# 1AC - Quotes

A&M Consolidated Affirms and provides a framework. You should

#### Vote for the team who best advocates for a resistance to the current neoliberal structures in America. Prefer this framework for 2 reasons

#### Root Cause – Neolib encourages profit over people as La Mothe 13 notes “corporate institutions can create a financial disaster and not be held accountable, but instead become even wealthier. neoliberal system[s] [are] largely weighted toward corporations and the wealthy rather than the common good. This shapes perceptions and behaviors, resulting in relations that undermine care, [and] reduce and corrupt the understanding of freedom”

#### Prefer this framework on Magnitude - Neoliberal systems incentivize people to prey on the weak, as La Mothe Continues that “in a neoliberal system it is entirely fair to charge what the market will bear even if it results in people being in crises, for instance, instead of charging $80 [people can] charge $500, knowing that desperate people will pay the price”

## Our Sole Contention is A Broken System

Right now, is the perfect time for reform as **Lent 20** notes that “Coronavirus is revealing the structural faults of [the] system. Like a crucible it has the potential to melt down the structures that exist and reshape them.

Currently, companies are valued more than people in the current system of Neoliberalism – the notion that the free market can solve all our issues. **Waitzkin 16 notes** that current health proposals “promote competing, for-profit, private insurance corporations. “

Thankfully a single payer system will resist the business take all mentality in 3 ways

### The First is by changing healthcare from a commodity to a right.

**Arno 20** notes that “the dilemma of the US health care system is due to a failure to implement a policy that constrains [business] excesses. The theology of the market and the mistaken belief that the problems of US health care can be solved if only the market could be perfected have effectively [stopped] the development of a[n] efficient, and humane national health care policy. no reforms except publicly financed, single-payer universal health care will solve the problems of our health care system

**Ackleman 14** notes that “an increased federal role [has] consequences beyond health markets. It may open the door to greater federal involvement in insurance regulation generally. If it overcomes its initial hiccups, [it] could generate further momentum for federal chartering […] in non-health insurance markets.

Basically, we curtail business profitability in Health which spills over to other sectors

###  The Second is by spearheading grassroots movements

#### M4A leads a charge against neoliberalism as whole as Day and Brown 17 explain “The challenge is to build durable organizations that can affect real change. Single-payer can help us do that [by increasing] organizing capacity and build working-class power for long-term struggle. Single payer is a strategic central focus. in fighting we build solidarity across difference and power the working class. Everyone needs health care. everyone has been hurt by insurance greed. Reforms advance the fight for more radical victories. They also build against new constituencies dedicated to defending public goods against privatization.

### The Third is through empowering unions

**Wolff 13** notes “organized labor’s decline is well-known. To reverse [this] decline requires a strategy that engages with employers and repositions labor unions as champions of broad social gains. Unions must work for far more than their own members.”

Luckily, **Martincheck 20** finds that “Medicare for All would take the burden of negotiating for [health] benefits away from unions. This would free Union leaders up in leverage and in time to negotiate on other issues. Money saved by taking healthcare from the employer is something Unions can negotiate to put towards workers”

**Albo 09** explains that “Neoliberalism sought to roll back the gains of unions and workers in the workplace. The ‘disorganization’ of unions was one of the central objectives of neoliberalism”

Thus, with the rise of unions, we can combat neoliberalism

### The Impact is the exploitation of the poor.

**Galvin** in 2019, 45 percent of working-age adults, or 87 million people, were either underinsured or had no coverage for at least part of the last year

Overall the direct effect, as noted by **Cecere of Harvard** who notes that **“**lack of health insurance causes 44 [thousand] excess deaths annually [because]**,** the uninsured are more likely to go without needed care”

This spreads beyond simply health and makes poverty inevitable as **Hinkelammert 04** notes “Neoliberalism represents the markets as perfect. No Imperfection of the market occurs only imperfections of people. If the market is perfect there can be no poverty”

Essentially, neoliberalism thinks of poverty as a personal problem and not a problem that society has to address.

Thus, we affirm

F2:

**Schuleman 11 notes that any** “effort is unreasonable as long as cost-containment and profitability remain the aims of insurers. until the U S moves to single-payer"

#### Companies sell people’s health like it’s a common toy, and this often causes harms. Waitzkin 16 notes “Many countries have rejected the neoliberal model and have instead constructed health care for all. For instance, Canada prohibits private insurance coverage for services [and thus] assures assures a high-quality national program.”

**Jeremy Lent**, openDemocracy, 4-1-2020 ["Coronavirus spells the end of the neoliberal era. What’s next?", <https://www.opendemocracy.net/en/transformation/coronavirus-spells-the-end-of-the-neoliberal-era-whats-next/>, accessed 9-13-2020] DuPont Manual SB

If Covid-19 was spreading across a stable and resilient world, its impact could be abrupt but contained. Leaders would consult together; economies disrupted temporarily; people would make do for a while with changed circumstances—and then, after the shock, look forward to getting back to normal. That’s not, however, the world in which we live. **Instead, this coronavirus is revealing the structural faults of a system that have been papered over for decades as they’ve been steadily worsening**. Gaping economic inequalities, rampant ecological destruction, and pervasive political corruption are all results of unbalanced systems relying on each other to remain precariously poised. **Now, as one system destabilizes, expect others to tumble down in tandem in a cascade known by researchers as “synchronous failure.” The first signs of this structural destabilization are just beginning to show.** Our globalized economy relies on just-in-time inventory for hyper-efficient production. As supply chains are disrupted through factory closures and border closings, shortages in household items, medications, and food will begin surfacing, leading to rounds of panic buying that will only exacerbate the situation. The world economy is entering a downturn so steep it could exceed the severity of the Great Depression. **The international political system—already on the ropes with Trump’s “America First” xenophobia and the Brexit fiasco—is likely to unravel further, as the global influence of the United States tanks while Chinese power strengthens. Meanwhile, the Global South, where Covid-19 is just beginning to make itself felt, may face disruption on a scale far greater than the more affluent Global North**. The Overton Window. **During normal times, out of all the possible ways to organize society, there is only a limited range of ideas considered acceptable for mainstream political discussion—known as the Overton window. Covid-19 has blown the Overton window wide open**. In just a few weeks, we’ve seen political and economic ideas seriously discussed that had previously been dismissed as fanciful or utterly unacceptable: universal basic income, government intervention to house the homeless, and state surveillance on individual activity, to name just a few. But remember—this is just the beginning of a process that will expand exponentially in the ensuing months. A crisis such as the coronavirus pandemic has a way of massively amplifying and accelerating changes that were already underway: shifts that might have taken decades can occur in weeks. **Like a crucible, it has the potential to melt down the structures that currently exist, and reshape them, perhaps unrecognizably**. What might the new shape of society look like? What will be center stage in the Overton window by the time it begins narrowing again? The example of World War II. We’re entering uncharted territory, but to get a feeling for **the scale of transformation we need to consider**, it helps to look back to the last time the world underwent an equivalent spasm of change: the Second World War.

####  <http://www.yorku.ca/albo/docs/2009/relay26_albo.pdf>

As a consequence of the economic slowdown and crisis, job losses are mounting in the labour market, and **unemployment is beginning to climb upward**. **This is intensifying a number of negative longer-term trends in the labour market in the capitalist countries over the period of neoliberalism**: downward pressures on real wages, an increase in precarious and marginal work, the undermining of public sector services and employment, increasing reliance on migrant workers with restricted rights, and mounting global inequalities. It has further encouraged employers to step up their political struggles against unions in favour of further policies of labour flexibilisation. There is developing, moreover, major employer efforts across the advanced capitalist bloc to undermine (at the state level) and redefine or even scrap (at the company level) workers’ pension plans, and to cut healthcare provisions (private health plans in the U.S. and public healthcare provision in other countries). **These calls from employers, despite the hardships they entail for working class people, have so far received a sympathetic hearing in the economic policy-making branches of states.** The initial policy efforts of governments have been an attempt to reconstruct the existing policy regime and political relations, despite the severity of the recession limiting the possibility of doing so. **The economic turmoil has produced, however, an ideological crisis of neoliberalism: the free market ideology that has been virtually uncontested at the level of political power for almost two decades is now totally discredited.** It has become impossible to contend that smaller states and liberalised markets will lead to prosperity for all **(the trickle-down thesis);** that public services could be protected and improved by increased reliance on markets (the theses of self-regulation and marketisation); that new financial instruments were spreading risk and increasing economic stability (the theses of transparency and shareholder value as central to efficient capital allocation); **that flexible labour markets and de-unionised workplaces improved job security and pay (the thesis of all employment and unemployment as voluntary individual decisions)**; and that increased market dependence meant a parallel increase in freedom and equality (the thesis that all collective action is coercive and anti-democratic). **These theoretical claims by neoliberal ideologues have now proven to be unmitigated failures as policy frameworks**, and a social disaster for whole societies and workers where they have been adopted. What remains of neoliberalism, it needs to be underlined, is its political embeddedness in state structures, policy instruments and the political field of social forces. **The ‘disorganisation’ of working class organisation, in unions and political parties, was one of the central objectives of neoliberalism**. It remains, at this point, the most formidable obstacle to both thinking about and establishing a postneoliberal political order. This is why it is necessary to make a deeper assessment of the impact of neoliberalism on the labour movement and the prospects for a new union politics in the context of the renewal of the Left. UNION MOVEMENT CHALLENGES **Unions have been one of the most effective social movements for the advancement of democracy and social justice in capitalist societies.** **Unions have been the first means by which workers, who to earn their living have only their labour to sell, struggle to equalise the advantages that the owners of capital assets have in bargaining over wages**and the distribution of new value-added activities in workplaces. Unions have also continually campaigned, in conjunction with socialist parties, for the extension of democracy through advocacy of universal participation in politics, civil rights such as freedoms of association, assembly and dissent, and the universalisation of social programmes to meet the basic social needs of all. These struggles for social justice were opposed historically by the capitalist classes, and the advent of neoliberalism as the policy response of employers and conservative parties renewed their anti-democratic efforts (Moody 1997). Neoliberalism sought to roll back the gains of unions and workers in the workplace, and put an end to the push by unions and Left parties for greater worker control in enterprises and democratic determination of economic priorities at the level of the state. Their policy response was measures to weaken unions in workplace representation, deregulation of labour markets, increased corporate property rights and free trade in capital and goods**.** After a long period after the war in which expansionary state policies and high employment strengthened the bargaining power of union, this was the first challenge unions faced. Beginning with the economic slowdown of the 1970s, and particularly after the ‘Volcker shock’ in the U.S. in 1981-82 radically drove up U.S. and thus world interest rates to force an economic restructuring to break workers’ wage expectations and power, an ‘employers’ offensive’ ensued across the advanced capitalist countries. Employers began a series of labour-saving plant shutdowns and a major shift of production to locales with lower union density, for example the southern U.S. and northern Mexico in the case of North America. Further workplace restructuring continued through the 1990s. It took the form of the socalled ‘new economy’: a rise in service sector employment (especially linked to ICT – information and communications technologies – and the mass growth of various kinds of low-paid servant work), lean production-intensifying work processes, flexible manufacturing systems, non-standard work arrangements and extensive resort to cheap migrant labour pools and temporary worker programmes. The ‘employers’ offensive’ and much higher levels of labour reserves meant that inter-worker competition increased as well, particularly as migration and increased female participation changed the character of the working classes. **Indeed, the entire period of neoliberalism has seen a remarkable degree of wage compression and widening gaps between the share of new value-added activity taken by capital and that taken by workers. The pressure on wages and workplace controls has posed, in turn, a challenge for collective bargaining. This has often entailed extensive efforts to overhaul union agreements to give management increased flexibility in employment, deployment of workers and over wage structures.** This has been quite diverse in the forms it has taken across the capitalist countries. In Europe, for example, this has been a form of ‘competitive corporatism’ where unions form social pacts with companies to increase competitiveness through wage restraint, new work arrangements and longterm contracts; while in North America flexibilisation agreements have been a more common pattern in unionised workplaces, along with sustained efforts at de-unionisation. In traditional manufacturing strongholds in North America, this has meant that unions like the United Steelworkers have often engaged in ‘partnership’ and co-management schemes introducing flexible work arrangements as a trade-off for some job protection and union security. And unions like the Canadian Auto Workers (CAW) have been willing to forego the right to strike to gain union recognition to bargain with auto parts companies, notably Magna. The latter is a variation of the ‘voluntary recognition agreements’ of unions by management occurring in the service sector, often after long unsuccessful organising campaigns but extensive losses to corporate image and time, with unions accepting certain workplace and bargaining concessions in the process. There have also been similar adjustments, again with significant national variations, to national and sectoral collective bargaining institutions. This has given variation to a common pattern of wage compression and bargaining setbacks: the ‘shared austerity’ of Sweden, the ‘comanaged austerity’ of Germany, and the ‘punitive austerity’ of Canada and the United States. A third challenge has come in the form of flexible labour market policies. Neoliberal governments explicitly abandoned Keynesian economic policies geared toward full employment for monetarist policies of ‘inflation-targeting.’ The latter has meant targeting low inflation rates normed so that wage increases largely do not surpass the rate of inflation and thus all productivity gains are claimed by employers. It has also meant a preference for maintaining a ready pool of labour, available – because of a ‘natural rate of unemployment’ – to take up new work, particularly in the service sector, as it becomes available. Another component of flexible policies has been restricting access to, and reducing benefits for, programmes such as unemployment insurance or social assistance. These are seen to cause disincentives to work and labour market rigidities which hamper economic stability. **Finally, flexible labour market policy has entailed a series of continual restrictions on union organising and free collective bargaining, notably the increasing invocation of back-to-work and right-to-work legislation across all North American jurisdictions.** The internationalisation of capital and the global reorganisation of labour processes has been a fourth challenge for unions. Multinational corporations have chosen expansion of international production networks, in particular distributing repetitive and ecologically damaging labour process in poorer countries where low wages can be paid. But they also shifted higher value-added activities to places where union strength is much weaker to allow the introduction of new labour processes. This reorganisation has increased the leverage for employers through the threat of capital flight and the relative immobility of labour. The World Trade Organization (WTO) and international trade agreements such as the North American Free Trade Agreement (NAFTA), as well as the political arrangements of the European Union, all have rules restricting the ability of governments to impede capital mobility. Moreover, they often contain clauses blocking more active industrial policies. Workers in Mexico, for example, earn about one-tenth or less of the wages of workers in Canada and the U.S. for similar work; the initial period of NAFTA saw some 2 million less skilled jobs move to Mexico, particularly in the maquilas free trade zones in the northern border states. Parallel global pressures have hit Mexican workers, and indeed all workers, by the massive shift of so much of the world’s manufacturing capacity to China and other low-wage Asian countries. The internationalisation of capitalism, aided by trade liberalisation and new trade rules, further compels employers to drive down unit labour costs and hold back wage gains. Indeed, the weakening of unions, in turn, fuels competition between workers and further shifts the balance of power in favour of employers. **In the most recent phase of neoliberalism, this has lead to the embrace of ‘competitive unionism.’ The inequalities and divisions between workers as a consequence become not only greater, but embedded in the very logic of union organisation and strategy**. **With competitive unionism, union democracy, mobilisational capacity and ideological independence from employers all become strained or even atrophy**. NEW STRUGGLES, NEW MOVEMENT? **The challenges that emerged with neoliberalism put union movements in the advanced capitalist countries on the defensive and, in more than a few cases, meant a decisive defeat**. Union density in the U.S., for instance, have declined to just over one in 10 workers being in a union today, and more than a dozen core capitalist economies have seen an absolute decline in union mem- bership. This reflects, in part, the difficulty of organising the service sector. **But the inability of collective bargaining to deliver systematic real wage gains and to block welfare state reforms also tells of the broader impasse of the labour movement over the period of neoliberalism**. **Still, despite the major challenges, it is necessary to note that key struggles and signs of political resistance keep surfacing, from both inside the labour movement and also associated social forces and movements (Schenk and Kumar 2006). In North America, some of this has come from ‘living wage’ struggles led by local labour councils in major cities, in alliance with community groups, to reach out to the low-waged and unorganised, who are predominantly women and people of colour. The mass immigrants’ rights May Day protests, as well as the day-to-day campaigns for the protection of non-status workers, have taken place outside the main union movements, but also led to new linkages and alliances. Similar types of struggles are helping to rebuild local labour movements in many countries. Despite often defensive and weak leadership beaten down by neoliberal attacks, central labour organisations are also developing a new sense of urgency, at least in the sense of convention resolutions on organising, mobilising and political issues. If there is still great distance to go in translating sentiment into political action, it does suggest some significant openings for rebuilding the labour movement.**

# 1AC

Analyze Defense:

How fast does the defense materialize?

* How long does it take doctors to come up

To do

* Replace Palek
* Find real impact for innovation
* Healthcare spills over

A&M Consolidated Affirms and Observes that you should

#### Use the ballot to deconstruct the uncontested neoliberal institutions that systems relies on. Vote for the team who best resists the existing neoliberal structures for 3 reasons

#### Root Cause – Neolib encourages all evil and makes societies encourage them as La Mothe 13 notes

**\*Neolib makes society think it’s ok to do anything as long as Elite and thus destroys society.** It’s a root cause of all evil\*

R. LaMothe, No Publication, xx-xx-2013 ["*Neoliberal Capitalism and the Corruption of Society: A Pastoral Political Analysis. Pastoral Psychology, 65(1), 5–21.* doi:10.1007/s11089-013-0577-x  ", [https://sci-hub.tw/https://link.springer.com/article/10.100](https://sci-hub.tw/https%3A//link.springer.com/article/10.100) 7/s11089-013-0577-x, accessed 7-16-2020] A&M SS

In a totalitarian society—classical or inverted—one can expect to see a distortion not only of care and the common good, but also of relational justice—wrong on the throne and right on the scaffold (Niebuhr 1941, p. 40). Neoliberal capitalism’s semiotic system[s] does not and cannot possess a notion of relational justice unless it is grafted on, and in those instances the idea of relational justice never quite fits with the core premise of achieving one’s own “rational” self interests. One could argue, however, that this semiotic system has a minimal version of fiduciary justice—a relationship of trust vis-à-vis financial exchanges between two or more parties, whether individuals or entities. Cheating or lying would be a breach, requiring some form of repair. Fiduciary justice, though, is not relational justice, because of the absence of necessary recognition and treatment of Others as persons and a very limited understanding of the common good. The concern is not for persons, but rather for economic fairness with the aims of relatively balanced competition and a well-run market. For instance, in a neoliberal capitalistic system it is entirely fair to charge what the market will bear even if it results in people being homeless and lacking food in crises like Hurricane Katrina. A motel owner, for instance, has limited rooms and instead of charging $80 he charges $500, knowing that desperate people will pay the price (see Sandel 2009, pp. 3–6). Sandel (2012) provides numerous illustrations of fiduciary “fairness” that undermine relational justice. I would add that there is a corruption n of relational justice whenever laws are promulgated to benefit corporations at the expense of working class, poor, and other marginalized people (e.g., immigrants). This legalized (fictional) “fairness” actually contributes to social injustices, and examples of this are depressingly legion (e.g., minimum wage laws [not living wage], so-called right-to-work laws, immigration reform laws that feed into the prison industrial complex, etc.). Even fiduciary justice goes terribly awry in a neoliberal capitalistic system when banking and other corporate institutions can create a financial disaster and not be held accountable, but instead become even wealthier.17 Unlike Judeo-Christian semiotic systems that possess a notion of relational justice aimed at care and the common good, neoliberal capitalism’s semiotic system[s] transforms relational justice into a narrow fiduciary justice that limits justice to financial exchanges, [are] largely weighted toward corporations and the wealthy rather than the common good. 17 Chris Hedges, The greatest crimes against humanity are perpetrated by people just doing their jobs, In summary, neoliberal capitalism’s semiotic system has become a dominant way of organizing social and political realities. A central tenet of this symbol system is the idea that the collective pursuit of each individual’s rational self-interests leads to the “well-being” of citizens. This belief shapes perceptions and behaviors, resulting in I-It relations that undermine care, [and] reduce and corrupt the understanding and practice of freedom, distort the space of appearances, and crowd out the idea of relational justice. Conclusion All societies rely on complex semiotic symbols systems and their attending social practices in organizing society—public and political spaces and institutions. I first contended that JudeoChristian (and humanistic) symbol systems have three core features that order society and contribute to the well-being of its citizens, namely, care common good, and relational justice. Naturally, no religious or humanistic semiotic system leads to a utopia, but these core attributes often function to provide people hope that current social failings can be addressed and the common good achieved. Using this as an interpretive frame of reference, I examined the rise of neoliberal capitalism as a dominant semiotic system for organizing social relations, arguing that it undermines care, community, the common good, and relational justice. In so doing, I am not making the case for a return to a Christian theocracy or some kind of Christian social democracy. Rather, I wished to lay claim that the only viable semiotic systems are those that possess, at their core, beliefs about and practices of care, the common good, and relational justice.

#### Failing to address the structures that cause harms to occur allows for these structures to reify, and continue those harms. Only through resisting these neoliberal structures can any long-term solutions be maintained.

#### Neoliberal systems incentivize people to prey on the weak, which exacerbates any impact as La Mothe Continues that

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In a totalitarian society—classical or inverted—one can expect to see a distortion not only of care and the common good, but also of relational justice—wrong on the throne and right on the scaffold (Niebuhr 1941, p. 40). Neoliberal capitalism’s semiotic system does not and cannot possess a notion of relational justice unless it is grafted on, and in those instances the idea of relational justice never quite fits with the core premise of achieving one’s own “rational” self interests. One could argue, however, that this semiotic system has a minimal version of fiduciary justice—a relationship of trust vis-à-vis financial exchanges between two or more parties, whether individuals or entities. Cheating or lying would be a breach, requiring some form of repair. Fiduciary justice, though, is not relational justice, because of the absence of necessary recognition and treatment of Others as persons and a very limited understanding of the common good. The concern is not for persons, but rather for economic fairness with the aims of relatively balanced competition and a well-run market. For instance, in a neoliberal capitalistic system it is entirely fair to charge what the market will bear even if it results in people being homeless and lacking food in crises like Hurricane Katrina. A motel owner, for instance, has limited rooms and instead of charging $80 he[people can] charges $500, knowing that desperate people will pay the price (see Sandel 2009, pp. 3–6). Sandel (2012) provides numerous illustrations of fiduciary “fairness” that undermine relational justice. I would add that there is a corruption of relational justice whenever laws are promulgated to benefit corporations at the expense of working class, poor, and other marginalized people (e.g., immigrants). This legalized (fictional) “fairness” actually contributes to social injustices, and examples of this are depressingly legion (e.g., minimum wage laws [not living wage], so-called right-to-work laws, immigration reform laws that feed into the prison industrial complex, etc.). Even fiduciary justice goes terribly awry in a neoliberal capitalistic system when banking and other corporate institutions can create a financial disaster and not be held accountable, but instead become even wealthier.17 Unlike Judeo-Christian semiotic systems that possess a notion of relational justice aimed at care and the common good, neoliberal capitalism’s semiotic system transforms relational justice into a narrow fiduciary justice that limits justice to financial exchanges, largely weighted toward corporations and the wealthy rather than the common good. 17 Chris Hedges, The greatest crimes against humanity are perpetrated by people just doing their jobs, In summary, neoliberal capitalism’s semiotic system has become a dominant way of organizing social and political realities. A central tenet of this symbol system is the idea that the collective pursuit of each individual’s rational self-interests leads to the “well-being” of citizens. This belief shapes perceptions and behaviors, resulting in I-It relations that undermine care, reduce and corrupt the understanding and practice of freedom, distort the space of appearances, and crowd out the idea of relational justice. Conclusion All societies rely on complex semiotic symbols systems and their attending social practices in organizing society—public and political spaces and institutions. I first contended that JudeoChristian (and humanistic) symbol systems have three core features that order society and contribute to the well-being of its citizens, namely, care common good, and relational justice. Naturally, no religious or humanistic semiotic system leads to a utopia, but these core attributes often function to provide people hope that current social failings can be addressed and the common good achieved. Using this as an interpretive frame of reference, I examined the rise of neoliberal capitalism as a dominant semiotic system for organizing social relations, arguing that it undermines care, community, the common good, and relational justice. In so doing, I am not making the case for a return to a Christian theocracy or some kind of Christian social democracy. Rather, I wished to lay claim that the only viable semiotic systems are those that possess, at their core, beliefs about and practices of care, the common good, and relational justice.

#### 3- Education. Our reading of the AFF to challenge the uncontested modes that have occupied the debate space allows for a form of true education. Hill 10 notes

Impacts on Democracy and on Critical Thinking The neoconservative faces of education reform, indeed, of the wider marketization and commodification of humanity and society, come to play in the enforcement and policing of consent, the de-legitimizing of deep dissent, and the weakening of oppositional centers and practices and thought. In eras of declining capital accumulation, an ultimately inevitable process, capital—and the governments and parties and generals and CEOs who act at their behest—more and more nakedly ratchet up the ideological and repressive state apparatuses of control (see also Hill, 2001, 2003, 2004b, 2006b, and 2007). Thus, key working class organizations such as trade unions and democratically elected municipal governments are marginalized, and their organizations, and those of other radically oppositional organizations based on race, ethnicity, religion, are attacked through laws, rhetoric, and, ultimately, sometimes by incarceration. In education, the combined neoliberal-neoconservative educational reform has led to a radical change in what governments and most school and college managements/leaderships themselves see as their mission. In the 1960s and 1970s (and with long prior histories), liberal-humanist or social democratic or socialist ends of education were common through the advanced capitalist (and parts of the anticolonialist developing) worlds. This has changed dramatically within the lifetimes of those over thirty. Now the curriculum is conservative and it is controlled. Now the hidden curriculum of pedagogy is performative processing and “delivery” or pre-digested points. Now the overwhelming and nakedly overriding and exclusive focus is on the production of a differentially educated, tiered (raced and gendered) social class workforce and compliant citizenry. Differentially skilled and socially/politically/culturally neutered and compliant human capital is now the production focus of neoliberalized education systems and institutions, hand in glove with and enforced by a Neoconservative ideology and state. Resistance But there is resistance; there are spaces, disarticulations, and contradictions (see for example, Jones, Cunchillos, Hatcher and Hirtt, 2007; and Hill, 2009b). There are people who want to realize a different vision of education. There are people who want a more human and more equal society, a society where students and citizens and workers are not sacrificed on the altar of profit before all else. And there are always, sometimes minor, sometimes major, awakenings that the material conditions of existence, for teacher educators, teacher, students, and workers and families more widely, simply do not match or recognize the validity of neoliberal or neoconservative or other capitalist discourse and policy. Cultural Workers as Critical Egalitarian Transformative Intellectuals and the Politics of Cultural/Educational Transformation What influence can critical librarians, information workers, cultural workers, teachers, pedagogues have in working toward a democratic, egalitarian society/economy/polity? How much autonomy from state suppression and control do/can state apparatuses and their workers—such as librarians, teachers, lecturers, youth workers, have in capitalist states such as England and Wales, or the United States? Don’t [if] they get slapped down, brought into line, controlled, or sat upon when they start getting dangerous, when they start getting a constituency/having an impact? When their activities are deemed by the capitalist class and the client states and governments of/for capital to be injurious to the interests of (national or international) capital? The repressive cards within the ideological state apparatuses are stacked against the possibilities of transformative change through the state apparatuses and their agents. But historically and internationally, this often has been the case. Spaces do exist for counter-hegemonic struggle—sometimes (as in the 1980s and 1990s) narrower, sometimes (as in the 1960s and 1970s and currently) broader. By itself, divorced from other arenas of progressive struggle, its success, the success of radical librarians, cultural workers, media workers, education workers will be limited. This necessitates the development of proactive debate both by and within the Radical Left. But it necessitates more than that; it calls for direct engagement with liberal, social democratic, and Radical Right ideologies and programs, including New Labour’s, in all the areas of the state and of civil society, in and through all the ideological and repressive state apparatuses, and in and through organizations and movements seeking a democratic egalitarian economy, polity, and society. It takes courage, what Gramsci called “civic courage.” It is often difficult. Some of our colleagues/comrades/companeras/companeras/political and organizational coworkers ain’t exactly easy to get along with. Neither are most managements; especially those infected with the curse of “new public managerialism,” the authoritarian managerialist, brutalist style of management and (anti-) human relations, where “bosses know best” and “don’t you dare step outa line, buddy!” But I want here to modify the phrase “better to die on your feet than live on your knees.” It is of course better to live on your/our feet than live on your/our knees. And whether it is millions on the streets defending democratic and workers’ rights (such as over pensions, in Britain and elsewhere, or opposing state sell-offs of publicly owned services, in France and elsewhere, or laws attacking workers’ rights, in Italy and Australia and elsewhere)—all in the last two years— in defense of popular socialist policies in Venezuela, Bolivia, Honduras, Nepal, we are able, in solidarity, and with political aims and organization, not only to stand/live on our feet, but to march with them, to have not just an individual impact, but a mass/massive impact. We have a three-way choice—to explicitly support the neoliberalization and commodification and capitalization of society; to be complicit, through our silence and inaction, in its rapacious and antihuman/antisocial development, or to explicitly oppose it. To live on our feet and use them and our brains, words, and actions to work and move with others for a more human, egalitarian, socially just, economically just, democratic, socialist society: in that way we maintain our dignity and hope.

#### This is because bleaker 02 notes that

bleiker, 02 [Bleiker 2, professor of international relations at the University of Queensland, Politics After Seattle: Dilemmasof the Anti-Globalisation Movement, conflits.revues.org/1057]

But an adequate response will need to engage in one way or another with the search for political engagements beyond the territorial boundaries of the nation state.¶ 50 An extension of democratic principles into the more ambiguous international realm is as essential as it is difficult. It will need to be based on a commitment to democracy that goes beyond the establishment of legal and institutional procedures. William Connolly has pointed in the right direction when arguing for a democratic ethos. The key to such cultural democratisation, he believes, "is that it embodies a productive ambiguity at its very centre, always resisting attempts to allow one side or the other to achieve final victory."70 Such a model is, of course, the antithesis of prevailing realist wisdom, and perhaps of modern attitudes in general, which seek to achieve security and democracy through the establishment of order and the repression of all ambiguity.71¶ 51Rather than posing a threat to human security, the rhizomatic dimension of the international system may well be a crucial element in the attempt to establish a democratic ethos that can keep up with the pace of globalisation. Some aspects of democratic participation can never be institutionalised. Any political system, no matter how just and refined, rests on a structure of exclusion. It has to separate right from wrong, good from evil, moral from immoral. This separation is both inevitable and desirable. But to remain legitimate the respective political foundations need to be submitted to periodic scrutiny. They require constant readjustments in order to remain adequate and fair. It is in the struggle for fairness, in the attempt to question established norms and procedures, that global protest movements, problematic as they are at times, make an indispensable contribution to democratic politics.¶ 52 The political significance of protest movments is located precisely in the fact that they cannot be controlled by a central regulatory force or an institutional framework. They open up possibilities for social change that are absent within the context of the established legal and political system.72 The various movements themselves are, of course, far from unproblematic. The violent nature of recent actions against neo-liberal governance may well point towards the need for greater political awareness among activists. But such awareness can neither be imposed by legal norms or political procedures. It needs to emerge from the struggle over values that takes place in civil society. The fact that this struggle is ongoing does not detract from the positive potential that is hidden in the movement's rhizomatic nature. These elements embody the very ideal of productive ambiguity that may well be essential for the long-term survival of democracy.

## Our Sole Contention is A Broken System

[Now is the perfect time for complete reform bc movements]

#### The Current system is one of where companies are valued more than the individual, also known as Neoliberalism – the notion that the free market can solve all our issues. Waitzkin 16 notes that current health proposals

Howard Waitzkin, PNHP, xx-xx-xxxx ["Does the neoliberal label apply to our health care system?", https://pnhp.org/news/does-the-neoliberal-label-apply-to-our-health-care-system/, accessed 6-30-2020] A&M SS

Abundant data substantiate that the failure of Obamacare has become nearly inevitable. Even after the ACA is fully implemented, more than one-half of the previously uninsured population will remain uninsured — at least 27 million people, according to the non-partisan Congressional Budget Office — and at least twice that number will remain underinsured. Due to high deductibles (about $10,000 for a family bronze plan and $6,000 for silver) and co-payments, coverage under Obamacare has become unusable for many individuals and families, and employer-sponsored coverage is headed in the same direction. Private insurance generally produces administrative expenses about eight times higher than public administration; administrative waste has increased even more under Obamacare, and remains much higher than in other capitalist countries with national health programs. These administrative expenditures pay for activities like marketing, billing, denials of claims, processing copayments and deductibles, exorbitant salaries and deferred income for executives (sometimes more than $30 million per year), profits, and dividends for corporate shareholders. The overall costs of the health system under Obamacare are projected to rise from 17.4 percent of GDP in 2013 to 19.6 percent in 2022. The overall structure of Obamacare is not new. Similar “reforms” have appeared in other countries over the last two decades. Such proposals fostered neoliberalism. They promoted multiple competing, for-profit, private insurance corporations. Programs and institutions previously based in the public sector were cut back and, if possible, privatized. Overall government budgets for public-sector health care were reduced. Private corporations gained access to public trust funds. Public hospitals and clinics entered into competition with private institutions, their budgets were determined by demand rather than supply, and prior global budgets for safety net institutions were not guaranteed. Insurance executives made operational decisions about services, and their authority superseded that of physicians and other clinicians. **The Boilerplate Neoliberal Health Reform** Health reform proposals across different countries have resembled one another closely. The specific details of each plan appeared to conform to a word-processed, cookie-cutter template, in which only the names of national institutions and local actors have varied. Six broad features have characterized nearly all neoliberal health initiatives. 1. Organizations of providers. One element of neoliberal proposals involves large privately controlled organizations of health care providers.

### This causes exploitation in 2 ways and the first is through R&D.

#### Paleck finds that

Mike Palecek, Socialist Appeal, 9-19-209 ["Capitalism Versus Science", https://www.socialist.net/capitalism-versus-science.htm, accessed 6-27-2020] A&M SS

The pharmaceutical industry is well known for price gouging and refusing to distribute medicines to those who can’t afford it. The lack of drugs to combat the AIDS pandemic, particularly in Africa, is enough to prove capitalism’s inability to distribute medicine to those in need. But what role does the profit motive play in developing new drugs? The big pharmaceuticals have an equally damning record in the research and development side of their industry. AIDS patients can pay tens of thousands of dollars per year for the medication they need to keep them alive. In 2003, when a new drug called Fuzeon was introduced, there was an outcry over the cost, which would hit patients with a bill of over $20,000 per year. Roche's chairman and chief executive, Franz Humer tried to justify the price tag, “We need to make a decent rate of return on our innovations. This is a major breakthrough therapy… I can't imagine a society that doesn't want that innovation to continue.” But the innovation that Mr. Humer speaks of is only half-hearted. Drug companies are not motivated by compassion; they are motivated by cash. To a drug company, a person with AIDS is not a patient, but a customer. The pharmaceutical industry has a financial incentive to make sure that these people are repeat-customers, consequently there is very little research being done to find a cure. Most research done by the private sector is centered on finding new anti-retroviral drugs - drugs that patients will have to continue taking for a lifetime. There has been a push to fund research for an AIDS vaccine and, more recently, an effective microbicide. However, the vast majority of this funding comes from government and non-profit groups. The pharmaceutical industry simply isn’t funding the research to tackle this pandemic. And why would they? No company on earth would fund research that is specifically designed to put them out of business. Similar problems arise in other areas of medical research. In the cancer field an extremely promising drug was discovered in early 2007. Researchers at the University of Alberta discovered that a simple molecule DCA can reactivate mitochondria in cancer cells, allowing them to die like normal cells. DCA was found to be extremely effective against many forms of cancer in the laboratory and shows promise for being an actual cure for cancer. DCA has been used for decades to treat people with mitochondria disorders. Its effects on the human body are therefore well known, making the development process much simpler. But clinical trials of DCA have been slowed by funding issues. DCA is not patented or patentable. Drug companies will not have the ability to make massive profits off the production of this drug, so they are not interested. Researchers have been forced to raise money themselves to fund their important work. Initial trials, on a small scale, are now under way and the preliminary results are very encouraging. But it has been two years since this breakthrough was made and serious study is only just getting underway. The U of A’s faculty of medicine has been forced to beg for money from government and non-profit organizations. To date, they have not received a single cent from a for-profit medical organization.

#### This real innovation is necessary as Healthline notes that

Healthline, xx-xx-xxxx ["12 Leading Causes of Death in the United States", https://www.healthline.com/health/leading-causes-of-death, accessed 7-13-2020] A&M SS

For more than a decade, heart disease and cancer have claimed the first and second spots respectively as the leading causes of deaths in America. Together, the two causes are responsible for [46 percentTrusted Source](https://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm) of deaths in the United States. Combined with the third most common cause of death — chronic lower respiratory diseases — the three diseases account for [halfTrusted Source](https://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm) of all deaths in the United States. For more than 30 years, the Centers for Disease Control and Prevention (CDC) has been collecting and examining causes of death. This information helps researchers and doctors understand if they need to address growing epidemics in healthcare. The numbers also help them understand how preventive measures may help people live longer and healthier lives. The top 12 causes of death in the United States account for more than 75 percent of all deaths. Learn about each of the main causes and what can be done to prevent them. The following data is taken from the [CDC’s 2017 reportTrusted Source](https://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm).

### The Second is through access

#### [The Kaiser Family Foundation finds in 2019](https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/) that of those people

Jennifer Tolbert, Kendal Orgera, Natalie Singer, and Anthony Damico, 12-13-2019, "Key Facts about the Uninsured Population," KFF, <https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/>

Cost still poses a major barrier to coverage for the uninsured. In 2018, 45% of [the 28 million] uninsured adults said they were uninsured because the cost is too high, making it the most common reason cited for being uninsured (Figure 6). Access to health coverage changes as a person’s situation changes. In 2018, 21% of uninsured nonelderly adults said they were uninsured because the person who carried the health coverage in their family lost their job or changed employers (Figure 6). More than one in ten were uninsured because they lost Medicaid due to a new job/increase in income or the plan stopping after pregnancy (13%) and one in ten were uninsured because of a marital status change, the death of a spouse or parent, or loss of eligibility due to age or

#### [Cecere 09 of Harvard University](https://news.harvard.edu/gazette/story/2009/09/new-study-finds-45000-deaths-annually-linked-to-lack-of-health-coverage/#:~:text=Nearly%2045%2C000%20annual%20deaths%20are,American%20Journal%20of%20Public%20Health.&text=It%20estimated%20that%20lack%20of,put%20that%20figure%20near%2018%2C000.) finds that

David Cecere, 09-17-2009, "New study finds 45,000 deaths annually linked to lack of health coverage," Harvard Gazette, <https://news.harvard.edu/gazette/story/2009/09/new-study-finds-45000-deaths-annually-linked-to-lack-of-health-coverage/>

The study, which analyzed data from national surveys carried out by the Centers for Disease Control and Prevention (CDC), assessed death rates after taking into account education, income, and many other factors, including smoking, drinking, and obesity. It estimated that lack of health insurance causes 44,789 excess deaths annually. Previous estimates from the IOM and others had put that figure near 18,000. The methods used in the current study were similar to those employed by the IOM in 2002, which in turn were based on a pioneering 1993 study of health insurance and mortality. Federal insurance has helped many, but system’s holes limit gains, Harvard analysts say Deaths associated with lack of health insurance now exceed those caused by many common killers such as kidney disease. An increase in the number of uninsured and an eroding medical safety net for the disadvantaged likely explain the substantial increase in the number of deaths, as the uninsured are more likely to go without needed care. Another factor contributing to the widening gap in the risk of death between those who have insurance and those who do not is the improved quality of care for those who can get it. The researchers analyzed U.S. adults under age 65 who participated in the annual National Health and Nutrition Examination Surveys (NHANES) between 1986 and 1994. Respondents first answered detailed questions about their socioeconomic status and health and were then examined by physicians. The CDC tracked study participants to see who died by 2000. The study found a [furthering that there is a] 40 percent increased risk of death among the uninsured. As expected, death rates were also higher for males (37 percent increase), current or former smokers (102 percent and 42 percent increases), people who said that their health was fair or poor (126 percent increase), and those who examining physicians said were in fair or poor health (222 percent increase).

#### We resist the system in 2 ways

### The First is by changing healthcare from a commodity to a right.

#### Companies sell people’s health like it’s a common toy, and this often causes harms. Waitzkin 16 notes a this is a key part of

Howard Waitzkin, PNHP, xx-xx-xxxx ["Does the neoliberal label apply to our health care system?", https://pnhp.org/news/does-the-neoliberal-label-apply-to-our-health-care-system/, accessed 6-30-2020] A&M SS

multi-payer and multi-payment financing . Financial flows under neoliberal health policies are very complex. The costs of administering these flows and other components of neoliberal policies also are quite high (about 25 to 28 percent of total health care expenditures) and keep increasing. Under Obamacare, administrative overhead — also referred to administrative “waste,” since the costs do not contribute to direct patient services — grew 10.6 percent in 2014, faster than any other component of health care except medications. 6. Changes in tax code. Partly because they increase administrative costs and profits, neoliberal reforms usually lead to higher taxes. Many countries have rejected the neoliberal model, and have instead constructed health systems based on the goal of “health care for all” (HCA). Such countries strive to provide universal access to care without tiers of differing benefit packages for rich and poor. For instance, Canada prohibits private insurance coverage for services provided by its national health program. Because Canada’s wealthy must participate in the publicly financed system, the presence of the entire population in a unitary system [and thus] assures a high-quality national program. In Latin America, countries trying to advance the HCA model include Bolivia, Brazil, Cuba, Ecuador, Uruguay, and Venezuela. The inevitable failure of Obamacare may open a space, finally, for even the United States to pursue a national health program that does not follow the neoliberal model. **The Single-Payer Proposal** The following features of a [under a] single-payer option come from the proposals of Physicians for a National Health Program (PNHP), a group of more than 20,000 medical professionals, spanning all specialties, states, age groups, and practice settings. According to the PNHP proposals, coverage would be universal for all needed services, including medications and long-term care. There would be no out-of-pocket premiums, copayments, or deductibles. Costs would be controlled by “monopsony” financing from a single, public source. The NHP would not permit competing private insurance and would eliminate multiple tiers of care for different income groups. Practitioners and clinics would be paid predetermined fees for services, without any need for costly billing procedures. Hospitals would negotiate an annual global budget for all operating costs. For-profit, investor-owned facilities would be prohibited from participation. Most non-profit hospitals would remain privately owned. To reduce overlapping and redundant facilities, capital purchases and expansion would be budgeted separately, based on regional health planning goals. Funding sources would include current federal spending for Medicare and Medicaid, a payroll tax on private businesses less than what businesses currently pay for coverage, and an income tax on households, with a surtax on high incomes and capital gains. A small tax on stock transactions would be implemented, while state and local taxes for health care would be eliminated. Under this financing plan, 95 percent of families would pay less for health care than they previously paid in insurance premiums, deductibles, copayments, other out-of-pocket spending, and reduced wages.

#### Arno 20 notes

Peter S Arno., Health Affairs, 3-25-2020 ["Medicare For All: The Social Transformation Of US Health Care", https://www.healthaffairs.org/do/10.1377/hblog20200319.920962/full/, accessed 7-13-2020] A&M SS

There is a large elephant in the room in the national discussion of Medicare for All: the transformation of the US health care system’s core mission from the prevention, diagnosis, and treatment of illness—and the promotion of healing—to an approach dominated by large, publicly traded corporate entities dedicated to growing profitability and share price, that is, the [business](https://www.nejm.org/doi/full/10.1056/NEJM198010233031703) of medicine. The problem is not that these corporate entities are doing something they shouldn’t. They are simply doing too much of what they were created to do—generate wealth for their owners. And, unlike any other wealthy country, we let them do it. The dilemma of the US health care system is due not to a failure of capitalism or corporatism per se, but a failure to implement a public policy that constrains their [business] excesses. Since the late 1970s, US public policy regarding health care has trended toward an increasing dependence on for-profit corporations and their accompanying reliance on the tools of the marketplace—such as competition, consolidation, marketing, and consumer choice—to expand access and assure quality in the provision of medical care. This commercialized, commodified, and corporatized model is driving the US public’s demand for fundamental reform and has elevated the issue of health care to the top of the political agenda in the current presidential election campaign. Costs have risen relentlessly, and the quality of and access to care for many Americans has deteriorated. The cultural changes accompanying these trends have affected every segment of the US health care system, including those that remain nominally not-for-profit. Excessive focus on health care as a business has had a destructive effect on both patients and caregivers, leading to increasing difficulties for many patients in accessing care and to anger, frustration, and burnout for many caregivers, especially those attempting to provide critical primary care. As a result, the ranks of primary care providers have eroded, and that erosion continues. One of the major reasons for [burnout in this group](http://bit.ly/2H4svIE) is the clash between its members’ professional ethics (put the patient first and “first do no harm”) and the profit-oriented demands of their corporate employers. Applying Band-Aids can’t cure the underlying causes of disease in medicine or public policy. Ignoring the underlying pathology in public policy, as in clinical medicine, is destined to fail. Many of the symptoms of our dysfunctional health care system are not in dispute: We pay more than [twice as much per person on total health care spending](https://data.oecd.org/healthres/health-spending.htm#indicator-chart) and on [prescription drugs](https://data.oecd.org/healthres/pharmaceutical-spending.htm#indicator-chart) in comparison to other developed countries. This spending totals nearly 18 percent of our economy. Between 2008 and 2018, [premiums for employer-sponsored insurance plans increased 55 percent](https://www.kff.org/health-costs/report/2018-employer-health-benefits-survey/), twice as fast as workers’ earnings (26 percent). Over the same time period, the average health insurance deductible for covered workers increased by 212 percent. An average employer-sponsored family health insurance policy now exceeds [$28,000 per year](http://assets.milliman.com/ektron/2019-milliman-medical-index.pdf), with employers paying about $16,000 and employees paying about $12,000. [Almost half (45 percent) of US adults ages 19 to 64, or more than 88 million people, were inadequately insured over the past year](https://www.commonwealthfund.org/sites/default/files/2019-02/EMBARGOED_Collins_hlt_ins_coverage_8_years_after_ACA_2018_biennial_survey_sb_v4.pdf) (either they were uninsured, had a gap in coverage, or were underinsured; that is, they had insurance all year but their out-of-pocket costs were so high that they frequently did not receive the care they needed). Compared to other developed countries, the US ranks near the bottom on a variety of health indicators including [infant mortality, life expectancy, and preventable mortality](https://interactives.commonwealthfund.org/2017/july/mirror-mirror/assets/EMBARGOED_Schneider_mirror_mirror_2017_EMBARGOED.pdf). We must therefore ask: How is it that we spend more on health care than any other nation, yet have arrived at such a sorry state of affairs? The answer is that only in the United States has corporatism engulfed so much of medical care and come so close to dominating the doctor-patient relationship. Publicly traded, profit-driven entities—under constant pressure from Wall Street—control the financing and delivery of medical care in the US to an extent seen nowhere else in the world. For instance, [seven investor-owned publicly traded health insurers now control almost a trillion dollars ($913 billion) of total national health care spending](https://www.modernhealthcare.com/finance/publicly-traded-health-insurers-revenue-nears-1-trillion-mark) and covers half the US population. In 2019, their revenue increased by 31 percent, while their profits grew by 66 percent. The corporatization of medical care may be the single most distinguishing characteristic of the modern US health care system and the one that has had the most profound impact on it since the early 1980s. The theology of the market and the strongly held—but mistaken—belief that the problems of US health care can be solved if only the market could be perfected have effectively obstructed the development of a[n] rational, efficient, and humane national health care policy. There are three main reasons to pursue a public policy that embraces genuine health care reform: Saving lives: To simplify our complex and confusing health care system while providing universal affordable health care coverage; Affordability: To rein in the relentless rise in health care costs that are cannibalizing private and public budgets; and Improving quality: To eliminate profitability and share price as the dominant and all-consuming mission of the entities that provide health care services and products when that mission influences clinical decision making. Profitability should be the servant of any health care system’s mission, not its master as seems to be increasingly the case in the US. What Is The Best Approach To Reform? It is not an exaggeration to say that no reforms except publicly financed, single-payer universal health care will solve the problems of our health care system. This is true whether we are talking about a public option, a Medicare option, Medicare buy-in, Medicare extra, or any other half-measure. The main reason is because of the savings that are inherent only in a truly universal single-payer plan. Specifically, the [administrative](https://jamanetwork.com/journals/jama/article-abstract/2752664) and [bureaucratic savings](https://annals.org/aim/article-abstract/2758511/health-care-administrative-costs-united-states-canada-2017) gained by eliminating private insurers are the largest potential source of savings in a universal single-payer framework, yet all the “option” reforms listed above leave largely intact the tangle of wasteful, inefficient, and costly private commercial health insurers. The second largest source of savings comes through reducing the cost of prescription drugs by using the negotiating leverage of the federal government to bring down prices, as is done in most other developed countries. The ability, will, and policy tools (such as global budgeting) to restrain these and other costs in a single-payer framework are the key to reining in the relentless rise in health care expenditures and providing universal coverage. The various “option” reform proposals will not simplify our confusing health care system nor will they lead to universal coverage. None have adequate means to restrain health care costs. So why go down this road? Is it too difficult for the US to guarantee everyone access to affordable care when every other developed country in the world has done so? The stated reason put forth in favor of these mixed option approaches is that Americans want “choice.” But choice of what? We know with certainty from former insurance company executives such as [Wendell Potter that the false “choice” meme polls well with the US public](https://www.nytimes.com/2020/01/14/opinion/healthcare-choice-democratic-debate.html) and was used to undermine the Clinton reform efforts more than 25 years ago. It is being widely used today to manipulate public opinion. But choice in our current system is largely an illusion. In 2019, [67.8 million workers across the country separated from their job at some point during the year](https://www.bls.gov/news.release/jolts.nr0.htm)—either through layoffs, terminations, or switching jobs. This labor turnover data leaves little doubt that people with employer-sponsored insurance are losing their insurance constantly, as are their spouses and children. And even for those who stay at the same job, insurance coverage often changes. In 2019, [more than half of all firms offering health benefits reported shopping for a new health plan](http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2019) and, among those, nearly 20 percent actually changed insurance carriers. Trading off choice of doctors or hospitals for choice of insurance companies is a bad bargain. The other major objection to a universal single-payer program is cost. Yet, public financing for health care is not a matter of raising new money for health care but of reducing total health care outlays and distributing payments more equitably and efficiently. Nearly every credible study concludes that a single-payer universal framework, with all its increased benefits, would be [less](https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1003013) [costly](https://www.sciencedirect.com/science/article/pii/S0140673619330193) [than the status quo](https://www.peri.umass.edu/publication/item/1127-economic-analysis-of-medicare-for-all), more effective in restraining future cost increases, and more popular with the public—as 50 years of experience with Medicare has demonstrated. The status quo generates hundreds of billions of dollars in surplus and profits to private stakeholders, who need only spend a small portion (millions of dollars) to [influence legislators, manipulate public opinion, distort the facts](https://www.opensecrets.org/federal-lobbying/industries/summary?cycle=2018&id=H4300), and obfuscate the issues with multiple competing reform efforts. Conclusion The real struggle for a universal single-payer system in the US is not technical or economic but almost entirely political. Retaining the status quo (for example, the Affordable Care Act) is the least disruptive course for the existing medical-industrial complex, and therefore the politically easiest route. Unfortunately, the status quo is disruptive to the lives of most Americans and the least effective route in attacking the underlying pathology of the US health care system—corporatism run amok. Following that route will do little more than kick the can down the road, which will require repeatedly revisiting the deficiencies in our health care system outlined above until we get it right. The US public and increasingly the business community are becoming acutely aware of the rising costs and inadequacies of our current system. It is the growing social movement, which rejects the false and misleading narratives, that will lead us to a universal single-payer system—truly the most effective way to [and] reform our health care system for the benefit of the US people.

#### Schuleman 11 notes that any

Additionally, there is no evidence suggesting that the insurance industry has made a greater effort to rely upon the evidence-basis in pain medicine for which Giordano and colleagues [129] called. The authors offered, “Although the various stakeholders in chronic pain care have a history of inchoate group dynamics, it is not unreasonable to believe that a common ground can be reached through a process of education, exchange, and compromise” (p. E270). Apparently, such an ambitious effort is unreasonable as long as cost-containment and profitability remain the aims of health insurers. Thus, until the United States moves to the type of single-payer, not-for-profit health care system enjoyed by the vast majority of the industrialized world (i.e., an ethical system), the insurance industry’s motivations will ensure that chronic pain patients continue to needlessly suffer.

[spillover]

### The Second is by spearheading grassroots movements

#### M4A builds up resistance against the Neoliberal State as Day and Brown 17 explain

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In Bernie Sanders’s wake, the socialist left has experienced a historic resurgence. The Democratic Socialists of America (DSA), which now counts over 25,000 members, is the largest socialist group in the United States since Students for a Democratic Society in the late 1960s. The challenge now is to hone its political vision and build a durable and democratic organizations that can affect real change. A focus on winning single-payer health care can help us do that. The growing demand for single payer rankles establishment Democrats, who insist that the Affordable Care Act — with its labyrinthine subsidies program meant to provide coverage without undermining the private insurance industry — is the best deal on offer, and to demand anything more is pie-in-the-sky and politically counterproductive. But with Obamacare given reprieve for the moment (albeit unsafe from future attacks), and our still-broken health care system on everyone’s mind, socialists have an opportunity to organize ordinary people toward a better common goal: genuine universal coverage, managed and dispersed by democratic, transparent, and efficient institutions that are accountable to us, not corporate shareholders. California has the unique potential to become the first state to pass single payer. A grassroots movement for the cause, spearheaded by the California Nurses Association, goes back decades. This movement twice passed single-payer bills through both houses of the state legislature in the 2000s, but both were vetoed by then-Governor Arnold Schwarzenegger. Out of this legacy of popular action, 70 percent of California voters now support single payer in polls. To appeal to that active grassroots and public support, California Democrats have made single payer an official plank of their party platform. Democrats hold the Governor’s seat and an exact two-thirds supermajority in both houses of the legislature, so the time has come to deliver on promises. We are two organizers with the East Bay chapter of DSA, which has made a strategic decision to focus on a single campaign: organizing around single-payer health care legislation, SB562, in California. The lessons from our campaign aren’t universal (no one’s are), but in explaining the strategic thinking behind our mass canvassing program and sharing the lessons we’ve learned from implementing it, we want to show how a focus on Medicare for All can increase socialist organizations’ [by increasing] organizing capacity and build working-class power for long-term struggle. Zeroing in on Single Payer In recent months, socialists — many of them newcomers to the movement — have flocked to DSA, seeking opportunities to continue pushing for left political-economic reforms after the Sanders campaign. Both the national DSA organization and local chapters have begun a program of political education to introduce these members to socialist history, theory, and strategy — some for the first time in their lives. The East Bay chapter has been no exception: over five hundred people joined after Trump’s election. At East Bay DSA’s chapter elections in January — our first following the membership explosion — many candidates running for a leadership role pledged to focus our organizing on the California single-payer effort. The members who won election were nearly unanimous in their interest in pursuing this campaign. Based on that mandate, the leadership voted to officially join the campaign for Healthy California in February and started canvassing almost immediately. Two generations of our elected leadership have now committed to single payer as the core focus for our organizing work. Importantly, this hasn’t prevented ongoing chapter actions on other issues: our direct action committee helped blockade an ICE office and held the line to protect an elderly renter from eviction; we were at the airport protests, the Women’s Strike, and May Day; we have a housing caucus, a prison abolition caucus, and a socialist feminist caucus. But we’ve found that focusing the bulk of our organizing effort on single payer comes with major benefits: we concentrate and replicate our capacity for training members, we stress-test our organizing against the clear benchmarks of a single campaign, and we build internal unity and transparency by working together on a common cause. The singular focus helps convey to our coalition partners and members alike that we’re in this for the long haul, and we’re in it to win. As a result of our recent growth in both size and legitimacy, coalition partners have asked to table with us at events for increased visibility, and local candidates have sought our endorsement. East Bay DSA’s commitment to campaigning for SB562 is a tactic in service of a larger strategy to build good internal structures in our burgeoning group and effective organizing skills among a new generation of grassroots leftist activists. We also seek to strengthen ties between socialists and the labor movement — in this case the women-led and substantially non-white nurses’ union — and win reforms that will strengthen the power of the working class. The Ground Game Our focus on winning single payer has driven the evolution of our organizing process. Our canvassing strategy began with a focus on large canvasses that gathered members from across our entire chapter as well as non-members interested in joining in. Before these canvasses, a select team of canvass captains received training from the union and community organizers in the chapter. On the day of the large canvasses, these captains trained and facilitated practice sessions for teams of about a dozen people each. To date, five hundred people have received training from team captains, then pounded the pavement together to knock on doors. In a frightening national political moment, door-to-door organizing has been heartening for many members, showing us we’re not as alone as we think. One of our members, who originally described herself as shy, remarked that her canvassing experiences with our chapter had convinced her there are only two kinds of people in the Bay Area: socialists, and people who aren’t home. Across all of our canvassing, we’ve focused on empowering neighbors to see their experiences with medical fees and debt in terms of class conflict, explained the mechanics and upsides of single payer, and gathered thousands of pledges to support DSA and our coalition partners in the fight for public universal coverage. In the process, our organizers have also developed as leaders. In a testament to the skill- and commitment-building potential of this tactic, about half of the chapter’s newly elected Local Council started out as single-payer canvassers. The large, chapter-wide canvasses provided a good way to kick start training across our membership but weren’t well suited to build steady teams of organizers consistently working the same neighborhoods. To address this issue, our organizing tactic has shifted since May to focus on district canvasses, where our members develop dedicated teams for their own neighborhoods. The point is for socialist organizers to talk to their own neighbors and build lasting political relationships. We live in an atomized, alienating society where most of us don’t know our neighbors’ names, and don’t see any reason to learn them. These district canvasses break our own members out of their isolation, while simultaneously building stronger community ties between our organization and existing neighborhood networks. In early July, one of our canvassers, after a particularly successful round of door-knocking, was invited to speak at a block party. The person then found themselves literally organizing their neighborhood. Another district canvasser was invited to give a talk for a second block party just last week. A third stage in the evolution of our organizing is just beginning. Our canvassing program has done well at training our members for the initial conversations with neighbors, but we’ve found we need more structure and shared skills for follow-up to keep our neighbors consistently involved. As our chapter grows, the most involved members have largely had their workload expand just as fast; this has made it clear that helping members develop into leaders needs to become a central part of our organizing system. To clarify who should take on our member development efforts, we passed new bylaws in April which created distinct positions (both elected and appointed) for internal organizers and external organizers. The internal organizers, who were elected in June, are now focused on developing a member steward system based on the model used in many unions and the New York City and Philadelphia DSA chapters. This will build a trained network of stewards among our membership, with each responsible for supporting and catalyzing a set of less-active members and interested neighbors to become regular participants. Strong local relationships like these are invaluable to socialist organizers and can be tapped in future campaigns for fights around housing justice or workers’ rights. Democratic elites have all but abandoned field organizing, especially in down-ballot races, in favor of exorbitant, consultant-led media strategies. In many places, by training even a few dozen regular canvassers through the single-payer cause, socialists can quickly develop one of the strongest ground games in town. By building ongoing relationships with our neighbors, this emphasis on field organizing will put us in a position to be helpful, in-demand allies for local unions and other Left campaigns, and lay the foundation for real impacts on electoral politics. And while we should only organize for what we are committed to winning, we should also organize so that, whether we win or lose one round in a fight, we are building the skills and relationships for power in the long term. The focused campaign gives us an opportunity to troubleshoot our organizational structure and its challenges, which makes our chapter increasingly resilient, responsive, and effective, and will serve us well beyond the fight for single payer. Already, our work has rippled outward; we’ve shared our training guides, canvassing scripts, and leave-behind literature to be put to use in chapters across California and as far afield as Ohio. Advancing the Program The advantages for our organization are only part of the equation. Any unifying campaign will be beneficial to an organization finding its footing, but single payer is a strategic central focus. In fighting for it, we can build solidarity across lines of difference and continue to build power for the working class. Everybody needs health care. Nearly everybody in the working class has been hurt by private insurance greed, or has seen a friend or family member denied care so that a rich few can profit. When we organize in the East Bay, we share our own personal stories and ask our neighbors about what they could personally gain from single payer. We work to show how our direct self-interest intersects with that of all working people: we can only win single payer for ourselves if we win it for each other. Political education that fosters this sense of shared self-interest — rather than charity for a distant other — is the foundation of a sense of solidarity built to last. The fight for single payer is an urgent anti-racist struggle. Currently in the United States, the uninsured rate is 60 percent higher for black people than for white people. The Movement for Black Lives platform demands a universal, guaranteed health care system, with particular focus on equitable access for currently excluded communities of color. In committing to the fight for single payer, socialists can take up that call to action. Meanwhile, across the US, Latinos have an uninsured rate 300 percent higher than white people. Undocumented immigrants — and many documented ones — are not covered by Medicare, nearly all Medicaid programs, and many subsidized private plans. This cruel exclusion is despite the fact that immigrants pay into the public system through taxes, and worse, is in spite of the fact that they are members of our communities who need care like everybody else. By providing coverage to all state residents regardless of documentation status, California and New York’s single-payer bills not only directly help millions, but could point a socialist path out of the current dead end around immigration politics in the US and Europe. Over the past decade, most parties of the center and many on the left have shifted towards far-right positions on refugees and migrants as a supposedly necessary concession to white-working-class xenophobia. This is morally and strategically wrong. When socialists win truly universal social programs that cover migrants, we can demonstrate that social care is not a zero-sum game. Instead, building social systems for everyone who lives here makes for stronger public institutions and a healthier society for all. If we are to push further towards building a powerful multiracial working-class movement, then a proud politics of inclusion for immigrants is not only right — it’s essential. Single payer is also a critical feminist fight. Public health coverage for all would be transformational to a society in which most unpaid and underpaid care work falls to women. When people can’t get the care they need, someone is usually compelled to pick up the slack — and, especially in the realm of home care for family members, those people are disproportionately women. (“The best long-term care insurance in our country,” concluded a recent study about home care for older adults, “is a conscientious daughter.”) Women are more likely to receive health insurance as dependents, which means that losing a spouse through death or divorce puts them at greater risk for being uninsured. Single mothers are nearly twice as likely to be uninsured as mothers in two-parent households. Meanwhile, women who are insured also suffer disproportionately from confusing and predatory private insurance industry practices. Care costs more for women, is harder to obtain, and employers can refuse to cover contraception on religious grounds, meaning a woman’s reproductive health is in many cases dependent on the conditions of her employment. California’s Medicaid program covers abortion, contraception, and prenatal care. To universalize that comprehensive and inclusive care is an urgent and crucial feminist reform. The California Nurses Association, which is leading the charge on the state single-payer effort, has eighty thousand members across both unionized and non-unionized workplaces in the state. These workers are overwhelmingly women, and about half are people of color. Women fill nearly all of the top leadership roles at CNA. Who better to lead the fight to bring care into the public sphere than women care workers, who disproportionately shoulder the burden of undervalued care? Organizing in close alliance with care workers is an essential way we can put our principles into practice and expand socialist-feminist understanding within our ranks. Working with organized nurses is also strategic for building solidarity between socialists, the labor movement, and the broad working class. CNA has led the drafting of legislation and steered the inside game while coordinating and supporting grassroots allies across the state. Nurses at the helm makes this not just a “consumer movement,” made up of health-care users, but a workers’ movement. The nurse-led campaign sets up a clear dynamic of workers, both inside and outside the industry, against our common adversaries at the very top: health insurance executives, shareholders, and the 1 percent. Over the last half-century, the relationship between socialists and the labor movement has grown tenuous, as both groups have been diminished and devitalized by state repression and capitalist advancement. As socialists, we know that acting in concert with organized labor is fundamental, and that it’s necessary to rebuild our role, both as socialist organizers and workers ourselves, in the labor movement. By uniting with nurses against CEOs, we’re committing to working-class solidarity in practice, not just in theory. Socialists must continue to build our own independent organizations steered by the democratic power of our members, but the nurses are a strategic ally to learn from and fight alongside in this moment. Finally, single payer would win power for the working class like no other reform popularly on the table in the US today. When socialists consider fighting for a reform, we should ask if it builds working-class power towards future struggles. Some left organizers and scholars call this “building the crisis”: by winning reforms that strengthen the material conditions and class consciousness of working people, we advance the fight for more radical victories. Many union workers, who have seen spiraling private health insurance costs undermine their position for wage and benefit increases, have rallied behind single payer as a bulwark for future battles with management. For non-union workers, too, single payer would strengthen both their actual health and their bargaining position for raises and other benefits. A push for single payer, in this political moment, is uniquely able to draw clear lines of class conflict: it’s capitalists versus all of us who work. Single payer is already a concession on the part of socialists. We want fully socialized medicine, which would function on the same principles but extend to hospitals and doctors themselves, and which already exists in many nations. We envision single payer as a first step in a long struggle to implement full universal social programs. We see it as a non-reformist reform: that is, a structural modification of power relations that elevates the ability of working-class people to fight against capital while radically shifting the window of political possibility. We’re interested in using SB562 as a political education opportunity for our membership and neighbors, and publicly advancing the idea that universal social programs are better than means-tested ones. According to the neoliberal logic of means-testing, some people need public assistance to attain things like health insurance, but only those in the direst of straits. Socialists, on the other hand, believe in the decommodification of essential goods and services for all, for both moral and politically strategic reasons. Universal programs are essential to eliminating wealth inequality. They decrease disparities in the here and now, creating a stronger working class that is less fearful and insecure, and therefore less easily exploited by capital. They also build powerful new constituencies dedicated to defending public goods against privatization. In this way, universal programs can function as “engines of solidarity.” To make health insurance universally guaranteed and public is to both assert that coverage is a right, and to build a stronger body politic that can mobilize to protect that right. In our discussions at peoples’ doors, we hear our neighbors’ indignation that the wealthy are able to receive medical care when necessary without fear of ruinous financial consequences, while everybody else is faced with hard choices about whether to go into massive amounts of debt to seek necessary treatment. In those conversations, we hear the raw material for a mass oppositional class politics. That’s why we ask for commitments from those people to join the campaign, instead of just signing a petition or donating once. For example, behind one door was a twenty-six year old with a bandage wrapped around his hand. He had just lost his job, where he was paid poorly to work with dogs, one of which had bitten him badly. He was a few months too old to be listed as a dependent, and suddenly found himself uninsured. He talked to our neighborhood canvassers for twenty minutes. At the next neighborhood canvass there he was, DSA clipboard in his healing hand, knocking on doors with the rest of us. California’s Single-Payer Melee Pressured by a growing movement and a single-payer bill that has passed the State Senate, elite Democrats have been forced to show their true loyalties. In late June, Assembly Speaker Anthony Rendon froze the bill in committee, halting any formal legislative progress in his chamber until next year. We knew this opposition was coming. Contrary to recent allegations of unpreparedness and deception, from the start of the campaign, CNA leaders have been clear on statewide conference calls with coalition activists that we are building strength for a multiple-year effort — which could require a ballot campaign as a costly last resort. That’s only necessary if the legislature can’t be pushed to deliver single payer past the state’s tax and spending constraints. The coalition’s current effort to turn up pressure on Rendon and other resistant Democrats is essential to build that necessary legislative will. At doorsteps, DSA organizers have been talking with our neighbors about what it will take to win this protracted and difficult fight. After fifty years of conservatives and centrists passing severe restrictions on taxes and spending, California’s political playing field is badly rigged. That’s why our victory requires building a powerful movement off that field. Democratic elites — steered by donors from real estate, insurance, dirty energy, and tech, and backed up by the management of huge non-profits and major unions — treat the handcuffs on state power as “sacred doctrine that should never be questioned.” Even if they wanted to overturn suffocating restrictions on the state, Democratic leaders can’t imagine building the popular power needed to do it. If Democrats bury the legislation now, they will be opposing the idea that politics ought to involve imagination, mass effort, and the will to fight uphill battles so that people’s lives might be freer and better. In this context, socialists have a critical role to play in the movement for single payer: unlike the Democrats, we can build broad working-class power while expanding the public imagination of what politics could be. East Bay DSA regards SB562 as an opportunity to build, mobilize, and grow our organizations and movement. While the bill is frozen in committee, we’re going to continue educating, coordinating, and taking full advantage of the swelling interest in both single payer and socialism. In those respects we’re already winning, and no legislative defeat can undo our victories. But this isn’t a trap, or a trick question meant to expose neoliberal hypocrisy. Single payer is a real policy demand, and we want it to pass. If it does, there will be several subsequent obstacles to actually implementing a functional single-payer health care system in our state. If we proceed to a ballot measure, the health insurance lobby will wage a media war to scare Californians out of it. (Of course, the best way to combat a propaganda campaign that well-funded is to organize and educate people on the ground, grassroots-style — which we’re currently doing.) In the meantime, socialists around the country must start thinking critically about building and wielding organizational power. Not every socialist group has the opportunity to rally behind state single-payer legislation like we have. But given our national moment of historic upheaval for health care and the broadening popularity of Medicare for All, we think socialists throughout the nation can build alliances and open political imagination by being a loud voice — and given the refusal of the Democratic Party to champion it, perhaps the loudest voice — for single payer in their specific political climate. A nationwide single-payer campaign that embraces a diversity of location-specific tactics can help socialists replicate a skill-building, infrastructure-honing strategy across cities and states. This shouldn’t preclude simultaneous local and regional campaigns on other issues, but we believe a primary nationwide focus on single payer, more than any other issue, will build power for socialists and the working class. East Bay DSA’s campaign for single-payer legislation shows how we can get started.

## Extensions

### Hill 10

Neoliberal thought has crowed our education system and m

### Root Cause – Econ Decline

#### neoliberalism is unsustainable - unfettered free markets will cause extinction unless mass movements can force change in global structures

**Makwana 13 -** executive director of Share The World's Resources, a London-based civil society organisation campaigning for a fairer sharing of wealth, power and resources within and between nations (Rajesh, Neoliberalism Can’t Die Soon Enough, JANUARY 23, 2013, http://www.counterpunch.org/2013/01/23/extreme-wealth-v-global-sharing/)

According to the briefing, the incomes of the top 1% of the world’s population have increased 60% in the past twenty years. While joblessness rocketed across the US and Europe after the financial crisis of 2008, the income of this elite group of multimillionaires continued to expand. And the growth in income for the top 0.01% has been even greater – there are now around 1200 billionaires in the world. Unsurprisingly, the market for luxury goods has ‘registered double-digit growth every year since the [financial] crisis hit’. Despite notable reductions in the number of people living in extreme poverty, the paper also highlights the rapid escalation of inequality in developing countries. For example, in China the top 10% of the population now earn nearly 60% of the country’s income, which places it almost on par with South Africa as one of the most unequal countries on earth. This trend has been just as pronounced in rich countries such as the UK, where inequality levels are fast reaching Dickensian proportions. Similarly, in the US the share of national income since 1980 has doubled for the top 1% and quadrupled for the top 0.01%. The slow death of neoliberalism It is important to understand the root cause of this all-pervasive growth in inequality and determine whether it constitutes a serious problem for society. As George Monbiot reminded us in a recent article, for many decades policymakers have regarded inequality as a necessary by-product of the neoliberal ideology to which they subscribe. For adherents of this extreme pro-market belief system, any attempts to enact policies to reduce inequality interfere with the efficiency of the free market and should be avoided at all costs. Instead more should be done to further deregulate economies, privatise resources, services and industry, downsize the public sector and open up markets to even more competition both within and between nations. As a theory based on the principles of individualism and self-interest, neoliberalism seeks to remove collective public oversight from economic activity, even when this could have dire implications for society and the environment. But the neoliberal experiment, which was most vociferously pursued by Thatcher, Regan, Kohl and others from the 1980s onwards, is now widely regarded as having been an utter failure – most notably in the aftermath of the 2008 financial crisis. As Monbiot explains, the growth in rich nations that occurred prior to the 1980s “was made possible by the destruction of the wealth and power of the elite, as a result of the Depression and the second world war.” The neoliberal experiment reversed these trends and, despite the weight of evidence against these policies, five years after the financial crisis the thrust of economic policy remains almost wholly neoliberal in nature. There is of course the age-old moral argument against allowing excessive levels of wealth and riches to exist alongside extreme poverty and deprivation. This is a basic ethical notion that rings true to the majority of people in rich and poor countries alike, and it has been a cornerstone of spiritual and religious philosophy for millennia. But even within the sadly amoral framework of economic decision-making today, it is widely accepted that neoliberal polices have failed to share the proceeds of growth fairly and led to levels of inequality that now threaten to undermine the very fabric of society. The consequences of inequality Oxfam is only one of a number of organisations that have reported on the human, economic and environmental impact of inequality in recent years, and the issue has been central to the discourse on a post-2015 development goal that can address inequality head on. In a misguided world where the pursuit of short-term economic growth remains the holy grail of public policy, even the International Monetary Fund is beginning to accede that inequality can stymie efficiency. In a recent report entitled ‘Fair Share‘, the Fund suggests that governments in both rich and developing countries should place more emphasis on progressive taxation and redistribution – policies that essentially embody the principle of sharing. Also highlighted in the Oxfam briefing is the way extreme wealth can damage democracy, especially through the enormous influence over the political process that money and power can buy. Many billions of dollars are spent each year by the financial industry and large corporations in lobbying politicians to pursue a market friendly agenda – the same neoliberal policies that have widened inequalities and eventually led to a global financial collapse in 2008. Resuscitating representative democracy will inevitably entail curbing the ability of any minority group to exert a disproportionate influence over political outcomes, which in turn might require limiting the excessive wealth that can facilitate this distortion. Policies that exaggerate inequality have also been a key driver of environmental degradation, as people in rich nations consume far more than their fair share of the earth’s finite resources. As Oxfam also previously highlighted in a discussion paper on planetary boundaries, it will be impossible to address ecological and social crises unless we share available resources more equitably and sustainably. The aim of development and environmental policy must be to ensure that people in all nations can secure their basic needs without transgressing environmental limits. Such statements have huge implications for policies that widen inequalities as they point to an urgent need for convergence and equity. As the historic events of 2011 demonstrated, inequality can also spur violent civil unrest. The experience of inequality and injustice over many years ultimately sparked the Arab Spring protests as well as many other spontaneous public demonstrations – from the global Occupy Movement to the protests in Spain, Greece, Israel and other countries in the same year. Many of those involved in these public mobilisations had first-hand experience of the social consequences of inequality that campaigners and analysts have long warned of. As explicitly detailed in the classic book The Spirit Level, it is now widely accepted that inequality impacts adversely on almost all indicators of societal wellbeing, from crime and obesity to mental health. Sharing as the obvious antidote Whether in discussions about the post-2015 development goals or in proposals for how to create an environmentally sustainable economy, it is increasingly difficult for policymakers to ignore the need to reverse decades of neoliberal policies and instead strengthen forms of sharing and redistribution. Policies guided by the principle of sharing are inimical to the neoliberal agenda as the very process of sharing is cooperative rather than individualistic. Systems of sharing such as progressive taxation and the provision of social welfare and public services have the power to build solidarity, bring communities and nations together, and help close the inequality gap. Oxfam’s report on the costs of inequality adds further weight to a growing body of research pointing to how forms of sharing and redistribution could have an important role in reducing inequality. Redistributing the combined annual income of the richest 100 billionaires may not be a workable temporary solution to world poverty unless the wealthy voluntarily share their bounty. But as Oxfam acknowledge, policy solutions for reducing inequality are plentiful and widely known. As one practical example, our recent report on ‘Financing the global sharing economy‘ demonstrates that governments could redistribute trillions of dollars to reduce extreme inequality through a variety of measures that range from tax and debt justice to redirecting perverse government subsidies. Regardless of the specific policies employed, sharing wealth and resources more equitably will require governments to overcome their fixation on an unsustainable model of development based on outdated assumptions about human nature. And however much neoliberals find it anathema, this will inevitably require government intervention: new policies, regulations and laws that guarantee fairness and equity in society, both nationally and globally. Will ordinary people lead the way? While governments remain preoccupied in trying to resurrect the old economic order, many questions will no doubt occupy the minds of campaigners and progressives across the world. In light of the mounting need for sharing and redistribution, what will the public have to do to wrestle politicians away from their fixation on policies that promote inequality? For how much longer will policymakers continue to ignore the common sense alternatives that millions of people across the world are calling for? What can be done to strengthen democracy and remind politicians that they are in office to serve ordinary people, not corporations? Perhaps the only answer is the mass mobilisation of engaged citizens in a common cause against rising inequality that extends beyond national borders. Or perhaps only further financial crises, environmental chaos and economic hardship will eventually force policymakers to rethink their distorted priorities. Irrespective of how transformative change finally takes place, it is clear that a much greater emphasis on sharing and redistribution will need to be at the heart of any program to reduce inequality and secure human needs within planetary limits. Otherwise, it might not be long before the annual income of the world’s richest person alone is sufficient to end global poverty.

### Root Cause – Brain Drain

### Root Cause – Hospital closure

### Root Cause – Racial Violence

#### recent brutal killings are not isolated incidents of racist violence, but an inevitable result of the neoliberal system that requires the marking of racialized populations as disposable by relegating them to social death across the world—however ferguson proves that there is still hope for change.

Giroux 14 Giroux, Henry. "Henry A. Giroux: The Militarization of Racism and Neoliberal Violence." Truthout. N.p., 18 Aug. 2014. Web. 21 Oct. 2014.

The recent killing of an unarmed 18-year-old African-American, Michael Brown, in Ferguson, Missouri, by a white police officer has made visible how a kind of racist, military metaphysics now dominates American life. His subsequent demonization by the media only confirms its entrance into the public consciousness as a form of vicious entertainment. The police have been turned into soldiers who view the neighborhoods in which they operate as war zones. Outfitted with full riot gear, submachine guns, armored vehicles, and other lethal weapons imported from the battlefields of Iraq and Afghanistan, their mission is to assume battle-ready behavior. Is it any wonder that violence rather than painstaking, neighborhood police work and community outreach and engagement becomes the norm for dealing with alleged "criminals," especially at a time when more and more behaviors are being criminalized? But I want to introduce a caveat. I think it is a mistake to simply focus on the militarization of the police and their racist actions in addressing the killing of Michael Brown. What we are witnessing in this brutal killing and mobilization of state violence is symptomatic of the neoliberal, racist, punishing state emerging all over the world, with its encroaching machinery of social death. The neoliberal killing machine is on the march globally. The spectacle of neoliberal misery is too great to deny any more and the only mode of control left by corporate-controlled societies is violence, but a violence that is waged against the most disposable such as immigrant children, protesting youth, the unemployed, the new precariat and black youth. Neoliberal states can no longer justify and legitimate their exercise of ruthless power and its effects under casino capitalism. Given the fact that corporate power now floats above and beyond national boundaries, the financial elite can dispense with political concessions in order to pursue their toxic agendas. Moreover, as Slavoj Žižek argues "worldwide capitalismcan no longer sustain or tolerate . . . global equality. It is just too much." [(1)](http://truth-out.org/opinion/item/25660-the-militarization-of-racism-and-neoliberal-violence%29#a1) Moreover, in the face of massive inequality, increasing poverty, the rise of the punishing state, and the attack on all public spheres, neoliberalism can no longer pass itself off as synonymous with democracy. The capitalist elite, whether they are hedge fund managers, the new billionaires from Silicon Valley, or the heads of banks and corporations, is no longer interested in ideology as their chief mode of legitimation. Force is now the arbiter of their power and ability to maintain control over the commanding institutions of American society. Finally, I think it is fair to say that they are too arrogant and indifferent to how the public feels. Neoliberal capitalism has nothing to do with democracy and this has become more and more evident among people, especially youth all over the globe. As Žižek has observed, "the link between democracy and capitalism has been broken." [(2)](http://truth-out.org/opinion/item/25660-the-militarization-of-racism-and-neoliberal-violence%29#a2)The important question of justice has been subordinated to the violence of unreason, to a market logic that divorces itself from social costs, and a ruling elite that has an allegiance to nothing but profit and will do anything to protect their interests. This is why I think it is dreadfully wrong to just talk about the militarization of local police forces without recognizing that the metaphor of "war zone" is apt for a global politics in which the social state and public spheres have been replaced by the machinery of finance, the militarization of entire societies not just the police, and the widespread use of punishment that extends from the prison to the schools to the streets. Some have rightly argued that these tactics have been going on in the black community for a long time and are not new. Police violence certainly has been going on for some time, but what is new is that the intensity of violence and the level of military-style machinery of death being employed is much more sophisticated and deadly. For instance, as Kevin Zeese and Margaret Flowers point out, the militarization of the police in the United States is a recent phenomenon that dates back to 1971. They write: The militarization of police is a more recent phenomenon [and marks] the rapid rise of Police Paramilitary Units (PPUs, informally SWAT teams) which are modeled after special operations teams in the military. PPUs did not exist anywhere until 1971when Los Angeles under the leadership of the infamous police chief Daryl Gates, formed the first one and used it for demolishing homes with tanks equipped with battering rams. By 2000, there were 30,000 police SWAT teams [and] by the late 1990s, 89% of police departments in cities of over 50,000 had PPUs, almost double the mid-80s figure; and in smaller towns of between 25,000 and 50,000 by 2007, 80% had a PPU quadrupling from 20% in the mid-80s. [Moreover,] SWAT teams were active with 45,000 deployments in 2007 compared to 3,000 in the early 80s. The most common use . . . was for serving drug search warrants where they were used 80% of the time, but they were also increasingly used for patrolling neighborhoods. [(3)](http://truth-out.org/opinion/item/25660-the-militarization-of-racism-and-neoliberal-violence%29#a3) At the same time, the impact of the rapid militarization of local police forces on poor black communities is nothing short of terrifying and symptomatic of the violence that takes place in advanced genocidal states. For instance, according to a recent report entitled "Operation Ghetto Storm," produced by the Malcolm X Grassroots Movement, "police officers, security guards, or self-appointed vigilantes extra judicially killed at least 313 African-Americans in 2012. . . . This means a black person was killed by a security officer every 28 hours. The report suggests that "the real number could be much higher." [(4)](http://truth-out.org/opinion/item/25660-the-militarization-of-racism-and-neoliberal-violence%29#a4) The emergence of the warrior cop and the surveillance state go hand in hand and are indicative not only of state sanctioned racism but also of the rise of an authoritarian society and the dismantling of civil liberties. Brutality mixed with attacks on freedom dissent, and peaceful protest harbors memories of past brutal regimes such as the dictatorships in Latin America in the 1970s and 1980s. The events in Ferguson speak to a history of representation in both the United States and abroad that Americans have chosen to forget at their own risk. In spite of his generally right-wing political views, Rand Paul got it right in arguing that "When you couple this militarization of law enforcement with an erosion of civil liberties and due process that allows the police to become judge and jury - national security letters, no-knock searches, broad general warrants, pre-conviction forfeiture - we begin to have a very serious problem on our hands." What he does not name is the problem, as Danielle LaSusa has observed, which is a society that is not simply on the precipice of authoritarianism, but has fallen over the edge. Truly, as Hannah Arendt pointed out, we live in "dark times Under the regime of neoliberalism, the circle of those considered disposable and subject to state violence is now expanding. The heavy hand of the state is not only racist; it is also part of an authoritarian mode of governance willing to do violence to anyone who threatens neoliberal capitalism, white Christian fundamentalism, and the power of the military-industrial-academic-surveillance state. The United States' embrace of murderous weapons to be used on enemies abroad has taken a new turn and now will be used on those considered disposable at home. As the police become more militarized, the weapons of death become more sophisticated and the legacy of killing civilians becomes both an element of domestic as well as foreign policy. Amid the growing intensity of state terrorism, violence becomes the DNA of a society that refuses to deal with larger structural issues such as massive inequality in wealth and power, a government that now unapologetically serves the rich and powerful corporate interests, and makes violence the organizing principle of governance. [(5)](http://truth-out.org/opinion/item/25660-the-militarization-of-racism-and-neoliberal-violence%29#a5) The worldwide response to what is happening in Ferguson sheds a light on the racist and militarized nature of American society so as to make its claim to democracy seem both hypocritical and politically insipid. At the same time, such protests make visible what the artist Francisco Goya called the sleep of reason, a lapse in witnessing, attentiveness, and the failure of conscience, which lie at the heart of neoliberal's ongoing attempt to depoliticize the American public. Political life has come alive once again in the United States, moving away from its withdrawal into consumer fantasies and privatized obsessions. The time has come to recognize that Ferguson is not only about the violence and consolidation of white power and racism in one town; it is also symptomatic of white power and the deep-seated legacy of racism in the country as a whole, which goes along with what the United States has become under the intensifying politics of market fundamentalism, militarism and disposability. Ferguson prompts us to rethink the meaning of politics and to begin to think not about reform but a major restructuring of our values, institutions and notions of what a real democracy might look like. We need to live in a country in which we are alarmed rather than entertained by violence. It is time for the American people to unite around our shared fate as stakeholders in a radical democracy, rather than being united around our shared fears and the toxic glue of state terrorism and everyday violence. Ferguson points to some nefarious truths about our past and present. But the public response points in another more hopeful direction. What Ferguson has told us is that the political and moral imagination is still alive, thirsting for justice, and unwilling to let the dark clouds of authoritarianism put the lights out for good. But for that to happen we must move from moral outrage to collective struggles as part of a wider effort to dismantle the mass incarceration society, the surveillance state and the military-industrial-academic complex. How many more children, black youth, immigrants and others have to die before the struggle deepens?

### Root cause – Deutch 9 (disease, Militarism, Climate)

**Deutsch 9 -** President of the Science for Peace, Member of Canadian psychoanalytic society (Judith, Pestilence, Famine, War, Neoliberalism, and Premature Deaths, Jul-Sep 2009, http://peacemagazine.org/archive/v25n3p18.htm)

The outlook for this century is dim. Climate change and nuclear weapons pose ever-worsening threats, and the living conditions on our "planet of slums" continue to deteriorate. Although a great deal is known about preventing premature deaths, there is a profound paralysis in applying this knowledge in an effective way. Worse still, many commentators suggest that there is a powerful worldwide elite who accrue wealth by increasing greenhouse gas emissions, by investing in nuclear weapons and militarism, and who are systematically depriving the majority world and nature of the right to life. There is a narrow time scale for reversing these trends in that scientists on the Intergovernmental Panel on Climate Change now predict a possible 90% extinction rate by the end of this century unless our way of life changes drastically. A significant fact about the Nazi Holocaust was the belief that "it can't happen here." People were in a state of denial about the readily apparent ominous danger. A number of fine films convey this delusion of safety in various societies. The Garden of the Finzi-Continis (Vittorio De Sica), and Burnt by the Sun (Nikita Mikhalkov) paint pictures of the exquisite, subtle beauty of life, while the characters are oblivious to their destiny in concentration camps and the Soviet gulag. There are exact parallels now: the perils to existence are barely mentioned in the media. Also, distortions and outright lies minimize the magnitude of the problems. FOUR THREATS TO HUMAN EXISTENCE At present, threats to human existence come from at least four directions: climate change with its consequences of catastrophic climate events and of drastic water and food shortages; from nuclear war; from pandemics; from the severe impoverishment and destruction of society that is a result of neo-liberal restructuring. All are due to human error. All are preventable. But the time factor is most crucial around climate change. The lack of attention to the time scale is tantamount to believing that "it can't happen here." Currently, most attempts to counter these dangers address the issues in isolation even though the main perpetrators implement a unified, relatively coherent programme that unites these threats. Neo-liberal plutocrats are the controlling shareholders of the large agri-business, weapons, water privatization, pharmaceutical ([or] anti national health care), mining, non-renewable energy companies. It is their economic practices that decimate water resources, deplete soil, pollute air, and increase greenhouse gas emissions. The culpable individuals, their think tanks, the supportive government bureaucracies, and the specific methods of control are well-documented in a number of recent works.1 From recent history it is readily apparent that mass extinction "can happen here." A similar confluence of climate events and exploitive socio-economic re-structuring occurred in the late-Victorian period. Retrospective statistical studies established that worldwide droughts between 1876 and 1902 were caused by El Nino weather events. Based on the British Empire's laissez-faire approach to famine that enjoined against state "interference" in the for-profit trade in wheat, between 13 million and 29 million people died in India alone. True to the precepts of liberalism, the British converted small subsistence farms in India into large scale monocrop farming for export on a world market. The new globally integrated grain trade meant that disturbances in distant parts of the world affected Indian farmers. Advances in technology actually made things worse, for steam-driven trains were used to transport grains to England while locals starved, and telegraph communication was used to process international monetary transactions that destroyed local communities. Gone were the traditional social institutions for managing food shortages and hardship. The Victorian world view also bequeathed us the myth of the inferior Third World and denial of British responsibility for the de-development of tropical countries. Mike Davis points out the compelling evidence that South Indian laborers had higher earnings than their British counterparts in the 18th century and lived lives of greater financial security, including better diets and lower unemployment. "If the history of British rule in India were to be condensed into a single fact, it is this: there was no increase in India's per capita income from 1757 to 1947. Indeed, in the last half of the nineteenth century [due to colonial structural adjustment], income probably declined by more than 50% There was no economic development at all in the usual sense of the term."( Davis, p. 311). In today's world, neo-liberalism continues to increase global misery and poverty and the dehumanization and invisibility of millions of "warehoused" people. Whatever conditions increase poverty also increase premature deaths. In the US, a 1% rise in unemployment increases the mortality rate by 2%, homicides and imprisonments by 6%, and infant mortality by 5%. The 225 richest individuals worldwide have a combined wealth of over $1 trillion, equal to the annual income of the poorest 47% of the world's population, or 2.5 billion people. By comparison, it is estimated that the additional cost of achieving and maintaining universal access to basic education for all, reproductive health care for all women, adequate food for all and safe water and sanitation for all is roughly $40 billion a year. This is less than 4% of the combined wealth of these 225 richest people.2 NEO-LIBERALISM Neo-liberal policies have mandated the destruction of the social safety net that would be the lifesaver in climate disaster, epidemics, and war. The International Monetary Fund has required countless countries to dismantle public education, health, water, and sanitation infrastructure. Neo-liberalism strenuously opposes government intervention on behalf of the common good while hypocritically and deceptively protecting narrow class interests and investments in the military, non-renewable energy, privatized health care. The powerful and wealthy few control the military-industrial complex, surveillance, and the media. The connections with climate change are manifold. Already there is military preparedness for the potential impacts on peace and security posed by climate change -- not to help victims but to keep refugees out. Ominously, there are now overt racist overtones to the discussion of "environmental refugees" and the closing of borders. The model of response to disasters is most likely Hurricane Katrina, namely, protection of the wealthy and outright cruelty to the poor. Wars are tremendously costly to the public but highly profitable to powerful elites. "The arms trade has expanded by more than 20% worldwide in the past five years" (The Guardian Weekly 01.05.09, p. 11). The military itself emits enormous amounts of greenhouse gases and brutally protects the extractive industries of the wealthy. There are innumerable unreported incidents: In May 2009, alone, the Nigerian army razed villages in the oil-rich Niger delta to protect oil companies, killing many civilians; in Papua New Guinea, 200 heavily armed soldiers and police were sent to the Barrick Gold Porgera area to destroy indigenous villages. In the 20th century, it is estimated that as many as 360 million people died prematurely due to state terrorism--"terrorism from above." BESIDES PROLIFERATION The use of nuclear weapons in wars would appear to be increasingly acceptable. "We have created a situation in the world where we have a very small number of people in control of nuclear arsenals - people whose competence is not necessarily proven, whose rationality is not necessarily at a high level, and whose ethical standards may or may not be acceptable. These people are in charge of making decisions about the use of weapons that could destroy civilization and most life on earth" (p. 245). In their recent collection of papers on nuclear weapons, Falk and Krieger further suggest that the grand military strategy is "largely to project power in order to reap the benefits of profitability for the few. To take control of resources, and to place our military bases strategically around the world in order to have greater degrees of control, sounds like a strategy to benefit corporate interests." They state that the power elite has cleverly manipulated the public by focusing almost exclusive attention on the issue of proliferation, "with corresponding inattention to possession, continuing weapons development, and thinly disguised reliance on threatened use." For real change to occur, it will be necessary to penetrate the "deepest bowels of the governmental bureaucracy," the silent and unknown people who support the nuclear weapon option. We must be realistic about the forces obstructing reduction of greenhouse gases, all forms of militarism, and economic inequity. Conventions and international law all too often provide a smokescreen that delays real change. For example, the United States simply changed the description of its captured detainees in Iraq and Afghanistan to avoid meeting the requirements of statutes on terror. Similarly, Israel invented a new term for Gaza, a "statal entity," to avoid the term "occupation" with its specific legal obligations.

## Frontlines

### F2: Smokescreen / Neolibs want it

* + - 1. **Arnos 20**
			2. Like Covid has fucked neolibs, now is the time to make reforms if anything

\*the man didn’t do it ☹\*

### A2: Can’t work within State (Statephobia K)

\*check out Srikar’s Neolib File in Folder\* - I’ll move it later

### F2: Lobbying takes out solvency \*This is Our Nocember 18 prep\*

* On top COVID Fucked everything especially lobby
1. **Realize this argument really isn't true. The pharmaceutical industry wants this as Health affairs explains in 2017 that “**pharmaceutical companies appear open to novel pricing arrangements. Some have even [signed](http://www.modernhealthcare.com/article/20160628/NEWS/160629889) outcome-based pricing contracts with insurers.”
2. **This is ridiculous. By their logic we should never impose price controls on industries that exploit their consumers because they can just use lobbying power to get out of regulation. The actor of the resolution is the federal government meaning that even if it did cause political backlash we FIAT that the resolution will pass**
3. **NU. There is always going to be political backlash. Either pharmaceutical companies are lobbying to stop price controls from happening or they are pushing for general drug regulation to be halted after the resolution is affirmed. Moreover, there has never been a time where the House or Senate have made an amicable agreement on policy making without having conflict. Their advocacy is only possible in utopia.**
4. **NU. Pharmaceutical companies have been lobbying since around the early 90’s so by their logic political backlash has been happening for over 20 years. Make them prove that price controls would all of a sudden fire up congressional leaders and cause more backlash.**
5. **Delink: According to Novak in 2016 from CNBC, there are two reasons why Pharmaceutical lobbying won’t work.**

**A) First, public and political sentiment against expensive medicines and the companies that charge those prices is at a fever pitch**

**B) M4a has 50% Republican Support, probably can’t find anyone to lobby significantly**

**6. This is another institution of Neoliberalism, our solvency takes out this link.**

1. **[don’t read]**
2. **Non-Unique: Hellman from The Hill in 2018 writes that Drug Companies have ramped up lobbying efforts as the industry faces uncertainty in the Trump Era. He furthers that from 2016 to 2017, Pharma increased its lobbying spending by thirty percent. This means that Everything that they tell you about should have already happened, and their argument isn’t true and what they talk about is inevitable anyways.**
3. **(**

Cards:

Jake Novak, 10-28-2016 “A Warning For Big Pharma: Lobbying Won’t Work Anymore” <https://www.cnbc.com/2016/10/28/a-warning-for-big-pharma-lobbying-wont-work-anymore-commentary.html>

A lot of industries are still blind to these new realities. And no industry seems more clueless right now than Big Pharma. If you think the presidential candidates have been spending big bucks and fighting hard, new reports out this week say the big drug companies are set to unleash a massive lobbying battle in Washington. Several reports say the the Big Pharma lobbying group known as PhRMA is looking to spend as much as $300 million and pull out lots of other stops in order to defend higher prescription drug costs. But here's the problem: this is a battle the drug giants can't win. Public and political sentiment against expensive medicines and the companies that charge those prices is at a fever pitch. All you need to do is remember this summer's outrage over Mylan's EpiPen prices to know this is true. This anger makes the ire many Americans have over rising cable bills look mild. And this time, there aren't a lot of Republicans in Congress who are likely to defend unpopular corporate sectors. The GOP Members of Congress proved that by piling on Stumpf during his hearing trial by fire and they did the same thing to Mylan CEO Heather Bresch during her turn in front of a Congressional committee.

Jessie Hellman, 4-20-2018, “PhRMA spends record amount on lobbying amid drug pricing fights” <https://thehill.com/policy/healthcare/384176-phrma-spends-record-amount-on-lobbying-amid-drug-pricing-fights> The Hill.

The largest drug lobby group in America spent record-breaking amounts on lobbying in the first quarter of 2018 as it fought a bipartisan drug pricing measure working its way through Congress. The Pharmaceutical Research and Manufacturers of America (PhRMA) spent nearly $10 million on lobbying efforts between Jan. 1 and March 31, according to federal filings, breaking its own record for the most spent in a single quarter. That's a $2 million increase compared to the same time last year, and a $4 million increase over the fourth quarter, which was the end of last year. PhRMA spent the first quarter of this year battling the CREATES Act, a bipartisan bill intended to increase competition among generic and branded drug manufacturers. Congressional supporters of the bill intended to include it in the spending bill passed in February, but it didn't make it in, a huge win for the drug industry and PhRMA, who argued it would have created "frivolous litigation." PhRMA did suffer one defeat in the budget deal, however. A provision included in the deal raised the share of costs that drug companies have to pick up as part of closing the "donut hole," a gap in drug coverage for Medicare Part D beneficiaries. PhRMA lobbied to have the change reversed in the March spending deal, but that didn't happen. Drug companies have ramped up lobbying efforts as the industry faces uncertainty in the Trump era. From 2016 to 2017, PhRMA increased its lobbying spending by 30 percent. President Trump frequently criticizes drug companies and PhRMA for high drug prices, but has yet to take substantial action. Trump is preparing to give a speech April 26 announcing reforms intended to lower the cost of prescription drugs.

Jay Hancock, 9-23-2017, “Everyone Wants to Reduce Drug Prices. So Why Can’t We Do It?”https://www.nytimes.com/2017/09/23/sunday-review/prescription-drugs-prices.html New York Times.

Of all the promises President Trump made for the early part of his term, controlling stinging drug prices might have seemed the easiest to achieve. An angry public overwhelmingly wants change in an easily vilified industry. The pharmaceutical industry’s recent publicity nightmare included 1,000 percent price increases and a smirking chief executive who said, “I liken myself to the robber barons.” Even powerful members of Congress from both parties have said that drug prices are too high. But any momentum to curtail prescription drug costs — a problem that a large number of Americans now believe government should solve — has been lost amid rancorous debates over replacing Obamacare and stalled amid roadblocks erected via lobbying and industry cash. “There is a very aggressive lobby that is finding any and all means to thwart any reform to a system that has produced very lucrative profits,” said Ameet Sarpatwari, an epidemiologist and lawyer at Harvard Medical School who follows drug legislation. “Everything that’s coming out is being hit and hit hard — even stuff that’s common-sensical.”

## Extra Framing Stuff – Don’t really need but can help

1. **Education. Our reading of the AFF to challenge the uncontested modes that have occupied the debate space allows for a form of true education. Hill 10** notes that ”the neoconservative faces of education weaken opposition thought. The curriculum is conservative and it is controlled now focus is on the production of a compliant citizen. What influence can pedagogues have [if] they get slapped down when they start getting dangerous. This neccessitates the development of proactive debate both by and within the Radical Left in defense of popular socialist policies we are able to have a massive impact”

**This is because bleiker 02** notes that “the attempt to question established norms. The political significance of movements is located precisely in the fact that they cannot be controlled by a central framework. They open up possibilities for social change that are absent within the established system”

Framing V1 – The idea is we can read root cause in case and read the other 2 as reasons to prefer our framing in rebuttal (aka win the counter framing).

#### Use the ballot to deconstruct the uncontested modes that our system rely on – this means you vote for the team that best resists structures that are present in the real world.

#### Prefer for 3 reasons.

#### Education – Without resisting the system, we are stuck in a batters box of thought. Only our framework allows for new modes of thought, which is inherently more valuable for education.

#### Root Cause – Failing to address the structures that cause harms to occur allows for these structures to reify, and continue those harms.. Only through resisting material structures can any long-term solutions be maintained.

#### Policy making - Bleiker 2 notes that

bleiker, 02 [Bleiker 2, professor of international relations at the University of Queensland, Politics After Seattle: Dilemmasof the Anti-Globalisation Movement, conflits.revues.org/1057]

46 While engendering a series of problematic processes, globalisation has also increased the possibility to engage political issues. Before the advent of speed, for instance, a protest event was a mostly local issue. But the presence of global media networks has fundamentally changed the dynamics and terrains of dissent. Political activism no longer takes place solely in the streets of Prague, Seoul or Asuncion. The Battle for Seattle, for instance, was above all a media spectacle, a battle for the hearts and minds of global television audiences. Political activism, wherever it occurs and whatever form it takes, has become intrinsically linked with the non-spatial logic of speed. It has turned into a significant transnational phenomena.¶ 47With the exploration of new terrains of dissent, global activists also face a series of political dilemmas. This essay has addressed two of them : the tension between violent and nonviolent means of resistance, and the issue of unequal representation, the question of who can speak for whom. Rather than suggesting that these issues can be understood and solved by applying a pre-existing body of universal norms and principles, the essay has drawn attention to the open-ended and contingent nature of the puzzles in question. Protest acts against the key multilateral institutions of the world economy will continue, and so will debates about the nature of globalisation and the methods of interfering with its governance. Keeping these debates alive, and seeking to include as many voices, perspectives and constituencies as possible, is a first step towards something that may one day resemble globalisation with a human face.¶ 48But making global governance more humane, more transparent and more democratic is no easy task. Principles of transparency and democracy have historically been confined to the territorial boundaries of the sovereign nation state. Within these boundaries there is the possibility for order and the rule of law. But the space beyond is seen as threatening and anarchical - that is, lacking a central regulatory institution. The standard realist response to these perceptions is well know : protect sovereignty, order and civility at the domestic level by promoting policies that maximise the state's military capacity and, so it is assumed, its security.68 It is questionable to what extent realist policies remain adequate - and ethical for that matter - at a time when process of globalisation have lead to a fundamental transformation of political dynamics.¶ 49The Battle for Seattle, and the media spectacle that issued form it, may well demonstrate that the struggle for power takes place in a realm that lacks a central regulatory institution. But realist interpretations make the mistake of embarking on a fatalistic interpretation of this political realm, constituting conflict as an inevitable element of the system's structure. It may be more adequate - and certainly more productive - to characterise the international system in the age of globalisation and transnational dynamics not as anarchical, but as rhizomatic. For Gilles Deleuze and Félix Guattari a rhizome is a multiplicity that has no coherent and bounded whole, no beginning or end, only a middle from where it expands and overspills. Any point of the rhizome is connected to any other. It has no fixed points to anchor thought, only lines, magnitudes, dimensions, plateaus, and they are always in motion.69 How, then, is one to reach a moral position in a world of webs, multitudes and multiplicities ? Are the lines, dimensions and plateaus of the rhizome so randomly arranged that we are no longer able to generate the kind of stable knowledge that is necessary to advance critique and, indeed, dissent ? Is the very notion of political foundations still possible at a time when social consciousness gushes out of five-second sound-bites and the corresponding hyperreal images that flicker over our television screens ? Are there alternatives to realist approaches that protect domestic order by warding off everything that threatens it from the outside ? Answers to such questions do, of course, not come easy. And they may not be uniform either. But an adequate response will need to engage in one way or another with the search for political engagements beyond the territorial boundaries of the nation state.¶ 50 An extension of democratic principles into the more ambiguous international realm is as essential as it is difficult. It will need to be based on a commitment to democracy that goes beyond the establishment of legal and institutional procedures. William Connolly has pointed in the right direction when arguing for a democratic ethos. The key to such cultural democratisation, he believes, "is that it embodies a productive ambiguity at its very centre, always resisting attempts to allow one side or the other to achieve final victory."70 Such a model is, of course, the antithesis of prevailing realist wisdom, and perhaps of modern attitudes in general, which seek to achieve security and democracy through the establishment of order and the repression of all ambiguity.71¶ 51Rather than posing a threat to human security, the rhizomatic dimension of the international system may well be a crucial element in the attempt to establish a democratic ethos that can keep up with the pace of globalisation. Some aspects of democratic participation can never be institutionalised. Any political system, no matter how just and refined, rests on a structure of exclusion. It has to separate right from wrong, good from evil, moral from immoral. This separation is both inevitable and desirable. But to remain legitimate the respective political foundations need to be submitted to periodic scrutiny. They require constant readjustments in order to remain adequate and fair. It is in the struggle for fairness, in the attempt to question established norms and procedures, that global protest movements, problematic as they are at times, make an indispensable contribution to democratic politics.¶ 52 The political significance of protest movments is located precisely in the fact that they cannot be controlled by a central regulatory force or an institutional framework. They open up possibilities for social change that are absent within the context of the established legal and political system.72 The various movements themselves are, of course, far from unproblematic. The violent nature of recent actions against neo-liberal governance may well point towards the need for greater political awareness among activists. But such awareness can neither be imposed by legal norms or political procedures. It needs to emerge from the struggle over values that takes place in civil society. The fact that this struggle is ongoing does not detract from the positive potential that is hidden in the movement's rhizomatic nature. These elements embody the very ideal of productive ambiguity that may well be essential for the long-term survival of democracy.

### AT Ground/Limits

#### You are not deciding FW for the rest of your life – the decision in this round doesn’t influence any other framework debates at this tournament.

#### If we win they had ground in this round against our aff no impact

* 1. **Our Education voter O/ws on Timeframe**

#### They can still contest us on arguments such as the merits of neoliberalism in IR, the effectiveness of critical pedagogy, our role as debaters, better methods of generating radical imagination, counter advocacies, K ground. Even if we don’t use the same stasis as them, there is no identifiable decrease in the value of arguments they can read.

#### Also, don’t let them create an absurd picture of what the affirmative justifies. Debate has shifted for years farther and farther to the left, yet there are still trad teams winning the TOC. We don’t steal all potential for contestation from debate. At best they will win that the affirmative is a bit harder to answer but A – don’t punish teams for making good cases but also B – It forces them to do critical thinking which outweighs.

#### Outweigh for a few reasons.

* + - * 1. **Fairness is subjective**, different people have different ideas as to what arguments and practices are fair so we can never know when fairness is being achieved. Further, people have different conceptions of what it means to be fair. For instance, we don't know if fairness is procedural or if it is substantive, ie if fairness means correcting the neg win skew or not.
				2. **Funding –** Schools fund debate for it’s education, not for it’s competitive edge
				3. **Our Real world education outweighs unfairness for a round.**

#### We might make them step out of their comfort zone but that’s a good thing and an independent reason to vote aff. Retreating into our comfort zones and never challenging ourselves is banking education that recreates oppression – allowing the aff is key to generating creativity.

#### Focus on limits engenders violent practices by stopping productive discussions.

**Bleiker and Leet 6** (Roland, prof of International Relations @ U of Queensland, Brisbane, and Martin, Senior Research Officer with the Brisbane Institute, *Millennium: Journal of International Studies*, 34(3), p. 733-734)JM

A subliminal orientation is attentive to what is bubbling along under the surface. It **is mindful of how** conscious **attempts to understand conceal** more than they reveal, **and** purposeful efforts of progressive change may **engender more violence than they erase**. For these reasons, Connolly emphasises that ‘ethical artistry’ has an element of naïveté and innocence. One is not quite sure what one is doing. Such naïveté need not lead us back to the idealism of the romantic period. ‘One should not be naïve about naïveté’, Simon Critchley would say.56 Rather, **the challenge of change is an experiment**. **It is not locked up in a predetermined conception of where one is going.** **It involves** tentatively **exploring** the **limits** **of** one’s **being** in the world, **to see** if **different interpretations** are possible, **how those interpretations might impact upon the affects below the level of conscious thought**, and vice versa. **This approach entails drawing upon multiple levels of thinking** and being, searching **for changes** in sensibilities **that could give more weight to minor feelings or to arguments that were previously ignored**.57 **Wonder needs to be at the heart of such experiments, in contrast to** the **resentment** of an intellect angry **with** its own **limitations**. The ingre d i e n t of **wonder is necessary to disrupt** and suspend the normal pre s s u res of returning to **conscious habit and control**. This exploration beyond the conscious implies the need for an ethos of theorising and acting that is quite diff e rent from the mode directed towards the cognitive justification of ideas and concepts. Stephen White talks about ‘circ u i t s of reflection, affect and arg umentation’.58 **Ideas and principles provide an orientation to practice**, **the implications of that practice feed back into our affective outlook**, **and processes of argumentation introduce other ideas and affects**. The shift, here, is from the ‘vertical’ search for foundations in ‘skyhooks’ above or ‘foundations’ below, to a ‘horizontal’ movement into the unknown.

### FW extension – U can read off this

Our Framework tells you to be a critical intellectual. Ask why things are, what structures make them so, and deconstruct these systems that we rely on.

#### Ext – Education – We say this model is best to educate us on other forms of thought, outside of the echo chamber we currently live in. This is the most important skill in debate

#### Ext – Compound effect – If we don’t solve for the systems that allows problems (such as access or process R&D) to occur, these systems will continue in either world and destroy any solvency.

#### Ext – Policy Making – Bliker 2 notes that policy making thoughts require readjustments and requires a constant questioning of the current system.

### F2 Education

#### The entire aff is an impact turn to their form of education – their form of debate teaches us to go back and forth about how major players should act but never asks how we can change the world around us.

#### Education is never neutral not inherently good – that was Giroux 16. They need to win that their form of education is better than our critical pedagogy

#### They have no way to actualize their form of education in the real world. Our Giroux 14 card says that the affirmative is a necessary first step to being able to generate sociopolitical change – their form of banking education teaches us to think about the status quo.

### F2: Portable Skills

#### Lol so you can go become part of the system get a job? We create the skills needed to make a change in the world

#### We still use the form of FIAT, we just value creating bottom up change over all else

### AT Predictability

#### You will never be able to predict every debate round - unpredictability is inevitable – embracing this fact, however, allows us to better situate ourselves in relation to the world

**Bleiker and Leet 6** (Roland, prof of International Relations @ U of Queensland, Brisbane, and Martin, Senior Research Officer with the Brisbane Institute, *Millennium: Journal of International Studies*, 34(3), p. 729-730)JM

Dramatic, sublime events can uproot entrenched habits, but so can a more mundane cultivation of wonder and curiosity. Friedrich Nietzsche pursued such a line of enquiry when reflecting upon what he called the ‘ after effects of knowledge’. He considered how **alternative ways** of life **open** **up through** a simple **awareness of the fallibility of knowledge**. **We endure** a series of non-dramatic **learning experiences as we emerge from** the illusions of **childhood**. **We are confronted with being uprooted from the safety of the house**. At first, **a plunge into despair is likely**, as one realises the contingent nature of the foundations on which we stand and the walls behind which we hide and shiver in fear: All **human life is sunk deep in untruth; the individual cannot pull it out of this well without growing** profoundly **annoyed** with his entire past, without finding his present motives (like honour) senseless, **and without opposing** scorn and **disdain to the passions that urge one on to the future and to the happiness in it**.43 The sense of **meaninglessness**, the anger at this situation, **represents a reaction against the habits of one’s upbringing** and culture. One no longer feels certain, **one no longer feels in control**. The sublime disruption of convention gives rise to the animosity of loss. The resentment may last a whole lifetime. Nietzsche insists, however, that **an alternative** reaction **is possible**. **A** completely different ‘**after effect of knowledge’ can emerge** over time **if we** are prepared to **free ourselves from** the **standards** we continue to apply, even if we do no longer believe in them. To be sure, **the: old motives of intense desire would still be strong at first**, due to old, inherited habit, **but they would gradually grow weaker** **under the influence of cleansing knowledge.** Finally one would live among men and with oneself as in nature, without praise, reproaches, overzealousness, delighting in many things as in a spectacle that one formerly had only to fear.44 The elements of fear and defensiveness are displaced by delight if and when we become aware of our own role in constructing the scene around us. The ‘**cleansing knowledge’** of which Nietzsche speaks **refers to exposing the entrenched habits of representation of which we were ignorant**. We realise, for example, that nature and culture are continuous rather than radically distinct. We may have expected culture to be chosen by us, to satisfy our needs, to be consistent and harmonious, in contrast to the strife, accident and instinct of nature. But **just as we can neither predict a thunderstorm striking nor prevent it, so we are unable ever to eliminate the chance of a terrorist striking in our midst**. **We can better reconcile ourselves to the unpredictability and ‘irrationality’ of politics** and culture **by overcoming** our childhood and idealistic **illusions**. The cultivation of the subliminal, then, can dilute our obsession with control by questioning the assumptions about nature and culture in which this obsession is embedded. **Without** this work of **cultivation**, **we are** far more **vulnerable** once hit by the after effects of knowledge. **We find ourselves** in a place we never expected to be, **overwhelmed** **by unexamined habits** of fear and loathing. But **if**, as Nietzsche suggests, **we experiment with the subliminal disruptions encountered in the process of ‘growing up’, we may become better prepared.** We may follow Bachelard’s lead and recognise that the house not only offers us a space to withdraw from the world when in fear, but also a shelter in which to daydream, to let our minds wander and explore subliminal possibilities. That, Bachelard believes, is indeed the chief benefit of the house: ‘it protects the dreamer’ .45

## Extra cards

#### Private insurers are a direct cause of the opioid crisis---distorted incentives for effective treatment---Aff solves by re-altering profit motives

Schatman 11 — Michael E. Schatman, Adjunct Clinical Professor at the Tufts School of Medicine Department of Public Health & Community Medicine, PhD in Clinical Psychology from the University of Texas, Director of Research and Network Development at Boston Pain Care, 02-18-2011, Date Accessed: 10-2-2017, “The Role of the Health Insurance Industry in Perpetuating Suboptimal Pain Management” Pain Medicine, 2011; 12: 415–426 Wiley Periodicals, Inc, http://onlinelibrary.wiley.com/doi/10.1111/j.1526-4637.2011.01061.x/abstract

The Insurance Industry and Pain Management

Fish and Nicholson [24] have suggested that while both payers and clinicians share the goal of pain management, payers are also concerned regarding the economic implications of treatment. This assessment of third-party payers’ motivations may, in fact, be generous. It has recently been posited that the fiduciary obligation of health insurers is not to its enrollees, but to its shareholders [25]. Concern with cost-containment (and, in most cases, profitability) inherent in the “business ethic” under which the health insurance industry operates trumps any sense of perceived responsibility to ameliorate enrollee suffering, including those enrollees suffering from pain. If the actions and inactions of the insurance industry are indeed based upon a legitimate ethical position, then empirical evidence supporting their management of enrollees suffering from chronic pain ought to be made available to patients and those care providers who attempt to treat them. Perhaps the most egregious manner in which the health insurance industry interferes with the provision of adequate pain management is through its refusal to reimburse clinicians for services that will potentially reduce pain and suffering. Although a certain percentage of providers and facilities are willing to provide limited pro-bono care, lack of third-party coverage generally translates to lack of pain treatment. This issue will be addressed first, and the analysis will then move on to some of the more subtle ways in which the insurance industry interferes with pain management in order to optimize cost-containment and maximize profitability. Schatman [26,27] has used the example of insurers’ refusal to reimburse interdisciplinary pain management programs to elucidate the severity of the problem. Numerous studies, meta-analyses, and systematic reviews have indicated that interdisciplinary chronic pain management constitutes the most clinically effective and cost-efficient means of treating most chronic pain conditions [28–35]. Additionally, interdisciplinary treatment programs are essentially devoid of adverse side effects and iatrogenic complications, which is untrue of treatments such as pharmacotherapy, surgery, intrathecal drug delivery systems, spinal cord stimulators, and other interventional approaches. The literature also supports the long-term efficacy of interdisciplinary chronic pain management, with follow-up studies conducted as long as 13 years posttreatment [36]. Additional support for the interdisciplinary approach can be found in a study that determined that patients who received interdisciplinary chronic pain treatment subsequently utilized medical services to a lower extent than those not treated in interdisciplinary programs [37]. The paradox of insurers’ refusal to cover interdisciplinary pain management programs is that this practice steers patients toward more expensive and less effective unimodal treatments, ultimately helping neither the patient nor the insurer [38]. A clear example of this phenomenon can be seen in insurance carriers’ implied support for chronic opioid therapy for chronic nonmalignant pain. In a recent study on the outcomes of chronic noncancer pain in workers compensation patients [39], the authors determined that the odds of chronic work loss were six times higher among those receiving Schedule II opioids vs those not receiving opioids, and that for those patients prescribed opioids for 90 or more days, the odds were even higher. These findings are consistent with those of earlier studies associating opioid utilization with work loss [40,41]. Volinn and colleagues [39] found that 3 years post-injury, the costs of claimants who filled Schedule II opioid prescriptions was almost $20,000 higher than costs for claimants not receiving opioids. Unfortunately, their data collection did not extent past 3 years, although it is extremely unlikely that these costs would not have continued to increase. Such increases can potentially be dramatic as the neuroendocrinological impacts of chronic opioid therapy [42,43] begin to manifest themselves. Although the goals of workers compensation are not necessarily identical to those of commercial carriers (e.g., commercial carriers are not necessarily concerned about an enrollee’s return to work status), all insurers share the goal of cost-containment. Chronic opioid users represent only 0.65% of the population, yet file 4.56% of all health insurance claims [44], and the dramatic increase in prescription opioid abuse has resulted in substantially higher costs among those covered by private insurance as well as by Medicaid [45]. Despite these recently published data, third-party payers remain generally willing to cover prescription opioid analgesics, with coverage for and availability of interdisciplinary chronic pain management in the United States rapidly declining [46]. Schatman and Sullivan [47] have recently outlined the factors that cause chronic pain sufferers to represent a particularly vulnerable population. In earlier works, Schatman [26,27] questioned the ethical implications of denying coverage of interdisciplinary pain management programs based upon a “policy” that is completely inconsistent with the evidence-basis. Virtue ethical as well as principlebased ethical arguments were presented in order to elucidate the moral hazard presented by reliance upon an essentially arbitrary policy. Interestingly, it has been noted that in order to legally overturn an insurance denial, beneficiaries are obligated to prove that an insurer’s decision is arbitrary and capricious, or unreasonable [48]. However, one should recognize that laws regarding insurance denial vary from state to state. Nevertheless, it is apparent that in certain jurisdictions, the law does not necessarily apply to the insurance industry’s management of chronic pain care, particularly in light of the aforementioned literature establishing interdisciplinary treatment of chronic pain as cost-effective as well as clinically sound. Additional evidence of the egregious policies adopted (or not adopted) by insurance carriers can be found in a study by Pellino and colleagues [49] in which two of the carriers surveyed indicated that pain management was not a part of company policy in any form. Tragically, results of this study indicated that one of the most common reasons for not covering various pain management services was a lack of understanding of their clinical efficacy. The ethical implications of denying services based upon ignorance are certainly clear, particularly when the evidence-bases are published in mainstream medical journals. One would assume that health insurance carriers employ medical directors, and that these physicians should guide company policies through their appreciation of the published evidence bases. Empirical evidence indicates that as insurance carriers increase their denial rates for claims relating to traumatically-induced injuries, the rate of claims that are filed decreases [50]. Pain, and particularly maldynic chronic pain, is an “easy target” for claim denial, as it is often considered less than legitimate by insurers due to its often-uncertain etiology. This appears to be particularly true in cases in which patients are traumatically injured, such as on-the-job injuries and motor vehicle collisions. Although physicians are the traditional adjudicators of whether care is needed, they must now answer to bureaucratic entities such as health insurers prior to passing such judgment [51]. Maldynic chronic pain, due to its frequent lack of a clear etiology, is often viewed by the health insurance industry as illegitimate. As certain forms of suffering lack clear cut definitions, it is assumed that the suffering of chronic pain victims is not suffering at all. Melucci [52]. has referred to this phenomenon as “symbolic domination” i.e., domination by information, symbols, categories, and bureaucracies. Empirical support for the stigmatization experienced by chronic pain sufferers is abundant [53–55]. In a recent essay, Goldberg [56] directly links this stigmatization to undertreatment of chronic pain and undue suffering. Within the field of pain medicine, much of the criticism of the health insurance industry has been targeted at managed care. Trueman [57], for example, has noted that in its efforts to reduce costs, managed care has failed to conceptualize pain as a biopsychosocial phenomenon. Instead, these companies tend to perceive pain as a financial perturbation and inadequately treat it in the cheapest possible manner, i.e., with medications—irrespective of the iatrogenic complications associated with their use. Prior to the appearance of a body of literature on insurance refusal to reimburse interdisciplinary chronic pain management, empirical investigation of the clinical impact of managed care “carving out” certain services from interdisciplinary programs and the ethical implications of doing so had been addressed. Because of this alleged costsaving practice of third-party payers, chronic pain patients are often treated by disconnected health care professionals operating out of different facilities and communicating with each other minimally, thereby precluding the possibility of evidence-based coordinated care. Gatchel and his colleagues [58,59] empirically established that “carving out” practices significantly detracted from the quality of care and both short-term and long-term outcomes experienced by chronic pain sufferers. In a more recent work, Gatchel and colleagues [60] refer to “carving out” practices by third-party payers as “a serious bioethical issue of which such payers may be accused when grass-root pain support groups become more politically active” (p. 45). While insurers’ failure to support treatment of chronic pain from a biopsychosocial perspective is problematic, it should be considered that their approach may be influenced by a parallel failure of many physicians to treat chronic pain biopsychosocially as well. As mentioned earlier in this analysis, it is important to recognize that all health insurance constitutes “managed care,” as it is the insurer rather than the patient and physician that decides which treatments can be provided [60]. Rather than focusing on patient well-being, the aim of every health insurance carrier, whether for-profit or not-for profit, is cost-containment. In a for-profit organization, the insurer’s fiduciary obligation is not to the pain patient who needs coverage of services in order to maintain hope of amelioration of his/her suffering, but to the shareholders who desire to see their investment dollars grow [61]. Equally distressing, perhaps, are not-for-profit third-party payers, such as state-funded workers compensation systems. Routinely, this type of agency will acknowledge that its fiduciary obligation is not to the injured worker, but to the taxpayers of the state. Limiting chronic pain treatment, particularly when doing so completely contradicts the abundant evidence-basis, is not necessarily unethical—particularly when insurers operate under the “business ethic” of cost-containment and profitability and do not see themselves as subject to the commonly cited principles of medical ethics. However, the practice of carving-out services from interdisciplinary programs whose evidence-bases are so strong can perpetuate, and perhaps exacerbate, suffering. Few would argue that any behavior that serves to perpetuate human suffering can in any way be considered “ethical.” The notion that health insurance carriers do not likely consider themselves unethical certainly supports the mutual exclusivity of business “ethics” and the standard of ethics governing social justice in health care. Third-party payers limit chronic pain treatment in other ways in the name of cost-containment. For example, insurance coverage for specialists is an issue affecting the availability and therefore the overall quality of pain care, as insurance coverage impacts the decision of whether to refer a patient to a pain specialist [62]. Another way in which insurance carrier policies can result in incomplete and, accordingly, ineffective treatment is through the limitation of physical therapy benefits. Mariner [63] has noted that such limiting strategies have the potential to result in “moral hazard,” as paying fewer benefits purely for their own financial benefit can result in harm to patients. Another strategy through which health insurance carriers pursue cost-containment and profitability is by delaying necessary pain management services, with these efforts having potentially catastrophic consequences. For example, Sinnott [64] found that each 2-week administrative delay of coverage of medical care for occupationally injured back patients resulted in increased odds of developing chronic disability. Although Frank and colleagues [65] suggest that treatment that is overly aggressive in the acute stage of low back injury can result in iatrogenesis, they also conclude that following acute low back pain treatment guidelines immediately after an injury is sustained can serve to reduce disability. In discussing the consequences of delay of appropriate, comprehensive treatment, Gallagher and Myers [66] note that this practice not only increases the likelihood of acute pain developing into long-term disability and its psychosocial sequelae, but increases unnecessary costs to society through additional compensation payments and medical expenses. However, the authors opine that delay may be caused by insurers because it directly benefits them to do so. Many enrollees in insurance plans will ultimately respond to insurance delay tactics by becoming frustrated and demoralized, ultimately giving up their efforts to receive adequate treatment. Additionally, they suggest that there may actually exist a disincentive for adjustors to approve of appropriate treatment, as the long-term cost-effectiveness of this practice may never be evaluated in the large bureaucracy of an insurance company. Finally, Gallagher and Myers note that the idiosyncratic beliefs of adjustors regarding pain and disability may negatively bias their decisions when reviewing cases [66]. Delay of pain treatment can also have a negative impact on the patientphysician relationship, as it has been empirically established that patients’ fiduciary trust in their physicians is negatively associated with delay of care [67]. Given the importance of trust in one’s health care providers in cases of chronic pain [68,69], erosion of patients’ trust in their health care providers secondary to insurance-instigated delay of treatment will not likely benefit outcomes. One mechanism through which insurers effectively delay necessary pain treatment is the requirement of preauthorization. Margolis and colleagues [70] have discussed the impact of the Medicaid requirement of preauthorization of pregabalin on pain patient well-being. A number of studies [71–73] have elucidated the process through which preauthorization requirements create a barrier for patients and their physicians, effectively reducing prescription of the target medicine. Margolis et al. [70] compared states with and without Medicaid pregabalin preauthorization policies, looking at patients with painful diabetic peripheral neuropathy and post-herpetic neuralgia. As expected, the authors found not only that patients in preauthorizationrequired states had a lower relative use of pregabalin, but also higher levels of utilization of opioid analgesics, nonsteroidal anti-inflammatories, nontricyclic antidepressants, and anxiolytics. Predictably, patients in states requiring preauthorization had significantly higher overall total direct pain treatment costs than those patients in states not requiring preauthorization. While the authors were able to measure direct treatment cost differences between the groups, they were unable to assess indirect costs associated with increased opioid utilization—e.g., treatment of iatrogenic complications such as opioid-induced hyperalgesia, endocrinopathy, and mood disorder, as well as treatment of adverse side effects. Most importantly, they were unable to quantify the exacerbated human sufferingthat was experienced as a result of the preauthorization policy. Similar to requiring preauthorization as a mechanism for delaying pain treatment is health insurance carriers’ practice of routinely interrupting treatment once it has been initiated. Even if prior authorization is obtained, third-party payers often preauthorize insufficient amounts of treatment, requiring providers to seek more sessions. Kulich and Adolph [74] note, “Well-organized programs that require coordination and continuity of care to achieve favorable outcomes may find it difficult to stop patient progress, file additional MCO (managed care organization) paperwork, await approval for five more physical therapy visits, the completion of four more psychology sessions, and approval for group therapy which was denied in the first place” (pp. 244–245). Through this practice, insurers effectively neutralize and even reverse any therapeutic momentum that these patients may have developed, thereby potentially adversely affecting patient hope and adherence to treatment. Another strategy commonly used by insurers to delay or terminate necessary pain treatment is ordering an independent medical examination (IME). Most likely to be utilized in situations in which pain sufferers have been traumatically injured, numerous authors [75–77] have questioned whether IME’s are particularly “independent.” Schofferman [78] has noted that although IME evaluators are expected to be held to the same scientific and ethical standards as other physicians, their primary obligation is not to the patient. Schofferman observes that the remuneration received for performing IMEs is far greater than the reimbursement for office-based patient care, and that IME physicians logically desire to be hired for more of such work. When IME physicians render opinions contrary to the best interests of the insurance companies that pay them, the likelihood that they will be rehired diminishes. Michael Baer, former Vice Chair of the American College of Forensic Examiners Institute, writes of IMEs, “I believe that even the fairest of us experiences unconscious pressure to report the results of these examinations in favor of our employer. The reason is undeniable: we want to be hired again” [79] (p. 33). Whether the bias demonstrated by IME providers is consciously or unconsciously motivated is difficult to ascertain, and probably immaterial. What is relevant is the suffering that the IME process can cause the patient [47]. Typically, one thinks of IMEs within the context of disability determination in cases of personal injury. However, third-party payers often order IMEs for the purpose of discontinuing treatment [80], with the bias inherent in the process potentially resulting in discontinuation of necessary pain care. Of IME, Benner [81] writes, “From the patient’s perspective, this examination will almost invariably be a degrading and demeaning experience” (p. 22), suggesting that it represents a no-win situation for the patient. As the IME causes unnecessary stress and anxiety for patients, Benner describes the process as being “. . . in opposition to standards of ethical medical practice” (p. 22). Paradoxically, many insurance carriers willingly cover expensive, high-technology approaches to pain management (e.g., intrathecal pumps, spinal cord stimulators) that have little evidence-basis while denying coverage for less expensive interventions whose evidence-bases are considerably stronger (e.g., physical therapy, cognitive behavior therapy) [29,35]. Interestingly, this embracement of technology-based approaches is an expensive endeavor, and in the long run, does not appear to be beneficial to the insurer or the patient. A 2006 study of the insurance industry’s response to pain found that nonpharmacologic treatments are less likely to be covered than are analgesics or interventional pain management approaches [49]. Curiously, the authors found that none of the insurance companies participating in the study systematically tracked, analyzed, or managed their data specific to pain management. In discussing the insurance industry’s refusal to pay for coordinated multidisciplinary care, Loeser [82] has posited that one of the reasons that this is the case is because proceduralists have done a better job lobbying funding agencies regarding the utility of their approaches—irrespective of their inferior evidence-basis as compared to interdisciplinary treatment. Again, it appears that special interests trump patient well-being. Variance among health insurers in their willingness to pay for prescription pain medication has existed for many years, with Health Maintenance Organizations (HMOs) cited as “restrictive” in this area of coverage [83]. Anecdotal reports and drug industry data [84], for example, note frequent denial of coverage for pregabalin for neuropathic pain, with coverage of the less expensive generic anti-convulsant gabapentin provided. In doing so, insurers ignore not only the evidence basis for pregabalin’s superior clinical efficacy [85,86], but also for its greater costeffectiveness [87,88]. Additionally, two studies of patients with post-herpetic neuralgia [85,89] have determined that initiation of therapy with gabapentin led to an increase in use of opioid analgesics, while initiation of pregabalin resulted in reduced opioid consumption. Another medication with established efficacy in the treatment of a number of types of pain [90–94] that is frequently subject to insurance coverage denial is duloxetine, although the denial rates are not quite as high as are those for pregablin [84]. In addition to its clinical efficacy, association with reduced opioid utilization, reduced health care costs, and relative cost-effectiveness have been empirically established in patients experiencing a variety of painful conditions [95–98]. Insurance companies often claim that medications such as pregabalin and duloxetine are not “medically necessary,” and will suggest alternative medications that are available in generic formulations. A frequently recommended class of alternative medications is tricyclic antidepressants, which indeed have empirically-established efficacy data supporting their use [99,100]. However, clinical efficacy in and by itself is insufficient, as the tolerability and safety profiles of tricyclics preclude their utilization in many instances [101,102]. In comparative studies and reviews, the frequency of adverse events associated with tricyclic use vs the use of pregabalin [103] and duloxetine [104] is significantly higher, although these data are apparently not of primary concern to third-party payers. As in other cases in which health insurers utilize service-limiting practices in pain medicine, their approach is shortsighted, even from a purely economic perspective. In these cases, third-party payers are not only doing a disservice to suffering patients, but appear to be counterintuitively negatively affecting their own bottom lines. On the other hand, insurers may look at this process very differently, as failure to cover expensive, evidence-based treatments may result in some chronic pain patients choosing not to reenroll—thereby resulting in potential future savings for the carrier. In addition to failing to pay for medications with empirical evidence-bases that can potentially ameliorate suffering among chronic pain patients, third-party payers have not been fully supportive regarding payment for urine drug testing (UDT), thereby putting both patients and physician practices at risk. Numerous studies have supported UDT as an effective means of protecting chronic pain patients from some of the adverse consequences potentially associated with opioid use [105–109]. This is of considerable importance, as the literature indicates that up to 75% of chronic pain patients who are prescribed opioid analgesics demonstrate inappropriate utilization/aberrant drugrelated behavior [110]. It would be unfair to suggest that some physicians and drug testing concerns have not abused third-party payers and patients in their billing practices associated with UDT. Manchikanti and colleagues [111] recently wrote, “In addition to becoming a routine test, UDT has been used, misused, and abused with financial incentives and influence of external forces including economic incentives” (p. E2). A thorough analysis of this emerging issue is beyond the scope of this article. Irrespective, it has been noted that appropriate monitoring of patients on opioids can serve to avoid escalation of health care costs [112], thereby ultimately assisting health insurers achieve their goals of cost-containment and profitability. Yet, in a recent editorial, the authors [113] list a lack of reimbursement for testing-related visits as a primary reason for the underutilization of UDT in clinical practice. A more subtle way in which the health insurance industry puts chronic pain patients at risk is through its failure to provide remuneration to physicians for time spent engaging in risk evaluation and mitigation strategies (REMS). In a recent white paper [114], the authors note this failure as a major barrier to enhancing patient safety. Although the authors suggest that insurers take measures to decrease the burden associated with REMS on health care providers and patients, they fail to explain how third-party payers will be convinced to do so. Given insurance carriers’ sense that they lack a fiduciary obligation to their enrollees, it is not surprising that patient safety is not a priority for them. Merskey and Teasell [115] have elucidated another potential way in which the insurance industry can have a deleterious effect on pain treatment, stating that “the view of pain may be diminished and minimized by members of the medical profession, sometimes directly because they have worked for insurance companies or provided opinions for insurance companies who seek such minimization of the suffering of their clients, our patients, and that such minimization of pain will extend not only to patients who have financial claims to make but inevitably to others who are being treated for pain by the same physicians” (p. 34). The authors indicate that much of the research and clinical practice guidelines published on chronic pain is done so by scientists beholden to insurers (either public or private), and accordingly are at risk for pro-insurance bias. It is also important to consider the ethical implications of the same physician both treating pain and rating disability for insurance purposes in the same patient. Sullivan and Loeser [116] examined this common practice and concluded that doing so is ethically suspect. Others [117] have expressed agreement regarding the potential pitfalls associated with both treating and rating pain and disability. A related way in which insurers cause harm to chronic pain sufferers is through manipulation of medical (and public) opinions regarding certain pain conditions. Despite a call for “evidence-based coverage policies” [118], it is apparent that in the field of pain medicine, the health insurance industry is far from implementing such an approach. An excellent example of this problem can be found in the health insurance industry’s position regarding fibromyalgia. Merskey [119] has noted that despite compelling evidence of the organic causation of fibromyalgia [120,121], insurers exert an impact on acceptance of the legitimacy, and therefore treatment, of fibromyalgia by hiring physicians to write articles questioning the validity of the disorder—irrespective of the evidence-basis. By choosing to essentially ignore the empirical evidence supporting treatments such as graded exercise, cognitive behavior therapy, and adjuvant pain medications, thirdparty payers “legitimize” their attitudes toward fibromyalgia based upon these sham “scholarly” works. As a result, insurance coverage for fibromyalgia treatment remains uneven [122], and would likely improve significantly if third party payers (as well as some physicians) abandoned the antiquated Cartesian model. Summary and Conclusions There is little doubt that the health insurance industry has developed numerous strategies for limiting the scope and the quality of care that chronic pain patients receive, with these strategies serving to perpetuate suffering in what is already a very vulnerable population. Whether the position of third-party payers represents intentional malfeasance as opposed to unintentional maleficence can certainly be debated. Irrespective, allowing an individual to remain in pain and to needlessly suffer when options for remedying or reducing these experiences has been described by Somerville as a “serious breach of fundamental human rights” [123] (p. 51). As clinicians, those who actually treat chronic pain are obligated to adhere to biomedical ethical principles such as no maleficence and beneficence [124]. It is quite evident that the health insurance industry does not recognize an obligation to help suffering patients, as the business ethic of cost-containment and profitability to which they choose to adhere has little room for aiding those in distress—particularly when they fail to recognize any fiduciary obligation to their enrollees. As the insurance community has clearly contributed to the commodification of the American health care system, it has contributed to the degree that chronic pain patients have become what Pellegrino [125] has referred to as “fungible.” Pellegrino writes, “The special needs of the chronically ill . . . are no longer valid claims to special attention. Rather, they are the occasion for higher premiums, more deductibles, or exclusion from enrollment” [125] (p. 253). This perceived attitude results in a lack of trust in the insurance industry among those suffering from chronic pain. Schatman [27] has noted that chronic pain patients have become considered little more than excessive users of health care commodities by third-party payers, thereby contributing to insurers’ lack of trust in this unfortunate population. As a result, a climate of mutual noncooperation has developed, with this climate serving to impede patient recovery and alleviation of suffering. Does the disconcordance of the professional ethic of pain care providers and the business ethic of the insurance industry doom chronic pain sufferers? As a “solution,” the crisis in pain care articulated by Giordano and Schatman [126–128], and Giordano, Schatman, and Hover [129] proposed the need for a model of rapprochement to reconcile the tensions and disparate attitudes of the stakeholders in pain medicine. Published shortly following the election of President Obama, their analyses emphasize the risk for continued inadequate pain treatment in the face of failure to balance multiple needs and agendas in a pluralistic health care system. In response to the new, “hopeful” political climate experienced by many following President Obama’s election, the authors offered direct strategies for reduction of the dissonance that had been plaguing the pain care system, with each of these strategies requiring at least a degree of compromise among all of the stakeholders. Like the political environment, however, the health care environment has only become more contentious over the past 2 years, with the health insurance industry certainly playing its part in fostering this contention. For example, rather than considering measures to provide a higher level of service to enrollees, insurers have continued to increase premiums and decrease benefits, thereby increasing their profitability [130]. Additionally, there is no evidence suggesting that the insurance industry has made a greater effort to rely upon the evidence-basis in pain medicine for which Giordano and colleagues [129] called. The authors offered, “Although the various stakeholders in chronic pain care have a history of inchoate group dynamics, it is not unreasonable to believe that a common ground can be reached through a process of education, exchange, and compromise” (p. E270). Apparently, such an ambitious effort is unreasonable as long as cost-containment and profitability remain the aims of health insurers. Thus, until the United States moves to the type of single-payer, not-for-profit health care system enjoyed by the vast majority of the industrialized world (i.e., an ethical system), the insurance industry’s motivations will ensure that chronic pain patients continue to needlessly suffer.

##### Ultimately Deutch 9 concludes

**Deutsch 9 -** President of the Science for Peace, Member of Canadian psychoanalytic society (Judith, Pestilence, Famine, War, Neoliberalism, and Premature Deaths, Jul-Sep 2009, http://peacemagazine.org/archive/v25n3p18.htm)

The outlook for this century is dim. Climate change and nuclear weapons pose ever-worsening threats, and the living conditions on our "planet of slums" continue to deteriorate. Although a great deal is known about preventing premature deaths, there is a profound paralysis in applying this knowledge in an effective way. Worse still, many commentators suggest that there is a powerful worldwide elite who accrue wealth by increasing greenhouse gas emissions, by investing in nuclear weapons and militarism, and who are systematically depriving the majority world and nature of the right to life. There is a narrow time scale for reversing these trends in that scientists on the Intergovernmental Panel on Climate Change now predict a possible 90% extinction rate by the end of this century unless our way of life changes drastically. A significant fact about the Nazi Holocaust was the belief that "it can't happen here." People were in a state of denial about the readily apparent ominous danger. A number of fine films convey this delusion of safety in various societies. The Garden of the Finzi-Continis (Vittorio De Sica), and Burnt by the Sun (Nikita Mikhalkov) paint pictures of the exquisite, subtle beauty of life, while the characters are oblivious to their destiny in concentration camps and the Soviet gulag. There are exact parallels now: the perils to existence are barely mentioned in the media. Also, distortions and outright lies minimize the magnitude of the problems. FOUR THREATS TO HUMAN EXISTENCE At present, threats to human existence come from at least four directions: climate change with its consequences of catastrophic climate events and of drastic water and food shortages; from nuclear war; from pandemics; from the severe impoverishment and destruction of society that is a result of neo-liberal restructuring. All are due to human error. All are preventable. But the time factor is most crucial around climate change. The lack of attention to the time scale is tantamount to believing that "it can't happen here." Currently, most attempts to counter these dangers address the issues in isolation even though the main perpetrators implement a unified, relatively coherent programme that unites these threats. Neo-liberal plutocrats are the controlling shareholders of the large agri-business, weapons, water privatization, pharmaceutical ([or] anti national health care), mining, non-renewable energy companies. It is their economic practices that decimate water resources, deplete soil, pollute air, and increase greenhouse gas emissions. The culpable individuals, their think tanks, the supportive government bureaucracies, and the specific methods of control are well-documented in a number of recent works.1 From recent history it is readily apparent that mass extinction "can happen here." A similar confluence of climate events and exploitive socio-economic re-structuring occurred in the late-Victorian period. Retrospective statistical studies established that worldwide droughts between 1876 and 1902 were caused by El Nino weather events. Based on the British Empire's laissez-faire approach to famine that enjoined against state "interference" in the for-profit trade in wheat, between 13 million and 29 million people died in India alone. True to the precepts of liberalism, the British converted small subsistence farms in India into large scale monocrop farming for export on a world market. The new globally integrated grain trade meant that disturbances in distant parts of the world affected Indian farmers. Advances in technology actually made things worse, for steam-driven trains were used to transport grains to England while locals starved, and telegraph communication was used to process international monetary transactions that destroyed local communities. Gone were the traditional social institutions for managing food shortages and hardship. The Victorian world view also bequeathed us the myth of the inferior Third World and denial of British responsibility for the de-development of tropical countries. Mike Davis points out the compelling evidence that South Indian laborers had higher earnings than their British counterparts in the 18th century and lived lives of greater financial security, including better diets and lower unemployment. "If the history of British rule in India were to be condensed into a single fact, it is this: there was no increase in India's per capita income from 1757 to 1947. Indeed, in the last half of the nineteenth century [due to colonial structural adjustment], income probably declined by more than 50% There was no economic development at all in the usual sense of the term."( Davis, p. 311). In today's world, neo-liberalism continues to increase global misery and poverty and the dehumanization and invisibility of millions of "warehoused" people. Whatever conditions increase poverty also increase premature deaths. In the US, a 1% rise in unemployment increases the mortality rate by 2%, homicides and imprisonments by 6%, and infant mortality by 5%. The 225 richest individuals worldwide have a combined wealth of over $1 trillion, equal to the annual income of the poorest 47% of the world's population, or 2.5 billion people. By comparison, it is estimated that the additional cost of achieving and maintaining universal access to basic education for all, reproductive health care for all women, adequate food for all and safe water and sanitation for all is roughly $40 billion a year. This is less than 4% of the combined wealth of these 225 richest people.2 NEO-LIBERALISM Neo-liberal policies have mandated the destruction of the social safety net that would be the lifesaver in climate disaster, epidemics, and war. The International Monetary Fund has required countless countries to dismantle public education, health, water, and sanitation infrastructure. Neo-liberalism strenuously opposes government intervention on behalf of the common good while hypocritically and deceptively protecting narrow class interests and investments in the military, non-renewable energy, privatized health care. The powerful and wealthy few control the military-industrial complex, surveillance, and the media. The connections with climate change are manifold. Already there is military preparedness for the potential impacts on peace and security posed by climate change -- not to help victims but to keep refugees out. Ominously, there are now overt racist overtones to the discussion of "environmental refugees" and the closing of borders. The model of response to disasters is most likely Hurricane Katrina, namely, protection of the wealthy and outright cruelty to the poor. Wars are tremendously costly to the public but highly profitable to powerful elites. "The arms trade has expanded by more than 20% worldwide in the past five years" (The Guardian Weekly 01.05.09, p. 11). The military itself emits enormous amounts of greenhouse gases and brutally protects the extractive industries of the wealthy. There are innumerable unreported incidents: In May 2009, alone, the Nigerian army razed villages in the oil-rich Niger delta to protect oil companies, killing many civilians; in Papua New Guinea, 200 heavily armed soldiers and police were sent to the Barrick Gold Porgera area to destroy indigenous villages. In the 20th century, it is estimated that as many as 360 million people died prematurely due to state terrorism--"terrorism from above." BESIDES PROLIFERATION The use of nuclear weapons in wars would appear to be increasingly acceptable. "We have created a situation in the world where we have a very small number of people in control of nuclear arsenals - people whose competence is not necessarily proven, whose rationality is not necessarily at a high level, and whose ethical standards may or may not be acceptable. These people are in charge of making decisions about the use of weapons that could destroy civilization and most life on earth" (p. 245). In their recent collection of papers on nuclear weapons, Falk and Krieger further suggest that the grand military strategy is "largely to project power in order to reap the benefits of profitability for the few. To take control of resources, and to place our military bases strategically around the world in order to have greater degrees of control, sounds like a strategy to benefit corporate interests." They state that the power elite has cleverly manipulated the public by focusing almost exclusive attention on the issue of proliferation, "with corresponding inattention to possession, continuing weapons development, and thinly disguised reliance on threatened use." For real change to occur, it will be necessary to penetrate the "deepest bowels of the governmental bureaucracy," the silent and unknown people who support the nuclear weapon option. We must be realistic about the forces obstructing reduction of greenhouse gases, all forms of militarism, and economic inequity. Conventions and international law all too often provide a smokescreen that delays real change. For example, the United States simply changed the description of its captured detainees in Iraq and Afghanistan to avoid meeting the requirements of statutes on terror. Similarly, Israel invented a new term for Gaza, a "statal entity," to avoid the term "occupation" with its specific legal obligations.

# 1AC Flay [F]

A&M *affirms.* Resolved: The United States federal government should enact the Medicare-For-All Act of 2019.

## Our Sole Argument concerns the Regulatory Wreck

Our current healthcare system is broken. **Holpuch from The Guardian 20** explains that “In the wealthiest country in the world, the Covid-19 pandemic has exposed the core of a healthcare system that is structurally incapable of dealing with the pandemic. [The current system] has for decades prioritized cost over care”

This has hurt Americans in 4 ways

### First is the opioid crisis

#### Right now, Harvard School of Public Health notes that “Opioid manufactures pay doctors huge sums of money [to advertise their product]. The more opioids a doctor prescribes the more money [they] get paid.”

Thankfully, **Roamer 19 notes that** “Medicare for All Section 301 [prohibits] financially-incentivized relations between parties” which basically means that drug companies can’t pay doctors to promote their opioids.

With pharma companies' ability to use doctors as an instrument for pumping out millions of opioids gone, the crisis soon dissolves. This is important because. **NIDA 20** finds every year, “[47 thousand people] died in opioid involved deaths”

### The Second is by exploiting the poor

Right now, **Galvin of the US News and World Report 19** reports that “87 million people, were either underinsured or had no [health insurance] coverage last year”

Thankfully Medicare for All reverses this trend as the **New York Times 20** explains that under the proposal “everyone in the United States would get health insurance [and] premiums, deductibles and copayments would be eliminated”

#### The lack of health insurance has also barred increased access to Technology. O’shea 17 notes “many devices for healthcare are out of the financial reach of average patients [and hospitals] without the help of insurance companies.”

Overall the direct effect, as noted by **Cecere of Harvard** who notes that **“**lack of health insurance causes 44 [thousand] excess deaths annually [because]**,** the uninsured are more likely to go without needed care”

### The Third is by ending medical bankruptcies

**Kalensky from The Hill 17** explains that “the United States is the only country where 650,000 people claim bankruptcy annually due to medical bills. Even those with private health insurance choose not to use it due to high out of pocket costs.”

It’s become so bad that **Kalensky** furthers that “without insurance, patients beg to avoid treatment, knowing that this treatment would bankrupt the family they leave behind.”

**Public Citizen 19 furthers** that “Medicare for All would end medical bankruptcy [because] Americans would no longer have to go into debt to receive treatment. They would [always] remain covered [which reduces] the risk for catastrophic out of pocket healthcare costs”

Thus, by eliminating out of pocket costs, **Bruenig 19** concludes that “Medicare for All would reduce poverty by 20 percent” or by 8 million people

By decreasing the amount spent on social safety net, **Weinstein 18** explains that “Medicare for All could reduce total health care spending in the U.S. by $[3] trillion”

### The fourth way business have hurt Americans is by halting research

Our Medical Sector is in dire need of an upgrade as **Dr. Light from Stanford 09** finds that “in the last 40 years, 89 percent of drugs were [essentially] clones of existing drugs” and provided no clinical benefit.

This is because pharma companies can make more profits in the current system by delaying a cure.

For example, **Butler 20** explains that big pharma companies like “Gilead [have] made enormous sums of money by delaying development of its own HIV medication” breakthrough.

Thankfully, **Section 616 of the Medicare for All Act** notes that “prices paid for covered pharmaceuticals [will take] into account the comparative clinical effectiveness and the number of similarly effective drugs”.

This process is known as value-based pricing

#### Stiglitz 8 furthers that “linking the price that regulators are willing to pay to a metric of [effectiveness] will reduce incentives to provide “me-too” products”

Indeed, **Kost 19** looking at 171 different drugs in the German Single Payer finds that “manufacturers were 10 times more likely to withdraw products that lacked any evidence of added benefit”

Quality innovation is critical as **Addy 16** notes that “the discovery, development, and delivery of new innovations could prevent up to 10 million deaths each year”

Thus, we affirm.

## Frontlines

### F2: Link 1

AI Responses to all of this,

**O’sean 17 –** we inc IoT bc ppl who are insured can afford to use it, they take care of literally everything.

* Telehealth, AI doctors

#### F2: Doctor Shortage

#### F2: Hospital Closures

# Frontlines

## F2: Shifts to heroin

1. We solve root cause which means we solve for LT
2. Heroin use is rare in prescription drug users. **NIDA 18** finds that less than 4 percent of people who had abused prescription opioids started using heroin within 5 years
3. T- **Petus 19** explains that Single payer actually solves for existing opiod abuse through also increasing access to treatment of substance abuse drugs and destigmatizing it. Thus, they conclude that single payer governments are best immunized against an opiod pandemic

## F2: Wait Times

#### Turn - Actual US evidence disproves. Waldrop 19 points to a study of Massachusetts’ mandate health reform legislation, where, while coverage significantly increased, researchers found no evidence of increased hospitalizations. More recent analysis has even found wait times have actually improved in the state for both privately insured and Medicaid patients as supply rises to meet the demand.

#### DL - Carevoyance 19: Looking at industrialized nations, the us is third to last in the percentage that can quickly see a doctor. Waldrop 19 corroborates: looking at a series of metrics for wait times, the US performs worse than several nations w universal coverage. This means a) a comparison w Canada isn’t that helpful bc other single-payer systems don’t have the same problem so they can’t even prove correlation let alone causation and b) the us isn’t doing well right now so uniqueness is on our side

## F2: Doctor Shortage

#### turn - First, Grisat 17 explains that the M4A bill has special decrees for scholarships and loan-repayment programs, making it so that we can increase domestic production of doctors and lower demand for foreign doctors.

#### Turn - Second, Tsega 17 explains that because the current system treats healthcare as a commodity, physicians are slammed with hours of bureaucratic paperwork, causing physician burnout which contributes to the domestic shortage. They continue that M4A is uniquely positioned to address this because revenue does not become the most important factor, so physicians focus on preventative care while the government takes care of bureaucracy.

## F2: Taxes

1. **Friedman 18** finds that a single payer system would actually see 95 percent of the population saving money while still getting better healthcare. Most will save thousands of dollars a year, compared to what they and their employer currently spend on health insurance premiums and out-of-pocket costs. Prefer this evidence over theirs
	1. Its probably not biased. Friedman is a professor of economics at Massachusetts and doesn’t have a financial incentive to report otherwise

Petus

https://blogs.lse.ac.uk/usappblog/2019/09/23/how-a-single-payer-system-can-help-solve-the-us-opioid-crisis/

Countries and sub-units of governments that have succeeded in balancing the imperatives of supply and control of medications containing opioids provide best practice models that exemplify political commitment, often generated and supported by the dedicated advocacy of non-governmental organisations of providers and patients, to ensure adequate access to opioids for medical purposes while preventing diversion and non-medical use. **Public health systems** such as Colombia’s, which provide basic coverage for the whole spectrum of services, **and in which the government acts as single payer for medicines, are the most strongly immunized against an opioid epidemic**. Of course, this does not describe the US model, which combines public and private services and multiple payers. In sum, the necessary and sufficient conditions for governments to achieve both Targets 3.5 and 3.8 are that they act as a **single payer for medical opioids and commit publicly to adequate availability of generic (stigmatised) internationally controlled essential medicines for palliative care and treatment of substance use disorde**r. It’s a ‘both/and’ not an ‘either/or’ prescription. The risk of diversion to the illicit market is minimised, since government procurement agencies will avoid purchasing the profitable “designer drugs” peddled by both pharmaceutical companies and traffickers. Governments that procure generic oral morphine and methadone in bulk as the staple medicines of choice in the public health system can use stigma to their advantage, getting a bargain on efficacious and essential controlled substances that are unattractive to the black and gray markets.

NIDA 18

National Institute on Drug Abuse. “Heroin Use Is Rare in Prescription Drug Users | National Institute on Drug Abuse.” National Institute on Drug Abuse, 9 June 2020, www.drugabuse.gov/publications/research-reports/prescription-opioids-heroin/heroin-use-rare-in-prescription-drug-users. Accessed 29 Sept. 2020.

While prescription opioid abuse is a growing risk factor for starting heroin use, **only a small fraction of people who abuse pain relievers switch to heroin use**. According to general population data from the National Survey on Drug Use and Health, **less than 4 percent of people who had abused prescription opioids started using heroin within 5 years**(Muhuri et al., 2013). This suggests that prescription opioid abuse is just one factor in the pathway to heroin.  Furthermore, analyses suggest that those who transition to heroin use tend to be frequent users of multiple substances (polydrug users)(Jones, et al., 2015). Additional analyses are needed to better characterize the population that abuses prescription opioids who transition to heroin use, including demographic criteria, what other drugs they use, and whether or not they are injection drug users.

## References:

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Friedman 18

https://wholewashington.org/wp-content/uploads/2018/08/Economic\_Analysis\_of\_Single\_Payer\_Health\_Care\_in\_\_Washington\_State\_\_180220\_1.pdf

More than **95% of the population** of Washington **will save money even while enjoying better access to health care under the single-payer program.** Savings come from two sources: the efficiency gains from the single-payer program and from shifting the basis of funding – from fixed premiums per covered individual and cost-sharing -- to a system where charges are related to ability to pay (see Figure 16**). Most will save thousands of dollars a year, compared to what they and their employer currently spend on health insurance premiums and out-of-pocket cost**s. The largest savings will go to working families and to middle-income households, especially those with children, because the burden of family health insurance coverage and cost sharing is particularly heavy on them. Businesses will also benefit, with the greatest savings going to 83 those that have been paying the highest health insurance premiums. These include small and mid-sized private establishments that offer health insurance at relatively high cost. Taxpayers will also benefit because local governments and the state will save money from reduced health insurance premiums for public employees. Family members will, of course, receive coverage, 84 like all Washingtonians. However, the cost will be spread across all payroll and non-payroll income, and not concentrated on certain employers.

Tsega 17

“Single-Payer Health Care: The Solution to Physician Burnout No One Is Talking about - Right Care Alliance.” Right Care Alliance, 14 Aug. 2017, rightcarealliance.org/article/2264/. Accessed 29 Sept. 2020.

We should be fighting for **a single payer health system as a means of addressing physician burnout**. **Physicians cite “bureaucratic tasks” as the primary reason for burnout**. For every hour of clinical work, primary care physicians complete two hours of administrative work. One of the hallmarks of **single payer is the reduction of administrative costs that translate into a reduction in physicians’ administrative work. Physicians could spend a little more time with patients**, discussing anything from end-of-life decisions, smoking cessation, to a grandson’s piano recital. **Single payer’s emphasis on primary care, preventive medicine, and mental health makes it well-equipped at addressing burnout in specialties with the highest rate of burnout, including emergency medicine and primary care**. In a single payer system, monetary resources and manpower are directed towards patient health instead of revenue production, and primary and preventive care are valued over expensive low-value interventions. **If patients no longer think of insurance as catastrophic coverage because of prohibitive costs, perhaps they’ll foster a relationship with a general practitioner earlier**. Visits would focus on wellness rather than illness. Clinicians could spend more time seeing fewer patients in a day, no longer worried about needing to meet a revenue quota, relieving clinicians of another key motivator for burnout. This could result in discovering and treating hypertension a few years before a patient presents with a stroke, diagnosing and treating depression earlier, or allowing a patient to feel more comfortable going to her PCP, rather than presenting to an emergency room for non-urgent issues. A healthier population (even marginally so) could reduce the strains on emergency rooms, unburdening those burned out physicians.

Grisat 17 [cites the bernie bill]

<https://medicare4all.org/wp-content/uploads/MedicareForAll-Report-TSI-NNU.pdf> LD

A recent survey found that average annual full-time physician compensation was $294,000 with specialist compensation 46% higher than primary care physicians at $316,000 and $217,000, respectively.65 Orthopedic surgeons, at the top of recent compensation surveys, make more than twice as much as family medicine physicians, who are at or near the bottom.66 A **Medicare-for-all program could address these needs, for example, by increasing the number of primary care residencies, scholarships, and loan-repayment programs**; targeting education of primary care physicians through dedicated Graduate Medical Education funding; and increasing the reimbursement of primary care physicians.67 Although none of these ideas is new, a Medicare-for-all program www.TheSandersInstitute.org www.NationalNursesUnited.org 8 would reorient our healthcare system to put primary care at the center with a focus on preventive care and early intervention and treatment.

carevoyance 19

<https://www.carevoyance.com/blog/healthcare-wait-times-by-country>

Data takes some time to analyze, but according to the [2016 KFF analysis of Commonwealth Fund International Health Policy Survey of Eleven Countries](http://tools.commonwealthfund.org/interactives-and-data/international-survey-data/results?ind=837&ch=651#/barchart/651/53,54,55,56,58,59,60,62,63,61,1/0/Ascending), the United States came in third to last for the percentage of adults who were able to make a same-day or next day appointment when care was needed. Only [fifty-one percent](https://www.healthsystemtracker.org/chart-collection/quality-u-s-healthcare-system-compare-countries/#item-percent-of-adults-who-made-a-same-day-or-next-day-appointment-when-needed-care-2016_updated) of Americans were successful in their same-day or next day appointment booking while the average of all of the eleven countries combined was fifty-seven percent.

Waldrop, Thomas “Center for American Progress.” Center for American Progress, Center for American Progress, Oct. 2019, www.americanprogress.org/issues/healthcare/reports/2019/10/18/475908/truth-wait-times-universal-coverage-systems/. Accessed 29 Sept. 2020. LD

President Trump is not the only person to make such claims. Health care industry actors and conservative groups have begun ramping up opposition to coverage expansion proposals. One such anti-Medicare for All ad, by conservative advocacy group One Nation, similarly argues that expanding coverage would dramatically increase wait times.However, **the data—both from other nations with universal coverage and from historic expansions of coverage within the United States—show that** this is not the case. **Patients in peer nations generally have similar or shorter wait times than patients in the United States for a variety of services, refuting the argument that universal coverage would necessarily result in longer wait times in the future**. This issue brief provides an overview of the factors that affect wait times, outlines evidence that suggests universal coverage need not increase wait times in the long run, and discusses policy solutions to mitigate any impact on wait times in the short run.

Waldrop, Thomas “Center for American Progress.” Center for American Progress, Center for American Progress, Oct. 2019, www.americanprogress.org/issues/healthcare/reports/2019/10/18/475908/truth-wait-times-universal-coverage-systems/. Accessed 29 Sept. 2020. LD

Expansions of coverage in the United States, while not resulting in universal coverage, show that **passing any of the universal coverage proposals currently being discussed in Congress would not significantly increase wait times**. For example, in 2006, **Massachusetts passed significant health reform legislation**—similar to the Affordable Care Act—that expanded Medicaid eligibility and encouraged health insurance enrollment through an individual mandate.[18](https://www.americanprogress.org/issues/healthcare/reports/2019/10/18/475908/truth-wait-times-universal-coverage-systems/#fn-475908-18) The law was extremely effective at its goals: Massachusetts continues to have the lowest uninsured rate in the country, currently estimated at 2.8 percent.[19](https://www.americanprogress.org/issues/healthcare/reports/2019/10/18/475908/truth-wait-times-universal-coverage-systems/#fn-475908-19) While wait times did increase in the short term following the implementation of the Massachusetts law, **researchers have found no evidence that this increase had any negative impact on preventable hospitalizations**.[20](https://www.americanprogress.org/issues/healthcare/reports/2019/10/18/475908/truth-wait-times-universal-coverage-systems/#fn-475908-20) Other, more recent research has examined primary care appointment wait times in 2012 and 2016, finding that while most states saw decreases in wait times of less than a week and increases in those of more than 30 days, Massachusetts saw the opposite.[21](https://www.americanprogress.org/issues/healthcare/reports/2019/10/18/475908/truth-wait-times-universal-coverage-systems/#fn-475908-21) **For both privately insured patients and Medicaid beneficiaries in the state, wait times improved during this period.**[22](https://www.americanprogress.org/issues/healthcare/reports/2019/10/18/475908/truth-wait-times-universal-coverage-systems/#fn-475908-22) This suggests that the impact of health coverage expansions diminishes over time **as provider supply rises to meet the new demand**. Policymakers can therefore be reassured that patients will not have worse health outcomes as a result of expanded coverage and that policies can be included in any expansion to help mitigate the effect in the short term and accelerate provider supply increases.