

# How Socialized Medicine Hurts Canadians and Leaves Them Worse Off Financially

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## KEY TAKEAWAYS

Every American should have access to low-cost, high-quality health care. The Canadian experience demonstrates that government-run health care is not the answer.

Canadians pay up to 51 percent more in taxes, yet out-of-pocket health costs are close to Americans', even though Canada covers only marginally more than the U.S.

Government rationing has left Canadians with months-long waiting lists for urgent care, endemic staff shortages, substandard equipment, and outdated drugs.

The Canadian health care system is frequently used as a model by Americans who advocate putting the government in charge of health care. As Senator Bernie Sanders (I-VT) put it: “In Canada, for a number of decades, they have provided quality care to all people without out-of-pocket expenses. You go in for cancer therapy, you don’t take out your wallet.”<sup>1</sup> In reality, Canadians suffer similar out-of-pocket burdens as Americans, while paying far higher taxes and receiving lower quality of care. Months-long waiting lists for urgent care, substandard equipment that would embarrass Turkey,<sup>2</sup> years of delay on life-saving drugs, and widespread capacity shortages have all become hallmarks of the Canadian health care system.

One major reform proposal endorsed by a majority of Democrats in the House of Representatives, known as Medicare for All, would outlaw<sup>3</sup> private coverage

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except for elective procedures like plastic surgery, and in its place would establish a government-run program to provide all U.S. residents with coverage across the board, including for hospitalization and doctor visits; dental, vision, and hearing care; and long-term care.<sup>4</sup> The plan would require no co-payments or fees, as all care would be funded by the government through taxes or public debt. The plan would specifically ban private insurance plans from providing the same benefits as public coverage, forcing all Americans onto the public plan.<sup>5</sup>

As proposed, Medicare for All is far more extensive, and far more distortionary, than even Canada's current system. It is worthwhile, then, to explore the problems that Canadian patients and Canadian taxpayers have come to face.

## Who Pays for Health Care in Canada?

Like the U.S., Canada's health care system is funded by a mixture of public and private insurers. These insurers pay for care that occurs at a mixture of private and public providers. Canada's mandatory public insurance covers most of two types of medical cost—hospitals and physicians' offices—which together make up about half of all medical expenses in Canada. For these categories, public spending covers 90 percent of hospital costs and 98 percent of doctors' offices costs.

For the remaining half of health costs, private spending makes up the majority of spending, paid either by private insurance or paid out of pocket by the patient. This includes pharmaceuticals (16 percent of total spending in Canada); "other institutions," including nursing homes and long-term care (11 percent of total spending); and "other professionals," including most vision and dental care, physical therapy, hearing aids, physiotherapy, and psychological treatment (11 percent of total spending).<sup>6</sup> Spending in the U.S. is distributed similarly, with hospitals and physicians totaling 53 percent of health care spending, while 10 percent of spending goes to prescription drugs, 5 percent to nursing home care, 3 percent to home health care, 4 percent to dental care, and 27 percent to "other" health care.<sup>7</sup>

For that half of health spending that occurs outside hospitals and physicians' offices, public spending in Canada covers just 36 percent of pharmaceutical spending, 70 percent of spending on "other institutions," and only 11 percent of spending on "other professionals."<sup>8</sup> So, for that half of medical spending, Canadians must find another way to pay for most care. As a result, 63 percent of Canadians have private

TABLE 1

## Composition of Health Insurance Plans in Canada, U.S.

Category	Canada	U.S.
Private insurance plans	63%	56%
Government comprehensive insurance	35%	36%
No private plan, no government comprehensive insurance	2%	8%

**SOURCES:** Edward R. Berchick, Jessica C. Barnett, and Rachel D. Upton, "Health Insurance Coverage in the United States: 2018," U.S. Census Bureau, November 8, 2019, <https://www.census.gov/library/publications/2019/demo/p60-267.html> (accessed January 7, 2020); and Canadian Life and Health Insurance Association, "Canadian Life and Health Insurance Facts, 2015 Edition," <http://clhia.uberflip.com/i/563156-canadian-life-and-health-insurance-facts/15> (accessed January 16, 2020).

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insurance, similar to the 56 percent of Americans with private insurance,<sup>9</sup> while 35 percent of Canadians and 36 percent of Americans are covered by comprehensive government plans.<sup>10</sup> In both countries, publicly funded comprehensive coverage goes mainly to the elderly and the poor, and in both countries, the government has various programs to proactively seek out and cover both groups. Finally, in both countries, many of these vulnerable populations nonetheless fail to claim benefits, leaving roughly 2 percent of Canadians and 8 percent of Americans uninsured.<sup>11</sup>

Because half of Canadian health care costs are for categories primarily paid privately, private spending makes up 31 percent of total Canadian health care costs (see Table 1), compared to about half in the U.S. Of that Canadian private spending, roughly half is paid by patients out of pocket, and half is paid by private insurers. Equivalent numbers for the United States vary between private spending making up 44 percent<sup>12</sup> and 51 percent<sup>13</sup> of health care costs, of which about one-quarter is paid out of pocket and the remaining three-quarters is paid by private insurers.<sup>14</sup>

Like all "universal" systems, the Canadian health system is only universal in the sense that everybody is forced to join. It is emphatically not universal in terms of what is covered. Proposals like Medicare for All, therefore, are promoting something far larger, in both taxes and in distortions, than what exists in Canada or, indeed, in any developed country including Europe.

TABLE 2

## Canadian Health Care Spending per Capita, 2018

Category	Total Spending per Capita	Private Spending per Capita	% Private Spending
Hospitals	\$1,933	\$194	10%
Physician Services	\$1,032	\$16	2%
Other Professionals (includes dental, vision, other)	\$758	\$676	89%
Other Institutions (includes nursing home, long-term care)	\$768	\$240	31%
Pharmaceuticals	\$1,075	\$686	64%
Other (includes capital budget, public health)	\$1,275	\$311	24%
<b>Total</b>	<b>\$6,840</b>	<b>\$2,124</b>	<b>31%</b>

**SOURCE:** Canadian Institute for Health Information, “How Canada Compares: Results from the Commonwealth Fund’s 2017 International Health Policy Survey of Older Adults in 11 Countries—Data Tables,” <https://www.cihi.ca/sites/default/files/document/cmwf-2017-data-tables-en-web.xlsx> (accessed January 7, 2020).

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## Out-of-Pocket Costs in Canada

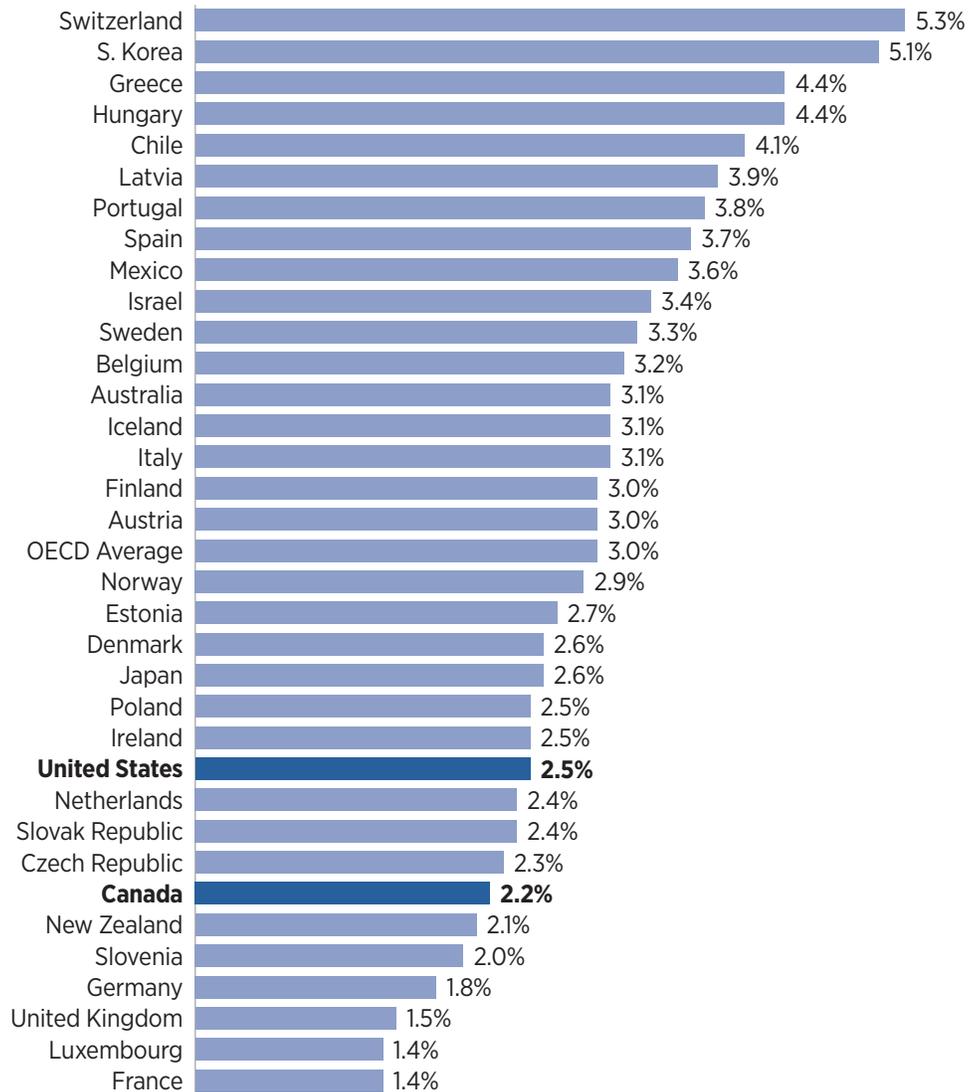
There are several ways to estimate the differences between Canadian and American out-of-pocket health care costs. The Peterson–Kaiser Family Foundation Health System Tracker estimates that, in purchasing-power-adjusted current U.S. dollars, the average Canadian pays US\$690 per year in out-of-pocket medical costs, while the average American pays \$1,103—about \$34 more per month.<sup>15</sup> However, this difference drops by about two-thirds when measured by household income or by gross domestic product (GDP). The Organization for Economic Development and Cooperation (OECD) estimates that Canadians pay 2.2 percent of final household consumption in out-of-pocket medical costs, while Americans pay 2.5 percent—a difference of roughly \$15 per month for the median American household. (See Chart 1.)<sup>16</sup>

Using GDP instead of household income yields similar results; the OECD calculates that Canadians spend 1.6 percent of GDP on out-of-pocket health spending, compared to 1.9 percent in the U.S. The World Bank<sup>17</sup> and the Peterson–Kaiser Family Foundation Health System Tracker<sup>18</sup> make similar estimates, agreeing that Canadians spend 1.5 percent of GDP on out-of-pocket medical costs, while Americans spend 1.9 percent of GDP.

CHART 1

## OECD Out-of-Pocket Medical Spending

AS A SHARE OF FINAL HOUSEHOLD CONSUMPTION



**NOTE:** OECD figures exclude long-term care expenditures.

**SOURCE:** Organisation for Economic Cooperation and Development, "Health at a Glance 2017," [https://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-2017\\_health\\_glance-2017-en](https://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-2017_health_glance-2017-en) (accessed January 7, 2019).

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While these numbers are very close, they are actually getting closer. Since 1970, U.S. out-of-pocket spending as a percentage of total medical spending

has been falling steadily, from 33 percent in 1970 to about 10 percent in 2017.<sup>19</sup> Meanwhile, Canadian out-of-pocket spending has been falling much slower, so that by 2016 it totaled 15 percent of total medical spending—a higher proportion than in the U.S.<sup>20</sup> As a result, Statistics Canada warned in early 2020 that the percentage of Canadians experiencing large out-of-pocket burdens is growing, writing that “[b]etween 1998 and 2009...the percentage of households spending more than 10% of their total after-tax income on health care rose by 56%.”<sup>21</sup>

Out-of-pocket spending in Canada disproportionately hits the poor. In a 2009 report, Statistics Canada<sup>22</sup> estimated that out-of-pocket spending as a percentage of household income is more than twice as high among the lowest-income quintile as among the highest, at 5.7 percent of after-tax income for the poorest one-fifth of Canadian households, and only 2.6 percent for the richest quintile.

Beyond out-of-pocket burdens, Canadians experience other health-care-related stresses familiar to Americans. In a 2015 survey commissioned by the Ontario Securities Commission,<sup>23</sup> 16 percent of Canadians over 50 reported that unexpected medical expenses used up a significant part of their retirement savings, while nearly two-thirds of early retirements in Canada were related to health expenses. The same report found that, despite public coverage, Canadians ages 75 and above have median out-of-pocket costs of \$2,000 per year, including supplementary health insurance premiums and out-of-pocket medications. Of this 75+ population, 69 percent report having to pay rising medical costs by selling off assets, cutting spending on necessities, getting a job, or borrowing money. More broadly, among Canadians ages 50 and above, fully 39 percent report out-of-pocket health costs as a “top concern,” making out-of-pocket costs the third-highest concern after inflation and declining health itself. Specific to drugs, one study in 2018 estimated that 731,000 Canadians per year—between 2.2 percent and 2.8 percent of the population—borrow money to pay for their prescription drugs.<sup>24</sup>

Finally, one key topic in the U.S. health care financial debate has been medical bankruptcy. As one Canadian research study concluded: “It is incorrect to assume that adopting [Canada’s medical] insurance system in the US will have a significant impact on bankruptcy rates. Bankruptcy and a lack of health insurance coverage are both caused by the same thing—a lack of income, which in turn is usually a result of unemployment.”<sup>25</sup> Indeed, a 2006 report commissioned by the Canadian government<sup>26</sup> found that medical reasons were cited as the primary cause of bankruptcy for approximately 15 percent of bankrupt Canadian seniors ages 55 and above, higher than some estimates for U.S. bankruptcy.<sup>27</sup>

## Taxes in Canada

Taxes in Canada are much higher than in the U.S., and this is largely because of government health care spending. In addition to combined sales taxes ranging from 11 percent to 15 percent for all but one province, personal income tax rates are also much higher. The OECD calculates that a married Canadian couple with two children and one earner making the median wage pays 27 percent of its income to the government, of which 10 percent is paid in income taxes and 17 percent in social security taxes. The comparable American couple pays just 4 percent of its earnings in income taxes and 15 percent in Social Security taxes. Moreover, Canadian taxes rise faster with income; if that same family earns 168 percent of the median wage—about \$90,000 in each country's currency—it will pay 18 percent of earnings in income taxes in Canada, and only 9 percent in the U.S.<sup>28</sup>

On a national level, according to the OECD, Canadian taxation sums to 33 percent of GDP, compared to 24 percent in the U.S., meaning it is 36 percent higher. Even so, nearly a quarter of what Americans pay in taxes consists of Social Security payments, while the far-less-generous Canadian social security makes up just 14 percent of taxation. This is because Canadian social security averages just \$984, compared to \$1,470 in the U.S.<sup>29</sup> Taxation excluding social security contributions, then, comes to 28 percent of GDP in Canada, compared to just 19 percent in the U.S.—meaning 51 percent more.<sup>30</sup>

This excess taxation is largely a result of health spending, which has bloated provincial budgets to nearly three times the taxes of U.S. states.<sup>31</sup> Provincial taxes have grown to nearly the same level as federal taxation. Meanwhile, provincial health costs have risen to fully 37 percent of provincial budgets in 2016—up from 33 percent in 1993<sup>32</sup>—and range as high as 42 percent.<sup>33</sup> Canada's Fraser Institute has estimated this excess tax burden from public health costs at roughly \$9,000 for a household of two adults with or without children,<sup>34</sup> or \$750 per month in additional taxes.

Beyond the financial stress of paying higher taxes, tax differences of this magnitude are large enough to materially affect national wealth. In a 2007 paper, economists Christina and David Romer estimated that an increase in taxes leads to a fall in GDP roughly two to three times larger than the amount raised.<sup>35</sup> This implies that Canada's excess tax burden could reduce GDP by between 16 percent and 24 percent. In fact, the World Bank estimates Canadian GDP as 26 percent lower than in the U.S.<sup>36</sup> There may be other reasons why Canada is so much poorer than the U.S., but the Romers' estimate suggests excess taxation is a serious problem.

This last point is important for discussions about net savings from socialized medicine. Democratic presidential candidates Senator Elizabeth Warren (D–MA) and Senator Bernie Sanders (I–VT) have claimed that their health care plans would cut total health spending, for example, by dictating lower hospital reimbursement rates or insurance payments.<sup>37</sup> Charles Blahous recently estimated that<sup>38</sup> Medicare for All would raise federal taxes by \$32 trillion over 10 years, and would likely raise total health care costs. Even under the most generous assumptions, health care costs could fall by, at most, \$2 trillion during that period—leaving \$30 trillion in tax damage.<sup>39</sup>

## Quality of Health Care in Canada: Waiting Lists

Medical waiting times have become a national crisis in Canada, and continue to worsen. The average wait time for medically necessary treatment between referral from a general practitioner and a consultation with a specialist was 8.7 weeks in 2018, 136 percent longer than in 1993. Patients then have to wait again between seeing the specialist and the actual treatment, another 11 weeks on average, 97 percent longer than in 1993.

From referral to treatment, then, it takes an average of 19.8 weeks (see Chart 2) to be treated, in addition to the original wait to see the family doctor in the first place—this for “medically necessary” treatment, not cosmetic surgery. In less-populated areas, wait times can stretch dramatically longer. In New Brunswick, for example, patients have to wait an average of *six and a half months* just to see a specialist, then another four months for the actual treatment—45.1 weeks on average, again, for “medically necessary” treatment.<sup>40</sup>

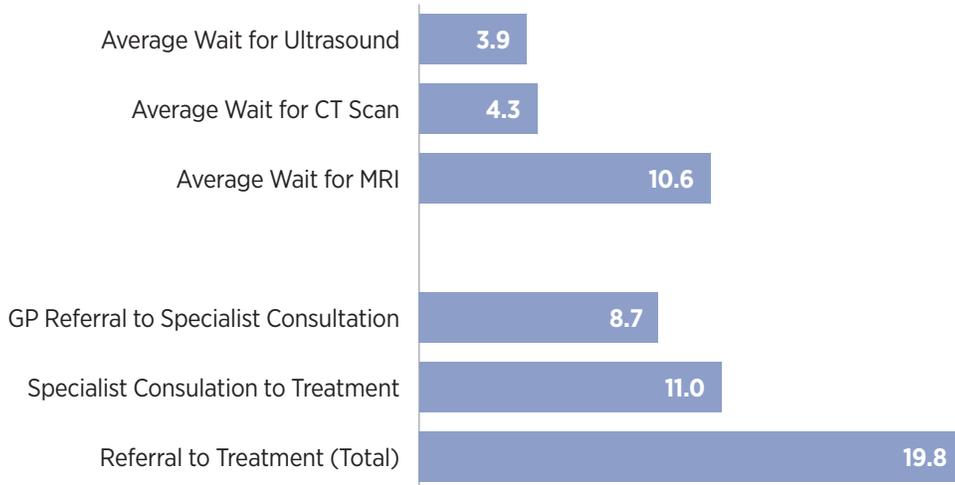
In contrast, nearly 77 percent of Americans are treated within four weeks of referral, and only 6 percent of Americans report waiting more than two months to see a specialist.<sup>41</sup> As for appointments, a 2017 survey of American physicians in the 15 largest U.S. cities found that it took just 24 days on average to schedule a new-patient physician appointment, including 11 days for an orthopedic surgeon and 21 days for a cardiologist.<sup>42</sup>

As a result of these long waits, by one recent estimate, at any given moment, over one million Canadians—3 percent of the entire population—are waiting for a medical treatment.<sup>43</sup> These lists can average six months, and often much longer in rural areas, which tend to suffer from doctor shortages so severe that many do not even have a family doctor.<sup>44</sup> The shortages ripple through the system; one doctor in Ontario called in a referral to the local hospital, only to be told there was a *four-and-a-half-year* wait to see a neurologist.<sup>45</sup> A Montreal man was finally called for his long-delayed

CHART 2

## Average Wait Times for Treatment and Tests in Canada

WAIT TIME IN WEEKS, 2018



**SOURCE:** Bacchus Barua and David Jacques, “Waiting Your Turn: Wait Times for Health Care in Canada 2018 Report,” Fraser Institute, December 2018, <https://www.fraserinstitute.org/sites/default/files/waiting-your-turn-2018.pdf> (accessed January 7, 2020).

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urgent surgery two months after he had died.<sup>46</sup> One 16-year-old boy in British Columbia waited *three years* for an “urgent” surgery, during which time his condition deteriorated so much that he became a paraplegic.<sup>47</sup>

These cases are, unfortunately, not isolated; a survey of specialists found that average wait times exceed what is deemed clinically “reasonable” for fully 72 percent of conditions in Canada. The situation continues to worsen every year: In 1994, the average gap between clinically reasonable delay and actual delay was only four days, and by 2018 had grown to 23 days. The worst gap was in orthopedic surgery, where some 150,000 Canadians per year suffered for 11 weeks longer than specialists determined as clinically reasonable. Neurosurgery wait times were nearly a month longer than clinically reasonable, cataract surgeries nearly two months longer, hip and knee replacements three months longer, and so on.<sup>48</sup>

With one million waiting, many Canadians turn in desperation to U.S. health care—the very system some U.S. policymakers propose to transform. In 2017 alone, Canadians made 217,500 trips to other countries for health care, of which 52,500 were to the U.S.,<sup>49</sup> paying out of

pocket to skip the waiting.<sup>50</sup> Medical trips abroad included 9,500 general surgeries, 6,400 urology treatments, and 5,000 diagnostic tests, including colonoscopies and angiographies of the veins.<sup>51</sup> One happy Albertan summed up the trade-off after her hip replacement in the Cayman Islands: “The total cost was \$25,000 Canadian to regain at least one year of my life.”<sup>52</sup> These desperate patients spent \$1.9 million per day to escape Canadian health care, up 54 percent in just the past four years.<sup>53</sup> Of course, those costs are not included in the Canadian health spending numbers, but can show up in U.S. health care spending when the dollars were spent in the U.S.

A major cause of Canada’s waiting lists is the use of so-called global budgets while effectively banning private clinics and private insurance for medically necessary treatment. Global budgets, in which health providers get a fixed budget each year rather than being paid per treatment, are a form of rationing that strongly tends to lead to long wait times.<sup>54</sup> Meanwhile, rules hobbling private provision in Canada mean that nearly half of existing doctors would like to work more hours, but are effectively banned from doing so.<sup>55</sup> Both Senator Warren’s plan<sup>56</sup> and Senator Sanders’ plan<sup>57</sup> explicitly propose global budgets, and both effectively ban private insurance.

When it comes to global budgets, a 2014 report from the University of British Columbia concluded:

One weakness of global budgets is that, under the impetus to meet budget targets, providers might restrict access to services or limit the number of admissions to facilities. Moreover, global budgets provide little incentive for innovation or to improve efficiency of care.... Global budgets do not promote coordination across service providers in acute and post-acute settings, creating a fragmented healthcare system that is often associated with inefficiencies and reduced quality of care.<sup>58</sup>

Indeed, the report noted, “Most of the countries that had previously used global budgets have since transitioned to other funding mechanisms, such as activity-based funding.”<sup>59</sup>

The prospect of importing Canadian-style medical wait lists is not merely hypothetical: The Veterans Health Administration, for example, recently admitted to off-books waiting lists running to four to six months.<sup>60</sup> This suggests that the tendency to cut corners and ration care is not some uniquely Canadian flaw, but rather a characteristic of government management of health care.

## Skimping on Care in Canada: Lack of Equipment, Outdated Drugs, Staff Shortages

Beyond rationing care by using waiting lists, the other key to Canada's government cost controls is underinvesting in equipment, using cheaper and outdated medicines, and staff shortages. While the average employer-sponsored private insurance plan in Canada covers between 10,000 and 12,000 drugs, most public plans in Canada only cover 4,000.<sup>61</sup> Canada has 35 percent fewer acute care beds than the U.S.,<sup>62</sup> and only one-fourth as many magnetic resonance imaging (MRI) units per capita—indeed, it has fewer MRI units per capita than Turkey, Chile, or Latvia.<sup>63</sup> As a result, Canadian waits for MRIs average almost 11 weeks, adding months of diagnostic delays on top of the months of treatment delays. Even routine diagnostic equipment like ultrasound machines has four-week waiting lists. In some provinces, the waits are much longer. In British Columbia, for example, patients wait nearly five months for an MRI, while in Quebec, New Brunswick, and Nova Scotia, patients wait eight weeks for a simple ultrasound.<sup>64</sup> Canada skimps on equipment even more than European countries: compared to the average OECD country, Canada has one-third fewer computerized tomography (CT) scanners, positron emission tomography (PET) scanners, and MRI units; half as many angiography units; and eight times fewer lithotriptors (machines that shatter kidney stones and gallstones).<sup>65</sup>

Some common treatments are simply unavailable to Canadians. For new pharmaceuticals, for example, Canada's policy of forcing down prices so that American consumers essentially pay for Canada's research and development<sup>66</sup> has led to years-long delays for Canadian patients. In addition to a 630-day average wait before new drugs are approved, Canadians must wait for the drugs to actually be listed on their plan, averaging 152 days for private plans and 473 days for public plans. Comparing to the U.S., for drugs submitted for regulatory approval in both jurisdictions Canada takes five times longer—434 days of additional delay.<sup>67</sup>

Cutting corners on facilities and using outdated drugs show up in Canadian mortality rates. Thirty-day in-hospital mortality rates in Canada are 20 percent higher than in the U.S. for heart attacks, and nearly three times the U.S. level for strokes.<sup>68</sup> Cancer age-standardized mortality is 10 percent higher in Canada than in the U.S.—despite far healthier lifestyles, with both obesity and diabetes rates a full third lower in Canada than in the U.S.

When it comes to personnel, Canada underspends on medical staff and doctors, ranking 29th out of 33 among high-income countries for doctors

per 1,000 population, accounting for a large part of those wait times.<sup>69</sup> Canada has half as many specialist physicians per capita as the U.S.,<sup>70</sup> and, while the number of general practitioners per capita is similar to the U.S., rules banning doctors from mixing public and private practice discourage doctors from working beyond the minimum hours. Despite these rules that have contributed to a doctor shortage in Canada termed “critical” for nearly 20 years,<sup>71</sup> nearly half of doctors would actually like to work overtime or see private patients, but are prevented from doing so by government rules that require doctors to resign completely from public patients if they see any private patients at all<sup>72</sup>—a daunting prospect for a doctor considering opening a private clinic. Meanwhile, Canada’s physician lobby actively limits the number of specialists.<sup>73</sup> The problem is proportionately worse in rural areas, where physician density is nearly two-thirds below the OECD-16 average for rural areas.<sup>74</sup> The doctor shortage, particularly in rural areas, is widely reported in the Canadian press.<sup>75</sup>

With such shortages and waiting lists, Canadian emergency rooms are packed. So packed that Canadians sometimes just give up and go home. Of Canadian ER visitors who are seen, 29 percent report wait times of over four hours, three times the U.S. level.<sup>76</sup> In Quebec, more than half of ER visits are longer than four hours.<sup>77</sup> Canadian seniors are 65 percent more likely to have visited the emergency room (ER) four or more times in the past year than American seniors.<sup>78</sup> Ultimately, nearly 5 percent of Canadian ER visitors end up leaving without ever being treated, giving up on a medical system that is perennially “free” but out of stock at the moment. In one study at two ERs in Alberta, 14 of the 498 walkaways were subsequently hospitalized, and one died within the week.<sup>79</sup>

Facing these widespread staff shortages, Canadian medical providers frequently do poorly on patient assessments. Canada scores 15th out of 20 OECD countries on “[d]octors spending enough time with patients,”<sup>80</sup> and one study on patient satisfaction found that the patients interviewed reported “feeling dehumanized in [the] current health care culture,”<sup>81</sup> as if the patient is a burden to the doctor instead of a client to serve. One recent trend in Canada is for medical providers to initiate “[o]ne issue per visit” rules that force patients to make multiple appointments, not only inconveniencing them but extending wait times yet again as patients work through their medical issues appointment by appointment, each with its own waiting list. As one doctor commented, such tactics raise an “ethical question about rationing health care in a public system and whether patients are being denied treatment as a result.”<sup>82</sup>

Beyond making patients feel dehumanized, overworked doctors risk compromising treatment. According to OECD numbers, Canada's doctors leave foreign bodies in patients at a rate 53 percent higher than U.S. doctors, and rates of postoperative sepsis are nearly 36 percent higher.<sup>83</sup>

The Canadian health care system has become a part of Canadian national identity, a treasured point of difference with Americans. Alas, in surveys, Canadians actually do not love their health care all that much. A 2017 survey found that while 74 percent of Americans are "completely" or "very" satisfied with the quality of health care they have received during the past 12 months, among Canadians it is only 66 percent. Meanwhile, only 25 percent of Americans rate their care as either "somewhat" or "not at all" satisfactory, with the comparable proportion of dissatisfied Canadians one-third higher, at 33 percent.<sup>84</sup>

Polling suggests that Americans' health care satisfaction would plunge if they were forced into the high taxes and waiting lists endemic to Canadian health care. A Kaiser Family Foundation poll found that net favorability to health care reform proposals "is negative 23% when participants hear it would require increases to taxes, and a staggering negative 44% when people hear it would cause delays in getting tests and procedures."<sup>85</sup> Higher taxes and delays of even "medically necessary" treatment are precisely what the Canadian health care model offers.

## Conclusion

Canadians bear similar medical out-of-pocket burdens as Americans, while paying far higher taxes. Lower overall health spending in Canada is largely achieved by rationing care with waiting lists, using cheaper drugs, skimping on equipment, and underinvesting in medical facilities and staff to the point of nationwide shortages. Far from the feel-good "we're all in this together" rhetoric, Canadian health care hides costs by throwing burdens on already suffering patients.

Sound proposals exist for reforming American health care, including price transparency, enabling patients to shop around and choose from a variety of insurance options, and eliminating anti-competitive rules. One could make a strong case for proactive policies to help those who cannot afford health care. But Canada's top-down, government-run model is one of the worst possible options. Copying, even extending, a failing and out-dated Canadian monopoly rife with unintended consequences and suffering patients is not what Americans deserve.

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