



CORE AND COMPREHENSIVE HEALTH CARE SERVICES (UPDATE 2008)

CMA believes that physicians must be actively involved in the decision-making process on core and comprehensive services. It developed a framework for this purpose after review and analysis of national and international decision-making frameworks, and after consideration of the political, policy and legal context of Canadian health care decision making. In addition to the framework, key terms associated with core and comprehensive health care services are operationally defined. Quality of care and ethical and economic factors are considered in a balanced and flexible manner, recognizing that the relative importance of any one factor may vary depending on the health care service being considered.

CMA first prepared this policy in 1994 to help physicians participate in making choices concerning core and comprehensive health care services. Over a decade later, the issue of defining these services remains a central issue for patients, providers and funders of Canada's health care system. Looking ahead, this will become even more pertinent as regional authorities assume greater authority in planning and allocating health funding across a broad range of programs.

Constructive leadership from the medical profession is essential to ensure a high quality Canadian health care system. Specifically, physicians must be actively involved in the decision-making process on core and comprehensive health care services.

CMA reviewed and analyzed several national and international decision-making frameworks and subsequently developed a framework for making decisions about core and comprehensive health care services (*Core and Comprehensive Health Care Services: a Framework for Decision Making*, CMA, 1994). It also considered the current political, policy and legal context in which decisions on health care are made in Canada. Key terms associated with core and comprehensive health care services were operationally defined.

CMA encourages the use of its framework for making decisions about these services. Quality of care and ethical and economic factors are considered in a balanced and

flexible manner, recognizing that the relative importance of any one factor may vary depending on the health care service being considered. Each factor affects decision making at the patient-physician (micro) level, the hospital and regional (meso) level and the provincial, territorial and national (macro) level.

This policy summary addresses the requirement for governments to fund core medical services but not the availability or desirability of private or alternative funding for these services.

Definitions

Uniform use and interpretation of the terms used in this area are particularly important in policy development, negotiations and communications. The 1984 *Canada Health Act* stipulates that all “medically necessary” services be insured; however, the act does not define “medically necessary.” This lack of a clear operational definition gives the provinces/territories some flexibility in the breadth of coverage provided by their insurance plans. However, it may also cause ambiguity and difficulty in selecting core health care services.

CMA defines **medically necessary services** as those “that a qualified physician determines are required to assess, prevent, treat, rehabilitate or palliate a given health concern or problem as supported by available scientific evidence and/or professional experience.” (Adapted from *Core and Comprehensive Health Care Services*, page 96.)

Health care services are “not only services provided by or under the supervision of a physician, but also a wide range of services performed by many other health care professionals.” (Adapted from *Core and*

Comprehensive Health Care Services, page 92.) **Medical services** is “a category of health care services provided by or under the supervision of a physician.” (*Core and Comprehensive Health Care Services*, page 96.)

Comprehensive health care and medical services are distinguished from core health care and medical services. **Comprehensive health care and medical services** are “a broad range of services that covers most, if not all, health care needs. These services may or may not be funded/insured by a government plan.” (*Core and Comprehensive Health Care Services*, page 86.) **Core health care and medical services** are those that “are available to everyone as funded/insured by a government plan. [Alternative] funding sources for these services are not necessarily excluded.” (*Core and Comprehensive Health Care Services*, page 86.)

Framework for decision making

CMA advocates a systematic and transparent decision-making framework for determining which services are considered core and comprehensive health care services. The framework was originally intended for medical services; however, it can also be applied to health care services. It is flexible so that users may adapt it to their own specific circumstances and needs. It is not a formula or set process that yields a quantifiable result for any given service, nor does it prescribe which services to insure or not insure. CMA has put forth the following principle concerning the framework.

When decisions about core and comprehensive health care services are made, the various levels at which decisions can be made must be considered. These include the patient-physician (micro) level, the hospital and regional (meso) level and the provincial,

territorial and national (macro) level.

CMA recognizes that decisions are made at several levels: (1) the micro level, which involves individual decisions about service delivery made by patients, physicians and other providers, (2) the meso level, which involves regional health authorities and health care institutions such as hospitals, community groups and professional staff, and (3) the macro level, which involves system wide decisions made by governments, the electorate and professions as a whole.

It is important to take into account the likely effect of any decision on each level: a decision that is acceptable at the macro level may be impossible to deliver at the meso level and inappropriate for patients or practitioners at the micro level. Coordination is essential to make consistent decisions among levels and incorporate the concerns of patients, providers and payers.

CMA upholds a second principle concerning the decision making framework.

Quality of care and ethical and economic factors must be considered when decisions about core and comprehensive health care services are made.

Quality of care

Effectiveness, efficiency, appropriateness and patient acceptance are elements of quality of care. To be considered a core medical service, a medical service must be of high quality (i.e., it addresses effectively a health concern or condition through improved health outcomes and is delivered efficiently, appropriately and in a manner acceptable to patients) as well as fulfilling ethical and economic criteria. A medical service that is shown to be of little effectiveness cannot be delivered efficiently or poses many problems for patient safety or

acceptance is less “medically necessary” than services that meet the quality of care criteria. Such a service is therefore unlikely to become or remain a core medical service.

The adoption of evidence-based medicine such as through the use of clinical practice guidelines (CPGs) is a key component of quality improvement. CPGs are based on a systematic review of experience and research, and they help physicians to make decisions about necessary care. CPGs that are well developed and appropriately evaluated may also help to define core health care services. CPGs are also tools for the pursuit of quality, to maximize effective care and to reduce waste and ineffective activity in a given service, resulting in savings.

Clinical research is a key aspect of improvement in quality of care. Such research focuses on the effectiveness and impact of health care services on health outcomes. Procedures that demonstrate better outcomes than others should be included in a core health care package, whereas those that demonstrate inferior outcomes may be limited or excluded in some instances. When applying the concept of core health care services, provision must be made for ongoing evaluation of the quality of current services and appropriate assessment of new ones.

While it is important that the decision-making framework be evidence-based to the greatest extent possible, it should not be evidence-bound — that is, decisions may still need to be made from limited evidence.

Ethical factors

Balancing finite fiscal resources and high quality medical and other health care services requires explicit societal choices about which services will be publicly funded (and for whom), which can be purchased and which

will not be available at all in the Canadian system. These issues are ethical ones because they involve rights, responsibilities and societal values.

Whether decisions about resource allocation are made at the macro, meso or micro level, they must be fair. This means that those likely to be affected by a decision, whether they are patients, providers or payers, must have adequate opportunity for input into the decision-making process and must be informed about the reasons for the decisions.

When the availability of a health care service is inadequate to meet the demand, the criteria for allocating it should be fair and explicit. One such criterion is medical need: even if not all needed services can be publicly funded, services that are clearly unnecessary should not be funded in this way. Funding decisions should be nondiscriminatory; decisions about which health care services should or should not be publicly funded should not be based on age, sex, race, lifestyle and other personal and social characteristics of the potential recipients of a service.

Economic factors (Cost-effectiveness)

The level of public funding for health care services is ultimately a societal decision, as discussed in the section on ethical factors. Once such a societal decision has been made, economic factors are useful in determining the allocation of resources among health care services, especially in times of fiscal restraint.

There are various economic methods for evaluating funding decisions, the most common of which is cost effectiveness analysis. This approach suggests that decisions to insure a particular service should take into account cost in relation to outcome, e.g., cost per quality-adjusted life-year. Services that have a low cost for a significant

gain in effectiveness may be more acceptable for public funding than others. This approach cannot be used in isolation; quality of care and ethical considerations must be taken into account before a final determination of the source of funding for core or comprehensive health care services is made.

Determination of which health care services are to be included in or excluded from a publicly financed health insurance plan should also incorporate an economic analysis of the primary and secondary effects on both the patient and provider populations. Some of the factors that should be included in such an analysis are: availability of substitutes, discretionary income, availability of private insurance, direct and indirect costs of service provision, barriers to entry and the existence of fixed global budgets. Economic analyses also include measurement of the opportunity costs, in terms of foregone services, associated with public financing of health care services. When possible, the public's needs should be distinguished from its wants for the purposes of public policy and funding.

From a clinical perspective, providers have always addressed patient needs on a case-by-case basis. However, fiscal restraint and the rationalization of health care services often result in the onus being placed on the provider to make micro resource allocation decisions. Local decisions (i.e., at the hospital and community level) about the rationalization of health care resources can restrict providers' ability to deliver services and patients' ability to receive them. Therefore, it is critical that the patient and provider perspectives be included in any economic analysis undertaken to define core health care services.

Future directions

As enunciated in its policy statement, *Federal Health Financing*, the CMA will urge the federal government to ensure that full funding be available to support provincial and territorial provision of core medical services.

Nevertheless, there remain concerns regarding how the comprehensiveness principle is being interpreted. First, the array of core services varies considerably among the provinces/territories (e.g., prescription drug coverage). Second, the basket of core health services needs to be modernized to reflect Canadians' emerging health needs and how health care is now being delivered (e.g., more out-patient care).

While a degree of latitude is required to accommodate differing regional needs, core services should be available to all Canadians on uniform terms and conditions and should not be limited to physician and hospital services. There should be ongoing periodic monitoring and reporting of the comparability of Canadians' access to a full range of medically necessary health services across the country.

Furthermore, there is a need for a federal/provincial/territorial process that is transparent, accountable, evidence-based and inclusive to regularly update the basket of core services. CMA will work with provincial/territorial medical associations and other stakeholders to develop a process for defining a national list of core medical services.

Greater transparency is required when de-insuring services, including the need for consultation and providing an adequate notice period for patients, providers and funders.

A new framework is also required to govern the funding of a basket of core health services that allows at least some core services to be cost-shared under uniform terms and conditions in all provinces and territories.