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Health care funding in surgical practice and the Canadian health care system

I read with great interest Dr. Waddell's Editors' View in the June 2000 issue of the Journal (page 164). Having been involved with surgical administration for the past 7 years and having recently gone through the debate on Bill 11 in the Province of Al-

berta, the issues raised by Waddell are important.

In the Province of Alberta there has been a recent infusion of resources into the health care system, restoring the funding on a *per capita* basis to the levels that existed before the budget-cutting of the mid-1990s. The difference, however, is that the restored funding is going to a much more broadly defined health care system, including community care and many services outside the acute care sector.

In Alberta, the funding in the tertiary care environment is further complicated by an entity defined as "province wide services." Certain services, such as cardiac surgery, some neurosurgical procedures, trauma and transplantation (generally procedures that are available only in major referral centres), have a specific pool of funds for service contracts (by volume). This has created, in essence, a 2-tiered system of funding within the public health care system, in which the tertiary care hospitals have an incentive to increase their revenue stream by fulfilling, and even exceeding, the mandate of their province wide services contract. This has the potential to be done at the expense of other, nonprovince-wide funded activity. Also, in Alberta, there have been sporadic increases in funding provided by the provincial ministry of health, usually directed toward specific "problem" waiting lists, which, as Waddell points out, are notoriously inaccurate, and the problem is compounded by the fact that little work has been done in regard to the timeliness of elective surgery.

As Waddell infers, the solutions to these problems will not be easy. They will require a paradigm shift for the surgical profession, which has been well served by its conservative nature and is proud of its autonomy. Solutions are, however, evolving. In many tertiary centres, the division between "hot and cold" (emergent and elective) surgery has become well established. The Vancouver model for orthopedic trauma has been emulated to a greater or lesser extent in most major trauma hospitals. Orthopedic surgery seems to have been very successful in separating elective from emergent practice. The orthopedic surgical community has adapted well to handing off emergency cases to the surgeon on call. Whether or not the quality of care is improved or worsened by this system has not, to my knowledge, been properly studied. This model is being adopted by other surgical specialties, specifically plastic surgery.

Within general surgery, the move to a "hot and cold" surgical service has been much less easily accomplished. Some would argue that this is due both to the nature of the patient population and to the surgical culture of that specialty. Perhaps the best model of "hot and cold" general surgery is the acute care surgical service at the Manitoba Health Sciences Centre in Winnipeg. This service has incorporated the general surgery trauma role with that of the emergency acute surgical service. An alternative funding model has been developed, and the surgeons remain in house to deal with trauma and emergency general surgery. This model appears to be working but, as far as I know, has not been emulated by other Canadian centres.

The separation of emergent from elective surgery within the publicly funded health care system is the beginning of the development of 2 streams of surgery. Separating "emergency" theatres within an operating suite allows for more detailed budgeting for emergent cases. It may be that in tertiary referral centres, a significant component of the budgeted activity will be for emergency, trauma and transplant activity. By separating this activity and developing accurate models for predicting volumes, the case can then be made for building more accurate budgets for elective surgery as well. There is currently so much overlap in the budgeting of these 2 types of surgical activity that doing more of one, by necessity takes from the other. Unfortunately, in the present health care environment, elective surgery seems to come out the loser. The key factor remains adequate funding of the acute care sector.

Waddell alludes to the possibility of further privatization of the Canadian health care system. Whether one agrees with it or not, the private sector is growing. Coupled with the congestion of emergent and urgent surgical interventions in Canada's major hospitals, the passage of Bill 11 in Alberta is likely to fuel the development of private surgical facilities in that province. A key element in the protection of the publicly funded system will be the defined relationship between the private and the public systems. This should stipulate the responsibility that physicians have to the public system, as well as establish an accountability process that is clear and that measures appropriate outcomes. If the private system develops with a loosely defined relationship to the public system and with loosely defined accountability, there is great potential for bleeding resources from the public system, which could lead to an emigration of surgeons and allied health professions from the publicaly funded system. Under the current fee-for-service remuneration scheme favoured by the provincial medical associations, there will be strong incentives for physicians to move into a private system where the patient flow will be rapid and the acuity of the patient case mix will be low.

The protection of surgical practice within the publicly funded system will depend not only on adequate funding and better accountability but probably on alternative funding, as has already been implemented in some jurisdictions. Most tertiary hospitals double as teaching centres. The need to find a

new model for reimbursement of the academic mission has never been greater. Furthermore, the old implicit contract between physicians and the public health care system needs to become much more explicit. A contractual basis for hospital privileges protects both parties. It would provide a contractual obligation on the part of the hospital to provide the resources, and an obligation by the individual surgeon (or group of surgeons) to commit to a volume and quality of elective surgical practice. A sessional fee could cover emergency activity. Finally, within the larger centres there will be an ever-increasing requirement for teamwork among surgeons, within and across disciplines. As budgeting and management processes become more complex, it is increasingly important for the surgical profession to play an informed and meaningful role. All of these potential solutions will require a quantum shift of attitudes within the surgical profession.

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In their 2 recent Editors' Views (*Can J Surg* 2000;43[3]:164-5 and *Can J Surg* 2000;43[4]:244-6) on health care funding and surgical practice and the Canadian health care system, the coeditors are "right on the mark" in their analysis and in using the Journal to stimulate debate within the surgical community about our health care system. However, there is another dimension to the discussion that needs to be addressed: What have we done (are doing) to convince the patient and the Government that what we are doing is right? Although we are doing some things right in this regard, I would argue that our efforts are inadequate.

As members of a Canadian surgical community we must upgrade our peer review system in regard to the attention paid to morbidity and mortality, we must insist on evidence-based decision-making and we must champion health outcomes research in its broadest sense. We must accomplish these objectives in a context that encourages innovation and creativity.

My suggestions for moving in this direction include the following:

1. **Taking the initiative within our own institutions as well as provincially and nationally to insist on the development of a national database that will give us the tools to do the job.** Recent newspaper editorials have commented that Tim Horton's and Canadian Tire have better information technology than we do in the health care system. Meaningful outcomes evaluation cannot be achieved without this technology. Such a national database would be expensive but should be regarded in the same way our predecessors regarded the building of the railway or the introduction of medicare itself. Our university departments of surgery need to place high priority on the recruitment of surgeons with a scientific background in health outcomes research. Nonuniversity hospitals require access to this expertise, which may be provided by PhDs with this special kind of training. We need the data and to a large extent we don't have it.
2. **Lobbying for changes to the hospital accreditation process.** I have been responsible for a department of surgery in 3 different university-affiliated hospitals for 19 years. Not once in those years have I been asked by an accreditation committee to give an account of my stewardship. In most large general hospitals, surgery accounts for 50% or more of the budget. This is counter-intuitive and gets to Dr. Meakins' comment about private sector management principles.
3. **Pointing our discipline away from independent practice toward an interdisciplinary method of providing surgical services.** All of us who provide surgical care are very dependent on fellow professionals to complete our obligations to our patients. Teams, not individual practitioners, look after patients. Surgeons need to lead many of these teams but not all of them.

I would suggest that the Journal have a point–counterpoint page in which some of these ideas might be debated.

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