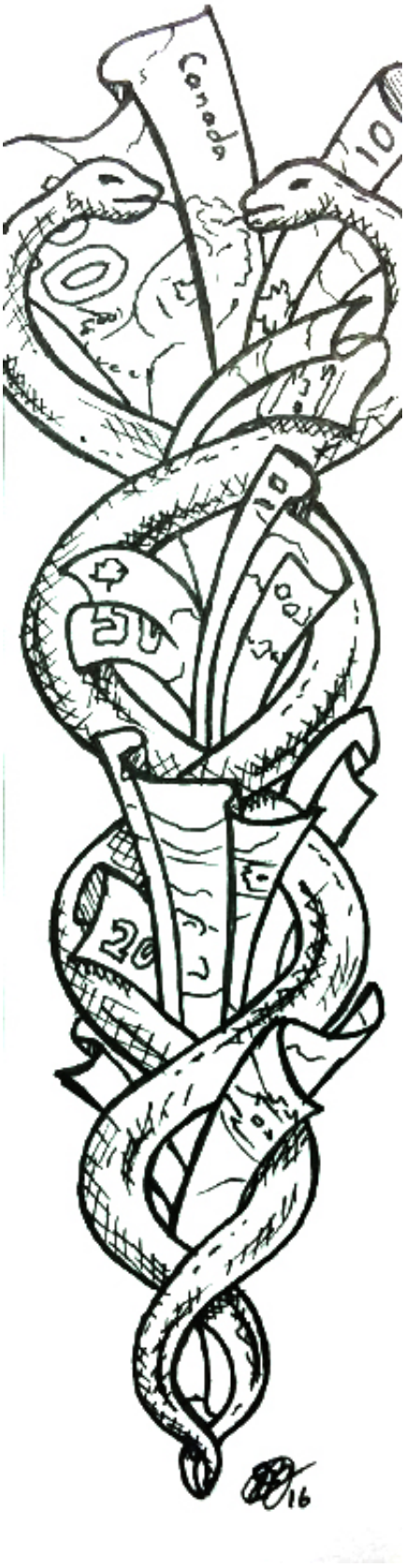
Opinion: What should be covered by publicly funded health care?

May 16 2016, by Dr. Brian Rotenberg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All across Canada, provincial governments are grappling with ever-growing health-care demands in the face of shrinking resources. Our enviable publicly funded health system is now well into a downward spiral of unenviable disrepair.

Here, in London, the hospital budgets seem unable to cope with the pressures of health care. We read, almost weekly, about hospital layoffs, operating room closures, longer emergency room waits and more. Patient needs for health care are growing faster than the system is able to provide for. The truth is, we can't have it all.

There is, however, a way out of the labyrinth of frustration health care is becoming. Both the physicians who deliver care, and the patients who receive it, need to start considering the concept of limited resources in our publicly funded health-care system.

For example, insured physician services in Ontario are covered under the Health Insurance Act. A condition for payment is the procedure be 'medically necessary.' Traditionally, if a procedure was listed in the physician's fee guide, then all instances of it have been considered medically necessary and, thus, would be covered by OHIP.

However, this has only been a long-standing interpretation, and is not, in fact, supported by either the College of Physicians and Surgeons of Ontario or OHIP – neither of which actually define medical necessity. This concept has been left up to the provider to adjudicate.

The doctors of Ontario should more strictly interpret the concept of medical necessity. Not every patient complaint should be considered

necessary to fix, even if a procedure that fixes the problem is listed in the fee guide. A good example of this would be a tonsillectomy. While some patients need this procedure out of medical necessity (i.e. for problematic sleep apnea, suspicion of cancer, etc.), others want the procedure to treat their tonsil stones, bad breath or certain kinds of tonsillitis. None of these procedures, in strictest definition, would be be medically necessary reasons for surgery. There are many other such examples.

Based on the physician's interpretation, where a procedure isn't medically necessary it would not be considered insured and patients would then be able, or expected, to pay for the procedure privately. Such an interpretation could, for example, be guided by whether or not the patient is able to perform activities of daily living, or generally function in life normally.

Someone who has a medical complaint, but can still do activities of daily living – go to work or school, drive normally, etc. – really cannot be said to have a problem necessary to fix. If that's the case, then his/her procedure wouldn't be covered.

There are examples beyond surgery too. For instance, there are a large number of low-quality, or low-impact, health interventions that continue to be publicly funded, but perhaps should not be. That blood test or chest X-ray your physician ordered for you before a low-risk elective operation? Very likely unnecessary. The CT scan you had for pain in your lower back? There is little evidence it will improve your outcome. The antibiotics you were prescribed for a persistent virus? Not only unnecessary, but they won't work anyway.

Tests and treatments like those are not only medically unnecessary, but they are also costly to the struggling health-care system. The Choosing Wisely Canada initiative, spearheaded by the Canadian Medical

Association, is just beginning to explore this massive scope of unnecessary care and the impact it has on patients and the health system.

Are doctors too often offering to use public funds to investigate or treat problems that are 'wants' versus 'needs,' and not actually medically necessary? Are patients losing sight of the fact no province has the funds to provide all care for all people all the time? Our contemporary free-for-all style of health care, a challenge on both sides of the medical consultation room, is totally unsustainable on the public purse.

By more strictly applying the concept of medical necessity, physicians would be stewarding scare resources with better judgment than we currently do. Problems that don't meet a reasonable interpretation of medical 'necessity' would simply no longer be covered by public funds. Meanwhile, there would be more money left in the system for patients who are truly in need. The decision of necessity would be up to individual provider's judgment, as it currently is, but we would be exercising that judgment in a more judicious way than we currently do.

Doctors need to start openly and directly talking with patients about medical necessity when offering tests or procedures. Patients, in turn, need to keep in mind their health care is not 'free,' and some of their health-related complaints likely represent wants, rather than needs. On neither side should all aspects of health care be automatically assumed to be covered by public funds.

Working together, we can salvage what is left of public health care, but only if both groups promptly adopt a more realistic attitude toward medical necessity.

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