The Role of Medical Necessity in Canadian Health Policy

Four Meanings and .... A Funeral?

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The current furor about using medical necessity as a means of determining which medical services should be insured in the Canadian medicare system is part of an ongoing and confusing debate stretching back almost four decades.

A historical analysis of the role of medical necessity in Canadian health policy shows that four very different meanings of the concept have predominated at different times and these meanings have shaped public policy discussions about health service coverage under Canada’s national health insurance program.

The researchers undertook this analysis by looking at reports and policy or position papers prepared by provincial governments and national health care interest groups from 1957 to 1994 as well as federal government health insurance legislation up to 1984. They argue that current definitions of medical necessity could be limiting today’s debate.

The analysis traced the development and evolution of four predominant meanings of medical necessity as:

what doctors and hospital do,
the maximum we can afford,
what is scientifically justified, and
what is consistently funded across all provinces.

The paper points out that the first meaning of medical necessity as what doctors and hospitals do predominated without much challenge from the late 1960’s with the passage of the Medical Care Act until the mid 1980 debates over the Canada Health Act. While both Acts required provinces to provide services that were medically required, in order to be eligible for federal funding, neither Act defined this term. By default medically required physician services and medically necessary hospital services took on the meaning of what doctors and hospitals do.
What is consistently funded by provincial government health insurance programs was a second early meaning of medical necessity in the early days of these public programs but this meaning has been eroded over time as provinces first expanded and later contracted service benefits, and initiated various de-insuring exercises during the 1980’s and 1990’s. This has prompted renewed concerns about the inter-provincial consistency of health insurance benefits across all provinces and calls for a definition of medical necessity, meaning clarification of which services must be included and which can be deleted from current publicly funded plans.

It was during the 1970s and onwards when fiscal concerns about medicare began to arise that other meanings of medical necessity came to the fore and then took on fiscal overtones. Associated with these meanings was the implication medical necessity should defined provincial ceiling of what all provinces had to pay for rather than a minimum of what the federal government required all provinces to provide.

Then in the 1980s, the growth of evidence-based medicine lead to arguments that medical necessity should mean what can be justified scientifically. While applying scientific evidence to the medical necessity debate has gathered steam in recent years, the paper points out that there are limitations to this approach. Research evidence is not available to evaluate the effectiveness of many interventions and practice guidelines are often either conflicting or refer to a specific context and would make this approach hard to apply effectively to national standards.

Now, the conglomeration of these meanings has lead to the concept of medical necessity becoming "elusive, ambiguous and confusing". The analysis points out that attempts to transform medical necessity into a specific policy process and criteria for determining what services to offer under medicare remains unresolved and has lead to problematic provincial attempts to "do-list" some medical services as not being medically necessary.

The analysis concludes that any attempts to achieve consensus on the meaning of medical necessity issue "are bound to fail" because each different meaning is motivated by different political objectives and also can change over time. It also notes that this preoccupation with defining medical necessity locks the debate into a discussion on specific medical service items rather than widening the focus to more fundamental issues about health goals.
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ABSTRACT

This paper explores the emergence, evolution and dominance of four predominant meanings of the concept of medical necessity that have been used in past and current health policy debates about the appropriate level of service coverage under Canada's health insurance program. Data for this study derived from a historical analysis of reports and policy or position papers prepared by provincial governments and national health care associations in response to federal legislative and policy reviews of Canada's evolving health insurance program from 1957 to 1984. More current reports focussing explicitly on medical necessity were also reviewed.

Our analysis revealed four predominant meanings of medical necessity. These are: "what doctors and hospitals do", "the maximum we can afford", "what is scientifically justified", and "what is consistently funded across all provinces". The paper explores how each of these meanings has evolved and been used by different stakeholder associations and governments to achieve different policy objectives at different points in time. Limitations of using the concept of medical necessity as a policy tool to determine health service coverage under public programs are also discussed.
INTRODUCTION

"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..." (Canada: 1984b, 7:49. Testimony Concerning The Canada Health Act by Dr. Alex McPherson, Canadian Medical Association).

"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 core 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 & Catz: 1994, pp.17-18).

"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, p.26).

"Provincial Health Ministers themselves 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 this definition to ensure consistency in the application of the principle of comprehensiveness across the provinces and territories." (Canadian Healthcare Association: 1996, p.6).

The odds are fairly high that anyone scanning a Canadian newspaper these days will encounter an article on provincial health care reform. Central to many of these reports are discussions of limited provincial budgets and revenue sources, and the perceived need to restrict publicly funded health services to those that are "medically required" or "medically necessary".
Since 1966, the concept of medical necessity has been a cornerstone of Canadian federal legislation regarding publicly funded health insurance coverage. Medical necessity, (along with comprehensiveness), was a key term in the 1966 Medical Care Act and in the 1984 Canada Health Act.\(^1\) In both these acts, medical necessity was used to identify the scope of services that provinces needed to publicly fund in order to meet the federal comprehensiveness condition and be eligible for federal funding. But despite the importance of this concept for defining provincial government health insurance responsibilities, medical necessity was never defined in either federal policy or legislation.\(^2\)

To the average Canadian, the concept of medical necessity is likely to invoke a meaning of health services that a patient, in need, must have access to in order to avoid a negative health consequence. The fact that Canada's public health insurance system provides universal coverage to all Canadians for any medical or hospital service deemed medically necessary contrasts with the much more restricted service coverage and eligibility criteria of public programs in the U.S. Tuohy and others (Tuohy: 1988; Osberg: 1996) have pointed out the symbolic importance of these Canadian program features as a source of national pride and a concrete emblem of Canada's more collective orientation compared to the United States (Lipset: 1990). The Canadian public has consistently given strong support to the national health insurance program (Schwartz: 1967; Blendon: 1990; Canada Health Monitor: 1994) which has been and still is extremely popular. Historically, Canadians have looked to the federal government to protect the national health insurance program standards,\(^3\) from erosion whenever these have been perceived to be threatened, as with the increase in extra-billing during the 1980's.

Yet, in the current climate of fiscal restraint, some Canadians have begun to question whether Canada's health insurance program is too rich in terms of covered benefits; i.e., too comprehensive. Public support for the comprehensiveness principle under the Canada Health Act declined from 88% in 1992 to 73% in 1994 (Canada Health Monitor: 1994). National health care associations such as the Health Action Lobby (HEAL\(^4\): 1994); The Canadian Medical Association (CMA: 1994); The Canadian Health-care Association (formerly The Canadian Hospital Association) (CHA: 1996) as well as the Federal Reform Party (Harper: 1995, p. A3), and provincial governments (British Columbia Ministry of Health: 1995) have all called for a definition of medical necessity and a clearer specification of its parameters. The objective of such an exercise would be to develop explicit criteria for determining which specific services must be included as insured health benefits under public programs to meet the federal condition of comprehensiveness and which are optional and could be removed.
However, as currently used in health policy debates, the concept of medical necessity remains elusive, ambiguous and confusing. A variety of meanings have been attached to the concept over time as a result of power struggles and conflicting political agendas. The basis for the confusion lies in the wording of the Canada Health Act where comprehensiveness is defined as:

“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.” (Canada Health Act: 1984a, Sec. 9, p.6).

This definition becomes tautological when insured health services are defined, in turn, as hospital, physician, and in-patient surgical-dental services (Canada Health Act: 1984a, Sec. 2). Hospital services mean “.services provided to in-patients or out-patients at a hospital, if the services are medically necessary...” (emphasis added). A specific list of included hospital services is then defined. Physician services mean “any medically required services rendered by medical practitioners,” (emphasis added).\(^5\)

While these definitions state that provincial government obligations regarding health service coverage rest on whether a specific service is deemed medically necessary or required, the act itself contains no criteria for determining this status. In the context of current health policy debates, a dilemma is thereby created. If there is no policy-based principle attached to the concept of medical necessity, it is unclear how provincial governments should use this as a basis for making service coverage decisions.

In this paper we argue that in Canada, as in the United States (Bergthold: 1995), the concept of medical necessity has taken on diverse, implicit, and sub-textual meanings over time in support of the different policy interests of specific groups\(^6\). By “meanings”, we refer to the ways in which the concept of medical necessity has been interpreted or “socially constructed” (Berger and Luckmann: 1967). Specific meanings, in turn, derive from the intended use of the concept as a policy tool to achieve specific policy objectives (Table 1).

In part one of this paper, we explore multiple and changing meanings of the concept of medical necessity using in our review not just the specific term, but also related terms such as medically required, comprehensiveness, core, and essential services. In part two, we trace the
origins, evolution, and dominance of these meanings over time and their use as policy tools in past and current debates. In part three, we discuss limitations of using the concept of medical necessity as an explicit policy tool to determine publicly funded health service benefits in Canada.
METHODS

To trace the evolution of meanings, we conducted an analysis of 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 (the introduction of the hospital insurance program) to 1984 (the passage of the Canada Health Act).

The eight federal policy or legislative reviews were: (1) the Hospital Insurance and Diagnostic Services Act (1957); (2) the Royal Commission on Health Services (1964); (3) the Medical Care Act (1966); (4) the Task Force Report on the Cost of Health Services in Canada (1969); (5) the Federal-Provincial Fiscal Arrangements and Established Program Financing Act (1977); (6) Canada’s National Provincial Health Program for the 1980’s: A Commitment for Renewal: 1980; (7) Fiscal Federalism in Canada (1981); (8) the Canada Health Act (1984a). 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. (For more information on methods, see Appendix 1).

For the four provincial governments, we also reviewed various provincial reform documents from 1984 to 1992, and provincial government reports from 1992 to 19957 where the term medical necessity or a synonym was used. This latter process of data collection was also used for the four national health care associations.

The following guide was used to identify statements reflecting potential policy uses of the concept of medical necessity.

“Statements made by individuals or groups that relate to medical necessity in the context of:

a) defining boundaries (either 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 allude to reasons or criteria or processes that are replicable across jurisdictions;

or

b) alluding to a recognition that we do not have a process or criteria for doing so.”

Our focus was limited to statements made about medical necessity in the policy context of defining what should (or should not) be included as publicly insured health care 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 be collected, to keep data collection within manageable limits, and to focus on a policy context important to current health policy debates.
THE FOUR MEANINGS

I. 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." (Canada: 1984b, 7:49).

Insured medical services under the Medical Care Act (1966) and the subsequent Canada Health Act (1984) were defined by provider: medically necessary services provided by physicians. Insured hospital services under the Canada Health Act were defined by setting: medically required services provided in a hospital. In the absence of federal government legislative or policy direction about the meaning of these concepts or their application to determine service coverage for public funding, responsibility for determining this status was left to physicians who applied their clinical judgement to each individual patient. By implication, this meant that if physicians provided the service, it must be medically necessary. Medically necessary services gradually took on the meaning of what physicians and hospitals do (column A, table I). This became the implicit and largely unquestioned federal floor of mandatory service coverage under Canada's national health insurance program.

II. 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 & Catz: 1994, pp.17-18).

Concern over rising public health care expenditures emerged during the late 1960's and 1970's and rose steadily in the 1980's. Faced with mounting public debt, high interest payments, and reductions in federal transfer payments, provincial governments began to look for ways to limit public spending for health care (approximately one third of provincial government expenditures). In the even more restricted fiscal climate of the 1990's, redefining the meaning of medical necessity as the maximum we can afford justifies cost cutting initiatives (column B, table I).
In this context, medical necessity is invoked to define a provincial ceiling (the maximum scope of services that provinces can afford) instead of a federal floor (the minimum scope of services that provinces must provide).

III 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 guarantees universal access across all jurisdictions." Canadian Hospital Association: 1994, p.26).

By the 1980's, a third meaning of medical necessity began to emerge as: "what is scientifically justified" on the basis of the best available evidence from clinical trials (column C, table 1). This evidence-based meaning derived from health services research on the effectiveness andappropriateness of various medical treatments and procedures during the 1980s. Many national health care associations now argue that the concept of medical necessity, meaning what is scientifically justified, can be transformed into explicit processes and criteria for identifying a smaller subset of "core" services from the more comprehensive service package currently publicly funded. This core would then become the new (and lowered) provincial floor or minimum standards of mandatory provincial service coverage.

IV 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, p.6).

A fourth meaning of medical necessity is "what is consistently funded across all provinces" (column D, table 1). The hospital and medical care insurance programs were designed to provide equity in entitlement to publicly funded health care for all Canadians, as measured by consistency across provinces in levels of service coverage. From this requirement, the concept
of medical necessity as the minimum requirement of what must be consistently funded across all provinces emerged.

Over time, provincial variations in service coverage grew as provinces first added benefits not required under federal legislation, such as optometry, dental care, and prescription drugs and later cut them back or introduced co-payments as economic conditions worsened. This has led to proposals for a renegotiation between the provinces and the federal government of a consistent package of medical services that all provinces must provide.

The emergence, salience, and dominance of the four meanings of medical necessity have waxed and waned over time (see Figure 1). Particularly since 1990, several different meanings have co-existed and vied for dominance. In the next section we discuss the evolution of these meanings.
WEDDING THE MEANINGS TO THEIR HISTORY

1 Improving Access: What Physicians and Hospitals Do

Introducing the federal Medical Care Act in the federal House of Commons in 1966, Allan J. MacEachen, then Minister of National Health and Welfare, asserted that the Act would: "insure access to medical care to all of our people regardless of means, of pre-existing conditions, of age, or other circumstances which may have barred such services in the past." (MacEachen: 1966). The Medical Care Act and the earlier HIDS Act reflected a fundamental shift in federal policy to reflect social welfare values. Rather than viewing publicly funded health insurance programs as residual, appropriate only when the market breaks down (Wilensky & Lebeaux: 1965), access to health care emerged as a social right (Marshall: 1970). Medically necessary services provided by physicians and hospitals defined the floor of entitlement to insured benefits to be made available to all Canadians. This concept of the federal floor or minimum standard of service coverage was well recognized in health policy documents and position papers prepared by various stakeholder associations. The Canadian Hospital Association, for example, reflecting back on the allure of federal funding for such programs stated in 1980:

"The introduction of health services with a high proportion of federal dollars was too attractive for provincial governments to refuse and the financial conditions and definitions of cost-shareable services became de facto the minimum standards of health care." (Canadian Hospital Association: 1980, p.16).

During the 1960’s, policy makers commonly interpreted medical necessity as an inherent element of specific programs or services. It was used by politicians and others to justify their particularly favoured laundry list of services to include in public health insurance programs, or later on, to defend services already included. The term was used largely without question or challenge. Medical necessity was defined inductively by example or illustration, and not deductively by 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, and directed the burden of proof of their medical necessity on those who thought the services should continue to be excluded rather than on those arguing 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 Submission to RCHS: 1962, Paragraph 1).

The Canadian Medical Association assumed as early as 1964 that comprehensiveness under any future health insurance program would refer to physicians’ services. In their submission to the Royal Commission on Health Services the association 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, p. 12922 of supplement to original submission).

Consistent with the views of the Canadian Medical Association, comprehensiveness was, in fact, defined in the Medical Care Act, and the subsequent Canada Health Act, in terms of physician services with the caveat that they be medically required. As provinces joined the national program, many provincial health ministries or commissions simply adopted the schedule of benefits developed by provincial medical associations for use in their voluntary medical care plans as a means of gaining physician support for the new public programs (Shillington: 1972, Ch. 16). These services presumably reflected what physicians thought was medically necessary, which, in turn, reflected services they provided. Thus, “services were medically required if physicians said they were” (Deber, Ross & Catz: 1994, p.4). Since then, provincial benefit lists have been updated periodically by bureaucrats or Cabinet through routine administrative procedures, without any requirement for legislative or public input or justification by reference to articulated policy principles (Canadian Bar Association: 1994, p.37).

During the 1960's and 1970's, the implicit meaning of medically necessary services as “what physicians and hospitals do” did not appear to be contentious for several reasons. First, responding to the federal incentive of “cost-shared funding for services insured under public programs, the dominant trend across provincial governments was to expand the range of publicly funded medical services rather than reduce service coverage. The concept of 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.
Second, 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 as was common in the United States. There, court challenges largely turned on whether the physician was deemed to have provided a necessary service (Hall and Anderson: 1992; Shainblum: 1995).

Third, Canadians trusted in the professional authority of medicine as an institution and physicians as practitioners. The formal authority of both physicians and the profession was sustained by the perceived dominance of medical expertise within the health division of labour (Freidson: 1970a; 1970b; 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 required to understand its content, led easily to the perception that medicine was an exact science. It followed that in the application of this knowledge by physicians in clinical practice, therewould be little room for differences of opinion or discretion in clinical judgement. Physicians would provide only needed care that was scientifically proven (Lomas: 1990b).

Fourth, without centrally derived criteria and processes to determine which services were medically necessary and which were not, this decision was left to physicians. This practice reinforced the belief that individual clinical judgement was the only 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, concern over rising health care costs, changes to the federal-provincial funding 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 health care policy issues requiring attention in the 1960’s and 1970’s (Charles and Badgley: 1987).

It was not until 1984 during hearings on the Canada Health Act that a clear statement was made about the difficulties caused by the lack of a formal definition of medical necessity, and a clear challenge made to the assumption that all services provided by doctors are medically necessary. This challenge came, perhaps surprisingly, from the President of the Canadian Medical Association. In his submission on behalf of the association, Dr. Alex McPherson remarked:
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;... (Canada: 1984b, 7:49).

Despite McPherson’s warning, the 1984 Canada Health Act continued to use the term medical necessity as the criterion for judging comprehensiveness in service coverage, but when the final version of the act was passed, no definition was offered in policy or legislation. Meanwhile, medical necessity was itself occasionally invoked as a criterion for other things. For example, in the debate over the Canada Health Act, the Ontario government regarded extra-billing as permissible as long as “this does not deter patients from seeking and obtaining necessary medical care.” (Ontario Government: 1984, p.10).

By the early 1990’s, the political and economic climate had changed and the concept of medical necessity became an issue of public debate. Cutbacks in federal transfer payments to the provinces, the introduction by the federal government of the new Canada Health and Social Transfer (Hurley, Bhatia & Markham: 1995), the unprecedented government and public concern over federal and provincial government debts, and receding tax bases all heightened concerns about provincial health care expenditures and led to recommendations to limit the scope of provincially funded services. 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 (Chassin et al.: 1986; Wennberg: 1990; Iscoe: 1994). This research dispelled the illusion that medicine was an exact science with no room for discretion in clinical judgement (Lomas & Contandriopoulos: 1994). In addition, scientific evidence suggested that many medical services were either unevaluated or ineffective (Berwick: 1989; Lomas: 1990a).

During the 1980’s and early 1990’s, the definition of comprehensiveness under the Canada Health Act also came under increasing attack. Some groups complained that the concept of medically necessary services, which served as the foundation for determining comprehensiveness, was being interpreted too broadly because it included whatever physicians wanted to include—a “blank cheque” approach (Deber, Ross, and Catz: 1994). Others interpreted it as being too narrow, as restricting insured services to those provided by physicians and hospitals and excluding other types of care such as community care. (Saskatchewan: 1979; Canadian Hospital Association: 1984; Canadian Nurses Association: 1984b). During the Canada Health Act de-
bates, those who stood to gain the most from an expanded definition were the most adamant in voicing their concerns about this issue. The Canadian Nurses Association, for example, lobbied for coverage of services provided by nurses as entry points to the health care system (Canadian Nurses Association: 1982; 1984a). A third complaint about the comprehensiveness principle was the failure of the definition 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 directly addressed the issue of medical necessity by noting that if governments wanted to increase control over the definition of medically necessary insured services, then the meaning or parameters of comprehensiveness would require clarification, and decisions would need to be made about how to define insured benefits. For example:

a) Are all health services performed by a “recognized” health care professional or in a “recognized” provider facility on the insured services list unless specifically excluded? OR

b) Are insured services on an established, limited list with additions requiring justification by a “recognized” health care professional/provider, possibly based on formal technology assessment? (Canadian Hospital Association: 1991, p.13).

By the mid 1990’s, opinion had shifted toward the latter. The convergence of cost control issues, a decline in belief in the infallibility of clinical judgement, as well as 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.”

II Cost Control: The Maximum We Can Afford

Medical necessity became linked to cost control issues around the mid 1980’s. By that time, the economic consequences of adhering to an elastic, open-ended and technology-driven meaning of medical necessity as “what physicians and hospitals do” had become apparent in increasing health care expenditures. At the same time, the Canada Health Act imposed financial sanctions on provinces permitting extra-billing and user charges. For physicians, this meant that the safety valve of supplementing their incomes drawn from the public purse with fees obtained directly from patients was no longer available. As one consequence, provincial medical associations lobbied hard with governments to obtain overall increases in the medical care budget, which would translate into increases in physicians’ incomes. Provincial governments, in turn,
faced mounting fiscal pressures as a result of the federal government's shift from cost-shared to block funding in 1977, federally imposed limits to the Established Programs Financing (E.P.F.) growth formula in the 1980's, and additional federal funding freezes to E.P.F. in the early 1990’s. These changes were intended to stabilize the federal contribution to the provinces for health care and to delink this contribution from provincial cost increases.

As a result of these federal policies, the provinces bore an expanding proportion of health care costs relative to the federal government. To control costs, provincial governments began to reconstruct the meaning of medical necessity from “what physicians and hospitals do” to “the maximum we can afford”. The federal floor of insured benefits (all medically necessary or required services) became the provinces’ preferred ceiling (the maximum insured benefits that provinces can afford).

The issue that remained unresolved throughout the late 1980’s and early 1990’s was how to transform the concept of medical necessity into a specific process and criteria for determining which services to retain on publicly insured lists, and which to de-insure or de-list as a means of saving public dollars. Attempts to remove services from provincial benefit schedules were largely ad hoc, arbitrary, opportunistic, and “driven by the need to save money” (Deber, Ross, & Catz: 1994, p.27). In 1985, for example, the Alberta government delisted several services including family planning counselling, tubal ligations, vasectomies, and mammoplasty. According to Tuohy: 1994, selection of these specific services was largely driven by the conservative ideology of the government in power and focused, with few exceptions, on lucrative procedures performed by relatively high earning specialists.

By deleting these services, a presumption was thereby created that they were no longer medically required (Canadian Bar Association Task Force: 1994, p. 37). But the Alberta public protested the cuts and the Health Minister of the day was forced to reinstate most of the services just delisted, thus creating the presumption that they were, once again, medically necessary. This experience highlighted how arbitrary the processes used for defining medically necessary services could be.

Other de-listing exercises were undertaken in the early 1990’s (Tuohy: 1994; Deber, Mhatre, and Baker: 1994; Rachlis and Kushner: 1994; Pringle: 1995) motivated by cost control. These havetypically lacked a credible process and criteria for determining which services to retain and which to delist. This has hindered the use of the concept of medical necessity as an explicit and practical policy tool for defining the maximum we can afford.
The various delisting activities undertaken by provincial governments in the 1980’s and early 1990’s highlighted a serious weakness in the entitlement to health care of Canadian citizens. A 1994 report of the Canadian Bar Association Task Force on Health Care described the problem:

"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.” (The Canadian Bar Association Task Force on Health Care: 1994, p.39).

By the early 1990’s, those advocating cost control were searching intensely for a more credible process and criteria to use in restricting service coverage. The “evidence-based medicine” and health technology assessment movements provided processes that had already been gaining their own momentum over the previous two decades. Belief in the ability of scientific evidence to differentiate in a more rational way medically necessary from medically unnecessary services in the aid of cost control is now widespread among Canadian national health care associations and coalitions (e.g. the Canadian Medical Association, the Canadian Healthcare Association, HEAL). 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 since unless delisted services (those deemed not scientifically justified) become banned altogether, they are likely to become available through the private sector.

It is not at all clear that delisting services on the grounds that they are not medically necessary will achieve substantial cost savings. The British experience suggests that when given authority to define a universal health care package, few purchasers chose to make certain procedures or services unavailable and little money was saved (Klein: 1994). Those services that were delisted shared two primary characteristics: they were marginal to the NHS’s activities in terms of cost, and they tended to blur “social and medical judgements” (Klein: 1994, p. 107). In Canada, provincial policy differences in the public insurance of IVF procedures provide a good example of this latter dilemma (Giacomini et al: 1996).

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 medical services that were not medically necessary and could be delisted to reduce health care costs. As in Britain, this exercise saved little money, approximately 0.3% of the Ontario budget for physicians, and 0.1% of the overall Ontario budget for health care (Rachlis: 1995). The Chairperson of the Ontario Panel has described several problems in attempting to document cost savings from the delisting exercise (Pringle: 1995). Perhaps most important, many of the procedures recommended for delisting were judged to be medically warranted for some patients but not for others. OHIP billing codes were not sufficiently specific to differentiate between these uses. This made predictions of potential cost savings from deleting use of a procedure for some but not other indications problematic (Pringle: 1995).

The above experiences, while limited, fail to support the thesis that delisting services on the grounds that they are not medically necessary saves money. Rather, the predominant and long-term effect of delisting will more likely be to both cost-shift funding from the public to the private sector and increase overall health care costs (both public and private).

III To Improve the Quality of Care: 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, p. 26).

Medical necessity, meaning “what is scientifically justified” involves the application of scientific evidence (e.g. from clinical trials to technology assessment and practice guidelines) to determine medically necessary services for public health insurance coverage by virtue of their effectiveness in achieving better health outcomes. This meaning originated in the health services research literature of the 1980’s which argued that many prevalent health care procedures were either ineffective or unevaluated (Berwick: 1989; Wennberg: 1990; Lomas 1990a). The evidence-based medicine movement is a more recent example of the scientific approach to enhance quality of care (Evidence-based Care Resource Group: 1994a; 1994b; 1994c).

Many Canadian health care associations enthusiastically 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, applied as sequential
“screens” to evaluate the quality of specific health services and to identify those that are medically necessary, “core”, or “essential”, meaning scientifically justified. (Deber, Ross, and Catz: 1994; HEAL: 1994; CMA: 1994; Wilson, Rowan and Henderson: 1995; Walters and Morgan: 1995; Sawyer and Williams: 1995; Wyman, Feeley, Brimacombe and Doucette: 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.” (HEAL: 1994, p. 14).

The framework has three sequential policy filters: efficacy/effectiveness, appropriateness, and affordability (HEAL: 1994, pp. 12-13).

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

The Canadian Medical Association report also raises the option of partial deinsurance or coverage of a service only in certain circumstances:

“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.” (CMA: 1994, p.22).

Since the early 1980’s, both the Canadian Nurses Association and the Canadian Hospital Association have invoked scientific evidence to justify expanding service coverage in certain
areas as a means to better control costs. The Canadian Nurses Association, for example, has argued that scientific evidence (e.g. the Burlington randomized trial of the nurse practitioner) demonstrated the cost-effectiveness of nurse practitioners compared to physicians in providing primary care services (Spitzer et al.: 1974; Denton et al.: 1982) and that nursing services should be included under public health insurance programs (Canadian Nurses Association: 1984a; 1986; 1988). It was not until the late 1980's, however, that scientific evidence became commonly and explicitly linked to the concept of medical necessity, which, in turn, has resulted in a delinking of the concepts of medically necessary and comprehensive services.

In the early years of universal medical care, scientific evidence about treatment outcomes from clinical trials was not yet sufficiently developed to play a significant role in determining which services to publicly fund. Comprehensiveness was defined in terms of medically necessary services which were defined by physicians in their day to day practice. Now, the new meaning of medical necessity as “what is scientifically justified” is being linked with the new and narrower concept of “core” services and delinked from comprehensiveness. In the Canadian Medical Association’s 1994 report, for example, “core” services are seen as a subset (albeit a rationally derived subset) of comprehensive services. Not all medical services currently publicly funded would be included in the “core”, while services other than medical may be included. The “core” is seen as a new (and lowered) floor - the minimum services that provinces must insure, replacing the earlier concept of comprehensiveness. At the same time, the evidentiary standards applied to retain a service as part of the “core” would be sharply increased. The Canadian Hospital Association, for example, has recommended that:

"Principles such as accessibility and comprehensiveness will be informed by evidence-based clinical consensus regarding the appropriateness and effectiveness of services on the insured service lists.” (Canadian Hospital Association: 1993, p. 101).

Notwithstanding the above pronouncement, the Canadian Hospital Association has historically urged the federal government to be concerned with outcomes in relation to the national standards and not with the range and type of services and programs provided. However, the development of evidence-based information and the incorporation of values into this process to define a list of medically necessary services for insurance coverage is no easy task (Bluestein and Marmor: 1992). The scientific approach assumes the availability of adequate and reliable information about the effectiveness and outcomes of services and their costs as well as agreement on the most appropriate outcomes to measure. In reality, relevant information is often patchy,
incomplete and non-existent (Klein: 1993). Even if the relevant information is found later, changes in technology may render the information obsolete. As 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, p.112).

Practice guidelines are advocated by several national health care associations as the mechanism to promote appropriate care. But here too, problems abound. Many procedures do not have guidelines, while others have conflicting guidelines. Clinical decisions about the appropriateness of a particular intervention need to be context specific because the same procedure may work well for one patient but not for another. Although clinical guidelines are hopefully based on the best scientific information available, it is not clear that one can always extrapolate average group outcomes from clinical trials to individual patients. These circumstances argue for the need to retain flexibility in clinical decision-making in light of individual circumstances (Mechanic: 1992). Using practice guidelines as a public policy tool for allocating funds on a population basis raises other troubling issues. For example, those services which have not yet been clinically evaluated but may nonetheless be effective will likely have less chance of being included as insured benefits (Redman: 1994).

For all the above reasons, transforming the concept of medical necessity meaning what is scientifically justified into an explicit policy tool to make publicly funded service coverage decisions is bound to be problematic. The current enthusiasm for this approach may well end up in disappointment.
IV What is Consistently Publicly Funded:

Across Provinces

"Provincial health ministers themselves 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. CHA [Canadian Healthcare Association] agrees there is a need to clarify this definition to ensure consistency (emphasis added) in the application of the principle of comprehensiveness across the provinces and territories." (Canadian Healthcare Association: 1996, p.6).

Insuring necessary medical services was a consistent expectation of all provinces joining the federal medical care program. Early on, the potential for inconsistent interpretations of this concept, and hence, in the scope of provincial medical service coverage did not emerge as a major concern. Medically necessary services were commonly understood to be those services consistently funded across all provinces. In 1979, the Nova Scotia government, in its submission to the Health Services Review, could still state that:

"On the national scene, there are some variations as to the interpretation of what is meant by a 'medically necessary' procedure. This is not a major problem at the present time, however, in the long term, Nova Scotia is concerned that variances in both the programs covered and the range of services may lead to disparities across the country." (Nova Scotia submission: 1979, p.11).

In fact, 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 other than hospital and medical care. Dental care, vision care, chiropractic services, massage therapy, drug benefits, home care and mental health care are all examples of additional services which came to be insured in various provinces over time. This trend reflected a broader view of comprehensiveness than hospital and medical care, and was more in keeping with the earlier philosophy outlined in the 1964 Royal Commission on Health Services.
As fiscal pressures increased, many provincial governments subsequently either reduced or eliminated service coverage in the above areas, or introduced co-payments. The Ontario Conservative government, for example, introduced a co-payment for prescription drug benefits for seniors in 1996, arguing that this policy did not violate the comprehensiveness condition of the Canada Health Act because this service was not considered medically necessary, meaning that it was not part of the original service package that all provinces participating in the national program were required to provide (Walker: 1995, p.A18).

By 1994, variability in coverage existed across provinces in such programs as: nursing home 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 the area of medical service coverage. These disparities have raised concerns that entitlement and access to medically necessary services, meaning what is consistently publicly funded across provinces have eroded, and that the time has come for provincial and federal governments to 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. The provinces have accused the federal government of acting arbitrarily and inconsistently in applying sanctions to provinces which it deems in violation of the comprehensiveness principle. 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. The federal government has argued that this practice precludes universal access to medically necessary services and has enacted the statutory penalty by withholding funding from the province in an amount equal to the amount charged through facility fees.

The introduction of the new Health and Social Transfer in 1996, and the continued decline in federal cash contributions to the provinces (even with the establishment of a cash floor) may make it even more difficult for the federal government to use fiscal tools to exert moral authority over provincial governments which it feels are failing to provide reasonable access to medically necessary services. If provincial disparities increase, this will further erode the meaning of medical necessity as what is consistently publicly funded across all provinces and put pressure on both levels of government to renegotiate the minimum service package which all provinces must provide.
Renegotiating such a package would clarify (and potentially broaden) the legitimate scope of private insurance for health care in Canada. The potential for an expanded private role was recognized by the former Alberta Health Minister who remarked that:

“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).

Allowing private funding for health care by delisting some services that are currently publicly funded would also provide physicians with an unregulated source of income outside the public sector. This is clearly recognized by the Canadian Medical Association in its 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.” (CMA: 1994, xii).

While re-negotiating the package of publicly funded services that all provinces must provide creates an opportunity to argue for inclusion of a broader range of services and providers, in keeping with a broader definition of health, 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 coverage.

The Canadian Healthcare Association has recently developed a proposal that would appear to no longer require provincial consistency in publicly funded services. The proposal recommends a two-stage process for developing “core” benefits under public health insurance programs. First, a national consensus would be developed on core insured health benefits defined as: beneficial or desired outcomes of a clinical intervention “which conform to the agreed-upon national principle of comprehensiveness.” (Canadian Healthcare Association: 1996, p. 16). Second, each province would develop a core insured service list which would include core services defined as: “a set clinical regimen or procedure for a certain condition.” (Canadian Healthcare
Association: 1996, p. 15). Presumably, this model would eliminate the federal government's role in monitoring provincial adherence to the current comprehensiveness condition since the development of core services would be defined as a provincial responsibility and there would be no requirement for consistency in service entitlement across provinces.

**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, p.3).

Establishing a consistent package of health services benefits for residents within a province is also an important policy objective for provincial governments which have devolved authority to the regional level (all provinces except Ontario). Nearly all such provinces have developed reports on "core" services that each regional jurisdiction will be required to provide as a minimum provincial floor (Hurley, Lomas, & Bhatia: 1994; Prince Edward Island Government: 1994; British Columbia Ministry of Health and Ministry Responsible for Seniors: 1994; Nova Scotia Regional Health Board: 1995; Saskatchewan Health: 1995; Alberta: 1995a). Core services in this context constitute a consistent minimum package of publicly funded broad service categories which each provincial region must make accessible to all its citizens.

Thus, two very different trends are emerging around the meaning of "core" services. On the one hand, the scale of what is being debated in terms of core or essential services to be retained on provincial health insurance lists focuses primarily on specific services or procedures. On the other, provincial reports regarding devolution activities refer to broad service categories or programs such as prevention and rehabilitation (much like those discussed in the 1964 report of the Royal Commission on Health Services). Many of these service categories lie outside the current purview of the Canada Health Act. Both provincial government reports on devolution activities and national health care association reports on comprehensive services use the term "core services" to define a floor or minimum standard of service coverage, but in very different ways. The provincial reports tend to emphasize a broad view of health as well as non-health care determinants of health. Hence, their plans include coverage for broad service categories that have traditionally not been seen as part of health care. Provincially defined cores represent a consistent minimum floor of services that are presumed to be most important in terms of health benefits, justified by a general appeal to the cost-effectiveness literature rather than by specific research evidence.
THE FLOW OF MEANINGS OVER TIME (FIGURE 1)

Over time, there has been an evolution (some might say revolution) in the meaning(s) of medical necessity:

- from a unidimensional to a multidimensional concept with the meanings we have discussed;
- from an implicit, seemingly self-evident and widely accepted principle - the cornerstone of medicare - to a problematic, confused, complicated concept that may well pose a threat to the comprehensiveness of medicare;
- from a concept closely linked to comprehensiveness in the Canada Health Act to one that some now think should be de-linked and attached to a smaller subset of comprehensiveness 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.

From the 1960’s until the mid 1980’s, the dominant meaning of medical necessity was services provided by physicians and hospitals. By 1970, rising health care costs became a concern, which increased steadily in the 1980’s and escalated in the 1990’s. This led to a new meaning of medical necessity as the maximum we can afford. Medical necessity as “what is scientifically justified” made early appearances in the 1980’s as a competing meaning to “what physicians and hospitals do”. The former meaning contributed to a decline in professional authority as the only legitimate basis for defining medical necessity. By the mid 1980’s, there was a beginning crisis of confusion over the meaning of medical necessity as what physicians and hospitals do, the maximum we can afford, and what is scientifically justified. Meanwhile, the meaning of medically necessary services as what is consistently provided across provinces had already started to decline as provinces first opened up and then subsequently restricted access to a variety of publicly funded health services not mandated under the Canada Health Act. The meaning of medical necessity as what is scientifically justified now dominates the thinking of many Canadian national health care associations and is invoked in the service of both cost control and quality of care. At the same time, provincial devolution activities and cost control
exercises such as delisting have prompted new concerns regarding both inter- and intra-provincial entitlement and access to a consistent service package for all provincial residents and has created a renewed interest in the appropriate role for the private sector.

THE FUNERAL?

We have argued that over time the concept of medical necessity has taken on different meanings depending on the perceived policy needs of the day. For the first 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 1980's, 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 different policy agendas. The result is confusion over the current array of meanings and how these are used in current health policy debates.

Understanding the various meanings of medical necessity requires looking behind the words themselves to the specific policy contexts within which they are embedded. As a socially constructed concept, meanings of medical necessity are created through a human interpretive and interactive process (Berger and Luckmann: 1967). As such, it is not surprising that different meanings have been attached to the concept in pursuit of different ends. In fact, the history of medical necessity can be seen as a history of conflict over meanings and attempts by various stakeholder associations and governments to gain public support for the particular meaning they attach to the concept and for belief in the "facts" that they claim about it (Gusfield: 1992).

Viewed in this context, attempts to achieve consensus on the meaning of medical necessity are bound to fail because the meanings constructed are motivated by different policy objectives and are fluid over time. This means that new meanings are likely to emerge, carrying ever new policy agendas into the health care arena. As one example, the recent Ontario government Omnibus legislation contains a provision enabling the General Manager of OHIP to recover post-hoc or withhold payments to physicians for non-medically necessary services (Ontario Ministry of Health News Release: 1996). This implies that the concept of medical necessity is to take on a new policy role, not only to control costs, but also to identify alleged cases of physician abuse.

Even if we could develop an agreed upon definition of medically necessary services, one potential implication would be a greater role for the federal government in monitoring or micro-managing provincial health care systems to ensure that each time a provincial government dropped
a medically necessary service from its list of insured benefits, it would feel the weight of federal
sanctions. This would raise contentious issues of jurisdictional authority between federal and
provincial governments and extend dramatically the policing role of the former at a time when its
fiscal leverage to do so is on the decline.

If we cannot achieve consensus on a definition of medical necessity, can we and should
we put effort into developing processes and criteria for determining which services are medi-
cally necessary for purposes of public health insurance coverage? Clearly, many national health
care associations in Canada would answer yes to this question. We, however, offer a more
guarded opinion.

There are significant limits to the extent to which scientific evidence is available and can
be applied effectively to this task. 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 these. Even if this could be
achieved, it is doubtful that the issue of appropriateness can be effectively managed by specifying
at a provincial level which services will be insured for all citizens and which will not. The
application of practice guidelines will not solve this task because of the context-specific nature
of many medical decisions in the face of uncertainty regarding outcomes and risks at an indi-
vidual patient level.

Historically, Canadians have given strong support for public health insurance as a right
of all who share this common identity (Osberg: 1995). Information recently released by the
National Forum on Health Care suggests continued public support for the national standards
(National Forum on Health: 1996). Nonetheless, erosion of these standards is occurring incre-
mentally and by and large, invisibly. At stake are fundamental values issues which include:

- What are the goals of the Canadian health care system?
- Do Canadians want to retain the national standards (especially comprehensiveness)?
- What level of government, if any, do Canadians want to monitor program standards
  (especially comprehensiveness)?
- What kind of balance do Canadians want between public and private funding for health
  care?
What is not clear is where Canadians currently stand on these issues. While the public may be willing to compromise to some extent on current national standards, it is unlikely that they would be willing to walk away altogether from a program with national standards. Unless Canadians take a stand on these fundamental value issues, medicare may simply slip away without even an explicit recognition of what is occurring.

A myopic focus on developing processes and criteria for defining medically necessary services detracts attention from debating these more fundamental issues of health care reform. Moreover, it locks us into a mindset of preserving the status quo (i.e., fee for service method of reimbursement). In any event, criteria for defining medical necessity, if they are to be developed, must be examined within the context of the goals of the health care system because what counts as necessary to achieve one set of goals may not be relevant to achieving others. Currently, there is no national consensus on what these goals should be. A companion paper developed by Hurley and colleagues (1996) explores this latter issue.
ENDNOTES

1. The term medical necessity was not included in the Hospital Insurance and Diagnostic Services Act, despite widespread belief to the contrary.

2. When the U.S. Congress established the Medicaid program of health care for the poor in 1965, it stipulated that recipients were to receive “medically necessary care.” The legislation did not define the term or specify any political procedures that could be used to give it content (Callahan: 1991, p.32).

3. In this paper, the terms national “standards”, “conditions”, and “principles” have the same meaning.


5. Surgical-dental services were also covered. Surgical-dental services were defined as “any medically or dentally required surgical-dental procedures performed by a dentist in a hospital, where a hospital is required for the proper performance of the procedures,” (Canada Health Act: 1984a, Sec. 2).

6. Evans has made a similar observation about the health field concept contained in the 1974 National Health & Welfare working document entitled, New Perspective on the Health of Canadians. According to Evans, ‘the data and the conceptual framework in the “New Perspective” were capable of bearing a very wide range of different interpretations. Particularly if one “heard” the message of the document selectively, leaving out significant components and emphasizing others, one would convert it into intellectual support for policy positions or for interest groups which were very far from what the authors had in mind.’ Evans: 1982, p. 328-329.

7. The Canadian Healthcare Association’s position statement: Canada’s Health System Under Challenge, Comprehensive and Core Insured Benefits in the Canadian Health System dated January 1996 was also reviewed. (Canadian Healthcare Association: 1996).
8. This did not mean that provincial governments agreed to pay 100% of the medical profession’s fee schedule in each province. When Newfoundland joined, for example, the doctors were to be reimbursed at 90% of the provincial medical association’s fee schedule. In PEI, it was 85%; New Brunswick, 87%; Manitoba, 85% (Shillington: 1972, p. 164-176).

9. In some cases, provincial governments are choosing to de-insure rather than delist specific services. Deinsuring means that the service is retained on the list of publicly insured benefits, thereby precluding its offering through the private sector, but the provincial government retains the legal power to pay nil to physicians providing this service through the public sector. Thus, there is a clear and compelling financial incentive for doctors not to perform such services.
Figure 1
Evolution and Dominance of Meanings of Medical Necessity Over Time

- What physicians and hospitals do
- What is consistently publicly funded across all provinces
- The maximum we can afford
- What is scientifically justified
- Renegotiate what ought to be consistently publicly funded across all provinces

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<td>Meaning of Medical Necessity</td>
<td>What physicians and hospitals do</td>
<td>The maximum we can afford</td>
<td>What is scientifically justified</td>
<td>What is consistently publicly funded across provinces</td>
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<td>Intended Use of Medical Necessity as a Policy Tool</td>
<td>Establish entitlement to a minimum federal floor of publicly funded services</td>
<td>Make the federal floor the provincial ceiling of publicly funded services</td>
<td>Limit public health service coverage to services/procedures justified by scientific evidence</td>
<td>Establish (and later renegotiate) a consistent package of publicly funded services across provinces</td>
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<td>Policy objective</td>
<td>Broaden access to publicly funded health services for all Canadians</td>
<td>Control costs</td>
<td>Improve the quality of care</td>
<td>Promote equity in entitlement and access to publicly funded services across provinces</td>
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REFERENCES


Canadian Nurses Association. (March 1984b). Brief to the Senate Committee on Social Affairs, Science and Technology in Response to the Amended Bill C-3 (The Canada Health Act). Ottawa: Author.


APPENDIX I

METHODS

1. Time Period
The time period for the study is 1957 to the present. This is divided into three sub-periods: 1) 1957 to 1984, an era of numerous federal initiatives in the health insurance field; 2) 1984 - 1992, an era of provincial initiatives in health care reform; and 3) 1992 to the present, an era of increased popularity for medical necessity as a policy issue in the public domain. The year 1957 was chosen because it was the beginning of public health insurance programs in Canada.

2. Rationale for the Choice of the Eight Federal Legislative/Policy Reviews
The eight federal legislative and policy reviews were chosen as a basis for organizing data collection because they provided an opportunity for stakeholders and provincial governments to voice concerns about and debate issues relating to the national health insurance programs. If there were concerns about the concept of medical necessity as specified in federal legislation, we felt that these would likely be aired during these reviews. Also, federal legislation regarding medical necessity sets the model for its wording in provincial legislation.

3. Rationale for the Choice of National Stakeholder Health Care Association and Provincial Governments
Groups were chosen on the basis that we wanted to represent: (1) key national professional or organizational health stakeholder associations which represented provincial constituencies; (2) groups making submissions over time (to explore changes in views; (3) groups representing different types of stakeholders (to include a range of views); (4) groups to whom the issue of medical necessity was likely to be salient; and (5) provincial governments which (largely) pay for insured health care. Data collection was limited to four provincial governments representing all regions of the country because of time constraints and the volume of data to be reviewed.

4. Data Sources
a) Federal Legislative/Policy Reviews:
The initial step in data collection was to locate and read the eight key federal legislative or policy reviews. Most contained a list of groups or individuals who had made submissions. For those reviews resulting in laws, copies of the House of Commons debates or Standing Committee debates were located in order to obtain the names of national stakeholders and provincial governments making submissions.

4b) Stakeholder Submissions:
After discovering who had made submissions and to what events, stakeholder groups were contacted directly and asked to provide copies of the relevant submissions. Contact persons are listed in Appendix 2. In some cases, stakeholder groups were unable to provide copies of the material requested. In others, officials in the organization checked in-house data bases and sent all relevant material.
All the stakeholders received a list of submissions we thought they had as well as a request for submissions on any of the other eight federal reviews. They were also asked for material dating from 1992 to the present that addressed the issue of medical necessity.

4c) Provincial Government Submissions:
Contacts with the provincial governments were handled similarly. The Ministries of Health of each of the four provinces of interest were contacted and asked to provide us with copies of relevant submissions. Each province had a different method of archiving so the position of the contact person varied from province to province. Contact persons are listed in Appendix 2.

It became evident from the responses that many of the provincial governments regarded what we were requesting as federal material and had not retained copies of submissions to some of the federal reviews of interest (especially the earlier reviews). The suggestion was made to look for these in the National Archives in Ottawa.

The project coordinator spent four days at the National Archives of Canada in order to locate and read copies of submissions that we had been unable to obtain from the provincial governments and stakeholder groups. These documents were read at the Archives and relevant quotes were recorded directly into a computer. The definition of medical necessity noted in the body of this paper was used as the criterion to identify relevant finds.

5. Database Searches
Several database searches were conducted in order to obtain information on the concept of medical necessity (and relevant synonyms) that may have appeared in the media during recent years. Databases used included: ABI/Inform (an index to business periodical literature, 1992 to the present), Social Science Index (an index to social science magazines and journals, 1989 to the present), Wilson General Sciences Index (an index to general science magazines and journals, 1989 to the present), Canadian Business and Current Affairs Index (an index to Canadian magazines and newspapers, 1988 to the present), and InfoTrac: Health Reference Centre (an index and database covering health related issues, including major medical journals, about 400 pseudo-scientific or health-related journals and magazines and an assortment of pamphlets published by medical organizations, May 1992- May 1995). Key words used in each search included: medically necessary, medical and necessary or necessity, essential services, core services and medical.
APPENDIX 2

CONTACT PERSONS

1. Associations

Canadian Public Health Association - Sandra Miller
Canadian Hospital Association - Carol Clemenhagen and Laurel Lemchuk-Favel
Canadian Nurses Association - Martha Ippersiel
Canadian Medical Association - Deborah Scott-Douglas

2. Provincial Governments

Alberta Health - Sherri Kashuba
Ontario Archives - Joseph Solovitch
Saskatchewan Health - Glenda Yeates
Nova Scotia Legislative Library - Sandy Scott
Nova Scotia Department of Health - Menna MacIsaac
Prince Edward Island Department of Health and Social Services - Rob Thomson
Manitoba Health - Heather McLaren, Andrea Zajac
British Columbia Ministry of Health - Marnie Dobell

3. Libraries

National Library of Canada - Diane Thomson
Mills Library, McMaster University - Vivian Lewis
Health and Welfare Library, Ottawa - Robin Nagy
National Archives of Canada - Catherine Bailey, Jim Whalen
APPENDIX 3

PROVINCIAL REFORM DOCUMENTS REVIEWED


50
APPENDIX 4

KEY FEDERAL LEGISLATIVE/POLICY SUBMISSIONS,
NATIONAL STAKEHOLDER ASSOCIATIONS, AND PROVINCIAL GOVERNMENTS

The chart on the following page was used to record which associations and provincial governments made submissions to the various federal legislative or policy reviews of interest. The notation “Submission” in the upper left hand corner of the box indicates that a reference in the federal policy review publication indicated that the provincial association or government made a submission. The notation “Located” means we were able to obtain a copy of the submission. The notes are as follows.

Notes:
1. The organization states that there was no official submission.
2. A document was received from the organization in response to our request.
   It was not an official submission for the specified event.
3. The document was received from the organization or via inter-library loan.
4. The document was read at the National Archives of Canada.
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