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Editor's preface

Français à la page suivante

For every reaction there is an equal and opposite reaction. For accountants, this is the national income accounting identity. Simply stated, the total of everyone's incomes must, as for an individual, equal the total of everyone's expenses, the latter determined by the amount of goods and services produced and their prices (the gross domestic product).

In health care there is an accounting identity similar to the national income accounting identity. It has 3 parts. First is the total quantity of goods and services produced and their prices, whether appendectomies, home care or PET scans. Second is the income derived from rendering these services. In health care this consists mainly of wages of health care providers and those providing support services, as well as return on capital required for the infrastructure. The third component is payment, in the form of taxes and out-of-pocket or private expenditures for services. Thus, taxes + private expenditures = quantity of health care × price = employees × earnings.

As Robert Evans has described, these components must add up, just as in our personal finances: a change in any one variable must be counterbalanced by a change in another. If we do more appendectomies, we must simultaneously and equally reduce price, usually by means of doing them more efficiently and therefore more cheaply. Or we could, as some have suggested, increase taxes, impose user fees, shift government funding from, say, schools to health, or increase private expenditures. Alternatively — or additionally — we could, as health care planners and others suggest, reduce the quantity of other health care services, especially those that are less cost-effective.

As we put this issue of *CMAJ* together Saskatchewan nurses were on strike, mainly because they considered their hourly wages to be unfair. They joined an increasing number of nurses from Newfoundland to BC with similar demands (see page 1490). Doctors in BC and elsewhere are also asking for fair compensation — indeed, any compensation — for extra work done, and there is a long string of unmet needs for additional health care services in areas ranging from long-term care (see page 1441) to screening for diabetes and, as we will highlight in our June 1 issue, treatment of end-stage renal disease. Although all of these demands, and others, may be legitimate, if they are met they will have a direct and immediate effect on the health care accounting identity. An increase in wages for nurses must be matched by a reduction in wages for someone else or a reduction in the quantity of services provided. In pre-election mode, governments — who used to build roads before elections — buy votes by increasing health care spending. This can only be a short-term and therefore unsatisfactory solution, one that will ultimately lead to either increased taxes or increased private expenditure.

The nurses had a strong case. It was easy for them to compare their hourly wages with those of their counterparts across the country and in the US. In the face of nursing shortages, supply and demand in a mobile labour market is a strong argument for meeting such demands. Otherwise, there will be fewer nurses, and demands will increase. However, in the long term the only lasting solution is to continually try to find the right quantity and mix of health care services in the light of patient needs and of assessment of cost-effectiveness derived from community-based studies.

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