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MOVING MEDICARE FORWARD

The flawed electronic health records strategy

A court fight for access to care

The Canada Health Act and health care reform

Receiving Medical Treatment Outside of Canada

Price of public health insurance in Canada

Swiss lessons for American health care

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THE FRASER INSTITUTE

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Health care is in the news again. Not that it is ever very far from the headlines. This time, the question of medical wait time "guarantees" has been revived as Parliament resumes sitting after the Christmas break. The apparent need for wait time guarantees points to just one imperfect aspect of our troubled health care system: many people are waiting an unreasonably long time to get the health care they need and want. There are many other difficulties with the system though, each of which bubbles to the media surface at one time or another. How has it come about that this one area of our society has become so muddled with so many apparently intractable problems?

At its most basic, individual Canadians want a system that delivers good health care, in a manner readily accessible to themselves and their families in times of need, for a reasonable price. But that doesn't seem to be happening. Instead, according to research conducted by Nadeem Esmail and Michael Walker (see their *How Good is Canadian Health Care* and *Waiting Your Turn: Hospital Waiting Lists in Canada* on our web site), people are sometimes getting mediocre care, for which they often have to wait an excessively long time, and yet taxpayers are forking out a bundle for it.

A big part of the problem is that as a nation, we seem to be absolutely, irrevocably stuck when it comes to this issue. Those who suggest that the change required to solve these problems goes beyond tweaking what we have now, or implementing new central management processes to run it, are often pilloried as heartless destroyers of Canada's Medicare program. The vociferous opposition leads to inaction; many of the necessary innovations that continuously take place in other aspects of our lives aren't taking place in health care.

But the situation for our health care system isn't all bleak. In the wings are many good ideas just waiting for a pilot project somewhere in Canada to give them a chance to demonstrate their worth. And these ideas for moving Medicare forward aren't simply theoretical, either. Many have been tried and found sensible in other jurisdictions.

This issue contains some articles that outline the extent of the problems our health care system currently faces: the cost to each of us of funding Canada's public health care insurance; an estimate of the number of Canadians getting treatment outside the country; and why we should beware of electronic health records. Other articles explain what the Canada Health Act really does (or doesn't) say; the Supreme Court's role, not just in maintaining the status quo, but in forcing change; and the lessons the Swiss can offer the American, and our own, health care systems.

There *are* solutions to Canada's health care woes. We just need the courage to begin implementing some of them, however loud the naysayers protest.

—Kristin McCahon (kristinm@fraserinstitute.ca)

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Compulsory Schooling No Substitute for Good Schools

by Claudia R. Hepburn

You can lead a horse to water, and you can lead a reluctant teenager to school. I'd put my money on the horse absorbing more from the experience than the teenager, but Kathleen Wynne, Ontario's education minister, seems to be putting hers on the teen. Ontario's Bill 52, which aims to increase the school leaving age from age 16 to 18, ignores how much more stubborn teenagers can be than horses.

The bill's goal, to reduce the dropout rate and increase academic achievement of Ontario teens by 2010, is certainly a noble one,[1] but as the past century's experience with public schooling has shown us, free, compulsory schooling does not result in a universally educated citizenry when it is insulated from competition. When 11 years of compulsory schooling have failed to produce the desired effect, it makes little sense simply to extend the number to 13.

A more creative way of cutting the dropout rate might be a policy implemented 16 years ago in Sweden. The Swedish policy wasn't designed to target Sweden's most recalcitrant students, nor was it widely expected to increase academic achievement in public schools. But competition for students has produced these salutary effects in Sweden, and might well help Ontario increase its high school graduation rate and overall academic attainment.

In 1991 a new Swedish government enacted a major reform to the country's education system, one which opposition parties, teachers' unions, and others claimed would threaten educational equity and erode the public system. Independent (or private) schools, which until then had been virtually non-existent, were given public funding for the first time.

Over the decade-and-a-half since, private schools have grown dramatically in number and share of students, but not in the ways critics predicted. Rather than targeting wealthy families and easy-to-teach students, private schools in Sweden have proliferated in areas where the quality of the public schools is poor and the number of "low ability" students is considerable (Sandstrom and Berstrom, 2005, pp. 373, 376).

Independent schools appear to have helped not just the most disenfranchised, but the average public school students, too. Research suggests that the more competition public schools face from private schools in a given municipality, the more public school students' academic performances improve overall. F. Mikael Sanstrom and Fredrik Bergstrom of the Stockhom-based Research Institute of Industrial Economics find:

> that the extent of competition from independent schools, measured as the proportion of students in the municipality that goes to independent schools, improves both the test results and the grades in public schools… The improvement is significant in statistical and real terms. This result holds for test results, final grades and for the likelihood that a student will leave school with no failing grades. Thus our results confirm findings from earlier research which indicate that competition is beneficial for students in public schools. (Sandstrom and Bergstrom, 2005, p. 356)

Funding private schools didn't result in a mass exodus of students from one system to the other, but rather in the gradual growth of the private sector from 1 percent of school-aged students to 6.8 percent. Public schools responded positively and, as a result, have maintained a large majority of students by improving the education they provide. Though private schools out-perform public schools, fears that competition would have deleterious consequences for the system as a whole have not been realized. Results have improved overall.

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Ontario's government might do well to heed these findings when developing strategies to help students. Rather than penalizing children who've had such bad experiences at public school that they want to drop out, why not encourage them to shop around for a school that might meet their particular learning needs better? Ontario has more than 800 independent schools, many of which cost less than public education. For instance, the 235 Ontario private schools currently involved in The Fraser Institute's school choice program, *Children First*, have an average annual tuition of $4,800. The tuition range is from $500 to $17,500 per pupil per year. With a little help, many families can afford the majority of these schools.[2]

The key to raising the educational achievement of students at risk of dropping out must surely be to engage them in their education, not just force them to sit unhappily in class for two more years. We should allow students to switch out of schools they hate—whether because they are bored, or bullied, have a learning disability or a disciplinary issue—and into schools that better suit their needs and temperament. Only then will we allow all students to learn better. The alternative suggested by the government—to force students to stay where they are unhappy and hope that things will improve—is likely only to compromise the education of their fellow students and frustrate their teachers.

The two approaches to disappointing graduation rates—the first, to confine students in a system they hate, the second, to free the students to leave school but strengthen the system so that students choose to stay of their own volition—reminds me of two approaches to treating back pain. At a recent visit to a back specialist I was warned against the old-school approach of using a brace to support the spine after an injury. If the spine is weak, don't let it move and you'll stop the pain, we back sufferers were once told. Today, the more acceptable approach is to exercise the muscles supporting the spine in an effort to help the body strengthen itself.

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Receiving Medical Treatment Outside of Canada

by Nadeem Esmail

In recent years a number of companies aiming to provide Canadians easier access to medically necessary treatments have appeared in Canada and elsewhere. Of course, leaving Canada for medically necessary treatment is nothing new—Canadians have been doing so for many years either in response to the unavailability of certain treatments in Canada or in response to long wait times for medically necessary treatment. This has left many asking the question: exactly how many Canadians leave Canada each year for treatment?

While data on this topic are difficult to come by, it is possible to roughly estimate that number using the results of The Fraser Institute's *Waiting Your Turn* surveys and the counts of procedures completed each year in Canada produced by the Canadian Institute for Health Information (CIHI) (including estimates for some provinces who do not provide comparable data to CIHI). Notably, *Waiting Your Turn* reports the only annual, national, and comprehensive measurement of Canadians receiving treatment in another nation.

While the computations below are rough, "back of the envelope" calculations, they are the most complete estimates available in Canada today and should provide some insight into just how many Canadians are choosing to seek care on their own terms outside of Canada. The calculations also provide some insight into the number of Canadians who might choose to stay in Canada and pay for treatment in their own home province if only that province's government would part from the status quo and allow them to do so.

Methodology

Each year, The Fraser Institute's *Waiting Your Turn* survey asks physicians across Canada, in 12 major medical specialties, the question, "Approximately what percentage of your patients *received* non-emergency medical treatment in the past 12 months outside Canada?" (emphasis in original). The answers to this question are averaged for each of the specialties studied in *Waiting Your Turn* in each province to produce a table that reports the "Average Percentage of Patients Receiving Treatment Outside of Canada." (For an example, see table 11 (p. 61) in Esmail and Walker with Wrona, 2006). In 2006, 1.0 percent of all patients in Canada were estimated to have received non-emergency medical treatment outside of Canada, which was a decrease from 1.1 percent in 2005 and 1.2 percent in 2004.

Combining these percentages with the number of procedures performed in each province and medical specialty in Canada gives a rough estimate of the number of Canadians who actually received treatment in another nation.

Two data-related issues must be noted before discussing the estimate.

First, the number of procedures performed in Canada is not readily available from the Canadian Institute for Health Information (CIHI). Notably, Alberta and Quebec, and in years past Manitoba, do not provide complete discharge abstract data (DAD) to CIHI (which is the source for the procedures counts data used in *Waiting Your Turn*). The authors of *Waiting Your Turn* deal with this concern by making a pro-rated estimate of procedures using older hospitalization data. These estimated procedure counts fill in for the actual number of procedures in Manitoba (2004 and 2005 only), Alberta, and Quebec.

Second, there is a temporal mismatch between the timing of The Fraser Institute's *Waiting Your Turn* survey and CIHI's annual DAD data release. Specifically, procedure counts data used for *Waiting Your Turn* are typically one year behind. For example, the 2006 edition of *Waiting Your Turn* used procedure counts from 2004-05. While the calculation below uses the temporally mismatched procedures counts to provide up-to-date information, it should be noted that adjusting for the temporal mismatch does not appear to materially affect the trend witnessed in the overall

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Table 1: Estimated Number of Patients Receiving Treatment Outside of Canada, 2004

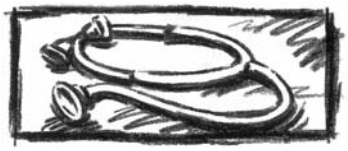
	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	CAN
Plastic Surgery	33	17	2	57	155	70	0	4	0	0	337
Gynaecology	373	169	123	301	952	217	0	61	0	0	2,197
Ophthalmology	549	304	116	0	1,822	770	41	89	0	9	3,700
Otolaryngology	145	167	14	49	1,103	224	1,381	0	—	0	3,081
General Surgery	1,755	343	113	29	2,451	464	256	99	24	89	5,625
Neurosurgery	46	10	19	75	523	0	0	2	—	0	676
Orthopaedic Surgery	559	274	64	91	1,071	306	8	115	5	53	2,546
Cardiovascular Surgery	118	50	34	9	322	95	4	9	—	—	641
Urology	923	779	70	204	2,716	576	494	80	—	11	5,853
Internal Medicine	793	566	125	183	1,798	1,014	43	7	14	16	4,560
Radiation Oncology	0	3	3	2	18	11	5	0	—	1	42
Medical Oncology	24	27	—	—	579	232	44	12	0	17	936
Residual*	3,032	1,857	479	876	9,021	2,251	1,140	353	26	163	19,198
Total	8,350	4,566	1,161	1,875	22,532	6,231	3,417	831	69	360	49,392

*The residual count was produced using the average provincial percent of patients receiving treatment outside of Canada and the residual count of procedures produced in *Waiting Your Turn*.
Note: All data regarding oncology refer only to procedures done in hospitals. Most cancer patients are treated in cancer agencies. Therefore, the oncology counts must be regarded as incomplete. Also, the procedure data reported generally includes only those procedures performed in public facilities. A large number of ophthalmological surgeries are performed in private facilities. The distribution of surgeries between public and private facilities varies significantly between provinces. Therefore, the ophthalmology counts must also be regarded as incomplete.
Sources: Esmail and Walker, 2004; calculations by author.

Table 2: Estimated Number of Patients Receiving Treatment Outside of Canada, 2005

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	CAN
Plastic Surgery	62	44	26	14	266	220	0	0	0	0	632
Gynaecology	518	292	41	86	970	316	9	9	0	0	2,240
Ophthalmology	588	418	32	64	2,810	1,686	16	110	21	44	5,789
Otolaryngology	268	143	19	63	649	100	52	6	—	0	1,300
General Surgery	332	312	110	72	2,019	466	39	104	0	30	3,483
Neurosurgery	19	62	2	0	330	60	49	2	—	50	573
Orthopaedic Surgery	598	269	52	106	1,023	136	147	39	0	17	2,388
Cardiovascular Surgery	57	42	15	0	232	4	0	7	—	9	366
Urology	514	782	34	25	2,564	108	18	8	—	9	4,062
Internal Medicine	1,364	341	68	110	2,063	792	6	12	0	0	4,757
Radiation Oncology	—	3	1	1	24	8	6	0	—	0	44
Medical Oncology	39	60	—	—	310	192	11	1	0	29	642
Residual*	3,085	1,997	291	436	8, 940	2,252	328	182	25	213	17,747
Total	7,444	4,764	689	977	22,199	6,340	681	479	46	401	44,022

*The residual count was produced using the average provincial percent of patients receiving treatment outside of Canada and the residual count of procedures produced in *Waiting Your Turn*.
Note: All data regarding oncology refer only to procedures done in hospitals. Most cancer patients are treated in cancer agencies. Therefore, the oncology counts must be regarded as incomplete. Also, the procedure data reported generally includes only those procedures performed in public facilities. A large number of ophthalmological surgeries are performed in private facilities. The distribution of surgeries between public and private facilities varies significantly between provinces. Therefore, the ophthalmology counts must also be regarded as incomplete.
Sources: Esmail and Walker, 2005; calculations by author.



count of Canadians, though it does (as expected) affect the actual counts of Canadians.[1]

It is also important to note that counts of the number of patients receiving treatment outside Canada each year produced by this methodology are likely to underestimate the actual number of patients being treated outside Canada each year. First, and most importantly, these numbers are based on specialist responses, which means that patients who leave Canada without consulting a specialist (in 2006, Canadians could expect a median wait of 8.8 weeks from GP referral to specialist consultation (Esmail and Walker with Wrona, 2006)) are not likely to be included in this count. Put more simply, patients who leave Canada without consultation with a specialist, and patients who leave but are not recognized as having done so by specialists, will likely not be counted below. In addition, the counts below are based on the number of procedures estimated to have been performed in Canada, which is less than the total number of patients consulted and less than the total number of Canadians who would have required treatment (including those who left).

An estimated count of patients leaving Canada

The product of the percentage of patients receiving non-emergency treatment outside of Canada and the number of patients treated in Canada estimated in *Waiting Your Turn* is shown below for the years 2004, 2005, and 2006.[2]

Two things become readily apparent from an examination of these estimates for the number of patients receiving treatment outside Canada each year. First, there is an overall downward trend in Canada, not just in percentage terms, but also in terms of the number of Canadians leaving. In 2004, an estimated 49,392 Canadians received treatment outside Canada while only 39,282 were estimated to have done so in 2006. Significant declines in the estimated number of patients going outside Canada for treatment were also seen in New Brunswick, Saskatchewan, British Columbia, Manitoba, and Ontario. Nova Scotia and Quebec also saw declines in the estimated number of patients receiving treatment outside of Canada.

Table 3: Estimated Number of Patients Receiving Treatment Outside of Canada, 2006

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	CAN
Plastic Surgery	34	6	10	16	119	141	0	0	0	0	327
Gynaecology	338	302	35	46	930	187	48	25	0	114	2,024
Ophthalmology	341	696	31	52	1,540	1,062	15	42	0	20	3,799
Otolaryngology	271	103	8	7	452	172	9	26	7	0	1,055
General Surgery	393	373	172	201	1,556	369	6	230	13	0	3,313
Neurosurgery	39	38	5	0	166	21	0	0	—	0	268
Orthopaedic Surgery	526	406	25	126	1,010	175	45	32	32	24	2,401
Cardiovascular Surgery	78	93	5	0	190	99	0	0	—	0	465
Urology	657	606	126	27	1,957	941	135	0	—	17	4,466
Internal Medicine	549	376	17	221	2,559	775	47	41	11	0	4,595
Radiation Oncology	—	2	0	—	21	8	9	—	—	4	43
Medical Oncology	37	16	—	—	488	32	55	26	1	98	753
Residual*	2,128	2,162	250	520	7,749	1,872	244	345	37	466	15,772
Total	5,391	5,180	682	1,216	18,736	5,855	611	767	101	743	39,282

*The residual count was produced using the average provincial percent of patients receiving treatment outside of Canada and the residual count of procedures produced in *Waiting Your Turn*.
Note: All data regarding oncology refer only to procedures done in hospitals. Most cancer patients are treated in cancer agencies. Therefore, the oncology counts must be regarded as incomplete. Also, the procedure data reported generally includes only those procedures performed in public facilities. A large number of ophthalmological surgeries are performed in private facilities. The distribution of surgeries between public and private facilities varies significantly between provinces. Therefore, the ophthalmology counts must also be regarded as incomplete.
Sources: Esmail and Walker with Wrona, 2006; calculations by author.

However, in some provinces the trend is reversed. For example, in 2004 an estimated 4,566 Albertans were treated outside Canada, while in 2006 an estimated 5,180 received their health care outside the country. Newfoundland and Prince Edward Island also bucked the national trend.

This national decrease in the number of patients treated outside Canada happened at the same time as a decrease in the wait time for medically necessary treatment. Specifically, the national median wait time for treatment (after consultation with a specialist) was 9.5 weeks in 2004 and fell to 9.0 weeks in 2006. However, the same is not true among the provinces—wait times fell in Alberta, Prince Edward Island, and Newfoundland, but they increased in Manitoba, Nova Scotia, and (slightly) in British Columbia and New Brunswick.

Conclusion

In 2006, an estimated 39,282 Canadians received non-emergency medical treatment outside Canada. While that was a decrease from the number who were estimated to have done so in 2004, it is nevertheless a significant figure and likely to be an underestimate of the actual number of patients who received treatment outside Canada that year. Equally importantly, that number represents a significant potential economic loss to Canada, since provinces that were willing to allow the private financing of medically necessary care by their citizens could likely have captured the dollars spent by many of these patients who went abroad.

Notes

[1]Specifically, the Canadian counts with the temporal mismatch for 2004, 2005, and 2006 are 49,392, 44,022, and 39,282 respectively. Accounting for the mismatch results in counts for 2004, and 2005 of 47,011, and 45,776 respectively.

[2]Note that a change in the procedures count methodology used for *Waiting Your Turn* in 2004 means that procedures counts prior to that year are not comparable with those for 2004, 2005, and 2006.

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The Canada Health Act: *Facts and Fallacies*

by Kieran A.G. Bridge

There are many myths and misunderstandings surrounding the health care and health insurance systems in this country. Very often, articles and commentaries that are presented as "informed" actually perpetuate these misunderstandings. At times they only misinform readers about fundamental aspects of these systems, their legal bases, and how they operate.

Nowhere is this more common than in discussions about the Canada Health Act (CHA). The CHA is in fact very limited in scope. To appreciate how the CHA operates, it is important to note two things: (1) there is a vital difference between health *care* and health *insurance*, and (2) the federal government has virtually no constitutional jurisdiction over either of these matters.

This article is intended to dispel some of these myths and misunderstandings.

Health *care* is the provision of medical services. Health *insurance* pays for those services. In Canada, many of these services are provided in public hospitals[1] and by provincially-employed staff. However, a large proportion of health care is provided in privately-owned clinics and other facilities. In fact, most doctors' offices and many other medical facilities in Canada are privately-owned and operated as businesses, even though much of their revenue comes from provincial governments' medical insurance plans.

One of the more prevalent myths is that the CHA requires that hospitals be government-owned and operated and prohibits privately-owned medical facilities. This fallacy is the touchstone of many who oppose private clinics on the basis that they are "violations of the Canada Health Act." In fact, the CHA says nothing about how, or where, health care is delivered. The CHA also does not require, or even mention, public ownership of medical facilities or public employment of doctors or other health care providers. Suggestions that private clinics or privately employed doctors and nurses amount to "violations" of the CHA are simply wrong.

The CHA is nothing more than a funding law. It governs, on rather loose terms, the transfer of money from the federal government to the provinces to subsidize the cost of provincial governments' health insurance plans. The CHA has been described by courts as an exercise of the federal government's "spending power" under the constitution.

It is also important to note that the federal government has no jurisdiction to make laws banning private health insurance, for example, or governing privately-owned medical facilities. Those are provincial matters under the constitution.[2] The CHA does not purport to control what individuals or businesses can or cannot do. It is therefore impossible for any citizen or business to "violate" the CHA. In fact, even provinces cannot be taken to court successfully for breaching the CHA. Courts have consistently held that they cannot rule on whether a province has complied with the CHA. Courts have held this is a political rather than a legal matter, and that the ramifications of non-compliance with the CHA must be determined by the federal cabinet and Minister of Health, by possibly withholding cash transfers to a province.

Every province has a taxpayer-funded health insurance plan. Provincial insurance plans are government-run systems that receive money from taxpayers, through premiums, or allocation of government revenue, or both. As a matter of constitutional law, provinces may pass any laws they want about whether there is any government medical insurance and, if so, what its limits are. The coverage under existing government plans is far from comprehensive. Two major gaps that are largely filled by private insurance are the costs of most dental care and medications. About 30 percent of health care costs in Canada are currently paid for by private insurance or directly by patients.

Most, but not all, provinces have laws that ban private medical insurance for services that are covered by government insurance plans. This is because of con-

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ditions that the federal government attaches to its contribution to the cost of health care. Since the late 1950s, the federal government has contributed to medical costs through financial transfers to the provinces. This culminated in the passing of the CHA in 1984. At that time the contribution of the federal government to taxpayer-funded medical costs was about 50 percent of the national total. Currently the contribution is about half that. Clearly, the level of federal financing that provided the political backdrop to the creation of the CHA no longer exists.

Despite this, the federal government continues to tie the provinces' hands by attaching conditions to its financial transfers. Under the CHA, for a province to receive a "full cash contribution" from the federal government, the province's health insurance plan must meet several criteria, including "public administration" and "comprehensiveness." "Public administration" is defined to mean that the provincial health *insurance* plan (*not* the provision of medical care) must be administered on a non-profit basis by a public authority. "Comprehensiveness" is not clearly defined. There is no national standard of what services must be covered by provincial insurance plans.

The CHA also says extra-billing and user charges must not be permitted by a province, or else funding from the federal government may be reduced. "Extra-billing" is charging a patient an amount above what is paid under the province's health insurance plan. "User charges" are any charges by care providers for provincially-insured services. In other insurance contexts, user charges are called "deductibles" and are intended to encourage safety and reduce claims. Imagine if automobile insurers were prohibited from selling collision insurance with a deductible; both the number of claims and the frequency of small claims would skyrocket.

The prohibition of government health insurance deductibles under the CHA does nothing to encourage Canadians to take care of their health, or to promote judicious use of health care facilities and services. This largely explains why health care costs are the biggest single component of provincial budgets. Various analysts have projected those costs will consume between 50 and 70 percent of British Columbia's total annual budget within 10 years. The situation is similar in other provinces as the population ages and treatment becomes more expensive. Such government expenditures are obviously not sustainable. This fact alone makes more reliance on private medical insurance inevitable.

Despite the increasing financial burden that provincial health insurance plans face, where any of the criteria in the CHA are not met by a province, the federal cabinet "may" withhold some or all of the federal cash contribution. Where user fees and extra-billing occur, the federal minister of health "shall" deduct from the federal cash contribution the estimated amount of the user charges or extra-billing.

Some provinces are looking to reduce the cost of provincially-insured medical care by using more efficient, lower cost care providers than those in government-operated facilities. Provinces are able, under the constitution, to pass laws about whether, and to what extent, medical facilities are owned, and health care workers are employed, by government. The CHA does not address this.

The political debate on reforming this system has become interminable. In 2005, the Supreme Court of Canada recognized this government inaction in the *Chaoulli* decision when it acknowledged that citizens have been forced to turn to the courts for relief because governments have failed to provide solutions to growing wait lists. The court also recognized that provinces use wait lists as a rationing system to reduce spending by government health insurance plans.

These facts indicate that more efficient provision of medical care will be necessary in the foreseeable future, and that provincial governments' insurance plans will not be able to afford the growing demand for health care without increasing supplements from private payers. As these realities take hold, the political will to maintain the restrictions in the CHA that stifle effective reform is likely to wane, as will be the willingness and—perhaps even more significantly—the financial ability of provinces to maintain restrictions on private medical insurance. In any event, if governments maintain those restrictions while continuing to fail to pay for or provide timely care, the courts will probably decide the matter for them, on behalf of adversely affected citizens.

Notes

[1]Although Canadian hospitals are legally considered private, not-for-profit entities, they are governed largely by a political process, given wage schedules for staff, are told when investment can be undertaken, denied the ability to borrow privately for investment, told which investments will be funded for operation, and forcibly merged or closed by provincial governments. Thus, they should be considered public hospitals.

[2]In a 2006 paper entitled *Restoring Fiscal Balance in Canada,* the federal government has clearly acknowledged that health care is an exclusive area of provincial jurisdiction.

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Taking Canada's Medical Monopolies to Court

by John Carpay

"Access to a waiting list is not access to health care," opined Chief Justice Beverley McLachlin in *Chaoulli* v. *Quebec (Attorney General)*, arguably the most controversial—and surprising—Supreme Court of Canada decision in recent memory ((*Chaoulli v. Quebec (Attorney General)*, [2005] 1 S.C.R. 791, at para. 123). A majority of the Court ruled that Quebec's prohibition on private health insurance for medical services provided in Quebec's government health system violated the "right to life, and to personal security, inviolability, and freedom" set out in Quebec's Charter of Human Rights and Freedoms. Looking at the experience of dozens of countries around the world that allow private health care while also maintaining a public system, the Court ruled that a prohibition on private health care is not necessary to protect the quality of the public system.

In *Chaoulli*, six of seven Supreme Court Justices agreed that Quebec's ban on private health insurance for necessary medical services violated the right to "life, liberty, and security of the person" found in section 7 of the Canadian Charter of Rights and Freedoms. Unfortunately, these six judges were evenly divided as to whether this violation of the right to life and security of the person is permissible as being "in accordance with the principles of fundamental justice." For this reason, it is not clear whether laws in other provinces, which ban private health insurance and erect other barriers to private health care, violate the Canadian Charter of Rights and Freedoms.

Nevertheless, all seven Justices in *Chaoulli* recognized that the *de facto* government monopoly over health care causes Canadians to suffer—both physically and psychologically—while waiting for medical treatment. All agreed that a law forbidding people to spend their own money on private health insurance also imposes a risk of death, and a risk of irreparable harm to one's health.

Lindsay McCreith of Newmarket, Ontario, is one individual who had access to a waiting list but not to health care. After suffering a mysterious seizure in January 2006, Mr. McCreith was diagnosed as epileptic, and prescribed anti-seizure drugs. His seizures and headaches continued, but he was told that a proper diagnosis with an MRI would not be available until the end of May, 2006. Unwilling to wait for four-and-a-half months, Mr. McCreith paid out of pocket for an MRI in Buffalo, which revealed that his problem was not epilepsy, but a tumour in the frontal area of his brain. In March 2006, doctors in Buffalo performed surgery to remove this brain tumour, which proved to be malignant. In a letter to Timely Medical Alternatives Inc., which arranged for Mr. McCreith's MRI and surgery in Buffalo, Mr. McCreith's own family physician stated that if surgery had been delayed, Mr. McCreith's "astrocytoma brain tumour would have metastasized to the point where he may not have recovered."

The Ontario government now refuses to reimburse Mr. McCreith the $27,600 ($US) he paid in medical costs, as he had not obtained pre-approval for out-of-country surgery. But the pre-approval process would have taken far longer than the four week interval between the MRI and the life-saving surgery in Buffalo. Further, in the absence of an MRI exposing the tumour, there was no guarantee that Ontario would have approved the out-of-country surgery.

Mr. McCreith is contemplating whether to sue the Ontario government.

Shirley Healey of Vernon, British Columbia, faces a similar decision:

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whether to sue the government for reimbursement of the $41,500 she paid for life-saving surgery in Bellingham, Washington. Like Mr. McCreith, Ms. Healey was not prepared to risk her life waiting for pre-approval for her out-of-country surgery, as she had already been "bumped" twice in BC for scheduled surgery to repair a 90 percent blocked artery. By the time she received surgery in the US in October of 2006, her mesenteric artery was found to be 99 percent occluded; a 100 percent blockage is fatal.

One Canadian who has actually proceeded with a court challenge to provincial health laws is Bill Murray, a chartered accountant in Calgary. Mr. Murray suffered from severe and worsening pain in his left hip for over a year before seeing a specialist, who recommended Birmingham hip resurfacing surgery as the best medical option. The Alberta government refused to provide it, claiming that Mr. Murray, at age 57, was too old to deserve or enjoy the benefits of this surgery. Had he been younger than 55, the surgery would have been permitted—subject to the usual long waiting times. In the absence of comprehensive medical insurance (prohibited by law in Alberta and other provinces), Mr. Murray paid out of pocket for this medically necessary treatment. After successful surgery on his left hip, Mr. Murray encountered severe and worsening pain in his right hip. Again a medical specialist recommended Birmingham hip resurfacing. But this time, Alberta government policy went so far as to deny the surgery outright, even if Mr. Murray paid for it himself. He eventually obtained treatment in Montreal, and is now back to an active lifestyle.

In seeking to extend the *Chaoulli* decision outside of Quebec, Mr. Murray claims that Alberta's ban on private health insurance for medically necessary services violates his Charter right to "life, liberty, and security of the person." He also alleges age discrimination, in violation of the Charter's equality rights.

Since the *Chaoulli* decision was issued in June 2005, provinces have continued to deny Canadians the choice of spending their own after-tax money to buy medical care outside of the government's monopoly. Canadians can spend their money on gambling, alcohol, tobacco, and pornography, but not on health insurance (or, in many cases, on private treatment) to provide better and faster access to quality medical care. Canadians can buy medical insurance for their pets, but not for themselves or for their children.

Every day, thousands of Canadians are forced to wait for months, even years, for necessary medical treatment. Even after a court action has been launched, it is still next to impossible for citizens like Bill Murray to learn why, and by whom, decisions are made to ration medical procedures such as Birmingham hip resurfacings. Forced to rely on an inefficient, unaccountable, government-run health care system, these citizens suffer pain, irreparable harm to their health, and sometimes death.

In spite of public opinion surveys showing that a majority of Canadians support the choice of individuals to use their own resources to preserve their own health, many politicians continue to trot out the tired old slogans of "equality," and the alleged need to prevent "two-tier" health care. But "two-tier" is already here: the very wealthy can opt out of Canada's "wait care" system and pay directly for their treatment in the US or elsewhere. Politicians, Workers' Compensation clients, professional athletes, and the well-connected can also skip the queue to receive care immediately. The clichés about "equality" are wearing thin, as more and more Canadians are recognizing that inequality is already entrenched, and that health care delayed is health care denied.

Further, Canadians know that throwing ever more tax dollars at an unaccountable monopoly has not reduced waiting lists. For example, Alberta's provincial government has more than doubled its health spending, which rose from $4.0 billion in 1996 to $10.5 billion in 2006, but waiting lists are as long as ever. Nationally, provincial and territorial health spending is up from $49.1 billion in 1996 to $94.7 billion in 2006 while wait times are hovering near their all-time high (CIHI, 2006; Esmail and Walker with Wrona, 2006).

In *Chaoulli*, Justice Marie Deschamps describes the courts as "the last line of defence for citizens" when governments "have lost sight of the urgency of taking concrete action" and—in spite of numerous promises—fail to find a solution to the problem of waiting lists (*Chaoulli*, para. 96).

These words have proven prophetic in the case of Bill Murray in Alberta, and may well become a reality through other court challenges in British Columbia and Ontario. While some would argue that policy reform should be pursued through the legislature rather than the courts, a dual approach may prove to be effective.

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Compulsory Schooling
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In education, as in other spheres, competition provides this exercise to strengthen the system. By forcing students to stay in school when they see no value to them in doing so, we weaken the system's natural ability to strengthen itself and solve its problems. By replacing competition with regulation we shield educators from the need to exercise their customer satisfaction muscles. Though its results may take a few years longer to show benefits, this strategy is likely to be more effective in the long-term. If Sweden's evidence is anything to go by, it's a strategy worth considering.

Note

[1]The bill pays lip service to the value of educational choices but prescribes regulation and approval of alternative educational choices (such as home schooling and community educational programs) that have never come under provincial scrutiny before. As discussed in a November 2006 *Fraser Forum* article by Deani Van Pelt, this promises to increase the government's interference in private education dramatically, increasing costs to the small community and family education providers.

[2]Ontario Families participating in Children First have an average household income of less than $28,000 yet on average pay $2,500 per child in tuition payments per year.

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The Price of Public Health Insurance in Canada in 2006

by Nadeem Esmail & Milagros Palacios

Canadians often misunderstand the true cost of their public health care system. Part of the explanation stems from the fact that health care consumption is free at the point of use, leading many to grossly underestimate the actual cost of care delivered. Second, health care is financed from general government revenues rather than through a dedicated tax, further blurring the true dollar cost of the service to taxpaying Canadians. In addition, health spending numbers are often presented in aggregate, which results in a number so large that it becomes almost meaningless to the average Canadian. (For instance, $102 billion of our tax dollars were spent on publicly funded health care in 2005/06 (Statistics Canada, Public Institutions Division, 2006).) However, it is critically important that Canadians understand the true costs of their publicly funded health care system. Armed with a more meaningful estimate, Canadians will be able to better assess whether or not they are receiving value for their health care dollars.

A more informative measure of the cost of our health care system can be obtained by calculating health expenditures on a *per capita* basis. The $102 billion presented above works out to approximately $3,170 per Canadian. This is the cost of Medicare (the public health care insurance plan) if every Canadian resident paid an equal share. But some Canadians are children and dependents and thus are not taxpayers, and Canadians certainly do not pay an equal amount in taxes each year. Given the nature of our tax system, higher income earners bear a greater proportion of the tax burden than lower income earners, and thus contribute proportionally more to our public health care system.

Medicare costs approximately $3,170 per Canadian...

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Table 1: Average Income, Average Total Tax Bill, and Public Health Care Expenditure of Representative Families, 2006*

Family Type	Average Cash Income ($)	Average Total Tax Bill ($)	Tax Rate (%)	Health Care Insurance ($)
Unattached Individuals	31,018	13,576	43.8	3,070
2 Parents, 0 Children	78,848	39,357	49.9	8,899
2 Parents, 1 Child	90,373	39,676	43.9	8,971
2 Parents, 2 Children	97,454	43,382	44.5	9,809
1 Parent, 1 Child	38,981	13,564	34.8	3,067
1 Parent, 2 Children	38,637	12,089	31.3	2,734

*Preliminary estimates
Sources: The Fraser Institute's Canadian Tax Simulator, 2007; Statistics Canada, 2005; Statistics Canada, Public Institutions Division, 2006; and calculations by authors.

Table 2: Average Income, Total Tax Bill, and Public Health Care Expenditure in Each Decile, 2006*

Decile	Average Cash Income ($)	Average Total Tax Bill ($)	Tax Rate (%)	Health Care Insurance ($)
1	10,845	1,600	14.8	362
2	22,244	4,604	20.7	1,041
3	30,377	9,076	29.9	2,052
4	38,106	14,533	38.1	3,286
5	47,059	20,507	43.6	4,637
6	58,446	25,941	44.4	5,865
7	71,169	32,692	45.9	7,392
8	87,475	41,053	46.9	9,282
9	109,450	52,530	48.0	11,877
10	204,954	116,859	57.0	26,423

*Preliminary estimates
Note: Deciles group families from lowest to highest incomes with each group containing ten percent of all families. The first decile, for example, represents the ten percent of families with the lowest incomes.
Sources: The Fraser Institute's Canadian Tax Simulator, 2007; Statistics Canada, 2005; Statistics Canada, Public Institutions Division, 2006; and calculations by authors.

In order to determine a more precise estimate for the cost of Medicare for the average Canadian family in 2006, we must determine how much an average family is expected to contribute (in taxes) to all three levels of government. The percentage of the family's total tax bill that pays for public health insurance is then assumed to match the share of total government tax revenues (including natural resource revenues) dedicated to health care (22.6 percent in 2005/06 (Statistics Canada, 2004; 2006; and calculations by authors). Table 1 shows six Canadian family types, the average income for these family types in 2006, and their dollar contribution to health care.

In 2006, the average unattached individual (earning slightly more than $31,000) paid approximately $3,070 for public health care insurance. An average Canadian family with 2 parents and 2 children (earning a little less than $97,500) paid a little more than $9,800 for public health care insurance.

Table 2 breaks down the Canadian population into ten income groups (deciles) to show what families in various income brackets will pay for public health care insurance in 2006. According to this calculation, the 10 percent of Canadian families with the lowest incomes will pay an average of $362 for public health care insurance a year. The 10 percent of Canadian families who fall into the fifth decile (earning an average income of $47,059) will pay an average of $4,637 for public health insurance. The top ten percent of income earners in Canada will pay a little more than $26,420 per family in 2006.

The costs of public health care insurance presented in tables 1 and 2 are a clear departure from the per capita figure of $3,170 given earlier. Our hope is that these figures will provide Canadians with a clearer picture of just how much they pay for public health care insurance. With a more precise estimate of what they really pay, Canadians will be in a better position to decide if they are getting good value for the money they spend.

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Swiss Lessons for American Health Care: More Cheese with Fewer Holes

by John R. Graham

The notion of what constitutes "universal" health care has been evolving in the United States. It previously tended to refer to Canadian-style, single-payer, government monopoly provision of so-called health "insurance." (It still does, according to worthies such as the Physicians for a National Health Plan and the ever-present Drs. Himmelstein and Woolhandler, who frequently launch tirades against private choice from the august platform of the *New England Journal of Medicine.*) Lately it has come to mean compulsory private health insurance, paid for by both employers and employees.

You are no doubt familiar with America's shame: 46 million health uninsured residents in 2005, an increase of 1.3 million over the previous year. The statistics on the uninsured are one of the key drivers behind the push for universal health insurance coverage in the United States, a push that has become the key issue in the US health policy debate.

For the record, this number has more holes in it than a slice of Swiss cheese and is not an accurate reflection of the number of people that go without access to health insurance. For example, many of the "uninsured" (including children) have access to publicly funded health insurance but have not enrolled, while others have incomes several times the federal poverty line suggesting that they could afford insurance if they wanted to. It is more likely that a lot of these people make risk-conscious decisions about whether or not to have health insurance each year, and act rationally when opting out—because government policy often makes it possible to get insured *after* becoming sick (Goodman, 2005)! So there is no permanent underclass of 46 million without access to health insurance—a more realistic estimate is likely somewhere in the low- to mid-20s. In addition, no American goes without treatment when the situation is really serious: it is illegal in all 50 states for a hospital or a doctor accepting any public funding for care to refuse emergency medical care to a patient.

That being said, there are still many Americans who don't have health insurance because their incomes are so low that they cannot afford the premiums but are high enough that they don't have access to the public insurance scheme for low-income Americans (Medicaid).

America in a parallel universe: the food safety net

Nevertheless, this "crisis" of the uninsured has led many policy makers to accept a diagnosis of American health care that is a half truth, at best: that the uninsured crowd into hospital emergency rooms for which other people must pay. At first glance, this is a reasonable belief.

Suppose that Americans ate meals the way they receive health care. Restaurants would claim that they are suffering a financial crisis caused by uninsured guests who, every year, take up more and more of the tables in the finest dining establishments in the state—and leave when the checks arrive.

Insured guests are a mixed blessing: paying, on average, only about an eighth of their bill as "co-payments," they are extremely receptive to the waiters' suggestions to buy more expensive bottles of wine, order the filet mignon instead of the flank steak, and always have dessert and coffee. Of course, this leads to a lot of time and paperwork wasted with the insurance plans, who continuously demand justification for such extravagance.

This bureaucracy has resulted in much higher prices since the bad old days

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when people were expected to pay for their own meals. However, the food insurers manage to keep raising their premiums, helped out by the fact that people who receive food plans from their employers get them tax-free. So, while most Americans know that food spending is going up "unsustainably," they're pretty happy as long as they're "covered," and the restaurants still get paid.

However, the uninsured are becoming a problem. Faced with the prospect of seeing millions of food uninsured starving, the government passed a law ordering restaurants to seat anyone who walks in the door and serve them a meal—whether or not they can pay for it.

People have come to believe that these folks, many of whom could afford to pay for a meal (especially if they bought groceries at the supermarket for lower prices, rather than waiting until they got too hungry to cook and went to the nearest restaurant), are creating a crisis.

Egged on by the restaurants and the food insurers, the governor and legislators of both parties hit upon a plan: *compulsory* food insurance! Surely, a citizen who has the means to buy food, but chooses to get it "free," is acting irresponsibly.

The "solution," gaining ground in both right- and left-wing circles, is to force every American to have health insurance, whether they want it or not. Massachusetts has recently passed such a plan on the grounds of personal responsibility.

Swiss seduction

Among conservative circles, support for mandatory private health insurance has grown, apparently because of Switzerland's experience. Harvard Professor Regina Herzlinger has described the Massachusetts reform plans favorably in the light of Switzerland's experience (Herzlinger, 2006). The author does not unequivocally support compulsory insurance mandates, but thinks it makes sense as a step in the right direction for American health care. This policy proposal is now respectable enough that politicians too numerous to count are putting forward versions thereof, including California Governor Schwarzenegger, New York Governor Spitzer, and the Chairman of the US Senate Finance Committee, Senator Wyden.

Switzerland is attractive because, while it mandates the purchase of health insurance, the state does not provide health insurance directly. Rather, competing plans supply the insurance, with state support for low-income residents. Therefore, conservatives rightly prefer this to a tax-funded government monopoly where competing private insurance is forbidden (as in Canada) or a tax-funded government service that high-income people can buy their way around (as in Britain).

The Fraser Institute's Nadeem Esmail has advocated moving Canada's single payer system in such a direction (Esmail, 2006). Though I agree that removing health resources from direct government control to competing private insurers is a fine way to move away from near-complete government monopoly, the unique context of American health care demands a different response than simply mandating the purchase of private health insurance, *á la Suisse*, in order to achieve so-called "universal health care."

Professor Herzlinger notes that health care in Switzerland costs much less than in the US and that people's health status is at least as good, even when comparing "apples with apples" (i.e., by taking account of confounding factors such as ethnicity, household income, population density, and education, which many other studies have failed to do) (Herzlinger, 2004). Fair enough, but Americans enamored of the Swiss system should be aware that it has characteristics other than compulsion that likely better explain its relative value for money. Adopting these other characteristics could make health insurance more affordable for many more Americans. Such more affordable options would encourage many people to buy coverage voluntarily, thus not requiring a law to compel them to do so.[1]

The key differences that Americans must understand are:

- The Swiss tax code does not punish people for buying health insurance directly as individuals as the US code does (i.e., insurance purchase in the US is tax deductible only if purchased by an employer on behalf of employees), so the Swiss are free to buy health insurance in a robust and competitive individual market. This means the Swiss are able to keep one health insurance policy, if not literally from "cradle to grave," at least from "graduation to grave," rather than switching insurers when they switch jobs. As a result, Swiss insurers have superior incentives to American insurers and are better able to price the risk in their plans than are American insurers.
- The Swiss government does not order its residents out of private insurance and into a government program when they turn 65, like the American government does. This reinforces the superior incentives discussed above.
- Swiss insurers have long had the freedom to levy higher deductibles and co-payments than has been practical in the US. American laws and regulations have, until recently,

inhibited the availability of such plans to most people. Our traditionally low deductibles and co-payments have led to "over insurance" and massive over-consumption of health care resources (Finkelstein, 2005).

However, Switzerland also still suffers from over-regulation, leading to a similar public dialogue as in the US. Some people think that costs have increased too much and are now too high (11.5 percent of Gross Domestic Product in 2003). This has resulted in two competing propositions: one for a government agency to take over as single payer and eliminate private insurers, and one to lower insurance premiums and deregulate the contracts between the insurers and providers (e.g. hospitals) to make that market more competitive (Herzlinger, 2004; Universà de la Svizzera Italiana, Lugano, 2005a, 2005b).

While the US federal government, along with some states, has taken small steps to allow Americans greater choice in health insurance, those choices are still unacceptably limited. Americans would be better served by deregulation of health insurance and hospitals, allowing Americans universal choice in health care. That would be better than forcing citizens into a system that is obviously not serving their needs (judging by the reality that many Americans choose to self-insure and not purchase tax-deductible insurance). The greater choice and better value that come from greater competition would likely increase voluntary health insurance coverage in the US. Then the core problem is isolated and can be dealt with directly: access for those who are still too poor to purchase insurance voluntarily (though they would be fewer in number if insurance were more accessible generally) and still too well off to be covered by government programs in place today.

Note

[1]Those who really do not want to be insured, whatever their income, will likely find a way around any mandate. For example, although automobile insurance is mandatory in all but three states, one in seven drivers on American roads remains uninsured (Scandlen, 2006).

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Electronic Health Records Strategy Needs a Second Look

by Gordon Atherley

Canada Health Infoway (Infoway), a government-owned charity that invests in health information systems across Canada, was a "strategic response" to needs expressed by Canada's First Ministers in September 2000. What the ministers wanted was "infostructure." At the start of 2007, the strategy seems elusive, so a fresh look is timely.

In 2002, Infoway persuaded the Romanow Commission that the electronic health record (EHR), a theoretical construct that contains all of the health information and medical history for each unique individual in Canada, would modernize Canada's health system and thereby improve access and outcomes for Canadians (Commission on the Future of Health Care in Canada, 2002, pp. 111-114). The Commission responded that Infoway should be responsible for developing a pan-Canadian electronic health record framework.

Infoway's target is to have an interoperable (interlinked) EHR in place for 50 percent of Canadians by the end of 2009.

A cameo of the EHR's progress comes from the June 2006 Canadian information technology experts' conference that debated whether physicians should be forced to use EHRs. Pat Rich (2006), a reporter for the Canadian Medical Association, viewed the conference as a demonstration of the frustration surrounding the lack of progress with the EHR. She reported one expert's assertion that the approach to the EHR isn't working, and that its use across Canada is either minimal or nonexistent. One attendee reminded the audience that it is impossible to mandate something that does not exist.

In contrast, the *electronic medical record,* the electronic derivative of the chart that every physician and all hospitals keep internally on every patient, is making headway and being implemented in a number of settings by health care practitioners and commercial vendors.

In the government's vision, millions of EHRs housed in massive, interlinked computer systems would be accessible from almost anywhere by anyone given authorization by the government or agency operating the systems. To make the vision work, patients could not opt out.

Opting out of EHRs

But opting out caused the English government's grand scheme for 50 million EHRs to stumble. After months of adverse media (see, for example, *The Guardian*, 2006), a November 2006 poll found that 53 percent of patients opposed on privacy grounds to having their data in the government system and that 52 percent of family doctors would refuse to upload data without the patient's specific consent (Dyer, 2006). In late December, in an abrupt U-turn, the government granted patients the right to opt out.

In promoting EHRs, all governments stress the value they place on privacy. For their privacy regulations, they rely on consent by patients to full, partial, or selective disclosure of their personal health information. But these restrictions may not apply to data that the government requires. Consent protects government and other information holders: if you give consent, the information holder is off the hook when your information flows out of your EHR.

Patricia Kosseim, general counsel in the office of the privacy commissioner of Canada, cautions that the consent approach excludes other data protection requirements (Kosseim, 2006). A critical example of the "other requirements" comes from Ontario's provincial auditor general, who warns that, as health care increasingly shares electronic records, the risk "increases that a patient could be misdiagnosed or mistreated if his or her health records have been compromised by those of another individual using the same health card number" (Office of the Auditor General of Ontario, 2006, p. 185).

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Documented or recognized instances of health card abuse include attempts by people not entitled to do so to acquire health care, such as illegal immigrants; the handing out of health cards by health ministry staff to people not entitled to have them; and patients presenting for therapeutic abortion with other patients' health cards. All risk compromise of electronic health records.

The potential for abuse

The potential for abuse and of compromise of EHRs is apparent in the auditor's observation that the number of Ontario health insurance plan cards in circulation exceeds Ontario's population by some 300,000, with addresses located mostly in Toronto or close to the US border.

From first-hand experience, more and more Canadians are aware of credit card fraud. From 1985 to 2005, fraudulent use of VISA and Master Card credit cards increased 994 percent; from 2004 to 2005 alone, by 30 percent (Canadian Bankers Association, 2006).

It is clear that information technology, when applied to human affairs, can pose a threat to individuals. The risk rises with the size of electronic systems and the extent to which they are interconnected.

Documented instances of health care providers abusing patient IDs include physicians, pharmacists, and physical therapists billing for services or medications not delivered to patients. All cases of abuse put the electronic health records at risk.

Canada jumps in

In their enthusiasm, governments in Canada gave special treatment to EHRs: considerable funding, on which surprisingly little comprehensive data exists; and exemption from important safety legislation.

The vulnerabilities of information technology beset the financial services industry... in health care, the same vulnerabilities can result in irretrievable losses of the health and even the life of patients.

The federal government exercises regulatory power pertaining to prescription drugs and medical devices. But nothing equivalent exists for EHRs. Even the federal privacy law is overridden by provincial statutes.

Exemption from important safety legislation needs review because information technology used in health care is the same as the information technology in other sectors. And because of the 40-some years of weaknesses in governments' management of IDs of persons in Canada, no one—certainly not governments—can truthfully assert that health care is immune to information-technology and ID-related threats.

There are several reasons why government strategy should change in 2007. First, there is insufficient protection of personal information, which is a result of people giving their consent for governments and others to manage that information. Second, the public is becoming increasingly aware of the risks that are inherent in information technology. Third, the government has previously failed at administering Canadian identification and information. And finally, there are dangers unique to EHRs (including the chance of inappropriate treatments being delivered as a result of records being compromised).

Furthermore, where is the public discussion of the protections for patients whose records are held within an EHR system? It is unclear whether Canadians are getting the full picture of EHRs.

A study by a US organization, the Commonwealth Fund of New York City, which reported that "[n]early all doctors in… the United Kingdom use electronic medical records" (Schoen, 2006) generated considerable Canadian publicity. But neither the study nor the Canadian publicity which used the study to promote the EHR concept even hinted at the misgivings on the part of English patients and physicians.

The vulnerabilities of information technology beset the financial services industry. The industry can insure consumers and reimburse them for losses that it is unable to protect them against. But in health care, the same vulnerabilities can result in irretrievable losses of the health and even the life of patients. That is why governments across Canada must change their views on EHRs. They must move from their current focus on promotion, which the health care and the vendor community can do more efficiently and effectively than govern-

ment can, to protection—a core responsibility of government.

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Economists Respond to the *Stern Review* on the Economics of Climate Change

by Nicholas Schneider

On October 30, 2006, the UK government released its long-awaited assessment of climate change economics titled the *Stern Review on the Economics of Climate Change*. This lengthy report led by Sir Nicholas Stern, a former chief economist of the World Bank, covers a wide range of topics from impacts and adaptations to economics and policy. But it was the review's main conclusion that received so much attention: "the benefits of strong, early action on climate change outweigh the costs" (Full executive summary, p. i).

Various interests have made similar statements for years, so it wasn't the novelty of the statement but the authority of who said it that caught most people's attention. The statement traveled quickly, making the lead story in newspapers and nightly news shows around the world. The timing of Stern's release was impeccable: one month later, 6000 UN delegates met in Nairobi to discuss the next stages of the Kyoto Protocol.

Stern's recommendations

Stern's conclusion is partly supported by his economic analysis. The review estimates that damages due to climate change may be equivalent to losing around 5 percent of world output (GDP). According to Stern, the 5 percent estimate may increase to 20 percent or more if we allow for the inclusion of non-market impacts (which include supposed impacts on the environment and health), the risks of unnamed catastrophic events,[1] and the use of "equity weighting" that incorporates Stern's belief that the impacts of climate change will fall hardest on the poor.[2] Stern's executive summary of the review, which most news media paraphrased, states that the 5 to 20 percent damage costs occur "now and forever." This state-

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ment is odd since the full report actually states that damages won't reach 5 percent until at least 2075, and the "forever" part incorrectly assumes that humans will never develop ways of coping with future climate change. Regardless, the review lends much support to policy positions advocating severe reductions in greenhouse gas (GHG) emissions by mid-century.

Pressuring for reductions in GHG emissions, the *Stern Review* focuses on a greenhouse gas concentration target of roughly 550ppm CO_2e.[3] Concentrations prior to the industrial revolution were around 280ppm and current concentrations are about 430ppm. In order to achieve the 550ppm concentration target, Stern estimates that the growth in global GHG emissions must peak in the next 10 to 20 years, and by 2050 yearly emissions must be roughly 25 percent below current emissions. Stern estimates that the costs of reducing emissions (called "mitigation") sufficient to achieve the 550ppm target are around 1 percent of world GDP (with a range from -1 to 3.5 percent).

Not surprisingly, the report was applauded by several environmental organizations in Canada who, within hours of its release, prepared press releases of their own, hyping Stern's conclusion along with a few sound-bites from their own staff. These press releases offered no criticisms of Stern's research. Thankfully, however, some experts in the academic community did take an honest look at the *Stern Review* before drawing conclusions. Three prominent climate change economists, Dr. Richard Tol of the University of Hamburg, Dr. William Nordhaus of Yale University, and Dr. Gary Yohe of Wesleyan University, and two economists with expertise in environmental economics, Professor Sir Partha Dasgupta of the University of Cambridge, and Dr. David Maddison of the University of Birmingham, have now publicly released their own independent assessments of the *Stern Review*.[4]

Cost-benefit analysis lacking

Tol (2006a) determined that Stern is selective and biased in his analysis, resulting in over-estimates of climate change damages and under-estimates of emissions reduction costs. To estimate damage costs due to climate change, Stern includes impacts on agriculture, water, disease, weather-related natural disasters, and sea-level rise—all of which is standard practice. However, what isn't standard practice is to "consistently select the most pessimistic study in the literature," (p. 2) as Tol accuses Stern of doing. In one example, Stern uses Tol's own research on the costs of sea level rise but ignores Tol's estimates showing how actions such as building dams and dykes can be very effective in reducing flood damages. Essentially, Stern chose to over-estimate the costs of sea-level rise.

Furthermore, Tol emphasizes that the *Stern Review* does not conduct a formal cost-benefit analysis, despite Stern claiming to have done so. By estimating the costs of mitigation (1%) to be lower than the cost of climate related damages (5 to 20%) readers may have falsely been led to believe that by spending 1 percent on mitigation now, we can avoid risking 5 to 20 percent of world output in climate related damages. This is incorrect, yet even well-known publications such as *Nature* fell for it (Giles, 2006). Even extreme levels of mitigation could only slow future climate change, rather than stopping it altogether. Therefore, spending 1 percent on mitigation as Stern advocates could only reduce the estimated 5 to 20 percent damages by some undetermined amount, but not the whole amount. In contrast to Stern's estimates, Tol (2006b) states that climate change can cause annual damages of around 0.5 percent of GDP rising potentially to 3 to 4 percent next century if nothing is done in response.

In his conclusion, Tol states that the *Stern Review* can be "dismissed as alarmist and incompetent" (Tol, 2006a, p. 4). Being slightly more diplomatic, Nordhaus (2006) offers the encouragement that the *Stern Review* is "worth a few days' study" (p. 4). Nordhaus then presents his criticisms, and shows that Stern's estimates depend critically on the choice of a very low "social discount" rate.

Social discount rate

When costs and benefits occur over time, we often discount the value of future costs and benefits. People do this discounting even if they don't recognize it. When given the choice, most people will choose to receive $1 today rather than $1 a year from now (even adjusting for inflation), thus discounting the value of a future benefit. The same holds for a cost incurred today versus the same cost occurring one year (or one hundred years) from now. This matters a lot in climate change economics. Do we agree that estimated costs and benefits occurring 100 years from now are less of a concern than if the same costs and benefits occur today, or is their value the same? By observing how people make choices in the marketplace between costs and benefits occurring over time, economists can estimate a discount rate. Nordhaus uses 3 percent as the discount rate, whereas Stern uses the much smaller value of 0.1 percent, which is essentially near-zero.

Near-zero discounting means that costs occurring a hundred years from now are discounted much less, which has the effect of magnifying how much we would be willing to spend today in order to avoid losses in the future. Nordhaus illustrates the practical implication of near-zero discounting with a hypothetical example. Suppose some damage due to climate change will result in a loss of 0.01 percent of GDP starting in the year 2200 and continuing thereafter. How much of an investment today would be justified to remove this 0.01 percent damage occurring 200 years from now? The answer is 15 percent of world GDP today—or roughly $7 trillion, to which Nordhaus adds, "this seems completely absurd" (p. 12).

Impoverishing present generations

The figure seems even more absurd considering that future generations are expected to be many times wealthier than we are today. Consumption per capita is currently $7,600 per person on average, and estimated to grow to $94,000 per person by the year 2200 (Nordhaus, 2006). Therefore, by using a near-zero discount rate, Stern has argued for reducing current consumption in order to prevent a decline in future consumption by people who will likely be more than ten times richer than we are today. Nordhaus, therefore, concludes that Stern's recommendations for sharp and immediate reductions in GHG emissions do not survive a discount rate that is more consistent with what is observable in the current market.

Dasgupta (2006) further highlights the practical implications of using a near-zero discount rate and other assumptions built into Stern's economic model by applying a common economic decision. Dasgupta asks what savings rate would be implied by Stern's discount rate assumption, and determines that the answer is 97.5 percent of all current GDP. Dasgupta concludes that a "97.5 percent saving rate is so patently absurd a figure that we must reject it out of hand" (p. 7). Stern's assumptions place such an emphasis on the future that if people actually behaved accordingly, then they would be saving roughly all of their current income and literally impoverishing themselves for the sake of distant future generations. According to the World Bank (2006), the aggregate savings ratio has never risen even to 30 percent in Canada over the last 40 years, which suggests that Stern's assumptions do not match reality.

Sensitivity analysis absent

The choice of a near-zero discount rate is perhaps the most controversial decision that Stern made in his analysis. Maddison (2006) recommends that the *Stern Review* should have used a range of discount rates, as is common in economic analysis, and should have conducted a sensitivity analysis to determine how the choice of different discount rates affects the results. Maddison also cautions that Stern used only one Integrated Assessment Model (IAM) and only one scenario of the future world economy, when in fact there are many others available. In 2000, the IPCC published a report (Nakicenovic and Swart, 2000) providing several hypothetical scenarios about the future state of world population, economic development, and greenhouse gas emissions, yet Stern chooses only one of the scenarios as input into his one model. Using only one model and one scenario leaves the potential that many of the results are influenced solely by the choice of the model and the scenario. Maddison concludes that there is much in the *Stern Review* that can be endorsed, but due to "errors, questionable judgement, and inconsistencies" it is "unclear whether the Stern report provides an economic rationale for the measures it recommends" (p. 9).

... if people actually behaved accordingly, then they would be literally impoverishing themselves for the sake of distant future generations.

Yohe (2006) performs the sensitivity analysis that Maddison recommends. Yohe determines that Stern's estimates do in fact rest largely on the choice of a near-zero discount rate. Substituting 1 percent as the discount rate instead of the rate Stern uses (0.1%) results in the estimated damages decreasing by 60 percent. Using a 2 percent discount rate decreases the estimates another 20 percent and a 3 percent rate decreases the estimates another 15 percent. Overall, a 3 percent discount rate results in estimated damages that are only one-tenth to one-fifth what Stern estimates, substantially lowering the 5 to 20 percent ("or more") damage estimates that Stern reports.

Yohe also makes a similar claim to Tol, in that spending Stern's recommended 1 percent on mitigation will not actually eliminate the 5 to 20 percent estimated damages due to climate change. Yohe states that achieving the recommended 550ppm concentration target would still leave the anticipated increase in mean temperature somewhere between 1.5C and 4.5C, and therefore, "[s]ignificant portions of the damages reported would therefore persist" (p. 69). To determine the net benefit of spending 1 percent on mitigation would require estimating the resulting decrease in climate-related damages, since it is conceivable that spending 1 percent on mitigation actually may result in less than 1 percent in benefits.

Conclusion

Note that both Tol and Nordhaus recommend reductions in greenhouse gas emissions—just not nearly as much or as fast as does Stern. Yohe also recommends reductions in emissions, but without stating whether the reductions should be larger or smaller than Stern recommends. Nordhaus states that climate policies should involve modest reductions in the near term, followed by sharper reductions in the future when we will be richer and more technologically able to reduce emissions. Many assumptions about climate science are needed for Nordhaus, Tol, and Yohe to reach their conclusions, but I'll leave that debate for another article.

In summary, despite much media fanfare, Stern's estimates will not likely survive critical thinking and academic review. More importantly, the academic debate that has followed the release of the *Stern Review* should remind everyone of the value of critically assessing research before accepting or endorsing it. In the end, the *Stern Review* may contain much information, but as Nordhaus cautions, Stern does not answer the fundamental questions of climate policy which is "how much, how fast, and how costly." Those, and many other questions, are still open to debate.

Notes

[1]Presumably the unlikely shutdown of the Gulf Stream, otherwise called the North Atlantic thermohaline current, or Meridional Overturning Circulation (MOC).

[2]According to Maddison (2006), equity weighting accounts for the marginal utility of money, and results in the same monetary loss counting for more if the loss is suffered by a poor person. According to Stern, the use of equity weighting increases the estimated costs of climate change-related damage by more than one quarter compared to estimates when such weighting is not used.

[3]ppm is "parts-per-million" and CO_2e is "carbon dioxide equivalents."

[4]Shortly before this article was published, two additional, thorough critiques of the *Stern Review* were published in the peer-reviewed journal *World Economics* (see Carter *et al.*, 2006; and Tol and Yohe, 2006). The critiques cover both the scientific and economic aspects of the *Stern Review* and are worth reading, but timing did not permit a summary of the critiques to be incorporated into this article.

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Europe's "Open Skies" Policy Benefits Consumers

by Mark Milke

Few people with any knowledge of European economic policy would recommend the continent as a model to emulate. For decades, too many European countries have practiced a soft version of command-and-control economics where full employment and cradle-to-grave government social programs took priority over productivity, private sector job creation, and wealth expansion. The approach was akin to hoping one's aging jalopy could make it from Vancouver to Los Angeles, but with half a tank of gas and a Lada-style engine.

However, there is at least one continent-wide policy which has been an unqualified success and which the United States and Canada should emulate. Starting in 1987, the European Union began to liberalize airline competition policy, a move that fully blossomed in 1997 when any airline within a member EU state was given the right to full cabotage—the right to pick up and drop off passengers within another member country.

The EU notes that the number of intra-community routes have increased by more than 40 percent between 1992 and 2003, the number of airlines increased by 25 percent, productivity of the main community carriers rose by 87 percent between 1990 and 2002, and low-cost carriers now represent more than 20 percent of the market. Within the European Union, 700 million passengers now travel by plane every year (European Commission, Transport, 2007).

The winners have been consumers who now have access to extremely competitive and inexpensive airlines fares. As the accompanying chart shows, in my mini-survey of five European in-country routes (London to Edinburgh, Paris to Nice, Milan to Rome, Dusseldorf to Berlin, and Barcelona to Madrid), a consumer could buy a return ticket on all five for a total cost of Cdn $461, including taxes and fees. That's less than the cost of *one* Vancouver to Toronto return ticket at $511. (The same assumptions were applied for all flights: 15-day advance booking and a six-day trip beginning on Tuesday and returning on Monday.)

My analysis used Kayak.com for all comparisons, a web site quite proficient at tracking cheap fares. However, even Kayak missed a few fares that were significantly cheaper. For example, Kayak said the lowest fare for Milan to Rome was $92. Actually, the low-cost Irish carrier Ryanair could provide that ticket at $45.75.

To be sure, some European carriers' fares are obvious loss leaders (such as a "zero" fare between Dusseldorf and Berlin by Germanwings). But that's the airlines' problem. The fact is that such loss leaders are unavailable in North America and even without such loss-leading, rock-bottom fares, European airfares are an unquestionable bargain. While critics may argue that Europe's great deals can't be replicated in Canada with its significantly smaller population, they overlook the point that a combined Canadian-American open skies agreement would create a continental market of over 330 million people. At that level, efficiencies and fare cuts become routine.

Slow plane coming: EU-US "Open Skies" and Canada-US "Blue Skies"

As for North America, negotiations and signed agreements on EU-type open skies agreements have been slow to materialize. The US and the European Union tentatively agreed in 2005 to an EU-style open skies agreement. It would allow American and European carriers to pick up passengers in each other's countries and fly them to third destinations (BBC, 2005), i.e., cabotage.

If implemented, the EU-US open skies agreement would mean better results for the airlines by giving them more passengers per flight, among other efficiencies. It would also benefit consumers who would pay lower ticket prices. The EU ambassador to the United States, John Bruton, has estimated that the savings to consumers would amount to $5 billion annually once the agreement was fully implemented (Bruton, 2006).

However, the potential deal was recently stymied by a roadblock in the US—the November 2006 election results which

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Table 1: Europe's "Open Skies" Policy versus North America's Unfriendly Skies

Route	Airfare	Taxes & fees	Best* 15-day advance booking	Airline
North America	**(in US $)**		**(converted to Cdn $)**	
TO- New York	US $180	US $101	Cdn $329	Continental/ US Airways
Vancouver-San Francisco	US $254	US $107	Cdn $422	America West
Calgary-Denver	US $216	US $93	Cdn $367	United/Northwest
Montreal-Miami	US $185	US $78	Cdn $308	American Airlines
Halifax-Boston	US $281	US $96	Cdn $441	Delta/Continental
Canada: in-country	**(in Cdn $)**		**(in Cdn $)**	
Calgary-Victoria	Cdn $184	Cdn $86	Cdn $270	WestJet
Toronto-Vancouver	Cdn $403	Cdn $108	Cdn $511	Harmony
Halifax-Montreal	Cdn $254	Cdn $131	Cdn $385	WestJet
Vancouver-Montreal	Cdn $368	Cdn $114	Cdn $482	WestJet
Winnipeg-Regina	Cdn $138	Cdn $85	Cdn $223	WestJet
Route	**Airfare**	**Taxes & fees**	**Best* 2-week advance booking**	**Airline**
Europe	**(various currencies)**		**(converted to Cdn $)**	
London-Paris	UK £20	UK £56	Cdn $174	Air France
Dublin - Berlin	N/A	N/A	Cdn $185	Ryanair/Air Lingus
Munich- Rome	€10	€80	Cdn $105	Condoi Flugdienst
Vienna - Athens	US $220	US $86	Cdn $358	Alitalia
Prague-Barcelona	US $141	US $71	Cdn $248	Czech Air
Europe: in-country	**(various currencies)**		**(converted to Cdn $)**	
London-Edinburgh	UK £11	UK £24	Cdn $80	Ryanair
Paris-Nice	€34	€40	Cdn $112	EasyJet
Milan-Rome	N/A	N/A	Cdn $92	Blue Panorama
Duseldorf-Berlin	€0	€58	Cdn $88	Germanwings
Barcelona-Madrid	€46	€13	Cdn $89	Vueling

*Total best return fare (taxes and fees inc.)
Flight prices from from Kayak.com and breakdowns from the airline. Booked 15 days in advance for travel on January 30, 2007 to February 5, 2007.
Total best return airfare calculated using currency conversion on January 14, 2007. Bank of Canada calculator.

gave Democrats, the more protectionist party, a majority in the House of Representatives and Senate. Their win was unhelpful to prospects of greater liberalization in the skies.

In Canada, in November 2006, the new Conservative government announced a "Blue Sky" policy to liberalize air transport between Canada and other countries. The mildly reformed policy noted that future open skies agreements would include: more open markets; no limits on the number of airlines permitted to operate or on the frequency of service or aircraft type; and unrestricted services to and from third countries, among other reforms (Transport Canada, 2006).

Problematically, however, the new government pointedly rejected EU-style open competition, stating that "Under no circumstances will the policy approach include cabotage rights—the right for a foreign airline to carry domestic traffic between points in Canada" (Transport Canada, 2006, p. 3).

Perhaps the federal government thinks Canadian airlines are unable to compete head-to-head with American and European countries. But such a misguided policy neglects the reality that if a cabotage policy is reciprocal Canadian airlines could then tap US and the European Union markets to service their domestic market; Canadian airlines have as much to gain as any in other countries.

Canada-EU prospects

In contrast to Canada's stated policy restrictions, in early January 2007, the EU released an official communiqué with regards to a potential EU-Canadian open skies agreement, one much more optimistic and aggressive than Canada's Blue Sky version. The EU noted there are now 17 bilateral agreements between Canada and the EU, but that "The existing air services agreements between the EU member states and Canada do not allow airlines, passengers, and shippers to take full advantage of the benefits of open markets" (Commission of the European Communities, 2007).

As the EU points out, while American transborder passenger traffic accounts

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Accountability in Ontario's Hospitals

by Rena Menaker

Late in 2006, the *Toronto Star* asked a very interesting question: why can't Ontarians compare or assess the quality of care inside their province's hospitals? Indeed, while The Fraser Institute's recently released *Hospital Report Card: Ontario 2006* provided a direct comparison of the care inside Ontario's acute care hospitals, only 43 out of a total of 136 hospitals allowed their names to be published alongside their results. The other 93 decided that they would rather not be held accountable for their performance.

While many critics claim the report is "useless" for patients and the public because only about ⅓ of the province's hospitals are named, others like the *Toronto Star* have latched on to the more important issue at hand: although The Fraser Institute's report compares the quality of care in all of Ontario's hospitals—a first for Canada—almost ⅔ of Ontario's hospitals did not want to be accountable for their performance!

The Fraser Institute's report employs a methodology for reporting on hospital performance developed by the United States Department of Health and Human Services' Agency for Health Care Research and Quality (AHRQ). This same methodology is widely used and currently accepted as the standard approach to measure hospital performance in over a dozen US states including New York (Alliance for Quality Health Care and the Niagara Health Quality Coalition, 2006), Texas (Texas Department of State Health Services, 2006), Florida (Agency for Health Care Administration, 2005), Oregon (Oregon Health Policy Commission and the Office for Oregon Health Policy and Research, 2005) and Colorado (Colorado Health and Hospital Association Performance and Quality Group, 2005). The Manitoba Centre for Health Policy also recently used the AHRQ methodology in a report on Manitoba's hospitals (Manitoba Centre for Health Policy, 2006).

So, if a hospital's anonymity cannot be explained by concerns over the calibre of the report's methodology, what can explain it?

The report's findings shed some light on the answer. *The Fraser Institute's Report Card on Ontario's Hospitals* included a summary measure of death rates, known as the Hospital Mortality Index or HMI. The HMI was created to allow for an examination of the overall performance of a hospital relative to other hospitals in Ontario across nine measures of mortality. Looking at the average rankings for Ontario's hospitals from 2002/03 to 2004/05, one point becomes clear: hospitals that perform poorly are less likely to be named.

Specifically, six of the top 20 ranked hospitals were not self-identified in the report. On the other hand, only 1 of the bottom 20 hospitals was named. This means that 19 of the bottom 20 hospitals chose not to be held accountable for their performance on these measures.

In Canada, individuals can research any problems they have with their automobiles or home stereos from information willingly supplied by consumers, the manufacturer, and industry experts. Yet when it comes to health care, consumers have been left with remarkably little information about where the best services are available, and many hospitals (particularly those with low HMI rankings) seem to want to keep it that way.

At a time in the information age when new Canadian privacy legislation has been written to increase the public's access to information, are residents of Ontario willing to accept this? Do Ontarians think it is acceptable to know which compact car on the market is the safest in a collision, but to not know if they are more likely to be harmed or die at a local hospital versus another one up the road? The majority of Ontario's acute care hospitals, funded through tax dollars and delivering care to residents through a government program, would rather not have the public be able to access information to decide whether they should be going to hospital x, y, or z.

At the same time, Ontarians should applaud the 43 hospitals that agreed to be identified in The Fraser Institute's report, for their efforts to empower patients with information regarding the health care they receive and for their

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ongoing commitment to quality improvement through accountability and transparency.

Public reporting does indeed make hospital care better for all. Outside of Canada, reports like that published by The Fraser Institute have had a number of measurable impacts on performance and the quality of patient care. A notable example comes from New York State, where a 41 percent decrease in the death rate in patients undergoing bypass surgery followed the publication of performance on this surgery (Hannan *et al.,* 1994). Pennsylvania and New Jersey experienced a similar overall trend following the publication of their report cards.

The Fraser Institute will continue to publish its *Hospital Report Card*, in Ontario and in other Canadian provinces. We believe that our report will contribute to the improvement of Canada's acute care hospitals by providing detailed and objective performance measurements directly to patients and to the general public. Whether or not more hospitals will agree to be identified will depend on the public's interest in holding their hospitals accountable.

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for half of incoming Canadian passengers, EU passenger traffic accounts for 27 percent of Canada's passenger volume. Also, the European component of our travel volume is increasing faster than either the US pool or the domestic Canadian market.

Between 2000 and 2005, European-Canada passenger volumes almost doubled. In other words, the EU and Canada should be a high priority for each other given such already significant and increasing flows. In the first year of more open markets, the EU estimates an additional half-million new passengers would be added to current passenger flows, producing 3,700 new jobs in the EU and Canada, and that consumers would save 72 million Euros in that year alone (or about Cdn $108 million).

By year five, the EU estimates 9 million new passengers would fly between Canada and the EU annually; that would be in *addition* to the 8.5 million passengers that flew between EU countries and Canada in 2005 and bring total EU-Canada passenger volumes to 17.5 million passengers annually. (In comparison, US-Canada transborder traffic amounted to 18.6 million passengers in 2005.)

Whether with the EU or the US, the potential benefits for Canadian travelers—and Canadian airlines—from greater and guaranteed access to markets and airlines from other countries is significant. Canada's new government should indeed seek fully open skies, but that also includes dropping its no-cabotage policy.

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Let's Celebrate Our Successful Educators

by Peter Cowley

On November 8, 2006, school teams—teachers, principals, and support workers—representing 50 elementary and high schools from across Alberta gathered at the Fairmont Palliser in Calgary to be honoured for their outstanding achievements. They were recognized for improving their students' academic results and for helping them achieve at levels far beyond that which the statistics might lead us to expect. It was an inspiring celebration of success. Over 250 educators attended the *Garfield Weston Awards for Excellence in Education* celebration dinner. They came from big schools in Edmonton and Calgary, and from small schools in towns like Manning and Bruderheim. They practice their profession in public schools and private schools. Some serve kids with a great many advantages, while others serve children who don't know where they'll sleep that night. But they all have something in common: they are determined that all kids can and will learn.

No one wanted to miss the party. Indeed, representatives from two schools drove for nearly 10 hours just to be part of the celebration. Why did so many go to such lengths to be there? Surely not just for a little bubbly and a decent meal. The answer, I believe, is obvious. They are proud of their work and they are happy to have their success publicly acknowledged. Educators across Alberta recognize the importance of celebrating success as one way to encourage their students to do their very best. It works for students and it works for the rest of us—including those who teach our children.

Certainly, these educators have every reason to be proud. The awards aren't part of a popularity contest. Instead, careful analysis of the same data upon which The Fraser Institute's report cards on Alberta schools are based identified the schools that achieved the highest results in two categories of academic performance: "Improvement in academic results" and "Academic achievement in excess of expectations."

When it comes to improvement, it really doesn't matter where you start. Indeed, some of the schools whose staff were honoured in this category have had very low academic performance levels, and even now are still performing below the average for the province. But their improvement during the five school years from 2000-01 through 2004-05 has been dramatic. There is not much more that you can ask of any school team than that every year it finds new ways to help the kids do better. The teams recognized for "Improvement in academic results" have risen to that challenge.

It is sometimes argued that success at school has more to do with how rich the students' parents are than with what happens in the classroom. Indeed, our analysis confirms that academic performance is, to some extent, predicted by family income. However, the school teams honoured for "Academic achievement in excess of expectations" have proven that kids whose parents are not high-income earners can still do very well at school. Their results greatly exceeded that predicted by the income of the school's parents in each of the years 2002-2003 through 2004-2005. Schools can make a difference and, at these schools, the difference is substantial.

The Weston Awards can have a positive impact on every school. Celebration of success is satisfying and fun, so this year's finalists will want to find a way to return to the podium next year. Schools awarded an honourable mention might ask themselves what they need to do to join next year's finalists. For those schools that were not recognized this year, the awards offer hope and encouragement by demonstrating what can be accomplished and by offering the prospect of public celebration when they are successful. As one of last year's winners told us, "the other high schools in my district would love to be here in my place next year."

In the end, the Weston Awards will benefit Alberta's students the most. When teachers and administrators enthusiastically embrace friendly competition between schools and public celebration of their success, students reap the benefits as educators intensify their efforts to ensure even greater levels of student success. Congratulations to all the school teams honoured. They deserve the accolades.

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