# Resolved: The United States has a moral obligation to adopt a single-payer healthcare system.

**Author: Scott Pettit**

**Edited by: Kyle Cheesewright**

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# TOPIC OVERVIEW

Thanks to the 2016 Presidential Election, single-payer healthcare has become a topic that is receiving a lot of attention in the United Sates. Bernie Sanders made single-payer healthcare a main talking point during his campaign. Donald Trump at one point even suggested that we should be seriously investigating the potential benefits of such a system. There are plenty of resources about single-payer healthcare but beware of the politics. Make sure your chosen resources are sourced from non-bias sources in order to ensure a quality debate.

The first thing to consider when looking at this resolution is the definition of single-payer healthcare. Contrary to popular opinion, the term does not always refer to socialized medicine. The basic definition found in Webster’s Dictionary is “of, relating to, or being a system in which health-care providers are paid for their services by the government rather than by private insurers”. The definition does not indicate who provides the healthcare. Some might chose to argue that the resolution indicates the government would provide the healthcare but this reasoning is reckless and non-topical.

There are examples of single-payer systems in the world that would be good to understand. Canada has been using a single-payer system for many years. The uniqueness of the Canadian system is that it uses private providers. The system has been compared to Medicare/Medicaid in the United States. There are both praises and criticisms for the Canadian system. Praises include equal access and longer life expectancy. Criticisms include waiting lists and a lower quality of care. Keep in mind that most of the literature found through simple internet searches are going to be political on this issue.

In 2011, Vermont passed a bill that would establish the first single-payer healthcare system in the United States. The plan was to use a private/public partnership that would create a single-payer entity, Green Mountain Care, which would insure all citizens of Vermont. In 2014, the Vermont State Legislature abandoned the plan before being fully implemented citing higher taxes and burdens placed on small business owners.

Affirmative strategies most show that single-payer healthcare is morally required. The affirmative does not need to present a plan or defend the feasibility of such a program. The resolution clearly states that the United States only has a moral obligation. Human rights, justice, and morality are going to be the bulk of the affirmatives strategies. The affirmative will also want to address the multiple issues with the status quo of American healthcare such as affordability, accessibility, and inequality. A parametric view may be sufficient to advocate for the affirmative but it isn’t necessary and might provide the negation with an easy way to argue against a very narrow argument.

The negation side of the argument needs to explain why single-payer healthcare is immoral. The negation does not have to try to convince the judge that the status quo is good or doesn’t need to change. Doing so might make the negation seem a little out of touch with reality. You could accept the status quo is dysfunctional and unjust while advocating that a single-payer system will not improve the issues or a single-payer system might make things worse. There is evidence that shows a single-payer system might be more expensive. The negation could use the current status of Medicare in the United States as an example of what would happen if the entire nation would adopt such a system.

Here are a few questions to consider. Can a single-payer system in the United States solve for some of the accessibility issues for the poor or can charitable organizations solve this issue? Would requiring all Americans to participate in a single-payer system violate the rights of the individual? Is it moral for the state to compete against the current health insurance industry in place? Is the access to healthcare a human right? If so, what happens when the right to healthcare conflicts with other human rights?

# AFF CASE

## 1AC

### Introduction

#### The US has a moral obligation to adopt a single payer system

Kennedy 1998 (Edward [US Senator], *Healthcare for All Americans*, Human Rights, Vol. 25(4), 1998)

This year marks the fiftieth anniversary of the Universal Declaration of Human Rights, and it is fitting to reflect on the nation's progress toward ensuring that healthcare is treated as a basic human right. According to Article 25 of the Declaration [of Human Rights], every person has a right to medical care and security. This ideal was reaffirmed and expanded in Article 12 of the International Covenant on Economic, Social, and Cultural Rights. Unfortunately, despite the clear statements contained in each of these basic human rights documents, the goal of guaranteeing healthcare as a basic right for all our citizens remains elusive.

In this time of unprecedented prosperity for the United States, it is clear that the rising tide is not lifting all boats. Millions of citizens work at minimum wage jobs and are unable to meet the needs of their families. They worry about food, clothes, and child care. Saving to buy a house or to help a child go to college is out of reach for large numbers of families. Tragically, for many of these struggling families, health insurance and adequate healthcare are luxuries they cannot afford.

Most Americans agree that good health is an essential part of the American dream. The pursuit of other goals depends on good health and access to good healthcare. Children suffer because their parents cannot afford decent care. Families face financial disaster because of the high cost of serious illness. Every such case in our affluent society mocks the right to life, liberty, and the pursuit of happiness that is the nation's founding ideal.

Disease and injury deprive too many Americans of the opportunity to enjoy these basic rights. Many of these individuals and families who go without coverage are the same persons who are disadvantaged in other areas. Good healthcare should ~~be~~ [is] a basic right for all Americans. It is unconscionable that in our wealthy nation, a child from a well-to-do family has a better chance for a full and healthy life than a child whose family must delay or do without healthcare because they fear the expense.

The number of Americans lacking health insurance continues to rise. During our most recent national debate on comprehensive health reform in 1993, 1994, nearly 40 million Americans were uninsured. That number has now risen to approximately 42 million, and is projected to grow by an additional one million a year for the foreseeable future, unless adequate reforms are enacted. Too many people work for employers that do not offer health insurance. Too many people delay medical care because they fear the cost. Too many people face bankruptcy as a result of medical costs. As the world's richest country, we should be ashamed to admit these shortcomings.

The United States spends more per capita for healthcare than any other industrial nation; however, we get far less value for the dollars we spend. Nearly every other developed nation ensures good healthcare to all its people at an affordable price, yet spends a smaller portion of its gross national product on healthcare than the United States. Leading public health indicators in these countries, such as infant mortality and life expectancy, reflect their investment.

Too often, individual providers take the Hippocratic oath to do no harm, but they are no longer the decision makers in today's healthcare system. Instead, HMOs and managed care plans are in the driver's seat, and the system is focused more on profits than on healing the sick or maintaining health.

Even though we are a nation that places a high value on healthcare, we have done very little to ensure that quality care is available to everyone at an affordable price. Inner-city and rural areas have difficulty in retaining doctors and hospitals. Complicated insurance policies confuse and trap patients in gaps, limitations, and exclusions in coverage. Some of these policies offer benefits so inadequate that serious injury or illness can mean financial ruin for many families.

Beginning with prenatal care, timely access to good health services is essential to proper development during the critically important first three years of life. As children grow, they need to be assured access to well-child care--including immunizations and developmental assessments -- to ensure they can perform to the best of their abilities. If a child's vision or hearing problems go undetected or untreated, the child is doomed to struggle unnecessarily, and, perhaps, face failure at school.

Investments in basic and medical research reap rewards in the form of scientific discoveries that can cure, treat, or prevent diseases and conditions that used to kill or permanently disable men, women, and children. But these discoveries are often not available to those in need.

Slowly, we are shifting our focus to preventive care. Managed care organizations, for all their operational flaws, were designed to provide incentives to keep patients healthy. But doing so for the benefit of all Americans requires commitments that we have so far been unwilling to make.

I believe that all Americans should contribute, according to their ability to pay, to a common fund that pays the cost to prevent and treat injury and illness. All should be eligible for the same comprehensive benefits. No one should fall between the cracks in coverage, and all should be continually covered, regardless of the status of their employment. Above all, no one should be excluded from coverage because the cost is prohibitive.

We also need an insurance program that persuades physicians, hospitals, and other providers to simultaneously control costs, monitor and improve quality, and prevent disability. Competition has failed in the current system because it is not a true free market, nor is it likely to become one in the near future. Purchasing healthcare is not like purchasing a car or other goods. Very few consumers are able to accurately evaluate their options and make informed choices. The answer does not lie in a two-tiered system that treats patients who can pay one way and those who cannot another. Two systems of care inevitably lead to two levels of care. If we decide that it is important to provide healthcare for all, then we must do so without the indignities, hardship, and inefficiency of a two-class system. In recent years, we have had modest successes in making incremental progress toward this goal.

In 1996, Congress passed the Health Insurance Portability and Accountability Act (the Kassebaum-Kennedy Act), which helps people keep their insurance when they change jobs or lose a job, and to avoid the burden of excessive exclusions for preexisting conditions in their insurance coverage.

In 1997, as part of the Balanced Budget Act, Congress created a new children's health insurance program (based on the Hatch-Kennedy Act), which will invest $24 billion to extend health insurance to children of low-income families during the next five years.

This year, I have introduced legislation that would expand coverage for early retirees and other uninsured Americans between the ages of fifty-five and sixty-four, until they qualify for Medicare. I have also introduced a bill that would require firms with more than fifty employees to offer health insurance and contribute toward its purchase.

Unfortunately, some in Congress are pursuing regressive alternatives that would encourage individual coverage at the expense of employer-based coverage. It makes no sense to address the inequities in our healthcare system in a way that would further undermine the employer-based system.

In the current patchwork system, too many families are forced to gamble with their financial future and their health because health insurance is out of reach. They cannot obtain good care because their incomes are too low to buy insurance, but too high to qualify for current government programs. Their age, employment status, or health status prevent them from being eligible for health insurance. Often, they live in an area where there is little or no care available. They suffer unnecessarily because the current system is unwilling or unable to respond to patients with special needs, such as those disadvantaged by disability, income, location, or age.

We have the knowledge, wealth, and ability to assure that all Americans get the healthcare they need, and at an affordable cost. What we lack is the will. I continue to be convinced that if the American public insists on reform, Congress will provide it, and I am optimistic that such a time will come sooner, not later.

### Value

#### Morality

Gert 1997 (Bernard [Professor of Philosophy], *Bioethics: A Return to Fundamentals*, Oxford University Press, Cary, NC, 1997)

The existence of a common morality is shown by the widespread agreement on most moral matters. Everyone agrees that such actions as killing, causing pain or disability, and depriving of freedom or pleasure are immoral unless one has an adequate justification for doing them. Similarly, everyone agrees that deceiving, breaking a promise, cheating, breaking the law, and neglecting one’s duties also need justification in order not to immoral. No one has any real doubts about this. People do disagree about the scope of morality, for example, whether animals or embryos are protected by morality; however, everyone agrees that moral agents – those whose actions are themselves subject to moral judgment – are protected. Thus doubt about whether killing animals or embryos needs to be justified does not lead to any doubt that killing moral agents needs justification. Similarly, people disagree about what counts as an adequate moral justification for some particular act of killing or deceiving and on some features of an adequate justification, but everyone agrees that what counts as an adequate justification for one person must be an adequate justification for anyone else in the same situation, that is, when all of the morally relevant features of the two situations are the same. This is part of what is meant by saying that morality requires impartiality.

Everyone also agrees that people, for example the severely retarded, should not be subject to moral judgment if they do not comprehend the nature of the general kinds of behavior morality prohibits (such as deceiving), requires (such as keeping one’s promise), encourages (relieving someone’s pain), and allows (going to a movie). Although it is difficult even for philosophers to provide an explicit, clear, and comprehensive account of morality, most cases are clear enough that everyone knows whether some particular act is morally acceptable. No one engages in a moral discussion of questions like “Is it morally acceptable to deceive patients in order to get them to participate in an experimental treatment that has no hope of benefiting them but that one happens to be curious about?” because everyone knows that such deception in not justified. The prevalence of hypocrisy shows that people do not always behave in the way that morality requires or encourages. It also shows that people know the general kind of behavior that morality does require and encourage even if they sometimes have difficulty applying this knowledge to particular cases, especially those in which they are emotionally involved. That everyone who is subject to moral judgment knows what morality prohibits, requires, encourages, and allows is part of what is meant by saying that morality is a public system.

### Criterion

#### Categorical Imperative

Encyclopedia Britannica (Accessed online at: https://www.britannica.com/topic/categorical-imperative)

Categorical imperative, in the ethics of the 18th-century German philosopher Immanuel Kant, founder of critical philosophy, a moral law that is unconditional or absolute for all agents, the validity or claim of which does not depend on any ulterior motive or end. “Thou shalt not steal,” for example, is categorical as distinct from the hypothetical imperatives associated with desire, such as “Do not steal if you want to be popular.” For Kant there was only one such categorical imperative, which he formulated in various ways. “Act only according to that maxim by which you can at the same time will that it should become a universal law” is a purely formal or logical statement and expresses the condition of the rationality of conduct rather than that of its morality, which is expressed in another Kantian formula: “So act as to treat humanity, whether in your own person or in another, always as an end, and never as only a means.”

### Observation 1 – Definitions

#### Single-Payer Healthcare

Webster’s New World Medical Dictionary

Single-payer health care: A system of health care characterized by universal and comprehensive coverage. Single-payer health care is similar to the health services provided by Medicare in the US. The government pays for care that is delivered in the private (mostly not-for-profit) sector. Doctors are in private practice and are paid on a fee-for-service basis from government funds. The government does not own or manage their medical practices or hospitals.

Single-payer health care is distinct and different from socialized medicine in which health care facilities and workers receive payment as government employees.

### Contention One

#### Access to healthcare is a human right

Denier 2005 (Yvonne [PhD., Professor of Ethics], *On Personal Responsibility and the Human Right to Healthcare*, Cambridge Quarterly of Healthcare Ethics, Vol. 14(2), April 2005, 224-234)

Why are certain interests, in this case healthcare interests, so important that they deserve such special protection? What is it about healthcare that is so special? A possible answer is that healthcare is special because of its instrumental power. Healthcare is the means to an end that is highly valued in most cultures: good health and a long life free from pain and disability. Without life-long access to appropriate healthcare, our chances of attaining [a life free from pain and disability] this goal are likely to be impaired. Yet the high value of good health alone cannot explain the particular status of healthcare as a focus of moral concern. There are many things we value highly, like companionship, aesthetic pleasure, love, and other such benefits to which we do not necessarily have a right. So in addition, three main arguments deserve attention: fair equality of opportunity, basic healthcare needs, and collective social protection.

First, contemporary healthcare involves a complex and heterogeneous framework of institutions, services, and policy measures that aim at prevention of disease and disability, restoration of health where possible, and personal and social support and care for the long-term ill or disabled. As such, healthcare greatly affects the risk of persons getting sick, the likelihood of being cured, and the degree to which one will receive support. Within this line of reasoning, healthcare theorist Norman Daniels has pointed at the way in which healthcare protects our level of normal functioning and consequently our opportunities to form, pursue, and revise our life-plans. Impairment of normal functioning through injury, disease, and disability creates significant disadvantages and reduces a person’s opportunities in life. What appears to make healthcare of special moral importance is its particular capacity, through prevention, restoration, and support, to affect our chances of leading a full, active, and morally fulfilling life. In this context, fair equality of opportunity means that all individuals are entitled to an equal opportunity for a chance to be healthy, insofar as possible.

Second, the effect of healthcare services on opportunities in life is a general fact that is common to all. This is ultimately grounded in the concept of basic needs or, as David Braybrooke has called them, “course-of-life-needs.” Basic needs are the things that are functionally necessary for the most fundamental projects, involved in living a human life, and are essential to living or functioning normally. They apply to an entire range of interests that concern a person’s physical (food, drink, shelter) and psychological existence (communication, affiliation, support). They are basic because they are restricted to universally recurrent phenomena rather than to particular individual whims or frivolous pursuits. This implies that basic needs are distinguishable from felt needs, preferences, or wants. Persons simply have these needs, whether they want to or not. To use a term from Harry Frankfurt: basic needs are “non-volitional needs”; they do not depend on what a person wants. As such, they are typically assumed to be given rather than acquired characteristics of the human condition. That means that they are not constituted by any action for which the person is responsible by virtue of his or her greater effort. Consequently, essential needs are independent from merits. Where they are unequal, one thinks of them as fortuitously distributed, as part of a kind of natural or social lottery or as the result of good or bad luck.

Likewise, healthcare needs are those things that every person needs in order to maintain or restore normal and healthy functioning (like adequate nutrition, shelter, sanitation, unpolluted living and working conditions, and preventive and curative medical services), or that a person needs to equal normal functioning as much as possible (like glasses, wheelchairs, hearing aids, and guide dogs). Essentially healthcare needs are basic needs: universal in character, necessary for the fundamental projects of every person, and generically originating from human vulnerability. Very often the advantages of health and the burdens of illness are arbitrary effects of a natural lottery (like one’s genetic makeup) or social conditions (being poor) or of bad luck (being at the wrong place at the wrong time) or good fortune (accidental discovery of cancer at a curable stage). Although there are interpersonal differences in healthcare needs to reach a normal functioning level, enjoying reasonably good health, being able to function normally, and through this having normal opportunities for a fulfilling life are of fundamental value for every person, and eliminating or reducing barriers that undermine this value, like disease, illness, or injury, is a basic moral obligation for every just society.

Third, it would be unreasonable to expect that individuals generally should be able to gain sufficient access to healthcare by relying solely on their own private resources for several reasons. First, healthcare needs are more unequally distributed than other basic needs like food, clothing, and shelter (some people need considerably more healthcare than others, whereas people’s need for food and clothing is generally the same). Second, healthcare needs can be highly unpredictable due to the element of luck. Third, the fulfillment of healthcare needs has an important impact on a person’s range of opportunities. And finally, healthcare can be catastrophically expensive. If private resources could generally cover healthcare needs, there would be little point in declaring entitlements to healthcare. This means that whereas it might be reasonably expected that people can adequately provide for food, clothing, and shelter from their own private shares of income and wealth, this does not apply to goods like healthcare services, which are an appropriate object of collective cost sharing schemes. Private insurance alone cannot provide sufficient access to care for everyone because those who are most in need of healthcare, as well as those with especially high risk of ill health, will not be able to purchase affordable coverage, if they can find insurance at all. That is why we speak of a collective obligation on the part of society as a whole.

Hertel & Libal 2011 (Shareen & Kathryn [Both Ph.D., University of Connecticut], *Entrenched Inequity: Health Care in the United* States, Human Rights in the United States: Beyond Exceptionalism, Cambridge University Press, New York, NY, 2011, 153-174)

The right to health is enshrined in international legal instruments, many of which were drafted with U.S. leadership. Among the most important are the Universal Declaration of Human Rights (UDHR) and the International Covenant on Economic Social and Cultural Rights (ICESCR) IUD. HR 1948; ICESCR 1966). A focus on health care leaves aside many salient issues concerning the right to health and its implementation at the national level. For example, the right to health requires not only that certain minimum standards of care be met or exceeded, but that basic preconditions to health also are met, including adequate shelter, food, and sanitation (CESCR 2000; Toebes 1998). In addition, as is the case with civil and political rights (e.g., the right to a fair trial), a government's responsibility to ensure the right to health is equally about process and outcome. Although the government must work to promote health, it cannot be held responsible for ensuring a particular individual's health unless that person's health problems stem directly from discrimination or other human rights violations. In other words, the right to health is not equivalent to a guarantee that one will actually be healthy.

### Contention Two

#### Americans do not have access to appropriate healthcare

Burkick 2016 (James [MD], Talking About Single Payer Health Care Equality for America, Near Horizons Publishing, St. Michaels, Maryland, 2016)

Too often a sick patient in America may be threatened not only by the illness but by the worry of how much the treatment will cost, unlike in other countries. Of course this is particularly true for the uninsured but also pertains to those who have insurance but are not well-to-do. For them, the questions of whether the care is covered and what the copayment will cost loom large. There was considerable public interest in the run-up to the passage of Obamacare. A Harris Interactive-Health Day poll found that 84% of people 45 – 64 years old with insurance still were worried about being able to pay for health care in 2009. Other polls underscore this: over 80% said that changing health care to make it more affordable is very important. When compared to other issues, 30 – 50% said improved affordability is more important than anything else. In the NYTimes/CBS News poll of June 2009 cited by Paul Krugman, 72% supported a government-sponsored health plan that would compete with private plans. Even with Republicans it is a toss-up with 50% support. Fifty percent overall thought the government would be better at providing health care and 59% said that the government would be better at containing costs. The percent in agreement with each of these increased quite a bit over the 2007 responses. These concerns of those with insurance have not changed since the ACA.

There are many examples of responsible, working citizens who are being dragged down by the traps in U.S. health care coverage. Incredibly, in Kaiser Family Foundation data, of the 22% who had trouble paying their medical bills in 2008, 4% had declared bankruptcy due to medical expenses. A recent study by Dr. David Himmelstein and other members of the Physicians for a National Health Program (PNHP) predicted over 800,000 bankruptcies due to illness in 2009. Very commonly this happens in spite of the bankrupted person having had health insurance. True, it seems likely that other factors are important in at least a reasonable fraction of these cases. But it is hard to avoid the conclusion that large numbers of bankruptcies would not have occurred had it not been for medical costs. Moreover, about 20% of people put off medical care or prescription medicine purchases because of cost (this has been found repeatedly). So medical costs because we lack a national system are hurting the health of those who are still solvent.

Matthews 1998 (Eric [University of Aberdeen], *“Is Health Care a Need?*, Medicine, Health Care, and Philosophy, Kluwer Academic Publishers, Netherlands, 155-161

There are some who would say, on these grounds, that the market is actually morally superior in a certain respect to other methods of allocation. For in a market system, each individual chooses for him- or herself which goods he or she will have (provided he or she has the money to pay for them), so that the market economy is morally superior in that it respects the freedom of choice of the individual. This argument is used by some to justify a market system of health care allocation. In a free health care market, for example, no one who wanted renal dialysis would be denied access to it as a result of decisions taken by others, as such sufferers are in the non-market allocation practiced in the British National Health Service. However, a market system denies access to medical treatment to those who are unable to pay for it (or who do not qualify for charitable provision). Under the market system, freedom of choice only really exists for those who have the ability to pay. This sort of objection on the part of writers such as Englhardt does not really, therefore, establish the moral superiority of market provision of health care.

#### Charitable healthcare organizations are not sufficient for everyone

D’Oronzio 2001 (Joseph [], *A Human Right to Healthcare Access: Returning to the Origins of the Patients’ Rights Movement*, Cambridge Quarterly of Healthcare Ethics, Vol. 10(3), July 2001, 285-298)

Healthcare ethics includes within its scope of legitimate concerns the establishment and maintenance of an ethical environment for the delivery of healthcare services. The lack of readily available, appropriate healthcare creates an environment as clearly conducive to illness as many identifiable pathogens or carcinogens. It makes little difference if there are committed and ethically motivated professionals delivering episodic care to the uninsured in this context. The care delivered is not equal, the health outcomes are not equal, and the resulting poor health of the uninsured is an ethical challenge to the healthcare professions as a whole. It is another example of the health impact of a human-rights deprivation.

### Contention Three

#### The United States should implement a single payer healthcare system

#### Benefits of Single-Payer Healthcare in the United States

Shuster 2013 (Kenneth [Rabbi and Attorney], *“Because of History, Philosophy, the Constitution, Fairness & Need: Why Americans Have a Right to National Health Care*, Indiana Health Law Review, Vol. 10(1), 2013, 76-113)

Although all such approaches have some merit, the best avenue by far that the United States should take to insure its people is a single-payer approach. This is for at least six reasons. First, unlike private insurance and even hybrid health care, all Americans regardless of income and assets would be covered for all medically necessary services, including physician visits and services, hospitalization, long-term care, dental needs, vision care, and prescription drug and medical supply costs. Such a plan is extremely necessary, because presently many government subsidized programs exclude many of the above services. Second, because a single-payer system will be funded and operated by a single entity, i.e. the government, it will cut down on the administrative costs that private and hybrid insurance plans require. Third, a single-payer plan will keep drug prices under control. This is because when patients are covered under one system, the payer, in this case the government, has more power to control costs than when multiple sources are responsible for providing drug care. To be sure, the unified source of their health care is a major reason drug prices in other countries are lower than they are in the U.S.. Fourth, because single-payer plans would cover items that are not traditionally covered in many plans, and would probably not carry copayments or deductibles, they would provide coverage to the presently underinsured as well as the uninsured. This is vital because as recently as 2009, 62% of U.S. bankruptcies were due to medical expenses and 80% of those bankruptcies were filed by people who had health insurance. Fifth, a national single-payer health plan will keep overall health care costs down by de-commercializing health care and limiting for-profit involvement in how health care is delivered. It would accomplish this in three ways. First, the payer (the government) would not spend more on medical technology than is needed to provide health care. Second, because a single-payer system would be delivered by the government, it would eliminate the excessive executive compensation packages in vogue at private insurance companies. Third, it would block the often enormous costs insurance companies spend to influence the public that private health insurance is the preferred manner in which they should obtain their health insurance. Finally, because a single-payer plan would be operated by the government, all medical data, including patient and hospital records, could be housed in one central computerized repository. This would further keep administrative costs down, discourage doctors from fraudulently billing for unperformed procedures, and make it much easier to coordinate patient health data between physicians and hospitals in the event a patient changes doctors or moves to another locale.

#### Socialized medicine is compatible with capitalism

Shuster 2013 (Kenneth [Rabbi and Attorney], *“Because of History, Philosophy, the Constitution, Fairness & Need: Why Americans Have a Right to National Health Care*, Indiana Health Law Review, Vol. 10(1), 2013, 76-113)

The reason socialized medicine is compatible with capitalism is because a government-funded and executed health care program, like other socialized entitlements (such as police, sanitation, education, etc.), does not prevent Americans from competing in a capitalistic, free-market environment to provide luxuries and a better standard of living for themselves in other areas that affect them. For example, even with government-guaranteed health coverage, Americans will still need to compete in a capitalist marketplace to obtain more spacious homes, more expensive cars and clothes, better vacations, etc. This reality takes the lie out of the misconception that capitalism is preferable to any amount of socialism because socialism, like communism, will chill incentives individuals have to work harder and be more productive. In fact, a "modified capitalism" which, as a result of the socialized benefits Americans already enjoy is the norm in present day America, may actually provide us with greater incentives to work and be productive. This is because, unlike members of a entirely capitalist society whose labor dollars must go to meet more of their basic needs, workers in a modified capitalist society that is paying more of those needs have that much more income at their disposal to fund a higher standard of living for themselves and their families. The awareness that their labor is helping to finance their dreams and goals, and not merely paying for essentials or increasing their employers' wealth, may motivate workers in a modified capitalistic environment to be more industrious.

#### Single-Payer Healthcare solves for medical costs and access

Oberlander 2016 (Jonathan [PhD. Political Science], *The Virtues and Vices of Single-Payer Health Care*, The New England Journal of Medicine, 374(15), April 24, 2016)

The lessons of Canadian national health insurance are as straightforward as they are neglected. Having a single government- operated insurance plan greatly reduces administrative costs and complexity. It concentrates purchasing power to reduce prices, enables budgetary control over health spending, and guarantees all legal residents, regardless of age, health status, income, or occupation, coverage for core medical services. Canadian Medicare charges patients no copayments or deductibles for hospital or physician services. Controlling medical spending does not, the Canadian experience demonstrates, require cost sharing that deters utilization. The Canadian system is hardly perfect. All countries struggle with tensions among cost, access, and quality; at times, Canada has grappled with fiscal pressures, wait lists for some services, and public dissatisfaction. Yet its problems pale in comparison to those in the United States.

### Contention Four

#### All people in the United States should contribute to the healthcare of everyone

Shuster 2013 (Kenneth [Rabbi and Attorney], *“Because of History, Philosophy, the Constitution, Fairness & Need: Why Americans Have a Right to National Health Care*, Indiana Health Law Review, Vol. 10(1), 2013, 76-113)

An issue that crops up repeatedly regarding national health care plans is the seeming unfairness of requiring more affluent and healthy individuals to pay, indirectly through taxation, for the health needs of the less affluent and less healthy in society. This objection is often compounded and complemented by the realization that many Americans bring disease onto themselves through lack of exercise and unhealthy food choices. Although there is truth to this complaint, when health care is seen as a right, it loses much of its bite. This is because there are numerous other areas of American life, from police protection and sanitation benefits, to public school education and military operations, which are supported by the tax dollars of Americans who live in affluent and clean neighborhoods that may not need as much police surveillance, or clean-up, as poorer, crime-ridden locales do, or who may not agree with all details of foreign policy expenditures. The fact is that just as police protection, sanitation benefits, educational resources, and a strong military presence are necessary if society is to function at a high level free from crime, garbage borne diseases, illiteracy, and threats from abroad, national health care is required to keep as many members of society healthy and therefore presumably productive, as possible.

The question of why society should pay to cover the health care expenses of those who have not made healthier lifestyle choices, may be answered via a two-pronged approach, both of which require not merely compassion, but a healthy dose of realism. First, I again look to those services that most Americans do not mind paying for to point out that many of them are necessary due to both the ill behavior of at least some members of society, as well as the impracticality of requiring individuals who are generally ill-equipped to effectively manage various facets of their lives, to teach themselves. For example, police are needed largely because people do not always act legally or peacefully. Public schools are needed, not just for the children of less affluent parents who cannot afford to send them to private or parochial schools, but for students whose parents are themselves illiterate, alcoholic, emotionally or developmentally disabled, or otherwise incapable of educating them. If this is true in these and other areas in which people are challenged and incapable, due to either irresponsibility or innate deficiency, why should it not be true in regards to the bad choices whole segments of our society make when it comes to life style? In fact, all of society will lose out, in lost productivity, prosperity, and contribution, if our government does not encourage us, through national health care, to provide health insurance for those who are less healthy than others, even if such compromised health status was caused by personal irresponsibility and neglect.

# NEG CASE

## 1NC

### Value

My value for this debate will be the **Quality of Life**. This is defined as having the ability or access to things that make your life worth living. This needs to be the paramount value in the round.

**Neeley, 1994** (Steven. 1994. Professor, Xavier University. THE CONSTITUTIONAL RIGHT TO SUICIDE, THE QUALITY OF LIFE, AND THE "SLIPPERY-SLOPE. Akron Law Review. Accessed 8/13/10.)

It is good that men should feel a horror of taking human life, but in a rational judgment the quality of the life must be considered. The absolute interdiction of suicide and euthanasia involves the impossible assertion that every life, no matter what its quality or circumstances, is worth living and obligatory to be lived. This assertion of the value of mere existence, in the absence of all the activities that give meaning to life, and in the face of the disintegration of personality that so often follows from prolonged agony, will not stand scrutiny. On any rationally acceptable philosophy there is no ethical value in living any sort of life: the only life that is worth living is the good life.

### Criterion

#### Consequentialism

Brock 1993 (Dan [Prof. of Philosophy, Brown University], *Quality of Life Measures in Health Care and Medical Ethics*, The Quality of Life, Oxford University Press, New York, NY, 1993)

The 'quality of life' can be given a number of more or less broad interpretations, depending on the scope of the evaluative factors concerning a person's life that it is taken to include. Medicine and health care often affect a person's life in only some limited areas or respects. Nevertheless, my concern will be with the broadest conception of, in Derek Parfit's words, 'what makes a life go best', and I shall try to show that medicine and health care may affect and illuminate more aspects of that question than might at first be thought." No concept is entirely apt or widely accepted in either philosophical or common usage for this broad role, but I shall use the concept of a 'good life' to refer to the quality of life of persons in its broadest interpretation.

Therefore, we must look to the consequences of single payer health care to determine if the single payer system greatly affects the “good life” and therefore violates the value of quality of life.

### Definitions

#### Single Payer Healthcare

Rovner 2016 (Julie[Distinguished Fellow Kaiser Health News, NPR Analyst], "*Debate Sharpens Over Single-Payer Health Care, But What Is It Exactly?*", National Public Radio, Jan. 22, 2016, Found online at http://www.npr.org/sections/health-shots/2016/01/22/463976098/debate-sharpens-over-single-payer-health-care-but-what-is-it-exactly

What Is A Single Payer? A single payer refers to a system in which one entity (usually the government) pays all the medical bills for a specific population. And usually (though, again, not always) that entity sets the prices for medical procedures. A single-payer system is not the same thing as socialized medicine. In a truly socialized medicine system, the government not only pays the bills but also owns the health care facilities and employs the professionals who work there. The [Veterans Health Administration](http://www.va.gov/health/) is an example of a socialized health system run by the government. The VA owns the hospitals and clinics and pays the doctors, nurses and other health providers. Medicare, on the other hand, is a single-payer system in which the federal government pays the bills for those who qualify, but hospitals and other providers remain private.

### Contention One

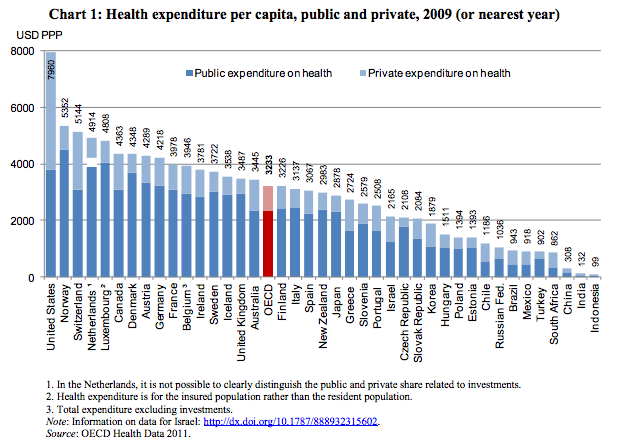
#### SPHC would hurt the quality of life for Americans

#### A. US already spends more on healthcare than any other nation

OECD 2011 (Organization for Economic Cooperation and Development, *Why is Health Sending in the United State So High?*, Health at a Glance 2011: OECD Indicators, accessed online at <https://www.oecd.org/unitedstates/49084355.pdf>, Jul. 22, 2016)

The United States spends two-and-a-half times more than the OECD average health expenditure per person (Chart 1). It even spends twice as much as France, for example, a country which is generally accepted as having very good health services. At 17.4% of GDP in 2009, US health spending is half as much again as any other country, and nearly twice the average.

Rich countries spend more than poor countries. Chart 3 shows that for nearly every country, if you know how rich they are, you can predict their health spending per person per year to within a few hundred dollars. The United States is an exception – Americans spends nearly $3000 per person per year more than Swiss people, even though Swiss people have about the same level of income.



#### B. A single payer healthcare system in the US would significantly raise costs

Oberlander 2016 (Jonathan [PhD. Political Science], *The Virtues and Vices of Single-Payer Health Care*, The New England Journal of Medicine, 374(15), April 24, 2016)

Single payer would also require the adoption of large-scale tax increases. Although Americans would save money by not paying premiums to private insurers, the politics of moving immense levels of health care spending visibly into the federal budget are daunting, given the prevailing anti-tax sentiment. Furthermore, converting our long-established patchwork of payers into a single program would require a substantial overhaul of the status quo, including the ACA. Then there are the familiar institutional barriers to major reform within U.S. government, including the necessity of securing a supermajority of 60 votes in the Senate to overcome a filibuster.

Meadowcroft 2015 (John [PhD. Dept. of Political Economy, Kings College], “Just Healthcare? The Moral Failure of Single-Tier Basic Healthcare”, Journal of Medicine and Philosophy, 2015, Vol. 40, 152-168)

The experience of the UK National Health Service is instructive here. On its foundation in 1948, the NHS was designed to be free at the point of use with no explicit limit on the resources that could be consumed by an individual or by the system as a whole. The architects of the NHS believed that the cost of the system would decrease as the backlog of ill-health was cleared and preventative medicine and public health measures reduced future morbidity. The reality of the NHS proved much different, however. The cost of the NHS quickly became unmanageable, leading to the introduction of charges for prescriptions and optical services within 3 years of its creation. Despite the continuation of these charges, the net cost of the NHS has continued to rise inexorably, from 3 percent of GDP in 1948 to 7 percent of a significantly larger GDP 60 years later.

#### C. Opportunity Costs – Money spent on healthcare needs to come from somewhere

Mankiw 2000 (Gregory [Professor of Economics, Harvard University], Principles of Microeconomics, 2nd Ed., South-Western College Publishing, 2000)

This concept of scarcity leads to the idea of opportunity cost. The opportunity cost of an action is what you must give up when you make that choice. Another way to say this is: it is the value of the next best opportunity. Opportunity cost is a direct implication of scarcity. People have to choose between different alternatives when deciding how to spend their money and their time. Milton Friedman, who won the Nobel Prize for Economics, is fond of saying "there is no such thing as a free lunch." What that means is that in a world of scarcity, everything has an opportunity cost. There is always a trade-off involved in any decision you make.

Klein 2012 (Ezra [Journalist], *“Why an MRI Cost $1,080 in America and $280 in France”*, The Washington Post, March 3, 2012, Found online at https://www.washingtonpost.com/blogs/ezra-klein/post/why-an-mri-costs-1080-in-america-and-280-in-france/2011/08/25/gIQAVHztoR\_blog.html)

And others point out that you also need to account for the innovations and investments that our spending on health care is squeezing out. “There are opportunity costs,” says Reinhardt, an economist at Princeton. “The money we spend on health care is money we don’t spend educating our children, or investing in infrastructure, scientific research and defense spending. So if what this means is we ultimately have over-medicalized, poorly educated Americans competing with China, that’s not a very good investment.”

### Contention Two

#### SPHC eliminates individuals’ right to make healthcare decisions

#### A. Loss of doctors and medical facilities

Summers 2016 (Daniel [MD], *Bernie Sanders’s Plan Would Hurt Not Only the Bottom Line of Heath Care Providers, but Patients as Well*, New Republic, Feb. 19, 2016, found online at https://newrepublic.com/article/130145/im-doctor-heres-oppose-single-payer-revolution)

The arithmetic behind Bernie Sanders’s single-payer health care proposal is the subject of much dispute. Whether or not the numbers add up at the federal level was one of the contentious points in the most recent Democratic debate, and it is far from a settled question.

What is not disputed to any great degree is that Sanders [it] would reduce payments to doctors and hospitals. His “Medicare for all” plan would result in a substantial reduction in revenue compared to what most private insurance plans currently pay. As a pediatrician in private practice, I have grave concerns that implementing a rapid transition to a single-payer system would be far more disruptive to many Americans’ health care than Sanders cares to discuss.

Compared to the lustrous ideals that inform the pursuit of a single-payer system, talking about profitability seems downright grungy. But businesses need to stay profitable in order to stay afloat, and medical practices are no different. Even not-for-profits need sufficient revenue to keep the doors open. Talking about substantially reducing payment to medical providers in one fell swoop, as though doctors and hospitals will say, “Alrighty then,” and carry on providing the exact same services without any appreciable change to patients strains credulity.

#### B. Decrease in quality of healthcare

Hogberg 2007 (David [Ph.D., Policy Analyst, National Center for Public Policy Research], *Sweden’s Single-Payer Health System Provides a Warning to Other Nations*, National Policy Analysis, Issue 555, May 2007)

In practice, the political notion of "equal access" actually means "restricted access." Swedes who do not have private insurance must wait, often for months, for treatment. For all Swedes who needed an operation in 2003, slightly more than half waited more than three months. The situation continues. Moreover, patients often wait in great pain and distress.

Researchers studying Swedes waiting for hip or knee replacement concluded that "almost every aspect of daily life is affected by the indeterminate wait for surgery and the related experiences of pain and disability. The respondents express a deep sense of lost dignity, powerlessness and frustration." One patient complained that the pain had gotten so bad that she "had no quality of life." "I can't participate in anything," she said. "I can't go for a walk, I can't do anything, so why on earth do I need to wake up in the morning!" Depression and hopelessness were other common symptoms. Another patient complained, "I feel as though I've lost my human dignity. You get depressed and fed up with the pain. Still I try to be patient. But you lose the desire (to live)." She further complained of her treatment by the clinic where her surgery was to take place. "I felt so neglected, you get treated, yes, worse than an animal because you can take an animal to the veterinary... I feel so powerless."

### Contention Three

#### Americans should not have the right to healthcare

#### A. Healthcare not recognized as a right in the industrial world

Goodman 2005 (John [President, National Center for Policy Analysis], Health Care in a Free Society: Rebutting the Myths of National Heath Insurance, Policy Analysis, CATO Institute, Jan. 27, 2005, page 2)

In fact, no country with national health insurance has established a right to health care. Citizens of Canada, for example, have no right to any particular health care service. They have no right to an MRI scan. They have no right to heart surgery. They do not even have the right to a place in line. The 100th person waiting for heart surgery is not entitled to the 100th surgery. Other people can and do jump the queue. One could even argue that Canadians have fewer rights to health services than their pets. While Canadian pet owners can purchase an MRI scan for their cat or dog, purchasing a scan for themselves is illegal (although more and more human patients are finding legal loopholes, as we shall see below)

Shuster 2013 (Kenneth [Rabbi and Attorney], *“Because of History, Philosophy, the Constitution, Fairness & Need: Why Americans Have a Right to National Health Care*, Indiana Health Law Review, Vol. 10(1), 2013, 76-113)

Finally, to further render the idea of government sponsored health care more palatable to a greater number of people, we should differentiate between a "right to health" and a "right to health care." The two are not synonymous. It may be that many Americans are opposed to national health care because they mistakenly believe this requires them to support a right to health. However, proponents of national health care actually mean there is a right to health care and not a right to health, because only God or nature, and to some extent, one's own efforts, can assure the state of an individual's health. In fact, because so many variables including food, exercise, genetics, and luck go into determining the state of one's health, it would be absurd to speak of a "right to health." This is equally true of all other areas in which the government provides national assistance to meet the needs of its residents. For example, although the government cannot guarantee that individual Americans will be safe at all times and in all locales, we, because we pay taxes, have a right to being protected by a militia. We do not have a right to safety. Because the trajectory from idiocy to genius allows for too much of a variable in the intelligence levels of individuals, Americans do not possess a right to be smart. Children have a right to education. This distinction is essential because a mistake in what any given right means and entails not only confuses the issue in the instant case of national health care, but obfuscates important reasons we have rights in the first place, namely the utilitarian basis of rights and society's duty to take care of those who cannot take care of themselves. For example, there may be occasions in which the greatest good for the most people requires that society not favor the greatest number, as when society must protect a minority from the tyranny of the majority.

#### B. Establishing a right to healthcare undermines individual rights

Cannon 2007 (Michael [Director of Health Policy Studies, Cato Institute], *A “Right” to Health Care?*, National Review, June 29, 2007)

The fundamental problem with the idea of a right to health care is that it turns the idea of individual rights on its head. Individual rights don't infringe on the rights of others. Smith's right to free speech takes nothing away from Jones. The only obligation Jones owes to Smith is not to interfere with Smith's exercise of her rights. A right to health care, however, says that [Person A] has a right to [Person B’s] labor. That turns the concept of individual rights from a shield into a sword. The underlying goal of a legally enforceable right to health care is to provide quality medical care to the greatest number possible. Perversely, making health care a "right" would make that goal harder to attain.

Dunn 2003 (Wayne [Staff Writer, Capitalism Magazine], *“Right”-to-heath-care Junkies*, Capitalism Magazine, Apr. 28, 2003)

Health care doesn't just pop into existence. It stems from individuals' intellectual achievements and productive abilities. It's the product of doctors and nurses spending a decade mastering their craft, of scientists toiling years to make life-saving breakthroughs, of capitalists staking fortunes on risky new ventures. And it's the product of businessmen transforming those dollars and breakthroughs into medicine and equipment, which doctors then bring to bear on human suffering. Sure, we can pass a law giving you a "right" to all that. Heck, with enough votes, we can pass a law giving your house to the homeless (after all, they need it). But just because something's legal doesn't make it right. Slavery, remember, was legal.

#### C. Establishing a right to healthcare unfairly advantages those who chose risky lifestyles

Daniels 2007 (Norman [Prof. of Ethics, Harvard School of Public Health], Just Health: Meeting Health Needs Fairly, Cambridge University Press, 2007)

Why should some pay for the risky lifestyle choices of others? There is much evidence that individuals can remain healthy by avoiding smoking, excessive alcohol use, unsafe sex, and certain foods, and by getting adequate exercise and rest. Unhealthy behaviors can give rise to claims on others that more careful people would not make.

But people who make risky lifestyle choices and expect others to assist them when ill health results have some resemblance to those who cultivate expensive tastes: Owing them assistance for their irresponsible choices would hijack others.

Orient 2006 (Jane [MD], *Your Money and Your Life: The Price of “Universal Health Care”*, The Freeman, Vol. 56(10), December, 2006)

There’s ample evidence that Americans don’t care very much about their health**. They grouse about copayments at the doctor’s office or pharmacy and may leave an office in high dudgeon if expected to pay a reasonable bill not “covered” by their insurance. They often refuse to buy medical insurance even if they can afford it. Aside from a subpopulation of health fanatics,** many Americans constantly defy the grandmotherly advice that is the proven basis for effective health maintenance. They smoke, drink, take drugs, engage in casual sex, and/or overeat. They do not exercise, eat their vegetables, or conscientiously wash their hands. They may be willing to take lots of pills, but appear to be allergic to anything that interferes with instant gratification or requires self-discipline. Establishing a “right” to health care would result in FRIVOLOUS treatment.

#### D. All rights impose obligations on others

Williams 2007 (Walter [Prof. of Economics, George Mason U.], *Bogus Rights*, Townhall, Feb. 8, 2006)

Rights do not include involuntary takings. Contrast that vision of a right to so-called rights to medical care, food or decent housing, independent of whether a person can pay. Those are not rights in the sense that free speech and freedom of travel are rights. If it is said that a person has rights to medical care, food and housing, and has no means of paying, how does he enjoy them? There's no Santa Claus or Tooth Fairy who provides them. You say, "The Congress provides for those rights." Not quite. Congress does not have any resources of its very own. The only way Congress can give one American something is to first, through the use of intimidation, threats and coercion, take it from another American. So-called rights to medical care, food and decent housing impose an obligation on some other American who, through the tax code, must be denied his right to his earnings. In other words, when Congress gives one American a right to something he didn't earn, it takes away the right of another American to something he did earn.

If this bogus concept of rights were applied to free speech rights and freedom to travel, my free speech rights would impose financial obligations on others to provide me with an auditorium and microphone. My right to travel freely would require that the government take the earnings of others to provide me with airplane tickets and hotel accommodations.

# AFF CARDS

#### Using the marketplace for access to healthcare is an injustice

Meadowcroft 2015 (John [PhD. Dept. of Political Economy, Kings College], “Just Healthcare? The Moral Failure of Single-Tier Basic Healthcare”, Journal of Medicine and Philosophy, 2015, Vol. 40, 152-168)

At the heart of the account of the moral superiority of single-tier basic healthcare is the notion that healthcare is special and this specialness means that, unlike other goods and services, healthcare should not be provided by the market. Informing this viewpoint is a powerful and widely held intuition that inequalities that may be tolerable in respect of access to other goods and services are intolerable in the case of healthcare.

Matthews (1998, 155–6), for example, has argued that while no one would consider it an injustice for chocolate cake to be provided by the market and thereby only be available to those people willing and/or able to pay for it, it is widely held that “an injustice is done when healthcare resources are allocated unequally,” so that “a health care system available to all free at the point of delivery is morally justified, indeed required.”

Similarly, Daniels has argued that there is a widely held belief that “health care is ‘special,’” and, “should be treated differently from other social goods,” so that, “even in societies in which people tolerate (and glorify) significant and pervasive inequalities in the distribution of most social goods, many feel there are special reasons of justice for distributing health care more equally” (Daniels, 1981, 146).

#### Only those who can pay for healthcare have the freedom of choice in a market system

Matthews 1998 (Eric [University of Aberdeen], *“Is Health Care a Need?*, Medicine, Health Care, and Philosophy, Kluwer Academic Publishers, Netherlands, 155-161

There are some who would say, on these grounds, that the market is actually morally superior in a certain respect to other methods of allocation. For in a market system, each individual chooses for him- or herself which goods he or she will have (provided he or she has the money to pay for them), so that the market economy is morally superior in that it respects the freedom of choice of the individual. This argument is used by some to justify a market system of health care allocation. In a free health care market, for example, no one who wanted renal dialysis would be denied access to it as a result of decisions taken by others, as such sufferers are in the non-market allocation practiced in the British National Health Service. However, a market system denies access to medical treatment to those who are unable to pay for it (or who do not qualify for charitable provision). Under the market system, freedom of choice only really exists for those who have the ability to pay. This sort of objection on the part of writers such as Englhardt does not really, therefore, establish the moral superiority of market provision of health care.

#### Access to Healthcare ought to be judged through a Rawlsian view of justice

Meadowcroft 2015 (John [PhD. Dept. of Political Economy, Kings College], “Just Healthcare? The Moral Failure of Single-Tier Basic Healthcare”, Journal of Medicine and Philosophy, 2015, Vol. 40, 152-168)

Daniels (1981, 1985) has sought to establish the uniqueness of healthcare by utilizing the Rawlsian idea of fair equality of opportunity. In Rawls’ (1999) A Theory of Justice, in what has become known as “the difference principle,” Rawls argued that social and economic inequalities may be justified if they are to the benefit of the least advantaged and “attached to offices and positions open to all under conditions of fair equality of opportunity” (Rawls, 1999, 302). Rawls argued that strict economic equality may not be to the benefit of the least advantaged because differential rewards may be necessary to incentivize the most productive members of society to maximize their contribution to the generation of wealth: “each society has a redistribution policy which if pushed beyond a certain point weakens incentives and thereby lowers production” (Rawls, 1999, 142).

Rawls excluded healthcare from his analysis, however, stating that in his identification of the least advantaged he assumed, “that everyone has physical needs and psychological capabilities within the normal range, so that questions of health care and mental capacity do not arise” (Rawls, 1999, 83–4). Daniels (1985, 43–8) has argued that Rawls’ exclusion of healthcare from his analysis was a simplification intended to enable him to establish a straightforward, idealized argument for distributive justice. Rawls’ simplifying assumption, Daniels has contended, did not preclude the extension of his analysis to more realistic and complex situations, such as the provision of healthcare, once the foundational principles had been established. Indeed, Daniels argued that the importance that Rawls attached to fair equality of opportunity within his theory of justice demanded that the analysis be extended to healthcare, given its impact on life chances.

#### Use of market forces in healthcare is morally intolerable

Meadowcroft 2015 (John [PhD. Dept. of Political Economy, Kings College], “Just Healthcare? The Moral Failure of Single-Tier Basic Healthcare”, Journal of Medicine and Philosophy, 2015, Vol. 40, 152-168)

Similarly, Stone has argued that the use of market forces in healthcare is morally intolerable because competitive pressures would allocate resources on the basis of ability to pay rather than clinical need: Market ideology turns the health care system into a competition between the rich and the poor instead of an orderly distribution of medical care according to clinical need . . . market ideology is the biggest obstacle to health care equity because in market theory, distribution is not supposed to follow need. It is supposed to follow economic demand.

#### UK’s experience with the NHS indicates that it will be expensive

Meadowcroft 2015 (John [PhD. Dept. of Political Economy, Kings College], “Just Healthcare? The Moral Failure of Single-Tier Basic Healthcare”, Journal of Medicine and Philosophy, 2015, Vol. 40, 152-168)

The experience of the UK National Health Service is instructive here. On its foundation in 1948, the NHS was designed to be free at the point of use with no explicit limit on the resources that could be consumed by an individual or by the system as a whole. The architects of the NHS believed that the cost of the system would decrease as the backlog of ill-health was cleared and preventative medicine and public health measures reduced future morbidity. The reality of the NHS proved much different, however. The cost of the NHS quickly became unmanageable, leading to the introduction of charges for prescriptions and optical services within 3 years of its creation. Despite the continuation of these charges, the net cost of the NHS has continued to rise inexorably, from 3 percent of GDP in 1948 to 7 percent of a significantly larger GDP 60 years later.

#### Prisoners in the US must be provided healthcare to avoid cruel punishment

Shuster 2013 (Kenneth [Rabbi and Attorney], *“Because of History, Philosophy, the Constitution, Fairness & Need: Why Americans Have a Right to National Health Care*, Indiana Health Law Review, Vol. 10(1), 2013, 76-113)

Although the Supreme Court has yet to found a right to government sponsored health care that individuals need not pay for themselves, the Court has found that, in certain circumstances, the government must provide health care to prisoners because it would violate the Eighth Amendment's ban on "cruel and unusual punishment" to not do so. 52 The first argument then in favor of a health care plan that is available to all Americans, regardless of their ability to pay, is an equal protection argument. Just as prisoners must be provided with health care although they cannot pay for it themselves, all Americans who cannot afford health insurance on their own must be provided with health care. This should be the case even if the Court employs a "rational basis" and not a "strict scrutiny" standard to find such an equal protection based health care right.

#### Single-Payer Healthcare is constitutional

Shuster 2013 (Kenneth [Rabbi and Attorney], *“Because of History, Philosophy, the Constitution, Fairness & Need: Why Americans Have a Right to National Health Care*, Indiana Health Law Review, Vol. 10(1), 2013, 76-113)

A second constitutional basis for national health care is the government's taxing and spending power, enumerated in Article 1, § 8, clause 1, which states in part that "[t]he Congress shall have Power to lay and collect Taxes ... to . . . provide for the . . . general Welfare of the United States." The last part of this section gives Congress authority to "make all laws which shall be necessary and proper for carrying into Execution the foregoing Powers." When we appreciate that the individual clauses, together with the above provisos, grant Congress the power to do whatever it must to insure a common defense, regulate interstate commerce, enact requirements for citizenship, coin money, establish post offices, and declare war, it is obvious that health care is as much of a prerequisite to the "general welfare" of the United States as any of the above listed necessities are. Moreover, that health care is a right, and not a privilege, inheres in the fact that the above enumerated powers, and the General Welfare Clause, are contained in the article which grants Congress taxation power. To be sure, if I as an American, have the right to a militia to protect me from invasion, a post office to deliver my mail, and a treasury to print money so I may engage in commerce, it follows that because I pay taxes, I have the right to have a portion of those taxes used to provide me with access to preventive health care to keep me well and to curative care should I get sick.

#### Benefits of Single-Payer Healthcare in the United States

Shuster 2013 (Kenneth [Rabbi and Attorney], *“Because of History, Philosophy, the Constitution, Fairness & Need: Why Americans Have a Right to National Health Care*, Indiana Health Law Review, Vol. 10(1), 2013, 76-113)

Although all such approaches have some merit, the best avenue by far that the United States should take to insure its people is a single-payer approach. This is for at least six reasons. First, unlike private insurance and even hybrid health care, all Americans regardless of income and assets would be covered for all medically necessary services, including physician visits and services, hospitalization, long-term care, dental needs, vision care, and prescription drug and medical supply costs. Such a plan is extremely necessary, because presently many government subsidized programs exclude many of the above services. Second, because a single-payer system will be funded and operated by a single entity, i.e. the government, it will cut down on the administrative costs that private and hybrid insurance plans require. Third, a single-payer plan will keep drug prices under control. This is because when patients are covered under one system, the payer, in this case the government, has more power to control costs than when multiple sources are responsible for providing drug care. To be sure, the unified source of their health care is a major reason drug prices in other countries are lower than they are in the U.S.. Fourth, because single-payer plans would cover items that are not traditionally covered in many plans, and would probably not carry copayments or deductibles, they would provide coverage to the presently underinsured as well as the uninsured. This is vital because as recently as 2009, 62% of U.S. bankruptcies were due to medical expenses and 80% of those bankruptcies were filed by people who had health insurance. Fifth, a national single-payer health plan will keep overall health care costs down by de-commercializing health care and limiting for-profit involvement in how health care is delivered. It would accomplish this in three ways. First, the payer (the government) would not spend more on medical technology than is needed to provide health care. Second, because a single-payer system would be delivered by the government, it would eliminate the excessive executive compensation packages in vogue at private insurance companies. Third, it would block the often enormous costs insurance companies spend to influence the public that private health insurance is the preferred manner in which they should obtain their health insurance. Finally, because a single-payer plan would be operated by the government, all medical data, including patient and hospital records, could be housed in one central computerized repository. This would further keep administrative costs down, discourage doctors from fraudulently billing for unperformed procedures, and make it much easier to coordinate patient health data between physicians and hospitals in the event a patient changes doctors or moves to another locale.

#### The US does not secure access to healthcare

Hertel & Libal 2011 (Shareen & Kathryn [Both Ph.D., University of Connecticut], *Entrenched Inequity: Health Care in the United* States, Human Rights in the United States: Beyond Exceptionalism, Cambridge University Press, New York, NY, 2011, 153-174)

The United States is the only industrialized country that does not recognize a government's obligations to provide health care. At the federal level, the closest Americans have come to securing their right to health are programs like the State Children's Health Insurance Program (SCHlP), Medicare, and Medicaid, which are rooted in the idea that children, the elderly, and the poor should be guaranteed a minimum level of health services. Federal legislation also guarantees a limited right to emergency care in the United States. Important as these programs are, and important as it is to extend them, as happens under the PPACA, the exclusivity of their premise contradicts the notion of a universal right to health elaborated under international law.

In the U.S. federalist system, states are largely responsible for implementing the few health care entitlements that exist. There is considerable variation among states both in law and practice, which is another factor that breeds inequity from the standpoint of international human rights laws. In many cases, even essential services and limited benefits can be taken away when the legislature determines, which is inconsistent with a rights-based view of entitlements not subject to retrogression.

American law and policy generally approach health care as a commodity - either to be doled out to the needy as a matter of charity or to be regulated through the market. Nonetheless, there have been repeated attempts to establish national health insurance in the United States. In '95, the American Association for Labor Legislation (unsuccessfully) campaigned for sickness insurance. President Harry Truman officially endorsed a national health insurance scheme proposed by the Wagner Murray-Dingell Bill, but it never came to a vote in Congress (Social Security Administration n.d.). The result is that the U.S. system views health as a commodity and funds health primarily through employers or other private financing Sources. However, from a rights-based perspective, the problem with U.S. health care is not the mixture of public and private funding per se, but rather the failure of the government to step in and level the playing field in the face of obvious inequities in the system.

#### Medicare doesn’t solve

Rovner 2016 Julie Rovner, 1-22-2016, "Debate Sharpens Over Single-Payer Health Care, But What Is It Exactly?," NPR.org, <http://www.npr.org/sections/health-shots/2016/01/22/463976098/debate-sharpens-over-single-payer-health-care-but-what-is-it-exactly> (BFI WQL)

Would Medicare For All Be Just Like The Existing Medicare Program? No, at least not as Sanders envisions it. Medicare is not nearly as generous as many people think. Between premiums (for doctor and drug coverage), cost-sharing (deductibles and coinsurance), and items Medicare does not cover at all (most dental, hearing and eye care), the average Medicare beneficiary still devotes an estimated [14 percent of all household spending](http://kff.org/medicare/issue-brief/health-care-on-a-budget-the-financial-burden-of-health-spending-by-medicare-households/) to health care. Sanders' plan would be far more generous, including dental, vision, hearing, mental health and long-term care, all without copays or deductibles (which has given rise to a [lively debate](http://www.newyorker.com/business/currency/what-bernie-sanderss-health-care-plan-leaves-out) about how to pay for it and whether middle-class families will save money or pay more).

#### Insurance companies fail the public

Klein 2014 Ezra Klein Washington Post, 1-13-2014, "What liberals get wrong about single payer," <https://www.washingtonpost.com/news/wonk/wp/2014/01/13/what-liberals-get-wrong-about-single-payer/> (BFI WQL)

Insurers are the bogeymen of American health care. That’s in part because they do a lot of the unpopular stuff: They’re the ones who charge you money for health care, who say you can’t get something you want, who your bosses blame when they deduct more money from your paycheck to cover health costs. And it’s hard to see what value they add to the system. Yet the problem with the Affordable Care Act isn’t the insurance industry. In fact, the main benefits of nationalized health care can be achieved in systems with hundreds, even thousands, of for-profit insurers. "By 2017," Moore writes, "we will be funneling over $100 billion annually to private insurance companies." The insurers will use the bulk of that money, however, to pay hospitals and pharmaceutical companies and device manufacturers for medical care. A clearer way to think about this is profits -- and insurers aren’t where the big profits in the health-care system go. In 2009, Forbes [ranked](http://money.cnn.com/magazines/fortune/fortune500/2009/performers/industries/profits/) health insurance as the 35th most profitable industry, with an anemic 2.2 percent return on revenue.

#### Opponents fight single-payer healthcare for selfish capitalist reasons

Oberlander 2016 (Jonathan [PhD. Political Science], *The Virtues and Vices of Single-Payer Health Care*, The New England Journal of Medicine, 374(15), April 24, 2016)

The substantive virtues of single-payer programs are compelling. But so are their political liabilities. Medicare for All, which aims to constrain health care spending, faces intense opposition from insurers, the medical care industry, and much of organized medicine. It would trigger fierce resistance from conservatives and the business community and anxiety in many insured Americans fearful about changing coverage and the specter of rationing. The Affordable Care Act’s comparatively conservative reform approach inspired false charges of “socialized medicine,” “pulling the plug on grandma,” and “death panels.” It takes only a little imagination — or a look back at the history books — to predict the reactions that an actual single-payer plan would evoke.

# NEG CARDS

#### Few individuals raise the cost of healthcare for everyone

Meadowcroft 2015 (John [PhD. Dept. of Political Economy, Kings College], “Just Healthcare? The Moral Failure of Single-Tier Basic Healthcare”, Journal of Medicine and Philosophy, 2015, Vol. 40, 152-168)

Without some restraint, healthcare costs will rise relentlessly because chronic conditions can act as an unlimited drain on resources. As Brock has noted, among individuals “with very severe cognitive and physical impairments who have a very low health related quality of life, there may be almost no end to the resources that might be devoted to them in the form of health care, medical research, and other supportive services” (Brock, 2001, 166–7). Similarly, endless resources can conceivably be devoted to achieving relatively minor health gains for people who consider themselves to be in reasonably good health.

#### Nationalized healthcare functions on politics/economic principles and not what’s best for the common people

Meadowcroft 2015 (John [PhD. Dept. of Political Economy, Kings College], “Just Healthcare? The Moral Failure of Single-Tier Basic Healthcare”, Journal of Medicine and Philosophy, 2015, Vol. 40, 152-168)

Those managing the single-tier healthcare systems of contemporary social democracies must make central, deliberative decisions about what conditions will be treated and what treatments will be provided, despite the fact that objectively ascribable and objectively important health needs cannot be established. In the United Kingdom, for example, the National Institute for Health and Care Excellence (known by the acronym NICE) issues guidelines on what treatments the NHS will fund for different conditions using basic cost-effectiveness analysis (Rawlins and Culyer, 2004; Meadowcroft, 2008).

In the absence of an objective basis for such decision-making, resource allocation within such a system becomes a political process in which different interest groups compete for control of scarce resources. Those groups that are able to effectively mobilize to capture the deliberative process will be able to secure substantial resources for the treatment of particular conditions, whereas those groups unable to mobilize so effectively will receive relatively limited resources.

This is one explanation of why in the UK NHS, for example, the treatment of some conditions, such as Parkinson’s disease, may be judged world leading, whereas the treatment of others, such as lung cancer, produces survival rates among the lowest in the developed world. An important factor in the relative allocation of resources to Parkinson’s care and lung cancer treatment is the different socioeconomic profiles of those who suffer from the two conditions. Resource allocation via the political process privileges the demands of those with the relevant economic, social, and/or cultural resources (Meadowcroft, 2008).

#### Single payer health care in the United States would not accomplish its goals, and even if it were it would still be the most expensive health care system in the world – multiple reasons why

Sanger-Katz 2016 Margot Sanger-Katz, 5-16-2016, "A Single-Payer Plan From Bernie Sanders Would Probably Still Be Expensive," New York Times, <http://www.nytimes.com/2016/05/17/upshot/why-single-payer-health-care-would-probably-still-be-expensive.html?_r=1> (BFI WQL)

If you look around the world, lots of countries have single-payer systems. And all of them pay substantially less for health care than we do in the United States. I am reminded of this often, in the comments by readers in some of my articles. So how could a single-payer system here still be so expensive? One reason is that the Sanders plan covers far more than typical insurance plans in the United States — or abroad. The Sanders plan would charge no premiums, require no out-of-pocket spending and would pay for services like dental care and long-term nursing home stays. Those things boost the total price tag. But imagine a universe where we had a single-payer health plan that was more like normal insurance. Perhaps it would be a true “Medicare for all,” where everyone has exactly the insurance that the federal government currently provides to older people and the disabled. That Medicare-for-all plan would still cost more than single-payer plans in other countries. Here’s why: Medicare pays doctors and hospitals higher prices than single-payer systems do in other countries. “The big thing is that providers here make quite a bit more money than they do anywhere else, and in order to get in the ballpark of where these other countries are, you’d have to reduce payment rates to physicians to much, much lower levels,” said John Holahan, one of the authors of the Urban analysis. “That’s just hard to do.” The Organization for Economic Cooperation and Development, which looks at a group of developed countries, has found that the United States pays substantially higher prices for doctors, hospital stays and prescription drugs than the rest of the group. Medicare pays less than the United States average, but not enough less to make up that difference. Making the American health care system significantly cheaper would mean more than just cutting the insurance companies out of the game and reducing the high administrative costs of the American system. It would also require paying doctors and nurses substantially lower salaries, using fewer new and high-tech treatments, and probably eliminating some of the perks of American hospital stays, like private patient rooms. The average family physician in the United States earns $207,000, according to the [Medscape Physician Compensation Report](http://www.medscape.com/viewarticle/860987_2). General practitioners in Britain, which has a single-payer system, [earn](http://www.hscic.gov.uk/searchcatalogue?productid=18736&q=title%3a%22GP+Earnings+and+Expenses%22&sort=Relevance&size=10&page=1#top) an average pay of around $130,000. The gaps in pay for specialists are even bigger. The Urban Institute report assumes that the Sanders plan would cut pay for doctors substantially, but not by half. That’s a reasonable assumption. We also pay more for drugs than the rest of the world, but many experts think that a single-payer health plan could push down drug prices because drug companies earn such high profit margins. The Urban analysis assumes that the country could quickly get to prices 25 percent lower than what Medicare pays. (That change assumes a political revolution, of course, because the pharmaceutical companies are an extremely effective lobby.) The Sanders campaign and its academic allies dispute some of the Urban Institute’s assumptions. [A critique of the Urban analysis](http://www.huffingtonpost.com/david-himmelstein/the-urban-institutes-attack-on-single-payer-ridiculous-assumptions-yield-ridiculous-estimates_b_9876640.html) from David Himmelstein and Steffie Woolhandler, professors of public health at the City University of New York, argues, for example, that drug prices could be pushed even lower. And the Sanders team says that the researchers overestimated the costs associated with administering the government program. But it doesn’t argue that the prices paid to medical providers could be cut more sharply. The same problem exists for other attempts to reduce health spending in the United States. Efforts by the Obama administration to pay doctors and hospitals differently are designed to squeegee some waste out of the system, by eliminating extra care that may not help people’s health. But it has done little to change the prices paid for medical care. That means that its best hope is to “bend the cost curve,” or reduce the rate that health spending grows. Republican proposals to make health care into more of a free market also tend to assume that they will slow spending growth, not actually reduce it. The Sanders plan would require a huge reorganization of the country’s health care system. Overnight, it would put the private insurance industry out of business, along with many other businesses that support it. It would shift billions of dollars of spending from individuals, workers and states into the federal budget. Doing that might well reduce some of the country’s health care spending that is going toward insurer profits and paper-pushing. But more than 80 percent of the dollars we currently spend on health care actually go toward health care. And making big cuts all at once to doctors and hospitals could cause substantial disruptions in care. Some hospitals would go out of business. Some doctors would default on their mortgages and student loans. Even if the country decided that medicine should become a more middle-class profession — not an obvious outcome, given the [substantial public support for the medical professions](http://www.gallup.com/poll/1654/honesty-ethics-professions.aspx) — it would be difficult to get there at once. All of that means that bringing a government-run, single-payer health care system could achieve many of the goals of its advocates: more equity, lower complexity and some reductions in cost. But the United States would probably continue to have the most expensive health care system in the world. And we’d have to raise taxes high enough to pay for it.

#### Their examples of a European utopia are incorrect as there’s a distinction between social insurance and single payer health care systems

Rovner 2016 Julie Rovner, 1-22-2016, "Debate Sharpens Over Single-Payer Health Care, But What Is It Exactly?," NPR.org, <http://www.npr.org/sections/health-shots/2016/01/22/463976098/debate-sharpens-over-single-payer-health-care-but-what-is-it-exactly> (BFI WQL)

Which Countries Have Single-Payer Health Systems? There are fewer than many people might think. Most European countries either never had or no longer have single-payer systems. "Most are basically what we call social insurance systems," says Gerard Anderson, a professor at Johns Hopkins Bloomberg School of Public Health who has studied international health systems. Social insurance programs ensure that almost everyone is covered. They are taxpayer-funded but aren't necessarily run by the government. Germany, for example, has 135 "[sickness funds](http://www.theatlantic.com/health/archive/2014/04/what-american-healthcare-can-learn-from-germany/360133/)," which are essentially private, nonprofit insurance plans that negotiate prices with health care providers. "So you have 135 funds to choose from," said Anderson. Nearby, [Switzerland](http://www.commonwealthfund.org/topics/international-health-policy/countries/switzerland) and the [Netherlands](http://www.commonwealthfund.org/topics/international-health-policy/countries/the-netherlands) require their residents to have private insurance (just like the Affordable Care Act does), with subsidies to help those who cannot otherwise afford coverage. And while conservatives in the United States often use Great Britain's National Health Service as the poster child for a socialized system, there are many [private insurance options available](http://thehealthcareblog.com/blog/2012/01/16/the-awkward-world-of-private-insurance-in-the-uk/) to residents there, too. As far as countries that have true single-payer systems, Anderson lists only two: [Canada](http://www.law.harvard.edu/programs/lwp/healthc.pdf) and [Taiwan](http://www.brookings.edu/research/opinions/2015/05/14-taiwan-national-healthcare-cheng).

#### Single payer plans don’t solve long term

Rovner 2016 Julie Rovner, 1-22-2016, "Debate Sharpens Over Single-Payer Health Care, But What Is It Exactly?," NPR.org, <http://www.npr.org/sections/health-shots/2016/01/22/463976098/debate-sharpens-over-single-payer-health-care-but-what-is-it-exactly> (BFI WQL)

Are Single-Payer Plans Less Expensive Than Other Health Coverage Systems? Not necessarily. True, eliminating the profits and duplicative administrative costs associated with hundreds of different private insurance plans would reduce spending, perhaps as much as 10 percent of the nation's [$3 trillion annual health care bill](https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf), says Anderson. But, he notes, once those savings are achieved, there wouldn't be further reductions afterward. More important, as [many analysts have noted](http://www.vox.com/2016/1/15/10775050/single-payer-debate), is how much health services cost and how those prices are determined. In most other developed countries, even those with private insurance, [writes Princeton health economist Uwe Reinhardt](http://economix.blogs.nytimes.com/2013/03/29/u-s-health-care-prices-are-the-elephant-in-the-room/), prices "either are set by government or negotiated between associations of insurers and providers of care on a regional, state or national basis." By contrast, in the U.S., "the payment side of the health care market in the private sector is fragmented, weakening the bargaining power of individual insurers."

#### Current plans for single payer tax plans would cost much more than thought

Sanger-Katz 2016 Margot Sanger-Katz, 5-16-2016, "A Single-Payer Plan From Bernie Sanders Would Probably Still Be Expensive," New York Times, <http://www.nytimes.com/2016/05/17/upshot/why-single-payer-health-care-would-probably-still-be-expensive.html?_r=1> (BFI WQL)

Bernie Sanders’s chances at enacting a “political revolution” [are all but gone](http://www.nytimes.com/aponline/2016/05/09/us/politics/ap-us-dem-2016-sanders.html). But that doesn’t mean his policy agenda won’t [continue to be felt](http://www.nytimes.com/2016/05/13/us/politics/sanders-supporters-propose-mobilizing-voters-to-defeat-trump.html) in this election or future Democratic platforms. One of his [signature proposals](https://berniesanders.com/wp-content/uploads/2016/01/Medicare-for-All.pdf) is to move the country’s health care system to a government-run, single-payer system. Last week, Hillary Clinton nodded in that direction, suggesting that she would be open to [allowing Americans older than 50 to buy into the government Medicare program](http://www.nytimes.com/2016/05/11/us/politics/hillary-clinton-health-care-public-option.html) that currently covers those 65 and older. But also last week, a [detailed analysis of the Sanders health care plan](http://www.urban.org/sites/default/files/alfresco/publication-pdfs/200785-The-Sanders-Single-Payer-Health-Care-Plan.pdf) from researchers at the Urban Institute showed that it would probably [cost the government](http://www.nytimes.com/aponline/2016/05/09/us/politics/ap-us-sanders-economic-plan.html) double what the campaign proposed. It is the second credible analysis to suggest that the Sanders plan costs more than advertised. ([The other](https://www.scribd.com/doc/296831690/Kenneth-Thorpe-s-analysis-of-Bernie-Sanders-s-single-payer-proposal) comes from the Emory health policy professor Kenneth Thorpe.) The Sanders plan is [light on some key details](http://www.nytimes.com/2016/01/20/upshot/for-now-bernie-sanderss-health-plan-is-more-of-a-tax-plan.html), but even in sketch form, it seems clear that it would require even bigger tax increases than the [sizable ones the campaign has called for](http://www.nytimes.com/2016/01/22/upshot/sanders-makes-a-rare-pitch-more-taxes-for-more-government.html).

#### Healthcare should not be considered a human right

Barlow 1999 (Philip [Consultant Neurosurgeon], *Heath Care is Not a Human Right*, BMJ, Vol. 319(7205), Jul. 1999)

A human right is a moral right of paramount importance applicable to every human being. There are several reasons why health care should not be considered a human right.

Firstly, health care is difficult to define. It clearly encompasses preventive care (for example, immunisation), public health measures, health promotion, and medical and surgical treatment of established illness. Is the so called human right to health care a right to basic provision of clean water and adequate food, or does everyone in the world have a right to organ transplantation, cosmetic surgery, infertility treatment, and the most expensive medicine? For something to count as a human right the minimum requirement should surely be that the right in question is capable of definition.

Secondly, all rights possessed by an individual imply a duty on the part of others. Thus the right to a fair trial imposes a duty on the prosecuting authority to be fair. On whom does the duty to provide health care to all the world’s citizens fall? Is it a duty on individual doctors, or hospital authorities, or governments, or only rich governments? It is difficult to see how any provision of benefits can be termed a human right (as opposed to a legal entitlement) when to meet such a requirement would impose an intolerable burden on others.

Thirdly, the philosophical basis of all human rights has always been shaky. Liberalism and humanism, the dominant philosophies of Western democracies, require human rights. Religion requires a God, but this is not in itself evidence of God’s existence. Most people can see some advantage in maintaining the concept of civil and political rights, but it is difficult to find any rational or utilitarian basis for viewing health care in the same way.

To propose that health care be considered a human right is not only wrong headed, it is unhelpful. Mature debate on the rationing and sharing of limited resources can hardly take place when citizens start from the premise that health care is their right, like a fair trial or the right to vote. I suspect that the proponents of the notion think that to claim health care as a human right adds some kind of weight or authority to the idea that health care, and by extension healthcare professionals, is important. A more humble approach would achieve more in the long run.

# Additional Web Resources

1) Vlog Brothers “What are American Health Care Cost So high?

https://www.youtube.com/watch?v=qSjGouBmo0M

2) Medical Economics – Many articles on the subject

http://medicaleconomics.modernmedicine.com/

3) Harvard Medical School - Single payer healthcare: Pluses, minuses, and what it means for you

<http://www.health.harvard.edu/blog/single-payer-healthcare-pluses-minuses-means-201606279835>

4) Gallop - Majority in U.S. Support Idea of Fed-Funded Healthcare System

<http://www.gallup.com/poll/191504/majority-support-idea-fed-funded-healthcare-system.aspx>

5) Vermont Health Care Reform

<http://hcr.vermont.gov/>

6) Wikipedia – Universal Health Care by Country

<https://en.wikipedia.org/wiki/Universal_health_coverage_by_country>

7) Official Canadian National Health Care

http://hc-sc.gc.ca/hcs-sss/medi-assur/index-eng.php