6. Does this Update completely reverse the Privatization position?

from being about privatization of public goods to being about the de-privatization of public goods?

The US League assures us that EVERY position includes accountability, even when accountability is implicit. In this case, the position is not totally silent about de-privatizing or in-sourcing: noting control of a public good "will be returned to the government if a contractor fails to perform." This is, definitionally "in-sourcing," AKA "de-privatizing," AKA returning a public good to public control.

About 70% of the position guides League advocacy on **transfers from public** to private and 12 words mention transfers BACK to the public. That concept is already in this position, and it in no way reverses it. Note the Update does NOT address privatizing any goods OTHER than public goods. The sole focus is on public goods, where the default is public control.

The Update does not reverse the current position. It only provides a clear standard for "fails to perform": "fiduciary responsibility to the public." Any private entity that serves the public adequately doesn't fail the standard and wouldn't trigger support to de-privatize or in-source.

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and pathology; Pharmacology & Immunology such as how drugs interact with the body and how diseases attack it; Clinical Skills such as learning how to interview patients, take medical histories, and perform physical exams; Medical Ethics & Law.

Public Health — People who want to work in public health attend schools of public health, focusing on Epidemiology, tracking disease outbreaks; Biostatistics, analyzing health data; Environmental Health, toxins and occupational safety; Health Policy, healthcare systems; and Social/Behavioral Sciences, community health education.

Update to Privatization Position

(LWV PWM/NYS, VT, and 90 more state & local Leagues)

FAQ & Fact Sheet — Part A

The Bottom Line:

- Our Privatization Position is about the control of public goods, defined as essential needs.
- Our Health Care Position does not address ownership and control, privatization or de-privatization, instead focusing on LWV goals of universal and affordable access to coverage.
- The Update provides a clear standard for Leagues to judge when a private entity "fails to perform" and brings the position into conformity with the rest of Impact on Issues, where health care is considered a basic human right and need.
- Privatized public goods typically cost more, offer less quality, exacerbate structural racism and DEI issues, and are harming democracy

A. The current PRIVATIZATION Position VS the current HEALTH Care Position

1. This Update is about health care, so why is it billed as Privatization?

The current national HC position does not provide criteria for legislating or regulating control of public goods (which is the focus of the Privatization position). This means it does not support advocacy such as below.

- opposing further privatization of healthcare — see FAQ #4
- prohibiting new for-profit entities (like for-profit hospices or nursing homes)
- insourcing, transferring back, or deprivatizing (all the same thing) any public good

2. Does this Update conflict with the LWVUS position on health care?

a) Since the current position supports a mix of "private and public"?

There is no conflict. The current HC position supports "administration ... by a combination of private and public

sectors" (language from 1991, before subsequent evidence-based research concluded that privatized healthcare harms patient health and wastes taxpayer dollars).

The 2022 Update could not remove this language per LWV rules even though it is now counter-factual.

It also supports "a national health insurance plan **financed through general taxes** in place of individual insurance premiums" and "the **single-payer concept** as a viable and desirable approach to implementing League positions on equitable access, affordability, and financial feasibility" (language added in 2022).

b) Since the current position does NOT OPPOSE further privatization of health care?

Like all other privately controlled (and often publicly funded) public goods, privatized control is opaque, difficult to audit and regulate — but highly profitable — so private equity acquisition (in particular) of provider groups and facilities has been accelerating, with more than $1 Trillion spent over the past decade.

About 35% of Americans are covered by public programs — but within those public programs,

- **78% of Medicaid enrollees** are in (private) Managed Care Organizations,
- **50% of Medicare** beneficiaries are in Medicare Advantage (fully private programs),
- **53% of traditional Medicare** beneficiaries see providers in (private) "accountable care"
- over **40% of veterans** get healthcare outside the Veterans Administration.

The Update allows local/state Leagues to support legislation that limits **"further privatization of healthcare, which is the most privatized public good in the country"** — but doesn't mandate action.

3. Why Update the Privatization position? Why can't we just use the current one?

In 2023 NYS Leagues attempted to use the national privatization position to advocate for NYS legislation and were told "the national position does not allow advocacy" to deprivatize nor to use "failure to serve the public" as a reason to regulate bad actors. AFTER LWV NYS adopted the Update in 2025, we again sought to advocate and were allowed to do advocate for 5 bills, supported by using the privatization position (not the Healthcare position).

We believe this demonstrates a need for the national position to be clarified because states with significant experience using positions for advocacy don't seem to use the national Privatization position. Indeed, the current Privatization position (2010) is the only national position adopted before the 2024 Convention WITHOUT any legislative history, making it somewhat problematic.

4. How is the Privatization position different from the Health Care position?

a) The HC position is about **patient care and supporting League goals for every resident** —full access to universal, affordable, and comprehensive care, funded fairly.

b) The Privatization position is about the ownership and control of public goods —70% of the text offers guidance on transfer from public control to private control, with one mention of transfer back.

c) The Update expands that mention to provide a clear standard to support League advocacy for legislation to reform predatory privatization by asserting more public control over public goods.

5. The current Privatization position includes public health so doesn't it therefore include health care?

a) The Health Care Position focuses on League goals for clinical care —universal (for every resident), affordable (to patient and taxpayer), comprehensive (breadth of coverage) care to individuals.

b) Public health refers to epidemiology — *who* is getting sick, *where* the disease is occurring, and *why* it is spreading — focusing "upstream" to recommend how to prevent illnesses, injuries, and health disparities across large populations.

c) Health Care and **Public Health** are distinct professions and distinct academic discipline[1]

[1] **Health Care —** People who want to work in clinical care attend medical, osteopathic, and nursing schools (beginning with Basic Science such as anatomy, including hands-on cadaver dissection, biochemistry, histology, and