









Questions for Plenary Session 6

1. Are there examples of activity based funding initiatives that incorporate a quality/outcome component (Les)?
2. How can you have robust patient-focused funding without a fully integrated electronic health record (Les and Jason)?
3. With regard to the surgeon example and doing cases on Saturday. Can you elaborate a bit more on the quality drivers that are built in to ensure that physicians and others are not being moved towards increased activity but reduced quality (or being overworked) – (Mark)?  1-1
4. With regard to "Thinking Different" and a private sector paradigm. What role should the BCMA and MSP play in setting physician's fee for service (Les and Mark)?  1-2
5. How can you have robust patient focused funding without a fully integrated electronic health record (**Les**)?
6. How does the private sector respond to complex cases (share the load) given there is a public system available as well (panel)?  1-3
7. When providing public paid cataract surgeries in a private facility do you expect a fixed number of cases per month which would enable you to make your clinic financially viable? (**mark**)  1-4
8. What percentage of false creek healthcare centers total budget is paid by public dollars? (**mark**)  1-5
9. Private facilities are all staffed by publicly educated staff. Can you comment on how this is justifiable in terms of competing for limited resources?  1-6
10. How does HSPO encourage "activity based funding" in new and innovative areas?
11. Doesn't Canada Health Care Act reduce funding to province in direct proportion to private healthcare money earned dollar for dollar? If so, how

2-1


does province reconcile this shortfall due to privatized healthcare? (Mark and Les) 

**12. Directed to Mark for further comments...** Your comments are upside down. What a deal! Physicians can keep driving volumes. They diagnose, they refer, they cause the waitlist. No appropriateness filter. No outcome measure. Then physicians get the hospital to cover all their overhead costs and hold no business risk. They admit. They discharge. Hospitals don't drive costs physicians do. The funding reform needed is on fee for service MSP system. Your comments. 


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**13. Mark:** Does your EMR based on Microsoft's CRM software allow for electronic clinical integration (e-prescribing, e-referral)? 


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**14. For mark:** You have referenced the American and South African systems, which have embraced privatization and in doing so have failed to adequately address the needs of their marginalized populations. Perhaps you can comment on this. 

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**15.** What specific innovations can the public system learn from the private system? 

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**16.** Aren't the private facilities conflicted? If waitlists go down they lose business. 

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**17.** I would like to hear some discussion on why activity-based funding for hospital services would be a good idea, when we have experience with the physician fee-for-service payment system, which has many issues, such as rewarding volume rather than quality, encouraging physicians to "pick and choose" from a menu rather than providing comprehensive care, provision of inappropriate services, not providing services which are seen as paying poorly, etc.

- 1-1** 2011-10-16 7:53 PM, Dr Mark Godley  
quality drivers for control of through put as set by the non hospital surgical medical facility committee of the college of physicians and surgeons.  
Mandatory reporting mechanisms for all unanticipated events such as 1. return to OR 2. visit to ER post surgery 3. Patient complaints 4. bleeding and pain management 5. Admission to hospital.
- This ensures an arms length protection of the public and good clinical governance through a strong college program
- 1-2** 2011-10-16 7:53 PM, Dr Mark Godley  
BCMA has very little influence over physician remuneration and employment contracts for hospital or HA based physicians.  
BCMA has a traditional role in negotiating the master agreement for Fee-for-Service billings for physicians. HA do have an excellent opportunity to link performance, outcome, and overall cost of care ( episode of care) to negotiated employment contracts with doctors. This would be very relevant to doctors working in units that are funding through Patient focused funding.
- 1-3** 2011-10-16 7:53 PM, Dr Mark Godley  
Sharing the load through complex cases cannot take place within existing legislation in BC. ( No hip or Knee replacement or ability to give blood products are good examples)  
Therefore the best approach would be for the hospitals to fund outsourcing to the private sector through the Patient focused funding initiative. This allows the Public sector to keep a portion of the funding and potentially reallocate this funding the areas of need.
- 1-4** 2011-10-16 7:53 PM, Dr Mark Godley  
It would be a poor business move for a private facility to be totally dependent on a public contract to be viable. ( eg. set volume of cataracts) unless the initial business plan was finite and had an end point. It would be better for the Public Sector ( hospital) to partner with a private company to deliver highly specialized services such as cataracts. Extend the PPP to PPPP.
- 1-5** 2011-10-16 7:53 PM, Dr Mark Godley  
For the 2011 fiscal period approximately 8%
- 1-6** 2011-10-16 7:53 PM, Dr Mark Godley  
As mentioned in one of my slides on innovation through contracts:  
The facilities must contribute Health Human Resources and not take away.  
1. WRHA/MH we imported-pediatric anesthesiologists from out of province that they could not attract.  
2. MH/WRHA we relocated ECHO technologists from out of Manitoba when the waitlist was 2 years, in 6 months we have achieved 3000 scans.  
3. FHA we are aligning Anesthesia to do FHA work in the midst of an anesthesia crisis in BC.  
The private sector can repatriate good nursing staff that recently retired back into the workforce with more attractive working conditions.  
The private sector can retrain nurses specifically to do focused healthcare tasks they may not have had the opportunity to do in the public system. This is often very rewarding and refreshing for nurses who have been working in the trade for many years.
- 2-1** 2011-10-16 7:53 PM, Dr Mark Godley  
The only way to reconcile this is through newspaper clippings and complaints to the medical services commission.  
Dollar for dollar deductions from social transfer each year has been minuscule.

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2011-10-16 7:53 PM, Dr Mark Godley

Within the Funding Following the Patient model ( so far less than 1% of the total healthcare budget in BC) the physician cannot be seen as an expense to the hospital. They have to be seen as a revenue generator otherwise the funding is not there for that particular clinical unit to grow successful.

Thats the idea. The PFF model is not ideal for all situations and makes sense under clear terms and conditions, such as elective surgery that demands better customer relations.

I have covered of on the governance which is arms length and ensures appropriateness for situations that may result in perverse incentives.

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2011-10-16 7:53 PM, Dr Mark Godley

The system is used for all referrals. Having this built in we can stop " leakage" ...loosing track of patients through the longitudinal process of delivering care.

The system does have electronic prescription capability but has to still use the FAX machine( FAX out from CRM) to capture the signature but the record of the fax and the document ( prescription) is attached to the EHR for that patient.

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2011-10-16 7:53 PM, Dr Mark Godley

Absolutely correct with respect to a marginalized population, and that is not because of private healthcare in isolation but rather because each country lacks a universal publicly funded system.

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2011-10-16 7:53 PM, Dr Mark Godley

Dr Vertesi is innovating through patient focused funding, this is what has been done for years in the private sector, and HSPO is acting.

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2011-10-16 7:53 PM, Dr Mark Godley

Yes they are!

Never place all your eggs in one basket.