1. Link:

Governmental universalization of health care leads to biopolitical logic and further to biopower.

Elbe- 2004, “AIDS, Security, Biopolitics.

One of these dangers is that the biopolitical imperative of optimizing the health of populations effectively constitutes disease – and by extension the diseased – as a social and political problem that needs to be addressed, but without specifying exactly how this problem should be dealt with. Unfortunately **the creation of universal healthcare programmes to treat the ill is** just **as compatible with** a **biopolitical logic as is the purging of populations of the diseased by more sinister means, such as killing them or letting them gradually die.** As counterintuitive and ironic as it may seem, **a biopolitical society based on the enhancement of ‘life’ and ‘health’ can still sanction and justify instances of mass death.** **The** European era of biopower, after all, coincided with twentieth-century political projects demanding the deaths of millions. Foucault later came to understand this bizarre confluence only on the basis of a new racism that biopolitical orders can give rise to. 36 **‘Racism’,** he contended from a biopolitical perspective, **‘is primarily a way of introducing a break into the domain of life that is under power’s control: the break between what must live and what must die.’** 37 The reason biopolitical **orders can still sanction mass death is because they can generate a powerful new form of racism that pits the ‘healthy’ members of the population against the ‘unhealthy’ who are deemed to sap the strength and vitality of the population as a whole. The** underlying **principle of this new biopolitical racism is thus not the primacy of cultural difference**, as with many more traditional forms of racism, but **rather the more subtle idea ‘that the death of others makes one biologically stronger insofar as one is a member of a race or a population’**. 38 The insistence on **maximizing the health of populations can** thus **be dangerous for those who are deemed to be unhealthy.**

1. Impact:

Biopower ends in genocidal practices.

Rabinow and Rose- 2006, “Biopower Today”.

Giorgio Agamben, in a series of haunting books, identifies **the Holocaust as the ultimate exemplar of biopower,** and biopower as the hidden meaning of all forms of power from the ancient world to the present. In particular he explores the moments that he terms, after Carl Schmitt, ‘states of exception’, when a sovereign state declares a time or a place where the rule of law can be suspended in the name of self-defence or national security (Agamben, 1995, 1996, 1998, 2000a, 2000b, 2005). There is much to be learned from these studies of the profound traumas that mark European histories: we agree that Holocaust is not anexceptional moment of throwback to a singular barbarianism, but an enduring possibility intrinsic to the very project of civilization and the law. However, Agamben grounds his analysis in a particular way that we find problematic. **He argues that all power rests ultimately on the ability of one to take the life of another—it is a power over life grounded in the possibility of enforcing death.** He characterizes this power by reference to the obscure metaphor of homo sacer—the enigmatic figure in Roman law whose crimes made his sacrifice impossible but who could be killed with impunity. Like this figure, who is reduced from bios— crudely, the way of life proper to an individual or group in a polity—to zo¨ e—‘bare life’**— he suggests that the birth of biopower in modernity marks the point at which the biological life of subjects enters politics and belongs entirely to the State.** **The ultimate grasp of the Sovereign or the State over the lives of subjects is exemplified, for him, in the concentration camps, labour camps and death camps of the Nazis: sovereign States depend on their capacity to create states of exception**. **Such states may be exceptional, but are nonetheless immanent in modernity itself a fourth space added to that of state, nation and land, in which inhabitants are stripped of everything but their bare life, which is placed without recourse in the hands of power.** Indeed they are the ‘nomos’ of modernity: ‘This is why the camp is the very paradigm of political space at the point at which politics becomes biopolitics and homo sacer is virtually confused with the citizen’ (Agamben, 1998: 171). Agamben takes seriously Adorno’s challenge—how is it possible to think after Auschwitz (Mesnard and Kahan, 2001)? But, for that very reason, it is to trivialize Auschwitz to see it as the hidden possibility in every instance where living beings enter the scope of regulation, control and government. **The power to command under threat of death is exercised by States** and their surrogates **in multiple instances, in micro forms and in geopolitical relations. But this does not demonstrate that this form of power—commands backed up by the ultimate threat of death—is the guarantee or underpinning principle of all forms of biopower in contemporary liberal societies. Nor is it useful to use this single diagram to analyse every contemporary instance of thanatopolitics—from Rwanda to the epidemic of Aids deaths across Africa**. Surely the essence of critical thought must be its capacity to make distinctions that can facilitate judgment and action

C. Turns Case. The AC’s efforts to protect the citizens are undermined by the power the state is assuming. This power triggers the impact.

Furthermore, the negative impacts of genocide outweigh the benefits of the AC.

1. Alt Text: Reject the AC’s embrace of biopower by not allowing health care to be universalized by the government. Allow other private agencies to universalize health care.

First, the government’s power is more influential on individuals than other agents’ power.

Lemke- (unknown year), “Foucault, Governmentality, and Critique”.

The lectures of 1978 and 1979 focus on the "genealogy of the modern state" (Lect. April 5, 1978/1982b, p. 43). **Foucault** coins the concept of "governmentality" as a "guideline" for the analysis he **offers by way of historical reconstructions embracing period starting from Ancient Greece through to modern neo-liberalism** (Foucault 1997b, p. 67). The semantic linking of governing ("gouverner") and modes of thought ("mentalité") indicates that it is not possible to study the technologies of power without an analysis of the political rationality underpinning them. But there is a second aspect of equal importance. Foucault uses the notion of government in a comprehensive sense geared strongly to the older meaning of the term and adumbrating the close link between forms of power and processes of subjectification. While the word government today possesses solely a political meaning**, Foucault is able to show that** up until well into the 18th century the problem of government was placed in a more general context. **Government was a term discussed not only in political tracts, but also in philosophical, religious, medical and pedagogic texts.** In addition to the management by the state or the administration, **"government" also signified problems of self-control, guidance for the family and for children, management of the household, directing the soul, etc.** For this reason, **Foucault defines government as conduct, or, more precisely, as "the conduct of conduct" and thus as a term which ranges from "governing the self" to "governing others".** All in all, in his history of governmentality **Foucault endeavors to show how the modern sovereign state and the modern autonomous individual co-determine each other**'semergence

Foreign systems prove that even public health care systems end up relying on the private sector to provide full coverage. The necessity is universalizing health care privately.

Beuhler – 2007, “**Private Sector Healthcare Can Also Be 'Universal'”. The American.**

Presidential hopefuls have begun to put forward proposals that would bring **about universal health coverage in America**. **Foreign systems** which seem to offer high qualitycare at relatively low cost are frequently held up as models to adapt and adopt. These systems **are attractive because a larger proportion of these populations have access to “basic” health care. In** many of **these cases, access to** so-called **“extended” care—things like dental and vision care—is only starting to open up through co-operation with the private sector.**

Canada’s single payer health care system, for example, does not fund dental care, and funding for vision care (determined by the provinces) often excludes the standard vision test. As a result these services are often obtained through employer-based private plans and upon leaving employment, many retirees experience difficulty paying for their extended care needs. Britain’s National Health Service (NHS) claims to fund dental care, but many Britons have an incredibly difficult time obtaining it. In July 2005 the UK Public Accounts Committee [reported](http://www.publications.parliament.uk/pa/cm200405/cmselect/cmpubacc/167/16702.htm" \t "_blank) significant regional variation in the quality of dental healthcare and found that children in some parts of Britain had twice the level of dental decay as elsewhere in Europe, and two million Britons did not have access to a public dentist.

The current vogue for venerating single-payer health care systems is reckless.

On the other hand, the vision care sector of England’s NHS has been deregulated and has partnered with the private opticians. The sight-test fee patients pay to the NHS has been subsidized through the sale of eyeglasses and is now well below the cost of providing the test (The [sight test fee](http://www.reform.co.uk/filestore/pdf/070227%20Final%20draft%20-%20UK%20growth%20and%20opportunity%20the%20need%20for%20a%20fundamental%20reassessment.pdf" \t "_blank) is at £18.39 and the cost of providing the fee is £37). The fee is an entitlement which customers can use at any practice (and is not restricted to a particular provider) so opticians must compete to attract customers. Money follows the patient and prices have deflated while access to care has increased. This opportunity has fostered significant growth in firms such as SpecSavers, a joint-venture partnership with opticians and other retailers whose profits have nearly [tripled](http://www.specsavers.co.uk/specsavers_2005/images/news/annualreport2006.pdf" \t "_blank) over the past ten years (from £310 million in 1996 to £880 million in 2006).

Democratic hopeful Chris Dodd recently proposed a “Universal HealthMart”, a system of comprehensive plans that would entitle every American to the same benefits and types of plans as Members of Congress. In John Edwards’ March 2007 proposal, he similarly argued that businesses have a responsibility to provide their employees with a “comprehensive health plan”. Mr. Edwards even stated that “over time, the system may evolve toward a single-payer approach”. **These proposals incorrectly think that foreign programs for universal care are “comprehensive.”** In fact **many cannot afford to provide dental and vision care, or claim that these services are covered but then have severe difficulty providing them. Mimic their approach in America, and we will see the same results.**

**The** current **vogue for venerating single-payer health care systems is reckless**. If **the federal government were to force everyone into a public system with comparable per-patient spending to today’s private sector, funding demands would be enormous and quality would have to decline.** Fairness would be compromised as patients accustomed to consumer-driven health services would attempt to navigate around “gatekeeper” referral structures and waiting lists, both of which are meant to keep costs down. An American single payer system would not be able to meet expectations for private-style benefits and its existence would reduce employers’ incentive to offer private health care options for their employees. Health care quality for all would be depressed. More people might gain access to preventive care and America’s performance on international health rankings could improve, but right now a majority of Americans enjoy private health insurance that pays for care superior to the public care assigned by the foreign universal access systems. Nationals of these countries make this fact clear when they opt to be treated in America, often entirely at their own expense.

At this time last year the UK House of Commons Health Select Committee [reported](http://www.publications.parliament.uk/pa/cm200506/cmselect/cmhealth/815/815-i.pdf" \t "_blank): “In the future, the NHS may not be able to pay for every possible medical treatment in a country with an ageing population, demographic pressures, rising public expectations and increased possibilities of medical treatment and long-term therapies. Some treatments or procedures may have to be charged for [that is, in addition to tax financing].... The Government should consider this possibility sooner rather than later to ensure that a set of consistent criteria apply to those areas for which a fee is charged, to avoid the development of charges in an ad hoc way, as has been the case until now.” Proponents of centrally planned systems of healthcare argue that “ad hoc” action won’t occur in a centralized system. However a program which encompasses five times as many individuals as does the NHS will be even more unwieldy.

A few universal health care systems do manage to provide high-quality, comprehensive benefits, but these systems are not single payer. They have competing insurance funds and they are more expensive to operate compared to their single payer counterparts, but the results are better. It was recently reported that the survival rates for stomach cancer are twice as poor as in the UK as in Germany.

**In Germany**, 90 percent of the population is insured publicly, **but a 10 percent privately insured “fringe” does exist**. The public system is not, as in Britain, financed through general tax revenues, but by a payroll tax. However, those who make more than the contribution limit for the payroll tax can opt out of the public system and contract with a private company. German government workers can opt out of the public system without reaching the contribution limit; they make up approximately half of the 10 percent “fringe.” **This privately insured proportion is highly competitive; private insurance finances the introduction of new technology** and after a few years the publicly insured demand similar benefits**.** As a result of this pressure, the German system is more expensive than the British system, but it is also highly regarded because Germans do not wait nearly as long for treatment and employ a higher usage of technology.

In Canada private provision of health care is much less widespread compared to the 10 percent level attained by Germany and the UK. When spokesmen for the Canadian public system discuss the use private contractors they use terms like “independent providers**.” It seems like in the USA, one needs to talk about [private] “universal” health care as opposed to public. Yet proposals that call for a single-payer government-led system will be public. Single payer health care systems struggle to compete with the health care paid for by private insurance. They have had to cooperate with the private sector**in order to begin to compete with the dental and vision care paid for by private insurance. It is wrong to assume that the implementation of a similar system in America will produce a different result.