Pro/Con for Proposed Update on Privatization

Question	Pro — Adopt the Update	Con — Don't adopt the Update
1. Should everyone in the United States have access to health care that is affordable to them?	A country with our stature and resources should ensure that all of us have access to health care. It's the right thing to do. We spend more public dollars (raised through taxes) per capita on health care than other countries. We are already paying enough to provide health care for everyone, if all the funds actually went to health care instead of excessive administrative costs and profits. Fiscal responsibility would require us to use those funds to cover what taxpayers intended: health care, not administration and profit. People can go bankrupt from medical debt even when they have insurance, and even without catastrophic illness. Half of US bankruptcies involve medical debt, with most of these for people who had insurance.	Health care is not a human right. We can't afford to make **unlimited** health care a public good for everyone living in the United States. People's access to health care should be influenced by their ability to pay If we provide health care without asking anything in return, people will abuse the system. If they have insurance and can't afford the deductibles and copays, they should take advantage of less expensive plans. Before we make any changes, we should be sure it's not regulations that are causing the high cost of health care.
2. If health care 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 health care without coverage gaps or limits due to age, loss of employment, catastrophic illness or accident, exceeding income or asset limits for public assistance, etc. Deductibles are so high that people are not accessing the care they need. 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.	There's nothing wrong with providing care relative to what people can pay. 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 insurance purchase decisions Providing health care as a public good to people with

	Lack of health care affects the whole community. Using the health care system to keep everyone well (and not contagious), and to be ready for public health emergencies, serves everyone.	disabilities who are 65 years of age or older just means we have compassion for them, not that they have a right to it. Private corporations don't want to insure the disabled or the elderly at a price they can afford, so we as a society have decided and continue to agree to pool funds gathered over a lifetime of employment, to provide that insurance. We don't have an obligation to do this.
3. Should hospitals be distributed such that rural residents, or inner-city residents, can (geographically and culturally) access care?	Everyone deserves to have a hospital within a distance that's safe for preserving health. We need farmers to grow our food, and we want hospitals to be distributed such that they are available when we travel for work or recreation. People with limited resources may have trouble getting to a hospital in a different part of town, or in a distant town.	Constantly losing money isn't a sustainable business model. If we want local access to health care for everyone, we need a model that doesn't constantly lose money Telehealth and other remote delivery options could be part of a less costly solution
4. 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 recommendations, distance to get to them, and other factors that they value, and not be limited by corporations'.	Corporations have data showing they manage care more efficiently & effectively, in part because of in-network models. If a patient's doctor is not in their insurance network, they can change doctors,

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5. Private for-profit corporations have a fiduciary responsibility to their shareholders rather than to patients or public health. ***Should the allocation of health care resources be made on the basis of responsibility to patients and communities?***	Health care resources for individuals should be allocated based on medical need, determined by clinical standards of care. Health care resources for communities should be allocated based on public health assessment of community needs. Because health care cannot follow free market principles, allocation of resources should not be left to the "free market." Whereas equity is crucial in the distribution of basic human needs, the "free market" does not take equity into account in allocation of goods and services. Health care is not a commodity, and people who need health care are not customers. Making the provision of health care a financial transaction distorts the cooperative nature of the ideal provider-patient relationship.	The majority of hospitals in the US are non-profit already. Funds collected for the purpose of providing health care can also be used to pay for private profit, as we do with prisons and road construction. Duplicating healthcare administration functions 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.
6. Should there be public participation in decisions about health care policy and its evaluation?	Because the public must live with the medical, financial, and societal impacts of health care policy, the public must be engaged in making these decisions.	The general public doesn't know enough about health care policy to contribute meaningfully, and they might cause misdirection of resources or other problems.
7. Should there be public participation in oversight of health care policy?	After policy is implemented, oversight and enforcement are crucial for meeting health care policy goals and public health goals. Because health care involves a large chunk of our economy and entities seeking profit have resources to thwart	The general public doesn't know enough about health care policy to contribute meaningfully to oversight. Public participation in oversight could waste time and funds in lengthy decision making and

	actions intended for the public good, transparency is essential for access by journalists and the public to factual information, and the public must have a seat at the table for oversight. Elected representatives are subject to lobbying by special interests; true public oversight requires representatives from nonprofit stakeholders across a broad range of constituencies, including civic groups.	highly contentious stand-offs, or could cause derailment of appropriate health policy. Public policy should recognize that corporations have great experience in managing health care costs while making a profit. The public already has oversight through their elected representatives.
8. Should health care decisions be made by patients and the health care providers they choose?	Health care decisions should be made by patients, who have to live, or die, with the results; and their chosen health care providers, who have the training and experience to guide them in their health care decisions; with input from their trusted advisors and family. Physicians make their decisions based on medical standards of care. These decisions should not vary based on income level or insurance coverage of the patient. Research shows that compared to people in countries with better outcomes and lower costs, US residents under-utilize health services, seeing their doctors less frequently and having shorter hospital stays. In the US, unlike other developed countries, part of the decision about whether to seek even basic care is whether they can afford it, before they have had a chance to get advice from their health care providers.	Patients have a bias for wanting as much care as they can get, which is wasteful. Health care providers have a vested interest in providing more care than is needed to increase their earnings and to protect them from malpractice lawsuits. A corporation can reduce overall costs by overriding 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. Without corporate restraints US residents would over-utilize health services even more than they do today, further accelerating health care costs.