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The Potential of Private Sector Health Care in Canada

Does It Cause Global Warming?

Brian Ferguson, Ph.D.
Department of Economics, University of Guelph
and Atlantic Institute for Market Studies

Members of the Canadian Health Care Consensus Group (CHCCG) have come together to provide a platform for bold, reasoned and practical plans for genuine reform of the health system and to demonstrate that there is an emerging consensus among reform-minded observers about the direction that real reform must take. The CHCCG, coordinated by the Atlantic Institute for Market Studies (www.aims.ca), includes medical practitioners, former health ministers, past presidents of the Canadian Medical Association and provincial medical and hospital associations, academics, and health care policy experts, all of whom are signatories to the Statement of Principles.

This paper is one of a series of discussion papers prepared for the CHCCG, which are intended to contribute to that new debate. These papers do not represent official positions of the Consensus Group, and are not themselves consensus documents, but rather are intended to act as starting points for debate, some of which will occur on the Consensus Group's website (www.consensusgroup.ca).

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"The man of system, on the contrary, is apt to be very wise in his own conceit; and is often so enamoured with the supposed beauty of his own ideal plan of government, that he cannot suffer the smallest deviation from any part of it. He goes on to establish it completely and in all its parts, without any regard either to the great interests, or to the strong prejudices which may oppose it. He seems to imagine that he can arrange the different members of a great society with as much ease as the hand arranges the different pieces upon a chess-board. He does not consider that the pieces upon the chess-board have no other principle of motion besides that which the hand impresses upon them; but that, in the great chessboard of human society, every single piece has a principle of motion of its own, altogether different from that which the legislature might choose to impress upon it. If those two principles coincide and act in the same direction, the game of human society will go on easily and harmoniously, and is very likely to be happy and successful. If they are opposite or different, the game will go on miserably, and the society must be at all time in the highest degree of disorder."

-Adam Smith, Theory of Moral Sentiments, VI ii 2 16 (pg 233)

Introduction

Perhaps the most valuable contribution of the Supreme Court's Chaoulli ruling was to force the policy debate to become a real debate, something that Canadians haven't seen for quite some time. The Court's comments suggested that assertions that disaster would inevitably follow should any significant changes be made to the structure of Medicare need, in future, to be backed up by more than the self-assurance of the speaker and his or her unshakable faith in "the system". As appeal to authority is weakened as a basis for policy design, it seems reasonable to hope that it will be replaced by rather more careful modeling and use of evidence than has tended to be the case in Canadian policy debate in the recent past. With any luck, the Chaoulli decision will clear room for serious evidence-based policy debate over the future of the Canadian health care system.

These apocalyptic forebodings would be more convincing if they could be backed up by evidence that any other country's health care system had failed as a consequence of the existence of parallel private insurance.

The purpose of this paper is to consider some of the arguments that have been made in the past with regard to the effects of an increased role in Canadian health care for what is generally referred to in a blanket manner as the private sector. Our hope is to be able to clarify some confusion that has entered the conventional wisdom and set out a framework for the analysis of where increased private sector involvement is and is not likely to make a significant contribution to the Canadian health care system.

Ironically, the private sector health care element that has tended to receive the greatest attention over the years is the one that would have the least impact on our system, even if it were to be introduced in full. Opening the market fully to private insurance would essentially be a non-event.

Private Insurance

Private insurance can take a number of forms, both as a supplement to or as a substitute for public health insurance. Canadians are already familiar with the role of private insurance as a supplement to Medicare – most of us get any pharmaceuticals we might need (outside hospitals) through private insurance, and many people have supplemental hospital insurance to pay for things like private rooms. Oddly enough, critics of public hospitals augmenting their budgets by allowing patients to pay for enhanced care have not been vocal in demanding the elimination of supplemental hospital insurance. With the growing importance of pharmaceuticals in medical care, pressure has been building for Medicare to be

extended to include drug coverage, and there have been demands for expansion of the existing provincial drug programs, but concerns about costs seem likely to delay any such moves.

The type of private insurance most people think of when they talk about the issue is private coverage that substitutes for public coverage. A number of OECD countries have this kind of private coverage, indeed Detsky and Naylor[1] characterize Canada as being "unique in the world in that it bans coverage of these core services by private insurance companies...".

The British and Australian cases are probably those which Canadians are most likely to have heard of, but there are others: in the Netherlands, historically, everybody with an income over a set maximum was required to take out private insurance (or go uninsured) while everybody on lower incomes was covered under the public plan; recent reforms have essentially moved all insurance to private carriers, with the government regulating the content of the insurance plans, while in Germany higher income earners have the option of enrolling in the public plan or buying private insurance in its place. In none of these cases has the presence of parallel private insurance done demonstrable harm to the public insurance system.

Critics of private insurance suggest that it will: "... create 'two-tiered' medicine, increase costs, compromise equity and reduce quality and access to publicly financed health care as those with the financial means (and often the strongest voice) exit to private insurance."[2] These apocalyptic forebodings would be more convincing if they could be backed up by evidence that any other country's health care system had failed as a consequence of the existence of parallel private insurance.

Most objections to private insurance assume that its introduction would induce large numbers of people to desert the public insurance system and join the private. The fact that this has not been a trend anywhere else in the world does not seem to hinder the assumption that it would happen here. In the UK, historically[3], about 10 per cent of the population has carried private insurance – lately that may have risen to closer to 15 per cent. In Australia[4] the figure is much higher, close to 50 per cent of the population, but that was reached only as a result of the introduction of a whole range of carrot and stick policies designed to increase private enrolment – the Australian population proved very resistant to leave the public system. In Germany, where anyone over a certain income level can opt for private insurance, 90 per cent of the population is covered by the public system, and that 10 per cent which has private coverage represents only 25 per cent of the population that is eligible to select private insurance[5]. There is simply no evidence to support the view that if people were allowed to switch to private health insurance they would do so in any number.

Critics of private insurance have suggested that the issue might not be that people would switch in large numbers, but rather that private insurers would design policies which would attract healthy individuals, leaving less healthy people to the public system. There are a couple of things that could be said about this.

First, the adverse selection argument is really meaningful only in a case where insurance is funded from premium revenue. Tax funding of the public system out of general revenues means that revenues do not follow individuals the way they do in a premium-funded system. Tax revenues, being fungible, are not

earmarked, even in those cases (like gasoline taxes, in some provinces) where they are nominally earmarked. (This is more of an issue in countries like Germany which rely on a range of sickness funds to provide public insurance coverage – in those cases the insurers are themselves covered by risk pools, to ensure that none have their financial viability threatened by an unfortunate draw of members.)

Second, the argument seems to suggest that there is something wrong with less healthy individuals being covered by the public insurance system. In the Canadian case those individuals are already covered by the public system: that would not change with the introduction of private insurance.

Third, and most importantly, the argument assumes that private insurers could lure healthy individuals away from the public system in large numbers. When Australia introduced policies intended to increase the role of private insurance in funding health care, some insurance companies, apparently believing what health policy experts said about their ability to draw the healthy population away from the public system, offered plans intended to do just that. The usual approach was to exclude certain types of care from the coverage so that it would be unattractive to individuals who knew they were at risk of potentially expensive illnesses. The plans failed. It turned out that even healthy individuals weren't interested in buying insurance that wouldn't cover the care they were likely to need if they happened to develop a serious illness. Plans that included only major medical coverage might well be attractive to healthy individuals[6], but plans that exclude catastrophic coverage are not.

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There is one circumstance that will prompt people to switch to private insurance, and that is when they begin to doubt that the public system will be there when they need it. Recent evidence from the UK[7] indicates that as waiting times under the NHS increased, people tended to switch to private insurance (and private supply) not necessarily to jump the queue, but because the longer waiting times signaled a decline in the quality of NHS care and a reduction in the probability that the public system would be there when they needed it. Dissatisfaction with the quality of the NHS seems to be a significant factor in prompting people to buy private insurance. Some commentators have suggested (although there does not seem to be statistical evidence for this yet) that reports of recent improvements in NHS waiting times (achieved in part by contracting out of NHS services to private providers) have reversed the trend, prompting individuals who had gone private to come back to the public system.

It has been suggested that a shift towards private insurance would weaken political support for public health care – as Hurley et. al. suggested, that those who would leave the public system would be those with the greatest financial resources and those with the strongest voice; the assumption is that those people would resent having to pay taxes to support the public system as well as paying premiums for private coverage and that, being among the politically influential socio-economic classes, they would be able to bring pressure to bear on governments, leading to a weakening in the political will to continue to support the public system. The analogy that is sometimes made is to the American public school system, although that analogy is weakened by the fact that funding for public schools comes from local property taxes, not from state income tax revenue, and the fact that the more serious threat to urban school funding is associated with individuals leaving the more central city areas, not to move to places where there are more private schools, but to move to suburbs where life is

generally safer, and where their children are likely to wind up back in the public school system.

Curiously, this argument against private insurance is often made by people who claim that Medicare is somehow a core Canadian value, that it is one of the most important things which differentiates not just Canada from the United States but, because it is somehow deeply rooted in the Canadian soul, Canadians from Americans[8.] This is a curious pairing of arguments, since the objection to private insurance is that, if Canadians are permitted to enroll in substitute private insurance plans, not only will they abandon Medicare as individuals, but they will also withdraw their political support for it. Apparently the depths of the Canadian soul are pretty shallow.

It is not a matter of private insurance leading, through loss of political support, to a decline in the quality of the public system; rather it is a matter of declining quality of the public system leading to increased support for substitute private insurance.

In any event, there is no empirical evidence in support of this argument. Propper, discussing the UK experience, notes that while declining quality of the NHS seems to have led to increased use of private insurance that increased private use did not lead to clear-cut changes in attitudes towards the NHS. She notes that studies of attitudes to the NHS did not reveal significant changes in support for traditional tax funding of the NHS even when more people were shifting to private coverage because they were unhappy with NHS quality, and concludes that "there may be scope for more private finance at the margin without threatening the tax base of the NHS." Since the international evidence suggests that people will not shift in large number away from a public system that they think is functioning well, the introduction of a private insurance alternative would mean that at the margin the increase in private finance that would result from the introduction of a private insurance option would be small.

The international evidence, then, suggests that those who oppose private insurance for fear that it will damage Medicare have got the causality backwards. It is not a matter of private insurance leading, through loss of political support, to a decline in the quality of the public system; rather it is a matter of declining quality of the public system leading to increased support for substitute private insurance.

Private insurance acts as the canary in the coal mine – the only places where enrolment in private insurance has grown without (as in the Australian case) the government putting a range of incentives in place to encourage that growth are places where the public system is of such poor quality that people do not trust it to be there when they need it. The British evidence suggests that the drop in quality has to be quite pronounced before you get significant movement away from the public system[9], which in turn means that a fringe private insurance system would probably be a better indicator than any we presently have of satisfaction with the public system.

Basically, the international evidence suggests that a government would have to put a lot of effort into messing up the public insurance system before the private system would grow to any significant degree.

Private Supply

Discussions about greater private sector involvement on the supply side of medical care in Canada have, in recent years, tended to be complicated by the issue of how we define private supply and how much of Canadian's medical care is currently privately supplied. The great majority of physicians are private

suppliers, who happen to earn virtually all of their income by selling services to the public health care plan. Their scope for expanding their practice beyond what the public system will buy is severely limited, though, so their choices about the form and extent of their practice are severely limited[10]. A few are able to supplement their public sector incomes by providing services to Americans coming across the border to buy pharmaceuticals, and needing prescriptions signed by Canadian physicians before they can do so. A few, notably in Quebec (notably meaning that they happened to be the ones who caught the attention of the national press) have been able to earn a living by opting out of Medicare altogether. Their capacity to do that is a result of public policies which have restricted the supply of physicians to the point where there are enough people who are both unable to get access to a physician in what they regard as reasonable time and are willing to pay out of pocket for faster access, to make opting out economically feasible for at least a few primary care physicians.

The restrictions placed by the public system on the way a physician organizes his practice must be seen as limits on his independence as a practitioner.

A few physicians manage to have Medicare and non-Medicare aspects to their practices by investing in non-Medicare imaging activities. Former Prime Minister Paul Martin's physician was a case which caught the attention of the press, and while Mr. Martin made it clear that he received only publicly paid services from his physician, it seems likely that amenities like the quality of the waiting room were funded at least in part out of Mr. Martin's physician's non-Medicare activities, but were shared by his non-Medicare and Medicare patients alike.

The restrictions placed by the public system on the way a physician organizes his practice must be seen as limits on his independence as a practitioner. Take the matter of non-physician staff. American evidence suggests that adding a nurse practitioner to a family practice can improve the efficiency of the practice not just because it increases the practice's labour input but also because it allows the GP to focus on patients with more serious conditions. The Canadian system is gradually expanding its use of NPs, but their employment in Canadian practices lags behind American practice and also lags behind the use of their counterparts in Canadian dentistry. Even if we assume that reports of the extent to which NPs can increase practice efficiency are biased on the optimistic side, restrictions on the ability of the individual physician to experiment with ways of increasing the productivity of his office seem unfortunate at a time when access to primary care is a growing concern in many parts of the country. It's the more unfortunate because the slow spread of NPs in GP offices is not a result of deliberate policy, but rather is a side effect of the way physicians are allowed to bill the public insurance plan for the services they provide through it.[11]

The picture on the physician supply side will undoubtedly become even more confused if alternative payment mechanisms come into widespread use. A physician receiving a salary through a clinic whose capital is entirely paid for by the government would presumably be regarded as a public sector employee; the status of a physician paid on a capitation basis would presumably be similar, and the requirement that a Medicare billing number become available before a physician can hang up his shingle as an independent practitioner would severely restrict the freedom of physicians who had opted for salaried clinic status to move into the private sector.

On the hospital side, the picture is clouded by the fact that most Canadian hospitals, or their responsible health authorities, have their own boards of directors, which has prompted some commentators to argue that because their administrative structure is similar to that of private American hospitals they are

private sector institutions. While the appearances might be similar, though, the practicalities are quite different. It is hard to characterize an institution as private sector when the provincial government has full authority to restrict the scope of their activities or close them altogether, as the Lord government in New Brunswick did in a number of cases in the past couple of years, or when, as happened in Ontario this year, the responsibility for resolving Emergency Room crises in a number of hospitals falls directly on the provincial Minister of Health. Whatever its formal structure, an institution which gets the vast majority of its budget from the government, and which is subject to government direction as to what services it may or may not, indeed, must or must not, provide, can hardly be referred to as private sector.[12]

Whatever its formal structure, an institution which gets the vast majority of its budget from the government, and which is subject to government direction as to what services it may or may not, indeed, must or must not, provide, can hardly be referred to as private sector.

Of late the American hospital debate has shifted away from the relative merits of for-profit, non-profit or government general hospitals[13] towards the issue of specialty hospitals, primarily surgical clinics specializing in orthopedic and cardiac surgery. There are also specialty Women's hospitals, but these, curiously, do not seem to attract the same level of criticism, as do the specialty surgical units.

Many of the criticisms of these units seem ill thought out. They are often criticized, for example, for not having emergency departments (although in fact a significant number of cardiac surgical clinics do have emergency facilities of some sort) but their critics do not seem to address the issue of whether it would really be a good idea for a surgical clinic which was equipped solely to handle orthopedic surgical cases to try and run a general emergency department. The issue of whether the public's health care would better be served if emergency services were themselves specialized facilities has received little attention in the literature on specialty clinics.

Much of the American debate about specialty hospitals does not translate to the Canadian system. For example, community hospitals in the United States argue that specialty units draw low-complication (and therefore low cost) cases away from general hospitals, leaving general hospitals to treat the more expensive cases. This is a criticism that makes sense only in the US context, where hospitals have argued that they need the surplus they make from treating low cost cases to cover their higher costs on more expensive cases and also to contribute to the funds they have available for treating the uninsured. Even in that context it makes sense only in those cases where the hospital is paid on a fee for service basis and where it is paid the same fee (presumably based on a weighted average of costs) for both low and high cost patients in a particular category.

Conclusion

The original intent of Medicare was to ensure that nobody lacked access to necessary medical care for financial reasons. While that is still a desirable goal, it's time we re-thought the way we achieve it. In the years since the early 70s, the role of the government, which was originally primarily to provide insurance[14] cover, has expanded to include taking more and more control over both the day-to-day operations and long term planning function of the system. Indeed, some people would, with considerable justification, argue that this is not just a problem with the health care system but the key problem with the health care system. Instead of acting as an insurer and external quality assuror for the system, government has effectively become the system's manager.

This process has, inevitably, meant that decision-making authority has moved farther and farther away from the delivery end of the system, and also that the resources available for decision-making have become overloaded. A medical care system is too complicated a thing to be micro-managed by a centralized bureaucracy, but as decision-making authority moves to the Department of Health, the system's decision-making capacity is actually reduced, as the people responsible for delivering care are effectively removed from the management and information system. The result is that the groups who have the authority to administer the system are overwhelmed by the information processing demands it faces. That's how we wind up in a situation in which, despite having a system where every contact between patient, physician and hospital is recorded somewhere; we still don't actually know how long people have to wait for fundamental medical care.

When we talk about increasing the role of the private sector in the health care system we should see it as a way of increasing the flexibility of the system.

The outcome of increased centralization is the sort of thing we have seen happen with Ontario's Emergency Rooms recently. Not only did the government seem to be taken by surprise by the news that several hospitals were on the verge of having to close their Emergency Rooms, the premier actually admitted that the government had had no idea of the seriousness of the situation that was developing. What evolves is management by crisis – when the critical decision-making authority is too far removed from day-to-day operations, it takes note of what is happening at the operations end only when things reach crisis stage. In the absence of visible crisis, it assumes that everything is fine.

Broadly defined, technological change in health care means new ways of treating patients – new ways of delivering the system's ultimate product. Whether a particular new technology is suited to a particular set of patients that ultimately is best assessed by the people directly involved – the people supplying and receiving the care. Government has a role to play in evaluating care, however, external assessors whom are not a risk of losing face often best handle a quality review. Government typically is not good at admitting that its policies have not worked well, and is even less able to admit that a system that it is administering is not achieving its goals. Faced with evidence of problems in the health care system, the typical administrative response is to concentrate even more decision-making authority in a limited number of hands. One thing that this can be virtually guaranteed to do is to reduce the flexibility of the system.

Canada's health care system is in trouble precisely because it lacks flexibility. It is facing fundamental changes on both the supply and demand sides – on the supply side as new technologies, especially pharmacological technologies, change the way care can be produced and on the demand side as the ageing of the population changes the mix of services demanded of the system and therefore changes the mix of technologies the system needs. The ageing of the population has an effect beyond simply meaning that the set of patients a doctor or hospital sees will be getting older. Population aging is more than just an increase in the number of older people; it is a change in the ratio of older to younger people – a change in the ratio of people who are heavy users of the system to people whose taxes fund the system. Japan, which is ahead of us in the population ageing process, is experiencing serious strains on its health care system as demands grow in excess of the revenues available to the public purse. The response that will be required is precisely the sort that a highly centralized system, in fact if not in name, is not good at delivering.

When we talk about increasing the role of the private sector in the health care

system we should see it as a way of increasing the flexibility of the system. It does not, despite what its critics claim, mean handing over the system in its entirety to evil private insurers who will gut it and flee the country. It does mean asking the people who are most directly involved in delivering care to take more responsibility for deciding how that care should be delivered, and giving them the scope to do exactly that. It means taking advantage of the information processing capacity which is embodied in the people who are responsible for delivering health care, and it means accepting that for the most part those people are trustworthy; not saints and angels and every bit as responsive to economic incentives as the rest of us (and as quick to deny it as any of us) but at the very least no more venal than public servants and self-accredited experts with academic appointments.

. . . the key is to recognize the ability of the people who are actually practicing medicine to spot changing circumstances before they reach the point where the national media start running crisis stories . . .

Critics of a greater role for the private sector tend to say that the health care system is too important to be left to the market. In fact, the health care system is too complicated to be run by a handful of administrators who assume that uttering decrees about things like waiting times is sufficient to solve the problem of waiting times. Health care is too important to be managed along the lines of a military campaign.

Opponents of increased private sector involvement are really opponents of increased individual initiative in health care. Their preference is for the system to be run by Adam Smith's Man of System who, as the quote above says, sees the people who are affected by his decisions as nothing more than pieces on a chessboard.

The most important thing any government could do for health care in Canada is to reject the approach of the Man of System. That would mean, first, stepping back from trying to manage every aspect of the delivery of care and concentrating on the job they were originally assigned in health care – that of national insurer. Running a sustainable insurance system is a difficult enough task in itself, and when government is doing it, the temptation to try and resolve difficulties by simply assuming authority over various other bits of the system is a hard one to resist[15].

As part of the reversion to the status of insurer, government has to redesign the health care payment system in a manner that encourages, rather than discourages, flexibility. It has to get away from the belief that doctors are the enemies of the health care system and accept that the people dealing with the day-to-day problems of health care are probably the ones most likely to see changes in the environment as they develop, and that they have a certain self-interest in finding ways of dealing with those changes before they reach crisis level.

Allowing groups of doctors to go to the private capital markets to obtain funding for new capital equipment, by taking out loans which will be secured by an expected stream of payments from Medicare will not cause the system to fall apart, instead it will facilitate the process by which capital and labour go where they are needed. Again, the key is to recognize the ability of the people who are actually practicing medicine to spot changing circumstances before they reach the point where the national media start running crisis stories, and to give them the scope to deal with those changes in whatever manner works for their patient population[16].

Allowing greater flexibility into Canada's health care system means making use

of the intelligence and problem solving abilities of a lot of private individuals, quite a few of them doctors. Since those individuals have not yet been legally conscripted into the public service, taking advantage of their abilities would amount to permitting greater private, as in non-government, sector involvement in the way Medicare operates.

Doing this will not, despite what certain academics and policy experts tell us, cause the sky to fall. In assessing the claims made by those academic experts, it is worth remembering that they are the same people who have had policy maker's ears for three decades now. They are the people whose policy advice had borne fruit in things like the lottery one community in Nova Scotia decided to hold recently to assign patients to three new doctors. Lottery winners got on a Family Practice's list; losers are, literally, still out of luck. Those experts are the people whose advice on workforce policy led to the situation where communities like Kitchener, Ontario, cannot be sure of keeping their Emergency Rooms open.

Those experts are the people who tell us that having the government settle for ensuring that nobody is denied access to necessary medical care for financial reasons and leaving it to private individuals to decide how that care will be delivered will lead to a takeover of our health care system by American corporations, which takeover will be followed by the sale of all of our water to the Coca Cola corporation, which will in turn lead to global warming.

They're wrong.

Endnotes

[1] Detsky, Alan S. And David C. Naylor (2003): "Canada's Health Care System - Reform Delayed" New England Journal of Medicine 349(8) 21 August, 804-810

[2] Hurley, J., R. Vaithianathan, T. F. Crossley and D. Cobb-Clark (2002): Parallel Private Health Insurance in Australia: A Cautionary Tale and Lessons for Canada Discussion Paper 448, Centre for Economic Policy Research, Australian National University, May

[3].Foubister, T., S. Thomson, E. Mossialos, A. McGuire (2006): Private Medical Insurance in the United Kingdom pub. World Health Organization on behalf of the European System on Health Systems and Policies, Copenhagen

[4] F. Colombo and N. Tepay (2003): Private Health Insurance in Australia: A Case Study OECD Health Working Paper No. 8, Organization for Economic Cooperation and Development, Paris

[5] For a general overview of Private Health Insurance in a range of countries, see F. Colombo and N. Tepay (2004): Private Health Insurance in OECD Countries: The Benefits and Costs for Individuals and Health Systems Organization for Economic Cooperation and Development Health Working Paper 15, Paris

[6] One of the chief problems with the American insurance system is that quite a number of states have laws forbidding the sale of catastrophic health insurance and requiring that any health insurance sold in them be comprehensive. Catastrophic coverage can be relatively inexpensive, even if the treatments it covers are expensive, because the probability of an individual needing that kind of treatment is relatively low. Comprehensive insurance is more expensive than catastrophic because of the much higher probability that the individual will make a claim.

[7] See Carol Propper (2001): "Expenditure on Healthcare in the UK: A Review of the Issues" Fiscal Studies 22(2), 151-183

[8]As one commentator on an earlier draft of this paper noted, it makes very little sense to take, as a measure of the quality of a health care system, the degree to which it differs from the American system. Unfortunately, many Canadian commentators seem to take as their starting point the proposition that Canada must under no circumstances copy an American innovation, no matter how well it might work.

[9] In this regard it is interesting to note the difference between the state of NHS medical care and the state of NHS dental care, especially in Scotland.

[10] One avenue for changing the mix of practice is to treat more Workers Compensation cases, since the Canada Health Act explicitly forbids billing Medicare for these cases. In practice, this is not an option open on a large scale to many physicians.

[11] The province of Ontario is now widely regarded as having taken significant steps towards integrating Nurse Practitioners into the publicly funded health care system. This does not alter the fact that the process has been unnecessarily slow. In addition, the mechanism they have chosen to use is likely, judging from international experience, to be cost increasing, not cost saving. We will discuss this point in detail in a later paper.

[12] We should also note that the key hospital management decisions, about which patients to treat and how to treat them, are made in large part by physicians, not by hospital managers. It is hard to think of any other institution in which the nominal managers have so little actual management authority as do the managers of hospitals.

[13] For a recent meta analysis of the general hospital literature, see Yu-Chu Shen, Karen Eggleston, Joseph Lau and Christopher Schmid (2005): Hospital Ownership and Financial Performance: A Quantitative Research Review, National Bureau of Economic Research Working Paper No. 11662, October, and Karen Eggleston, Yu-Chu Shen, Joseph Lau, Christopher H. Schmid and Jia Chan (2006): Hospital Ownership and Quality of Care: What Explains the Different Results? National Bureau of Economic Research Working Paper No. 12241, May.

[14] One thing which government could do right now, very easily, is resolve some of the open questions about the real state of our system simply by making the data which it already possesses generally available.

[15] Provincial Medicare and hospital plans collect immense amounts of data on how the system is being used, most of which is carefully hidden away in Ottawa and never made available to anyone. Ottawa's data agencies still operate on a cost recovery basis, as if computers had not yet made it to the national capital region, and Al Gore had not yet invented the internet.

[16] While the internet revolution is in many ways overblown, one thing it has done is turn data into virtually, in economic jargon, a public good. Simply requiring that data to be made available the same way as American government agencies make vast amounts of health data freely available would be a major advance.