"Divide and rule, a sound motto. Unite and lead, a better one."

—Johann Wolfgang von Goethe (1794–1832)

After winning the nomination for CMA president elect, I was fortunate to receive many messages of support and congratulations—and a few expressions of concern. I remain very respectful of my fellow candidates, who put in many years of service to the CMA and in many ways are more qualified than I to assume the role of CMA president. I have participated in many political forums and debates, sat on panels, and given many interviews and talks relating to health care policy and the role of physicians. When it comes to physicians, I have noticed a common thread that is a major barrier to solving our concerns. We are divided. Despite our common goals of providing excellent patient care and maintaining enthusiasm in our work, we seem unable to act as a cohesive group. I do not mean to imply that those who disagree with the philosophy of the majority must simply succumb and abandon their principles. However, the main cause of our division is resource based (including income), and a divided profession is less effective as an advocate or lobbyist. When governments implemented the Canada Health Act, they set the stage for rationed care that is now the hallmark of our system. The model of physician funding based on government regulated fixed fees, tied to an unregulated free market for expenses, has led to a fall in net income. We have the worst of both worlds. We have been forced to distribute a declining base of funding to physicians providing ever-increasing numbers and complexities of services. General practice fees are less than half of that required for a viable practice, and there is no chance that any government will ever increase funding to adequate levels. Satisfactory division of a pie is impossible if the pie is too small. The result is a divide and conquer scenario, in which we negotiate as adversaries, first with government and then with one another about our relative worth. Sections, coalitions, provincial and national colleges, societies, and associations (both academic and political) are repeatedly engaged in disputes with each other based on their individual agenda. Even doctors within the same disciplines argue about the relative worth and value of what they do. United action is needed. We should not be our own enemy, though some act as though it is so. We need to recognize our differences and understand the many complexities as we work toward solutions.

Efforts to maximize the billing of noninsured services are important as

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they attach a finite value to such services, but the available gains will not compensate for underfunded insured services. Patients suffer as a result of deficit financing. The diagnosis is an outdated Canada Health Act (CHA) that in recent years has stifled progress and led to our crisis. The treatment is to update the Act. Of its five principles—comprehensive, universal, accessible, portable, and publicly administered—only the last is being enforced. No government has ever defined "medically necessary or required," even though the terms are widely used in various pieces of legislation. It is strange that drug treatment and dentistry were never included within the principle of comprehensiveness. It was politicians and bureaucrats, not us, who decided that the diagnosis, but not the treatment, of pneumonia should be covered or that a bruised toe was a medicare benefit, but a tooth abscess that might burst into the cerebellum was not. A national drug plan and dental coverage must be included under the term *comprehensive.* Universality is an antisocialist concept in which resources are distributed equally instead of a means test being used so we may give relatively more to the poor. User fees and co-payments for physician and hospital services exist in all parts of our system, including fees for casts, splints, braces, drugs, crutches, eye and dental care, and ambulance fees to name just a few. We even charge for prosthetic limbs after amputations for cancer or for a voice box following laryngectomy. Similar user fees exist in all other OECD countries and do not lead to the less privileged being denied service. Rich financiers, lawyers, businesspeople, and doctors should pay user fees and those who cannot afford them should not. Ask any Quebecer (or any Canadian who travels abroad) if their care is *portable.* Question the millions of patients suffering on wait lists about *accessibility.* The CHA needs to be revised to enforce those principles that are being ignored and to add three new ones:

- Excellence and quality care. The widespread denial of access to new treatments and technologies would be rendered illegal.
- Accountability and sustainability. Governments should be legally required to deliver service efficiently and be required to ensure sustainability. User fees and co-payments are needed, but will be waived for lower-income citizens. Global budget funding would be replaced by performance funding.
- Children shall not wait. No exceptions.

These changes are affordable and attainable. Through studying systems in countries that have successfully accomplished most or all of the above goals (Switzerland, Germany, Austria, France, Belgium, Japan, and others), we can learn from successes and failures, and apply the lessons to design a new and better Canadian model. Some increased privatization will not, in itself, solve all our problems, but the new sense of competition and independence will be good for doctors and patients. New private sector funding will help reverse the deficit financing that characterizes our Canadian model.

Over 15 years ago governments, on the advice of now-discredited health economists, decided that doctors were the cause of rising health costs and cut medical school intake, leading to our physician supply crisis. At 1.9 doctors per 1000 population, we have the lowest physician ratio of developed nations. Up to 5 million Canadians lack access to a family doctor. Current efforts to increase medical school intake are not enough. We need incentives to repatriate doctors who have left and to encourage the return of thousands who leave to obtain a medical education abroad. Many hundreds of young Canadians are in medical schools in Ireland, Australia, Mexico, the Caribbean, and elsewhere. Bring them home and also consider developing private Canadian medical schools. There are 53 private medical schools in the US, including such prestigious institutions as Yale, Harvard, Princeton, and Stanford. However, training and repatriation are futile if we do not provide resources—such as operating room time for surgeons—that allow young doctors to stay here and work. Is it not a dysfunctional system that, despite a shortage, forces half of newly graduated orthopaedic surgeons and neurosurgeons to emigrate within 5 years?

Finally, let's apply a reality check on equality of access. There never was and never will be equal access in a country like Canada (the third most sparsely populated country on Earth). Equal service is simply not feasible in remote areas (paramedics, sub-specialists, ICUs, and so on). Even within cities, not all doctors are equal, not all hospitals are equal, and not all health care is equal. In a compassionate society we must provide for those who are underprivileged and ensure good basic health care for all. I hope that the largest federal association of physicians, the CMA, can be the force that unites the profession as we seek to remedy governments' mistakes of the past and work to update the CHA. Partisan politics has blocked meaningful reform. Support for a failed system of health care delivery should be a losing strategy for any political party. Perhaps the CMA, with the support of physicians and physician groups across the country, can convince both major political parties that this issue demands a bipartisan agreement and effort. It is often said by supporters of the status quo that no one should be denied access to health care based on their ability to pay. At present, patients are denied care based on governments' inability to deliver. Both can be addressed by a strong and united profession that insists on reform.

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