

# Going Canuck

BY MARNI SOUPCOFF

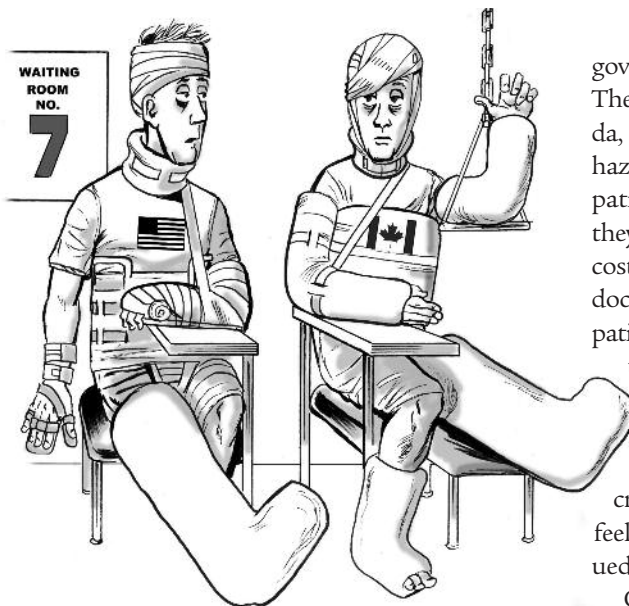
**N**ow that you Americans are looking for a new health-care model, you may be thinking about “going Canuck,” by which I mean trying a single-payer system like the one we have here in Canada, not wearing maple leaf underwear — or a maple leaf in lieu of underwear. I know you’ve heard about our family doctor shortages and wait lists, but goodness, how glorious it is not to have to do any paperwork after seeing a doctor or visiting an emergency room. For anyone who’s ever muttered the words “I’d rather die than fill out another insurance form,” ours just may be the plan for you.

Still skeptical? Well, all right, maybe Canada doesn’t have all the answers. But don’t tell me you don’t have your own problems. I read the article by David Goldhill in last September’s *The Atlantic* about how American health care killed his father. What struck me most about what Goldhill wrote is that your system seems like it’s awful in many of the same ways that our system is awful.

The common terribleness of our health schemes is not something Americans and Canadians tend to dwell on. We are usually too busy pointing out the differences: Americans have HMOs, Canadians don’t. (Advantage Canadians.) Americans have ready access to CAT scanners and MRI machines, Canadians don’t. (Advantage Americans.) While in the throes of a catastrophic illness, a lower-middle-class American will spend more time worrying about going bankrupt than about getting well. In the throes of a catastrophic illness, a lower-middle-class Canadian will spend more time worrying about whether he’d be getting better care in Boston than about getting well. (Push.) You get the idea.

Yet consider this: Goldhill, who’s a Democrat, thinks that no matter what reforms Obama and company make, they won’t do any good unless Americans learn to “rely more on ourselves, the consumers, as the ultimate guarantors of good service, reasonable prices, and sensible trade-offs between health-care spending and spending on all the other good things money can buy.”

In other words, the problem lies not with who’s insured or what’s covered, but with placing all the power in the hands of one or a few bureaucratic entities (insurance companies and/or



government) instead of consumers. The theory applies equally to Canada, where we have the same moral hazard problem that you do. Since patients don’t pay their own bills, they pay little, if any, attention to the cost of their treatments. And since doctors and hospitals aren’t paid by patients, they have no reason to cater to them or try to win their favor like they would if they were competing for them as customers. The result is costly, crummy care that makes a person feel more like a beggar than a valued client receiving a service.

Goldhill devotes much of his article to preventable hospital-borne illnesses, which is understandable since that’s what killed his father. If I were to write a similar article, I’d highlight some other problems that I’ve witnessed in both Canada and the United States: lengthy emergency room waits with no pain killers for the broken-limbed; delayed and botched lab results; week-long stays in the ER because no beds are available in real hospital rooms; nurse call buttons unanswered; nurse call buttons answered by surly and overstretched nurses; misdiagnoses; lost records; broken diagnostic equipment; and months-long waits for tests and specialists. And I’ve witnessed these as a healthy person under 40 with a decent ability to be my own patient advocate — imagine the experience of a frail, frightened 70-year-old.

We put up with this poor treatment only because we have no choice. I emphasize “choice,” since this is something that my fellow Canadians tend to assume Americans have more of in the health arena. But having lived in both countries, I know that Americans really don’t have much choice in health care. You’re locked into government programs, or whatever private plan your employer has chosen for you, or whatever few direct-purchase plans your state regulators have approved and allowed to be viable.

So should you make your system more like Canada’s? Go ahead. Or don’t. It doesn’t really matter. Both countries have such serious problems with quality and cost (Canada’s is more with quality, while the U.S.’s is more with cost, but essentially the two nations share the same troubles) that worrying about coverage is pointless until the heart of the mess is addressed: patients need more power. And to get it, they’re going to have to start paying more of their own bills themselves.

It’s nasty-tasting medicine, but it’s the only way to cure a disease that knows no borders. **R**

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