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Guest Column: Patient Focused Funding - **Dr. Brian Day**

Canada is now the only remaining OECD country that funds public hospitals almost exclusively through block budgets. Block funding was popularized in the early 1970s as a means of simplifying hospital reimbursement by governments. In that pre-computer era, when waiting lists did not exist, there were reasonable arguments for this. However, times have changed, and we must rediscover what I prefer to call Patient Focused Funding (PFF). This was one of many recommendations of Kirby's Senate Committee and was reiterated in a May 2006 **Vancouver Board of Trade** report, *Reforming the Canadian Healthcare System*, and in a June 2006 policy paper by the **BC Medical Association** (BCMA). In our enthusiasm to come up with cures for our ailing health system, this reform has not received the priority it deserves. It should be our number one focus.

The British have recently changed the way they fund hospitals. Service-based funding has replaced block funding and wait lists have been dramatically reduced. Britain is close to realizing its goal of an 18-week maximum wait by 2008. In 1997, there were 284,000 patients waiting over six months for hospital care in Britain. By 2006, there were none. When public funding is attached to patients, they can exercise choice. In Britain, patients may choose from five providers, one of which may be independent. Hospitals compete to attract patients. There is increased co-operation between workers and managers and technologies that improve the quality and efficiency of care are embraced. Every hospital admission generates revenue from government. Canada can benefit from the U.K. experience, learning from their successes and mistakes.

Additionally, it is cheaper to treat patients quickly. A recent BCMA-**Canadian Medical Association** review revealed that, aside from the pain and suffering, the cumulative economic costs in B.C., Alberta, Saskatchewan and Ontario of waiting for joint replacement, cataracts, coronary bypass and MRIs will total more than $1.8 billion in 2006. Governments lose $500 million in revenue from the reduced economic activity of patients waiting for care. This conservative analysis addressed only the wait time after the specialist had been seen. And, despite its superior performance on wait times, Britain spends less of its GDP on health care (8.5 per cent to Canada's 10.3 per cent).

Finally, Canadians who travel abroad for health care represent a real export of jobs and funding. The elimination of wait lists would reverse this exodus and allow public hospitals in Canada to generate revenue by engaging in "medical tourism" themselves. The **Royal Marsden Hospital** in England generates 25 per cent of its revenue from treating offshore patients. The 100-bed **Frank Pais Orthopaedic Hospital** in Havana generates USD$20 million a year treating Latin Americans; this money is used to fund care for Cubans. Canadian hospitals could offer services to patients from abroad, including the U.S., where health care is a USD$2 trillion-plus industry. Health care, instead of being our biggest expense, could become our greatest source of national income. Canadian initiatives on PFF must occur at the provincial level. I believe that governments, health workers and, most importantly, patients will support the concept. Studying wait lists was a good start. Now it's time to eliminate them. The potential downside of introducing PFF is that productive, efficient and patient-focused hospitals will be rewarded at the expense of others. So be it.

Dr. Brian Day is president-elect of the Canadian Medical Association. This article deals with a topic that is not yet official CMA policy. The opinions represent the author's personal viewpoint, as presented at the B.C. government's Provincial Conference, October 10, 2006.