Features

Chroniques

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CMA's core-services framework featured at international conference

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In brief

There was wide interest in the CMA's approach to determining core services during the 1st International Conference on Priorities in Health Care that was held in Stockholm last year. Representatives from about 50 countries shared their experiences, ideas, successes and failures in allocating scarce resources for health care.

En bref

La stratégie suivie par l'AMC pour définir les services de base a suscité beaucoup d'intérêt au cours de la première Conférence internationale sur les priorités dans les soins de santé qui s'est tenue à Stockholm l'année dernière. Des représentants d'une cinquantaine de pays ont mis en commun leur vécu, leurs idées, leurs réussites et leurs échecs dans l'affectation de ressources rares aux soins de santé.

The CMA's approach to determining core services received widespread attention during the 1st International Conference on Priorities in Health Care, which took place in Stockholm last fall.

The conference, which drew more than 560 participants from 49 countries, was another sign of the growing international interest in learning from other countries' experiences in the health care field.

In his opening address, American health economist Victor Fuchs announced the basic premise of the conference. Since no nation can provide its citizens with all the medical care that might do them some good, he said, priorities must be established and resources must be allocated, and health care resources should be allocated as fairly as possible to do as much good as possible.

Societal values such as democracy, freedom, intergenerational equity and scientific progress are key factors in determining priorities, added Fuchs, but sometimes they cannot all be honoured and choices must be made about which are most important.

Fuchs' theoretical approach was complemented by Dorothy Widderburn, chair of a local health authority in the United Kingdom, who asked conference participants to provide practical answers to 6 questions faced by decision-makers everywhere:

- Is the financial crisis likely to pass?
- What is appropriate and effective health care?
- Who should make decisions about priorities and policies?
- What is health and what is the best way to achieve it?
- How can desired outcomes be identified and measured?
- Can health care values survive in the face of market ideals?

In a panel discussion involving countries with formal priority-setting mechanisms, chairpersons of commissions created to recommend priorities reflected on their experiences and influence. A representative from Oregon, Dr. Richard Wopat, said the exercise there continues to be a success despite its drawbacks. Professor A.J. Dunning, who chaired the commission in the Netherlands, reported that most of its recommendations have not been implemented.

In New Zealand the former Core Services Committee has been renamed the National Health Committee; it provides advice to the Ministry of Health, the regional health authorities that purchase services and the physicians and other

workers who provide them. The Swedish commission spent 1 year developing an ethical platform based on 3 principles: human equality, the need for solidarity, and efficiency. It identified as top priorities acute disease, severe chronic disease and palliative care. The report was submitted in 1995 and legislation to implement its recommendations is expected shortly.

Another panel discussion dealt with countries without formal national priority-setting mechanisms. These include the US, where priorities are increasingly set by managed care organizations, and the United Kingdom, where local health authorities have some limited flexibility in what services they should provide. In Germany priorities are set by 'social partnerships' between unions and employers, while Malaysia has a long-range plan to provide government-funded health services.

The role the media can play in subverting priority setting was examined in detail during a panel discussion dealing with the 1995 Child B case in Cambridge, England. After the local health authority refused a request for a second bone-marrow transplant, the child's father obtained a court order requiring the treatment. This order was overturned on appeal, but the child then received privately funded treatment. She died shortly afterwards. Commenting on this case, Malcolm Dean, assistant editor of *The Guardian*, stated the 3 rules of journalism: readers thrive on bad news, human-interest articles are essential and campaigns that support the underdog sell newspapers. Health authorities need to manipulate the media by going beyond the individual case to the general issue.

The health ministers of Norway, the Netherlands and Bolivia spoke about the political difficulties that arise when implementing health care priorities. Dr. Else Borst-Eilers of the Netherlands has found extra funds for new priorities by trimming the basic package of funded services, introducing copayments, lowering drug prices and implementing medical-technology assessment. Services that have been delisted include long-term in-vitro fertilization, cosmetic surgery, eyeglasses, homeopathic drugs, self-care drugs, ineffective drugs, dental care for those over 18 and long-term physiotherapy; attempts to delist contraceptive pills and long-term psychotherapy failed. The delisting exercise produced savings of 4.5%.

Should rationing be implicit or explicit? In a plenary debate Professor Chris Ham of the UK argued for explicitness because that ensures accountability. Politicians must lead the public discussion at the macro level, while insurers and purchasers take the lead at the meso (intermediate) level. There is a great need for innovative thinking about how best to structure this process. Professor David Mechanic of Rutgers University in New Brunswick, New Jersey, responded by focusing on the micro level, where most transactions between physicians and patients take place. They are not governed by scientific evidence but by the art of medicine, and therefore cannot be subject to general rules.

The CMA presentation, during a session on health system financing/economics, included a brief description of the Canadian health care system, a discussion of the fiscal imperative driving health care reform in Canada, an overview of the core-services approach to setting priorities and an explanation of the CMA's core services framework.

While defending the core approach, the CMA called for more research on appropriate public consultation, access to noncore services, scientific evaluation of many services and the relevance of lifestyle. Despite its shortcomings, this approach is arguably superior to the others described during the conference.

The high turnout and enthusiasm of the participants have encouraged plans for more conferences on this topic. The United Kingdom will host the next one in 1998. ?