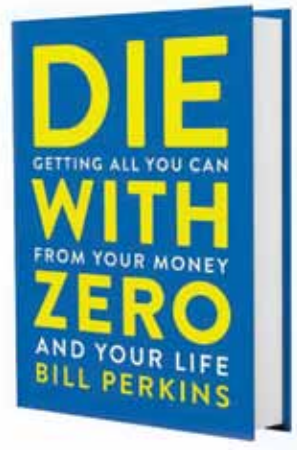
Die with zero

How much money is "enough"? Are you working toward a specific number in order to retire? Perhaps you think you'll know when the right time comes? Or maybe you're so busy with your office, patients, mortgage, and student debt that you haven't had time to consider it. And if someone asked you what your savings were for, how would you respond? To enjoy retirement? Invest? Donate?

In his book *Die with Zero: Getting All You Can from Your Money and Your Life*, Bill Perkins suggests that we should all aim to die with as little money in the bank as possible. I read the book last year, and it had an enduring influence on how I think about building my "wealth." The premise of the book (as I adopted it) is that we need to redefine wealth. Wealth is not the same as net worth. Net worth refers to your assets minus liabilities, whereas wealth should encompass a more holistic view of how you spend your life's resources. I should clarify that this book was not written for millionaires; its philosophy is meant for anyone who is working and has savings.

The author, an electrical engineer turned hedge-fund manager, proposes a strategy to avoid "over-saving and under-living." He explains that most of us are saving now in order to give the money to our older, richer selves. Considered in this way, saving is a form of delayed gratification. We invest money to earn dividends so that we will have more money to spend on positive experiences later in life. However, as the book describes, there is a fundamental problem with this approach—wealth is nothing without health. Some experiences either cannot be enjoyed or would be less enjoyable when we are older. Early in his finance career, the author turned down an opportunity to backpack through Europe with a buddy because the $10 000 loan and high interest rate seemed irrational. Looking back on it as a financially secure 30-year-old, he realized that he had lost the opportunity to broaden his horizons with hostels, sightseeing, parties, and new friends, because that no longer appealed to him in his current stage of life. He was troubled by the fact that when he finally decided he could "afford" the trip, it no longer had the same value. This resonated with me. Is anyone else hoping to trek in El Salvador, learn to play tennis, or build a cabin during retirement?



To me, the most metamorphic concept in *Die with Zero* was "experience dividends." In this nontraditional view of wealth, the author posits that experiences are *investments*, rather than expenses. For example, imagine you are a 50-year-old physician who invested in a family trip to Disneyland when your children were young. The initial experience created a surge of joy, but so does each recollection of the trip. Your memory pays you dividends in the form of smaller surges of joy each time you recall the kids happily screaming on the teacup ride or holding a melted ice cream while asleep in the stroller. If you envision the initial experience as the highest bar on a chart and each subsequent memory comprising a tail of smaller bars, the memory dividends may, summated over a lifetime, even surpass the value of the original experience. My goal is to be experientially wealthy.

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Dying with zero does not mean spending your kids' inheritance or wasting money on frivolous pursuits. The book simply encourages you to make donations and gifts when you can, rather than waiting until death. Charities can make a bigger impact if you give them your money today, instead of at some undetermined time in the future. They, too, are investing for experience dividends.

Time is a nonrenewable resource. However, many of us are too busy working to thoughtfully consider how to use the money we accumulate while we are spending our time. *Die with Zero* proposes that we think of the phases of our life as buckets, make a wish list of experiences, and then figure out which bucket each experience should fall within. Invest in creating memories today that will make you happier in the future. I think Drake said it best: YOLO. ■

—Caitlin Dunne, MD, FRCSC

Our health ministers need to take a lesson from hockey coaches

Those of you who are tired of my rants about the demise of our once great health system will be pleased to know that this is my last editorial. I am retiring from the *BCMJ* Editorial Board; currently, I am the longest-serving member (more than 20 years). I have been a supporter and fan of the journal for even longer; my first *BCMJ* article was published in 1981.[1]

It will surprise no one that I will end my term with a commentary on the state of medicare. The topic has gathered a lot of media attention recently, related to the nationwide suffering of patients. Ironically, the Conservative premier of Ontario, Doug Ford, has been attacked for contracting out procedures to private clinics, something that was started under the BC NDP government of the 1990s and continues today. His decision resulted in me being deluged with many media interviews and caused me to write an editorial in a national newspaper.[2] My philosophy is largely based on the premise that no monopoly serves the recipients of its services well. The evidence is clear that competition in health care saves lives and reduces costs.[3]

The five principles of the Canada Health Act are public administration, comprehensiveness, universality, portability, and accessibility. But governments are not conforming to the latter four, and even the first principle should be renamed "state control."

The principle of comprehensiveness is not respected. Physicians understand that excluded provisions such as medications, ambulances, physiotherapy, artificial limbs, psychologic counseling, speech therapy, preventive care, and even dentistry (an abscess in a wisdom tooth may penetrate to the brain) are more "medically necessary" than the diagnosis or treatment of tennis elbow in a recreational tennis player with a sore elbow after a 4-hour game or a mild case of plantar fasciitis after running back-to-back marathons.

Most Canadians are unaware that virtually all the excluded services listed above are covered in every developed country that offers universal health care.

As president of the Canadian Medical Association (CMA) in 2007–2008, I lobbied hard for prescription drugs to be available for all. Canadians are 3 to 5 times more likely than residents of comparable countries to skip prescriptions because of cost issues. A 2012 Ontario study[4] estimated that the lack of insurance for medications for working-age individuals with diabetes was associated with 5000 deaths and nearly 2700 heart attacks over a 6-year period. Nationally, of course, this toll would be far greater. Physicians are aware that many Canadian patients (a CMA report revealed it was 1 in 3) who do not have private extended health insurance go without necessary care.

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However, my recommendation on extended coverage was intended not to expand state bureaucratic control, but to fund premiums to existing independent providers for the minority who lack and cannot afford such coverage. I can illustrate my concerns with a hypothetical three-phase scenario.

Phase 1: In a pre-election speech, the Minister of Health announces that, if re-elected, his party will add coverage for all currently excluded services (as listed above) to the existing medicare system.

Phase 2: The promise leads to re-election with a massive majority. Extended health plans and self-funding for such services are all rendered unlawful since the state will now cover them all.

Phase 3: Within 2 years the costs have become so high that the government caps funding and rations access to pharmacists, physiotherapists, ambulance services, dentists, prosthetic limb suppliers, etc. Long wait lists to access those services result, and those in need suffer.

The above accurately describes the current state of our medicare system regarding physician and hospital services. I view the elimination of choice in the presence of enforced rationing as unethical and immoral. I hope the highest court in the land will also find it unlawful.

Our governments have historically deemed the concept of equality as paramount, when in fact, Canada ranks very low among its peers in terms of equality and equity. This is not a rich versus poor discussion. There is no health care system in the world in which the rich suffer. An Italian law expert described Canada's health care system as being designed for the wealthy who can afford to travel to the US if they really need care.[5] Many politicians have extolled the virtues of our system while following that route themselves.

If there is a perception that a private option offers better care, the state has two choices. Make the public sector better and eliminate the need for private care or pay the premiums for those who can't afford them. Australia has a publicly funded system but also subsidizes private insurance premiums for 9 million lower-income families.

The Commonwealth Fund ranks Canada next to last and the United States last of 11 developed countries. Of the 10 countries

with universal care (i.e., excluding the US), Canada was last overall and tellingly last in equity and outcomes. It was also the most expensive.[6] The head coach of the bottom teams in hockey looks to emulate the top teams. Let's do the same for our health system. ■

—Brian Day, MB

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A fond farewell to Dr Brian Day, and a warm hello to Dr Michael Schwandt

Dr Brian Day

Dr Michael Schwandt

After more than 20 years of service to BC doctors as a member of the *BCMJ* Editorial Board, Dr Brian Day is retiring from the position, with his final editorial appearing in the March 2023 issue. A well-known orthopaedic surgeon, his passion for the state of medical care in Canada has been reflected over the years in his rousing editorials, provocative to some. His thoughtful contributions to the *BCMJ* have also included scientific articles, physician profiles and interviews, and obituaries, illustrating his deep caring for his colleagues and patients and his talents as a writer. His article reviews at the Editorial Board table were swift and decisive, as one would expect from a surgeon.

We are excited to welcome Dr Michael Schwandt to the Editorial Board as its newest member.

Dr Schwandt is a medical health officer with Vancouver Coastal Health and a clinical assistant professor in the UBC School of Population and Public Health. He entered practice in 2013, after training at the University of Manitoba, the University of Toronto, and the Harvard School of Public Health. As a specialist in public health and preventive medicine, Dr Schwandt works to protect and promote health at the population level, providing leadership in areas including emergency preparedness, healthy environments, and climate change adaptation. Committed to promoting health equity, Dr Schwandt works with partners including local governments and community-based organizations to identify and act on root causes of illness and wellness. Dr Schwandt regularly shares public health information through scientific journals and media conversations, and his interest in healthy public spaces extends to pastimes as an avid runner and fan of local music.