Competition

It is easier to run when you are not in a race and easier to compete when there is no competition.

Excellence in any area is seldom achieved in the absence of competition. Two recent personal encounters have reinforced my belief that the introduction of competition is the key to improving patient care in Canadian hospitals. One of these encounters was with a final year medical student on an elective "externship" from Germany; the other was with a visiting health trade mission from Britain. The student was shocked that Canadian patients with serious medical problems wait for necessary care. She described the situation in her country, where the public system (of which she and her family are a part) is kept "honest" by a *competitive* private system. Government funded German patients with cancer, heart disease, or advanced arthritis do not languish and suffer on long waiting lists. The same cannot be said about patients in Canada. Britain, like Germany and most of the civilized world, also has a private system that *competes* with the "free" public system. The public system there was, until recently, relatively underfunded, a situation that is now in the process of being addressed. The British government has recently added a new form of competition. Prime Minister Tony Blair has introduced a system in which all hospitals are ranked. Hospitals are graded based upon such criteria as waiting times, the quality and availability of staff, patient satisfaction, clinical audit, cleanliness, research, and educational activities.

This has led to the production of a national performance league table for hospitals. Managers and administrators who are not performing are replaced and successful ones are rewarded. Patients can exercise choice—they naturally choose to go to the better hospitals. Unlike the system in Canada, publicly funded hospitals in Britain receive their revenue through treating patients. This form of funding must be introduced in Canada. Our global budget system of financing hospitals should be replaced by one in which an institution's income is directly linked to patient care and in which the funding follows the patient. A dramatic change in attitudes would result. Hospital patients would find themselves moved to the top of the pyramid. Closures and cutbacks would be made only in areas that did not involve patient care. New technologies that were shown to be effective would be embraced and consumers could identify such hospitals and take their business (i.e., themselves) there. Hospitals would have an incentive to attract better doctors, nurses, and other hospital employees to work in their facility.

In Britain, this program has led to a dramatic change in attitudes among hospital administrators. Their anxiety level rises as they await the announcement of the annual rankings. Three-star hospitals are rewarded with better funding. Those with two stars work to rise in the rankings, while zero- and one-star facilities are threatened with closure. If they do not improve, their resources are transferred to the better hospitals. It is a formula that has worked worldwide for restaurants and hotels (e.g., the Michelin Guide). It is time that we aspired to the same level of audit and review for one of the most important institutions that we have—our hospitals. Hospital administrators in Britain have denounced the scheme as "unproven, destructive, unfair, and counter-productive." Surely such statements provide strong evidence that the scheme is effective and working? Those interested in learning more about the process can visit the Commission for Health Improvement website at www.ratings.chi.nhs.uk/.

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