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# A Framework for Determining the Extent of Public Financing of Programs and Services

by

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## Highlights

- The goal of a sustainable, high-quality, universal health care system must involve an examination of how public health care funding is allocated and whether the money is “well spent.”
- The central concept of the *Canada Health Act* (CHA), medical necessity, has not been officially determined, therefore, the extent of public insurance varies from province to province. Only the governments of Alberta and Quebec have stated that they will establish an expert panel to review and make decisions on which health services and treatments are publicly insured.
- Most industrialized countries have been dealing explicitly with the rationing of health care services for years. The methods range from attempting to draft a specific list of services (Oregon) to determining guidelines for rationing decisions (New Zealand).
- The delisting of health services is unlikely to produce substantial savings to the government.
- While the mix of public and private financing has been associated with health inequities, the more likely connection is between health status and being insured at all, publicly or privately.
- In terms of access, quality and health system performance, Canada ranks better than some countries and worse than others. There is no clear public or private financing demarcation.
- The process of deciding which health services to publicly fund should begin with a discussion of the relative importance of the system’s goals. Then there must be a reasoned approach to determining which services or programs are considered. The evaluation process should incorporate cost-effectiveness analysis and consider the relevance of the service to the health system’s goals. The public should be involved in priority setting.

## Executive Summary

The Conference Board of Canada estimates that public health expenditures are projected to rise from 31.1 percent in 2000 to 42.0 percent by 2020 as a share of total provincial and territorial government revenues, reducing the funding available for other social programs and government initiatives. As well, several other analysts and organizations are concerned about the financial pressures on the health care system: advances in technology, new pharmaceuticals, population aging, etc. In this context, the goal of the Commission on the Future of Health Care in Canada for a sustainable, high-quality and universal health care system must involve an examination of how public health care funding is allocated and whether the money is “well spent.”

In general, hospital and physician services are publicly funded, as required by the *Canada Health Act* (CHA). However, the central concept of the CHA, medical necessity, has not been officially defined, therefore, the extent of public insurance varies from province to province. For example, only some provinces cover the services of non-physician health care providers, only some cover hearing aids for certain age groups and coverage of prescription drugs varies. This may not be problematic in and of itself but it begs the question as to whether it is desirable and/or feasible to develop a more structured framework for deciding on the nature and extent of public health care financing. Thus far, only the governments of Alberta and Quebec have stated an intention to establish a permanent expert panel to review and make decisions on which health services and treatments are publicly funded.

This paper examines the question of public funding from a macro-level perspective. First, it provides an overview of which health care services are currently paid for by the public and private sectors in Canada and describes how several other countries deal with financing issues. Then it discusses how the source of funding for services is related to the quality, accessibility and cost of services. Finally, it proposes a general framework for public funding decisions.

### How Do Other Countries Determine Public Financing Arrangements?

Many other industrialized countries have been dealing explicitly with the rationing of health care services for years. The methods vary from drafting a specific list of services with public involvement (Oregon), to having a national committee make the main decisions with some public input (United States, United Kingdom and Australia), to a system in which the government makes the decisions with little public input (Singapore), to the use of guidelines (New Zealand).

All countries have found that setting health care priorities cannot be done systematically from cost-benefit analysis alone. As well, the delisting of health services is unlikely to produce substantial savings.

## **Access, Quality, Cost and Public Health Care Funding**

While many analysts believe that it is the mix of public and private financing that causes health inequities, the more likely connection is between health status and being insured at all, publicly or privately. There are differences in the use of health care services by the insured and the uninsured, and in their health outcomes. But there are numerous studies showing that health status and access to the medical system are not necessarily correlated, and that health status is related more to income, education and access to public health programs such as immunization, screening, etc.

In terms of access, quality and overall health system performance, Canada ranks better than some countries and worse than others. Canada spends more than most industrialized countries on health care, but it is unclear what effect this greater expenditure has on Canadians' health status.

## **Framework for Determining Extent of Public Financing**

### **1. Clarify the Purpose of the Health System**

Before discussing what health services the public sector should fund, there needs to be agreement on the relative importance of the health system's goals: maximize the amount of health in society, treat disease, meet health care needs or ensure equality in health status. As well, there are interventions that maintain function at high cost, interventions that are mainly used to enhance quality of life, heroic but marginally effective technologies, emerging advances in genetic diagnosis and treatment, and numerous socio-economic factors that have been associated with health status, such as housing, income and education.

### **2. Decide Which Services to Evaluate**

Decision makers/funders should ask the following questions about program and service trade-offs before heading into the evaluation stage:

1. *What is it?* Interventions (e.g., heart transplant) and medical and diagnostic technologies vary in practice/method, function and effects.
2. *What is it for?* Services must be considered in terms of public policy goals and values. At issue may not be the effectiveness of the service but less tangible concerns about the medicalization of problems or the legitimacy of recipients' needs.
3. *How is it situated?* Interventions may be interdependent; restricting one may affect the other.
4. *Whose is it?* Lobbyists/constituencies may influence the assessment process.
5. *Who is it for?* Services/technologies may work better in particular populations.

### **3. Evaluate Cost-Effectiveness and Relevance of Programs and Services**

Some form of cost-effectiveness analysis should be used to determine which health care services to cover publicly, balancing the need for rigor against the limitations of the current state of medical knowledge. The relevance of particular services to a health system's goals must also be established. For example, U.K. decision makers have decided that the National Health Service (NHS) is not obliged to subsidize a lifestyle drug such as Viagra for everyone who might benefit from it; they have determined that Viagra, in most cases, is not *relevant* to a publicly funded, universal service.

### **4. Involve the Public**

Priorities are set at many levels: federal and provincial governments set priorities and budgets; funding is allocated between geographical areas and specialties; which services, how they are delivered and to whom must be decided; and there are decisions about how much to spend on individual patients. These issues raise a number of areas for potential public involvement in decision making, including in the definition of the values of the system and which groups or treatments receive priority. Individuals (patients, providers and those directly affected by the policy/choices) must have the right to challenge any rationing decisions.

## **Introduction**

Public sector spending accounts for almost 73 percent of total spending on health and represents about 30 percent of governments' total revenues in Canada. (Canadian Institute for Health Information 2001; Conference Board of Canada 2001) The Conference Board of Canada estimates that public health expenditures are projected to rise from 31.1 percent in 2000 to 42.0 percent by 2020 as a share of total provincial and territorial government revenues, reducing the funding available for other social programs and government initiatives. (Conference Board of Canada 2001) As well, several other analysts and research organizations are concerned about the financial pressures on the current health care system: advances in technology, new pharmaceuticals, population aging, etc. (Baxter 2002; Standing Senate Committee April 2002; Baxter and Ramlo 1998; and Canadian Institute of Actuaries 2001 and 1995) In this context, the goal of the Commission on the Future of Health Care in Canada for a sustainable, high-quality and universal health care system must involve an examination of how public health care funding is allocated and whether the money is "well spent."

In general, hospital and physician services are government-funded, as required by the *Canada Health Act* (CHA). However, the central concept of the CHA, medical necessity, has not been officially defined, and what is publicly insured varies from province to province, even for services provided in-hospital, such as certain prosthetic devices and crutches, for example. (Prince Edward Island Department of Health and Social Services 2001) This may not be problematic in and of itself but it begs the question as to whether it is desirable and/or feasible to develop a more structured framework for making health care financing decisions.

This paper examines this question from a macro-level perspective. First, it provides an overview of which health care services are currently paid for by the public and private sectors in Canada and describes how several other countries deal with financing issues. Then it discusses how public funding of services is related to the quality, accessibility and cost of services. Finally, it proposes a general framework for public funding decisions.

## Government Funding of Health Care Services

### The Financing of Health Care in Canada

Total health care spending in Canada is projected to have been almost \$96 billion in 2000 and more than \$102 billion in 2001. The public sector share of health spending has risen from 70.2 percent in 1997 to 72.6 percent in 2001. (Canadian Institute for Health Information 2001) Table 1 outlines the basic structure of health care financing in Canada.

Most provinces cover only a portion of the fees charged by chiropractors and other non-physician health care providers. Only some provinces cover hearing aids for certain age groups and coverage of prescription drugs varies. Most provincial insurance plans do not cover acupuncture, naturopathy, cosmetic surgery, physical examinations for employment or insurance purposes and sterilization reversals. With respect to these differences, a paper by the National Forum on Health asked: What is the proper way for provincial insurance plans to define “medically necessary”? What standards of evidence should govern decisions about insuring or not insuring services? (National Forum on Health 1995)

<b>Table 1 The Financing of Health Care Services in Canada</b>	
<b>Service</b>	<b>Method(s) of financing</b>
Hospitals	100 percent public financing for medically necessary services; private payment for upgraded accommodation or non-medically necessary services provided in hospitals
Private clinics	Privately funded for services not considered medically necessary
Long-term care	Mixed
Home care	Partial public coverage provided in most provinces
Physicians	100 percent public for medically necessary services; majority is paid fee-for-service, with some salary and capitation payments; private payment for non-medically necessary services
Other health care professionals	Mainly private (insurance and out-of-pocket); some services covered by provincial plans for long-term care or home care
Prescription drugs	Mixed: drugs within hospitals covered by government-allocated hospital budgets; provincial plans pay for a large percentage of drugs dispensed outside hospitals; coverage is typically limited to target populations; balance funded privately
Non-prescription drugs	Private
Dental/optometry care	Mainly private; some provincial plans cover some services for children and seniors
Alternative medicine	Mainly private; limited coverage by some provincial plans
Ambulance services	Partial public coverage in some provinces; special programs for residents in remote areas
Public health programs	Public
First Nations health	Public directly delivers some services
Sources: El Feki 1998, 38; National Forum on Health 1995; Newfoundland Department of Health and Community Services 1999; Prince Edward Island Department of Health and Social Services 2001; Government of New Brunswick 2002; Nova Scotia Department of Health 2001; Government of Quebec 2001; Ontario Ministry of Health and Long-Term Care 2000; Manitoba Health 2002; Saskatchewan Health 2000; Alberta Health and Wellness 2002; British Columbia Ministry of Health 2002.	

Since the Forum, there has not been much movement toward answering these questions and building a framework for determining core services. However, there have been many methods proposed and a few provinces have said they are now going to be seriously examining this issue.

Most recently, the government of Alberta accepted all the recommendations for reform proposed by an advisory council. The council states that the CHA was never designed to cover the full range of health care services now available, but, over the years, many new treatments and technologies have been added to the list of insured services. Generally, decisions involve assessment of the technology, analysis of the impact, expert consultations, government review, development of legislation if necessary, review by the legislature or government and implementation. Ultimately, the funding decision is made by the health minister or by the government collectively. (Premier's Advisory Council 2001)

As there likely will be continued pressure to add more treatments, programs and drugs to the list of insured services, the government needs to reconsider what gets insured and what does not, and decide what services could be funded in other ways. One of the council's proposals was to establish a permanent expert panel to review and make decisions on which health services and treatments are publicly funded. The expert panel will start by reviewing the broad categories of services currently provided and deciding which ones should be "grandfathered" for continued public funding. (Premier's Advisory Council 2001)

In Quebec, the Clair Commission also recommended the establishment of a permanent committee to review and decide which services to publicly insure. (Standing Senate Committee April 2002) Saskatchewan is also moving toward formalizing evidence-based funding of health care. In its 2001 action plan, it supports the formation of a quality council to advise government, develop evidence-based approaches and promote effective practices throughout the system. (Saskatchewan Health 2001)

A rationalization of services is not easy to achieve. Ontario's 1994 deinsurance initiative illustrates the variety of principles and interests that are involved in the process. The initiative was part of an agreement between the Ontario Medical Association (OMA) and the Ministry of Health to cut \$20 million worth of services in order to keep within the budget allocated to the profession, which had been recently capped. The services for deinsurance were nominated by the OMA and the ministry, and reviewed by an ad hoc commission. Because the CHA requires that provinces insure all medically necessary care, the candidates for deinsurance had to seem "medically unnecessary" in some sense – cosmetic surgery, for example. Additionally, since deinsured services would be privatized, an existent or potential private market helped flag certain choices. It was a difficult process and there were attempts to include the public in the decision-making process. Nonetheless, even the chair of the commission that reviewed the candidates for deinsurance described the final selection as "bizarre." (Giacomini 1999, 728-730)

## **Some Methods Proposed for Priority Setting in Canada**

John Williams and Michael Yeo, ethicists at the Canadian Medical Association, make a few general suggestions about priority setting in Canada:

- Regional boards and the federal and provincial governments should clarify the values and principles that guide their priority-setting work, as regards both the goals of health and health care and the means for attaining these goals.
- Decision making at all levels should be transparent and open to scrutiny.
- Public education programs should be developed to prepare the public to participate in priority setting and demand accountability from the decision makers. (Williams and Yeo 2000, 132)

### ***The Canadian Medical Association Core and Comprehensiveness Project***

The Canadian Medical Association (CMA) has constructed a decision-making framework on core (publicly funded) health care services. The association uses the terms core, basic and optional services, rather than medically necessary. The CMA believes that there are three key factors to making the decision: quality of care (effectiveness, appropriateness, efficiency, patient acceptance and safety), ethics (fairness, age, lifestyle, the identifiable patient versus the statistical patient and futility) and economics (cost-effectiveness analysis). The CMA states that an ethical process recognizes that decisions are made between patients and physicians, in the community or by society, and by governments. It advocates for public involvement in the decision-making process. (Wilson, Rowan and Henderson 1995; Walters and Morgan 1995; and Sawyer and Williams 1995) The CMA model was first used to make recommendations on three clinical issues: prostate specific antigen (PSA) screening, gastroplasty and the annual physical examination. (Deber et al. 1995, part 2)

### ***The Four-Screen Model***

The 1995 paper *The Public/Private Mix in Health Care*, by Deber et al., proposes a four-screen (Deber-Ross) model of prioritizing government health care financing decisions. Decisions about coverage are made as a function of four screens, with only those interventions passing an earlier screen considered at the next stage. Screen 1 (effectiveness) examines whether the intervention works. Screen 2 (appropriateness) incorporates information about the risks and benefits to particular individuals. Screen 3 (informed choice) incorporates the views of recipients of care and Screen 4 (public provision) asks whether a third party should pay for the intervention. This decision requires the consideration of such factors as cost minimization, social values and advancement of knowledge. (Deber et al. 1995, part 2)

The model begins at the level of the individual, but implementation is simplified if it is then aggregated to determine a global budget. Rather than list which procedures would be covered,

the budget is based on an estimate that, for a given population, there should be approximately X hip replacements, Y cases of diabetes and Z with high blood pressure. This model presupposes reforms of the way in which health care is delivered in Canada. (Deber et al. 1995, part 2)

## **How Do Other Countries Determine Public Financing Arrangements?**

In all countries, the government plays a significant role in the financing of health care. The programs and services that other countries publicly fund vary, as does the method by which these countries determine these financing arrangements. This section looks at what services are publicly covered in Australia, New Zealand, Singapore, the United Kingdom, and the United States, and how these coverage decisions are made.

### ***Australia***

The Commonwealth and state and territorial governments account for about 70 percent of health expenditures in Australia. The Commonwealth government is the primary public insurer of prescription drugs and physician services, and it funds some 50 percent of hospital expenditures. (Standing Senate Committee January 2002a, 8)

The Commonwealth government's Medicare program provides "free" treatment to Medicare patients in public hospitals, and free or subsidized treatment to patients treated by doctors (and optometrists or dentists for some services). Patients may insure with private organizations for the gap between the Medicare benefit (subsidy) and the fees. (Ramsay 2001)

Medicare pays benefits for services that are considered "clinically relevant," such as consultation fees for doctors, tests and exams by practitioners to treat illness, eye tests performed by optometrists, and most surgical and therapeutic procedures performed by doctors. Medicare does not cover such things as dental exams and treatment, ambulance services, home nursing, physiotherapy, chiropractic, glasses and contact lenses, hearing aids, prostheses, medicines and non-clinically necessary services. (Health Insurance Commission 2001)

In what it calls an effort to ease the financial burden on the public health system, the Commonwealth government has implemented reforms intended to improve the affordability of private health care and enhance choice for consumers. Specifically, among other measures, the government encourages the purchase of private health insurance with a 30 percent refundable tax credit. (Australian Department of Health and Aged Care 2000, 4) However, there is debate as to whether a public subsidy in the form of tax relief on the purchase of private *insurance* is an effective use of funds, in that it could cost governments more than it would save them. (Standing Senate Committee January 2002a, 11; Emmerson, Frayne and Goodman 2000, 31-32) As well, there are those who contend that private *insurance* or private *hospitals* result in longer queues in the public system. (Standing Senate Committee January 2002a, 11-12; Currie 2000)

The Commonwealth government's approach to Medicare is increasingly to fund interventions that are safe, clinically effective and cost-effective. During 2000-01, the Quality

and Safety Council and the National Institute of Clinical Studies were contracted to examine a “whole of system” approach to quality and safety, focusing on best practice models for acute care and the treatment of a range of national health priority areas. Already, the Pharmaceutical Benefits and Medicare Services advisory committees recommend funding for services and medicines proven to be appropriate and effective. (Australian Department of Health and Aged Care 2000)

### ***New Zealand***

In 1998-99, the proportion of publicly funded health and disability support services accounted for around 77.5 percent of the total health expenditure in New Zealand. Individuals may also choose to use private health care services; the proportion of health expenditure financed privately has risen from 12.0 to 22.5 percent over the last two decades. (New Zealand Ministry of Health 2001*b*, 12-13)

Most New Zealanders are eligible for publicly funded health and disability services, as they are either permanent or long-term residents. Eligible people may receive free inpatient and outpatient public hospital services, subsidies on prescription items and a range of support services for people with disabilities. There is a fee-for-service system for primary care, although visits to the doctor and prescription items are generally free for children under age 6 and basic dental care for children is generally free until age 16. For people who have to make many doctor visits or who require a lot of medication, there is the possibility of getting a government subsidy. (New Zealand Ministry of Health 2001*a*)

In 2000, the central government transferred decision-making responsibilities to community-focused district health boards (DHBs). The central government provides broad guidelines on what services the DHBs must provide and national priorities have been identified in the New Zealand Health Strategy. (New Zealand Ministry of Health 2001*b*)

The national Health Funding Authority is expected to reflect the needs of users and is obliged to consult communities about its plans for the purchase of services. As well, the National Health Committee (NHC) was set up in 1992 to advise the government on the types of health and disability services that should be publicly funded and their relative priorities, given available resources. Over the years, the NHC has engaged the public in its work: there have been town hall meetings, focus groups and calls for submissions. The NHC even runs a consumer-training program in guidelines development. (Edgar 2000)

The philosophy behind the NHC’s rationing process includes consideration of the effectiveness of the services, value-for-money, fairness in access and use of the services and consistency with communities’ values. (Edgar 2000) Four assumptions underlie the NHC’s work:

- Rationing of services is inevitable.
- The processes for making rationing decisions must be transparent.

- Communities must be involved – their values are essential when rationing decisions mean that not everyone will get all the health services they want.
- There are transparent tools – guidelines and priority criteria – that can help decision makers. (Edgar 2000, 186)

While there have been few well-designed research studies conducted on NHC initiatives, the committee still feels it important to continue learning how to make difficult choices. Even if total spending on health care were to double, decisions would still need to be made on the margins of funding and acceptance of the need to make such decisions is important. (Edgar 2000)

## **Singapore**

Health services in Singapore are provided by three different ministries and by the private sector. In 1999, Singapore spent about 3 percent of GDP on health care in total; government health spending accounted for 0.8 percent of GDP. (Singapore Ministry of Health 2001, 10)

The Ministry of Health provides preventive, curative and rehabilitative services; formulates national health policies; co-ordinates planning and development between the public and private health sectors; and regulates health standards. (Singapore Ministry of Health 2001) The Singapore health care philosophy emphasizes the building of a healthy population through preventive health care programs and the promotion of healthy living. Immunization, health education in schools and dental services are free. (Hsiao 1995)

Primary health care is delivered at government outpatient polyclinics and private medical practitioners' clinics. There is an outpatient consultation fee, which includes medication. At the government polyclinics, all services are subsidized. (Hsiao 1995) However, co-payments apply even to most heavily subsidized hospital wards and are designed to limit demand by making patients cost-conscious. (Ham 1996)

To ensure that basic medical services are available to all Singaporeans, the government also subsidizes medical services at public hospitals and government clinics. The basic medical package is intended to reflect up-to-date medical practice that is cost-effective and of proven value. It excludes non-essential or cosmetic services, experimental drugs and procedures of unproven value. The goal of the system is to allocate resources in such a manner as to do the most good for the largest number of people. (Ham 1996)

Singaporeans are required by law to save for their medical expenses. Under the Medisave scheme, all working persons must set aside 6 to 8 percent of their income for a personal Medisave account. Singaporeans use the money in this account to help pay for any hospitalization costs they, or their immediate family, incur. In addition, there is Medishield, a voluntary insurance plan designed to help Singaporeans meet any medical expenses arising from a major accident or prolonged illness. Medishield reimbursements are based on a system of deductibles and co-insurance, and there are claim limits per policy year and per lifetime. Lastly, there is Medifund, an endowment fund set up by the government as a safety net to help low-income Singaporeans pay for

their medical care. The amount of help given to a patient depends on individual circumstances and is decided upon by a committee at the hospital level. (Ramsay 2001)

The Singaporean government has also introduced low-cost community hospitals for the convalescent sick and elderly not requiring the more expensive care of the acute general hospitals. Health care services for the elderly are mostly run by voluntary welfare organizations that are subsidized by government. Most support services to the hospital and primary health care programs are found in both the public and private sectors. (Singapore Ministry of Health 2001)

### **United Kingdom**

The National Health Service (NHS) is the main provider of health care in the United Kingdom. It is based on the ideal of universal coverage for all British citizens, paid for from general tax revenues. But initial cost estimates for the NHS were soon exceeded and fees were added for such services as prescriptions and dental care. (However, today, about 85 percent of prescriptions are dispensed to people who are exempt from the charges.) (British Medical Association [BMA] 1999)

About 11 percent of the U.K. population have private medical insurance. (Ramsay 2001) The number of people paying directly for elective surgery in the private sector accounts for about 19 percent of private treatment and the private sector also provides the majority of places in residential and nursing homes. (BMA 1999)

Despite cost pressures on the system, the NHS's 10-year modernization plan rejects the suggestion that the NHS should only cover a defined set of individual conditions or treatments:

First, advocates of this position usually have great difficulty specifying what they would rule out. The sorts of treatments that commonly feature include varicose veins, wisdom teeth extraction or cosmetic procedures. The problem is that these sorts of services account for less than 0.5 percent of the NHS budget, and are not major cost-drivers for the future. Instead, the vast majority of spending – and spending increases – go on childbirth, elderly care and major conditions such as cancer, heart disease and mental health problems. (United Kingdom Department of Health 2001, chap. 3)

The other reason given in *The NHS Plan* for not restricting spending to a defined set of core services is that effectiveness is subjective: different patients under different circumstances can derive different benefits from the same treatment.

However, *The NHS Plan* acknowledges that priorities have to be determined. The National Institute for Clinical Excellence provides guidance on the clinical and cost-effectiveness of new and existing health technologies, including medications, with the aid of a Citizens Council. (United Kingdom Department of Health 2001) While the context for prioritizing decisions is national, many choices are made by local health authorities and, more often, rationing is done implicitly by individual physicians, using clinical judgment applied to the individual case. (BMA 1999)

## **United States**

### *Medicare/Medicaid*

In the United States, there are two main government health care programs. Medicare covers elderly Americans (aged 65 and over) and disabled Americans, and Medicaid provides health insurance and services for lower income Americans. Medicare covers more than 39 million Americans and Medicaid had 36 million recipients. (Health Care Financing Administration [HCFA] 2001c; 2001a) In 1997, the public sector in the United States accounted for 46.4 percent of total health care spending. (Ramsay 2001)

Medicare is a federal program that reimburses the elderly for their health care expenses. Of seniors, 98.6 percent were enrolled in Medicare and most elderly (70 percent) have both Medicare and additional private insurance for those costs not covered by the public program. (Ramsay 2001) Medicare Part A is hospital insurance that helps beneficiaries cover the costs of inpatient hospital care, critical access hospitals, skilled nursing facilities, hospice care and some home care. Medicare Part B is optional insurance and covers medically necessary doctors' services, outpatient hospital care and some services that Part A does not cover, such as the services of physical and occupational therapists. For both Medicare parts A and B, there are premiums, deductibles and co-payments.

State governments contribute to Medicaid, and also fund such things as public health services (e.g., immunizations and Native health), community-based services (e.g., mental health and substance abuse services), state university-based teaching hospitals and state employee health premiums. As Medicaid is a joint federal-state program, its benefits and eligibility requirements vary from state to state. Coverage is not available to all low-income people, but to those who are considered by the various state definitions to be "categorically" or "medically" needy; most states fund assistance programs for specified poor persons who do not qualify for Medicaid. (Standing Senate Committee January 2002a, 48) Nominal deductibles and cost-sharing may be imposed on some Medicaid recipients for certain services, however, there are some recipients who must be exempt from cost-sharing: pregnant women and children under 18 years of age, for example. (HCFA 2001b)

In general, basic Medicaid coverage must include inpatient and outpatient hospital services, physician services, surgical dental services, nursing facility services and home health care for some individuals, family planning services and supplies, rural clinic and ambulance services, laboratory and X-ray services and periodic screening. The most commonly covered optional services include clinic services, intermediate care facility/mentally ill services, optometrist services and eyeglasses, prescribed drugs, prosthetic devices and dental services. (HCFA 2001b)

It is the responsibility of the Health Care Financing Administration (HCFA), now called the Centers for Medicare and Medicaid Services, to track emerging technologies and patterns of care to determine the need to change national coverage policies. In making these decisions, the HCFA considers whether an item or service demonstrates medical benefit and added value (either in terms of more health benefits or lower cost) to what is already covered for the Medicare population. (HCFA 2001d) Part of the HCFA's approach is to use the Internet to inform people about how coverage decisions are made and the progress of each issue under coverage review. (HCFA 2001e)

Oregon

The Oregon Health Plan (OHP) provides insurance coverage for some one million low-income Oregonians, but it is estimated that about 400,000 people remain without health coverage. (Oregon Health Services Commission 2001)

The OHP is the only state Medicaid program that explicitly rations medical care, funding services using various measures of value. In broad terms, covered services include diagnosis, physician services, medical and dental check-ups, family planning services, maternity, prenatal and newborn care, prescriptions, hospital services, comfort care and hospices, dental services, alcohol and drug treatment, and mental health services. Services not covered are those for conditions that will get better on their own, conditions that have no useful treatment, treatments that are not generally effective, cosmetic surgeries, gender changes, treatment for infertility and weight-loss programs. (Office of Medical Assistance Programs 2001)

There is a priority list of 736 medical conditions and their related treatments. As of October 2001, the government funding line went up to and included 566 of these condition/treatment pairs. Table 2 gives an indication of the complexity of the funding list.

<b>Table 2 Selected Services Covered by the Oregon Health Plan as of October 2001</b>		
<b>Ranking</b>	<b>Diagnosis</b>	<b>Treatment</b>
<i>Government-funded services include the following:</i>		
1	Severe/moderate head injury: hematoma/edema with loss of consciousness	Medical and surgical treatment
2	Type I diabetes mellitus	Medical therapy
565	Symptomatic urticaria	Medical therapy
566	Dysfunction of nasolacrimal system	Medical and surgical treatment
<i>Government funding does not include the following:</i>		
567	Chronic anal fissure, anal fistula	Sphincterectomy, fissurectomy, fistulectomy, medical therapy
568	Dental conditions (ex. broken appliances)	Periodontics and complex prosthetics
735	Spastic dysphonia	Medical therapy
736	Disorders of refraction and accommodation	Radial keratotomy
<i>Source: Oregon Health Services Commission, 1 October 2001, Prioritized List of Health Services.</i>		

The impetus for Oregon to rank procedures came in 1987, when the state deinsured transplants for Medicaid patients. As a consequence, a boy needing a bone marrow transplant died before his family could raise enough private money for the procedure. The incident led to public outrage and a more systematic and evidence-informed method of rationing was deemed necessary.

The initial process involved ranking health services by their value to the community and their cost-effectiveness. Multiple rankings were required before the end result was achieved. In later stages, analysts ranked finer categories (eventually diagnosis-treatment pairs) according to an algorithm that used criteria including cost-effectiveness, public opinions of service types and health states, and expert opinions of the ranks produced. Eventually, 17 categories were developed and then ranked by a state-appointed Health Services Commission. They covered more than 10,000 medical procedures, which were reduced to 709 diagnosis-treatment pairs.

Oregon's efforts to rationalize the Medicaid benefit package met with lobbying by providers and consumers who wanted to protect their own favoured services from being rationed by the government. There was some success by lobbyists in proscribing or delaying the addition of particular services to the ranking list. For example, most psychiatric care was excluded from the ranking. The excluded services accounted for about 70 percent of Medicaid spending, leaving 30 percent of the budget to be controlled by the priority-setting process. (Giacomini 1999, 725-726) "Because Oregon [in the end] did not ration care based on cost-effectiveness, their basic benefits package fails to maximize health outcomes to Medicaid recipients." (Tengs 1996, 181)

The central idea behind the OHP was that, given fiscal limits, it is better to provide some health insurance for everyone rather than only covering some people for everything. However, the benefits package today is more generous than Oregon's old Medicaid system and the costs for the OHP have increased over the last decade. (Oregon Health Services Commission 2001)

Other U.S. states have tried alternative methods of expanding public coverage of health services to those who are uninsured. For example, Massachusetts expanded coverage with a basic option for the non-categorical needy called MassHealth. New York's Healthy New York package is for small businesses that do not provide health insurance for their employees and to working, uninsured individuals. Washington State's Basic Health Plan gives low-income Washingtonians a choice between a managed-care-style plan and a less managed plan with higher out-of-pocket costs. Minnesota's MinnesotaCare has a basic benefit that includes single adults without dependent children; initially offering only outpatient services, inpatient services for this population were recently added. (Oregon Health Services Commission 2001)

Despite such efforts, in 2000, 14 percent of Oregonians were uninsured, 9 percent of Massachusetts residents, 15 percent of New Yorkers, 14 percent of Washingtonians and 8 percent of Minnesotans; the national figure was 14 percent. (Kaiser Family Foundation 2002) As well, there is some evidence that programs to publicly insure low-income adults might not be increasing overall coverage but, rather, crowding out private. A study examining the expansion of public insurance in four states found that the programs in Oregon and Washington "resulted in a decline in the number of uninsured and very little crowding out of private insurance," whereas

in Tennessee there was “a decrease in the number of both uninsured persons and privately insured persons” and, in Minnesota, there was “a decline in the number of privately insured persons and virtually no change in that of uninsured persons.” (Kronick and Gilmer 2002, 225)

There seems to be no correlation between how much a state spends on health care and the extent of insurance coverage. State health care expenditures per capita for the United States averaged US\$872.64 in 1999: Minnesota (US\$807.83) and Oregon (US\$774.18) spent less than the national average, while New York (US\$1,615.64) and Massachusetts (\$1,455.21) were the top two spenders in the country. (Kaiser Family Foundation 2002)

## **Lessons for Canada from the International Experience**

Many other industrialized countries have been dealing explicitly with the rationing of health care services for years. The methods vary from drafting a specific list of services with public involvement (Oregon), to having a national committee make the main decisions with some public input (United States, United Kingdom and Australia), to the government making the decisions with little public input (Singapore), to the use of guidelines (New Zealand).

All countries have found that setting health care priorities cannot be done systematically from cost-benefit analysis alone. As well, the delisting of health services is unlikely to produce substantial savings. In both Oregon and New Zealand, explicit priority setting resulted in more services being covered rather than fewer. (Coulter and Ham 2001) In other countries, such as the Netherlands, services that have been delisted (long-term in-vitro fertilization, cosmetic surgery, eyeglasses, homeopathic drugs, dental care for those over age 18, and several other items) produced a savings of 4.5 percent to the government. (Williams 1997)

If major cost-savings are a goal of government, there must be more substantial reform than simply delisting certain services. The prioritizing process, however, is a good way for governments to finance and ensure universal access to those interventions that best meet the needs of the population:

... it is also a matter of equity: in contrast to actuarial private insurance, where every purchaser buys the expected value of the health services needed, public finance is involuntary. It comes from the taxpayers who have a legitimate interest in meeting needs and thereby getting value for their money, but not necessarily in paying for wants. (Musgrove 1996, 56)

The rationale for encouraging democratic deliberation of rationing is that choices in health care involve moral issues and, more pragmatically, it is likely that legal challenges to rationing decisions will increase and this reinforces the need to make the decision-making process fair and transparent. (Coulter and Ham 2000)

Professor Norman Daniels of Tufts University believes that, to legitimize limit setting, there must be what he calls accountability for reasonableness, which demands public access to the reasons for priority-setting decisions and requires that fair-minded people consider these reasons

relevant to meeting population health needs with limited resources. (Daniels 2000) According to Daniels, accountability for reasonableness requires four necessary (but not sufficient) conditions to be met:

- *Publicity*: decisions regarding coverage for new technologies (and other limit-setting decisions) and their rationales must be publicly accessible.
- *Reasonableness*: the rationales for coverage decisions should aim to provide a *reasonable* construal of how the organization should provide “value-for-money” in meeting the varied health needs of a defined population under reasonable resource constraints....
- *Appeals*: there is a mechanism for challenge and dispute resolution regarding limit-setting decisions, including the opportunity for revising decisions in light of further evidence or arguments.
- *Enforcement*: there is either voluntary or public regulation of the process to ensure that conditions 1-3 are met. (Daniels 2000, 92)

## **Access, Quality, Cost and Public Health Care Funding**

One of the main purposes of a health care system is to improve the health of the population and, ideally, this is achieved by providing broad access to quality health care at a manageable cost. Since Canada's health care system is mainly publicly funded, it is necessary to discuss what is known about how public financing of services affects the accessibility, quality and cost of services. As well, there must be discussion of whether the method of financing health care matters in the pursuit of better population health status.

Deber et al. summarized conventional thought about the financing of health care for the National Forum on Health: "it is widely recognized that divorcing access to a comprehensive mix of health services from ability to pay inherent in public financing enhances equity. As one moves along the public/private continuum to include more private sector involvement, equity decreases. At the extreme, one has the U.S. system, in which a large proportion of the American public is either uninsured or underinsured for health care." (Deber et al. 1995, part 1)

The problem with this argument is that it implies that it is private sector involvement that decreases equity rather than the fact of being uninsured, publicly or privately. Being uninsured in the United States does not mean that you will be denied care when you need it.<sup>1</sup> As well, statistics show that many of the uninsured are only temporarily so. For example, the uninsured rate in Minnesota is about 8 percent, but it declines to 3.1 percent if one considers those Minnesotans who were uninsured for the entire year of 2001. (Minnesota Department of Health 2002)

However, there are differences in the use of health care services by the insured and the uninsured, and in their health outcomes. For example, uninsured children in the United States were 2.5 times as likely as children with health insurance to be without a recent visit to a physician in 1995-96. (National Center for Health Statistics 1999) As well, from an analysis of 125 peer-reviewed research papers, the Oregon Health Services Commission concluded that uninsurance is associated with increased mortality (e.g., diagnosis of disease at a late and incurable stage); more pain, disability and suffering (e.g., uninsured children are less likely to receive treatment for sore throats, earaches and asthma); and expensive care (e.g., the uninsured are more likely to use the emergency room for care). (Oregon Health Services Commission 2001)

Universal insurance, then, is a desirable goal. But there are myriad ways of insuring an entire population and basic health status measures, such as life expectancy and infant mortality, do not indicate that one method is particularly better or worse at reducing inequities in health. In Canada, for example, there is evidence of queue jumping for non-medical reasons and evidence that family physicians are not referring the sick and elderly as readily as they should for such treatments as kidney dialysis. (Gratzer 1999, 24 and 43) As well, in attempting to balance their fiscal situations, many provincial governments have delisted services, resulting in more people paying for needed services. If having to pay for care is inherently unfair to people with lower incomes, then this "cost-saving" measure represents increasing inequity in the Canadian system.

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<sup>1</sup> By law, neither public nor private hospitals are permitted to refuse treatment to an indigent patient. For more information, go to <http://www.medlaw.com>.

## **Access**

In terms of access, there are many studies that seem to indicate that patients wait longer for care in Canada than in countries such as the United States, Sweden or Germany; but less time than patients in the United Kingdom and New Zealand.

A study in the 1980s found that Canadians waited longer than Americans for orthopaedic consultation and for surgery post-consultation. (Coyte et al. 1994) Research in the 1990s showed Canadians waiting longer than Germans and Americans for several cardiac procedures. (Collins-Nakai, Huysmans and Skully 1992) Another study found that, in 1992, Canadians generally waited longer for bypasses than Americans or Swedes, but less time than the British, (Carroll et al. 1995) and another study, conducted in 1998, indicated that Canadians had shorter waiting times than New Zealanders for bypasses. (Jackson, Doogue and Elliott 1999) Research at Dalhousie University found that proper follow-up and diagnosis for patients with gross hematuria (bloody urine) took longer in Canada than in the United States. (Moulton 1998)

A study conducted in the early 1990s by the Queen's Radiation Oncology Research Unit found that, for all but emergency care, Canadian patients waited longer for radiation treatment of cancer than their American counterparts, and longer than oncologists considered to be medically acceptable. (Mackillop 1994) A recent report on cancer care by the Cancer Advocacy Coalition warns that long waiting lists for radiation and the slow approval of new chemotherapy drugs have a negative impact on patient survival, and provides data showing that Canadian provinces tend to have higher cancer mortality rates than American states. (Cancer Advocacy Coalition 2001)

As well, the situation in Canada does not seem to be improving. A study of almost 30,000 breast surgery patient cases in Quebec found that the median waiting times between diagnosis and surgery rose from 29 days in 1992 to 42 days in 1998. (Mayo et al. 2001) An update of an audit by the Manitoba Centre for Health Policy and Evaluation of waiting times for eight non-urgent surgical procedures in Winnipeg from 1992 to 1997 found increases in the waiting times of six of the eight procedures, including breast tumor removal and carotid endarterectomies, from the 1992-93/1996-97 period to 1998-99. (Currie 2000) While the Manitoba authors do not draw any conclusions from the increase in waiting times, they note that the trend is of concern.

What should also be of concern to Canadians is that our system, which is intended to provide equal access to care, may not be succeeding in that area. One study shows that low-income Canadians are less likely to visit medical specialists (Dunlop, Coyte and McIsaac 2000), and others show low-income Canadians to have lower cardiac (Alter et al. 1999) and cancer (Mackillop et al. 1997) survival rates than Canadians with higher incomes.

In 2000, the Canadian Association of Radiologists released a report suggesting that 63 percent of X-ray equipment is out of date, as is the majority of diagnostic machinery in Canada. (Canadian Association of Radiologists 2000) Out of 25 OECD countries, Canada ranked 19th in terms of magnetic resonance imagers (MRIs) per million population. (Esmail 2001) Out of 23 OECD countries, Canada ranked 18th in terms of computed tomography scans per million population. (Esmail 2001) For health care services (hospital beds, physicians and other resources), Canada

ranked 5th of 8 countries, having more resources available than the United Kingdom, Singapore and South Africa, but fewer than Germany, Switzerland, the United States and Australia. (Ramsay 2001)

At minimum, such findings bring into question the belief that a publicly funded health care system that prohibits the private financing of medically necessary services is necessarily better at providing greater and more equal access to health care than one that allows public and private funding of these services. There are problems in Canada and the United Kingdom with waiting lists and survival rates for certain illnesses, for example, but there are Americans who go without health care because of its cost.

A recent survey looked at patient views regarding access, quality and costs of care in Australia, Canada, New Zealand, the United Kingdom, and the United States. It found that the United Kingdom had the largest share of the population waiting four months or more for elective surgery, while Canada had the only statistically significant increase in the number of people waiting four months or more for treatment. However, Canadians and Britons were much less likely to report going without medical care because of costs than were adults in Australia, New Zealand and the United States. (Blendon et al. 2002)

## **Quality**

There are few, if any, that can point to whether a publicly or privately funded health care system is better or worse for population health. For example, research by the Institute for Clinical Evaluative Sciences in 1999 concluded, after having examined some 18 studies of health outcomes in Canada and the United States, that “none of these studies proved that differences in health outcomes were due solely to differences in the health care systems of these two countries. As a result, formulation of a distinct hypothesis regarding the relationship(s) between quality of care of each distinct health care system and outcomes in comparison to each other is unlikely.” (Szick et al. 1999, 17)

In the aforementioned five-country survey, respondents in all of the countries rated their physician care as excellent or very good. With respect to hospital care, a majority in every country except the United Kingdom rated the care they received as excellent or very good. Canadians and Americans with lower incomes were less likely than those with higher incomes to rate their care as excellent or very good; the opposite was true for Britons. (Blendon et al. 2002)

In *World Health Report 2000*, the World Health Organization (WHO) ranked the performance of health care systems around the world in trying to achieve three main goals: good health, responsiveness to the expectations of the population and fairness of financial contribution (how much people pay out-of-pocket). In the comparison of overall system performance, Canada ranked better than countries such as the United States and Australia but worse than France, Italy, Singapore, the United Kingdom, Germany and 20-plus other countries. (World Health Organization [WHO] 2000) Being a first attempt at ranking health systems, there are debatable methodological aspects of this report and, being a complex and lengthy report, it would be foolhardy to take the results as indicating that any one country’s health care system was

unambiguously better than another's. However, the ordering of the countries should at least cause people to question whether Canada's health care system as it stands should be sacrosanct, or if we cannot learn from how other countries organize their systems.

## **Cost**

Deber et al., in their report to the National Forum on Health, state a common view in Canada:

... from both international and Canadian evidence, [is the finding] that exclusive public financing of medically necessary care is also the most economically efficient method. Efficiency is increased through the state's monopsony power over the control of total budgets and over fee and salary negotiations with providers, and through minimizing cost shifting and risk selection. Case studies of Canadian experience reveal that cost escalation is higher in those areas of health care with greater roles for private financing (e.g. drugs, automobile insurance, travel health insurance) than those with public financing and monopsony control (e.g. hospitals).... The only justification for the mixed financing plans is that they may provide enhanced consumer and provider choice (liberty). (Deber et al. 1995)

While there is some evidence that governments can increase the efficiency of health care markets because there are social returns to health, asymmetric information and other market failures, there is little, if any, evidence that "exclusive" public financing of medically necessary services is the most economically efficient method. As well, there has been documentation of government failures that are as serious as market failures: poor public accountability, information asymmetry, abuse of monopoly power and failure to provide public goods. (Harding and Preker 2000)

Dr. Ake Blomqvist told the Standing Senate Committee on Social Affairs, Science and Technology, "if cost containment is a main objective, there would seem to be a *prima facie* case for extending public sector coverage to encompass a broader range of benefits, for example, by introducing a system of publicly funded Pharmacare, as suggested by the National Forum on Health." (Standing Senate Committee January 2002a, 68) While it is true that countries with publicly funded systems *may* be able to control costs by brute force – capping physicians' fees, closing hospitals and delisting services, for example – better than countries that rely more on private financing, they are not necessarily less expensive systems. Canada spends more on health care than most industrialized countries, all of which allow private sector financing of medically necessary services.

As well, a recent comparison published in the *British Medical Journal* of Britain's publicly funded National Health Service with California's private, nonprofit Kaiser Permanente found that the per capita costs of the two systems, adjusted for such aspects as differences in benefits and population characteristics, were similar to within 10 percent. But it also found that Kaiser members experienced more comprehensive and convenient primary care services and much more rapid access to specialist services and hospital admissions. Kaiser's superior access, quality and cost performance was attributed to better system integration, more efficient management of

hospital use, the benefits of competition and greater investment in information technology. (Feachem, Sekhri and White 2002)

The struggles faced by Canada's health care system are numerous: waiting lists, emergency room back-ups, a lack of high-tech medical equipment, limits on newer pharmaceutical treatments and low provider morale. Many of these issues arise because health care in Canada is organized mainly as a function of government and, therefore, increasing health care costs is problematic. By continuing to demand "exclusive" public financing of medically necessary services in Canada, the federal government is potentially harming Canadians' health and hindering the future prospects of the health care sector. (Ramsay and Walker 1996) For reasons such as these, and not only for "enhanced consumer and provider choice," is there justification for mixed financing plans.

### **Public or Private Financing and Population Health Status**

*Beyond the Public-Private Debate: An Examination of Quality, Access and Cost in the Health-Care Systems of Eight Countries* found that, of the many possible determinants of health, income per capita and literacy have the strongest relationship to health status. It also found immunization rates to be important. Given these findings, *Beyond the Public-Private Debate* concludes that government intervention should focus on (given scarce resources) assuring universal access to and the availability of preventive and basic primary care, even increasing their availability. Beyond this, governments should work to ensure that people who cannot afford to pay for medical services have access to care when they need it and, perhaps, governments should require their citizens to purchase health insurance for catastrophic events. (Ramsay 2001)

*World Health Report 2000* states that "scientific and technical progress ... explained almost half of the reduction in mortality between 1960 and 1990 in a sample of 115 low- and middle-income countries, while income growth explained less than 20 percent and increases in the educational level of adult females less than 40 percent." (WHO 2000, 9) With respect to developed countries, WHO's report claims that a large portion of the improvement in life expectancy in Europe has been due to modern medical care. But, it also says that health systems do little to improve health: studies have shown life expectancy to be correlated with income per capita but not to the numbers of doctors, hospital beds or health expenditure. And, WHO notes that, while "rich" people tend to benefit more from the use of hospital and primary care services, "the distribution of primary care is almost always more beneficial to the poor than hospital care...." (WHO 2000, 16)

Nonetheless, *World Health Report 2000* advocates for all countries – developed and developing – a universal, publicly financed health system that encompasses everything from road safety to prevention to surgery. For WHO, "the ideal is largely to disconnect a household's financial contribution to the health care system from its health risks and separate it almost entirely from the use of needed services." (WHO 2000, 36) However, there are extensive studies that show that completely disconnecting use and costs is not necessary to ensure people's good health.

One of the most comprehensive studies of health insurance is that of the RAND Corp. More than 7,000 non-elderly families from six regions of the United States were assigned to different insurance plans and monitored over a period of three to five years. All of the plans had a limit on out-of-pocket expenditure and ranged from free care (zero coinsurance) to a variety of user-pay plans (with different coinsurance rates for different services). Two of the findings were that the *total* expenditure for the high-coinsurance group (95 percent) was well below that of the free-care group and that the different levels of maximum out-of-pocket spending did not result in significant differences in medical use. (Ramsay 1998)

The RAND study concluded that the increased use of services by the free-care group had little or no measurable effect on the health status and there was no significant difference between the groups in the risk of dying or measures of pain and worry. In only one instance was the free-care plan better, and that was for low-income people with high blood pressure. However, the researchers note that a “one-time screening examination achieved most of the gain in blood pressure that free care achieved.” (Gratzer 1999, 124-125)

While the RAND study implies that targeted public interventions might be preferable than universal coverage, other analyses discount the idea of targeting health spending on low-income individuals or even on specific diseases, believing the practice to be ineffective. (Deaton 2002) Princeton University Professor Angus Deaton writes, “it is time that the educational debate was more cognizant of health benefits. As for income, there is a very strong case in poor countries, and among the poor in rich countries, for whom nutrition, nutritional-linked disease and poor housing are important determinants of adult and child health ... [that] a policy of income provision to the poor may well be more effective than spending the same amount of public funds on a weak health care delivery system.” (Deaton 2002, 27-28) Another study discusses the “fact that many of the conditions driving the need for [acute care] are preventable ought to draw attention to policy opportunities for promoting health.” (McGinnis, Williams-Russo and Knickman 2002, 78)

Results such as these explain why all other industrialized nations have some type of private financing of services that are considered medically necessary by the somewhat mutable Canadian standard. Austrian ambulatory patients pay a quarterly fee for physician services; inpatients pay a fixed fee for all medication. Belgium inpatients pay a fixed daily fee for all medication received. In Germany, patients pay a fixed “hotel” fee, but are exempt from other co-payments while in hospital. Switzerland has an annual deductible for ambulatory care and a fixed daily rate for inpatient stays. (National Economic Research Associates 2001)

Every country attempts to mitigate the potential harmful effects of such cost-sharing measures, which include a potential redistribution of income from the poor and sick to the healthy and wealthy, and the lower use of health services by and worse health status of people with lower incomes. There are many studies, going years back, showing that cost-sharing mechanisms, such as user fees, can negatively impact certain populations. (For example, Beck 1974, 1980; Roemer et al. 1975; Evans 1993; and Ramsay 1998)

Because of these types of concerns, an alternative to traditional forms of cost-sharing, and one which would maintain the integrity of the *Canada Health Act*'s five principles, has been

recommended by some health care policy analysts and by Alberta's advisory council: medical savings accounts (MSAs). Proponents of this idea believe that transferring most of the coverage decisions to individuals and allowing an expanded role for the private sector will make the health care system more efficient and cost-effective at delivering care, while broadening coverage of services for all citizens. An in-depth discussion of the pros and cons of MSAs is beyond the scope of this paper, however, there are several detailed presentations on how MSAs work in other countries and how they could work in Canada. (For example, Standing Senate Committee January 2002*a*; Premier's Advisory Council on Health for Alberta 2001; Gratzer 1999; Litow and Muller 1998; Ramsay 1998; and Massaro and Wong 1996)

## Framework for Determining Extent of Public Financing

### 1. Clarify the Purpose of the Health System

A public health-care system is not there simply to maximize the amount of health in society (however we choose to measure health). It is not there merely to treat disease (however we choose to define disease). It is not there solely to meet health-care needs (however we choose to define health-care needs). And it is not there to ensure equality in health status (however we choose to conceptualize equality). The goal of a public health-care system is a complex composite of a range of goals ... it becomes impossible to use a simple maximizing algorithm as a basis for the priority-setting system. (Holm 2000, 31-2)

There are interventions that maintain function at high cost (e.g., organ transplants), interventions that enhance quality of life (e.g., Viagra), heroic but marginally effective technologies (e.g., high-dose chemotherapy) and advances in genetic diagnosis and treatment. (Clancy and Danis 2000) As well, there are numerous non-medical factors that have been associated with health status, such as housing, income and education. There needs to be agreement on the priorities of the health system.

### 2. Decide Which Services to Evaluate

The rationing process produces trade-offs that cut along divisions created by budget structures (fee schedules), institutionalized interests (clinical specialties), ideology (personal versus collective responsibility for illness and care) and information (available evaluation research). (Giacomini 1999) Therefore, decision makers should consider the following questions about each trade-off before proceeding to the evaluation stage:

- *What is it?* Interventions and technologies with a given label (e.g., heart transplant, prenatal care) may have many manifestations of practice, function and effects.
- *What is it for?* At issue may not be the effectiveness of the service, but some less tractable question about the medicalization of problems or the legitimacy of recipients' needs. Services must be considered in terms of public policy goals and values.
- *How is it situated?* Interventions can be interdependent; restricting one may affect the other.
- *Whose is it?* Services/technologies have constituencies of innovators, marketers, users and beneficiaries who may influence the assessment contest, such as whether a technology is exempt from scrutiny, etc.
- *Who is it for?* The more narrowly defined a technology's boundaries, the more burden placed on users to supply the supporting structures that make it "work." For example, many innovations have not been tested on (or adapted to) women. (Giacomini 1999, 750-751)

### 3. Evaluate Cost-Effectiveness and Relevance of Programs and Services

Most countries use some form of cost-effectiveness analysis to determine which health care services to cover publicly. Increasingly, they are also evaluating the relevance of particular services to their system's goals.

The most crucial – and controversial – question for evidence-based coverage policy concerns the adequacy of evidence.... One policy is to cover an intervention unless there is compelling evidence that it is more harmful than beneficial.... Another standard is the “best guess”: cover if the preponderance of evidence, whether extensive or meagre, suggests that the technology is beneficial.... Judging the adequacy of evidence is often subjective.... (Garber 2001, 66-67)

In the United Kingdom, practitioners involved in the priority-setting process make a judgment about the effectiveness of an intervention if good quality evidence is unavailable. In New Zealand, consensus panels of expert professionals and community people are involved in decisions regarding the effectiveness of some treatments. (Edgar 2000) Most evidence-based coverage processes are flexible, balancing the need for rigor against the limitations of the state of medical knowledge. (Garber 2001)

Another concern is that priority-funding lists provide a very diverse mix of services from which it is often difficult to evaluate the implications in practice of the trade-offs presented. For example, Oregon covers services relating to treating diabetes, newborn care and medical therapy for psoriasis, but does not cover treatment of sexual dysfunction or treatment for cancers where the potential to improve survival is low. (Oregon Health Services Commission October 2001)

As well, cost-effectiveness criteria are not generally sufficient to determine whether to publicly insure a health service: lifestyle drugs, such as Viagra, are a case in point. Used to combat the symptoms of erectile dysfunction in men, Viagra has been shown to be effective. However, even if a very large number of patients benefited in terms of a higher quality of life, are Canadians willing to close a cardiac surgery unit in order to publicly fund Viagra? (Ferguson, 13 January 2002) In the United Kingdom, Viagra is only available from the NHS for certain clinical conditions. The U.K. decision makers have decided that the NHS is not obliged to subsidize this lifestyle drug for everyone who might benefit from it; they have determined that Viagra, in most cases, is not *relevant* to a publicly funded, universal service. (New 2000)

### 4. Involve the Public

Most Canadians strongly agree with the concept of a mainly publicly funded health care system and the principles of the *Canada Health Act*. However, Canadians' support for increased public spending on health care is conditional on the system being made more efficient, effective and accountable for how new spending will be used; there is support for reducing the scope of coverage if necessary. (Vail 2001) As well, 30 to 50 percent of Canadians are willing to consider options that allow increased private delivery and financing of health care to either preserve the public system or ensure access to quality care. (Vail 2001)

Another survey, reported in the *Medical Post*, found that Canadians are not interested in “dumping more money in to make the pie bigger,” but “the idea that governments should fund all health services proven to improve health or quality of life received 90 percent approval.” (Milne 2001) As to what these services should be, Canadians favoured diagnostic services, such as MRIs, acute care, long-term care, home and community care and illness prevention. Lower on the list were health promotion, prescription medications, end-of-life care and public health. (Milne 2001)

There are many potential areas for public involvement in the rationing process: the articulation of the ethos and values of the system, which health care services/treatments are publicly provided, which groups receive priority (e.g., elderly versus young) and the location of health service provision (e.g., institution versus community), for example. (Mullen 2000)

One challenge will be to educate citizens on the cost-effectiveness of various programs and services. As indicated by the *Medical Post* survey, many Canadians perceive universal access to acute care to be more valuable than access to public health. The importance of perception was evident in Oregon, where the initial deinsurance of organ transplantation was based on the popular belief that transplants are only marginally beneficial. Another common way of cursorily differentiating health care services is newness versus oldness: transplants and infertility treatments, for example, are included in almost every priority-setting exercise. (Giacomini 1999)

Another challenge will be to effectively manage the various lobby groups in Canada. Practitioners – chiropractors and massage therapists in British Columbia’s most recent delisting exercise, for instance – have protested the move by governments to decrease public funding of the services they provide. Hospital employees have raised concerns over initiatives to privately provide auxiliary services. Physicians and hospitals have resisted attempts to cap their budgets. Residents have complained loudly when a hospital is closed in their area. These are but a few of the many groups that place demands on limited public sector funds.

The point to keep in mind is that the reasonableness and transparency of the approach to rationing are most important. The public can be involved in varying degrees but, at the least, the information and criteria on which the priority-setting decisions are based must be made publicly available. Once the funding decisions have been made – which procedures to cover or which practice guidelines to implement – individuals (patients, providers and those directly affected by the policy/choices) must have the right to challenge the decisions.

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