consumers' choices of insurer/purchaser and to allow greater competition among purchaser organizations have sought to avoid the excesses of the US managed care system (Smith et al. 2005). In the Netherlands, for example, policies designed to increase competition between insurers and sickness funds have devoted considerable effort to the derivation of appropriate risk-adjustment formulae in order to avoid adverse risk selection.

Notwithstanding these developments in the Netherlands (as well as in Germany and Switzerland), the most striking finding to emerge from our study is that, despite the considerable pro-competition rhetoric that has characterized health service debates in Europe in recent years, the overwhelming majority of purchasing organizations continue to operate in non-competitive environments. Sometimes this occurs because macro-purchasers are, by definition, monopoly purchasers. In other cases, effective competition is made difficult because purchasers are territorially based. In yet other cases, the requirement for purchasers to make standard packages of care available reduces the dimensions over which competition can operate.

Does the absence of demand-side competition matter? To those who argue that choice and competition are powerful stimulants for improved provider responsiveness and increased efficiency, the absence of competition is a cause for concern. However, if a country's institutional structure does not lend itself to purchaser competition or if the downside of competition (e.g., reduced equity and increased transactions costs) is considered too great, alternative mechanisms can be used

to achieve similar ends. Overall, there does not seem to be a strong case for relying on demand-side competition as a mechanism for improving purchaser performance (Maarse et al. 2005).

Improving Provider Performance

Bearing in mind the timing of most purchasing reforms, it is too early to make firm policy conclusions. Nonetheless, it is possible to draw some general lessons about the main factors and conditions that influence providers' responses to purchasing.

Increasing Provider Autonomy

Institutional providers in Europe vary greatly in their degree of autonomy. Limited autonomy and flexibility to respond to new contracting incentives have been major causes of purchasing failure in many countries.

To achieve greater hospital autonomy (see Harding and Preker 2000) and hence more flexibility for providers to respond, policy-makers can extend decision-making rights over key areas such as hiring and firing; determining the number of staff members and their skill mix; financial management (e.g., the ability to take loans); determining the level and scope of activities; and making decisions about capital development, including ones related to numbers of beds and technology. Moreover, decision can increase market exposure by introducing some form of provider market competition combined with a regulation of residual claims in such a way that "leftover" resources remain with providers (Saltman and Busse 2002).

Making Providers More Accountable

There are several mechanisms to ensure managerial accountability linked to the contracting process. Purchasers can negotiate performance targets with providers, monitor the extent to which these have been achieved

and, if the targets have not been achieved, amend or terminate contractual agreements.

Public accountability means that providers must also communicate the results of their performance to patients and the public. Information such as numbers of patients treated, complication rates, wait times and procedures completed can be made accessible via media such as consumer journals, Web sites, newspapers and/or hospital-based publications. Emphasis is growing on the systematic and independent measurement of provider performance. This is increasingly used in countries to benchmark performance across providers (e.g., via hospital leagues). Provider autonomy must be accompanied by increased transparency, and these efforts are likely to continue and grow.

Managing a New Power Balance

The introduction of purchasing – and its subsequent increase in provider autonomy – results in a different balance of power and incentives among purchasers, providers and consumers. Policy-makers need to be aware of the range of provider responses to these new balances. These responses might be positive or negative depending on whether providers see the introduction of purchasing as an opportunity or a threat.

Providers might respond to new power balances in a structural or a tactical manner. An example of a structural response is a merger with other providers to increase market power. Tactical responses refer to how a provider operates in a concrete contracting process with a provider. Provider behaviour might be entirely opportunistic and contrary to system-wide objectives (e.g., by increasing activities in order not to miss out on extra resources) but can also be in line with a system's objectives of equity, effectiveness and efficiency. Contracting out, creating integrated healthcare delivery networks and developing

initiatives to reduce wait times are examples of such provider-driven responses. The strength of provider-driven responses will depend on each provider's ambitions (in this regard, a distinction should be made between pioneers, followers and conservatives).

A final distinction resides among political, judicial and managerial responses. A political response, in particular, has caused the failure of purchasing in many European countries. Providers often mobilize political resources to increase pressure on a purchasing agency and to influence the contracting process in their favour.

Conclusions

Analysis of many European countries shows, not surprisingly, diverse approaches to purchasing (Figueras et al. 2005). There are, however, some clear common trends.

The various approaches undertaken across Europe reveal that reform efforts must focus on strengthening purchasers' ability to respond to consumer needs and to establish more cost-effective contracts with providers. Concurrently, without capable government stewardship, strategic purchasing is bound to fail. Government needs to provide clear leadership by formulating health policies and establishing a set of health targets that can guide purchasing decisions and provide a basis on which to evaluate its overall impact. The high complexity of strategic purchasing also requires putting in place a comprehensive regulatory framework that integrates and coordinates purchasing's various components. This framework must achieve a fine balance between regulation that favours and limits entrepreneurial behaviour so as to ensure the attainment of health system objectives.

The political, technical and financial ability to implement strategic purchasing is the most important factor determining its success. Most, if not all, of the strategies we have

reviewed in this paper are complex and require a high level of technical and managerial skills, together with wide-ranging information systems that are lacking in many countries. In addition, strategic purchasing leads to new power balances among key stakeholders and, therefore, it might often face major political obstacles to implementation. This possibility calls for an incremental approach to implementing strategic purchasing, one that uses pilot experiments to test the most complex strategies and limits, at the outset, the scope of purchasing to some services as well as builds political consensus to ensure purchasing's sustainability.

Endnotes

1 This chapter summarizes the topics developed in depth in Figueras et al. (2005).

2 These explicit decisions are an expansion of the discussion by the World Health Organization (2000).

3 In this paper we distinguish between the upper-case National Health Service found in the UK and the similar lower-case national-health-service type of system found in several other countries. For convenience, we employ the initialism NHS to refer to both; in every case, our meaning is readily apparent from the contexts.

4 The results of citizen consultations and debate on priorities in Sweden are reflected in a series of guidelines (McKee and Figueras 1996).

References

- Borowitz, M., R. Massoud and Martin McKee. 2004. "Improving the Quality of Health Systems." In J. Figueras, M. McKee, J. Cain and S. Lessof, eds., *Health Systems in Transition: Learning from Experience*. Copenhagen: WHO for the European Observatory on Health Systems and Policies.
- Busse, R., R.B. Saltman and H.F.W. Dubois. 2004. "Organization and Financing of Social Health Insurance Systems: Current Status and Recent Policy Developments." In R.B. Saltman, R. Busse and J. Figueras, eds., *Social Health Insurance Systems in Western Europe*. Maidenhead: Open University Press.
- den Exter, A.P. 2005. "Purchasers as the Public's Agent." In J. Figueras, E. Jakubowski and R. Robinson, eds., *Purchasing to Improve Health Systems Performance*. Maidenhead: Open University Press.

- Duran, A., I. Sheiman, M. Schneider and J. Øvretveit. 2005. "Purchasers, Providers and Contracts." In J. Figueras, E. Jakubowski and R. Robinson, eds., *Purchasing to Improve Health Systems Performance*. Maidenhead: Open University Press.
- Figueras, J., E. Jakubowski and R. Robinson, eds. 2005. *Purchasing to Improve Health Systems Performance*. Maidenhead: Open University Press.
- Gibis, B., P.W. Koch-Wulkan and J. Bultman. 2004. "Shifting Criteria for Benefit Decisions in Social Health Insurance Systems." In R.B. Saltman, R. Busse and J. Figueras, eds., *Social Health Insurance Systems in Western Europe*. Maidenhead: Open University Press.
- Harding, A. and A.S. Preker. 2000. "Organizational Reform in the Hospital Sector: A Conceptual Framework." In A.S. Preker and A. Harding, eds., *Innovations in Health Care Reform: The Corporatization of Public Hospitals*. Baltimore: Johns Hopkins University Press.
- Hirschman, A. 1970. *Exit, Voice and Loyalty*. Cambridge: Harvard University Press.
- Hunter, D.J., S. Shishkin and F. Taroni. 2005. "Steering the Purchaser: Stewardship and Government." In J. Figueras, E. Jakubowski and R. Robinson, eds., *Purchasing to Improve Health Systems Performance*. Maidenhead: Open University Press.
- Langenbrunner, J., E. Orosz, J. Kutzin and M. Wiley. 2005. "Purchasing and Paying Providers." In J. Figueras, E. Jakubowski and R. Robinson, eds., *Purchasing to Improve Health Systems Performance*. Maidenhead: Open University Press.
- Maarse, H., T.A. Rathwell, T. Evetovits, A.S. Preker and E. Jakubowski. 2005. "Responding to Purchasing Provider Perspectives" In J. Figueras, E. Jakubowski and R. Robinson, eds., *Purchasing to Improve Health Systems Performance*. Maidenhead: Open University Press.
- McKee, M. and H. Brand. 2005. "Purchasing to Promote Population Health." In J. Figueras, E. Jakubowski and R. Robinson, eds., *Purchasing to Improve Health Systems Performance*. Maidenhead: Open University Press.
- McKee, M. and J. Figueras. 1996. "For Debate: Setting Priorities: Can Britain Learn from Sweden?" *BMJ* 312: 691–94.
- Mossialos, E. and A. Maynard. 1999. "Setting Health Care Priorities: To Whom and on What Basis?" *Health Policy* 49(1).
- Rice, N. and P. Smith. 2002. "Strategic Resource Allocation and Funding Decisions." In E. Mossialos, A. Dixon, J. Figueras and J. Kutzin, eds., *Funding Health Care: Options for Europe*. Buckingham: Open University Press.
- Robinson, R., E. Jakubowski and J. Figueras. 2005. "Organization of Purchasing in Europe." In J. Figueras, E. Jakubowski and R. Robinson, eds., *Purchasing to Improve Health Systems Performance*. Maidenhead: Open University Press.
- Rochaix, L. 1998. "Performance-Tied Payment Systems for Physicians." In R.B. Saltman, J. Figueras and C. Sakellarides, eds., *Critical Challenges for Health Care Reform in Europe*. Buckingham: Open University Press.
- Saltman, R.B. and R. Busse. 2002. "Balancing Regulation and Entrepreneurialism in Europe's Health Sector: Theory and Practice." In R.B. Saltman, R. Busse and E. Mossialos, eds., *Regulating Entrepreneurial Behaviour in European Health Care Systems*. Buckingham: Open University Press.
- Saltman, R.B. and O. Ferroussier-Davis. 2000. "The Concept of Stewardship." *Bulletin of the World Health Organization* 78(6): 733–39.
- Sandier, S., V. Paris and D. Polton. 2004. *Health Care Systems in Transition: France*. Copenhagen: European Observatory on Health Systems and Policies.
- Smith, P., A.S. Preker, D. Light and S. Richard. 2005. "Role of Markets and Competition." In J. Figueras, E. Jakubowski and R. Robinson, eds., *Purchasing to Improve Health Systems Performance*. Maidenhead: Open University Press.
- Travis, P., D. Egger, P. Davies and A. Mechbal. 2003. "Towards Better Stewardship: Concepts and Critical Issues." In C.J.L. Murray and D.B. Evans, eds., *Health Systems Performance Assessment Debates, Methods and Empiricism*. Geneva: World Health Organization.
- Velasco-Garrido, M., M. Borowitz, J. Øvretveit and R. Busse. 2005. "Purchasing for Quality of Care." In J. Figueras, E. Jakubowski and R. Robinson, eds., *Purchasing to Improve Health Systems Performance*. Maidenhead: Open University Press.
- World Health Organization. 2000. *World Health Report 2000. Health Systems: Improving Performance*. Geneva: Author.

Strategic Purchasing: The Experience in England



PURCHASING

Gerry McSorley, DBA

Director, Centre for Health Improvement and Leadership, University of Lincoln
Visiting Professor in Healthcare Management and Leadership, University of Lincoln



Introduction

Healthcare policy in the United Kingdom (UK) is placing increasing emphasis on the innovation and creativity of healthcare purchasing for health improvement, as well as on the skills and competencies of those charged with its leadership and management. In considering these developments, the current state of healthcare strategic purchasing in the UK must be framed within a number of key contextual issues:

- The divergent approaches to health policy and its implementation being taken by each of the four different government departments in England, Wales, Northern Ireland and Scotland (Greer 2004)
- The impact of the history of healthcare funding and the current financial climate

on the demands placed on those responsible for health purchasing and the relative scope for health improvement that improving or deteriorating levels of funding create (Wanless 2002)

- The central government's broader approach to public services and public services management known as the New Public Management, in which government should "steer" not "row" (Kelman 2005; Pollitt 2002; Osborn and Gaebler 1992)

Health Policy Implementation in the UK

With the advent of increased devolution of power to the devolved administrations of Scotland, Wales and Northern Ireland, the UK has no single unified approach to health policy or its implementation. I have adapted the following descriptions from Greer (2004):

- England has opted for markets, hoping that competition between independent trusts (similar to private firms) and between trusts and privately run treatment centres will drive up standards and efficiency. It is hoped that this model will rescue the government from responsibility for every detail of health service delivery.
- Scotland has bet on professionalism, reducing layers of management, placing NHS trusts within integrated boards (along with clinical networks) and increasing the role of professionals in rationing and resource allocation.
- Wales has relied on a professionalist and localist approach, integrating health and local government to improve the coordination of different forms of care at the local level and to raise standards. It is hoped that this will increase local participation in healthcare.
- Northern Ireland has resorted to permissive management, in and out of devolution, concentrating on keeping services going in tough conditions.

The results of such policy divergence among the four UK countries and the relative spend on healthcare might not lead to more activity being delivered, to better population health or to higher levels of public satisfaction. These outcomes might depend more on how resources are deployed and how factors outside the healthcare system influence health (Alvarez-Rosete et al. 2005).

Notwithstanding the nature of this policy divergence, the four countries still share a number of critical challenges:

- Demographic changes – in particular the proportional rise of the elderly population
- Increasing technological developments

- and associated costs, both human and financial
- Finite resources to fund healthcare
- Potentially unlimited demand for healthcare
- The prevention of unnecessary hospital admission
- Correctly incentivizing the system so as to optimize the chance of achieving the health system's goals

In England, the overall spend on the National Health Service (NHS) has historically been below continental European levels. While many might argue that this comparator is inappropriate given the variations among health systems – some of which are based on social insurance or mixtures of social insurance and private care – the British government committed itself to achieving the target of matching continental European levels of healthcare spending by 2008. This commitment is coupled with the impact of the Treasury forecast of slowing growth in further investment in health services arising from Wanless's *Securing Our Future* review (2002).

In this paper I place particular emphasis on the situation in England. This is not because that country has the right or wrong solution to strategic purchasing. Rather, given that the majority of the British population lives in England, that is the country in which the greatest impact of health policy reforms will fall.

Background to the Current Situation in England

Since its election to power in 1997, the Labour government's policy for the English NHS has moved through a number of initiatives and positions. On election, the key attribute was fiscal prudence, largely accepting the previous Conservative government's

somewhat constraining spending policy. General practice fundholding, a major plank of the Conservative government's reform program, was scrapped. A New Commission for Health Improvement was created to enhance the drive for quality. Many have argued that these early reforms were merely stop-gap measures pending agreement on the future ways forward (Klein 2001).

The first major directional vision was therefore contained in *The NHS Plan*, which was published with considerable professional support and laid out a 10-year strategy to modernize health services (Department of Health 2000). The key tenets of this plan were as follows:

- “Investment accompanied by reform” (the plan's mission phrase)
- Extra acute hospital beds
- New hospitals funded through the Private Finance Initiative
- Extra staff members who were paid more money
- Creation of the “earned autonomy” concept for hospitals, which provided those hospitals judged to be successful with greater scope to innovate
- Creation of a Modernisation Agency to spread best practices
- Bringing together local municipal services and the NHS to pool resources (e.g., creation of care trusts to commission health and social care in a single organization)
- Extended roles for nurses and allied health professionals
- Creation of patient advocacy and liaison services in each healthcare organization
- A national patient survey
- Reaching a concordat with private sector providers with a view to ending the historical divide between private and public sector providers
- Setting new wait time targets

- New investment and service delivery programs in cancer, coronary heart disease and healthcare for older people

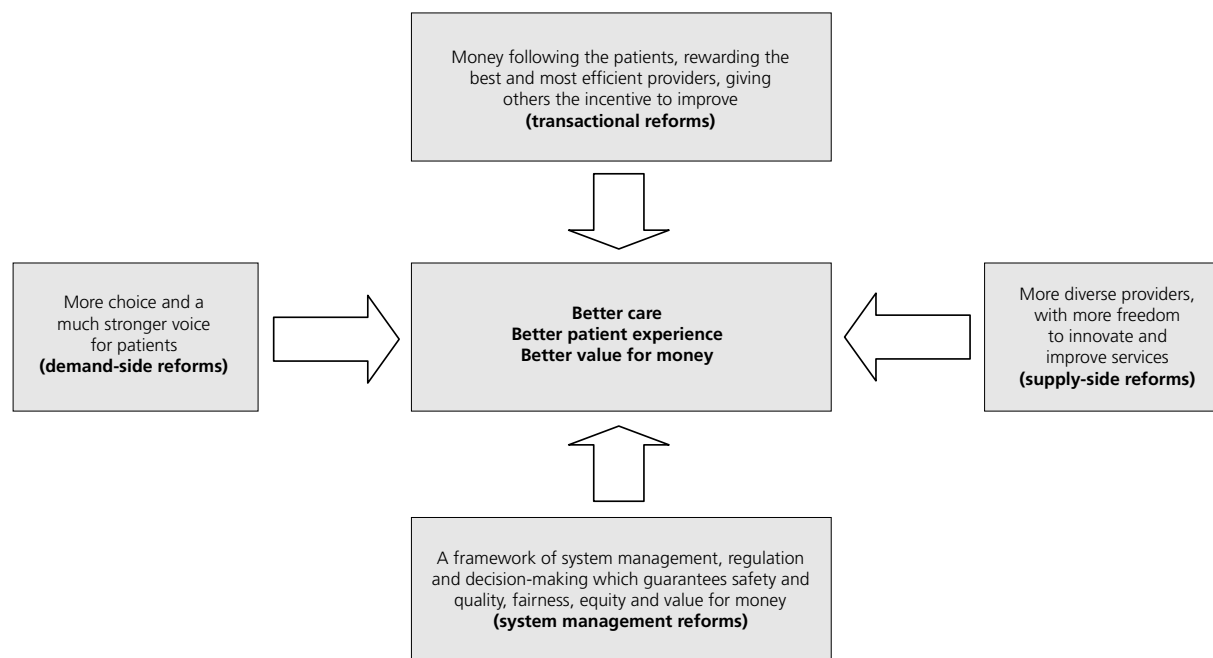
Over time, however, the sense at the government level was that, while *The NHS Plan* had considerable support, the NHS was not moving quickly enough to modernize and meet patients' and the public's expectations of care and access. *The NHS Plan* was therefore followed up with the *NHS Improvement Plan* in 2004 (Department of Health 2004), which added new reform components, including the following:

- Reforming both the supply side and the demand side
- Introducing patient choice of acute sector providers
- Revising the role of the New Commission for Health Improvement to an inspectorate role as the Commission for Healthcare Audit and Inspection
- Setting challenging new targets for access time for diagnosis and treatment
- Advocating the adoption of the triangle of care, with self-management of health by far the most potent proportion of care, followed by disease management (i.e., more proactive support) and, finally, case management for the smallest group of patients with complex needs (i.e., active and specialist care)

The recognition of the divergence between the supply and demand sides embodied by the purchaser–provider split indicated the need for vision and skills on both sides if major progress were to be made in healthcare reform, efficiency and productivity.

The final piece of the reform jigsaw – *Creating a Patient-Led NHS* (Department of Health 2005) – saw the culmination of growing concerns about the unbalanced nature

Figure 1. Organising Framework for NHS Reforms (Healthcare Financial Management Association 2006)



of the power of the NHS supply side in the absence of assertive and skilled purchasing (or “commissioning,” as it will be referred to in the rest of this paper). *Creating a Patient-Led NHS* sprang from a recognition that the main focus since 1997 had been the acute care sector, incentivizing it to reduce wait times and to improve its services. In doing so, there was a clear risk that a strong, vibrant, incentivized hospital sector would suck all investment into hospital care unless it was balanced by an equally strong and vibrant commissioning function. *Creating a Patient-Led NHS* focused specifically on the importance of expert, imaginative commissioning. It promoted the belief that a revitalized commissioning function must represent patients, centre on prevention and public health and ensure hospital providers deliver good value for money.

Figure 1 captures the resulting model, based on the reforms of 2000, 2004 and 2005. The Organising Framework for NHS Reforms was based on the political need to

devolve power at the same time as introducing market-style incentives, which were stimulated by allowing patients to choose which providers to visit (whether not-for-profit or for-profit private hospitals, or public hospitals in the shape of foundation hospitals operating in a quasi-commercial fashion). In order to provide that better balance of skills on the commissioning side of the equation, the Department of Health committed itself to devolving 75% of the NHS budget directly to primary care trusts (PCTs), with a further level of devolution to individual practices in the form of practice-based commissioning (PBC). The unit of currency in this new model was the patient. The method of payment was the tariff: a fixed price for individual procedures based on diagnostic-related groups (DRGs) but adapted to UK clinical practice and renamed healthcare resource groups (HRGs).

This combination of demand- and supply-side reforms has resulted in NHS England

in 2007 being in a state of transition from a public monopoly insurer and provider of healthcare, governed from Whitehall, to an insurer with devolved commissioning from a mixed market of providers. The question follows, therefore, as to where on a spectrum of market models NHS England will rest? At one end is a wholly market-based health system in which competition rules and regulation is light; at the other end is a system that is nationally planned, owned, provided and governed from the centre. One way to answer the question would be to consider the following criteria (Lewis and Dixon 2005):

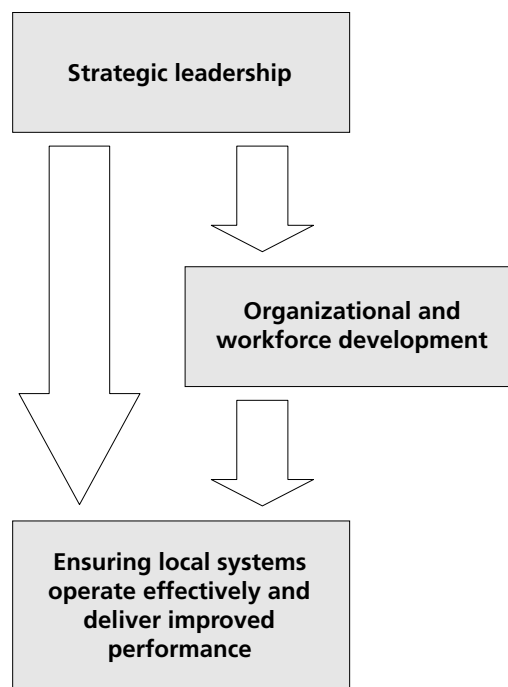
- The government’s values and ideology
- How the existing reform program is led and managed
- The level of political support for changes
- Public perceptions of the reform program
- Evidence of improvements in patient care
- Public satisfaction with local health services when compared with other developed countries

In essence, the Labour government’s philosophy appears to be “what counts is what works” (Greer 2004: 225). Stevens (2004: 42) offers an alternative perspective on such a multidimensional approach to health policy, describing the need to overcome the inertia inherent in all human systems as “constructive discomfort.”

Finally, the Organising Framework for NHS Reforms considered the need for system-management reforms. Organizationally, *Creating a Patient-Led NHS* required changes to the structures underpinning excellent commissioning and to the mechanism by which the Department of Health devolved market management to the regional level. Figures 2 and 3 illustrate the main functions of the new strategic health authorities (SHAs) – overseeing millions

of people – and PCTs – delivering services to hundreds of thousands of people (see Department of Health 2006b).

Figure 2. The three main functions of SHAs



Strategic Commissioning

Definitional clarity is needed in any debate about the value of commissioning. Such clarity requires answering the following three questions:

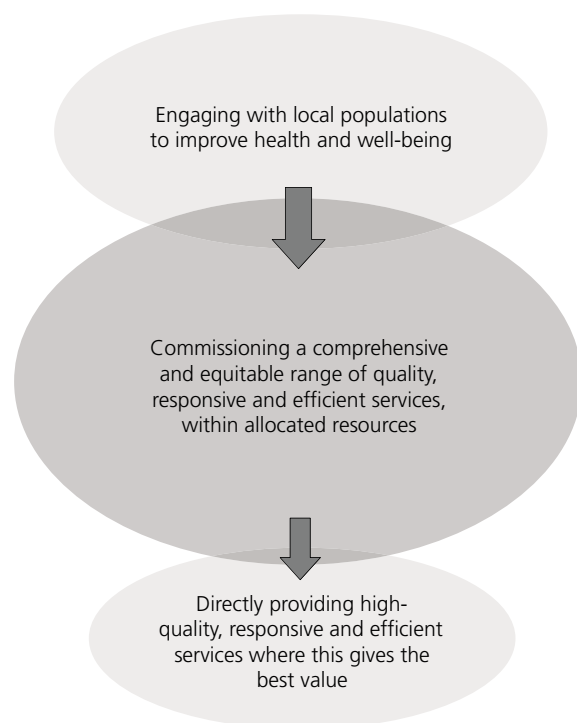
- What is commissioning?
- What does it involve?
- What does it seek to achieve?

The Department of Health (2006a: 3) defines commissioning as “the means by which we secure the best value for patients and taxpayers.” By “best value,” the Department of Health means “the best possible health outcomes, including reduced health inequalities” and “the best possible healthcare”

delivered “within the resources made available by the taxpayer.” In 1995, Øvretveit provided an alternative definition of commissioning as a sophisticated and strategic process of assessing health needs, developing new services or providers, contracting for services and undertaking a range of strategic efforts to improve population health. Work by Smith and Mays (cited in Wade et al. [2006]) provides a further characterization of commissioning:

- It has a conscience, setting out “how things should be” (i.e., what the system aims to achieve and how).
- It has eyes and ears, observing and reporting on “how things are” (i.e., what the system is currently delivering).
- It has a brain, processing information from both sources (i.e., identifying and implementing the optimal solutions for delivering stated objectives).

Figure 3. The three main functions of PCTs



The similarities and differences among these definitions underscore the variety of perspectives that characterize the debate about the role and purpose of commissioning. In particular, they question what emphasis ought to be put on each of the elements of successful commissioning. Wade et al. (2006) underscore the visionary and transactional components, while Øvretveit (1995) stresses the health-gain outcomes. Meantime, the Department of Health model adds the concept of value for money, an essential element in a publicly funded system. The criteria for judging what successful commissioning would add to the health of a local population are, however, less clear. This lack of clarity might reflect the continually changing expectations of healthcare by the public, staff and politicians.

Practice-Based Commissioning

The final act of devolved decision-making within the Organising Framework for NHS Reforms in England was to devolve purchasing to the lowest organizational level – individual general practitioner (GP) practices. PBC involves passing funds from a PCT to individual GP practices so that they can commission services for their populations as they see fit and within their PCTs’ overall strategic aims (Department of Health 2004).¹ PBC is aimed at enhancing the prospects of the following (Crisp 2005):

- The design of improved patient pathways
- A better working partnership with PCTs to create convenient community-based services
- GPs taking responsibility for the budgets delegated by their PCTs, which cover acute, community and emergency care
- More effective budget management

Studies examining the efficacy of effective commissioning by PCTs indicate that the

following factors are important (Smith et al. 2005):

- Stability in health organizations
- Time for clinical engagement
- Policies that support patient choice
- Policies to allow shifts of resources both between providers and between different sectors
- Incentives for GPs to develop new forms of care
- Effective management support and information
- Regulations to minimize potential conflicts of interest arising from GPs being both commissioners and providers

While compelling, these factors and the seed of reform and innovation are fraught with the following complexities when considered at the level of implementation:

- How to provide stability for healthcare organizations when the prevailing climate has favoured repetitive reconfiguration
- How to deliver effective management support when cost constraints are a constant feature of public service management (as part of the implementation of *Creating a Patient-Led NHS*, management-cost reductions of 15% are required)
- How to encourage clinical engagement when demands on GPs are expanded through increasing patient expectations of service alongside a change in culture to a better work/life balance

Smith et al. (2005) further postulate that the greatest challenge facing commissioning will be to create a set of incentives that will engage GPs and enable the development of new forms of seamless services for people with long-term conditions that have eluded previous forms of primary care – led commissioning.

In addition to these organizational factors, there are also profound changes in the skills and competencies required of commissioning leaders and managers, whether clinical or general management. One of the most thoughtful exponents of commissioning skill sets, Simon Stevens, president of United Health in the UK and previously health advisor to the prime minister, has remarked on the need for commissioners to have access to a number of tools, such as the following:

- Actuarial design of risk pools and incentives
- Utilization and equity auditing
- Elective care demand management
- Emergency care subsystems redesign (including out-of-hours and community hospital usage)
- Primary care performance profiles
- Medicines management to ensure appropriate prescribing
- Skill-mix redesign, especially at the primary/secondary, health/social care boundary
- Patient and public engagement, including self-care
- Strategies for changing clinical practice, including clinical decision-support methodologies

The Commissioning Cycle

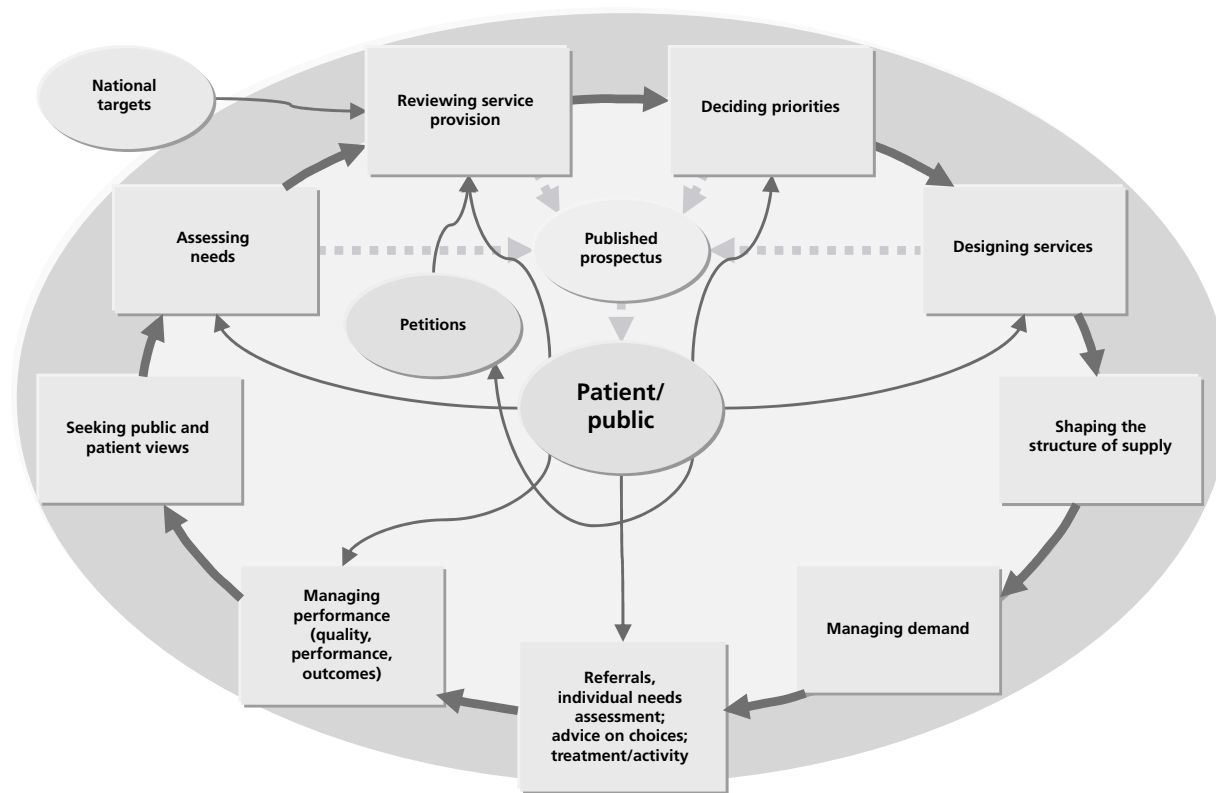
The Department of Health (2006a) has identified for local commissioners the cycle and descriptors shown in Figure 4 as additional aids for thinking about translating plans into action.

The following sub-sections explain each of the elements presented in Figure 4 (Department of Health 2006a).

Assessing Needs

Increasingly, assessing needs will be based on more rigorous analytical approaches involving

Figure 4. The commissioning cycle for health services



population segmentation and risk stratification. It will involve public health professionals, local authorities, GPs, patients and the local community.

Reviewing Service Provision

Practices should identify gaps and the potential for improvements in existing services. PCTs should utilize the aggregated intelligence of their practices and their local needs assessment to identify gaps or inadequacies in provision as well as broader requirements for service development.

Deciding Priorities

PCTs should produce a strategic plan for the health community based on data on needs assessment collated from practices and on the clear choices patients are making. Practices and PCTs are encouraged to work collectively

to reinvest resources that have been released through service redesign where these would achieve greater impact. PCTs should ensure their patients and local communities, as well as municipal authorities and other partners, are properly involved in the process of deciding priorities.

Published Prospectus

Published PCT prospecti will signal the strategic directions for local services, highlighting commissioning priorities, needs and opportunities to service providers. The prospecti offer a focus for discussion with patients and local communities and an opportunity to open dialogues with potential providers.

Designing Services

Practices are expected to work individually, or in groups, to develop strategies and service

models to improve healthcare services for the public and to address its priorities.

Shaping the Structure of Supply

PCTs should be clear about the services and service specifications they and their practices and patients want to see developed and give strategic support to proposals where necessary. PCTs have a role in encouraging and supporting practices that offer services locally and attract private sector and third sector (voluntary) providers to offer services in line with identified needs and priorities. Incentives and levers should be used by PCTs to stimulate the supply of services. PCTs will make contracts with local secondary care providers within a new national contracting framework, with the involvement of practice-based commissioners. For a few very specialized services, contracts will be held at the national level. For other specialized services, PCTs should group together to set contracts.

Managing Demand

Practices and PCTs will establish strategies for care and resource utilization to ensure that patients receive the most appropriate care in the right setting. This will guarantee that the benefits of healthcare resources are maximized.

Referrals; Individual Needs Assessment; Advice on Choices; Treatment/Activity

Individual practices and clinicians undertake individual needs assessments, make referrals and advise patients on choices and the treatments available to them – each referral is effectively a micro-commissioning decision. Practices must work with social service and other agencies to facilitate the opportunity for patients to make their choices with the benefit of good advice from their GPs.

Managing Performance

Practices will always seek to manage their budgets to maximize the benefits of the resources available to them. To help them, PCTs have a responsibility to provide support programs, including training and development, developing systems to allow practices to monitor the services their patients receive through accurate, relevant and timely data. PCTs remain responsible for the aggregated financial position and for ensuring overall financial balance.

Seeking Public and Patient Views

PCTs will be responsible for measuring and reporting on patients' experiences. Practices will also want to monitor patients' satisfaction. Robust mechanisms for collecting and understanding patients' views will need to be developed by PCTs and made available to practices. Throughout, PCTs must ensure that the public voice is heard in the development of priorities and the shaping of services.

Possible Implications of the Organising Framework for NHS Reforms

No reform program ever has all the facets of its consequences worked out in advance. The Organising Framework raises many questions about the inter-relationship of its components. Work undertaken at the Kings Fund in London, for example, explored a number of key questions about commissioning's ability to effect a shift from secondary to primary care (Palmer 2006):

How will it help cope with potentially unlimited patient demand?

Demand is unlimited because healthcare is free at the point of need. As the public becomes increasingly health-savvy and assertive, there is a greater likelihood that demands will increase. Palmer (2006) argues that

commissioning can partly mediate between potential demand and affordability, seeking to obtain the greatest patient benefit with the funds available. Historically, lengthening wait lists/times constituted the pressure valve; however, with the policy drive to reduce wait times this option is no longer available.

In particular, how will PCTs reduce patient demand well below the growth rate seen in recent years – and below the levels required to achieve the access targets – when they have weak levers to manage hospital referrals? The framework says that PCTs and providers should agree on activity levels;

“As the public becomes increasingly health-savvy and assertive, there is a greater likelihood that demands will increase.

however, what happens if they cannot agree or if they do reach agreement but the actual referrals exceed agreed levels? NHS trusts and foundation trusts argue that there is a quasi-market and that they should be free to use available capacity to provide more patient services if patients choose them. They also say they are obliged to make progress toward achieving the access targets. This progress might, however, involve an increase in elective activity that is unaffordable for PCTs and, therefore, inconsistent with PCTs’ statutory duty to break even.

How will affordability influence demand?

If PCTs fail to limit demand they will run up deficits. The key question thus becomes what levers and instruments do they have available

to control the volume of hospital referrals? In addition to the above considerations, PCTs will require strong leadership to hold their local markets to account because unpalatable decisions might, in some cases, have to be made about removing certain providers or, at least, exposing them to external competition. The degree to which the government would be willing to see such levels of contestability is as yet unclear. SHAs also have a role in moderating between commissioners and providers over these precise points (Smith et al. 2006). This is also particularly important where “stranded capacity” exists in a system. Palmer (2006) argues that the use of the Private Finance Initiative (PFI) to expand secondary provision will lead to a reduction in the need for more new PFI schemes to be approved.

Where stranded capacity exists, hospitals with annual financial balance targets tend to close this down to save costs. In an unfettered market, the price would fall and the utilization rate would rise as demand rose. If this were allowed in the NHS, Palmer (2006) suggests that commissioners would be able to purchase more services for patients, and providers would be able to provide more services, thereby earning more income and reducing deficits. The result would be less stranded capacity and fewer services closed. Arguably, the NHS can work effectively only when downward price flexibility is allowed (Kings Fund 2006).

What are the incentives for hospitals to increase admissions?

Hospital providers receive payment for almost all elective procedures under the fixed tariff within the payment-by-results (PbR) system. It follows, therefore, that in a market system hospitals will seek to expand their revenue base to allow for investment in new services by increasing the numbers of “profitable” patients they can see and treat under PbR. However, a number of key constraints apply:

- Because they are required to consult with their PCT before taking any action, it is difficult for a provider simply to drop “unprofitable” services. Each PCT, not the providers, has the statutory right to consult on service alterations, especially when a change is seen as substantial. The PCT, not the provider, consults with the Local Municipal Authority Health Overview and Scrutiny Committee (OSC) on the proposal. If the OSC objects, it can refer the proposed change to central government.
- The provider may face relatively long lead-in times to bring on extra capacity, both physical (e.g., beds, operating theatres) and human resource. This step change in capacity is high risk unless it can be shed according to changing circumstances.
- PBC encourages GPs to hold funds for close-to-home care and encourages the development of joint protocols with secondary providers to ensure that only those patients who need acute care are referred. Providers are more likely to respond well to sophisticated commissioning if they are confident in the future of strategic planning – even if it does not maximize their income.
- The development of a national framework of clinical governance places considerable emphasis on clinical quality and standards. Because providers are subject to independent assessment by the Commission for Healthcare Audit and Inspection, a going-for-everything-you-can-get strategy carries additional risks.

It is important to understand that neither additional nor less work comes at marginal cost. The extra revenue a hospital gains for doing more work – or loses for doing less work – is still paid at the average cost for treating patients. While there will undoubt-

edly be marginal costs of treating one patient, work on that case will still be paid at the average cost. Expansion and contraction therefore carry the same management issues of complexity. Equally, there might come a point at which a hospital faces expensive step-costs of bringing on new facilities or resources to cope with extra demand. However, each extra case will still be funded at the average cost. Work by Palmer (2006), based on unpublished data, indicates that the typical hospital cost structure is about 10%–15% variable costs, about 60%–75% semi-fixed costs and about 15%–25% fixed costs.

How are PCTs to shift funding from existing hospital providers to support the provision of new services closer to home?

The Organising Framework recognizes the need to fund providers of new services closer to home and, in some cases, to offer them incentives. It does not, however, address the fact that PCTs can do this only if they are sure that spending on hospital care will be reduced. Because PCTs have no effective levers to bring about a reduction of revenue spending on hospital care, they are not in a position to contract with new providers to purchase new services. That is because the new services will be affordable for PCTs only if hospital spending goes down, thereby releasing funds to pay for them. This problem is particularly acute for PCTs that are in deficit and/or under strong financial pressure. PCTs cannot expect any help from hospital trusts to reduce hospital demand because that would make it even more difficult for them to achieve financial balance. This situation results in a vicious circle because if there were alternative cheaper services closer to home to which GPs could refer it would be much easier for GP practices and PCTs to manage hospital referrals. These systems are not yet mature; therefore, elective demand remains difficult to manage.

Consequently, a high proportion of PCTs' budgets is spent on hospital care, making it harder for them to afford to commission or provide alternative services closer to home. PBC can – and should – motivate greater and more rapid development in this direction.

How are PCTs to deliver the commissioning priorities they identify in their strategic plans for the medium term?

The description of the commissioning cycle in the framework clearly envisages a strategic commissioning role for PCTs, one that involves deciding priorities in collaboration with local stakeholders and then shaping the structure of supply to ensure that the pattern of expenditure reflects those priorities. A PCT might want to spend more on disease prevention, cancer services or care closer to home; however, if patients exercise choice for more elective hospital care and all the PCT's budget is used to fund this care at full tariff, then there is little the PCT can do about it. This sort of weak commissioning regime leaves the level and pattern of service provision largely to the market. Demand is determined by short-term GP referral practices and supply is determined by the response of existing providers (who are aiming to maximize admissions) to the incentives embedded in the tariffs. Over time, the demand for elective services to hit wait time targets and for technologies is always likely to outstrip available funding – particularly from 2008 when the Wanless effect begins to be felt and funding growth slows sharply.

Some Possible Solutions

There are many possible refinements that can minimize such consequences; e.g., moving from annual to longer-term contracts and paying the full tariff only for contracted volumes of activity and at a standard marginal

cost thereafter. Such an approach could have many advantages:

- Commissioners would be seen to have real teeth through their ability to shift resources.
- Providers would be more likely to support the care-closer-to-home agenda as their ability to expand beyond contracted volumes became more muted. They would also be under a statutory obligation to work in partnership with their PCTs and Health Overview and Scrutiny committees.
- Medium-term contracts would provide greater certainty for providers. This might be less destabilizing for both providers and commissioners because marginal costs would be less severe.
- The incentives for providers to improve efficiency would be greater because of marginal income derived only from extra work.

Following Palmer (2006), however, I should note that some observers might feel that in a market-based system such matters should be left entirely to the market. These same observers might also argue that lower marginal prices for above-contract volumes would reduce the incentive to expand supply, which is an important characteristic of a system that has lower wait times and relatively robust room for patient choices.

In addition, the whole basis of the tariff requires reworking. Such reworking involves, for example, the treatment of excluded costs, the treatment of “sunk costs,” the methodology for allocating costs across HRGs, the finished consultant episode (FCE)/spell conversion and the impact of any market factors to recognize unusual costs (e.g., land values in London).

Understanding the Information Needs of PCT Boards

The issues discussed above illustrate that commissioning – at whatever level – demands strong information in order continually to assess progress. This information can be in many forms and used in many ways, ranging from public health improvement to contract monitoring of providers. This diversity of information and its application suggests the importance of some underpinning principles (Dr Foster 2006):

- All information should
 - be clearly and simply presented;
 - be forward-looking and present trends;
 - be updated in a timely manner according to its purpose and potential volatility;
 - direct the boards' attention to significant risks, issues and expectations; and
 - provide the level of detail that is appropriate to the boards' roles.
- Strategic information should
 - show trends in health needs, provision and patient satisfaction;
 - provide forecasts and anticipate future performance issues; and
 - encourage an external focus and understanding of the context for reform and local action.
- Information for performance monitoring should
 - provide an accurate and balanced picture of current and recent performance, including financial, clinical, regulatory and patient expectations;
 - focus on the most important measures of performance and highlight exceptions;
 - be appropriately standardized in order to take account of known factors that

affect outcomes, such as the age and deprivation of patients; and

- enable comparisons with the performance of similar organizations and health economies.
- The key tests of the success of any information resource for boards will be the extent to which it
 - prompts relevant and constructive challenges;
 - supports informed decision-making;
 - provides early warning of potential financial or other problems; and
 - develops all directors' understanding of the organization, the local health economy and its performance.

The method whereby commissioners acquire this information – given that this responsibility rests with PCTs and is not to be delegated to practice-based commissioners – can be contracted out to third-party agencies, a number of which already exist or might enter the market. Wade et al. (2006: 10) highlight this point using the example of the Greater Manchester Commissioning Business Services:

The Commissioning Business Service (CBS) is a new venture developed by the 14 Greater Manchester primary care trusts (PCTs). The CBS has as its mission the sourcing, procurement and contract-management of the delivery of quality and cost-effective services. It will provide a service to PCTs, practice based commissioners, local authorities, collaborative commissioners, and even providers who sub-contract services. CBS services will include: the provision of off the shelf or bespoke service specifications; a detailed directory of providers and services; public health and comparative clinical data and intelligence; and the full range of opera-

tional contract management including contract compliance and resource utilisation analysis. The CBS is planned to become operational in April 2006 and is currently working on business modeling, the development of memoranda of information for each of its business areas, due diligence, the seeking of expressions of interest in providing CBS services, and the detailed design of the organisational model.

Leadership in Commissioning

The agenda mapped above highlights the significant leadership task for commissioners. The complexity of the task, taken together with the prospect of national elections in the near future and the financial position required by Wanless (2002), creates a hothouse climate for accelerating progress. The successful management of change and of harnessing the various interests, both organizational and professional, will be critical. Such leader attributes will require development throughout the organizations, not just at the most senior levels (Wade et al. 2006).

This organization-deep leadership function mimics the move away from the heroic leader model, so prevalent during recent decades, to a more empowering and engaging style of leader behaviour and change leadership (although one that is no less transforming in its ideology) (Smith 2002; Higgs and Rowland 2005). Additional leader behaviours particularly critical in this situation are as follows (Alimo-Metcalf and Alban-Metcalf 2003):

- Showing genuine concern
- Enabling
- Being accessible
- Encouraging change
- Being honest and consistent and acting with integrity

- Being decisive in resolving complex problems
- Leading the organization and inspiring others
- Focusing effort and supporting a developmental culture
- Facilitating change sensitively

The development of clinical leadership and engagement in the new commissioning models at the PCT and PBC levels will be critical to their success. Clinical leaders add knowledge, experience and skills to the commissioning map. Their leadership development must not be left to chance but supported with personal coaching and organizational development nested in a framework of patient and public engagement in the commissioning process and anticipated outcomes.

What if the Model as Conceived Doesn't Deliver?

Speculating about “what if” might seem a little advanced when the reform program is still so young. However, a number of issues remain on which further work will be needed.

To begin with, “choice” implies that there needs to be headroom in system capacity in order to offer real choice to patients. PCTs will have the task of determining the desirable characteristics of their local health markets, one aspect of which will be the extent of “free capacity” and how that capacity can be accessed equitably. Easing market entry will require using new flexibilities to help encourage new entrants where normal market signals might be insufficient (Department of Health 2006a). These flexibilities include payments above tariff, guaranteed income for providers and reduced capital investment for providers through PCT capital grants or joint ventures.

It will also be important to find ways to deal with market exit. Many hospitals are

constructed financially and physically on the basis of an historical legacy. They might argue that the volumes of activity are not readily influenced, prices are fixed and wages are set nationally. Hospitals might also contend that they carry significant fixed costs and they must break even each year. Rules for foundation trusts offer greater budgetary flexibility due to their financial framework; however, they still form the minority of hospitals in England. Where a hospital is failing, Palmer (2006) suggests three options:

- Restructure the trust on a stand-alone basis. This might involve the closure of certain services for which sufficient demand no longer exists, merging clinical services across trusts under common management where this is cost effective and expanding out-patient services to address the closer-to-home agenda.
- Close the trust only when it can be shown that it can be achieved consistent with protecting patients, preserving the concept of patient choice and delivering essential services locally, albeit through a possible alternative supplier.
- Transfer the trust to another party, such as another NHS trust or foundation trust, or to an independent provider. In 2007, a foundation trust absorbed a failing NHS trust (Timmins 2007).

Equally, commissioners would need to lead or endorse such activities as those highlighted earlier. This would place PCTs' decision-making very much in the public gaze. PCTs remain largely answerable to the public by proxy rather than directly (although this might change). Work commissioned by the Health Policy Forum has touched on alternative, and perhaps more radical, options, should these be needed (Smith et al. 2006). These include, for example, holding PCTs more

accountable to their local populations through quasi-democratic processes by direct elections to PCT boards, or through a stronger mandate on PCTs from municipal authorities. In addition, while providers compete under patient choice, commissioners have locked-in populations – competition among commissioners might therefore be required. It is, however, too early to be judgemental about the rate, pace and success of the current reform program in England.

Conclusion

The new commissioning within the English NHS is still very much in its early days. There are hopes and dangers in equal measure. The divergence of health policy approaches within the UK's four countries will allow important comparisons to be made among them. In addition, the complexity of the reform agenda, the newness of the commissioning organizations and the need to accelerate organizational and personal development to deliver the health gains the public and politicians expect are not risk free. These health gains will require influential and visionary leadership. Likewise, significant organizational development will be needed to secure the potential in the system in which clinical and public engagement is an integral part of that leadership drive.

If it is successful, England's health system reform agenda will deliver benefits to individuals and communities. Looking further into the future, more radical changes might then be required to optimize those benefits.

Endnote

1 The English NHS is unusual in its continuing faith in primary care-based organizations to carry out effective purchasing of healthcare services (Smith et al. 2005).

References

Alimo-Metcalfe, B. and R.J. Alban-Metcalfe. 2003. "Under the Influence." *People Management* 9: 32–35.

- Alvarez-Rosete, A., G. Bevan, N. Mays and J. Dixon. 2005. "Effect of Diverging Policy across the NHS." *BMJ* 331: 946–50.
- Crisp, N. 2005. *Commissioning a Patient-Led NHS*. London: Department of Health.
- Department of Health. 2000. *The NHS Plan: A Plan for Investment, a Plan for Reform*. London: Author. Retrieved May 31, 2007. <http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4002960>
- Department of Health. 2004. *NHS Improvement Plan: Putting People at the Heart of Public Services*. London: The Stationery Office. Retrieved May 31, 2007. <http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4084476>
- Department of Health. 2005. *Creating a Patient-Led NHS: Delivering the NHS Improvement Plan*. London: Author. Retrieved May 31, 2007. <http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4106506>
- Department of Health. 2006a. *Health Reform in England: Update and Commissioning Framework*. London: Author. Retrieved May 31, 2007. <http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4137229>
- Department of Health. 2006b. *PCT and SHA Roles and Functions*. London: Author. Retrieved May 31, 2007. <http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4134649>
- Dr Foster. 2006. *The Intelligent Commissioning Board*. London: Author.
- Greer, S. 2004. *Territorial Politics and Health Policy*. Manchester: Manchester University Press.
- Healthcare Financial Management Association. 2006. *Introduction to Health Service Finance for Non-Executive Directors*. Bristol: Author.
- Higgs, M. and D. Rowland. 2005. "All Changes Great and Small: Exploring Approaches to Change and Its Leadership." *Journal of Change Management* 5(2): 121–51.
- Kelman, S. 2005. *Unleashing Change: A Study of Organizational Renewal in Government*. Washington, DC: Brookings Institution Press.
- Kings Fund. 2006. *Designing the "New" NHS*. London: Author.
- Klein, R. 2001. *The New Politics of the NHS*. Harlow: Prentice Hall.
- Lewis, R. and J. Dixon. 2005. *NHS Market Futures: Exploring the Impact of Health Service Market Returns*. London: Kings Fund.
- Osborn, R.N. and T. Gaebler. 1992. *Reinventing Government: How the Entrepreneurial Spirit is Transforming the Public Sector*. Reading, MA: Addison Wesley.
- Øvretveit, J. 1995. *Purchasing for Health: A Multi-disciplinary Introduction to the Theory and Practice of Purchasing*. Buckingham: Open University Press.
- Palmer, K. 2006. *NHS Reform: Getting Back on Track*. London: Kings Fund.
- Pollitt, C. 2002. "Clarifying Convergence: Striking Similarities and Durable Differences in Public Management Reform." *Public Management Review* 4(1): 471–92.
- Smith, J., J. Dixon, N. Mays, H. McLeod, N. Goodwin, S. McClelland, R. Lewis and S. Wyke. 2005. "Practice-Based Commissioning: Applying the Research Evidence." *BMJ* 331: 1397–99.
- Smith, J., R. Lewis and T. Harrison. 2006. *Making Commissioning Effective in the Reformed NHS*. London: Health Policy Forum.
- Smith, R. 2002. "Needed: Transformational Leaders." *BMJ* 325: 1351.
- Stevens, S. 2004. "Reform Strategies for the English NHS." *Health Affairs* 23(3): 7–44.
- Timmins, N. 2007, April 2. "Trust Takeover of Failed Hospital Shows Way Forward." *Financial Times (FT.com)*. Retrieved May 30, 2007. <<http://www.ft.com/cms/s/253bf6d4-e0b6-11db-8b48-000b5df10621.html>>
- Wade, E., J. Smith, E. Peck and T. Freeman. 2006. *Commissioning in the Reformed NHS: Policy into Practice*. Birmingham: University of Birmingham/NHS Alliance.
- Wanless, D. 2002. *Securing Our Future: Taking a Long-Term View*. London: HM Treasury.

Strategic Purchasing in Home and Community Care across Canada: Coming to Grips with “What” to Purchase



PURCHASING

A. Paul Williams, PhD

Professor, Department of Health Policy, Management and Evaluation,
University of Toronto



Introduction

Over the past two decades Ontario’s healthcare system, like those in other industrialized jurisdictions nationally and internationally, has experienced converging demographic, economic and political pressures. These pressures have pushed policy-makers to rethink how health services should be funded and delivered.

On the one hand, after a period of constrained spending during the mid-1990s governments are once again confronted with rising healthcare costs, a situation that fuels public and political concerns about system sustainability. On the other hand, there is a growing sense that simply spending more

money might complicate, rather than cure, health-system ills. While Ontario’s healthcare system continues to provide a wide array of publicly funded services on the basis of need, it is also characterized by a lack of integration between healthcare silos, including hospitals, physicians, home care, long-term care (LTC) facilities, community-based support services and public health. This lack of integration erects barriers to accessing care, thereby undermining care coordination and continuity and raising important questions about the appropriateness of the care that is provided. Rather than encouraging efficiencies or more innovative, cost-effective approaches to care, this fragmented system has instead reinforced

a tendency, particularly under conditions of fiscal constraint, for providers to attempt to shift costs elsewhere through referrals, earlier discharges, tighter eligibility requirements and service restrictions. It has also led the provincial government to try to limit its costs through capping service budgets, de-listing certain insured services and an unwillingness to cover new procedures and treatments.

It is in this context that, in 2006, Ontario established 14 Local Health Integration Networks (LHINs) responsible for planning, funding and monitoring hospitals, home care, community-based support services, community-based mental health and addictions services and LTC facilities (albeit not physicians, drugs or public health). According to the Government of Ontario (2006), “LHINs are a critical part of the evolution of health care in Ontario from a collection of services to a true system that is patient-focused, results-driven, integrated, and sustainable.”

Like other provinces, Ontario is now attempting to integrate its healthcare system at the regional level, emphasizing that cookie-cutter approaches will not work. Unlike regional authorities in other provinces, however, LHINs will not provide any services directly; rather, they will use budgets set by the province to purchase services from multiple and potentially competing providers (e.g., hospitals) that will continue to operate under their own governance. Policy-makers in Ontario thus confront a key question: What mechanism or mechanisms can LHINs employ to ensure their funding and purchasing decisions create the right incentives to generate a high-performing, responsive and innovative healthcare system?

In responding to this question, I focus in this paper on home and community care (H&CC), a sector that falls under the auspices of LHINs. Located outside of the medicare mainstream of medically necessary hospital

and physician care, H&CC encompasses a wide range of professional and non-professional health and social services (e.g., nursing and rehabilitation therapy services, Meals on Wheels, homemaking and transportation) aimed at helping people who need assistance to live as independently as possible in the community. Consumers include those who require minimal assistance with activities of daily living, as well as individuals with such high needs that they are at risk of hospitalization or LTC facility placement. Most of these consumers are seniors; however, other needs groups – including acute care patients discharged from hospital earlier than was previously typical before the number of hospital beds was reduced, persons with disabilities and a growing number of medically fragile children and their families – also utilize H&CC. A growing body of international research suggests that, when appropriately targeted, managed and integrated into the broader health services continuum, H&CC can play an important role in maintaining the health, well-being and autonomy of individuals and families, while reducing demand for more costly emergency, hospital and LTC facilities.

In the sections below, I briefly review the logic of strategic purchasing, now being positioned in Ontario as a key lever for forging a closer link between health outcomes and the approximately \$35 billion the province spends annually on healthcare (Ministry of Health and Long-Term Care 2006-07). I then describe the mix of approaches for funding H&CC currently used across Canada, noting that these almost always include some service provision by in-house staff. Additional questions arise out of my review of these approaches:

- To what extent can strategic purchasing, which assumes a high degree of individual agency and choice on the part of consumers, be applied in a sector populated by

- vulnerable and often dependent individuals (e.g., frail seniors)?
- To what extent can forms of strategic purchasing, particularly those involving elements of market competition, be expected to achieve performance gains in areas where services are in short supply or for relatively small but specialized-needs populations such as technology-dependent children?
 - Are there other, more fundamental, changes that need to be made before strategic purchasing can be expected to deliver on the promise of achieving a high-performing healthcare system?

A key take-home message is that, particularly in the complex field of H&CC, decisions about what services to purchase and for whom are as important, or even more important, than decisions about how to purchase services and from whom. Indeed, as the examples I give below demonstrate, a robust understanding of the purchasing context at the local level – including both demand- and supply-side variables and the social, political and economic forces that shape them – is a crucial prerequisite for defining clear objectives for purchasing, developing appropriate purchasing mechanisms and linking services to people in ways that serve their needs and contribute to health system sustainability. Even if efficiently purchased, the wrong services are never a bargain.

The Logic of Strategic Purchasing

Strategic purchasing is only narrowly interpreted in the literature as a purchasing mechanism per se. Rather, it is a broad conceptual approach that emphasizes the active involvement of funders and consumers in decision-making around healthcare planning, funding and delivery.

Although the need for such involvement

might seem self-evident, it stands in contrast to the historical logic that governments should finance healthcare but leave responsibility for service delivery largely in the hands of providers. Canadian medicare is essentially a funding mechanism for medically necessary hospital and physician services. It sets clear conditions for eligibility, access and administration but does not direct service mix, volume or quality.

In Ontario, a main role of the provincial government has been to negotiate the size of the insured fee-for-service payment pool for physicians and the amount to be transferred to individual hospitals and community care access centres through annual global budgets – albeit with few performance benchmarks. While minimizing many of the perceived pitfalls of bureaucratic command-and-control structures, this approach has left the province with few tools (short of the blunt instrument of funding constraints) to encourage high performance, integrate care or ensure the attainment of social goals. However, as political pressure has built to address concerns around access, equity and quality – in the face of rising costs – there has been a push away from government as a passive purchaser to a more active role that requires “a continuous search for the best interventions to purchase, the best providers to purchase from, and the best payment mechanisms and contracting mechanisms to pay for such interventions” (World Health Organization 2000: 105; see also Custers 2006; Preker et al. 2006; McKee and Brand 2005; Duran et al. 2005; Department of Health 2006a, 2006b). Rather than withdrawing from healthcare in favour of private markets, since this could also make the attainment of social goals such as equity and access problematic, strategic purchasing points toward public agencies taking a stronger role in the quest to ensure that such goals are met by assessing health needs, using evidence to develop models of care that meet priority

needs, creating the appropriate combination of regulations and economic incentives to implement those models and then evaluating the results (Preker et al. 2006).

The idea of individual choice and agency is also key to the logic of strategic purchasing. In its groundbreaking report on improving health system performance, the World Health Organization (WHO) describes strategic purchasing and emphasizes that final purchasing decisions are to be made by individuals armed with sufficient knowledge to select among high-performing providers (2000). Rather than following the money and taking what's given, consumers are now to use evidence to choose among alternatives, thus establishing incentives for providers to be more responsive and to perform at a higher level. As the recent report in the United Kingdom (UK) on the commissioning of health services also points out, however, individual choice will almost always be qualified by structural factors, including an individual's capacity to access and apply often complex technical information about services and service alternatives and by the availability (and sometimes short supply) of needed services (Department of Health 2006a). Such qualifications might be particularly marked in H&CC, where relevant information about alternatives; remains difficult to access; where, particularly outside of urban centres, there might be few providers and few service alternatives; and where vulnerable, often dependent individuals – such as frail seniors and those with cognitive impairments, mental illness or literacy problems – might face formidable obstacles in navigating healthcare silos.

Approaches to Funding and Purchasing H&CC across Canada

In spite of growing interest in improving health system performance in Canada and internationally, there is little published

research documenting and evaluating different funding and purchasing mechanisms, particularly outside of the acute care sector (McNamara 2006). In Canada, a continuing lack of evaluation of regionalization initiatives that integrate H&CC compounds this general lack of evidence.

In part, this lack of evidence reflects policy-makers' continued preoccupation with acute care. It also reflects the challenges associated with measuring soft outcomes such as quality of life and well-being; the fact that many circumstances and factors beyond the healthcare system – including the presence of family carers, social connectedness and the broader determinants of health – strongly affect outcomes; the reality that many individuals – particularly frail seniors – experience functional decline and death regardless of the quality of care provided and that many of those who depend on H&CC – including frail seniors, children with continuing complex care needs and persons with mental health problems – are among those least likely to be able either to exit from services that do not meet their needs or to voice their concerns about inadequate or inappropriate care (Baranek et al. 2000, 2004; Williams et al. 1999).

Nevertheless, the grey literature in this sector is growing, albeit slowly. A scan of this literature suggests that no single approach to funding and purchasing “fits all” – a mix of approaches is currently used for H&CC within and between jurisdictions across Canada. For example, Alberta's East-Central Health Authority directly provides in-home nursing, rehabilitation services, respite and home support personal care; coordinates access to meal programs, home support, homemaking and home maintenance; refers clients to day hospitals and group homes and directly provides or coordinates home care services for children with complex care needs (Hollander 2007). Three cases below highlight

three different approaches: coordination of care across multiple providers, self-managed care models and managed competition.

Program of Research to Integrate Services for the Maintenance of Autonomy, Quebec

An inter-sectoral cooperative model is at the core of Quebec's Program of Research to Integrate Services for the Maintenance of Autonomy (PRISMA) that aims to meet the care needs of frail seniors (Hébert et al. 2003a, 2003b; Hollander 2007). In contrast to fully integrated models – in which a single entity subsumes different elements of the care delivery system under one administrative structure – this model relies heavily on coordination among independent providers (funded through different sources), which retain their own governance but agree to participate under an umbrella system. Coordination takes place at multiple levels, including the strategic or governance level (through creation of a joint governing board comprising senior directors/decision-makers from different provider organizations); the tactical or management level (through a service coordination committee comprising intermediate-level managers who facilitate and monitor the service delivery continuum); and the clinical or operational level (where case managers evaluate clients' needs and manage care delivery).

PRISMA has several features that promote the most appropriate use of services across the continuum (Hébert 2006):

- A single point of entry
- Support for frail seniors who require multiple services and complex service coordination by case managers who assess needs, plan services, negotiate and coordinate required services and ensure that services are provided
- A single assessment instrument that elaborates a case-mix classification system

used to determine the service needs of individuals and populations

- An inter-institutional electronic clinical chart that makes critical information available to providers and consumers in real time

Self-Managed Care Programs, Alberta

A second approach relies heavily on the capacity of individuals and families to identify needs and purchase services. A range of self-managed care models are now being used by seniors, persons with disabilities and children with continuing care needs (Spalding et al. 2006). Three such models are found in Alberta.

Alberta's Self-Managed Care Program is available to people of any age who are eligible for home care, have stable medical conditions or care needs and require personal care services. Applicants are assessed by an occupational therapist who determines the number of hours of care an individual is eligible for per month and assigns a care budget. Care recipients may receive funds directly into their bank accounts to hire and train care providers or they may elect to have family members or friends manage funds and care on their behalf. Consumers who are legally incapacitated (e.g., people with developmental disabilities, seniors with dementia) may have their care managed by a legal guardian.

Alberta's Individualised Funding Program is available to people over 18 years of age who are assessed (usually by a physician or through a school program) as having a developmental disability (defined as having significantly below-average intellectual capabilities) and require assistance in at least two areas. The majority of individuals in this program require assistance to self-manage. With the aid of a family member or client-service coordinator, the individual must submit a plan of care that outlines his or her support and financial needs. To receive funds, individuals must either

designate a funds administrator or arrange to have their service providers paid directly.

A third Alberta approach involves the conversion of publicly funded LTC facility beds into designated assisted living units (Armstrong and Deber 2006). While conventional nursing homes offer a range of bundled services paid through a combination of public funding and resident charges, this form of assisted living offers lower accommodation fees but shifts more responsibility onto residents and their families for purchasing and managing services. For instance, according to a recent review (Armstrong and Deber 2006), conversion of a nursing home to assisted living units in the town of Hinton has meant that housing and support services (e.g., meals, laundry, cleaning, emergency call systems) are now private contractual arrangements between operators and residents/families, who must also take on direct financial responsibility for a range of medically necessary products and services and for managing other services (e.g., nursing, physiotherapy) that have moved off site. While thus offering care recipients and carers greater control, questions have arisen regarding the capacity of high-needs individuals who are eligible for LTC placement to access and manage services themselves and about the availability of service options in smaller centres.

Managed Competition, Ontario

A further approach introduces competitive market forces into the purchasing process. In 1996, Ontario launched a managed competition model for procuring home care services as a means of achieving “highest quality” at the “best price” (Randall and Williams 2006). While competition was seen as a mechanism for encouraging innovation, responsiveness and cost-efficiency, the process itself was still to be managed so that the lowest price did not trump goals such as quality and accessibility.

As part of its reform, the government created 43 community care access centres (CCACs) – recently restructured to create 14 larger CCACs under the auspices of LHINs – that serve as single points of access for individuals requiring professional home care services (e.g., nursing, rehabilitation therapy), placement in LTC facilities (e.g., nursing homes) or referral to community-based support services (e.g., Meals on Wheels, transportation) (Baranek et al. 2004).

From an operational standpoint, the CCACs represented a dramatic departure from the logic of the home care programs that preceded them. Rather than more or less automatically relying on established, mostly not-for-profit providers and rolling-forward service contracts, the reform required that contracts be awarded on the basis of a competitive request-for-proposal bidding process open to for-profit and not-for-profit providers. Moreover, often due to difficulties in finding external contractors, CCACs that had previously provided some services (e.g., nursing, rehabilitation) in house were no longer permitted to do so. Instead, they were to divest staff that would then, presumably, compete for service contracts. In a number of cases, however, CCACs were unable to divest because providers were unwilling to bid for contracts (Randall and Williams 2006; Williams et al. 2005).

As the 2004 report of the Office of the Provincial Auditor and a subsequent provincially commissioned report concluded (Caplan 2005), a lack of evidence, information and benchmarks hampered systematic evaluation of the impact of managed competition on quality, client outcomes and overall home care performance. Nevertheless, Caplan concluded that service quality had improved due to the competitive bidding process. Two more recent studies (Randall and Williams 2006; Williams et al. 2005), however, suggest important limi-

tations to this process in two areas characterized by high specialization and low volume: paediatric and rehabilitation home care.

The first limitation involves the introduction of competitive bidding, which appears to have complicated existing health human resource shortages. Uncertainty and the cost of producing bids resulted in few bids from providers, with fewer individuals willing to work in the sector given higher wages and more stable work environments in proximate sectors (e.g., hospitals). Second, the combination of short supply and limited competition contributed to higher bids, particularly outside urban areas where there were fewer providers and individual professionals had more market leverage. Third, significant overhead costs were incurred as a result of the competitive bidding process, both by the CCACs, which managed the process, and by providers, which now had to produce detailed bids. In 2001, for-profit and not-for-profit providers estimated that overhead costs accounted for between 20% and 35% of CCAC expenditures (Ontario Home Health Care Providers Association and Ontario Community Support Association 2001). Fourth, given capped CCAC budgets, higher service costs led to lower service volumes and reduced access. Finally, the competitive process was widely seen to have established a disincentive to collaboration and the sharing of evidence and best practices because providers were increasingly concerned they might lose their competitive edge.

Toward an Integrated Continuum

My brief review suggests that a range of different approaches to funding and purchasing H&CC are now being used across Canada, albeit with little evaluation of outcomes. Two additional examples, however, offer preliminary but persuasive evidence that, regardless of how services are funded and purchased, integrating and managing H&CC

within the broader healthcare continuum is a crucial prerequisite for attaining many of the individual and system-level goals associated with strategic purchasing.

Vancouver Coastal Health

The first example concerns Vancouver Coastal Health (VCH), a regional health authority in British Columbia (BC) that provides a comprehensive range of health services and programs – including hospitals, community-based care, residential care, home-based care and mental health and public health services – to over one million people (25% of BC's population) in communities stretching from Richmond and Vancouver (Rigg 2006; see also Goodreau's contribution to this collection). VCH is noteworthy in that it has explicitly linked community-based services to performance benchmarks in the acute and LTC sectors. For example, as part of its alternate level of care ALC bed strategy, VCH aimed to reduce the number of acute and rehabilitation in-patient beds occupied by individuals who could not be discharged due to a lack of appropriate community care options. In addition to using costly hospital beds inappropriately, it was estimated that seniors in ALC beds lost up to 5% of their functional capacity each day they spent in hospital. VCH also aimed to reduce the number of LTC beds as well as inappropriate use of hospital emergency rooms (ERs).

Although a comprehensive evaluation has not yet been completed, preliminary results appear remarkable. By providing integrated, case-managed care targeted particularly at high-needs individuals, an estimated 500 LTC beds have been closed; individuals with lower needs can now be directed toward assisted living. Moreover, through a combination of measures – including transitional care units, priority placements for patients waiting in acute care and increased home support budg-

ets – ALC days dropped from 12% to 6% (with a final target of 4%), thereby freeing up additional resources for community care. Finally, through the introduction of geriatric nurses in hospital ERs who diverted inappropriate admissions to community care, an equivalent of 17 in-patient beds were saved. Currently, VCH is developing partnerships with family physicians aimed at integrating primary care into its continuum.

The Veterans Independence Program

A second example is the federal Veterans Independence Program (VIP). This program offers a comprehensive suite of services to 103,000 clients. Services include the following (Pedlar 2006):

- Assistance with daily personal care (e.g., bathing, dressing)
- Health and support services provided by professionals (e.g. nurses, occupational therapists)
- Access to nutrition (e.g., Meals on Wheels)
- Housekeeping (e.g., laundry, vacuuming, meal preparation)
- Grounds maintenance (e.g., grass cutting, snow removal)
- Ambulatory health assists outside the home (e.g., adult day care, health assessments, diagnostic services)
- Transportation to activities (e.g., shopping, banking, visiting friends) when transportation is not otherwise available
- Home adaptations to facilitate access/mobility (e.g., modifications of bathrooms, kitchens, doorways)
- Nursing home care in the client's community if/when he or she can no longer remain at home

VIP's success in substituting community-based support services for residential care is

particularly noteworthy. Prior to VIP's implementation, aging veterans had experienced growing wait lists for contracted LTC beds; it was estimated that 20,000 beds would be required to meet their needs (Pedlar 2006). As an alternative, VIP offered wait-listed veterans community care packages in their own homes or in settings such as supportive housing. The result was that most veterans preferred to stay at home and, following VIP's implementation nationally in 2003, LTC wait lists were virtually eliminated. Moreover, the most-used services for these at-risk individuals proved to be homemaking and grounds maintenance.

Note that most of the services provided by VIP are contracted out, or accessed through provincial programs. What seems to be key is the important role of the case manager in assessing needs, planning care, managing access to appropriate care across the continuum, following up to ensure care continuity and managing care transitions.

Discussion and Conclusions

Faced with rising costs and growing challenges on both the demand and supply sides, governments in Canada and other industrialized countries are now seeking ways to provide high-quality, cost-effective and appropriate care to aging and increasingly diverse populations. In Ontario, the government has positioned strategic purchasing as a lever for improving health system performance. In its narrowest conceptualization, strategic purchasing refers to specific purchasing mechanisms. Conceptualized more broadly, however, strategic purchasing encompasses the dynamic processes of strategic thinking and action through which funders continuously assess needs as well as plan, fund and evaluate services. H&CC's greatest potential lies within this broader conceptualization.

An expanding grey literature clarifies that a mix of approaches is now being used across

Canada at the regional level to fund and purchase H&CC. This literature also clarifies that, regardless of the funding and purchasing approach used, the most notable successes involve initiatives that integrate and manage care across the continuum and that therefore permit H&CC to be substituted, where appropriate, for more costly care in hospitals and institutions. When provided in a fragmented system, or to individuals who do not require them to avoid functional decline or related health problems, support services such as grounds maintenance and housekeeping are unlikely to be more than a convenient cost add-on and a source of concern for policy-makers. However, as the VIP example shows, when provided within an integrated package to individuals at risk of becoming ill or losing independence, such services can effectively substitute for LTC facility care. The VHA example further suggests that targeted, managed and integrated H&CC can relieve pressure on hospital ALC and ER beds, key concerns in Ontario and many other jurisdictions.

Conversely, a failure to acknowledge H&CC as a crucial element of the healthcare continuum can have negative consequences for individuals and health system sustainability. For example, Hollander (2004) observes that a continuing preoccupation with curative, institutionally based care actually fuels a cycle of increasing costs as individuals, lacking lower-level community-based care, end up making greater use of more costly hospitals and LTC facilities. This, in turn, draws more resources away from the community sector, leading to further rounds of increased demand on hospitals and facilities.

With respect to the role of individual agency and choice, case-management models seem to be important, particularly for vulnerable, high-needs individuals and their carers. A key factor in VIP's success is the ability of

case managers to select appropriate services from across the continuum. This is consistent with the recent policy thrust in the UK (Department of Health 2005), which differentiates between the majority of the population that requires only minimal support or information to self-manage; a smaller, but still significant group that includes people who require specialist support to manage their care; and a small minority of high-intensity users of unplanned secondary care who are to be assigned a case manager to anticipate, coordinate and integrate needed healthcare and social care services.

The question is not whether individual choice is important, but how best to support choice. Indeed, the Alberta self-managed care options suggest that individuals with different levels of need will require different levels of support. They also underline the fact, recognized by a recent UK report (Department of Health 2006a), that choice depends both on the capacity of individuals to negotiate services (which will be limited particularly for people with complex, long-term conditions) and on the availability of service options (which also may be limited, particularly outside of urban areas).

With regard to the use of competitive market models, Ontario's experience with managed competition suggests some related cautions. Particularly where services are in short supply, competitive models might result in higher service costs, higher overhead costs and reduced access to care. They might also create disincentives toward collaboration and the sharing of best practices, crucial requirements for overcoming silos, allowing cost-effective substitutions and encouraging high performance at both the provider and system levels.

This brings me back to my key take-home message: Particularly in the field of H&CC, which is heavily populated by vulnerable

individuals at the margins of dependency and institutionalization, decisions about what services to purchase and for whom are as important, or even more important, than decisions about how to purchase services and from whom. No matter how efficiently purchased, LTC, ER and ALC beds are never going to be a bargain for individuals or the healthcare system if more appropriate – and more cost-effective – H&CC options are available. Indeed, as noted, a continued preoccupation with finding solutions within the mainstream of the hospital and physician system might actually prove to be counterproductive if it means that individuals lacking lower-level services closer to home can access care only after they become ill or dependent. This point emphasizes the importance of conceptualizing strategic purchasing as a dynamic process of strategic thought and action – one that involves policy-makers, individuals and carers – aimed at integrating services across a continuum that includes both institutional care and H&CC.

References

- Armstrong, W. and R. Deber. 2006. *Missing Pieces of the Shift to Home and Community Care: A Case Study of the Conversion of an Alberta Nursing Home to a Designated Assisted Living Program*. Retrieved March 6, 2007. <<http://www2.m-thac.org/cgi-bin/WebObjects/mthac.woa>>
- Baranek, P., R.B. Deber and A.P. Williams. 2000. "Policy Trade-Offs in 'Home Care': The Ontario Example." *Canadian Journal of Public Administration* 42(1): 69 – 92.
- Baranek, P., R.B. Deber and A.P. Williams. 2004. *Are We Home Yet? Reforming Home and Community Care in Ontario*. Toronto: University of Toronto Press.
- Caplan, E. 2005. *Realizing the Potential of Home Care: Competing for Excellence by Rewarding Results: A Review of the Competitive Bidding Process Used by Ontario's Community Care Access Centres (CCACs) to Select Providers of Goods and Services*. Toronto: CCAC Procurement Review. Retrieved March 6, 2007. <http://www.health.gov.on.ca/english/public/pub/ministry_reports/ccac_05/ccac_05.pdf>
- Custers, T. 2006. *Strategic Purchasing in the LHIN Context: An Exploration*. Toronto: Ontario Ministry of Health and Long-Term Care.
- Department of Health. 2005. *Supporting People with Long Term Conditions*. London: Author. Retrieved March 6, 2007. <http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4100252>
- Department of Health. 2006a. *Health Reform in England: Update and Commissioning Framework*. London: Author. Retrieved March 6, 2007. <http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4137226>
- Department of Health. 2006b. *A Stronger Local Voice: A Framework for Creating a Stronger Local Voice in the Development of Health and Social Care Services*. London: Author. Retrieved March 6, 2007. <http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4137040>
- Duran, A., I. Sheiman, M. Schneider and J. Øvretveit. 2005. "Purchasers, Providers and Contracts." In J. Figueras, R. Robinson and E. Jakubowski, eds., *Purchasing to Improve Health Systems Performance*. Berkshire: Open University Press.
- Government of Ontario. 2006. *Local Health System Integration Act, 2006*. Toronto: The Queen's Printer. Retrieved March 6, 2007. <http://www.health.gov.on.ca/english/public/legislation/lhins/hu_lhins.html>
- Hébert, R. 2006. "PRISMA: An Innovative Model of Integrated Service Delivery Network." Presentation to Ideas to Action – Integrating Community Support Services within Regionalized Models: Innovations and Best Practices from across Canada. Toronto. October 20, 2006. Retrieved March 6, 2007. <<http://www.crnc.ca/events/presentations/Rejean%20Hebert%20-%20PRISMA%20an%20innovative%20model%20of%20Integrated%20Service%20Delivery%20Network.pdf>>
- Hébert, R., P.J. Duran, N. Dubuc and A. Tourigny. 2003a. "PRISMA: A New Model of Integrated Service Delivery for the Frail Older People in Canada." *International Journal of Integrated Care* 3: 1 – 10.
- Hébert, R., P.J. Durand, N. Dubuc and A. Tourigny. 2003b. "Frail Elderly Patients: New Model for Integrated Service Delivery." *Canadian Family Physician* (August). Retrieved March 6, 2007. <<http://www.cfpc.ca/cfp/2003/aug/vol49-aug-cme-2.asp>>
- Hollander, M. 2004. *Unfinished Business: The Case for Chronic Home Care Services, a Policy Paper*. Victoria:

- Hollander Analytical Services. Retrieved March 6, 2007. <http://www.hollanderanalytical.com/downloads/unfinished_business.pdf>
- Hollander, M. 2007. *Development of a Strategic Framework for Continuing Care Services: Continuing Care Service Delivery Systems – Case Studies of Current Models*. Rev. ed. Victoria: Hollander Analytical Services. Retrieved March 6, 2007. <[http://www.hollanderanalytical.com/downloads/Case%20Studies%20of%20Current%20Models%20\(January%202007\).pdf](http://www.hollanderanalytical.com/downloads/Case%20Studies%20of%20Current%20Models%20(January%202007).pdf)>
- McKee, M. and H. Brand. 2005. "Purchasing to Promote Population Health." In J. Figueras, R. Robinson and E. Jakubowski, eds., *Purchasing to Improve Health System Performance*. Berkshire: Open University Press.
- McNamara, P. 2006. "Purchaser Strategies to Influence Quality of Care: From Rhetoric to Global Applications." *Quality and Safety in Health Care* 15: 171–73.
- Ministry of Health and Long-Term Care. 2006. *Results-Based Plan Briefing Book 2006–07*. Toronto: Author. Retrieved March 6, 2007. <http://www.health.gov.on.ca/english/public/pub/ministry_annual/annual_rep06_07/annual_rep06_07.pdf>
- Office of the Provincial Auditor of Ontario. 2004. *Annual Report*. Toronto: Government of Ontario.
- Ontario Home Health Care Providers Association and Ontario Community Support Association. 2001. *Building a High Performance Home and Community Care System in Ontario*. Retrieved March 6, 2007. <<http://ocsa.on.ca/PDF/OHHCPA-OCSAPositionPaper.pdf>>
- Pedlar, D. 2006. "The Veterans Independence Program (VIP)." Presentation to Ideas to Action – Integrating Community Support Services within Regionalized Models: Innovations and Best Practices from across Canada. Toronto. Retrieved March 6, 2007. <<http://www.crnc.ca/events/presentations/David%20Pedlar%20--%20The%20Veterans%20Independence%20Program.pdf>>
- Preker, A.S., M.A. McKee and S. Wibulpolprasert. 2006. "Strategic Management of Clinical Services." In D.T. Jamison, J.G. Breman, A.R. Measham, G. Alleyne, M. Claeson, D.B. Evans, P. Jha, A. Mills and P. Musgrove, eds., *Disease Control Priorities in Developing Countries*. 2nd ed. New York: Oxford University Press. Retrieved March 6, 2007. <<http://files.dcp2.org/pdf/DCP/DCP73.pdf>>
- Randall, G.E. and A.P. Williams. 2006. "Exploring Limits to Market-Based Reform: Managed Competition and Rehabilitation Home Care Services in Ontario." *Social Science and Medicine* 62: 1594–1604. Retrieved March 6, 2007. <http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6VBF-4H6PKWB-2&_user=10&_coverDate=04%2F30%2F2006&_rdoc=1&_fmt=summary&_orig=browse&_sort=d&view=c&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=7598ced6906d4172423e0bec53a11de>
- Rigg, N. 2006. "Community Health Services Integration in a Regionalized Model: Vancouver Coastal Health." Presentation to Ideas to Action – Integrating Community Support Services within Regionalized Models: Innovations and Best Practices from across Canada. Toronto. Retrieved March 6, 2007. <<http://www.crnc.ca/events/presentations/Nancy%20Rigg%20--%20Community%20Health%20Services%20Integration%20in%20a%20Regionalized%20Model.pdf>>
- Spalding, K., J.R. Watkins and A.P. Williams. 2006. *Self-Managed Care Programs in Canada: Report to Health Canada*. Toronto: Ryerson University School of Nursing.
- Williams, A.P., J. Barnsley, S. Leggat, R.B. Deber and P. Baranek. 1999. "Long-Term Care Goes to Market: Managed Competition and Ontario's Reform of Community-Based Services." *Canadian Journal on Aging* 18(2): 126–53.
- Williams, A.P., K. Spalding, R.B. Deber and P. McKeever. 2005. *Prescriptions for Pediatric Home Care: Analysing the Impact of the Shift from Hospital to Home and Community on Children and Families*. Toronto: Department of Health Policy, Management and Evaluation and Medicare to Home and Community (M-THAC) Research Unit, University of Toronto. Retrieved March 6, 2007. <http://www.crnc.ca/knowledge/related_reports/index.html>
- World Health Organization. 2000. *The World Health Report 2000. Health Systems: Improving Performance*. Geneva: Author.

Strategic Outsourcing by a Regional Health Authority: The Experience of the Vancouver Island Health Authority



PURCHASING

Joe Murphy, BSc PHARM, MBA
Vice-President, Operations and Support Services,
Vancouver Island Health Authority



Introduction

This paper is based on the experience of the Vancouver Island Health Authority's (VIHA's) outsourcing initiatives for select support services as well as residential care and assisted living. I describe the formation and functions of health authorities in British Columbia (BC) in general and VIHA in particular. I also address the initiatives VIHA undertook in support of its strategies and priorities and I include a discussion of results to date.

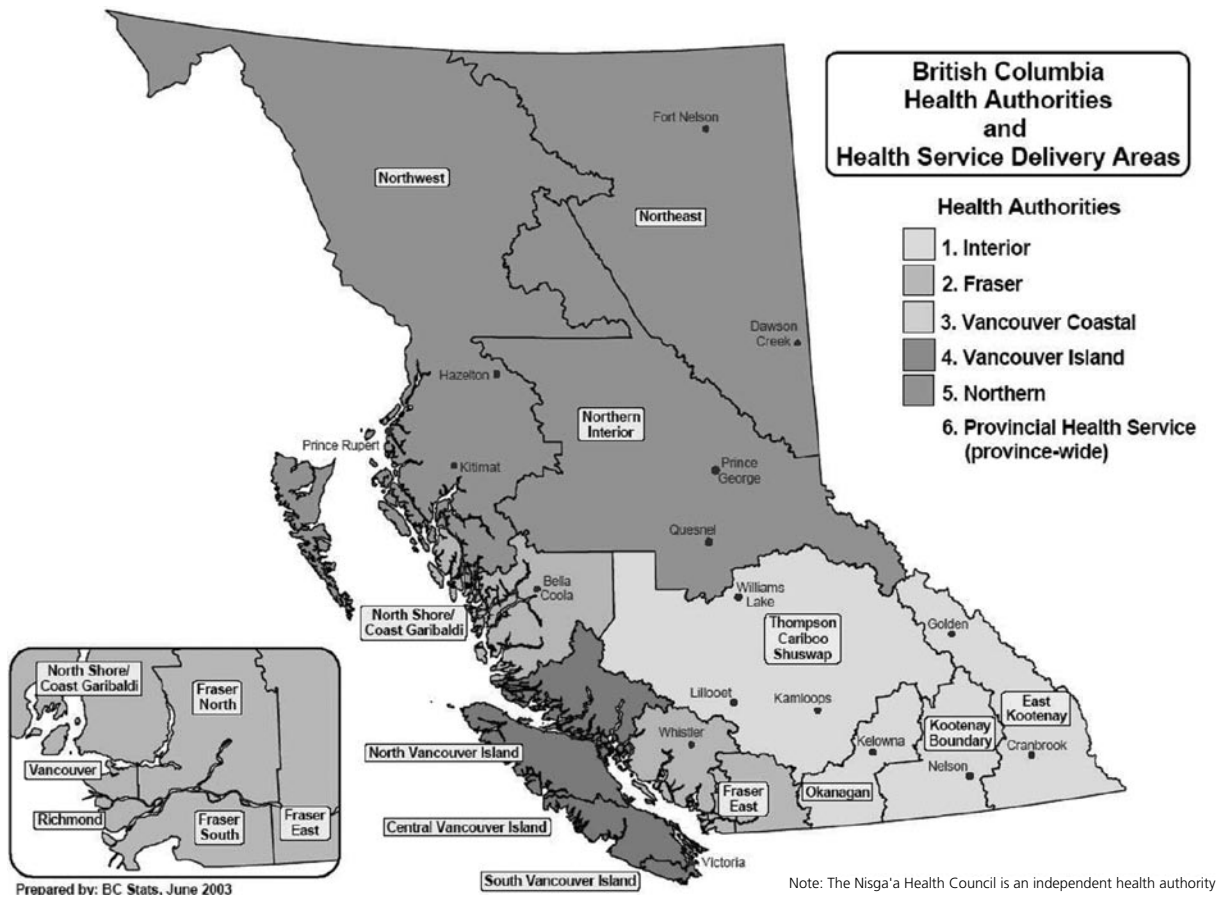
BC's Health Authorities

In December 2001 the BC government merged 52 health organizations to form a

new governance and management structure that involved the creation of five regional health authorities and a province-wide health authority (see Figure 1). These bodies govern, plan and coordinate regional services and participate with the Provincial Health Services Authority, which coordinates and provides programs and specialized services across BC.

The minister of health appoints the health authorities' board members and chairs for two-year terms. The maximum length of time a board member may serve is three two-year terms. Board chairs typically have a strong private sector business background. Performance contracts were created for all six

Figure 1. British Columbia's health authorities and health service delivery areas



health authorities. Fiscal restraint during the first three years of the health authorities' existence (2002–2004) was widespread.

VIHA

VIHA's geographical area covers 56,000 square kilometres and includes Vancouver Island, the Gulf and Discovery Islands and part of the mainland area opposite Northern Vancouver Island (see Figure 2). VIHA serves the health needs of over 730,000 people. It operates a network of hospitals, clinics, centres, health units and long-term care facilities (138 facilities in total). It employs or contracts with 16,000 healthcare professionals, technicians and support staff as well as approximately 1,600 physicians. VIHA's

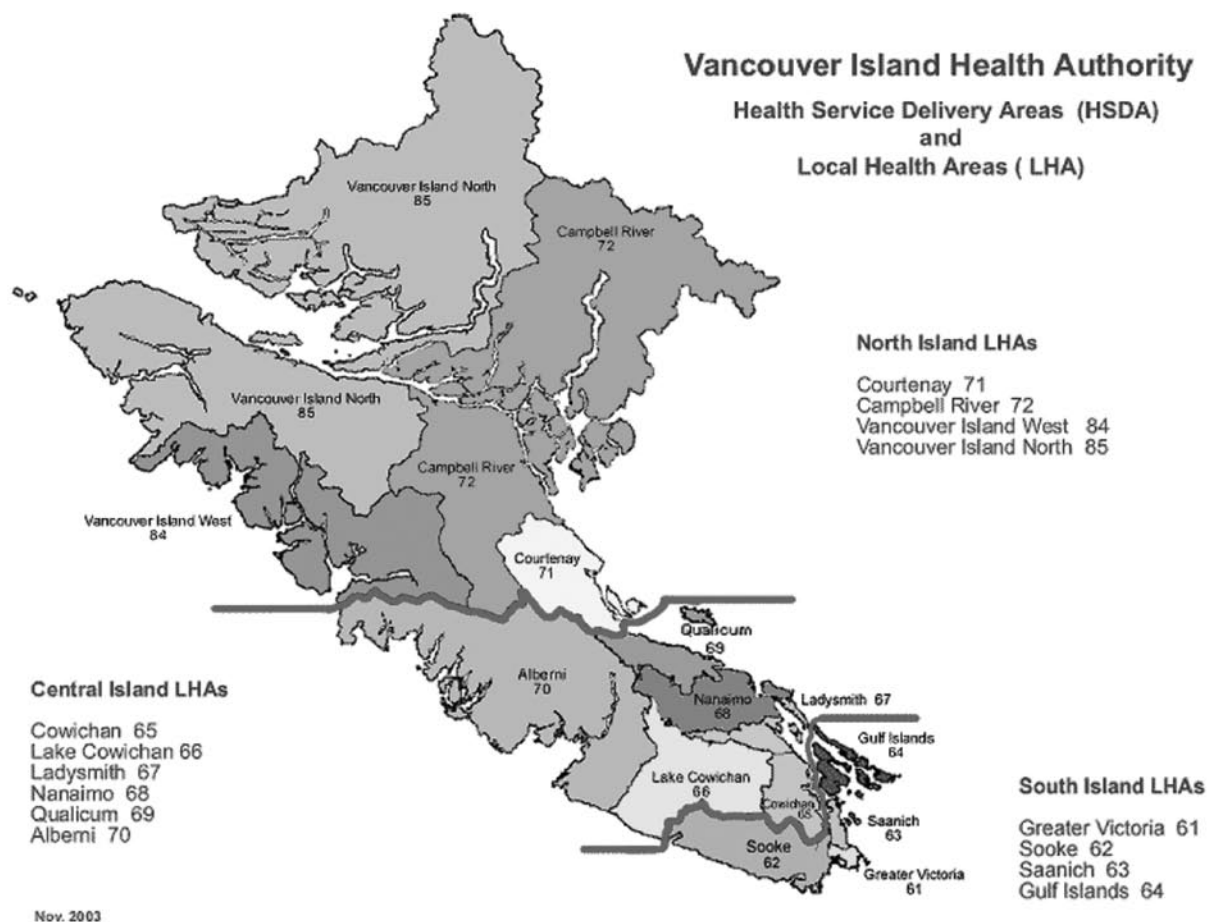
annual operating budget is over \$1.4 billion and it provides approximately 1,534 acute care beds and 4,900 residential care beds/assisted living units.

VIHA is representative of BC overall. Size-wise – i.e., budget, population and area covered – it is at about the middle of the five regional health authorities, with a balance between major urban and rural/remote components. It is also one of the most self-reliant of the health authorities, with well over 95% of the workload for Vancouver Island residents provided from VIHA facilities.

VIHA's Five-Year Strategic Plan

VIHA's *Five-Year Strategic Plan* provides the overall direction for service delivery to

Figure 2. VIHA's territorial components



the year 2010 (Vancouver Island Health Authority 2006). It articulates the need for enhanced integration, responsiveness and innovation. The plan also identifies priority issues along with challenges associated with population and service delivery growth. Likewise, it sets goals, strategic themes and strategic directions by sector and geographical area. The plan also addresses the following:

- New and innovative service delivery models
- Capacity forecasts
- Alignment with the Ministry of Health's strategic direction
- Recognition of the significant demo-

graphic and health status differences throughout VIHA

- Clinical input and practical experience

Support Service Outsourcing

The fact that each of BC's health authorities must deal with a unique political and financial context has resulted in different outsourcing approaches across the five regional bodies. In addition, agreement between the BC government and healthcare unions has limited the amount of outsourcing permitted. For its part, VIHA has outsourced environmental support services (ESS), food services and a portion of security.¹ Other BC health authorities have outsourced other services, such as laundry.

The following issues influenced VIHA's (and other health authorities') review of the potential to outsource select support services:

- Performance agreements included a 7% decrease in administrative and support costs over three years.
- Existing collective agreements for the major support services union called for wage increases in each of the following three years (8%–10% total).
- A 0% increase to budgets for three years was projected.
- Provincial legislation allowed contracting public health sector support services to the private sector.

There were also multiple risks to consider when contemplating outsourcing. These included, but were not limited to, the following:

- Limited competition
- Organizational disruption
- Organizational culture
- Union response
- Media interest
- Public confidence
- Legal
- Changing political landscape
- Vendor capability

VIHA's key objectives when contemplating outsourcing included the following:

- Reducing support services costs in order to maintain patient/client care services volumes
- Facilitating raising the food-service delivery system to meet the industry's best-practice level
- Acquiring the capital equipment and information technology infrastructure

required to meet industry best practices (historically, support services requests for capital equipment were treated as a lower priority than patient care requests)

- Examining how performance agreement targets could be met
- Maintaining or exceeding current standards of quality and service volume

VIHA was the fourth BC health authority to enter the market, and three international vendors expressed an interest in providing services. This undertaking required the full support of the board of directors and virtually all segments of VIHA.

The environmental support services agreement, which incorporated 80% of VIHA's ESS budget, resulted in the following:

- Annual savings of \$6 million
- Performance standards
- Internal/external audit procedures
- Public reporting of results
- Performance bonuses/penalties
- \$500,000 investment in capital equipment
- \$1 million signing bonus for VIHA

The food service agreement resulted in the following:

- Greater Victoria sites converted >6,000 meals per day projected
- Annual savings of \$2.5 million
- \$5 million capital/information technology (IT) investment
- Performance standards
- Internal/external audit
- Public reporting of audit results
- Performance bonuses/penalties
- \$1 million signing bonus for VIHA

When outsourcing a large and critical component of an organization's infrastruc-

ture, risk mitigation is important. Both the ESS and food service agreements therefore contained the following clauses:

- Recruitment/retention became the sole responsibility of the successful vendor.
- Wage rate increases became the sole responsibility of the successful vendor.
- Significant performance bonds were secured for each contract.
- The contracts are renewable for an additional five years or parts thereof.
- The contents are expandable to other VIHA sites or affiliate organizations.

Results

ESS standards have consistently been met after the first two years of operation (these incorporate infection control standards). Food safety standards are also being met. Food satisfaction ratings, however, remain challenging and require significant investment of time by both the vendor and VIHA. Provincial standards and audit methodology have been developed and adopted by all BC's health authorities for ESS and food services. Standards and audit procedures have been extended to all VIHA facilities regardless of the providers involved. Finally, cost savings are still being realized and have allowed patient/client/resident services to be maintained, thus enabling VIHA to meet its strategic priorities.

Lessons

We learned abundant lessons from undertaking outsourcing of this magnitude:

- A tight request for proposal (RFP) process

and contract provides risk mitigation.

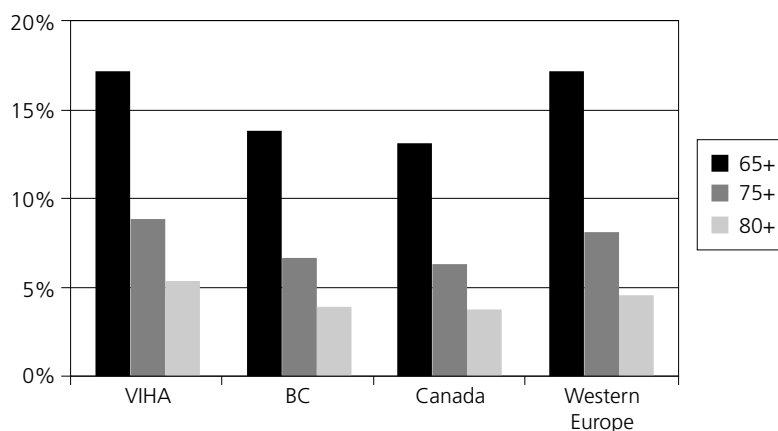
- A changing environment can impact a proponent's success.
- Variables such as low unemployment rates, high cost of living, increased competition in the same wage band, the robustness of union/labour strategy and a changing political landscape all play a role in a private sector vendor's success.

Residential Care and Assisted Living

VIHA's Senior Population

The most notable difference between VIHA and the province's other health authorities is the age of the population we serve, largely because Vancouver Island is a preferred retirement destination. This is one of the most significant challenges we face and will continue

Figure 3. Proportion of seniors in VIHA, BC, Canada and Western Europe



to face for at least the next 20 years. Figure 3 shows that our demographic profile resembles that of Western Europe more than the rest of BC and Canada, as those aged 65 and over make up almost 17% of the total population (compared to 14% in BC and 13% in Canada).

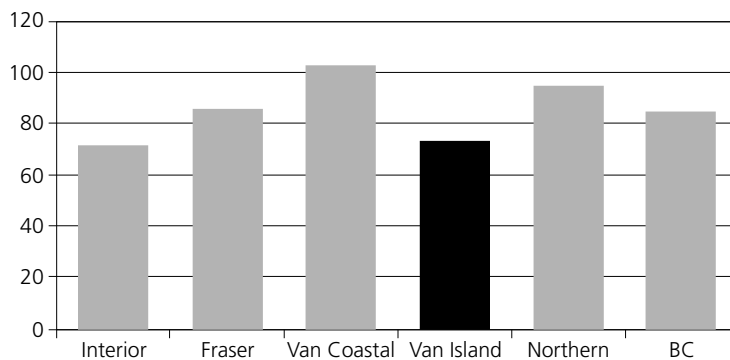
About 8.6% of the VIHA population

is aged 75 and over (compared to 6.4% for BC) and 2.2% of the population is aged 85 and over (compared to 1.6% for BC). Within VIHA, the south area has the greatest proportion of seniors. The largest growth in seniors will, however, occur in VIHA's central area, where a 40% increase (2,119) in residents aged 85 and over is expected by the year 2010.

Outsourcing Residential Care and Assisted Living Services for VIHA's Seniors

Figure 4 shows that VIHA is significantly below the provincial average for home and community beds per 1,000 people aged 75 and over.

Figure 4. Home and community beds per 1,000 people aged 75 and over



The BC government has committed to opening 5,000 additional long-term care beds by the end of 2008. VIHA and BC Housing² have initiated a procurement process to secure 980 residential care beds and assisted living spaces by 2008 and up to 1,230 residential care beds and assisted living spaces by 2010. Partnerships BC³ was engaged to manage the procurement process involved in delivering firm contracts for this capacity.

BC's asset management framework is based on the following principles (Ministry of Finance 2002):

- Value for money
- Sound fiscal and risk management
- Strong accountability in a flexible and streamlined process
- Emphasis on service delivery
- Serving the public interest
- Competition and transparency

Coinciding with these principles, VIHA's key objectives for its residential care and assisted living initiative include the following:

- Deliver on the strategic plan targets for BC and open all units no later than December 2008.
 - Develop communities of care where possible and appropriate.
 - Capture creativity and innovation through the process.
 - Introduce the new Provincial Residential Care Services Operating Agreement.

Time-wise, the competitive selection process was extremely tight: we issued a notice of intent in December 2005 and contracts were signed by May 2006. Our RFPs sought innovations in the area of complex care and

assisted living. Ideally, they were to be set up as communities of care and located in eight different communities on Vancouver Island to meet the demographic needs we identified in our strategic plan. The key terms of the contracts were as follows:

- Project development agreements – terms and conditions:
 - Design requirements
 - Review process
 - Agreed-upon schedule
 - Sanctions if terms and conditions were not met

- Residential care services operating agreements
- Assisted living services operating agreements

We anticipate that all facilities will be open by September 2008. Service providers are responsible for all aspects of financing, including design, development, construction and operational costs. Funding commences

“... low unemployment rates, high cost of living, increased competition in the same wage band, the robustness of union/labour strategy and a changing political landscape all play a role in a private sector vendor’s success.

upon receipt of each provider’s first client and penalties are included for each day a service provider is behind schedule. Service providers are also responsible for all risks associated with construction cost escalation. VIHA and BC Housing have contracted to fund the facilities at the agreed-upon contract prices.

Results

VIHA’s residential care and assisted living initiative has achieved numerous positive results:

- Value for money has been achieved: the successful proponent(s) in all four major geographical areas (eight communities) presented either the lowest bid (3/4) or close to the lowest bid (1/4).

- All contracted proponents’ proposed facilities have been established as communities of care.
- Innovation was sought and provided. Some of the areas of innovation included in the proposals were as follows:
 - Provision of respite or hospice care within the community of care
 - Adult day programs
 - Community outreach
 - Intergenerational programming
 - A community of care model
 - Delivery of a new model of dementia care
 - Therapeutic community bathing programs
 - Delivery of mental health services within specialized areas
 - Design flexibility to allow expansion
 - Design that incorporates a co-located primary health centre

Taken as a whole, the overall development schedule is three months ahead of schedule.

Conclusion

BC’s health environment and structure have changed in the last five years to provide a wide range of health services under large health authorities, and a performance monitoring system is in place to monitor their delivery. VIHA has a well-thought-out strategic plan that captures the demographics and needs of the residents it serves until the year 2010. The two examples given in this paper reveal how VIHA has operationalized strategic levers in order to meet its strategic goals.

Addendum

On July 8, 2007, the Supreme Court of Canada rendered its judgement on the constitutional validity of Bill 29, BC’s Health and Social Services Delivery Improvement Act.

The justices found three sections of Bill 29 to be constitutionally invalid. The decision struck down sections 6.2 (no restrictions on contracting out), 6.4 (no requirement of consultation prior to contracting out) and 9 (layoff and bumping). The judgement overrules previous Supreme Court decisions, which held that collective bargaining was not constitutionally protected. The effect of the decision has been suspended for 12 months to allow the government to address the repercussions of this decision.

The consequences for the province's health authorities and contracted service providers concerning liability and indemnification are undetermined at this time. The Government of British Columbia is currently analyzing the implications of the Supreme Court's verdict.

Endnotes

1 ESS covers housekeeping, linen and laundry distribution, recycling and pest control.

2 The British Columbia Housing Management Commission (BC Housing) was created in 1967 under an Order in Council to fulfill the government's commitment to the development, management and administration of subsidized housing.

3 Partnerships BC is a company responsible for bringing together ministries and the private sector to develop projects through public-private partnerships. Registered under the Business Corporations Act, Partnerships BC is wholly owned by the province of BC and reports to its shareholder, the Ministry of Finance.

References

Ministry of Finance. 2002. *Capital Asset Management Framework*. Victoria: Government of British Columbia. Retrieved April 23, 2007. <<http://www.fin.gov.bc.ca/tbs/camf.htm>>

Vancouver Island Health Authority. 2006. *Five-Year Strategic Plan*. Victoria: Author. Retrieved April 23, 2007. <http://www.viha.ca/about_viha/accountability/strategic_plan_2010>

Over 1.2 million hits a month

See what you're missing



longwoods.com

ALL THINGS CONSIDERED

Healthcare*Papers*

Thoughts on the Day: Strategic Purchasing and Equity



Raisa Deber, PhD

Professor, Department of Health Policy, Management and Evaluation,
University of Toronto

Steven Lewis

President, Access Consulting Ltd., Saskatoon
Adjunct Professor, Centre for Health and Policy Studies,
University of Calgary



HEALTH REFORM IS complex, and simple solutions tend to be elusive. The speakers at the Strategic Levers for a High-Performing Health System symposium presented valuable insights about two key issues confronting health system reform: strategic purchasing and equity. Given the dollars at stake – \$148 billion annually and counting in Canada, nearly \$100 billion of which comes from the public purse – and the fact that we are often talking about life-and-death decisions, it is hardly surprising that interests, power and perceived legitimacy affect how we choose to proceed. What can we conclude from what we heard?¹

Strategic Purchasing

Narrowly understood, strategic purchasing can be considered synonymous with prudent buying: getting good value for money, specifying with some precision the terms of a transaction, managing risks and negotiating good prices. In effect, it shifts the argument from who should finance care (Figueras et al. 2005; Marchildon et al. 2004; Mossialos et al. 2002) to who should deliver it (Deber 2004). Strategic purchasing also entails addressing the incentives inherent in various payment mechanisms. As the symposium's speakers clarified, these considerations, in turn, involve

a series of questions, including the following:

- *Who decides about what?* Ron Sapsford's discussion of the extent to which such decisions should be decentralized touched on the roles of Ontario's new Local Health Integrated Networks (LHINs) and Ministry of Health and Long-Term Care. Reinhard Busse observed similar issues in Organisation for Economic Co-operation and Development (OECD) countries.
- *What criteria will be used? Quality? Volume? Cost? Outcomes? Innovation? Satisfaction? And how will performance be measured?* Adalsteinn Brown commented on key issues involved in such activities.
- *What issues are entailed in deciding whether systems should rely on public delivery or shift to private providers?* Gerry McSorley described the shift as it unfolded in the United Kingdom (UK) and Reinhard Busse addressed the transformation in the OECD systems that use public delivery.
- *What are the issues involved in using for-profit or not-for-profit delivery?* Joe Murphy discussed this topic as it applied to British Columbia (BC).
- *What is incorporated in the delivery model?* Paul Williams discussed sector-specific models (emphasizing home care) and David Levine addressed Quebec's integrated models.

Putting it all together, we are prompted to ask, "When might strategic purchasing work?" Here is the short answer: "It depends."

The concept of strategy suggests that purchasers must make choices, invest and buy coherently and should ultimately be accountable for achieving their declared ends. For a number of reasons, this has proven to be a very tall order in healthcare (Belli 2004; Figueras et al. 2005). One must consider, for example, the characteristics of what is being

purchased, for whom and the processes used to determine how purchasing is done.

One element of the "what" question relates to the outcomes sought. At an aggregate level, once a certain level of spending has been achieved there is no clear relationship between per-capita spending on health – which is itself a function of the mix of services, volume provided and price paid for each – and such aggregate outcomes as life expectancy and infant mortality rates (Kanavos and Mossialos 1999; Leon et al. 2001; Retzlaff-Roberts et al. 2004). Even considering the specific items, the huge body of research attempting to estimate the cost per Quality-Adjusted Life Year (QALY) has its own controversies, including how best to capture softer outcomes (Birch and Donaldson 2003; Daniels and Sabin 1998; Deber and Goel 1990; Donaldson 2004; Drummond and Sculpher 2005; Gold et al. 1996; Menzel et al. 1999).

An optimist might suggest that strategic purchasing could help to deter or eliminate demonstrably inefficient purchases that have appeared otherwise impervious to change (Fisher et al. 2000; Wright et al. 2002). Others might note that the first problem is specifying what is to be purchased in broad terms. Strategic purchasing will be enormously influenced depending on whether one seeks to buy the greatest health impact per dollar (a utilitarian approach), to meet needs (however defined), to enhance equity or even to pursue additional policy goals such as encouraging job creation or research, building healthy communities or respecting clinical autonomy. Similarly, concepts such as "value for money" can imply cutting costs by a variety of methods, including lowering wages and salaries, improving productivity, rearranging the division of labour or reducing utilization, not all of which are compatible with each other and which might or might not be widely endorsed. Indeed, to the extent that

some cost cutting has replaced full-time with part-time/casual positions and has otherwise affected recruitment and retention, the resulting shortages of skilled labour (particularly, but not exclusively, in nursing) have often meant that short-term savings have translated into higher long-term costs (Alameddine et al. 2005, 2006; Simoens et al. 2005).

A second element of the “what” question relates to the production characteristics needed to generate particular goods and services. Classical economics assumes that markets, which balance supply and demand, can ensure efficient outcomes. But this, in turn, presupposes perfect (or at least reasonably perfect) competition, whereby no single buyer or seller can dominate the prices to be paid. It also implies that the supply of services can expand or shrink to balance changing demand, which further requires the presence of excess supply that can be called into service if demand increases. As Alan Hudson noted in his presentation, additional capacity can come either from existing providers operating more efficiently or from new ones, which in turn suggests something about how easy and desirable it is for new providers to enter the market and old ones to exit it. Clarifying where strategic purchasing might work thus leads to the need to examine what economists term contestability, measurability and complexity (Deber 2004; Preker and Harding 2000).

Contestable goods are defined as being characterized by low barriers to entry and exit from the market. In contrast, non-contestable goods may have any or all of high sunk costs, monopoly market power, geographic advantages and asset specificity (a technical term used to refer to difficulties in redeploying assets from one use to another). For example, the equipment and skills needed to perform open-heart surgery have few alternative uses, and few policy-makers would wish to “waste” highly skilled and trusted providers

merely because they had not won a particular competitive contract, or to risk the erosion of clinical skills by allowing volume to fall below a critical mass. The ability to contract selectively is larger for contestable than for non-contestable goods.

Measurability relates to how precisely the inputs, processes, outputs and outcomes of a good or service can be measured. Again, monitoring performance is easiest when measurability is high. It is relatively simple, for example, to specify the performance desired for laboratory tests. In contrast, it would be more difficult to specify the activities to be expected of a general practitioner. Selective purchasing is simplified for measurable goods.

What might be done, however, if measurability is low? The transaction costs of monitoring can be high. These issues are not unique to healthcare. Examination of other fields, including military procurement, suggests “the more completely rules, obligations, and procedures are defined in order to enforce accountability, the higher the price in time, money and flexibility” (Donahue 1989: 108).

Complexity refers, somewhat confusingly, not to goods themselves but to the extent to which they are “stand alone” or must be coordinated with other elements of care. Laboratory tests might be highly measurable, but they are also less useful if their results cannot be delivered promptly to clinical decision-makers. Again, it is difficult to hive off goods that must be integrated with other services. McSorley accordingly noted the need to pay careful attention to the extent of “unbundling” deemed desirable.

Competitive markets may also be hard to sustain, particularly when only one purchaser exists. In such cases, potential suppliers are likely to request guarantees of volume. Taken together, this implies that it is easier selectively to purchase cleaning services than open-heart surgeries. Murphy noted that BC

has been relatively successful in contracting housekeeping and food services, both of which are relatively measurable, contestable and non-complex. As McSorley suggested, for less-contestable goods one would also make a case for longer-term contracts, as opposed to encouraging continuous competition. And as Williams showed, when goods have production characteristics that are incompatible with competitive markets, costs can go up rather than down, as occurred with home rehabilitation in Ontario (Randall and Williams 2006).

The literature suggests that not-for-profit providers have a better record of providing services in the interest of clients if this requires going beyond the precise terms specified in contracts (Deber 2004). When measurability is low, this willingness to do more can produce superior outcomes. As the literature has noted, it is important to distinguish between high-trust and low-trust models; at a certain stage, it might be wisest to adopt the concept of stewardship and encourage those providers who, because they have goals other than profit maximization, can ensure needs are met even if purchasers have not clearly specified them (Saltman and Ferroussier-Davis 2000; Saltman et al. 2002).

Indeed, there are also issues concerning how to balance competition with the sort of cooperation required to achieve better integration and coordination. Such balancing has been a major focus for health reformers, leading to questions such as, “Do we wish to lose key providers?” and “How do we distinguish between encouraging best practices and protecting intellectual property?”

The “who” question is also important – are we purchasing for a population or for the small proportion of people who are sick and use healthcare services? In general, health expenditures are heavily skewed: the lowest-spending 50% of the population accounts for less than 5% of expenditures on hospitals and

physicians (Berk and Monheit 2001; Deber et al. 2004; Forget et al. 2002). There is a risk that the wrong payment mechanisms will provide a strong disincentive to serve such high-cost clients, particularly in a competitive market. There are also ongoing issues about whether purchasers should be meeting needs or demands.

Finally, it is important to clarify how decisions will be made, and by whom. A “social good” orientation will lead to a different notion of strategic purchasing than will a “rights” orientation; such factors as decision-making criteria and the entitlements to care under different conditions will vary. Formally, one could achieve consensus by having people express their preferences behind a Rawlsian “veil of ignorance,” whereby they would assume they have an equal probability of being rich or poor, healthy or sick. But in real life we are not so ignorant of our circumstances and our preferences might well shift over time and in response to our own, our family’s or our community’s experiences.

As the symposium speakers suggested, there is no magic solution to the strategic-purchasing issue. Nonetheless, tough cases should not distract us from solving simpler problems. The very term strategic purchasing is loaded, as Williams observed in his presentation. It suggests an ethos of consumerism and choice, and the challenge is to determine whether and where it can be successfully applied. Some guides for genuine strategic purchasing are as follows:

- Be precise and transparent about exactly what we want to purchase, for whom, how, by whom and why. Similarly, recognize that certain goods and services might not lend themselves to strategic purchasing.
- Where purchasing is deemed appropriate, ensure there are different consequences, rewards and other signals for good and

bad performance, however defined and nuanced they might be.

- Capacity, authority, and accountability must be aligned. Busse highlighted the role of genuine devolution in using resources more effectively. In Canada, responsibility has already been devolved from the national to provincial governments, but it has proven difficult to shift any meaningful accountability from the provincial to the regional or local levels, even when regional health authorities exist. Who should decide? What some would term democratic control, others might call politicization. To what extent should purchasers be empowered to make allocative decisions and be held accountable for them – as Busse notes is the case in European systems – as opposed to holding governments accountable for meso- and even micro-level events?

Equity

A similar definitional problem arises when we speak of equity. During the symposium, Gwyn Bevan emphasized equal resources per capita, with a stress on inputs and access. Anthony Culyer added the need to pay attention to outcomes, outputs and process. He emphasized efficiency, with the strong suggestion that ineffective healthcare ought not to be provided at public expense. The question of whether effective healthcare should be purchased regardless of cost, however, remained unresolved, and gave rise to the question how would/should cost-effectiveness be incorporated into an equitable health system?

To make progress on health equity, it will be necessary to leave the comfort zones of rhetoric and hand wringing, and to pay attention to language, politics and evidence. Vocabulary matters; “equity” is an elastic term that people with very different notions of distributive justice can all embrace. It can

be used to justify a whole host of political agendas. As such, unless it is carefully defined the term confuses more than it clarifies. As Stone (1997) has noted, equity can refer to the characteristics of potential recipients of an item, to the item itself and/or to the processes used to distribute it. During her talk, Jeanette Vega (not represented in this collection) highlighted large discrepancies across various nations. It is fine to follow Aristotle’s injunction to “treat likes alike” but who will be classified in the group of “likes”? To what extent should Canadians be concerned about health outcomes in other countries? Indeed, as care in Ontario regionalizes, to what extent should residents of one LHIN be concerned about health outcomes in another? Again, a series of compelling, pivotal issues arise, which we will now discuss.

Precisely what do we want to be equitable about – health or healthcare? And are we concerned with short-term or long-term outcomes? If we focus on the short term, which is where most policy-makers spend their attention, where does prevention fit?

How much inequality of access and/or outcome is acceptable? Indeed, how much is addressable by public policy? Obviously, some people will always be healthier than others, even after adjusting for every conceivable social determinant of health. Genetic endowment, behaviour and luck will all play roles. As population health researchers have ably described, inequality might also be related to class, gender, race/ethnicity and geography, which to varying degrees interact (Evans et al. 1994; Starfield 2006). Socio-economic status (SES), which is about more than money, appears to be the dominant influence on inequality. From the evidence available, to be in favour of wide socio-economic disparities is to be in favour of irreducibly wide health disparities. There is no society-wide consensus on the acceptable degree of general

inequality; indeed, this is the appropriately contested ground of democratic politics. The odds against there being a true consensus – implying near unanimity – on these matters are long. This is not fatal to the enterprise of reducing inequalities; it means merely that we should understand the nature of what is required to make it a public policy priority in a democratic context. The essential condition is not consensus but reasonably stable, consistent and sustained majority support.

If one takes a single set of definitions linked to a coherent set of principles, as Culyer suggested, how can the quest for such support be balanced against the recognition that trade-offs are inescapable, that most difficult decisions generate winners and losers and that the losers will, in turn, try to change the rules to increase their probability of winning (Schattschneider 1964)? Participation is one way to do this, which in turn leads to consideration of who is seated at the deliberative table.

Sustained democratic support confers legitimacy, which entitles the state to act and allocate even if some people do not get what they want some of the time. Here the class divide becomes critical. Canada's healthcare system is a cross-subsidization scheme whereby the healthy and wealthy pay for their own care *and* for a large proportion of the care of the poor and the sick. Thus far this transfer of wealth has been broadly accepted across Canadian society; approval, however, is contingent on the subsidizers continuing to believe that the system by and large serves them at least adequately, and preferably that it serves them well (Evans 2006). As a result, the system is organized mainly to meet the needs of the middle class (and often for the convenience of providers). If a fundamental reorganization of healthcare to improve access and outcomes among the disadvantaged clashes with the preferences or sensibilities of the middle class, legitimacy will be among

the casualties. In this regard, Richard Glazier described the current crisis in Canadian primary healthcare, but also presented data showing some successes, particularly the small or absent SES gradients for many services, albeit with considerable room for improvement for others. But the reform of primary healthcare could also threaten legitimacy: under some models, the main beneficiaries are likely to be the disadvantaged, for whom episodic, conventional care from stand-alone medical clinics is insufficiently effective. To the extent that well-off people seem to be content with conventional care and are not demanding the socially oriented, comprehensive centres promoted by primary healthcare visionaries and population health experts, tension might arise. If they perceive that major primary healthcare restructuring reduces access to or quality of care they receive, their support will wane and, as Vega noted, allowing the rich to opt out of a health system is enormously risky because such withdrawal erodes support for the overall system. Ideally, the needs of well-off members of society will also be better met by the restructuring, in which case there will be no tensions to resolve. But often there will be trade-offs and reallocations – a simple example is locating clinics and other facilities closer to those in need and farther from where the well-off live.

Engaged citizen participation in policy-making and preference-sorting exercises is much in vogue these days, and the literature suggests that it can be fruitful and enlightening. Whatever its virtues, it is neither a proxy nor a substitute for democratic decision-making. Engaged and informed citizens are, by virtue of these very characteristics, atypical; their views and preferences may change during the deliberative process in response to group interaction and an increasingly sophisticated understanding of issues and options. The more engaged and informed

they become, the less representative they are of the process of everyday opinion formation and expression. Enriched participation might generate wise and nuanced policy ideas but not a deeper understanding of what the public thinks, or finds acceptable, under the usual conditions of indifference and surface reflection. Healthcare in most industrialized countries is a public realm and, ultimately, subject to democratic forces; citizens can thus exert power without having passed a knowledge test. One could well imagine a citizen-participation process that would rank wait times rather low on the priority list once people had been fully apprised of a system's actual performance, the quality of care of the frail elderly, the state of mental health services and other considerations. Such a ranking would, however, be a lonely voice amid a constellation of interests that insist on making hip- and knee-surgery wait times every decision-maker's top priority.

Are improved payment and incentive systems pathways to increased equity, however defined? As Culyer pointed out, these would be ambitious expectations to thrust upon revised processes – financial incentives and targets can lead to “ridiculous distortions,” formulas do not always adhere to cost structures and capitation and similarly granular funding approaches do not always capture fixed costs. As is well recognized, fee-for-service is not the best way to ensure that the emergency room in a small hospital in a remote community is financially viable. Indeed, teaching hospitals were not included in the Quebec models Levine presented and Ida Goodreau showed how the high cost of teaching hospitals affected the funding allocation to those BC health authorities in which they existed.

As Culyer and Vega noted, there is a need for government to set and monitor standards and to ensure that data are avail-

able. Professionalism is critical; the most we should expect is that the payment and incentive systems should get out of the way of the advance toward whatever notion of equity we seek to achieve. Here there are reasons for optimism, if only because existing financial incentives tend to discourage first-rate chronic disease management, optimal care of the frail elderly and comprehensive approaches to care for the disadvantaged. Removing the perverse incentives that affect provider behaviour is useful work, and anyone interested in marrying strategic purchasing to increased equity needs to address the matter.

Related to this concern are the mixed signals about payment-for-results vs payment-for-activity. In Canada, we preach the former and practise the latter. After exhorting practitioners to abandon fee-for-service and to spend their time on high-need patients, managers grumble about reduced productivity and demand shadow billing to track how the new-style clinicians stack up against the ostensibly obsolete practices of their fee-for-service counterparts. Increased rates of interventions and throughput are uncritically accepted as improvements in productivity, without consideration of whether the outcomes are worth the cost and whether new thresholds of intervention are defensible. Funders must decide where they stand on the issue and practitioners have a right to expect consistency of both message and policy, as well as clear standards and rules of accountability. In this regard, it is important to clarify whether we are interested in redistribution or just in targeting new money to particular activities. Redistribution presents major challenges to power relationships; new money is much less contentious (Kellow 1988).

Finally, even if there is a stable majority commitment to reduced disparities, there are no guarantees of success. European countries have adopted a population health perspective

and some have created holistic frameworks for equity that focus on the social determinants of health as well as the reorganization of care (Department of Health 2003; Mackenbach and Bakker 2003). Yet in some countries disparities are widening, while others are holding the line; nowhere are there dramatic reductions in health inequality (Mackenbach and Stronks 2002; Mackenbach et al. 2003). Canadian research has also identified widening disparities (Brownell et al. 2003), despite the country's strong tradition of population health research and advocacy.

The etiology of disparities is complex and the extent to which they are amenable to public policy solutions is debatable. There have been dramatic reductions in some disparities such as infant mortality and certain communicable disease rates, where the interventions are relatively straightforward and baseline differences were very large. In some cases all ships rise with the tide (e.g., extending clean water to entire communities and effective immunization campaigns). It could be that the generally more egalitarian societies of northern Europe have achieved all of the easier wins and now confront seemingly intractable levels of health inequality. After all, as Marmot and Wilkinson (1999) have shown, there is a gradient of inequality that affects every social class. No one fully understands why upper-middle-class people are healthier than middle-class people, and few are concerned about that disparity. The gap widens as one approaches the bottom quintile of the SES ladder and spreads further toward its lowest rungs.

Thus, before we can strategically purchase equity, we must define what equity we wish to purchase and learn more about the capacity of various forms of capital to get the job done. Again, honesty about willingness to pay for reducing disparities would add a more pointed, if uncomfortable, element to

the debate. To cite one example: economists have long maintained that a certain level of structural unemployment is required to make economies function well. That perspective guarantees that a significant group in society will be vulnerable to marginalization and poor health even if there is a strong social safety net. The organization of a great deal of human life involves hierarchy, which seems in itself to create a health gradient regardless of absolute levels of abundance or deprivation. If hierarchy is intrinsic to the human condition – hard-wired into our psyches and sense of worth – then so too, at least to some degree, is health inequality.

While all these complexities are real and intellectually interesting, they should not result in policy paralysis or seduce us into believing that nothing can be done. It is within our power to eliminate poverty even if we cannot make everyone content or provide opportunities for all to reach their full potential. We can make the healthcare system more needs oriented and responsive to the unhealthier end of the gradient (Health Disparities Task Group 2004). And we can certainly develop indicators that are sensitive to SES and other markers of inequality instead of reporting aggregate measures of performance that mask differential effects. Simply reconceptualizing the idea of performance might, over time, create greater awareness of and momentum for addressing the determinants of health, while still enabling recognition of the need to treat the small proportion of the population that at any given time urgently requires care.

Indeed, careful thought suggests that we might not be interested in equality at all. Presumably, an easy way to reduce inequality would be to encourage higher SES people to smoke, drink, eat poorly, drive recklessly and otherwise decrease their health outcomes to the lowest common denominator. Few so

advocate. Similarly, should a focus on equity lead us to reject health promotion activities that are more likely to be adopted by those with higher levels of education and thereby increase health disparities? What we are interested in, we suggest, is improvement. Such improvement might well focus upon those sub-populations with the greatest scope for gains; however, the ultimate aim would appear to be improving health outcomes for all, as efficiently as possible.

Endnote

1 Our paper is based on the live proceedings of the two-day symposium. The contributions that speakers subsequently prepared for this issue of *Healthcare Papers* closely resemble but do not replicate the contents of their verbal remarks. Thus, there might be slight variations between our discussion here and the speakers' contributions to this collection.

References

Alameddine, M., A. Laporte, A. Baumann, L. O'Brien-Pallas and R. Deber. 2005. "Stickiness and 'Inflow' as Proxy Measures of the Relative Attractiveness of Various Sub-Sectors of Nursing Employment." *Social Science and Medicine* 63(9): 2310–19.

Alameddine, M., A. Laporte, A. Baumann, L. O'Brien-Pallas, R. Croxford, S. Wang, B. Milburn and R. Deber. 2006. "Where are Nurses Working? Employment Patterns by Sub-Sector in Ontario, Canada." *Healthcare Policy* 1(3): 65–86.

Belli, P.C. 2004. "The Impact of Resource Allocation and Purchasing Reforms on Equity." HNP Discussion Paper, Washington, DC: The International Bank for Reconstruction and Development, The World Bank. Retrieved February 16, 2007. <<http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1095698140167/Chap7BelliFinal.pdf>>

Berk, M.L. and A.C. Monheit. 2001. "The Concentration of Health Care Expenditures, Revisited." *Health Affairs* 20(2): 9–18.

Birch, S. and C. Donaldson. 2003. "Valuing the Benefits and Costs of Health Care Programmes: Where's the 'Extra' in Extra-Welfarism?" *Social Science and Medicine* 56: 1121–33.

Brownell, M., L. Lix, O. Ekuma, S. Derksen, S. De Haney, R. Bond, R. Fransoo, L. MacWilliam

and J. Bodnarchuk. 2003. "Why is the Health Status of Some Manitobans not Improving? The Widening Gap in the Health Status of Manitobans." Winnipeg: Manitoba Centre for Health Policy. Retrieved January 25, 2007. <<http://www.umanitoba.ca/centres/mchp/reports.htm>>

Daniels, N. and J.E. Sabin. 1998. "Last Chance Therapies and Managed Care: Pluralism, Fair Procedures, and Legitimacy." *Hastings Center Report* 28(2): 27–41.

Deber, R. 2004. "Delivering Health Care Services: Public, Not-for-Profit, or Private?" In G.P. Marchildon, T. McIntosh and P.-G. Forest, eds., *The Fiscal Sustainability of Health Care in Canada: Romanow Papers, Volume 1*. Toronto: University of Toronto Press.

Deber, R. and V. Goel. 1990. "Using Explicit Decision Rules to Manage Issues of Justice, Risk, and Ethics in Decision Analysis: When is it not Rational to Maximize Expected Utility?" *Medical Decision Making* 10(3): 181–94.

Deber, R., E. Forget and L. Roos. 2004. "Medical Savings Accounts in a Universal System: Wishful Thinking Meets Evidence." *Health Policy* 70(1): 49–66.

Department of Health. 2003. "Tackling Health Inequalities: A Programme for Action." London: Author. Retrieved January 8, 2007. <<http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENTID=4008268&chk=Ad%2BpLD>>

Donahue, J.D. 1989. *The Privatization Decision: Public Ends, Private Means*. New York: Basic Books.

Donaldson, C. 2004. *Economics of Health Care Financing: The Visible Hand*. New York: Palgrave-Macmillan.

Drummond, M. and M. Sculpher. 2005. "Common Methodological Flaws in Economic Evaluations." *Medical Care* 43(7 Suppl): 5–14.

Evans, R.G. 2006. "From World War to Class War: The Rebound of the Rich." *Healthcare Policy* 2(1): 14–24.

Evans, R.G., M.L. Barer and T.R. Marmor. 1994. *Why are Some People Healthy and Others Not: The Determinants of Health of Populations*. New York: Walter de Gruyter.

Figueras, J., E. Jakubowski and R. Robinson, eds. 2005. *Purchasing to Improve Health Systems Performance*. New York: Open University Press.

Fisher, E.S., J.E. Wennberg, T.A. Stukel, J.S. Skinner, S.M. Sharp, J.L. Freeman and A.M. Gittlesohn. 2000.

- “Associations among Hospital Capacity, Utilization, and Mortality of U.S. Medicare Beneficiaries, Controlling for Sociodemographic Factors.” *Health Services Research* 34(6): 1351–62.
- Forget, E.L., R. Deber and L.L. Roos. 2002. “Medical Savings Accounts: Will They Reduce Costs?” *Canadian Medical Association Journal* 167(2): 143–47.
- Gold, M.R., J.E. Siegel, L.B. Russell and M.C. Weinstein. 1996. *Cost-Effectiveness in Health and Medicine*. New York: Oxford University Press.
- Health Disparities Task Group and Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security. 2004. “Reducing Health Disparities – Roles of the Health Sector: Recommended Policy Directions and Activities.” Ottawa: Public Health Agency of Canada. Retrieved January 25, 2007. <<http://www.phac-aspc.gc.ca/ph-sp/disparities/drpolicey.html>>
- Kanavos, P. and E. Mossialos. 1999. “International Comparisons of Health Care Expenditures: What We Know and What We Do Not Know.” *Journal of Health Services Research and Policy* 4(2): 122–26.
- Kellow, A.J. 1988. “Promoting Elegance in Policy Theory: Simplifying Lowi’s Arenas of Power.” *Policy Studies Journal* 16(4): 713–24.
- Leon, D.A., G. Walt and L. Gilson. 2001. “International Perspectives on Health Inequalities and Policy.” *BMJ* 322: 591–94.
- Mackenbach, J.P. and M.J. Bakker. 2003. “Tackling Socioeconomic Inequalities in Health: Analysis of European Experiences.” *The Lancet* 362: 1409–14.
- Mackenbach, J.P., V. Bos, O. Anderson, M. Cardano, G. Costa, S. Harding, A. Reid, Ö. Hemström, T. Valkonen and A.E. Kunst. 2003. “Widening Socioeconomic Inequalities in Mortality in Six Western European Countries.” *International Journal of Epidemiology* 32(5): 830–37.
- Mackenbach, J.P. and K. Stronks. 2002. “A Strategy for Tackling Health Inequalities in the Netherlands.” *BMJ* 325: 1029–32.
- Marchildon, G.P., T. McIntosh and P.-G. Forest, eds. 2004. *The Fiscal Sustainability of Health Care in Canada: Romanow Papers, Volume 1*. Toronto: University of Toronto Press.
- Marmot, M. and R.G. Wilkinson. 1999. *Social Determinants of Health*. New York: Oxford University Press.
- Menzel, P., M.R. Gold, E. Nord, J.L. Pinto-Prades, J. Richardson and P. Ubel. 1999. “Toward a Broader View of Values in Cost-Effectiveness Analysis of Health.” *Hastings Center Report* 29(3): 7–15.
- Mossialos, E., A. Dixon, J. Figueras and J. Kutzin. 2002. *Funding Health Care: Options for Europe*. Buckingham: Open University Press.
- Preker, A.S. and A. Harding. 2000. “The Economics of Public and Private Roles in Health Care: Insights from Institutional Economics and Organizational Theory.” Washington, DC: Health, Nutrition and Population Discussion Paper, Human Development Network, World Bank. Retrieved February 16, 2007. <<http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1095698140167/Preker-TheEconomicsOfPublic-whole.pdf>>
- Randall, G.E. and A.P. Williams. 2006. “Exploring Limits to Market-Based Reform: Managed Competition and Rehabilitation Home Care Services in Ontario.” *Social Science and Medicine* 62(7): 1594–1604.
- Retzlaff-Roberts, D., C.F. Chang and R.M. Rubin. 2004. “A Comparison of OECD Countries.” *Health Policy* 69(1): 55–72.
- Saltman, R.B. and O. Ferroussier-Davis. 2000. “The Concept of Stewardship in Health Policy.” *Bulletin of the World Health Organization* 78(6): 732–39.
- Saltman, R.B., R. Busse and E. Mossailos. 2002. *Regulating Entrepreneurial Behaviour in European Healthcare Systems*. Buckingham: Open University Press.
- Schattschneider, E.E. 1964. *The Semisovereign People: A Realist’s View of Democracy in America*. New York: Holt, Rinehart and Winston.
- Simoens, S., M. Villeneuve and J. Hurst. 2005. “Tackling Nurse Shortages in OECD Countries.” *OECD Health Working Papers* 19. Geneva: OECD. Retrieved February 16, 2007. <<http://www.oecd.org/dataoecd/11/10/34571365.pdf>>
- Starfield, B. 2006. “State of the Art Research on Equity in Health.” *Journal of Health Politics, Policy and Law* 31(1): 11–31.
- Stone, D.A. 1997. *Policy Paradox: The Art of Political Decision Making*. New York: Norton.
- Wright, C.J., G.K. Chambers and Y. Robens-Paradise. 2002. “Evaluation of Indications for and Outcomes of Elective Surgery.” *Canadian Medical Association Journal* 167(5): 461–66.

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



Adalsteinn D. Brown

Assistant Deputy Minister, Health Systems Strategy Division,
Ontario Ministry of Health and Long-Term Care
Assistant Professor, Department of Health, Policy and Evaluation,
University of Toronto

Jeremy Veillard

Formerly Lead, Measuring Performance for Change, Health Results Team on Information Management, Ontario Ministry of Health and Long-Term Care

Richard Prial

Director, Strategic Alignment Branch,
Ontario Ministry of Health and Long-Term Care
Ryerson University



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

“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.

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.

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

“... efficiency in health system management depends on ensuring the right level of care for each individual.

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.

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.

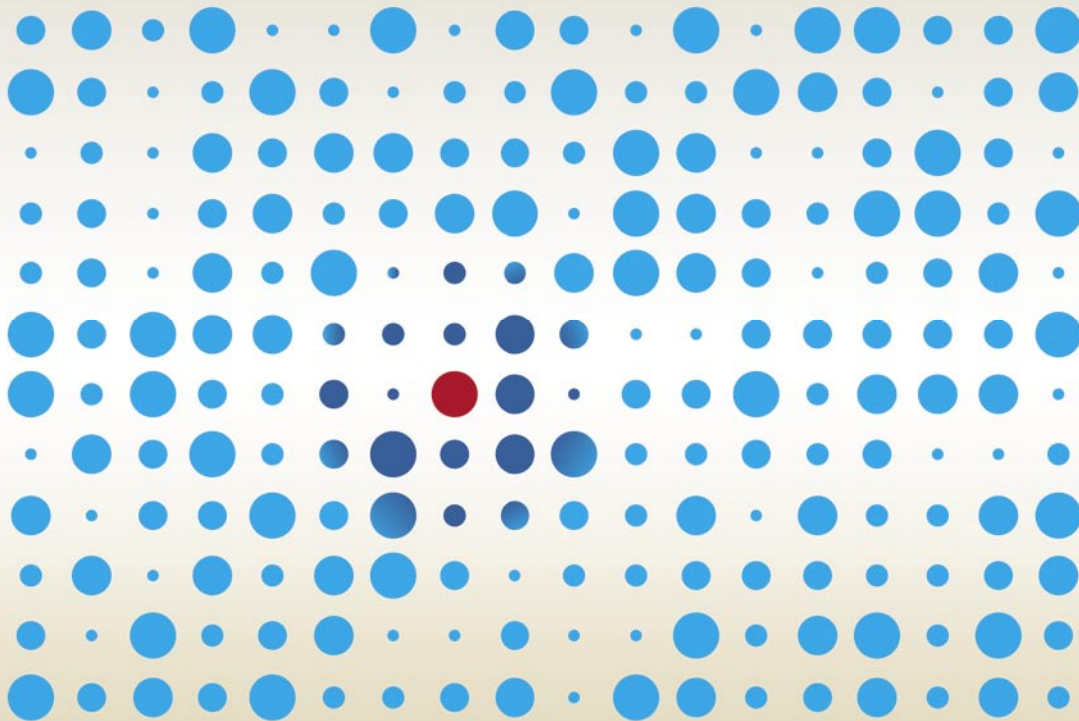
In every country currently experimenting with strategic purchasing and equity policies, none of this balancing will occur without regular measurement and evaluation of health system performance. Success will also depend on developing strategies that make targets explicit and on constantly reviewing –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

References

- Brown A., C. Porcellato, G. Baker and D. Stewart. 2003. *Hospital Report 2002: Women's Health*. Toronto: Government of Ontario and the Ontario Hospital Association.
- Government of Ontario. 2006. *Commitment to the Future of Medicare*. Toronto: The Queen's Printer.
- Institute of Medicine. 2001. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: Author.
- Judge, K., S. Platt, C. Costongs and K. Jurczak. 2006. *Health Inequalities: A Challenge for Europe*. Brussels: European Union.
- Okun, A. 1975. *Equality and Efficiency: The Great Tradeoff*. Washington, DC: Brookings Institution.
- Ringen, S. 1987. *The Possibility of Politics*. Oxford: Oxford University Press.
- Schauffler, H.H., C. Brown and A. Milstein. 1999. "Raising the Bar: The Use of Performance Guarantees by the Pacific Business Group on Health." *Health Affairs* 18: 134–42.
- World Health Organization. 2000. *The World Health Report 2000. Health Systems: Improving Performance*. Geneva: Author.
- World Health Organization. 2001. *Transforming Health Systems: Gender and Rights in Reproductive Health*. Geneva: Author.

Clinical Epidemiology Institute

A practical introduction to critical appraisal skills and evidence-based practice and policy for clinicians, decision-makers, industry representatives and novice researchers



Visit www.hpme.utoronto.ca

University of Toronto
Toronto, Ontario

HealthcarePapers

Volume 8 • Special Issue

EDITOR-IN-CHIEF

Peggy Leatt

EDITORIAL ADVISORY BOARD FOR HEALTHCAREPAPERS

Owen B. Adams, Director of Research, Policy and Planning, Canadian Medical Association
Dr. Arif Bhimji, Executive Vice-President, RJA Centres Canada Inc., Edmonton, AB
Dr. Gordon D. Brown, Professor and Director, University of Missouri-Columbia, Department of Health Management & Informatics
Mr. Tom Closson, Victoria, BC and Toronto, ON
Mr. William Carter, Borden Ladner Gervais, Toronto, Ontario
Mr. Michael Decter, Toronto, Ontario
Dr. Jeff Edelson, Vice-President Therapeutic Area Head, Johnson and Johnson, Spring House, PA
Dr. Bruce J. Fried, Associate Professor and Director, University of North Carolina at Chapel Hill, North Carolina
Mr. Peter Goodband, CEO, Canadian Cancer Society, Ontario Division
Dr. Toby Gordon, Associate Professor and Director, The Johns Hopkins University, Department of Health Policy and Management, Baltimore, Maryland and Vice-President Planning & Marketing, Johns Hopkins Medicine
Dr. Carol Herbert, Dean, Faculty of Medicine and Dentistry, University of Western Ontario, London, Ontario
Dr. Alan Hudson, Toronto, Ontario
Mr. Ron Kaczorowski, Chairman, Kensington Health Centre Board of Directors, Toronto, Ontario
Mr. John King, Executive Vice-President, Hospital Services, St. Michael's Hospital, Toronto, Ontario
Dr. Peggy Leatt, Professor and Chair, Department of Health Policy and Administration and Associate Dean for Academic Affairs, School of Public Health, University of North Carolina at Chapel Hill
Dr. Sandra Leggatt, School of Public Health, LaTrobe University, Bundoora, Victoria, Australia
Mr. Steven Lewis, Partner, Access Management, Saskatoon, Saskatchewan and University of Calgary, Department of Community Health Services, Alberta
Mr. Jonathan Lomas, Founding Executive Director, Canadian Health Services Research Foundation, Ottawa, Ontario
Dr. Noni MacDonald, Dalhousie Medical School, Halifax, Nova Scotia
Mr. Bruce S. MacLellan, President, Environics Communications Inc., Toronto and New York
Mr. Joseph Mapa, President and CEO, Mount Sinai Hospital, Toronto, Ontario
Dr. Michael McGuigan, Medical Director, Long Island Regional Poison Control Center, New York
Dr. Robert McMurtry, Professor of Surgery, University of Western Ontario and Orthopedic Consultant, St. Joseph's Health Care, London, Ontario
Dr. Eric Meslin, Director, Indiana University Center for Bioethics, Indianapolis
Dr. Terrence J. Montague, Professor of Medicine and Director, Disease Management Research Group, University of Montreal, Montreal, Quebec
Mr. Torbjörn Pelow, Health Administrator & Consultant, Gothenburg, Sweden
Dr. Bernardo Ramirez, Academy for Educational Development, Washington, DC

Dr. Janet Thompson Reagan, Professor and Director, Health Administration Programs, California State University, Northridge, California
Dr. Anne E. Rogers, Professor of the Sociology of Health Care, National Primary Care Research and Development Centre, University of Manchester, England
Dr. Judith Shamian, President and CEO, VON Canada
Ms. Tina Smith, Program Director, University of Toronto, Department of Health Policy, Management and Evaluation, Toronto, Ontario
Dr. Willem Wassenaar, President, Wellesley Therapeutics, Toronto, Ontario
Dr. Ruth Wilson, Professor, Department of Family Medicine, Queen's University, Kingston, Ontario
Dr. Howard S. Zuckerman, Professor and Director, Center for Health Management Research, University of Washington, Seattle, Washington

EDITORIAL ADVISORY BOARD FOR HEALTHCARE QUARTERLY PUBLICATIONS

Mr. Richard Alvarez, President and CEO, Canada Health Infoway Inc.
Dr. Charlyn Black, Director, Centre for Health Services and Policy Research, University of British Columbia
Dr. Christopher Carruthers, Chief of Staff, The Ottawa Hospital and President, Society of Physician Executives, Ottawa, Ontario
Sister Elizabeth M. Davis, Sisters of Mercy of Newfoundland & Labrador
Dr. Jeff Edelson, Vice-President Therapeutic Area Head, Johnson and Johnson, Spring House, PA
Mr. Hy Eliasoph, CEO, South Central LHINS, Markham, Ontario
Mr. Ted Freedman, Toronto, Ontario
Mr. Chris Helyar, Associate Director, Hay Health Care Consulting
Mr. Kevin Higgins, Vice-President, Healthcare Markets, 3M Canada Company, London, Ontario
Dr. Peggy Leatt, Professor and Chair, Department of Health Policy and Administration and Associate Dean for Academic Affairs, School of Public Health, University of North Carolina at Chapel Hill
Mr. John Malcom, President and CEO, Cape Breton District Health Authority, Sydney, Nova Scotia
Mr. Joseph Mapa, President and CEO, Mount Sinai Hospital
Mr. Murray Martin, President and CEO, Hamilton Health Sciences Centre
Mr. James Saunders, President, J.L. Saunders and Associates Inc., Calgary, Alberta
Mr. Don Schurman, Sierra Systems, Edmonton, Alberta
Dr. Judith Shamian, President and CEO, VON Canada
Ms. Linda Moxey, Vice-President, Customer Care, Syneron Medical Ltd.

CONSULTING EDITORS FOR HEALTHCARE QUARTERLY PUBLICATIONS

Dr. Robert Filler, Founding Member and Chair, Ontario Telehealth Network
Dr. Michael Guerriere, Managing Partner, Courtyard Group Ltd.
Mr. Ken Tremblay, CEO, Chatham-Kent Alliance, Chatham, Ontario



This issue of *HealthcarePapers* was made possible through the support of:
Ontario Ministry of Health and Long-Term Care
University of Toronto, Department of Health Policy, Management and Evaluation