Pro/Con for NY Update (Vermont) Privatization Concurrence

1. Should LWV US consider healthcare like other programs that provide and protect basic human needs, considered a public good?	
The LWV Healthcare position supports quality care that is affordable, accessible, and able to protect the health of the nation's most vulnerable urban and rural populations. Furthermore, it supports single-payer funding as desirable and viable approach with health insurance access independent of employment status.	We cannot afford to make unlimited healthcare a public good for all residents. Taxes will rise. Wait times may increase. Universal coverage would further ration resources and treatments, even for those able to pay. If they have insurance and can't afford the deductibles and copays, they should take advantage of less expensive plans. So long as the US does not treat healthcare as a basic human need, the League cannot.
2. If healthcare is a public good for people on Medicare (over 65 or disabled), should it be a public good for everyone?	
Everyone should have access to healthcare without coverage gaps or limits due to age, loss of employment, catastrophic illness or accident, exceeding income or asset limits for public assistance, etc. Lack of healthcare affects the whole community and cost-sharing (deductibles, co-pays, co-insurance, etc.) are so high that people are not accessing the care they need. Ensuring that the healthcare system keeps everyone well, not contagious, and prepared for public health emergencies, serves everyone. Communities benefit from people who are pregnant or raising families getting the care they need. Economies benefit from adults being healthy enough to be fully productive.	People who are young and healthy shouldn't have to pay higher premiums to cover the medical costs of people who are old and ill. It's not fair to make society pay for people's poor lifestyle, diet, or poor insurance purchase decisions. We as a society pool funds gathered over a lifetime of employment, to provide Medicare, but it is not sustainable. It's cost prohibitive to cover everyone with healthcare in a free-market economy and we have no social obligation to do so; however, we treat the elderly and disabled differently out of respect and compassion, not because it's required. Healthcare is now 20% of GDP; universal healthcare would crater our economy.
3. Should people be limited in their choice of doctor based on what they can afford for insurance, and what contracts employers of doctors may choose to sign?	
People who are happy with their doctor should be able to keep their doctor. People should be able to choose their doctor based on factors that they value (recommendations, distance, bedside manner) and not be limited by corporations.	Corporations claim to manage care more efficiently & effectively, in part by controlling cost and usage through in-network models. If a patient's doctor is not in their insurance network, they can change doctors.

4. Should healthcare decisions be made by patients and their doctors, rather than insurers and for-profit corporations?

Today, the insurer makes many decisions about provider access and treatment because the insurer determines what is covered and its cost.

Research shows that compared to people in countries with better outcomes and lower costs, US residents under-utilize health services, seeing doctors less frequently and having shorter hospital stays. In the US, unlike other developed countries, the decision to seek basic care includes concern about unaffordable cost.

Patients whose lives are at stake should make healthcare decisions with their chosen healthcare providers, who have the training and experience to guide them, involving trusted advisors or family as the patient chooses..

Physicians make their decisions based on medical standards of care. These decisions should not vary based on the patient's income or insurance coverage.

Patients will seek as much care as they can get, which is wasteful and leads to over-using healthcare resources.

Healthcare providers have a vested interest in providing more care than is needed to increase their earnings, to protect themselves from malpractice lawsuits, and to ensure good results on customer surveys.

Private entities know how to manage efficiently. A corporation can reduce overall costs by over-riding provider decisions that cause over-utilization, by providing incentives to reduce the amount of care provided, and by ensuring only medically necessary care is provided. We should trust the free-market mechanisms our economy is based on.

Without corporate restraints US residents would over-utilize health services even more than they do today, further accelerating healthcare costs.

5. Should allocation of healthcare resources be made based on fiduciary responsibility to patients and communities — or to shareholders of for-profit corporations who own the physician group, the hospital, the clinic, the nursing home and have a right to profit?

Equity is crucial in the distribution of basic human needs, but not in "free market" healthcare where middlemen (insurers) determine and collect payments and (without medical expertise) decide the health services to be rendered.

Patients are not customers; providers are not salesmen. Patient healthcare should be allocated based on medical need and decided by clinical standards of care, not on ability to pay. Healthcare resources for communities should be allocated based on public health assessment of community needs, not its wealth.

Free market principles distort the allocation of public goods by seeking to maximize profit rather than public benefit.

The majority of hospitals in the US are non-profit already and many corporate entities, including private equity corporations, have physicians on their boards of directors.

Nothing keeps funds collected for the purpose of providing healthcare from paying for private profit, as we do with prisons and road construction. Public-private partnerships marry the best of both worlds: public financing and private efficiency

Duplicating healthcare administration activities is the price we pay for the better service and customer-aligned care a competitive environment provides.

Spending tax-payer dollars wisely means letting the free-market work for us, letting efficient corporate entities be rewarded for their good management.

6. Is there any evidence that profit-seeking is limiting access and affordability?

As many as 40% of insured US residents report skipping medications or follow-up care because of cost.

If Americans were healthier, they wouldn't be so dependent on accessing healthcare.

The populations with the worst health have had worse health for generations and it runs in families.

Significant disparities in access and outcome persist (maternal mortality, medical debt, distance from care) for various vulnerable populations. Costs are out-pacing inflation — as are profits (especially for insurers, e.g., United Health). The federal Budget is under pressure to reduce benefits, while paying out billions in corporate profits/excess revenues and administration that give no value.	Whether it's a matter of genetics or poor decision-making, corporate profits don't cause most health disparities, such as those stemming from increased and mismanaged chronic disease among marginalized population segments. Healthcare costs in the US are higher for many reasons besides profit-seeking, such as the cost of malpractice insurance and a widespread higher standard of living.
7. Should there be public participation in the oversight of healthcare policy?	
Because the public must live with the medical, financial, and societal impacts of healthcare policy, healthcare policy should be transparent and subject to regulatory criteria to ensure protection of the public good. Further, healthcare funded by tax dollars should be held to high standards, particularly around equitable access and quality.	The general public doesn't know enough about healthcare policy to contribute meaningfully. Public participation in oversight could waste time and funds in lengthy decision making or misdirect resources based on non-relevant criteria. Public policy should recognize that corporations have great experience both in managing healthcare costs and in doing so profitably.
8. What would it mean that a for-profit entity would "fail to deliver programs that provide and protect basic human needs"?	
Examples of such failures — to greater or lesser degrees — abound in healthcare: nursing homes with higher death rates and more frequent hospitalizations (from falls, bed sores, infection), with insufficient staff to attend to residents, with sweetheart for-profit contracts. Similarly, insurers may charge a premium for managed care they don't provide, simply administering fee-for-service contracted labor, while reducing access to needed care via hurdles and delays.	For-profit entities have a right to make a profit and to keep their financial/operational records private. Healthcare can be very expensive to administer, and protecting against fraud requires strict tests of eligibility and medical need. Further, over-utilization is a driver of cost that must be stopped or slowed, even if doing so triggers complaints from patients and their families who feel entitled to more than is efficient to provide.
9. Isn't de-privatization an extreme step?	
All LWVs assess every bill prior to supporting, opposing, or seeking to amend it. Leagues will assess if de-privatization is warranted, e.g., in failing to serve the public good by failing in equitable health access or quality. If regulation, constraint, or oversight could fix the failure, the League could advocate for that — after determining its cost/benefit in comparison to de-privatization. Public policy that funds assets/services that serve basic needs with taxpayer dollars requires fiduciary responsibility to the taxpayer/public purse.	Governments should not take over ownership or management of private enterprises. That is the definition of socialism. Healthcare facilities and businesses have a right to make a profit, and healthy competition focused on profit is what makes the free market work. When a market is not working, it may be caused by over-regulation that has stifled innovation and new technological solutions. Adding regulation or depriving corporations of the revenue needed to engage in free-market practices is short-sided and will lead to further inefficiencies and poor performance, not better.

10. Should all healthcare be de-privatized to remove "profit" from healthcare?	
Not at all. Corporations composed of providers exercising fiduciary duties to patients may earn more because corporate middlemen no longer "squeeze" them. Providers who serve patients well are serving the public good, not failing to serve it. At risk of de-privatization are corporations that — to increase profits — limit, delay, or refuse clinical standard of care.	Governments should not take over private enterprises. That is the definition of socialism. This is a slippery slope that needs guardrails. The threat of de-privatization may cause private entities to refuse to make the investments required to improve healthcare services or to refuse to invest in leading edge treatments or medications, reducing quality of care.