Green Mountain CITIZEN

Fall 2023

LWVVT Prepares for Privatization Consensus

INTRODUCTION

The LWVUS adopted a position on Privatization in 2012. The position states, in part, "Privatization is not appropriate when the provision of services by the government is necessary to preserve the common good, to protect national or local security or to meet the needs of the most vulnerable members of society. These services include the electoral process, justice system, military, public safety, public health, education, transportation, environmental protection, and programs that protect and provide basic human needs."

Although the position specifies public health, public safety, and basic human needs on the list of public goods, it does not specify health care; and it does not address concerns about services (and the cost of services) that are currently provided by the private sector that might be better provided by the public sector.

At its convention in June, the LWVVT voted to conduct a study determine if we believe health care should be included as a public good. The intent of this study is to provide a well-researched position with which other states may choose to concur, and to propose a national concurrence to the 2024 LWVUS Convention.

Scope: *To examine and evaluate the various ways that health care fits the criteria to be included as a public good as defined in our position; and whether the position should be expanded to include the other direction as well: movement of services that are public goods from the private sector to the public sector.*

The remainder of this article is to provide you with background and information found in our research that will prepare you to participate in our **consensus meeting** on **Thursday, Nov. 9 at 7:00 pm by Zoom.** We also hope you will find it interesting in itself. -- The Study Committee

WHAT IS A PUBLIC GOOD?

Public Good: A commodity or service which if supplied to one person is available to others at no extra cost. It may be contrasted with a private good where one person's consumption precludes the consumption of the same unit by another person. A public good is thus said to exhibit non-rival consumption; one person's consumption of the good does not reduce its availability to anyone else. The provision of a public good is a matter of collective choice. Generally, we expect to find public goods provided by governments and paid for through compulsory taxation.[1]

But there are other definitions:

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"The history of civilization is a history of public goods... The more complex the civilization the greater the number of public goods that needed to be provided. Ours is far and away the most complex civilization humanity has ever developed. So its need for public goods – and goods with public goods aspects, such as education and health – is extraordinarily large."[1]

June Sekera[2] writes: "From a functional perspective, public goods are created to serve a *public purpose*. That fundamental purpose is to *meet the unmet needs of a society.*

"Public goods are created by human effort, as contrasted with "natural goods." Air, water and land are *natural* goods. Air is a natural good; *clean* air is a public good. Land is a natural good; *national parks* are public goods. Some public goods (like standards, regulations and land preservation) are created to *protect* and *preserve* natural goods or to make essential resources, like water and air available or suitable for human consumption."

Public goods also vary by place: things that are public goods in one country may not be so in another. Health care for all has long been a public good in most developed countries, but not in the U.S. Education is "free" for all in many countries, but in some countries it is free through university level, and in others parents must pay individually for their children to be educated even in primary grades.

PRIVATIZATION

Privatization is the transfer of government services to the private sector (that is, to corporations, including for-profit enterprises). State-owned assets may be sold to private owners. Statutory restrictions on competition between privately and publicly owned enterprises may be lifted. Services formerly provided by government may be contracted out. Services that were once administered, staffed, and fully funded by taxes that have been privatized include airport operation, government data processing of government operations, corrections (prisons), water and wastewater utilities, waste collection and disposal.

Government operations that have been outsourced include Maximus Inc., which administers federal assistance programs such as Medicaid and Medicare, Children's Health Insurance Program (CHIP), welfare-to-work, and child support enforcement. Most states also outsource state assistance programs.

Major areas of privatization in the US (Wikipedia) are:

Medicare and Medicaid managed care

In the United States, under Medicare managed care the government pays a managed care organization (MCO) a fixed amount called the "capitated rate" for all medical services received by a beneficiary in a given period. Enrollment in the programs has increased substantially since 1990; in 2002 60% of Medicaid beneficiaries and 12% of Medicare beneficiaries were being treated by MCOs. (Consider, however, Connecticut's experience after taking back Medicaid managed care from private insurance: administrative costs dropped from 25% to 3.5%.)

Welfare

Homeless shelters and food banks are now typically run by nonprofit private organizations, which also provide treatment services, operate Head Start programs and work with child welfare agencies. Privatization of welfare system expanded in 1996, when the Aid to Families with Dependent Children (AFDC) program was replaced with the Temporary Aid to Needy Families (TANF) program. Welfare services that are most often privatized include benefits administration, workforce development, job training and job placement.

Public education

The private sector has become increasingly involved in public education, e.g., charter schools, Educational Management Organization (EMOs) and school voucher programs. EMOs, typically for-profit entities, manage charter schools and sometimes traditional public schools.

Private prisons

In the US, private for-profit prisons housed 12.3% of all federal prisoners and 5.8% of state prisoners in 2001. Contracts for these private prisons regulate prison conditions and operation.

SHOULD HEALTH CARE BE A PUBLIC GOOD?

Months before the LWVVT Convention adopted a study of health care as a public good, the Health Care Committee presented public programs on the impact that privatization of Medicare is having on our health care and pocketbook. What we learned was valuable to our study of what things are or should be provided by public or private sources.

Our February 2023 presentation at Montpelier's Kellogg-Hubbard Library was recorded for public access television. You are encouraged to watch it in preparation for the December consensus meeting: **<https://www.youtube.com/watch?v=TBlduVzyolo>**

Fifty years ago, Kenneth Arrow,[4] an eminent health care economist, argued that free-market models do not apply to health care:

- patient demand for health care is erratic, unpredictable, and often life-threatening;
- providers are expected to behave differently from ordinary sellers, e.g., they are expected to put patient health before sales quotas, that is, the patient's objective need for care, not the provider's personal financial self-interest;
- unlike an efficient market, both sides often have uncertain information about the quality, cost, and effectiveness of the service being bought (the patient is buying the provider's knowledge but even the provider cannot predict the prognosis or how the patient will respond to treatment);
- finally, the supply conditions and pricing mechanisms do not follow “free market” rules.

Uwe Reinhardt,[5] who in 1989 helped Taiwan move to a single-payer system, argued that the notion of "cost efficiency" has a very narrow economic definition (i.e., being "Pareto optimal") and is inappropriate when discussing health care. *[Pareto optimality (also referred to as Pareto efficiency) is a standard often used in economics. It describes a situation where no further improvements to society's well-being can be made through a reallocation of resources that makes at least one person better off without making someone else worse off.]*

Similarly, Reinhardt questioned the way cost-benefit analysis is often applied to health care, offering this hypothetical: "Suppose the Jones family is wealthy and has a healthy baby, and the Smith family is poor with a sickly baby. ...[and cost of care] resulted in 5 visits demanded by the rich Joneses with the healthy baby, but only 3 by the poor Smiths and their sickly baby. To an economist, this is optimal: people's willingness to pay reflects the value they ascribe to the care." Reinhardt's bottom line: “Granting more visits to the sick child and fewer to the health child – would be 'inefficient' as the term is defined in standard 'welfare economics'.”

A 2020 McKinsey[6] report, *Prioritizing health: A prescription for prosperity*, noted that health care has long been recognized as a "crucial determinant" of a country's overall well-being, it also has significant economic impact. Better health grows the economy, productivity, and the labor force. Similarly, poor health and poverty have a two-way causality. And, in the US, medical debt triggers most bankruptcies. Better health also improves national security and military readiness.

The issue is not simply whether ownership is private or public. Rather, the key question is under what conditions will health care providers and the organizations that employ them be more likely to act in the public’s interest — providing equitable, accessible, affordable quality care. Privatization replaces

managers focused on agency mission and oath of office and answerable to taxpayers —that is, to all of us – with managers who are legally obligated to maximize shareholder return on investment.

In his book *Equal is Equal, Fair is Fair,* Allen Gilbert[7] writes, "Perhaps there is something unique about health care than makes reform of medical services so difficult. Medical needs are individual. Some people get cancer or need a hip replacement, and others don't. Even if you get prostate or breast cancer, there's a question of whether expensive surgeries are justified."

A recent development regarding Medicare Advantage plans:

Medicare Advantage provides health coverage to more than half of the nation's seniors, but a growing number of hospitals and health systems nationwide are pushing back and dropping the private plans altogether.

Among the most commonly cited reasons are excessive prior authorization denial rates and slow payments from insurers. Some systems have noted that most MA carriers have faced allegations of billing fraud from the federal government and are being probed by lawmakers over their high denial rates.

CONSENSUS

Your part in completing this study is to take part in the consensus meeting on Nov. 9, where we will consider these questions:

Where is the US health care system most efficient and most equitable? What groups of our population do not have equitable access to health care today, with particular attention to marginalized and underserved populations? What aspects of our health care system exacerbate these disparities?

Should health care be a private good or a public good? (A private good benefits only the individual and only individuals who can buy it can access it. A public good benefits everyone and everyone should have access to it.) Should people only have access to health care if they have the money to pay for it?

If health care is a public good for people over 65 or disabled, why isn't it accessible to everyone? Why isn't it a public good for everyone?

What effect would equal access to healthcare for everyone have on the quality of life of our people, and the productivity of our country?

REFERENCES

1. Wolf, Martin (2012) "The World's Hunger for Public Goods," *Financial Times*, Jan. 4, 2012

2. Pearce, David (Ed,) (1992) *The MIT Dictionary of Modern Economics, 4th Edition*

3. Sekera, June (undated teaching module) *Public Goods in Everyday Life*, Tufts University Global Development and Environment Institute

4. Arrow, Kenneth (1963) *The American Economic Review, Vol. 53, Issue 5*

5. Rice, Thomas (2020) "Uwe Reinhardt on being a good economist," *Health Services Research, Vol. 55, No. 6*

6. Remes, Jaana, et al. (July 2020) "Prioritizing Health: A prescription for prosperity," McKinsey & Co.

7. Gilbert, Allen (2020) *Equal is Equal, Fair is Fair,* Onion River Press, Burlington, VT

More resources used in our research can be found at
https://drive.google.com/drive/u/1/folders/181Lf6j2D_yxId7bEIeKiqlDbWH5CI8vS.

Participate in Community Forums for Health Care Reform

(Special Report)\

This fall, League members have an opportunity to provide important information about their experiences with the current health care system and their suggestions for improvements in service delivery. In 2022, the Vermont legislature passed Act 167: An act relating to health care reform initiatives, data collection, and access to home- and community-based services, calling for health-care delivery reform in the state of Vermont. Input from community members is a central part of this legislation. The League worked with other health care advocates to ensure that Act 167 included a robust community engagement process.

In late October and November, the Green Mountain Care Board, in collaboration with the Agency of Human Services, is holding a "listening tour" to hear directly from Vermonters about their current "lived experiences" with the health care system and their suggestions for future system changes.

Specific questions to be explored include

I*s the health care system serving you and your family?*

Are you able to access and afford the care you need?

What do you want to see more of in your community?

The Board has scheduled virtual **Community Engagement Meetings** that are organized by region based on Vermont's 14 hospital service areas at the following times:

Barre / Central Vermont Medical Center
Wed., Nov. 15, 2023 from 4:00 - 6:00 pm

Bennington / SW Vermont Medical Center
Wed., Nov. 1, 2023 from 4:00 - 6:00 pm

Brattleboro / Brattleboro Memorial Hospital
Thurs., Nov. 2, 2023 from 4:00 - 6:00 pm

Burlington / UVM Medical Center
Fri., Nov. 3, 2023 from 4:00 - 6:00 pm

Middlebury / Porter Medical Center
Mon., Oct.30, 2023 from 4:00 - 6:00 pm

Morrisville / Copley Hospital
Wed., Oct. 25, 2023 from 4:00 - 6:00 pm

Newport / North Country Hospital
Tues., Nov.7, 2023 from 4:00 - 6:00 pm

Randolph / Gifford Medical Center
Wed,, Nov. 8, 2023 from 4:00 - 6:00 pm

Rutland / Rutland Regional Medical Center
Thurs., Nov.9, 2023 from 4:00 - 6:00 pm

Springfield / Springfield Hospital
Mon., Nov. 13, 2023 from 4:00 - 6:00 pm

St. Albans / Northwestern Medical Center
Tues., Nov. 14, 2023 from 4:00 - 6:00 pm

St. Johnsbury / NE Vermont Regional Hospital
Thurs., Oct. 26, 2023 from 4:00 - 6:00 pm

Townshend / Grace Cottage Hospital
Fri., Oct. 27, 2023 from 4:00 - 6:00 pm

White River Jct. Mt. Ascutney Hospital and Health Center
Mon., Nov. 6, 2023 from 4:00 - 6:00 pm

Four State-wide /All Hospitals Community Meetings are also scheduled on the following dates:

Wed., Nov.1, 2023 from 9:30 - 11:30 am

Fri., Nov. 3, 2023 from 9:30 - 11:30 am

Mon., Nov. 6, 2023 from 9:30 - 11:30 am

Wed., Nov. 8, 2023 from 11:30 - 1:30 pm

The Board invites community members to join the discussion "for any region you feel connected to – this could be where you or your loved ones live, work, or receive health care services." Those who cannot attend the meeting for their region or who want to provide additional input can attend one of the state-wide meetings and/or submit written comments.

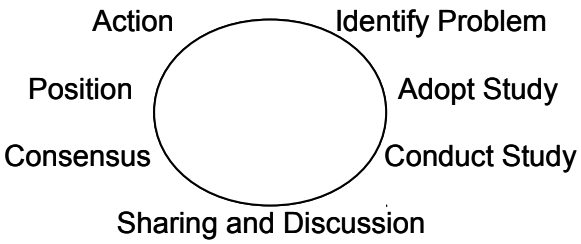
Information about the community engagement process, including links to register for the meetings is at https://gmcboard.vermont.gov/Act-167-Community-Meetings.

LEAGUE OF WOMEN VOTERS OF VERMONT

Consensus: Linchpin of League Program

The League of Women Voters' credibility comes from how the League works – how it arrives at its lobbying (action) positions. However, not everyone understands just what the process is, and new members, especially, need an explanation of how the League works. Below is a brief review, which we hope will demonstrate how important member participation is.

The process:



The League "program" (issues chosen for study and action) is adopted by the membership at the local annual meeting and at biennial state and national conventions. There are local program planning meetings at each level in advance to determine the will of the membership and to guide the leadership in recommending programs.

Upon adoption of the program, study/action committees are self-selected. After several months of study by interested members, findings are presented and discussed by the general membership and consensus is (or is not) reached. *Consensus is a process which aims at arriving at some general agreement through group discussion*. It is not determined by a simple majority, nor is it unanimity, but an overall sense of the group.

A position statement is drawn up on the basis of consensus, and is in turn the basis for League action.

It is because League positions are based on research, discussion, and critical examination by the membership that the LWV has such credibility when it takes political or educational action.

The process is the same for every level of the league: information is presented to local units which then reach consensus. Results from all over the state or country are then tabulated to develop a position at the study level. Local action may be taken under state or national positions. Members or local Leagues need not agree with a state or national position, but may not take action as a League (or League member) in opposition to it.

It is easy to get the impression that the study (or research) portion of the program is the most important part. But as you can see for the chart, there is much more involved. Up to this point, except for adoption at the annual meeting, only a relatively small group of league members have been involved. But the work is only half finished.

All members now have a chance to participate in a study through consensus. Consensus questions should elicit responses that will give the League the basis for an action position. Information is provided, through the newsletter and/or at a consensus meeting, to allow members to give informed responses. Without broad participation in consensus, a study is of benefit only to those who conducted it. A handful of people cannot presume to speak for the League membership on controversial issues. Without a position backed by research and the informed opinion of the membership, no action can be taken.

You joined the League because you believe in its mission as a force for political action and voter service. We recognize that not everyone has time for active involvement in League program. But please make a commitment to come to consensus meetings – two or three hours out of 365 days in the study year. The vitality of the League depends on it.

GREEN MOUNTAIN CITIZEN

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