Defining Basic Services and De-insurance:

The Wrong Diagnosis and the Wrong Prescription

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De-insurance: The wrong prescription

Abstract

The Canada Health Act of 1984 says that the provinces must cover all "medically necessary" medical services to be eligible for full federal contributions. However, neither the federal government nor any province has operationally defined these terms. As a result coverage for certain medical services is uneven across the country. There is even greater variation in the coverage of non-medical services (eg.. drugs, home care) which are not included in the federal legislation.

Recently several provincial medical associations and their respective provincial governments have agreed to define basic covered services and de-insure those services not found to be "medically necessary".

However, trying to define so-called basic services and de-insuring the rest entails the wrong diagnosis of the health care system' woes and then issues the wrong prescription. The process of de-insurance also distracts decision-makers from more worthwhile policies to reform the health care system.
Key words: Health Insurance, health economics

Introduction

The Canada Health Act of 1984 outlines the terms and conditions to be met by provincial health insurance plans to be eligible for full federal contributions. The Act builds upon previous federal health insurance legislation including the Hospital Insurance and Diagnostic Services Act (1957) and the Medical Insurance Act (1966). All these Acts require the provinces to cover those services which are "medically necessary" or "medically required". However, neither the federal government nor any province has operationally defined these terms.<[1]> As a result coverage for certain medical services is uneven across the country.<[2]> For example, Ontario presently provides coverage for invitro fertilization for some patients while other provinces do not cover this service for any.

Recently several provincial medical associations and their respective provincial governments have agreed to define basic covered services and de-insure those services not found to be "medically necessary". These policy initiatives have been partly inspired by the State of Oregon's decision to define basic covered services within their Medicaid program.<[3]>

However, trying to define so-called basic services and de-insuring the rest entails the wrong diagnosis of the health care system's woes and then issues the wrong prescription., Unfortunately this prescription will not heal the health care system's problems and it may involve some potentially dangerous side effects. This article outlines the problems associated with diagnosing the health care system's woes symptoms as being caused (even partially) by a lack of definition of basic services and then critiques the prescription for de-insurance. Finally, a brief overview of some of the alternative policy remedies are offered.

What's wrong with the diagnosis that the lack of definition of basic services is a major problem with Canada's health care system

The policy recommendation for a definition of basic services implicitly entails two faulty diagnoses about the problems besetting Canada's health care system:

1. There are many health care services which we can no longer afford to cover by public health insurance.

2. There is relatively little problem with the appropriateness of delivery of those services which should be covered.

This section will outline the problems with these assumptions.

<u>There are many health care services which we can no longer afford to cover by public health insurance</u>

There are some services which appear to be completely ineffective or frivolous. But, the reality is that almost all services are appropriate for some people at some times. Even public coverage for tatoo removals could easily be justified in certain circumstances. For example, consider a teenager who flees abuse at home, takes to the streets, becomes a drug addict, and gets a death's head tatoo on her face. Suppose, now in her twenties, she goes through drug rehabilitation and educational upgrading. After years of pain and now thousands of dollars of publicly-covered rehabilitation, she can't get a job because of her disfiguring tatoo. Should not Medicare be prepared to pay for the tatoo's removal as part of her overall rehabilitation?

There is relatively little problem with the appropriateness of delivery of those services which should be covered. There is little pay-off in this area compared to de-listing presently covered benefits.

This assumption is more than slightly faulty. Recent reports on health care have consistently noted that inappropriate care is a major problem. To quote from the Ontario Health Review Panel (Evans Report) from 1987:

"Evidence of inappropriate care can be found throughout the Province's health care system, from inappropriate institutional admissions to overuse of medications among the elderly."<[4]>

Other provinces commissions on health care have come to similar conclusions.<[5],[6]> Although it may be relatively simple in retrospect to determine that a particular diagnostic test or therapy has not helped an individual patient, an inappropriate service should be defined as one which the best scientific evidence would indicate in advance would be of no net benefit to the patient **or** one which could be predicted to be of benefit but of no more benefit than one which is less expensive.

Using this definition, there is substantial evidence of the provision of inappropriate services.

* There are dramatic differences in the rates of delivery of certain services between different geographical areas despite the similar health status of the populations.<[7,8,9,10]> Often the best explanation for the differences are the number of doctors and the procedures they prefer as opposed to real differences in rates of illness or patient preferences for treatment.<[11]>

* A large proportion of services are labelled as inappropriate when expert panels are convened to define standards of care for particular illness episodes. <[12,13]>

* Several studies in Canada <[14,15]> and the United States <[16,17]>have found that the fee-for-service method of remuneration is associated with a 25 to 40 percent increase in overall health care costs. The most comprehensive such study was the Rand Health Insurance Experiment. In one part of this experiment over 1600 hundred patients were randomly allocated to receive their health care from

either the Group Health Cooperative of Puget Sound (a Seattle based, non-fee-for-service health maintenance organization - HMO) or fee-for-service providers in the Seattle area. At the end of the experiment there were no overall differences in the health of the two groups of patients but there was a very large difference in costs. The average costs of the patients attending fee-for-service doctors were 40% higher than those for the patients attending the HMO due almost entirely to 40% fewer hospital days. <16> However, it should be noted that there were some differences in the health of some subgroups (wealthy, sick persons did better with the HMO, poor, sick persons did better with fee-for-service) and the persons attending the HMO had lower satisfaction with care.<[18]>

* If consumers are allowed to make informed choices about their care they often choose different services than if the options for care are presented in a traditional fashion. For example, many of the frail elderly and terminally ill would like to chose effective symptom control instead of potentially curative care but often don't have this option presented to them. A study in Hamilton demonstrated that the use of advanced directives in a home for the aged led to more appropriate, less intensive care for he dying with a 50% reduction in hospital use.<[19],[20]> Some research has indicated that at least part of this inappropriate care might be due to

poor communication.<[21,22]>

* Many medical services could be provided by non-physicians (such as nurses) with less cost and, sometimes, improved quality.<[23,24,25,26,27]> Family doctors and emergency departments spend much of their time treating people with minor illnesses which they could be taught to manage themselves.<[28,29,30]>

<u>What's wrong with a prescription for de-insurance?</u>

Not only are there faulty assumptions with the diagnosis that the basic problem is a lack of definition for basic services, but there are problems with the proposed prescription for a "cure". The process is very difficult to conduct scientifically. There is little money to be re-couped . And, finally, the process of defining basic services and then de-listing distracts policy-makers from more important issues affecting the health care system. Paradoxically, if policy-makers did deal with some of these issues then there would be less need to consider de-insurance.

<u>It is extraordinarily difficult to establish which services should be covered</u>

It is extraordinarily difficult to establish which services should be covered as opposed to what outcomes should be achieved. The values assigned to various outcomes by individual patients or Canadian society at large are much less subject to change than the technical processes (i.e. individual services) by which they might be achieved. As research progresses and technology changes, a health care system which is restricted to paying for certain services will provide coverage to increasingly ineffective and inefficient health care. For example, coronary artery bypass surgery is effective at reducing angina in patients with one or two vessel disease not involving the left main or proximal left anterior descending coronary arteries <[31]> but it is more dangerous and probably less efficient than intensive cardiac rehabilitation <[32],[33]> which is not fully publicly covered. Provincial governments could facilitate the development of more effective and efficient systems if they identified the desired outcomes from health care instead of simply enumerating the specific services they will re-imburse. In the United States a group of health maintenance organizations and private insurers have formed the HMO Quality of Care Consortium which is elaborating standardized outcome indicators for health programs.<[34]>

There is little money to be found by defining basic services and de-listing services

which are presently covered

In 1994, the Ontario government and the Ontario Medical Association expended considerable effort and expense to identify eight services for de-listing with an estimated savings of $10 million for the Ontario Health Insurance Plan.<[35]> Without trivializing a sum of this magnitude, it is worth remembering that it represents only about 0.25% of the physicians' budget and less than 0.06% of the overall Ontario health budget.<[36]> On the other hand, Ontario spends approximately $200 million on physician payments for colds <[37]> and this could easily be reduced by more self-care and telephone access to a nurse.

Attempting to define basic services distracts policy makers for much more important areas of health care reform

Attempting to define basic services risks distracting decision makers from the policies that are necessary to develop a more effective and efficient health care system. And, it does so in a fashion which is very socially divisive. Policy makers have only a limited amount of time and energy. These precious qualities can easily be sapped by the emotionally draining exercise of deciding which Canadians have

deserving health problems.

Perhaps the most devastating blow to constructive policy would be the loss of a discussion of the overall health outcomes expected from the publicly funded health services which could have a major steering effect on the structure and process of care and services provided.

Towards a more accurate diagnosis and long term cure

The Ontario Health Review Panel chaired by Dr. John Evans summarized the conclusions of many other Canadian reports on health care by saying:

> "Current submissions and earlier reports highlight the need to place greater emphasis on primary care, to integrate and coordinate services, to achieve a community focus for health and to increase the emphasis on health promotion and disease prevention."<[38]>

There are many other methods to improve the efficiency of health services than de-

insurance. In fact, the best way to decrease the utilization of questionable categories of services might be to not tackle the issue directly. For example, if most physician reimbursement were not on a fee-for-item-of-service basis then there would be much less need to focus on coverage of specific services. Another promising policy direction, provider friendly, clinical quality assurance programs, would dramatically improve health care's quality and focus it on more appropriate services.<[39]> Finally, if the provinces eschewed a discussion on de-listing and de-insurance then they could engage their citizens in a dialogue on the overall health outcomes expected from the publicly funded health services. This policy direction could have a major steering effect on the development of more efficient delviery models. These kinds of policies are particularly needed at this time because most provinces are radically restructuring the administrative framework for health services.

Conclusion

The provinces are under pressure to make their health care systems more efficient. However, if the provinces feel that they must cut their health care funding (a point open to legitimate debate), they could do so in a fashion which does not involve

the definition of basic services and the denial of needed care. Various Canadian reports of the past decade have highlighted the need to fundamentally re-structure the organization and financing of the health care system. These are the policy directions which need more attention from decision makers. Defining basic services and de-insurance are the wrong prescription for what ails Canada's health care system.

Endnotes:

[1] Proceed with Care. Final Report of the Royal Commission on New Reproductive Technologies. (Chair Dr. Patricia Baird). Ministry of Government Services. Ottawa. 1993.
[2] Deber R, Ross E, Catz M. Comprehensiveness in health care. Report to The Health Action Lobby (HEAL). Mimeo. University of Toronto, Department of Health Administration. July 31, 1993.
[3] Harrison B, Noseworthy T. Is there a role for physicians in health and medical resource allocation? Annals RCPSC. 1994;27:12-14.
[4] The Report of the Ontario Health Review Panel. (Chair Dr. John Evans) Government of Ontario. Toronto. 1987.
[5] Report of the Commission on Selected Health Care Programs. (Co-chairs Mr. E. Neil McKelvey and Sr. Bernadette Levesque) Government of New Brunswick. Fredericton. 1989.
[6] The Report of the Nova Scotia Royal Commission on Health Care: Towards a New Strategy. (Chair M. J. Camille Gallant) The Government of Nova Scotia. Halifax. 1989.
[7] Blais R. Variations in surgical rates in Quebec: Does access to teaching hospitals make a difference? Can Med Assoc J. 1993;148:1729-1736.
[8] Naylor CD, Anderson GM, Goel V. Patterns of health care in Ontario. (The Institute for Clinical Evaluative Sciences Practice Atlas). The Canadian Medical Association. Ottawa. 1994.
[9] Sheps S, Scrivens S, Gait J. Perceptions and Realities: Medical and surgical procedure variation - a literature review. Background paper for the Conference of Deputy Ministers of Health. Health and Welfare Canada. Ottawa. 1990.
[10] Health Services Research Group. Small area variations: What are they and what do they mean? Can Med Assoc J. 1992;146:467-470.
[11] Wennberg JE, Freeman JL, Culp WJ. Are hospital services rationed in New Haven or over-utilised in Boston. Lancet. 1987;1:1185-1189.
[12] Park RE, Fink A, Brook RH, et al. Physician ratings of appropriate indications for six medical and surgical procedures. Am J Public Health. 1986;76:766-772.
[13] Chassin MR, Kosecoff J, Park RE, et al. Does inappropriate use explain geographic variations in the use of health care services: a study of three procedures. JAMA. 1987;258:2533-2537.
[14] Hastings JEF, Mott FD, Barclay A, Hewitt D. Prepaid group practice in Sault Ste. Marie, Ontario. Med Care. 1973;11:91-103.
[15] Saskatchewan Department of Health. Community Clinic Study. Government of Saskatchewan. Regina. 1983.
[16] Manning WG, Leibowitz A, Goldberg GA, Rogers WH, Newhouse JP. A controlled trial of the effect of prepaid group practice in the use of services. N Engl J Med. 1984;310:1505-1510.
[17] Ware JE, Rogers WH, Davies AR, et al. Comparison of health outcomes at a health maintenance organisation with those of fee-for-service care. Lancet. 1986;1:1017-1022.
[18] Davies AR, Ware JE, Brook RH, Peterson JR, Newhouse JP. Consumer acceptance of prepaid and fee-for-service medical care: results from a randomized controlled trial. Health Serv Res. 1986;21:429-452.
[19] Malloy DW, Guyatt GH. A comprehensive health care directive in a home for the aged. Can Med Assoc J. 1991;145:307-311.
[20] Malloy DW, Urbanyi M, Horsman JR, Guyatt GH, Bedard M. Two years experience with a comprehensive health care directive in a home for the aged. Ann RCPSC. 1992;25:433-436.
[21] Simpson M, Buckman R, Stewart M, et al. Doctor-patient communication: The Toronto Consensus Statement. BMJ. 1991;303:1385-1387.
[22] Beckman HB, Frankel RM. The effect of physician behavior on the collection of data. Ann Int Med. 1984;101:692-696.
[23] Spitzer WO, Sackett DL, Sibley JC et al. The Burlington randomized trial of the nurse practitioner. N Engl J Med. 1974;290:251-256.
[24] Everitt DE, Avorn J, Baker MW. Clinical decision-making in the evaluation and treatment of insomnia. Am J Med. 1990;89:357-362.
[25] Avorn J, Everitt DE, Baker MW. The neglected medical history and therapeutic choices for abdominal pain. Arch Int Med. 1991;151:694-698.
[26] Mitchell A, Watts J, Whyte R, et al. Evaluation of graduating neonatal nurse practitioners. Pediatrics. 1991;88:789-794.
[27] Brown SA, Grimes DE. A meta-analysis of process of care, clinical outcomes, and cost-effectiveness of nurses in primary care roles: Nurse practitioners and midwives. (Prepared for and published by the American Nurses Association, Division of Health Policy). Chicago. 1992.

[28] Vickery DM, Kalmer H, Lowry D, et al. Effect of self-care education program on medical visits. JAMA. 1983;250-2952-2956.
[29] Roberts CR, Imrey PB, Turner JD, et al. Reducing physician visits for cods through consumer education. JAMA. 1983;250:1986-1989.
[30] Stergachis A. Use of controlled trial to evaluate the impact of self-care on health services utilization. J Ambul Care Management. 1986;9(4):16-22.
[31] CASS principal investigators and their associates. Coronary artery surgery study (CASS): A randomized trial of coronary artery bypass surgery: quality of life in patients randomly assigned to treatment groups. Circulation. 1983;68:951-960.
[32] Ornish D, Brown SE, Scherwitz LW, et al. Can lifestyle changes reverse coronary heart disease? The lifestyle heart trial. Lancet. 1990;336:129-133.

[33] Schuler G, Hambrecht R, Schlierf G, et al. Regular physical exercise and low-fat diet: effects on progression of coronary artery disease. Circulation. 1992;86:1-11.
[34] Siu AL, McGlynn EA, Morgenstern H, Brook RH. A fair approach to comparing quality of care. Health Aff. 1991;10(1):62-75.
[35] The Joint Review Panel. Recommendations of the Joint Review Panel to the Joint Management Committee Re the De-insuring of Medical Procedures. Ontario Ministry of Health. Toronto. 1994.
[36] Ontario Ministry of Finance. Public Accounts in Ontario 1992-93. Volume 1. Queen's Printer for Ontario. Toronto. 1993.
[37] The Ontario Task Force on the Use and Provision of Medical Services. 1989-90 Annual Report. Ontario Ministry of Health. Toronto. 1990.
[38] The Ontario Health Review Panel (Chair Dr. John Evans). Towards a Shared Direction for Health in Ontario. Government of Ontario. Toronto. 1987.
[39] Lomas J, Enkin M, Anderson GM, et al. Opinion leaders vs. audit and feedback to implement practice guidelines: delivery after previous cesarean section. JAMA. 1991;265:2202-2207.