Baneful Legacy: Medicare and Mr. Trudeau

The Constitution created by the Trudeau government is now threatening Canada's medicare system. What can be done to defend it?

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Well, the bomb ticking away at the heart of Mr. Trudeau's Constitution has finally gone off. An arrogant, ignorant and irresponsible court – jurisdictionally arrogant, substantively ignorant and politically irresponsible – has determined (by a vote of four to three) that medicare must be restructured to show due respect for the rights of those with money – and the rights of private corporations to make profits – regardless of the wishes of Canadians or the impact on our most important social institution. *Fiat justitia, ruat caela*. But if the heavens fall, what kind of justice is that? Ask those underneath.

"Judges," said Bacon, "ought to remember that their office is *jus dicere*, not *jus dare*; to interpret law, and not to make law, or give law. They must be lions under the throne, as Solomon's throne was upheld by lions" (Essays, "Of Judicature"). In fact, of course, their judgments inevitably do make new law, but always subject to the legislative authority of the Crown in Parliament. Ultimate sovereign power rests with the representatives of the electorate.

Or it did. Our new Constitution, of which Mr. Trudeau (among many others) was so proud, in effect permits the lions to climb onto the throne and thrust aside the sovereign. In the enthusiasm for individual rights, few can have imagined that these could be used to bring down medicare. It is difficult yet to say with any certainty how much damage has been done, and whether we are now committed in due course to

an American-style catastrophe. How severely will the allegedly guaranteed right to "security of the person" be abridged for the unhealthy and unwealthy? Much depends on the response by provincial and federal governments. But whatever public–private hybrid emerges will be less equitable and more costly than our present healthcare system. And there will be no road back.

The Constitution did originally provide for the ultimate assertion of parliamentary sovereignty through the "notwithstanding" clause. In some mysterious way, however, the Constitution has been silently amended, over the last two decades, to remove this last protection. How did this happen? The amendment was never formally proposed, nor its possible consequences debated; indeed, it has left no track in the written law. Yet, there seems universal agreement that it would be political suicide for any government, for any reason, to invoke the "notwithstanding" clause. Even Premier Ralph Klein, surely the most secure politician in Canada, backed away.

If ever there was an occasion for a government to reassert its ultimate sovereignty, nominally protected in the Constitution, with a reasonable expectation of strong public support, surely the time is now. But I wouldn't bet on it.

The disappearance of the "notwithstanding" clause has left parliamentary sovereignty conditional upon judicial deference. This is not a trivial defence, as illustrated in *Auton*.[1] But when it fails, four sovereign individuals, representing no one but themselves and responsible only to their own consciences, can dictate the future direction of our healthcare system. This looks more like judicial tyranny than democracy. "There is no social program that we have that more defines Canadianism or that is more important to the people of our country."[2] Well, so what? We think otherwise.

The Constitution is currently the most prominent part of Mr. Trudeau's legacy to medicare, but as always there is a history. At the end of the 1980s, surveys found higher levels of public satisfaction with healthcare among Canadians than in any other country surveyed. Ten years later, we barely ranked above the Americans. The reductions in federal transfers to the provinces, both the slow erosion of the 1980s and the much larger cuts of the 1990s (reductions made possible by the termination of federal cost sharing through the federally initiated EPF agreements of the late 1970s), led to major cuts in provincial hospital spending (real, per capita) in the early 1990s. Whether or not the system really was underfunded as a result is in fact debatable – the cost pressures were associated with a considerable reduction, long overdue, in unnecessary inpatient care. But there is no doubt in the media, or in the perceptions of the general public: the system is broken.

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1. *Auton (Guardian ad litem of) v. British Columbia (Attorney General)*, [2004] 3 SC.R 657
2. Premier David Peterson of Ontario, opening the International Conference on Quality Assurance and Effectiveness in Health Care, Toronto, November 8–10, 1989.

The decline in public confidence in the healthcare system, though not in the fundamental principles of medicare, created a golden opportunity for those who, for ideological or economic reasons, have always rejected those principles. Insurance companies, entrepreneurial physicians and private corporate providers more generally have always sought ways to circumvent restraints on their access to patients' resources. There is a great deal of money to be made by wrecking medicare. Meanwhile, those at the top of the income distribution have everything to gain from private payment, preferred access – and lower taxes. These interests, and their representatives, have generated a flood of lurid anecdotes, selective reporting and outright disinformation about medicare's failings and the need for private care, all uncritically recycled by the media. "If it bleeds, it leads." The daily successes experienced by millions of satisfied patients go unreported. What impact did this long-term campaign have on the members of the Supreme Court, and the social milieu in which they are immersed?

The cuts, as we all know, were motivated by the steady increase in the federal debt, following the recession of 1982 and the even bigger one of 1990–93, with slow and incomplete recovery between. By 1995–96 federal debt charges were nearly $50 billion per year, 37.6% of budgetary revenues, and the federal debt amounted to 69.3% of GDP.[3] What is rarely noticed, however, is that the net federal debt-to-GDP ratio actually began to rise in the mid-1970s. The long post-war decline reached a trough of 5.7% in 1974, but then began a slow and steady climb to 13.5% in 1981. The share of federal revenues absorbed by debt charges, 11.7% in 1973–74, had doubled to 25.1% in 1981–82 – just before the first big recession hit.

All of this was on Mr. Trudeau's watch. The federal operating budget, in surplus for all but two years from 1961–62 to 1974–75, then went into deficit and stayed there until 1987–88. Subsequent surpluses were too small to reverse the massive momentum built up by the accumulated debt; not until the huge operating surpluses of the mid-1990s did the federal government begin to regain fiscal ground. Those huge surpluses, however, required the large cuts in federal expenditures – and transfers.

The debt accumulation prior to the recessions of the 1980s was relatively small in light of what was to come. But the deficits of the later 1970s, interacting with historically high interest rates, weakened the federal fiscal position just before the economic weather turned foul. What if, in 1981–82, debt charges had been taking 5% of federal revenues instead of 25%? The brutal deficit-fighting of the 1990s, with its massive impact on the healthcare system, would at least have been much less severe.

So, what swung the federal operating budget sharply into deficit in 1975–76? Well- and conventionally trained economists, including those in the Department of Finance, were inclined to blame the rising costs of social programs, particularly public

3. Data here and subsequently are from Finance Canada, Fiscal Reference Tables, 2004.

health insurance. They tend to be suspicious of social spending generally, and deeply suspicious of "free" public services. They are ever alert for "allocative distortions" and "welfare burdens" generated (under powerful, rarely explicit and usually inappropriate assumptions) by such programs. Distributional questions – who gets what – are implicitly irrelevant, even though they are at the heart of all social policy.

A pair of humble number-grubbers at Statistics Canada, however, pointed out (to the discomfiture of Finance Canada) that the real answer was – tax cuts![4] Social spending surged in the late 1960s and early 1970s, but federal revenue growth was sufficient that the debt burden continued to fall. After 1974–75, spending growth actually flattened out relative to GDP, but revenues over GDP fell and remained permanently lower in response to major changes to the income tax.

Mr. Trudeau's government had stumbled, presumably inadvertently, onto the formula since used so deliberately and effectively by many right-wing governments: cut taxes, create a deficit, lament it and be "forced" to cut social spending. The result? Higher take-home incomes for the wealthy and fortunate, and lower public benefits for the unwealthy or unfortunate. Mr. Trudeau surely did not foresee or intend the ultimate effects of his tax changes. Those effects depended, *inter alia*, on the contributing impact of two major recessions. But the trail starts with him.

While apparently not hostile to the fundamental principles of medicare, Mr. Trudeau seems to have been more or less indifferent. That indifference has had very long-term and very negative consequences. The architects of medicare viewed universal coverage of hospital and medical services as only the first stage in the construction of a healthcare financing system that would be effective and efficient as well as equitable. Coverage should be extended to dental and pharmaceutical services – there was never any logic to their exclusion. And, armed with fiscal leverage, governments should take on the major task of structural reform of the delivery system itself. With the election of Mr. Trudeau, this follow-on agenda was quietly abandoned. We are now suffering the consequences.

Prescription drugs provide the leading example. Last year Canadians spent, on average, $562.05 each on prescription drugs, 13.8% of total healthcare costs.[5] Physicians and hospitals accounted for 12.8% and 29.9%, respectively. In 1975 prescriptions cost us $33.34, only 6.3% of the total, while doctors and hospitals took up 15.1% and 44.7%. Over the last 30 years, the share of our national income spent on prescription drugs has tripled, from 0.44% to 1.39%. Spending on doctors and hospitals, by contrast, has risen from 4.19% of GDP to 4.32% – essentially unchanged.

4. Mimoto, H. and P. Cross. 1991 (June). "The Growth of the Federal Debt." *Canadian Economic Observer*: 3.1–3.9.

5. Data here and subsequently are from the Canadian Institute for Health Information (2004), "National Health Expenditure Trends in Canada, 1975–2004." Ottawa: CIHI.

The point is well understood by students of healthcare finance. Sole-source public financing permits (but does not guarantee) global cost control; mixed and fragmented public and private financing promotes unconstrained cost escalation. Before medicare, spending in both Canada and the United States was escalating in parallel; the introduction of medicare was associated with an abrupt halt in the Canadian trend. Pharmaceuticals in Canada, financed in essentially the same multi-source way as American healthcare generally, show exactly the same pattern of continuing escalation.

These facts require constant reiteration, because the disinformation industry constantly promotes the message that public healthcare is "fiscally unsustainable" and that the only viable solution is a shift to more private coverage. Bluntly, this is a lie. Cost control has worked, when governments are on the hook for those costs and must tackle the political challenges they present. But a federal government with no responsibility for drug costs makes expensive regulatory concessions to the industry – backed by foreign governments. Provinces able to shift rising costs onto users, do so. Those costs come back again, of course, but are some later government's problem. So the escalation goes on, and by now Canadian patients, businesses and taxpayers pay several billion dollars a year in inflated drug costs.

It didn't have to be this way. Mr. Trudeau's government could easily have brought in pharmacare in the early 1970s. The sector was still relatively small and already partly funded by governments. Full public funding would have added another 6.5% to public sector health costs, well under one year's growth. In fact, the public share of drug costs went up sharply in the 1970s, anyway – but bought no control.

Today, however, Big Pharma is an international monster, vastly more wealthy and powerful than 30 years ago. It is hedged about with the barbed wire of trade agreements – for which its members provided good advice – and backed by the full weight of American trade policy. It has good friends in both Congress and the presidency.

Big Pharma is fully aware of, and bitterly opposed to, the cost-containment potential of universal programs. Every dollar of public or private cost is a dollar of their sales and, at the margin, mostly profit. A Canadian pharmacare program now, modelled on medicare, would not only be vastly more expensive, but would meet vastly more powerful resistance on many fronts. Big Pharma epitomizes Joel Bakan's description of the modern corporation as an amoral, sociopathic organization, profit- and power-driven, that seeks to escape all forms of social control (and in the United States has largely succeeded).[6] The chance that Mr. Trudeau's government threw away is probably lost forever.

That was then; this is now. Mr. Trudeau is history. What's the point?

Well, history can repeat itself, and when the same forces are at work, it does.

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6. Bakan, J. 2004. *The Corporation: The Pathological Pursuit of Profit and Power*. New York: Free Press.

Ignoring the threat of the private health insurance industry now can have the same long-run consequences as ignoring the pharmaceutical industry then. If private insurance becomes as solidly entrenched in Canada as it is in the United States, generating a similar scale of administrative waste – "costs without benefits"[7] – we will never get it out again. We will be permanently saddled with another inefficient and inequitable component in our financing mix, a component whose primary functions are to undermine cost control and to redistribute health costs from the healthy and wealthy to the unhealthy and unwealthy.

It was our great good fortune, when medicare was being introduced, that the private industry was insufficiently developed to put up much political resistance. Nor were there trade agreements, backed by foreign sanctions, protecting corporate rights to profit against the policies of duly elected democratic governments. That time is gone.

Mr. Trudeau's legacy underlines powerfully the very large, though sometimes very long-term, costs of failure to take appropriate action at critical times. The present threat to medicare has its origins in decisions taken, and especially not taken, 20 and 30 years ago. That threat is real and very serious and, most importantly, its effects will be irreversible. We, and our governments, need to be thinking immediately and very hard about how to salvage the situation.

Indeed, that same message comes from the advocates of private healthcare, when they tell us not to be unduly alarmed – that the Supreme Court's decision will not undermine medicare and may even strengthen it. When the right wing says: "Don't worry, be happy," we should worry a lot – and act. Now is no time to shrug.

What to do? My preferred choice, obviously, would be to disinter the "notwithstanding" clause, but that, as Sir Humphrey would say, would be a "courageous" decision. Just for starters, then, consider the tax-expenditure subsidy for employer-paid private health insurance – much less politically sensitive, and wholly within the jurisdiction of the federal government. Canadian governments actually cover about a third of the costs of these premiums by treating them as tax-free benefits. This subsidy could be removed selectively for, or perhaps more accurately not extended to, employer-paid health insurance that parallels medicare (as Quebec did when mandating employer-paid private pharmaceutical insurance). Taxing employer-paid premiums in the hands of the employee is no "magic bullet," but should at least inhibit the spread of private coverage. This could be done quickly, and the announcement alone would send a very strong signal of intent to defend. If we can no longer ban private coverage, for heaven's sake let's not subsidize it!

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7. Woolhandler, S., T. Campbell and D.U. Himmelstein. 2003. "Costs of Health Care Administration in the United States and Canada." *New England Journal of Medicine* 349 (8): 768–75.