



Face Off – Stay Public or Go Private? Let's Do It Osler's Way

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"Personally, I do not see in Canada it would be a feasible thing if any Ministry organized taking over both the Health and the Disease of the entire community... even in the most favourable circumstancesthere would be that absence of competition and that sense of independence...I do not believe it would be good for the profession or good for the Public."

Sir William Osler

My wife was upset a few years ago to see my face on the front page of a national business magazine, with the label "Dr. Profit". "Better that than Dr. Loss" I told her. Most of us operate "private for profit" clinics and fund their infrastructure and operating expenses. Without adequate revenue we cannot provide excellent patient service, nor can we finance continuing medical education, new technology, and sustain a modern practice.

The fee for service model will continue as our main funding mechanism, though I would like to see the term "fee" replaced by "gross revenue". Those who propose saving the system by placing doctors on salary might be surprised by the interest shown in a 37 hour week with benefits, overtime and holiday pay, pensions, and all overhead paid. The reality is that governments know they are on to a good thing. Fee for service is piece work as exists in sweat shops and, though good for employer and consumer, is demanding on the worker. Global funding and rationing of health care are barriers to efficiency, productivity and excellence. Patients lie just below us at the bottom of the pyramid. How does one value saving a life, relieving pain or restoring the ability to walk? Are we worth as much as corporate executives or lawyers? Should some doctors be paid more than others and should there be financial rewards for expertise or additional training? In the non-medical world, the market influences income levels and helps determine worth. Lawyers pay surgeons more for describing surgery than governments pay for performing it.

The rising costs of health care have led to reduced practice revenue. In accepting conscription we have allowed governments to offset some of the costs of health care inflation on ourselves. In 1944, when an average BC worker made 91 cents an hour, an orthopaedic surgeon's fee for treating osteomyelitis was \$300! (In 2004, the fee is \$313.57). In 1961, the surgeon's fee for surgical reduction of a patella fracture was \$100.00. By 2004, the fee had increased to \$318.00. In 1981, the fee for arthroscopic meniscectomy (the most commonly performed orthopaedic operation) was \$294, while today it is \$236 (a 1981 dollar is worth \$2.11 in 2004). To put inflation in context, the cost of a Vancouver house in 1944 was about \$4,000.00; in 1961 it was \$13,900.00, and by 2004, the median price was \$503,141.00. This is why newly qualified practitioners lag behind the older generation in their ability to pay off debts or purchase a home. Statistics show that doctors have helped curb rather than increase health care costs. The percentage of total health expenditures spent on physicians was estimated at 12.9% in 2003, having declined steadily since from its peak of 15.7% in 1987 (CIHI). An anti-doctor propaganda campaign has focused on the overpaid doctor concept. *"Doctors' fees and salaries combined now account for about two-thirds of total health care expenditures in Manitoba"*, wrote Peter Hudson, of the Canadian Centre for Policy Alternatives Health in an article targeting "overpaid" doctors. How would the average reader interpret that statement? In fact, the "salaries" actually referred to all salaries of all workers in health care.

As doctors, we should reject the concepts of "benchmarking", "waiting list strategies", and the listing of wait times on web sites and advocate for the total elimination of wait lists. We must promote systems like those in France, Germany and Switzerland where there is universal health care without waits in both public and private systems. Canada's 30th world ranking is not good enough.

The plan to "fix health care for a generation" by adding \$4 billion a year (less than half the rate of health care inflation) must be exposed as too little, too late. Only a small part of any increased government health expenditures will go to doctors and we must look elsewhere for the restoration of resources. The market system has been largely excluded from the world of Canadian medicine, but get ready for a new era in which we must adapt to a new style of practice mandated by the Supreme Court of Canada. The "market" is no panacea for the ills of our health system, but I trust doctors' integrity and commitment enough to believe they will perform better than government bureaucrats at directing resources in ways that benefit patient care.

Tom Sackville, a former British Minister of Health under Maggie Thatcher, told delegates at the recent CIMCA Health Summit in Vancouver of the fear the "Iron Lady" had when it came to confrontation with doctors. "She would order the British Navy (with Prince Andrew) to the South Atlantic and engage Argentina in war, but drew the line at waging battle against the British Medical Association" he said. Organizations like the COA and the CMA need to take the lead in enforcing

patient and doctor rights and must seize the political power they are capable of. The divide and rule strategy that has been used by government to attack us must be fought with aggression. "Access to a wait list is not access to care" stated the Supreme Court. "Canadians are suffering and dying on wait lists", they wrote. It is our duty to eliminate wait lists for suffering patients and we need to challenge, defy and defeat any government that stands in our way.