Panelist

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Panel on HTA and Fairness
ISPOR, Santiago, 7 September 2015

Equity and Efficiency

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Not considered here…

Many principles of equity are worthy of exploration and clarification:

- equity in health care financing
- equity in the ownership of health care resources
- equity in accessing career opportunities in health care
- equity in policies concerning the non-health care determinants of health
  - like the equity of the distribution of purchasing power
  - good quality housing
  - good social care
  - clean air
  - workplace safety
  - equity in the health care workforce
  - political influence
- equity in processes of health care (e.g. issues of accountability - whose and to whom and for what?), transparency of decisions (why were decisions made as they were, by whom, with what evidence in support and what values embodied?) and participation (who may participate in decision making at various levels from the doctor-patient decisions to public policy decisions, who may be consulted, who has a vote or a veto, who may appeal a decision?).

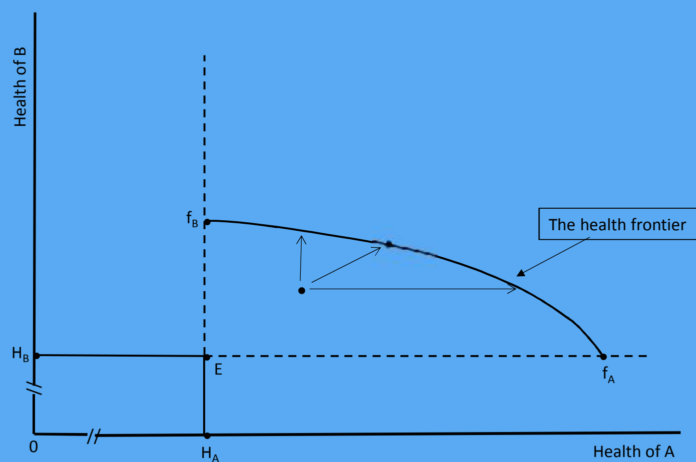
My topics

- distribution of health (what is fair?)
- efficiency in the production of health (what is efficient?)
- are efficiency and equity inherently in conflict?

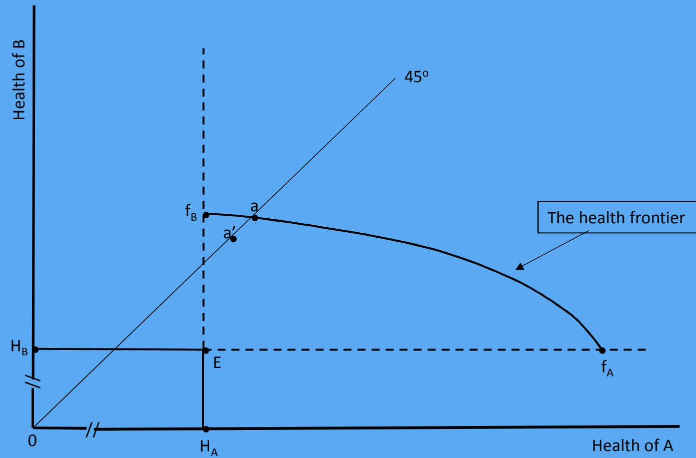
Where I come from – extra-welfarism

- extra-welfarism not welfarism
- extra like 'extra-marital relations' are extra, i.e. additional, beyond, outside (e.g. to include concerns about distributive justice)
- extra also like a newspaper 'extra', e.g. a special edition
- special in that (for example):
  - Individual preferences are not necessarily taken as the base from which social preferences are constructed
  - Policy preferences may be validly expressed by accountable public agents
  - Policy objectives are cast in concrete terms (like 'health promotion') rather than utilitarian generalities (like 'welfare' or 'utility')
  - Processes, deliberation and consultation are part of the analysis and the evaluation of policies
- equity counts no less than efficiency and is also to be defined and measured

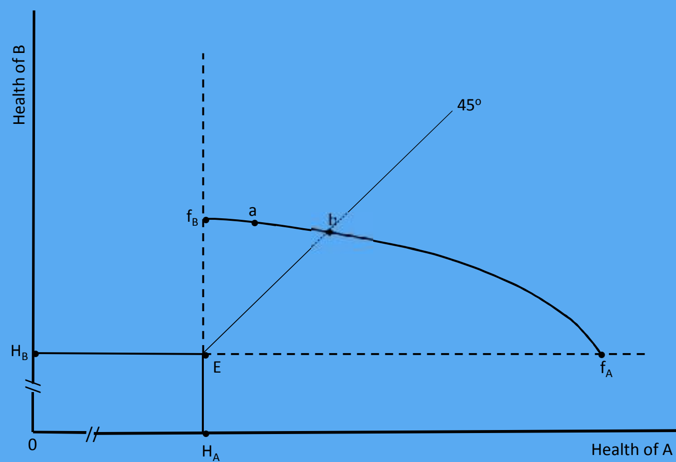
The health frontier (efficiency and inefficiency)



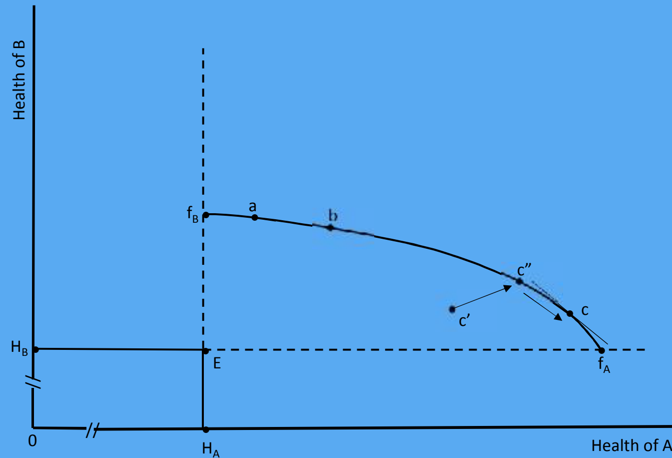
The health frontier (equity = equal health)



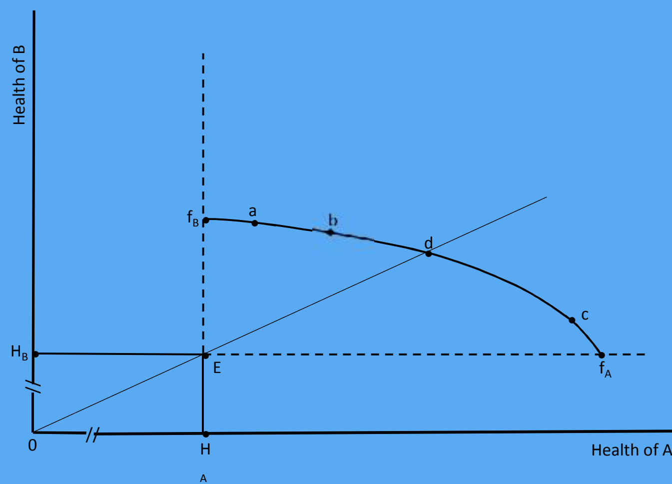
Equity = equal health gain



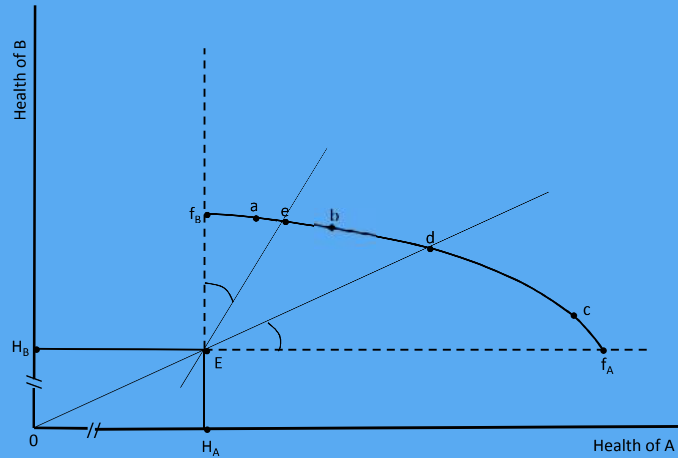
Equity = QALY=QALY=QALY



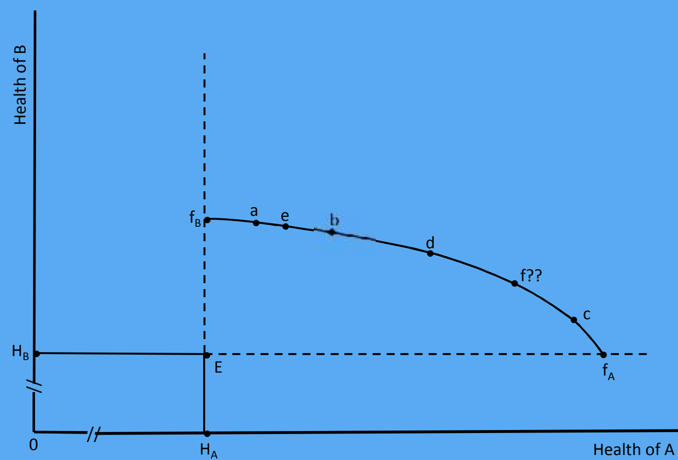
Equity = maintaining initial distribution of burden



Equity = distribution in proportion to need



Equity = equal shares of resource



Main (qualitative) messages

- This is a model – a toy. You can play with it. The frontier is determined by the budget, the health production functions and the initial distribution of the burden of disease. You can make different assumptions from mine, as well as play with different criteria for equity
- Efficiency (in the conventional Paretian sense) and common equity principles are not in inherent conflict
- Efficiency embodying an equality value assumption (viz. QALY=QALY=QALY) may be judged unfair
- Common equity principles are, however, in mutual conflict
- Equity principles must be discussed and (if possible) agreed
- Removing avoidable ill-health/mortality and promoting greater health equality requires *equitable inequality* in resource distribution
- Greater health equality requires discrimination in favour of people in the poorest health and with the highest capacity to benefit
- To achieve that *and efficiency* in any jurisdiction requires that only the most cost-effective interventions for that jurisdiction's equity targets are used

Main reference

A J Culyer, A Wagstaff. "Equity and equality in health and health care", *Journal of Health Economics*, 1993, **12**: 431-457 (reprinted in N Barr (ed.) *Economic Theory and the Welfare State*, Cheltenham: Edward Elgar, 2001, 231-257 and in A J Culyer (Ed.) *Health Economics: Critical Perspectives on the World Economy,* London: Routledge, 2006, 483-509).

Thank you
and
BE GOOD!