Medical Necessity in Canadian Health Policy: Four Meanings and . . . a Funeral?

CATHY CHARLES, JONATHAN LOMAS, MITA GIACOMINI, et al.*

McMaster University: Canadian Institute for Advanced Research, Hamilton, Ontario

SINCE 1966, THE CONCEPT OF MEDICAL NECESSITY has been a cornerstone of Canadian federal legislation regarding publicly funded health service coverage. Medical necessity was a critical term in both the 1966 Medical Care Act and the 1984 Canada Health Act. Despite the importance of this concept in defining the scope of provincial government responsibilities for insuring health care, medical necessity was never defined in either federal policy or legislation.

The common sense meaning of a medically necessary service is one that a patient needs in order to avoid a negative health consequence. The fact that Canadians have universal coverage for any medical or hospital service deemed medically necessary contrasts with the more restricted service coverage and eligibility criteria of public programs in the United States. The symbolic importance of these Canadian program features is a source of national pride and a concrete emblem of Canada's more collective orientation (Tuohy 1988; Lipset 1990; Osberg 1995). Cana-

*Coauthors are listed at the end of the article.

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dians have consistently supported the national health insurance program (Schwartz 1967; Blendon et al. 1990; Berger 1994) and have looked to the federal government to protect the national program standards (universal coverage, reasonable access, comprehensive services, portability of benefits, and public administration) from erosion whenever these appear to be threatened, as occurred with the increase in extra billing during the 1980s.

Yet in the current climate of fiscal restraint, some Canadians have begun to question whether Canada's publicly funded health insurance program is too rich in terms of covered benefits, that is, too comprehensive. According to one poll, public support for the comprehensiveness principle under the Canada Health Act, while still substantial, declined from 88 percent in 1992 to 73 percent in 1994 (Berger 1994). National associations like the Health Action Lobby (HEAL) (see Health Action Lobby 1994; Canadian Medical Association 1994; Canadian Health Care Association 1996) and provincial governments (see British Columbia Ministry of Health 1995) have called for a definition of medically necessary services in order to identify the specific services that must be included under provincial public health insurance programs in order to meet the federal comprehensiveness condition.

In the Canada Health Act,[1] comprehensiveness is defined as follows:

> In order to satisfy the criterion respecting comprehensiveness, the health care insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners.

Insured health services are defined, in turn, as hospital, physician, and inpatient surgical–dental services.[2] Hospital services mean "services provided to in-patients or out-patients at a hospital, if the services are *medically necessary* . . ." (emphasis added). Included hospital services are listed and defined: physician services mean "any *medically required* services rendered by medical practitioners . . ." (emphasis added). Because the act contains no definition of, or criteria for, determining medical necessity, a policy dilemma is created. If no policy-based principle is

[1] Canada Health Act 1984, §9, p.6.
[2] Canada Health Act 1984, §2.

attached to the concept, it is unclear how provincial governments should use this legislation as a basis for making service coverage decisions.

We argue that in Canada, as in the United States (Bergthold 1995), the concept of medical necessity has taken on diverse, implicit, and subtextual meanings over time to accommodate the different policy interests of specific groups. By "meanings," we refer to the ways in which the concept of medical necessity has been interpreted or "socially constructed" (Berger and Luckmann 1967; Blumer 1969). Like Stone, we argue that problem definition of a health policy issue is not given, but rather is created in the minds of individuals or organizations as an essential part of political maneuvering (Stone 1988). The more ambiguous the concept used to characterize a problem, the more amenable it is to multiple interpretations, which can then be converted into intellectual support for a variety of different policy positions (Evans 1982).

We will explore, first, the multiple and changing meanings of the concept of medical necessity, using not just that particular term, but also related ones like "medically required," "comprehensive," "core," and "essential services." Next, we will trace the origins, evolution, and dominance of different meanings and their use by different groups to achieve certain policy objectives. Finally, we discuss the limitations of using medical necessity as an explicit policy tool to determine the scope of publicly funded health service benefits in Canada.

Methods

We reviewed written submissions from four provincial governments and four national health care stakeholder associations to eight federal legislative or policy reviews pertaining to national health insurance from 1957, when the national hospital insurance program was introduced, to 1984, when the Canada Health Act was passed.

Following is a list of the federal policy or legislative reviews that we used:

Acts:

1957. Hospital Insurance and Diagnostic Services Act. Ottawa: Queen's Printer (R.S.C. 1970 c.H-8, repealed S.C. 1984; c.6 §32).
1966. Medical Care Act. Ottawa: Queen's Printer (R.S.C. 1970, c.M-8, repealed S.C. 1984, c.6 §32).

1977. Federal–Provincial Fiscal Arrangements and Established Programs Financing Act. Ottawa: Queen's Printer (R.S.C. 1977 c.C-37).
1984. The Canada Health Act. Ottawa: Queen's Printer (R.S.C. 1985, c.C-6).

Reports:

1964. *Royal Commission on Health Services.* Ottawa: Queen's Printer.
1969. *Task Force Reports on the Cost of Health Services in Canada.* Ottawa: Queen's Printer.
1980. [E.M. Hall.] *Canada's National Health Program for the 1980's: A Commitment for Renewal.* Saskatoon: Craft Litho.
1981. *Fiscal Federalism in Canada: Report of the Parliamentary Task Force on Federal–Provincial Fiscal Arrangements.* Ottawa: Supply and Services.

We chose these eight legislative and policy reviews as a basis for organizing data collection because they provided an explicit, structured opportunity for stakeholders and provincial governments to raise concerns about the national health insurance program.

The four stakeholder associations were the Canadian Hospital Association (now the Canadian Healthcare Association), the Canadian Medical Association, the Canadian Public Health Association, and the Canadian Nurses Association. The four provincial governments were Alberta, Saskatchewan, Ontario, and Nova Scotia. National associations were chosen according to the following characteristics:

1. They were leading health professional and organizational stakeholders representing provincial constituencies.
2. They were stakeholders making submissions over time (to explore change in views).
3. They consisted of different types of stakeholders (to include a range of views).
4. They were stakeholders to whom the issue of medical necessity was most likely to be salient.

Provincial governments were chosen to represent different regions of the country.

In reviewing material for the four provinces, we also looked at government reform documents for the years 1984 to 1992 and studied

reports in which the term "medical necessity," or a synonym, was used. The latter process was also used for the health care associations.

In order to identify potential policy uses of the concept of medical necessity, we relied on statements by individuals or groups that either (1) defined boundaries (floors or ceilings) for services, providers, or delivery sites to be included (versus excluded) as insured benefits under publicly funded health care programs *and* that alluded to reasons or criteria or processes that are replicable across jurisdictions; *or* (2) alluded to a recognition that there was no process or criterion for doing so.

Our focus was limited to the policy context of defining what should (or should not) be included as publicly funded insured health benefits, using as a criterion some notion of medical necessity (although the term itself may not have been used). This (restricted) focus was taken to provide clear direction on the scope of relevant data to collect, to keep data collection within manageable limits, and to focus on a policy context that applied to current debates.

Using our guide, we found that four meanings of medical necessity predominated across time and stakeholders in framing discussions about the appropriate scope of publicly funded health care. We will explore each of these meanings, illustrating the use of medical necessity as a policy tool to achieve different policy objectives (see table 1).

Wedding the Meanings to Their History

What Physicians and Hospitals Do

> At no time have we ever, in this country, come to a realization of what is an essential health care service.... It appears that anything that is provided by a physician to a patient is an essential health care service.... (McPherson 1984)

Insured medical services under the 1966 Medical Care Act and the 1984 Canada Health Act were identified by provider as required services that physicians provided. Insured hospital services under the 1984 Act were defined by setting as medically necessary services provided in the hospital. Because these terms were not defined, responsibility for determining which services met these implicit criteria was left to physicians, who applied their clinical judgement to individual patients. By implication, this meant that if physicians provided a service, it must be

TABLE 1
Four Meanings of Medical Necessity

	A	B	C	D
Meaning of medical necessity	What physicians and hospitals do	The maximum we can afford	What is scientifically justified	What is consistently publicly funded across provinces
Intended use of medical necessity as a policy tool	Establish entitlement to a minimum *federal* floor of publicly funded services	Make the federal floor the *provincial* ceiling of publicly funded services	Limit public health service coverage to services/procedures justified by scientific evidence	Establish (and later renegotiate) a consistent package of publicly funded services across provinces
Policy objective	Broaden access to publicly funded health services for all Canadians	Control costs	Improve the quality of care	Promote equity in entitlement and access to publicly funded services across provinces

medically necessary. Medically necessary services gradually took on the meaning of "what physicians and hospitals do" and became the implicit and largely unquestioned federal floor (minimum standard) of mandatory publicly funded services. The concept of a federal floor was well recognized in health policy documents prepared by stakeholder associations. The Canadian Hospital Association, for example, reflecting back on the origins of the national health insurance program, stated that "the financial conditions and definitions of cost-shareable services became de facto the minimum standards of health care" (Canadian Hospital Association 1980, 16).

During the 1960s, policy makers commonly interpreted medical necessity as an inherent element of specific programs or services. Politicians and others used it to justify their favored laundry list of services or programs (e.g., home care) to include under a national public health insurance program, and the term was seldom questioned or challenged. Medical necessity was defined inductively by example or illustration, not deductively by reference to broader policy principles or "scientific" criteria.

The Ontario government, for example, in its submission to the Royal Commission on Health Services, recommended that in-patient care in mental hospitals be included in the national program, directing that the burden of disproving medical necessity be placed on those who thought the services should continue to be excluded and not on those who argued for their inclusion. "In-patient care in mental hospitals, which can be justified on the grounds of medical necessity, should be included in the existing Federal-Provincial shared hospital insurance plan, there being no justification for its continued exclusion" (Ontario Provincial Government 1962, paragraph J).

The Canadian Medical Association assumed as early as 1964 that comprehensiveness under any future health insurance program would refer to physicians' services. Its submission to the Royal Commission on Health Services stated: "The word comprehensiveness has been used in many discussions . . . and we are sure that you understand that . . . it means payment for the services of participating physicians rendered in home, office or hospital" (Canadian Medical Association 1964, 12922).

Consistent with this view, comprehensiveness was defined in the federal medical care legislation in terms of medically required physician services. As provinces joined the national program, many provincial health ministries or commissions simply adopted the schedule of ben-

efits previously developed by provincial medical associations for use in their voluntary medical care plans in order to gain physician support for the new public programs (Shillington 1972, chap. 16). These services presumably reflected what physicians thought was medically necessary, which, in turn, reflected services they provided. Subsequently, provincial benefit lists were updated periodically by provincial bureaucrats or provincial cabinets through routine administrative procedures. These officials were not required to consult the legislature or the public, nor did they have to justify their changes by reference to articulated policy principles (Canadian Bar Association Task Force on Health Care 1994, 37).

During the 1960s and 1970s, the dominant, if implicit, meaning of medically necessary services as "what physicians and hospitals do" was not controversial. Responding to the federal incentive of cost-shared funding, provincial governments expanded the range of publicly funded medical services. Medical necessity was commonly interpreted as specifying a floor, rather than a ceiling; hence, there was little cause for complaint about the adequacy of service coverage. The publicly funded nature of the program meant that Canadians did not have to resort to legally challenging private third-party payers over rights to care. Such challenges have become increasingly common in the United States, and they largely turn on whether the physician was deemed to have provided a necessary service (Hall and Anderson 1992; Shainblum 1995).

Canadians during this period trusted the professional authority of medicine as an institution and physicians as practitioners. This authority was sustained by the perceived dominance of medical expertise within the health division of labor (Freidson 1970a,b; Coburn, Torrance, and Kaufert 1983; Torrance 1987). The institutionalization of medical knowledge in abstract theory and scientific facts, combined with a long and arduous training period, led easily to the perception that medicine was an exact science. It followed that, in applying this knowledge, there would be little room for differences of opinion or discretion in clinical judgment. Physicians would provide only scientifically proven, needed care (Lomas 1990b). The absence of federal criteria and processes to determine which services were medically necessary, and which were not, reinforced the belief that individual clinical judgment was the accepted approach to resolving this issue.

Finally, medical necessity was simply overshadowed by other, more pressing issues in the health policy agenda. Implementing provincial medical care plans, rising health care costs, changes to the federal fund-

ing formula for cost-shared programs, controversy over the extent of extra-billing and user charges, allegations of federal underfunding and of provincial diversion of health care funds were all major policy issues requiring attention (Charles and Badgley 1987).

It was not until 1984, during hearings on the Canada Health Act, that the difficulties caused by the lack of a formal definition of medical necessity were clearly articulated and the assumption regarding the medical necessity of all services provided by doctors was openly questioned. The challenge came, perhaps surprisingly, from the president of the Canadian Medical Association, who argued as follows:

> This Bill in no way addresses, or tries to identify, what is or what is not an essential health care service. At no time have we ever, in this country, come to a realization of what is an essential health care service.... It appears that anything that is provided by a physician to a patient is an essential health care service.... The whole thing is anomalous. There are many things that we as physicians do—and I am probably going to get my head knocked off—there are many things we physicians do that by the strictest criteria could not be considered to be essential health services;... (McPherson 1984, 7:49)

Despite Dr. McPherson's call for clarification, medical necessity as the criterion for judging provincial comprehensiveness in service coverage remained undefined in the Canada Health Act. Meanwhile, during these debates, medical necessity was itself occasionally invoked as a criterion for other things. The Ontario government, for example, regarded extra billing as permissible as long as it "[did] not deter patients from seeking and obtaining necessary medical care" (Norton 1984, 10).

By the early 1990s the political and economic climate had changed, and the concept of medical necessity became a contentious, and visible, health policy issue. Concerns about provincial health care expenditures were heightened by certain political realities: cutbacks in federal transfer payments to the provinces; the introduction by the federal government of the Canada Health and Social Transfer legislation, which created a new framework for funding health, postsecondary education, and social welfare (Hurley, Bhatia, and Markham 1995); federal and provincial government debts; and receding tax bases. Recommendations to limit the scope of provincially funded services began to be heard. By this time, deference to professional authority was on the decline. Research

evidence on practice variations was filtering into the public as well as the policy domain (Wennberg and Gittelsohn 1973; Roos 1984; Chassin et al. 1986; Chassin et al. 1987; Wennberg, Freeman, and Culp 1987; Roos, Wennberg, and McPherson 1988; Wennberg 1990; Iscoe et al. 1994), dispelling the illusion that medicine was an exact science with no room for discretion in clinical judgement (Lomas and Contandriopoulos 1994). In addition, scientific evidence suggested that many medical services were either unevaluated or ineffective (Berwick 1989; Lomas 1990a).

The definition of comprehensiveness under the Canada Health Act also came under increasing attack. Some groups complained that the concept of medically necessary services, the foundation of comprehensiveness, was being interpreted too broadly because it included whatever physicians wanted to include—a "blank check" approach (Deber, Ross, and Catz 1994). Others interpreted it as being too narrow, as restricting insured services to those provided by physicians and hospitals, excluding community care (Rolfes 1979; Canadian Hospital Association 1984; Canadian Nurses Association 1984b). Those who stood to gain from an expanded definition were the most adamant in voicing concerns. The Canadian Nurses Association, for example, lobbied for public funding of services provided by nurses as entry points to the health care system (Canadian Nurses Association 1982, 1984a). A third complaint was the failure of the definition of comprehensiveness to keep pace with changing (and broadening) definitions of health and health care determinants (Canadian Hospital Association 1982, 1984, 1993, 1994).

In 1991, the Canadian Hospital Association argued that, if governments wanted to increase control over the definition of medically necessary insured services, they would have to decide how to define them. For example:

1. Should all health services performed by a "recognized" health care professional or in a "recognized" provider facility be included on the insured services list unless specifically excluded?

or

2. Should insured health services be identified on an established, limited list to which additions require justification by a "recognized" health care professional/provider, possibly based on formal technology assessment? (Canadian Hospital Association 1991, 13).

By the mid-1990s, opinion was shifting toward the second criterion. The convergence of cost-control issues, a decline in belief in the infallibility of clinical judgement, and an increased faith in the ability of scientific evidence to identify "essential" or "core" services resulted in a sharp decline in credibility for the open-ended meaning of medical necessity as "what physicians and hospitals do."

"The Maximum We Can Afford"

> Although the concept of medical necessity is ambiguous, it has taken on new life as governments and insuring bodies seek a way of defining and limiting health benefits. Basic benefit packages derive from the concept of medically necessary care or "essential" services.... The concept of essential services has been an appealing one to those attempting to restrict the costs of health plans,... (Deber, Ross, and Catz 1994, 17–18)

The Canada Health Act imposed financial sanctions on provinces that permitted extra-billing and user charges. As one consequence, medical associations lobbied hard to obtain global increases in the provincial medical care budgets, which would translate into increases in physicians' incomes. Provincial governments, in turn, faced federally imposed limits to the Established Programs Financing (EPF) growth formula in the mid-1980s and beyond. While the federal EPF grants for health (and postsecondary education) were initially designed to increase annually at the same rate as the GNP, the Conservative government in 1986 revised the formula, linking EPF increases to the GNP minus 2 percent. Subsequently, in the 1990 and 1991 federal budgets, total annual EPF grants to the provinces were frozen for five years (Rachlis and Kushner 1994). These changes were intended to stabilize the federal contribution to the provinces for health care and to delink this contribution from provincial cost increases (Charles and Badgley 1987).

Federal funding policies resulted in the provinces assuming a higher proportion of health care costs relative to the federal government, which led them to search intensively for ways to limit public spending for health care (approximately one-third of provincial government expenditures). To justify cost-cutting initiatives, provincial governments began to reconstruct the meaning of medical necessity from "what physicians and hospitals do" to "the maximum we can afford." Medical necessity

was regarded as a potential cost-cutting policy tool to transform the federal floor of insured health benefits (all medically necessary services) into the provinces' preferred ceiling (the maximum insured benefits that provinces can afford).

The issue that remained unresolved throughout the late 1980s and early 1990s was how to translate the concept of medical necessity into a specific policy process that would clarify the criteria for determining which services to retain on publicly insured lists and which to remove in order to save public dollars. The attempts by provincial governments to remove services from their benefit schedules during this period were largely ad hoc, arbitrary, opportunistic, and "driven by the need to save money" (Deber, Ross and Catz 1994, 27).

In 1985, for example, the Alberta government removed several services from the list: family planning counseling, tubal ligations, vasectomies, and mammoplasty. Deleting them created a presumption that they were no longer medically necessary (Canadian Bar Association Task Force on Health Care 1994, 37). But when the Alberta public protested the cuts, the health minister was forced to reinstate most of the delisted services, creating the presumption that they were once again medically necessary. This experience highlighted the arbitrariness of provincial processes for defining medically necessary services.

The desire to cut costs led to other delisting exercises in the early 1990s (Tuohy 1994; Deber, Mhatre, and Baker 1994; Rachlis 1995; Pringle 1995). These also lacked credibility, undermining the use of medical necessity as an explicit and practical policy tool for defining "the maximum we can afford" (Pringle 1995).

The various delisting activities undertaken by provincial governments in the 1980s and early 1990s highlighted a serious weakness in the entitlement to health care of Canadian citizens:

> From this brief review, it seems clear that the provinces have not defined "medically required services" or the criteria on which they are established, but have simply listed them in regulations which may be changed through administrative procedures. Criteria for such changes [are] not set out in legislation. Public consultation is not mandatory, nor is it common practice. This reveals a great weakness at the core of the entitlement to health care in Canada. (Canadian Bar Association Task Force on Health Care 1994, 39)

By the early 1990s, cost control advocates were desperate to find more credible criteria and processes to use in restricting service cover-

age. These would be found in the "evidence-based medicine" and health technology assessment movements, which had gained their own momentum over the previous two decades. Belief in the ability of scientific evidence to identify in a more rational way medically necessary (effective and appropriate) health services in the aid of cost control is now widespread among Canadian national health care association and coalitions. Advocacy of these views also means that, unwittingly or not, these associations are caught in a process that potentially promotes the privatization of health care because, unless delisted services (those deemed not scientifically justified) are banned altogether, they are likely to become available through the private sector.

Some provincial governments have recently found a way to preclude the privatization of services that they no longer wish to fund publicly: a particular service is retained on the provincial list of insured benefits, but the minister of health has the legal power to pay nil to physicians providing that service through the public sector. This process is called deinsuring rather than delisting. Because the particular service remains on the public list, it cannot be provided in the private sector. Yet, there is a clear and compelling financial incentive for doctors not to provide it in the public system.

Although provincial governments hope to achieve substantial cost savings by delisting services on the grounds that they are not medically necessary, experience to date in Britain and in Ontario does not bear this out. Few purchasers in England, when given authority to define a universal health care package, chose to make procedures or services unavailable, and little money was saved. Services that were delisted were marginal to the activities in the National Health Service in terms of cost and tended to blur "social and medical judgements" (Klein 1994, 107).

In Ontario, as part of the former New Democratic government's expenditure control package, a joint management committee of the provincial government and the Ontario Medical Association was asked to identify $20 million worth of services that were not medically necessary, and thus would be eligible for delisting in order to reduce health care costs. As in Britain, this exercise saved little money: approximately 0.3 percent of the Ontario budget for physicians and 0.1 percent of the overall Ontario budget for health care (Rachlis 1995). Implementation was impeded by difficulties in accurately documenting cost savings from the delisting exercise (Pringle 1995). Many of the procedures recommended for delisting were judged to be medically warranted for

some patients but not for others, and billing codes from the Ontario Health Insurance Plan did not adequately specify the difference between the two, which made it difficult to predict the cost savings that would result from barring the funding for some indications but not for others.

These experiences, while limited, suggest that delisting specific services because they are deemed medically unnecessary may not substantially save public funds. The predominant and long-term effect on costs will more likely be a shift of funding from the public to the private sector and an overall increase in health care costs (both public and private). Opinions may well vary regarding the appropriate threshold of affordability (i.e., the point when maximum affordability has been reached), making the definition of medical necessity as "the maximum we can afford" an ever-moving, often implicit and variable target, depending on who is making this value judgment.

"What Is Scientifically Justified"

> Value for money is not explicit in the concept of "medically necessary services." There is a growing recognition of the need to apply evidence-based, clinical knowledge to defining the comprehensive lists of insured services to which the Canada Health Act guarantees universal access across all jurisdictions. (Canadian Hospital Association 1994, 26)

By the 1980s, a third meaning of medical necessity began to emerge: "what is scientifically justified" on the basis of the best available evidence from clinical trials, technology assessment, and practice guidelines. This evidence-based meaning originated in the research of the 1980s and 1990s on the effectiveness and appropriateness of medical treatments and procedures (Berwick 1989; Brook 1989; Wennberg 1990; Lomas 1990a; Evidence-Based Care Resource Group 1994a,b,c). Many national health care associations now argue that the concept of medical necessity, meaning "what is scientifically justified," can be transformed into an explicit evaluation process for identifying a smaller subset of "core" effective and appropriate health services from the more comprehensive service package that is currently publicly funded. This "core" would then become the new (and lowered) provincial floor, or minimum standard of mandatory provincial service coverage. At the same time,

the evidentiary standards applied to retain a service as part of the "core" would be raised.

Health care associations endorse the scientific approach for both cost and quality reasons (Canadian Hospital Association 1989, 1991, 1994; Canadian Healthcare Association 1996). Some have developed scientific criteria, which are applied as sequential "screens" to evaluate the quality of specific health services and to identify those that are medically necessary, "core," or "essential" (Deber, Ross, and Catz 1994; Health Action Lobby 1994; Canadian Medical Association 1994; Wilson, Rowan, and Henderson 1995; Walters and Morgan 1995; Sawyer and Williams 1995; Wyman et al. 1995). The Health Action Lobby, for example, has proposed a decision-making framework to "assist decision-makers in distinguishing priorities, to the greatest extent possible, in the process of determining the comprehensiveness of benefits, while still allowing the influence of professional and political judgement"(Health Action Lobby 1994, 14).

This framework has three sequential policy filters: efficacy/effectiveness, appropriateness, and affordability (Health Action Lobby 1994, 12–13).

The Canadian Medical Association has also developed a framework for determining "core" services, which they, in turn, define as "services that are available to everyone as funded/insured by a government program" (Canadian Medical Association 1994, 86). The criteria to be applied are quality of care, ethics, and economics (Canadian Medical Association 1994, 65). These two frameworks, as well as others, propose using scientific evidence as the first screen through which services must pass in order to be considered for public funding.

While scientific evidence is now seen by many as the means to limit service coverage rationally and to reduce costs, during the early 1980s both the Canadian Nurses Association and the Canadian Hospital Association invoked scientific evidence to justify *expanding* service coverage as a means to control costs. The Canadian Nurses Association, for example, argued that the Burlington randomized trial of the nurse practitioner demonstrated the cost-effectiveness of nurse practitioners, compared with physicians, in providing primary care services (Spitzer et al. 1974; Denton et al. 1982, 1983) and that nursing services should be included under public health insurance programs (Canadian Nurses Association 1984a, 1986, 1988).

The current enthusiasm for applying scientific evidence to the determination of medically necessary services for public health insurance

coverage masks several problems with this approach (Blustein and Marmor 1992). It assumes the availability of accurate, reliable information about the effectiveness, appropriateness, and costs of different treatments, as well as agreement on the most appropriate outcomes to measure. In reality, this type of information is often patchy, incomplete, or nonexistent. As Rudolf Klein argues:

> Policy making, if it is to be rational, must start by acknowledging that health care is characterized by a high degree of uncertainty and that the information required for central decision making will always be inadequate. The hope that "science" will allow us to roll back the frontiers of ignorance to the point where it is possible to define a limited package of health care, which is defensible because it is based on demonstrated effectiveness, is therefore likely to prove delusory. (Klein 1994, 112)

Practice guidelines are advocated by several national health care associations as the mechanism to promote appropriate care. The Canadian Medical Association, for example, has argued:

> Governments may achieve cost reductions for health care services in a number of ways including deinsuring a particular procedure or service by limiting the availability of an insured service through the use of practice guidelines. The guidelines method . . . may include recommendations about such things as risk factors and the number of times in a given period a test should be done.... [The guidelines method] has the advantage of being less politically contentious and less vulnerable to legal challenge, as it does not remove needed health care services across the board, but rather depends on a review of an individual patient's situation. (Canadian Medical Association 1994, 22)

Guidelines, while helpful, will not solve the issue of appropriateness. Some practice guidelines are contentious or conflicting; for many treatments, no guidelines exist. Although guidelines are presumably based on the best scientific evidence available, it is not always clear that one can extrapolate average group outcomes from clinical trials to individual patients. Opinions differ on methodological issues, such as whose views should count in assessing treatment benefits and harm (Eddy 1991). Most important, from a clinical perspective, the appropriateness of any given treatment cannot be determined in isolation from the particular

circumstances of a given patient because the same procedure may work well for one patient but not for another.

When guidelines are used to educate physicians and promote behavioral change on a voluntary basis toward the provision of more effective and appropriate care, clinical discretion in treatment decision making is maintained. But the use of practice guidelines as a public policy tool to ration the availability of publicly insured services on a population basis would considerably reduce the flexibility needed by physicians to make clinical decisions in light of individual circumstances (Mechanic 1992). Moreover, such a policy would require an elaborate appeals process to review situations where physicians provided care that they considered effective and appropriate, even though that particular indication was not included or was simply not addressed in the relevant guideline.

Some investigators in the United States (Matchar et al. 1992; Leape et al. 1993; McGlynn et al. 1994) have developed a system for measuring appropriateness that relies on expert panels. A list of indications for a particular procedure is defined, based on a review of the literature (Matchar et al. 1992). The indications are then presented to an expert panel. The panel rates whether it would be appropriate or inappropriate to perform the procedure on a given patient with specified indications (Hopkins et al. 1993). The assessment of appropriateness is both patient- and service-specific. While the RAND method represents a major contribution to the thorny issue of conceptualizing and measuring appropriateness, this type of microscrutiny of physicians' clinical judgments at a broad provincial (or national) policy level would be both prohibitively expensive and excessively intrusive on physicians and patients. Although this kind of measure would be tolerated in the United States, it is a policy that would fit poorly in the Canadian context.

What Is Publicly Funded across All Provinces

> Provincial Health Ministers have remarked that the comprehensiveness principle of the Canada Health Act is ambiguous and at their September 1995 meeting in Victoria, indicated their intention to reach an agreement on what constitutes a medically necessary service under the Act. [The] CHA [Canadian Healthcare Association] agrees there is a need to clarify the definition to ensure consistency in the application of the principle of comprehensiveness across provinces and territories. (Canadian Healthcare Association 1996, 6)

A fourth meaning of medical necessity is "what is consistently funded across all provinces." The national medical care insurance program was designed to provide equity in entitlement and access to medical care for all Canadians, as measured by a minimum level of consistency in the comprehensiveness of publicly insured services. In a reversal of meaning, this legal requirement gave rise to the notion that if a medical service was publicly funded consistently across all provinces, it must be medically necessary.

In fact, over time, the scope of medical coverage did not change significantly from the base of coverage initially established by provinces as they entered the national program (Tuohy 1994). What did expand was public coverage of services in addition to hospital and medical care. Dental care, vision care, chiropractic services, massage therapy, drug benefits, home care, and mental health care are examples of additional services that came to be insured in various provinces. This trend reflected a view of comprehensiveness that extended beyond the limits of hospital and medical care, in keeping with the earlier philosophy of the 1964 Royal Commission on Health Services.

As fiscal pressures increased, many provincial governments subsequently either reduced or eliminated service coverage in these ancillary areas or introduced copayments. The Ontario Conservative government, for example, introduced a copayment for prescription drug benefits for seniors in 1996. The government argued that this policy did not violate the federal condition of comprehensiveness because drug benefits were not medically necessary, meaning that they were not part of the original service package that all participating provinces were required to provide (Walker 1995, A18).

By 1994, variability in coverage existed across provinces in nursing homes and other long-term-care facility services, out-of-country benefits, prescription drugs, dental, optometric, chiropractic, and physiotherapy programs, and in requirements for payment of health insurance premiums (Crichton, Hsu, and Tsang 1994). Recent provincial delisting exercises have created new variations across provinces, even in medical service coverage. Such disparities have raised concerns that consistency across provinces in entitlement and access to medically necessary services has been eroded. This, in turn, has led to recommendations that the provincial and federal governments renegotiate the terms of the publicly funded health care package.

By 1995, all provincial governments were urging the federal government to clarify its position on what counts as a medically necessary

service, accusing it of acting arbitrarily and inconsistently in applying fiscal sanctions to provinces under provisions of the Canada Health Act. The lengthy and acrimonious dispute between the federal and Alberta governments over facility fees charged to patients by publicly funded clinics is a case in point. Claiming that this practice precluded universal access to medically necessary services, the federal government held back funding from Alberta in an amount equal to what the clinics charged patients for facility fees.

The introduction of the new federal Health and Social Transfer in 1995, along with the continued decline in federal cash contributions to the provinces (even with the establishment of a cash floor), will make the federal government's use of fiscal tools to exert moral authority over provincial governments more difficult. Yet, an increase in provincial disparities will put pressure on both levels of government to renegotiate the minimum service package that all provinces must provide. A renegotiation could clarify (and potentially broaden) the scope of private insurance for health care in Canada, a point clearly recognized by the former Alberta Health Minister:

> In Alberta, we offer a range of home and community services, as well as support for physical therapy, optometry, and other services. None of these additional services is recognized by the Canada Health Act and their availability varies from province to province. We need national standards for basic services that provincial health plans must fully cover. These standards must set out the appropriate responsibilities of the public sector and what the role of the private sector could be. (Alberta Health 1995b)

Delisting some services that are currently publicly funded would also benefit physicians by providing them with an unregulated source of income outside the public sector. This is acknowledged in the Canadian Medical Association's report on core and comprehensive health care services: Preliminary analysis suggests that, under the right circumstances, strategic [delisting] or deinsurance can be economically better for both patients and physicians (Canadian Medical Association 1994, xii).

A federal–provincial renegotiation of publicly funded services would create an opportunity to expand service coverage, in keeping with a broader definition of health. But the opposite is also true, and perhaps more likely. In this fiscal climate, the outcome could well be a consistent, but more *restricted*, package of public service benefits.

The Canadian Healthcare Association has recently developed a proposal that would appear no longer to require the federal government to play a role in ensuring provincial consistency in publicly funded services. The proposal recommends that a national consensus be developed on core insured health *benefits*, defined as beneficial or desired *outcomes* of a clinical intervention (Canadian Healthcare Association 1996, 16). Core insured benefits would be developed "not just based on cost, but on health goals, evidence-based outcomes and social values" (Canadian Healthcare Association 1996, 17). Each *province* would then develop a *service list* of insured core services that have passed an evidence-based test. Such services are defined as "a set clinical regimen or procedure for a certain condition" (Canadian Healthcare Association 1996, 15). Because the development of core services is considered a provincial responsibility, there appears to be no requirement in this model for consistency in *service* entitlement across provinces; rather, a national consensus is proposed on desired outcomes or benefits that might be met through a variety of interventions. Few details are provided on how this plan would actually work in practice.

Funding within Provinces

> The Health and Community Services Act states that core programs and services are those prescribed programs that a required authority is obliged to provide. (Prince Edward Island Government 1994, 3)

Establishing a consistent package of health services benefits for residents *within* a province is also an important policy objective for provincial governments that have devolved authority to the regional level. This includes all provinces except Ontario (Lomas, Woods, and Veenstra 1997). Nearly all these provinces have developed reports on broad "core" service categories that each regional jurisdiction must provide as a minimum provincial floor (Hurley, Lomas, and Bhatia 1994; Prince Edward Island Provincial Government 1994; British Columbia Ministry of Health and Ministry Responsible for Seniors 1994; Nova Scotia Regional Health Board 1995; Saskatchewan Health 1995; Alberta Health 1995a). Thus, two very different trends are emerging around the meaning of "core" services. On the one hand, stakeholder association debates over core or essential services to be retained on provincial health insurance lists focus on specific services or procedures. On the other, provincial reports regarding devolution activities focus on broad service categories or pro-

grams like prevention or rehabilitation. Each uses the term "core services" to define a floor, or minimum standard, of service coverage, but in very different ways. The provincial reports emphasize a broad view of health and the importance of non-health-care determinants of health. Their plans typically include service categories that traditionally have not been part of the health care system and lie outside the current purview of the Canada Health Act. These service categories tend to be justified by reference to general literature on cost-effectiveness rather than by specific research studies.

In summary, there has been an evolution (some might say revolution) in the meaning(s) of medical necessity over time. The concept has evolved as follows:

- from a undimensional to a multidimensional concept, assuming various meanings
- from an implicit, seemingly self-evident, and widely accepted principle of the Canadian national health insurance program to a concept whose usage in health policy debates is problematic, complex, malleable, and confusing
- from a concept closely linked to the comprehensiveness standard in the Canada Health Act to one that some now think should be delinked and attached to a smaller subset of comprehensiveness, which is defined as the core
- from an assumed descriptive principle of service inclusion to an evaluative criterion of service exclusion
- from a minimum federal floor of services that must be insured by each province to a maximum provincial ceiling of insured services (the maximum we can afford)
- from a concept whose meaning was derived inductively by example and illustration to one whose meaning is increasingly derived deductively by reference to abstract principles and "scientific" algorithms

The Funeral?

We have argued that the concept of medical necessity has taken on different meanings over time, depending on the perceived policy needs of the day. During the decade following the introduction of universal medical care, the concept slept quietly, like Rip Van Winkle, embedded

comfortably in legislation and attracting little policy attention. In the mid-1980s, policy makers "discovered" medical necessity, woke it from a long sleep, and capitalized on its malleability to attach different meanings to the concept in pursuit of their own policy agendas. The result is confusion over the array of meanings and how these are used in current health policy debates.

The meaning of medical necessity is not intrinsic to it but, rather, depends on how people interpret and use the concept. Meanings are created through an interpretive and interactive process (Berger and Luckmann 1967; Blumer 1969). The history of medical necessity can be seen as a history of conflict over meanings and attempts by various groups to gain public support for their particular view and for the "facts" that they claim about it (Gusfield 1992). As Stone argues (1988, 121), meanings can be used to "create associations that lend legitimacy and attract support to a course of action." Whoever gains control over the definition of a particular problem will likely be the one to set the policy agenda for its resolution.

Viewed in this context, attempts to achieve consensus on the meaning of medical necessity are likely to fail. Stakeholders have a vested interest in preserving their favored meaning and in advocating for its broader acceptance. Consensus regarding a definition of medical necessity is difficult to achieve precisely because its value to stakeholders lies in the ease with which it can be construed to serve multiple policy and ideological ends. For this reason, new meanings are likely to emerge over time, carrying ever new policy agendas into the health care arena. As one example, the recent Ontario government omnibus legislation (bill 26) contains a provision enabling the general manager of the Ontario Health Insurance Plan to recover post hoc or to withhold payments to physicians for medically unnecessary services (Ontario Ministry of Health 1996). This implies that medical necessity is to take on a policy role, not only to control costs but also to identify alleged cases of physician abuse.

The ambiguity of the concept of medical necessity is also advantageous to the federal government. In the face of provincial challenges to the national health insurance standards precipitated by both cost cutting and privatization ideology, the federal government can use the concept of medical necessity to interpret strategically its view of what constitutes a provincial violation of consistent service coverage and reasonable access to medically necessary services across provinces. This

policy role for medical necessity reflects the federal government's underlying objective of preserving the national health insurance program and the collectivist values that underlie it.

It is inevitable that values will shape the meanings attached to the concept of medical necessity and its use. To a large extent, however, these values have not been made explicit by stakeholders advocating a particular meaning. Acknowledging the values and goals that underlie various interpretations of medical necessity would help to illuminate more explicitly the different value commitments of stakeholders, which can then be the subject of more thorough public debate.

If it seems unlikely that a consensus can be reached on a definition of medical necessity, should we instead work on developing a process and the criteria for assessing medically necessary services to be publicly funded? Clearly, many Canadian national health care associations would answer yes to this question. We, however, offer a more guarded opinion.

The extent to which scientific evidence is available and can be applied effectively to this task is sharply limited. Equally difficult methodological problems surround the task of eliciting, aggregating, and integrating individual consumer and collective (community) values about specific health outcomes and priority services to achieve them. Even if this task could be accomplished, it is doubtful that the issue of appropriateness could be effectively managed by practice guidelines specifying the conditions for making insured services available at a provincial level because of the context-specific nature of treatment decision-making and the role of patient preferences in this process (Lomas and Lavis 1996).

The focus on medical necessity also locks us into a policy framework of preserving the status quo. The need to assess the medical necessity of individual services derives from the fee-for-service reimbursement system, in which physicians are paid a fixed price for each service provided on the benefit list (Hurley et al. 1996). Support for alternative funding arrangements that do not require exhaustive lists of services as a basis of reimbursement makes the issue of medical necessity much less problematic (although by no means eliminating it completely). In a capitated system, for example, the funder specifies general types of care to be funded (e.g., primary care), but reimbursement to the organization is not tied to the cost of each service. The organization can choose to deliver services through a variety of providers, not just physicians, creating opportunities for more cost-effective care through the substitution of less costly health care providers for those providing more expensive care.

It seems an obvious point that the meaning of necessary services depends, to a large extent, on the goals of the health care system (Sharpe and Faden 1996). Yet there is no consensus in Canada on this issue. Goals can be narrowly or broadly defined. Services deemed necessary to achieve one set of health goals—physical health, for example—may not be sufficient to achieve a different one—well-being perhaps being another (Hurley et al. 1996). It is important for Canadians to develop a consensus on health care goals in order to set the policy framework for discussions of necessary services.

Currently, the concept of medical necessity carries a heavy policy load for which it is ill equipped. The focus on developing screening tools to differentiate between medically necessary and unnecessary services creates an illusion that a more rational process for making such decisions will resolve long-standing health care issues like cost control and access to health care according to need. This is unlikely to be the case. Framing these issues in terms of developing criteria for identifying medically necessary services focuses attention on micro- rather than macro-level issues and marginalizes discussions of social values by using scientific discourse to define the nature of the problems and their solutions. Yet fundamental social values are precisely what Canadians should be debating because these will set the broad boundaries within which structural reforms to health care can take place. These value issues include, for example, the extent to which Canadians want to retain the national standards, which level of government, if any, should be responsible for monitoring these standards, and the balance between public and private funding for health care. A myopic focus on defining medical necessity draws attention away from these important issues.

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Coauthors of the article are VANDNA BHATIA *and* VICTORIA A. VINCENT.

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Address correspondence to: Cathy Charles, PhD, Centre for Health Economics and Policy Analysis, Department of Clinical Epidemiology and Biostatistics, McMaster University, 1200 Main Street West, HSC 3H5, Hamilton, Ontario L8N 3Z5 (e-mail: charlesc@fhs.mcmaster.ca).