Consent is a journal of ideas and opinions on individual freedom.
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Consent

CAN IT WORK? ---ANYWHERE?

by William E. Goodman, M.D.

(Dr. Goodman is an otorhinolaryngologist in Toronto. The following speech, originally titled "The Canadian Model: Could It Work Here?" was presented at the 46th Annual Meeting of the Association of American Physicians and Surgeons, in Orlando, Florida, on September 21, 1989.)

With the increasing concern about deficiencies in health care delivery in the United States, and the Canadian experiment looming before you in the north, the question in the title of my talk was inevitable.

I was in private practice in Canada long before the advent of national health insurance there and continued to practice for some 15 years after its introduction. From this experience, I can draw certain conclusions. However, to discuss the question that is before us, I must begin by asking some questions of my own.

CONSTITUTIONAL & POLITICAL ISSUES

Because I acquired an honors degree in economics and political science before studying medicine, the first issue that came to my mind was whether it is constitutionally possible for the U.S. governments (state and/or federal) to institute (legally) a Canadian-style system.

Although you and I speak the same language, have much the same culture, are exposed to the same media influences, and spend a great deal of time in each other's countries, you must understand that the Canadian political structure, not to mention its national psyche, is very different from yours. Our parliamentary system, unlike your republican form, allows the man at the head of the party having a simple majority of seats in the House of Commons to do almost anything --- and to get away with it. We have recently acquired a much-vaunted, so-called Charter of Rights. But unlike your Bill of Rights, it was so emasculated before being passed that it isn't worth the paper it's printed on. As for our psyches, the best way to compare them is to tell you that, while the key words in your Declaration of Independence are "life, liberty, and the pursuit of happiness," the key words in our constitution are "peace, order, and good government."

By and large, Canadians are middle-of-the-roaders who love security and hate to rock the boat. In contrast, Americans are a nation of protesters who tend to admire boat-rockers and self-made achievers. As Professor Russel Knight of the University of Western Ontario once said, "In the United States, everyone aspires to be an entrepreneur; in Canada, everyone wants to be a civil servant."

Notwithstanding these differences, both our governments learned long ago how to get around constitutional limitations and embarrassments. (Look at what's happened here since the passage of California's Proposition 13, and Washington's Gramm-Rudman Act.) In health care as in other matters, legislators have known since time immemorial that what could not be achieved by purely legislative measures could nonetheless be attained by fiscal arm-twisting --- in other words, by bribery.

It's legal bribery, but still bribery, to make opponents an offer they can't refuse. That's what happened in Canada. Under our constitution, the federal government has virtually no powers in health matters. Yet, by taxing everyone across the country indiscriminately, but offering billions of dollars in grants to only those provinces that introduced a national health insurance system of the federal government's choice, it finally forced all of them to participate.

From what I know of your constitutional setup, I believe it would be much more difficult, in legal terms, for your government to impose its will on a reluctant State, reluctant public, or reluctant profession. Nonetheless, I expect that the outcome for the U.S. health care system will ultimately be determined by the power of the dollar, not by ringing Jeffersonian statements.

(Continued next page)

PUBLIC ACCEPTANCE

Even if a Canadian-style model is constitutionally possible here, a second question arises: Would your doctors, your hospitals, your diagnostic laboratories, your insurance companies, your employers, and, most of all, your patients be prepared to pay the enormous cost involved? A recent US public opinion poll showed that, although a majority of Americans would love access to such a Canadian-patterned system, only a very small minority were prepared to pay even $50 more a year. (So much for the validity of polls.)

And the cost is not measured solely in dollars. Much more important costs are a lack of access to health care personnel, institutions, diagnostic and therapeutic facilities; waits for essential services and surgery that run into years; and what I regret to have to refer to as the "lowest-common-denominator" quality of medical care. More about the last later.

HEALTH CARE COSTS

It has been claimed that, according to the most recent statistics, Canadian medical care uses up about 8.6% of our gross national product, with full universal coverage, while US health care consumes 12% of your GNP, even though some 35 million Americans reportedly have no health insurance at all. Without exploring possible reasons for the difference (e.g., leaving aside the fact that a lower percentage in Canada may actually mean a lower level of accessibility and quality), I find these figures highly suspect, based on previous experience with government statistics.

Our government's statisticians, like yours, are capable of enormous errors. Let me read you an Associated Press report from Washington, dated September 5, 1989:

"Chagrined economists watched in horror as the government made revision after revision last month in data on past performance that they use in their prognostications. The net result was that the economy was not nearly as weak during the spring as originally thought. Consumers spent at least double the pace first reported, employment growth was much stronger, and the overall economy, rather than limping along at an anemic annual growth rate of 1.7% from April through June, actually grew at a healthy 2.7% rate... The government's reports on factory orders and retail sales have been notoriously unreliable, and analysts have grown accustomed to looking at the figures with skepticism... The Labor Department's monthly employment report --- generally considered one of the most accurate economic measurements --- veered far off the mark earlier this year. Almost half the actual job growth in April, May, and June was missed in the original report."

As you all know, politicians and their minions are past masters in the art of disguising, manipulating, and fudging figures to their advantage, in addition to making presumably honest but gigantic errors. You will remember, to quote Mark Twain, that there are three kinds of lies: lies, damn lies, and statistics.

However, even if we accept the estimate of the percentages of our respective GNPs devoted to health care costs, the expense of health care in Canada is one of the major factors in a Canadian federal per capita debt and per capita annual deficit that is twice as bad as yours. As to provincial budgets, over a third of the revenue is already committed to health care, and the proportion is rising inexorably.

Notwithstanding these huge expenditures, the obvious deficiencies of the sytem are such that everyone --- the public, the hospitals, the media, the doctors and nurses, the health economists, the budgetary experts, and even the government's own representatives speak incessantly about the crisis in our health care system. So what has gone wrong?

Apart from any political philosophy that you may espouse, be it free-enterprise or welfare-state, it's essential to realize that the basic and unalterable flaw in any system like the Canadian model is that, in economic terms, it is an open-ended scheme with closed-end funding. In other words, the potential demands are completely unrestricted, but the money to pay for them is not. It's like giving the public a no-dollar-limit, no-responsibility-for-payment medical credit card --- an open invitation to unlimited abuse by both patients and doctors. Therein lies the politicians' dilemma: how to continue to buy votes with grandiose give-away schemes when it becomes evident that the money is running out. This is a generic problem, not confined to any one country or system of government. Its end result, no matter where practiced or how implemented, is always bankruptcy --- unless major (and painful and politically very unpopular) changes are instituted in time, to the chagrin, disappointment, and detriment of the sick.

CANADIAN VIGNETTES: TRUE STORIES OF "UNIVERSAL ACCESS"

How does one define the "Canadian model"? Let me paint you a few scenarios --- all taken from the pages of Canadian newspapers and magazines, or from our broadcast media.

1. You're sick and need access to some special diagnostic or therapeutic equipment, but because of the constraints of government global budgeting, your hospital (in this case the largest teaching hospital of the largest university faculty of medicine in Canada's largest city), can't afford it. Hospital administrators are having to go, hat in hand, begging for handouts from the general public or former patients, to buy the necessary machinery.

"Only a country that is rich and safe can afford to be a democracy, for democracy is the most expensive and nefarious kind of government ever heard of on earth." - H.L. Mencken

2. You're sick and need to be admitted to your local community hospital but can't get in. Notwithstanding the waiting list, many months long, of people with elective or urgent problems, the hospital has decided to close 12% of its beds --- one in eight --- taking them completely out of service because of the government's refusal to provide adequate funding. At the same time, the hospital is legally prohibited from accepting any additional private payments that might have permitted it to continue in full operation.

3. You're sick and need cardiac bypass surgery, but the list of patients waiting for similar and sometimes more urgent surgery is so long that your hospital admission is postponed 11 times in the year before you finally come to surgery. Or you die of cardiac disease before your turn comes up. This has happened to many patients.

4. You need an elective procedure like a lens implant or hip transplant. Since your hospital has used up the annual allotment that the government allows, you are willing to pay the cost of the prosthesis yourself, rather than waiting ten months or a year until the hospital receives a new allotment. The answer is no. The government will not allow you to pay for your own procedure, and it is illegal for a doctor or hospital to participate in such a queue-jumping measure. (Interestingly enough, if you're an American or other foreigner who has seen fit to come to Canada at your own expense for the surgery, it is permissable.)

As Professor Arnold Aberman put it: "The monopoly on health care exercised by the government is such that, if the government decides that it can't afford it, (Canadians) are not allowed (privately) to buy it." The only way for Canadians to get around this idiotic rule is to leave the country to go to the USA for the diagnostic or therapeutic modality they require.

5. Your wife, your mother, your sister, or your daughter is asymptomatic but wants the reassurance of mammography or a Pap smear to rule out early breast or cervical cancer. She has great difficulty arranging this because the government has decreed to the profession that these procedures are justified only in certain age or other risk groups and are not required more often than at certain specified intervals. The criteria used for making such determinations are epidemiological and have nothing to do with the well-being of the individual patient. To use their own euphemistic words, the government asks: "Is it cost-effective? Can it withstand economic appraisal?"

6. You've had a sudden myocardial infarction and your family wants your doctor to administer the drug TPA or APSAC immediately. They have read that it is more effective than the streptokinase currently used in most Canadian hospitals. The government or the hospital will not be willing to pay for the newer drug because it is much more expensive. And even if your family were willing to pay the extra cost themselves, permission for the doctor or hospital to use the drug might not be granted.

7. You're a 37-year-old pregnant physician in Vancouver and believe that you should have an amniocentesis to rule out genetic abnormalities in the fetus. By government edict, local doctors and hospitals cannot perform it, even if you're willing to pay the total cost yourself, unless you are over a certain age or have a specific history of genetic abnormalities. So you have to cross the border to Seattle if you wish to have the procedure, at considerable added expenditure of both time and money, not reimbursed by our government medical plan.

8. You're a medical department head in a university teaching hospital and need a certain complement of interns and residents for your department to function properly. But the government (which now pays the salaries of in-hospital personnel) says no. It thinks the country already has too many people in that specialty and besides, it can only afford half or two-thirds of the number you requested, so you'll have to make do with less. (In most cases, the government even refuses to allow house officers to work without pay (as some are willing to do in order to acquire necessary practical experience and academic credit).

9. You're head of housekeeping in one of the largest university teaching hospitals in Montreal and need a minimum number of workers to keep the wards clean and tidy. "Sorry," says the hospital administrator. The halls may be littered with old cartons, soft drink cans, and other garbage, but with its limited government budget, the hospital has to cut corners somewhere. There is not even sufficient money to pay for the nurses who are desperately required --- and nurses are far more important that floor cleaners.

10. You're the mayor in a small, remote northern Ontario community. Your community hospital desperately needs money to upgrade its facilities, the only ones available for a very large but sparsely populated region. In addition, you have great difficulty recruiting any doctors to settle and work in your rather less than desirable area. "That's your problem," say the provincial government authorities. They offer to give the hospital money only if, by refusing hospital privileges, you force any doctor working there to accept "capping", that is, maximum global annual payments.

11. You're a family practitioner and want to refer a patient with a particular problem to a particular specialist who has great expertise in that field. Unfortunately, he works in one of the hospitals in which doctors' incomes are capped annually, and he has already reached his maximum for the year. There being no incentive for him to

" It is a besetting vice of democracies to substitute public opinion for law. This is the usual form in which masses of men exhibit their tyranny." -James Fenimore Cooper

work, since he would be earning absolutely nothing for the extra time and effort, he's off attending conferences, writing books, taking part in seminars, or even perhaps playing golf. Accordingly, your patient may have to wait eight to ten months for an appointment.

12. You're a surgical specialist doing cataract surgery or nasal surgery or arthroscopy. Tired of having a ten-month list of patients waiting for hospital facilities to become available, you decide to invest your own funds in your own first-class facility, thereby reducing your patients' wait to a couple of weeks. "Uh, uh," says the government bureaucrat. First, you will have to have a special license. Second, the bureaucrats will decide if and where and by whom such facilities may be set up, what procedures they will be permitted to perform, and how much they will be allowed to charge. Furthermore, government control is such that they have the legal authority to walk in at any time without a search warrant to review your pattern of operations and your patient files and to seize any records they like.

13. Your child has been born prematurely and needs highly specialized neonatal care to survive. Too bad. Although you live close to a large city with teaching hospitals associated with a university medical faculty, many of the beds in the critical neonatal service lie empty, out of service because of lack of funding. No functioning bed is available for your child in the entire city, and he has to be flown hundreds of miles to another city, or perhaps across the border to Buffalo or Detroit, where such beds are much more readily found. It's true that under these circumstances the provincial government will pay for most of the hospital costs involved, but neither you nor your wife will be reimbursed for trips back and forth to that location, for the necessary hotel accommodations, for the long-distance telephone calls, or for lost wages. And there is no way to compensate a family for the emotional trauma of being hundreds of miles away from a loved one who is critically ill.

14. You're a gourmet who loves fatty French foods. You are approaching age 40 and have begun to worry about your cholesterol level. You ask your general practitioner or cardiologist to order the necessary laboratory tests. "Not necessary," says the health ministry --- unless you're in a certain age group and demonstrate certain "identifying risk factors for coronary heart disease." Your GP isn't actually forbidden --- yet --- to order the tests, but he knows that if he does he'll be receiving telephone calls and letters from the ministry demanding that he justify his course of action. Net result: he probably won't order the test. As in most other areas of life, a threat, actual or implied, is sufficient for deterrance.

15. You're an older physician with a particular empathy for other old people and work 80 hour weeks visiting them at their homes or in nursing homes --- calls that very few doctors are prepared to make nowadays and for which your patients are extremely grateful. But instead of receiving thanks from the health administrators, you are ordered to appear before a review committee. You've been "gouging the scheme," say the health police, costing the government thousands of dollars for "unnecessary visits"! You end up having to spend many hours of your precious time and many of your own dollars for a lawyer's services before you are completely exonerated by the quasi-judicial Medical Review Committee or the Health Disciplines Board.

16. You're a specialist in private practice, with a teaching appointment at a hospital affiliated with a medical school. Each year, the hospital, hit harder and harder by increasing costs due to technical advances and inflation, has been issuing more and more strident appeals to the medical staff for voluntary and sometimes not-so-voluntary donations to tide it over financial crises caused by government global budgets that often don't even cover the inflation rate.

Under our system, hospital appointments, especially those in university hospitals, are very limited; and your right to admit your patients to that hospital depends entirely on such an appointment. Your unwillingness to contribute annual "donations" on a scale deemed adequate by the hospital authorities may bring a veiled threat of freezing --- or even termination --- of your academic appointment. It's a form of hidden but nonetheless compulsory additional taxation, enforced by what is now essentially an arm of the government --- the hospital.

To quote the Dean of the Faculty of Health Sciences at one of our medical schools: "Governments across the country are in hot pursuit of cost containment... The medical schools have become increasingly dependent on service income generated by practicing academic clinicians." So you have now become a de facto hospital employee, generating income for your employer not only by admitting your patients but also, willingly or unwillingly, sharing your own piece-work income with it.

17. You're a radiologist specializing in mammography, for which the government has heretofore paid a professional reading fee of $17.50. Now, because the incidence of breast cancer in women is about one in ten, the female public and particularly the militant feminist organizations have started clamoring for regular universal screening for adult women. To placate them, the government agrees to set up radiographic screening centers. However, because of the added cost, radiologists are informed that since they should be able to read 40 such films per hour, the payment rate per patient will be reduced, in Ontario to $10 and in British Columbia to $5. The

radiologists' society, insisting that adequate readings cannot be done at a rate of more than eight per hour, is appalled, and predicts that such superficial mass-produced readings will result in missed cases of cancer. No matter: the health ministry is interested in epidemiological, not individual outcomes.

18. You have just been diagnosed as having cancer and require immediate radiation therapy. You live in Canada's largest city, boasting the two largest cancer centers in the country, but you are told that both have such long waiting lists that they're not accepting new patients. You are instructed to report to a cancer center in a distant Canadian city, or more likely to an American center, at an enormous cost in time and inconvenience, as well as money, to you and your family.

19. You are a doctor in a small community in one of Canada's smaller provinces. Since these areas have trouble attracting doctors at the best of times, you're working yourself to death trying to provide services to your patients. Along comes a politically appointed "Commission on Selected Health Care Programs," to tell you that: (a) The supply and activities of doctors will have to be controlled to stop spiralling health care costs; (b) Doctors admit too many people to hospital, run too many unnecessary tests, write too many prescriptions, and prescribe expensive brand-name drugs (instead of) generics; (c) Doctors should be penalised if their patients are admitted to hospital and not operated on within 48 hours or, if operated on, are not released within their expected length of stay. So much for professional independence.

20. You're a long-suffering Canadian taxpayer and have been comparing notes with American friends. If an American works full-time for a full year, your friends complain, the total burden of taxes is so heavy that it consumes his entire income from January 1 to May 3. In other words, he has to work four months of the year for the government. To your horror, you discover that the comparable figures for a citizen of Ontario are January 1 to July 7th! A Canadian has to work over six months solely to satisfy government's constantly increasing demand for taxes.

21. You are a family doctor, and a patient with a serious but not immediately life-threatening illness is furious when he's told that he'll have to wait three to six months for an appointment to see a particular specialist and six to 18 months for urgent hospitalization. What advice do you give him? The answer is obviously to buy a health insurance policy offered to Canadians by US insurance companies for treatment in the US. Since 90% of Canadians live within 100 miles of the American border, it's no great problem for them to drive to Boston, Albany, Buffalo, Detroit, Cleveland, Seattle, or a dozen other border cities.

OTHER PROBLEMS

I'm sorry to overwhelm you with such a lengthy litany of horrors, but we see, hear, and read such repeated references in your media to the marvels of the Canadian model that I felt it essential you should know some of the warts on this much-touted scheme. I've restricted myself to the problems arising from the financial absurdity of the system. But there are many others, equally important: the total loss of medical confidentiality; the loss of morale and dedication among medical personnel; the loss of health care workers by emigration, change of vocation, or early retirement; the massive intrusion by the bureaucracy into the doctor-patient relationship; the civil servantization and inevitable unionization of the medical profession; and so on. It would take five more lectures of this length to describe in detail all the pernicious ramifications of socialized medicine, Canadian style.

WILL THE CANADIAN SYSTEM BE TRANSPLANTED?

Returning to the questions that I posed earlier: Could the US government introduce a scheme like the Canadian one in this country, regardless of constitutional niceties? The answer is clearly yes. What the politicians can't do by purely legislative means, they will accomplish by financial coercion.

WILL THE U.S. ACCEPT IT?

For the public, the answer, I'm sorry to say, is yes --- overwhelmingly and gladly. They'd love it, because 95% of them won't understand its long-term effects on their lives, their liberties, their access to first-class medical care, or even on their pocketbooks. All they would know is that they had to pay nothing out of pocket at the time and place of actual medical service, at least initially. The vast majority of Canadians had and still have similar difficulties in associating "free" benefits on one hand with massive increases in taxes, public debt, and inflation on the other. Canadians still do not understand that their rapidly decreasing access to first-class medical care is an inevitable consequence of these "benefits".

As to industry, unionized facilities such as Lee Iacocca's Chrysler Corporation and many members of the National Association of Manufacturers have already indicated that they would welcome Canadian-style medicine with open arms. Why not? It would allow them to foist onto the general taxpayer most of the cost of their present employee health plans. In the long run, they'll rue the day, but industry tends to concentrate on the needs and stresses of the moment without much concern for the long-range perspective.

As to physicians, most would, sad to say, also approve of the Canadian scheme --- whether because of inertia,

as in older doctors; or out of a fatalistic resignation to what many consider inevitable; or because they realize, from the experience of the medical profession after introduction of national health insurance in other countries, that they will earn far more money than at present, at least for the first few years; or because they actually welcome increasing government intervention out of philosophical convictions, possibly due to having grown up in an increasingly welfare-state, do-gooder environment. Whatever the cause, I predict that over 80% of your doctors would raise no significant objection to national health insurance. Some will grumble and scream; some will threaten and issue bulletins; some may even withdraw services temporarily. But eventually, especially if significant financial or other penalties are involved, the rush to join the bandwagon will be overwhelming. This has been the experience in nations all over the world, and I see no reason to believe that the US response will be different. You have already seen a portent of this in the alacrity with which American doctors have joined HMOs or accepted Medicare assignment, even when it was not mandatory.

As to health-related industries, their acceptance will at first be grudging because of the perceived governmental regulation. However, I would remind you of American economics Nobel laureate George Stigler's famous pronouncement that regulation usually ends up benefiting those being regulated. Consider the billions of dollars earned by the defense industries under government regulation. Who minds a little supervision when the supervisors will approve a $650 toilet seat?

WOULD THE SYSTEM LEAD TO BANKRUPTCY?

The US is still better off financially than Canada. But that situation will no long survive the introduction of a few of our open-ended social welfare schemes like national health insurance. Soon, the US, like Canada, would start lowering medical and institutional standards and reducing access to care. However, it takes a number of years for this to happen. In the meantime, the politician who fostered and promoted the system will be collecting votes, and the massively increased bureaucracy will have acquired a vested interest in maintaining and expanding the play. It took almost 20 years after the introduction of socialized medicine in Ontario for the politicians to grudgingly acknowledge, as our Minister of Health did last year, that "health care spending is on a collision course with economic realities." Yet any first-year economics student could have predicted, 20 years ago, exactly what would happen.

CONCLUSIONS

Let me give you the short answer to the question posed in the title of this address. If you define "could the Canadian model work here?" to mean "would it improve quality and accessibility of health care for a majority of Americans?" my answer is yes --- but only temporarily. Your citizens, like ours, will experience only briefly the medical Utopia that they have been promised, and at an enormous and eventually unbearable cost. Given your government's already astronomical deficits, I would guess that the time before imminent financial collapse would be much shorter than in Canada --- perhaps five years.

The crux of the problem in any national health insurance program like the Canadian one is the large and ever-increasing gap between politicians' extravagant promises, public expectations arising from those promises, and cruel financial reality. The reality, sad as it may seem, is that not even you, the richest country in the world can afford everything for everybody for very long.

It's a pretty dismal picture, isn't it? Yet, if you think about it, this is a hopeful circumstance for AAPS. You and others who share your beliefs have a long and bitter struggle ahead, with many disappointments. But I'm convinced that in the long run, you'll prevail. You'll win, not only because you have the courage of your convictions and the will to continue fighting, but because the Canadian-style edifice that your opponents are in the process of constructing is built on sand.

(Editor's Note: Dr. Goodman was incorrectly described in a previous article (Consent #6) as a "member" of Freedom Party. We apologize for any inconvenience or misunderstanding that may have arisen by this designation. Reprints of the above article, in pamphlet form, are available from the Association of American Physicians and Surgeons (AAPS), 1601 North Tucson Blvd., Suite 9, Tucson, AZ 85716. Refer to pamphlet 1007/10-89. Already in its fourth printing, the AAPS has distributed over 10,000 copies of Dr. Goodman's speech. It has also been printed and distributed by the Illinois Medical Journal, the Medical Association of Puerto Rico and appears in Vital Speeches of the Day.)

"Plus, our candidate has two great new ideas. He's going to work hard and be an honest politician."

"A man will fight harder for his interests than his rights." -Napoleon Bonaparte

Introduction: *Throughout the pages of our first eleven issues of* ***Consent****, a number of essays have appeared which deeply reflect upon the fundamental nature of our democratic system:* ***The Issue Is Consent (#1); Can Democracy Save South Africa? (#1); No Referendums, Please (#3);*** *and* ***Only Rights Reveal the Wrongs of Democracy (#8).*** *In addition, the first two parts of the essay series* ***Can We Survive Democracy?,*** *appeared in* ***Consent #5 (Pt. 1 - The Curse of Majority Rule)*** *and* ***Consent #6 (Pt. 2 - Freedom Betrayed: The Inevitable Course of Majority Rule).*** *The following essay is the third part of that series,* ***Theory vs. Practice,*** *and to be properly understood should be considered in light of the contents of the previous two installments, co-authored by Robert Metz and Marc Emery.*

Together, these essays, along with a sampling of other essays which have appeared in other ***Freedom Party*** *publications, will be reprinted in a future* ***special edition*** *of* ***Consent,*** *provocatively entitled:* ***Can We Survive Democracy?*** *If individual freedom is to survive as a viable political value, then a critical re-examination and understanding of the political system we institute to preserve that freedom is paramount.* ***Can We Survive Democracy?*** *will form the groundwork for that necessary reassessment of our democracy, the principles that drive it, and the inherent dangers and risks associated with any political system that subordinates individual rights to majority rule.*

CAN WE SURVIVE DEMOCRACY?

Part 3

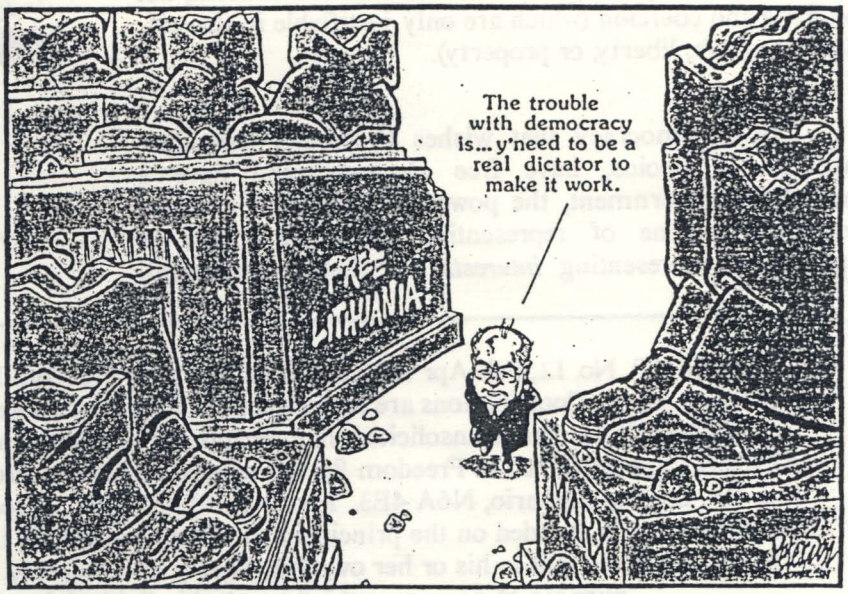
Theory vs. Practice

by Robert Metz

(Mr. Metz is president, leader, and founding member of Freedom Party)

Rather than offering a rational defense for the system of governance we have come to know as "democracy", most of its supporters merely end up apologizing for it. Fundamentally, their arguments all boil down to this: "What --- in practice, not in theory --- works better than democracy?" as if their inability to consider viable alternatives somehow constitutes an intellectual defense. But for those who ask, my answer is simply this: a social system under which individuals can freely exercise their freedom of choice, and where that freedom of choice is *protected* (by law!) from majority rule, not made subservient to it.

It is understandable that most people, when comparing "democracies" to totalitarian regimes, have come to associate the "theory" of democracy as a system of government that protects individual rights and freedoms; however, this is not true when democracy degenerates into a system of majority-rule, without the proper checks and balances that will guarantee the protection of individual rights and freedoms.



There are, after all, many kinds of "democracies" in the world; a failure to distinguish between free democracies and authoritarian democracies represents an intellectual and moral rejection of the former and acceptance of the latter. A democracy is no less socially evil than a totalitarian regime if it is incapable of protecting the individual rights of its citizens.

"The herd instinct makes the average man afraid to stand alone; he is always afraid to stand alone for an idea, no matter how good, simply as a matter of prejudice. Our herd, like every herd, when stampeded is liable to trample under its feet anybody who does not run with it." -Victor Berger

The *Oxford English Dictionary* defines "democracy" as "Government by the people; that form of government in which the sovereign power resides in the people as a whole, and is exercised either directly by them (as in the small republics of antiquity) or by officers elected by them. In modern use, often more vaguely denoting a social state in which all have equal rights, without hereditary or arbitrary differences of rank or privilege."

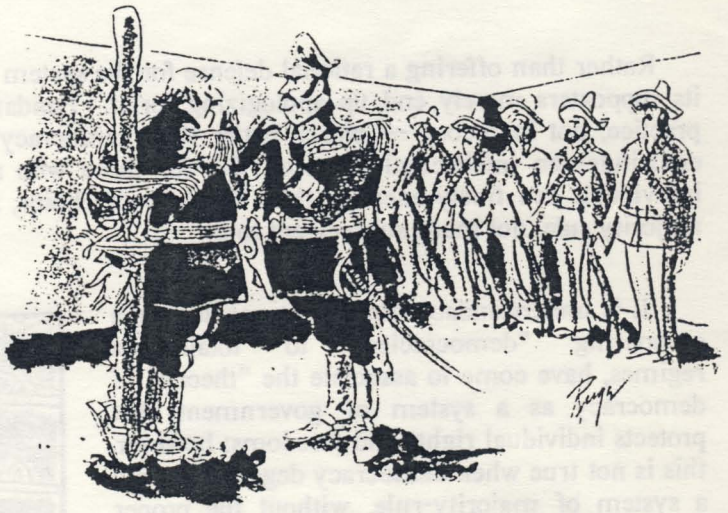
Thus, as you can see, even the dictionary definition of the word refers only to a "vague" association of democracy with equal rights, while making it very clear that *both in theory and in practice,* democracy bestows "sovereign power" upon majorities. If we now turn our dictionaries to the word "sovereign", we will discover that this does indeed mean "supreme in power, rank, etc.,; above all others; greatest; of or being a ruler; reigning." Now ask yourself a simple question: How can being "supreme", "above all others", or "being a ruler" possibly be compatible with a society where all individuals are *equal* before the law? The contradiction is obvious.

In a truly free society where individuals have equal inalienable rights, *no one,* not even "majorities", should have "sovereign" power over others; this destroys the entire spirit and original intent of "democracy". The only form of democracy compatible --- both in theory and in practice --- with individual rights and freedoms is the "democracy" of the free market, where individuals freely "vote" with their minds, their hearts, their actions, and their money for the things and ideals that they each individually support, and where they are not forced (i.e., legally coerced) to support causes or act in a manner with which they do not agree. In such a society, the rules of social behaviour would be based on the principles of voluntarism and consent, not on force and coercion (which are only justifiable in the self-defense of life, liberty, or property).

In a democracy that wishes to protect individual freedom of choice, have free elections, and have a responsible government, the power of politicians must be restricted to one of representing individual *rights* as opposed to representing *interests* --- whether individual, minority group, or majority group interests. Thus, the interest of individual, politicians, or lobby groups opposed to something like Sunday shopping should have no justifiable bearing on the rights of other individuals who may wish to shop or work on Sundays. When store owners are being legally forced --- even by a "democratic majority" (which, by the way, is not even the case in Ontario's Sunday shopping issue) --- to close the doors of their own private property on a given day of the week, then their fundamental rights and freedoms have been directly violated, not protected, by the "democratic" process.

I have heard many people, by their own admission, suggest that "Sunday shopping laws are ridiculous", yet go on to proudly boast their willingness to sacrifice their freedom of choice to the will of the majority: "I don't feel that stongly about it, and any way the matter turns out will be fine with me," said one editorial writer in the local press. Clearly, for apathetic individuals who are not even willing to stand up for what they believe in, Majority-Rule-Democracy may indeed "work best". But at what, and to what end?

This may well be the most profound political question facing generations of the next century.



"If I thought you were serious about wanting a change of government, I'd have resigned!"

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"One of the best ways to get yourself a reputation as a dangerous citizen these days is to go about repeating the very phrases which our founding fathers used in the great struggle for independence." - Charles Beard