Editors' View
Mot de la rédaction

THE CANADIAN HEALTH CARE SYSTEM

In the last issue of the Journal, Dr. Waddell raised some important issues in his Editors' View entitled "Health care funding and surgical practice" (*Can J Surg* 2000;43[3]: 164-5). As part of the medical community we must find solutions to the present and predicted difficulties in delivering elective and semielective surgical care. Dr. Waddell highlighted some of the societal pressures that will force a change in the services we deliver unless reorganization of our system considers the needs and desires of our patients for elective surgery. He focussed on the pressures exerted on the system by the urgent and emergency surgical needs of our aging population. We must recognize that if the elderly are able to remain independent at home or in modified surroundings their quality of life, health and burden on the health care system will likely be reduced. Therefore, the management of orthopedic conditions to improve mobility, cataract removal to aid vision and independence, vascular reconstruction to preserve limbs and mobility all have an impact on the overall costs and efficacy of our system. Up to now, most of the choices about allocation of resources have been made at the local level as budgets are being ratcheted back in the areas over which governments have control, specifically hospital global budgets and physicians' income.

Our system has been rocked by budget cutbacks, changes in funding and priorities, and organizational shifts based on political needs and fiscal restraint. Even in the wealthy provinces there have been draconian changes in the funding formulas and in regional organization and delivery of care. Not all have been successful, and the politicians are returning to previous organizational structures because poorly thought-out innovations have lacked infrastructure, patients have been resistant, there are gross inefficiencies in the use of physicians' time and the the requirements to allow better implementation of the concepts of ambulatory services have not been introduced. Neither Dr. Waddell nor I wish to be drawn into the discussion of two-tiered medicine. Pushing for a privatized system smacks of a self-serving attitude that does not address the problem of how to remodel the system to preserve its 5 principles. The surgical community would be better served if the system was organized differently and included the management principles of the private sector where competition — the delivery of efficient and patient-centred service — was rewarded.

In his recent rereview of the Canadian health care system (*N Engl J Med* 2000;342(26):2007-12) Iglehart does not paint a pretty picture. Although he does not make comparisons with other systems, particularly that in the United States, the reader senses that we are underfunded and are not getting our money's worth for the expenditures made. Canada now spends 9.3% of its gross domestic product on health, unchanged since 1990 when our expenditures were second only to the US. We are now fifth behind the US, Germany, Switzerland and France. Although we surgeons feel that we are exclusively in a publicly funded system, at least 32% of health care dollars are in the private sector in providing among others physiotherapy, home services, dentistry, chiropractic and alternative medicine. We do not see much of that as less than 1% goes to physicians. What is almost exclusively publicly funded are hospital care and

physicians' services. Marcia Angell, the retiring Editor-in-Chief of the *New England Journal of Medicine* speaking recently in Victoria, BC, stated that Canada has a vastly better system than the US, it only needs money. The reality is that not only does the system need money but the money must be directed in a coherent fashion and the system managed with vision. There is a limit to the value of delivering efficiencies in the delivery of clinical care. Specifically, if we implement great improvements in delivery using day surgery, preadmission, decreased length of stay, fast-tracking, care-maps and so on and save money but no one else in the institution does the same, the Department of Surgery's base budget will decrease and other departments will have their deficits funded. This is bad management, providing no incentive to perform beyond maintaining the status quo — a hopeless situation.

The next federal election is likely to be fought on the shoulders of health care. New thinking is required. New structures are needed to deliver the care the public wants, so that many of the elective procedures that we are having trouble doing now will have a positive impact on the overall health of the population, particularly the elderly. They want to have their cataracts removed, their joints replaced, their legs and hearts revascularized in addition to the urgent and medically required procedures. Canada is a wealthy country and should not have the fifth largest per capita health expenditures yet be ranked 30th in the world for overall health care. The money needs to be reinvested in human and capital resources to allow us to "get the greatest bang for our buck." In addition, let us introduce private sector management principles and reward functions into our system as well as a competitive mode so that the well-managed units do well and deliver high-quality care at a reasonable cost.

Jonathan L. Meakins, MD
Coeditor