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### Adv

#### The right to strike for health care workers is blocked by NLRA Section 8g, which requires 10 days’ notice for strikes, making strikes a conditional right

NLRB [The National Labor Relations Board (NLRB) is comprised of a team of professionals who work to assure fair labor practices and workplace democracy nationwide. Since its creation by Congress in 1935, this small, highly respected, independent Federal agency has had daily impact on the way America's companies, industries and unions conduct business. Agency staff members investigate and remedy unfair labor practices by unions and employers. No date. “The right to strike” <https://www.nlrb.gov/strikes> Accessed 10/27 //gord0]

Strikes unlawful because of misconduct of strikers. Strikers who engage in serious misconduct in the course of a strike may be refused reinstatement to their former jobs. This applies to both economic strikers and unfair labor practice strikers. Serious misconduct has been held to include, among other things, violence and threats of violence. The U.S. Supreme Court has ruled that a “sitdown” strike, when employees simply stay in the plant and refuse to work, thus depriving the owner of property, is not protected by the law. Examples of serious misconduct that could cause the employees involved to lose their right to reinstatement are: Strikers physically blocking persons from entering or leaving a struck plant.Strikers threatening violence against nonstriking employees. Strikers attacking management representatives.

Section 8(g)—Striking or Picketing a Health Care Institution Without Notice. Section 8(g) prohibits a labor organization from engaging in a strike, picketing, or other concerted refusal to work at any health care institution without first giving at least 10 days’ notice in writing to the institution and the Federal Mediation and Conciliation Service.

#### Hospitals are agreeing to no-strike clauses now, and have huge staffing shortages, while simultaneously ruining patient care. Neg arguments concerning “patient abandonment” are rooted in hypocritical neoliberal ideologies. Mercy Hospital proves.

Pappas et al 10/23 [Mike Pappas is an activist and medical doctor working in New York City. Luigi Morris is a freelance photographer, socialist journalist and videographer. He is an activist for immigrants' rights. Olivia Wood is a writer and editor at Left Voice and an adjunct English lecturer in the NYC metropolitan area. October 23, 2021. “Buffalo Healthcare Workers Strike for Better Patient Care and Fair Wages” <https://www.leftvoice.org/buffalo-healthcare-workers-strike-for-better-patient-care-and-fair-wages/> Accessed 10/28 //gord0]

<https://www.leftvoice.org/buffalo-healthcare-workers-strike-for-better-patient-care-and-fair-wages/>

More than 2,000 healthcare workers — including nurses, technicians, clerical workers, and custodians — at Mercy Hospital in Buffalo, New York have been on strike since October 1. Similar to other [healthcare workers around the country](https://www.leftvoice.org/healthcare-workers-are-fed-up-and-hitting-the-picket-lines/), the striking workers’ main demand is improved staffing ratios to allow for safer care for patients. In addition, workers are fighting for better wages to attract more qualified staff, to prevent their health insurance plan from being converted to a high deductible plan, and to prevent their pension plans being converted to a 401(k).

Mercy Hospital is owned by Catholic Health System (CHS), which also owns other hospitals in the area. The striking workers at Mercy Hospital are part of the Communications Workers of America (CWA) union and were originally supposed to strike with two other hospitals, the Sisters of Charity Hospital and Kenmore Mercy Hospital. However, as reported by[Labor Notes](https://labornotes.org/2021/10/two-thousand-hospital-workers-strike-buffalo), “recognizing the potential strength of bargaining together against the chain, Locals 1133 and 1168 sought to coordinate the expiration dates of their contracts and force a master agreement in the last round of negotiations in 2019.” CHS tried to push back against this tactic, and a no-strike clause was eventually agreed to for two out of three of the hospitals, leaving Mercy Hospital as the one location able to strike on behalf of all three.

Although negotiations were supposed to begin in the middle of last year, healthcare workers agreed to delay bargaining during Covid-19 as the hospital claimed to be struggling financially — despite the CEO’s $2 million per year salary. The union healthcare workers agreed to continue working and accepted a temporary contract extension with a raise of just half a percent for the year. But despite these sacrifices, the hospital continues to refuse to give healthcare workers what they need. Hospital management’s proposals do not go nearly far enough: they proposed to add 250 new positions, similar to a proposal made back in 2016, which did nothing to resolve staffing crises.

Management Lies

It is clear that CHS management is trying to frame the ongoing lack of a contract as the fault of the workers and the union itself. In a [recent interview with local press](https://www.wivb.com/catholic-health-hospital-strike/live-catholic-health-ceo-addresses-contract-negotiations-amid-strike/), CHS CEO Mark Sullivan stated he was optimistic a deal would be reached, but “only CWA can end the strike.” Nurses Left Voice spoke with say that when they initially announced the plan to strike, the hospital tried to frame it as workers abandoning patients, putting press releases out to the community.

But healthcare workers know how hypocritical this rhetoric is, and they know they care about their patients more than anyone. Workers put their lives on line throughout the pandemic — the striking healthcare workers created Covid-19 Memorial Walls around each of the picket areas commemorating both those who became ill and those who lost their lives during the pandemic’s peaks — and were called “heroes” when the label could be used as propaganda by management. Workers were even given “healthcare heroes” shirts from CHS, but now, they say they’re seen as “zeroes” and are told they are “abandoning” patients. These claims of abandoning patients are especially ironic because, as one nurse pointed out, not only are these striking healthcare workers the ones who actually care about patient well-being — hence their resistance to the continual drive to cut staffing and costs to increase profits — but the hospital’s CEO, Mark Sullivan, who makes between $1.5-2 million a year, was planning on abandoning contract negotiations midway for vacation to Europe.

It appears the hospital’s rhetoric backfired, as there has been an outpouring of community support, with many residents of the neighborhoods around the hospital putting union signs in their front lawns. Healthcare workers from the two other hospitals not currently striking have been working in solidarity, raising money at Buffalo Bills games and other community events for the union strike fund. Healthcare workers want to get back to work, but they refuse to accept horrible working conditions that lead to poor patient outcomes. Contrary to CHS’s claims, healthcare workers actually care so much about patients that they are willing to strike to see their demands met. They refuse to let the hospital force them into a poor contract that will ultimately threaten the health of patients.

The Hospital System’s Response: Scabs and Security Firms

Those who run hospital firms like CHS know what the threat of striking and winning demands could mean for other hospital systems in the area or the country, so instead of simply meeting the healthcare workers’ demands, they continue to resist. CHS has hired the global parasitic, blood-sucking, anti-strike firm Huffmaster to not just provide scabs, but also provide security. Per their [website](https://huffmaster.com/), “Huffmaster is a master staffing agency for healthcare, security, and other industries. Specializing in rapid strike staffing, we keep business in business.” Huffmaster advertises for job fulfillment and provides housing, travel, and meals for scabs in order to break strikes. As [WNYLaborToday.com reported](https://www.wnylabortoday.com/news/2021/10/04/buffalo-and-western-new-york-labor-news/as-striking-cwa-represented-nurses-continue-to-walk-the-picket-line-outside-south-buffalo-s-mercy-hospital-in-a-battle-over-patient-care-how-can-catholic-health-not-pay-them-but-bring-in-nearly-200-out-of-town-caregivers-at-150-an-hour/), CHS is paying Huffmaster to pay these scabs between $100 and $150 an hour, plus $45 per day for their meals, but they are not willing to pay their regular unionized employees anywhere near as much. Even the pay for the X-ray technicians, one of the higher-paid positions among the striking workers, only reaches $80 per hour — far less than the scabs are being paid.

In their effort to claim the title for one of the worst companies in the world, not only does Huffmaster provide scab healthcare workers, but also violent security personnel. Healthcare workers at Mercy Hospital showed Left Voice reporters video footage and photos of how the security personnel at Mercy are the same security that were hired to help break the [Nabisco strike](https://www.leftvoice.org/nabisco-workers-face-pay-cuts-while-the-company-doubles-its-profits/) and brutally attacked workers. Now there is an injunction from New York State Attorney General Letitia James claiming the company is not licensed to do work in New York State, but as of October 21, Left Voice observed Huffmaster security personnel still on the hospital property, protecting scabs and using fake badges to hide their company logo. In addition to the hired security, Buffalo police were also present and coordinated with the drivers of the scab vehicles.

CHS CEO Trying to Deflect: CEOs Gonna CEO

In the early days of the strike, [CEO Mark Sullivan said](https://www.wivb.com/catholic-health-hospital-strike/live-catholic-health-ceo-addresses-contract-negotiations-amid-strike/) healthcare staffing is a struggle across the nation, not just at Catholic Health: “One in five healthcare workers, since the pandemic has started, has left healthcare. This is not a Mercy Hospital staffing crisis, this is not a Catholic Health staffing crisis, this is a national staffing crisis. Healthcare, overall, is broken.” And he’s right: Healthcare is “broken,” but not because of the workers. Rather, healthcare is broken because under capitalist healthcare, the primary goal is to maximize profit from people’s bodies. Everything else, [including patient care](https://www.leftvoice.org/capitalist-healthcare-killed-my-grandparent-and-hurts-all-elderly/), is secondary. Therefore, under this model, it becomes logical to cut costs whenever possible — for example, by decreasing staffing ratios. Healthcare workers have left the industry because they are tired of working in a system that does not care about patient well-being and continues to put money over lives. They joined their workplaces hoping to help others, but many workers soon find out that the system itself does not hold this priority.

Healthcare is “broken” because the system as it stands was never meant for the maintenance of health for health’s sake — instead, its origins lie in [racism](https://www.leftvoice.org/the-racist-history-of-medical-research/), white supremacy, and [maintaining worker wellbeing just enough to be tools of labor](https://books.google.com/books?id=2MYwMb9hApQC&printsec=frontcover#v=onepage&q&f=false). In some respects it isn’t “broken” but functions just how CEOs like Sullivan — along with the heads of other sectors of the medical industrial complex such as insurance companies, device manufacturers, and pharmaceutical companies — want it to, as they have the main same goal: profit maximization at all cost. This leads them to constantly work to uphold a destructive healthcare system, while the actual maintenance of health and well being remains secondary. Since a CEO like Sullivan can’t say “I am horrible and part of upholding a horrible system,” he must resort to a refrain like “healthcare is broken” to misdirect the public gaze. Executives like to pretend everyone is “on the same team” wanting to care for patients, but this is not the case. It is the healthcare workers who actually care for patients and communities, and CEOs like Sullivan who are a barrier to providing adequate care.

#### Staff shortages are high, and pay inequality among temporary and permanent staff only exacerbates the issue

Hwang 10/19 [Kristen Hwang reports on health care and policy for CalMatters. She is passionate about humanizing data-driven stories and examining the intersection of public health and social justice. Prior to joining CalMatters, Kristen earned a master’s degree in journalism and a master’s degree in public health from UC Berkeley, where she researched water quality in the Central Valley. She has previously worked as a beat reporter for The Desert Sun and a stringer for the New York Times California COVID-19 team. October 19, 2021. “Hospitals brace for strikes as California workers protest staff shortages” [https://www.ivpressonline.com/news/state/hospitals-brace-for-strikes-as-california-workers-protest-staff-shortages/article\_e8023a82-3094-11ec-a2f2-230b2ba54887.html Accessed 10/28](https://www.ivpressonline.com/news/state/hospitals-brace-for-strikes-as-california-workers-protest-staff-shortages/article_e8023a82-3094-11ec-a2f2-230b2ba54887.html%20Accessed%2010/28) //gord0]

Labor advocates are calling it “Striketober.”

As weary health care workers across California enter the 19th month of the pandemic, thousands are walking off the job and onto the picket line, demanding more staffing.

The strikes and rallies threaten to cripple hospital operations that have been inundated by the COVID-19 Delta surge as well as patients seeking long-delayed care.

More than two dozen hospitals across the state — including some Kaiser Permanente and Sutter Health facilities and USC Keck Medicine — have experienced strikes by engineers, janitorial staff, respiratory therapists, nurses, midwives, physical therapists and technicians over the past four months.

This week, nearly a third of all California hospitals reported “critical staffing shortages” to the federal government, with more predicting shortages in the coming week. Hospitals are unable to meet the state’s required staff-to-patient ratios for nurses or schedule adequate numbers of other critical personnel.

In the Central Valley, the region hit hardest by the Delta surge, National Guard medics have been deployed since September to assist area hospitals.

The reason for the shortages? Record patient volumes at the same time that many workers have been driven away from the bedside by burnout, early retirement and the seemingly unending stress of the pandemic.

SEIU-United Healthcare Workers West estimates that about 10 percent of its members — close to 10,000 people — have retired, left the profession, or taken extended leaves of absence during the pandemic.

“What’s really important is that 10 percent doesn’t turn into 15 percent, does not turn into 20 percent. There’s not enough temporary staff out there to fix what’s going on,” said Dave Regan, president of SEIU-UHW.

The shortages are an untenable scenario, unions say — one that has persisted for many years brought to a boiling point by the pandemic.

Since the pandemic began, union grievances with hospitals are increasingly about inadequate staffing, although bargaining over pay remains a key issue.

Money matters when it comes to holding onto workers, they say, especially because temporary staff brought on for pandemic response often make more than regular employees. In some instances, traveling nurses have been paid $10,000 per week at California hospitals with severe staffing needs.

“You’re paying exorbitant amounts for travelers while the existing workforce makes exactly the same amount (as before the pandemic),” Regan said.

**Striking to 'stop the bleeding'**

Early in the pandemic, Gov. Gavin Newsom announced efforts to expand the healthcare workforce through a volunteer health corps. Although tens of thousands signed up, most people didn’t have the necessary medical skills, and only 14 volunteers worked out.

The California Department of Public Health also signed a $500 million contract to help hospitals pay for emergency health care workers like traveling nurses. That contract expired in June.

Unions say those efforts are a Band-aid on a larger problem. Instead, they say policymakers should get hospitals to try harder to retain their current employees.

“Right now, hospitals, the health industry, the state of California, you need to do a lot more so that it doesn’t get worse,” Regan said. “We’re doing very little as a state to support this workforce that has been under a really unique set of pressures.”

In an early attempt to stop the churn, SEIU-UHW sponsored a bill that would have provided hazard pay retention bonuses to health workers. Opposed by the hospital association. the bill stalled before it was voted upon by the Assembly and did not make it to the Senate.

Assemblymember Al Muratsuchi, a Democrat from Torrance who introduced the bill, said the hospitals’ claims that they couldn’t afford hazard pay were unfounded since they received billions in federal pandemic funds, some “specifically earmarked for hazard pay and bonuses for frontline workers.”

“The state made a decision that they were not going to provide financial incentives to recognize and retain healthcare workers, and we think that’s shortsighted,” Regan said.

Over the summer, hundreds of nurses at hospitals, including USC’s Keck Medicine, San Francisco’s Chinese Hospital and Riverside Community Hospital, staged strikes over inadequate staffing and safety concerns.

Now more than 700 hospital engineers employed by Kaiser Permanente facilities in Northern California have been striking for four weeks, demanding higher wages.

In Antioch, more than 350 workers at Sutter Delta ended a week-long strike over inadequate staffing Friday but have yet to reach a contract agreement with their employer.

In the Victor Valley and Roseville, hundreds of workers staged recent rallies and vigils to highlight what they’re calling a “worker crisis.” Advocates say their upcoming schedules are packed with pickets planned in solidarity with other unions.

And perhaps the strongest flexing of union muscle has come in Southern California, where members of the United Nurses Associations of California/Union of Health Care Professionals, or UNAC/UHCP, voted overwhelmingly to approve a strike against Kaiser Permanente if negotiations remain at a standstill. Should a strike materialize in the coming weeks, more than 24,000 members would walk out of the health care giant’s medical centers and clinics in more than a dozen cities.

Although the dollars and cents of bargaining vary from union to union, the common thread is clear: They want employers to “stop the bleeding” of health care workers fleeing the profession and invest more in recruiting and retaining staff.

The union found 72 percent of its members — which includes nurses, occupational and physical therapists, midwives and other medical staff — were struggling with anxiety and burnout, and between 42 percent and 45 percent reported depression and insomnia. About 74 percent said staffing was a primary concern.

#### Understaffing harms patient safety and increases mortality rates. Also causes further staff absence because of mental and physical health issues, which results in cyclical staffing shortages.

EMU 19 [Eastern Michigan University. October 10, 2019. “How Nurse Staffing Affects Patient Safety and Satisfaction” <https://online.emich.edu/articles/rnbsn/nurse-staffing-affects-patient-safety-satisfaction.aspx#:~:text=This%20lack%20of%20focus%20can%20lead%20to%20medical,postoperative%20complications%2C%20and%20a%20greater%20number%20of%20falls>. Accessed 10/28 //gord0]

When healthcare facilities have insufficient nurses on staff, the welfare of patients can be compromised. Moreover, overwhelmed nurses could overlook details or not fully engage with patients. This can leave patients feeling dissatisfied with nurse performance.

Why Does Understaffing Occur?

Budget cuts, nurses reaching retirement age and a shortage of nurse faculty to prepare new nurses are just a few reasons for understaffing.

Is There a Link Between Understaffing and Negative Patient Outcomes?

Healthcare facilities that do not keep an adequate number of nurses on duty can jeopardize the safety of their patients. Overworked nurses may suffer from fatigue or burnout which can impair their ability to focus on tasks. This lack of focus can lead to medical errors, a lack of engagement and missed nursing care. Patients in understaffed facilities face an increased rate of in-hospital mortality, a higher risk of infection, a rise in postoperative complications, and a greater number of falls.

How Does Understaffing Affect Nurses?

When a healthcare facility is understaffed, the same amount of work falls to fewer nurses who typically end up working longer hours. Doing so with little to no relief can cause a breakdown in mental, emotional and physical health. Nurses who are sick or injured may be absent from work, which can also compound the staffing problem. In addition, nurses who face constant stress can develop a number of health issues, including anxiety, exhaustion, depression, heart disease, hypertension and musculoskeletal disorders.

Does Inadequate Nurse Staffing Affect Patient Satisfaction?

A scarcity of available nurses can affect patient satisfaction. In a [study](https://bmjopen.bmj.com/content/8/1/e019189) cited by the British Medical Journal, negative patient perceptions of nursing care relate to missed care, which can be a result of a shortage of nursing staff. Patients can also lose confidence in the care they receive when RNs are too rushed to explain medications or coordinate care with other team members.

Why Is Patient Satisfaction Important to the Healthcare Industry?

The healthcare industry is moving toward patient-centered care, so good satisfaction ratings are important. As consumers, patients can boost or damage the reputation of a facility with their opinions. Satisfied patients could become loyal patrons, contributing to the financial stability of a healthcare organization.

What Can Healthcare Organizations Do to Improve Nurse Staffing?

Healthcare organizations need to focus on retaining nurses by maintaining an effective and supportive work environment. The [American Nurses Association](https://www.nursingworld.org/practice-policy/work-environment/nurse-staffing) (ANA) recommends that employers allow RNs to work together to create flexible staffing schedules for their units. ANA suggests that employers should consider these factors when determining nurse staffing:

Condition of patients based on complexity, acuity or stability

Number of discharges, admissions or transfers to the unit

The staff's level of nursing preparation, expertise and skills

Size of the nursing unit

Technical support and additional resources

Given that nurses provide care and safeguard the well-being of patients, it is imperative for employers to keep qualified nurses from exiting the workforce. Nurses who not only have proper nursing preparation but are also empathetic, dedicated and vigilant can help improve patient outcomes and ensure that patients are satisfied with their care.

#### Causes burnout for nurses and prevents effective pandemic response – covid proves

Lasater et al 20 [Karen B Lasater Center for Health Outcomes and Policy Research, School of Nursing, University of Pennsylvania, Philadelphia, Pennsylvania, USA. Linda H Aiken Center for Health Outcomes and Policy Research, School of Nursing, University of Pennsylvania, Philadelphia, Pennsylvania, USA. Douglas M Sloane Center for Health Outcomes and Policy Research, School of Nursing, University of Pennsylvania, Philadelphia, Pennsylvania, USA. Rachel French Center for Health Outcomes and Policy Research, School of Nursing, University of Pennsylvania, Philadelphia, Pennsylvania, USA. Brendan Martin National Council of State Boards of Nursing, Chicago, Illinois, USA. Kyrani Reneau National Council of State Boards of Nursing, Chicago, Illinois, USA. Maryann Alexander National Council of State Boards of Nursing, Chicago, Illinois, USA. Matthew D McHugh Center for Health Outcomes and Policy Research, School of Nursing, University of Pennsylvania, Philadelphia, Pennsylvania, USA. Published August 18, 2020. “Chronic hospital nurse understaffing meets COVID-19: an observational study” <https://qualitysafety.bmj.com/content/30/8/639> Accessed 10/28 //gord0]

**Introduction** Efforts to enact nurse staffing legislation often lack timely, local evidence about how specific policies could directly impact the public’s health. Despite numerous studies indicating better staffing is associated with more favourable patient outcomes, only one US state (California) sets patient-to-nurse staffing standards. To inform staffing legislation actively under consideration in two other US states (New York, Illinois), we sought to determine whether staffing varies across hospitals and the consequences for patient outcomes. Coincidentally, data collection occurred just prior to the COVID-19 outbreak; thus, these data also provide a real-time example of the public health implications of chronic hospital nurse understaffing.

**Methods** Survey data from nurses and patients in 254 hospitals in New York and Illinois between December 2019 and February 2020 document associations of nurse staffing with care quality, patient experiences and nurse burnout.

**Results** Mean staffing in medical-surgical units varied from 3.3 to 9.7 patients per nurse, with the worst mean staffing in New York City. Over half the nurses in both states experienced high burnout. Half gave their hospitals unfavourable safety grades and two-thirds would not definitely recommend their hospitals. One-third of patients rated their hospitals less than excellent and would not definitely recommend it to others. After adjusting for confounding factors, each additional patient per nurse increased odds of nurses and per cent of patients giving unfavourable reports; ORs ranged from 1.15 to 1.52 for nurses on medical-surgical units and from 1.32 to 3.63 for nurses on intensive care units.

**Conclusions** Hospital nurses were burned out and working in understaffed conditions in the weeks prior to the first wave of COVID-19 cases, posing risks to the public’s health. Such risks could be addressed by safe nurse staffing policies currently under consideration.

#### COVID and future pandemics will reproduce untenable working conditions and racialized and classed life outcomes.

Sell 20 – Susan K. Sell is a Professor of Political Science and International Affairs at George Washington University. (“What COVID‑19 Reveals About Twenty‑First Century Capitalism: Adversity and Opportunity,” pg. 152-153) julian

The COVID-19 pandemic has revealed the lethal consequences of the sharp rise in economic inequality, the concentration of wealth in fewer and fewer hands and the increasing precarity of labour. For example, as COVID-19 slammed Manhattan, members of the top 1% flocked to their beach retreats in the Hamptons to ride out the contagion (Sellinger 2020). Meanwhile, ‘essential workers’ at the bottom of the contemporary economic hierarchy had no options but to continue to show up for work and face exposure to the deadly virus. First responders, bus drivers, nursing home workers, janitors, postal workers, grocery stockers, agricultural workers, Wal-Mart employees, Amazon warehouse workers, delivery drivers, and meat packers—many earning minimum wage and most without employer-subsidized health insurance or other benefits—had to keep working. As Bertha Bradley, a food service worker in North Carolina stated, ‘I don’t get health benefits, I don’t get sick time, I don’t get paid vacations, I don’t get a living wage’ (Jaffe and Chen 2020: 126). Katie Pine and Kate Henne refer to them as ‘new risk workers’, many of whom are given mandates for minimizing risk but few resources to implement them (Pine and Henne 2020). For example, in the John H. Stroger Hospital in Chicago, nurses were being told to reuse N95 masks, ‘sometimes up to forty-five days’ (Jaffe and Chen 2020: 138). By contrast, knowledge workers could work from the safety of their own homes and reduce their risks of becoming infected.

COVID-19 has disproportionately attacked communities of colour, compounding economic inequality and systemic racism. It is clear that ‘race matters for the way that markets have been built historically and function today’ (McNamara and Newman 2020: 6). As Presidential candidate Joe Biden pointed out during the presidential debate in September 2020, 1 out of every one-thousand African Americans in the US has died from COVID-19. In Chicago about 70% of the COVID deaths were African Americans (Jaffe and Chen 2020: 140). The UN Secretary-General António Guterres pointed out that COVID-19 ‘is exposing fallacies and falsehoods everywhere … the delusion that we live in a post-racist world, the myth that we are all in the same boat’ (Guterres 2020). In September, Citigroup released a report that systemic racism, discrimination against African Americans, has cost the economy $16 trillion (Akala 2020).

Many of the precariat are people of colour, recent immigrants and undocumented workers. By May 2020 slaughterhouses around the world became virus hot spots and exposed multiple layers of dysfunction. The meat processing industry is highly consolidated, dominated by global multinational corporations including Cargill, JBS, Smithfield and Tyson. Since the 1980s this industry has pursued the financialized model of consolidation and vertical integration, ‘aimed at increasing profits through efficiency and low wages’ (van der Zee et al. 2020). Many migrant workers in these plants live in communal housing; crowded working conditions, large plants and cramped housing, and lack of paid sick leave all exacerbate the spread of coronavirus in these environments. Indeed, Tyson was even offering workers $500 bonuses to keep working in the midst of plant outbreaks (van der Zee et al. 2020). Workers are shouldering all of the risk as slaughterhouse companies get the rewards. Structures of the global economy, including financialization and monopoly capitalism have amplified the dangers of the pandemic and pushed people further ‘into unequal groups that are not only divided by money but by matters of life and death’ (McNamara and Newman 2020: 11; Sell and Williams 2019).

#### Denying the right to strike is morally indefensible in all instances.

Chima 13 [Chima, S.C. Program of Bio & Research Ethics and Medical Law, Nelson R Mandela School of Medicine & School of Nursing and Public Health, College of Health Sciences, University of KwaZulu-Natal, Durban, South Africa. “Global medicine: Is it ethical or morally justifiable for doctors and other healthcare workers to go on strike?” *BMC Med Ethics* **14,** S5 (2013). <https://doi.org/10.1186/1472-6939-14-S1-S5>. Accessed 10/28 //gord0]

It has been suggested that doctor and HCW strikes can create a tension between the obligation on doctors and other HCWs to provide adequate care to current patients versus the need to advocate for improved healthcare services for future patients and for society in general [[2](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR2), [31](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR31)]. There is also a potential conflict between doctors' role in advocating for improved healthcare service for others versus the need to advocate for justifiable wages for self and the fulfilment of basic biological needs like all humans [[4](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR4), [32](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR32)]. It has been suggested that since strikes are considered a fundamental right or entitlement during collective bargaining and labour negotiations [[33](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR33)]. Therefore to deny any employee the right to strike would be an argument for enslavement of such an employee, because this would simply mean that whatever the circumstances-such an individual must work! A situation deemed to be both ethically and morally indefensible [[4](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR4)]. It is pertinent to observe that there is an on-going paradigm shift in the organization of healthcare services and doctors' employment options with a change in the role of doctors from self-employment, and medical practice based on benevolent paternalism, to consumer rights and managed healthcare [[2](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR2)]. Historically, doctors had the sole responsibility within the doctor-patient relationship, to determine the costs of medical care to their patients, however, current trends show that doctors are increasingly becoming employees of managed healthcare organizations (HCOs) or employees of public health services [[2](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR2), [34](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR34)–[36](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR36)]. These changes in physicians' practices and methods of payment may impact on patient trust, physician behaviour and decision-making, thereby permanently altering the doctor-patient relationship [[3](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR3), [37](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR37)]. It has been observed, especially in advanced capitalist societies like the United States, that there is an on-going shift in doctors practice options from self-employment as owners of their own practices [[34](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR34)–[36](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR36)], to doctors becoming employees of HCOs in a managed healthcare environment [[2](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR2), [34](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR34), [35](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR35)]. The factors driving this sea change in physicians employment options have been ascribed to "the complex corporate environment coupled with the stress of high malpractice rates, the struggle for reimbursement, administrative duties and the general risks and burden of solo or small group practice" [[35](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR35), [38](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR38)]. One can therefore anticipate that in the near future there could be more wage negotiations and collective bargaining between doctors as employees and the employing HCOs [[35](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR35), [36](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR36)]. This will be similar to the practice in systems where medicine is centralized or socialized, and where doctors and HCWs are mostly public service employees [[7](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR7), [10](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR10), [11](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR11), [14](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR14), [16](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR16), [18](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR18), [20](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR20)]. These ongoing changes in the organization of healthcare services and modern medical practice may denote a change in the Hippocratic tenets of the medical profession, creating ethical and moral dilemmas [[2](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR2), [39](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR39)], which could permanently alter the nature of the relationship between doctors and patients [[3](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR3), [37](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR37)], and the putative 'contract' between medicine and society [[10](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR10), [40](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR40)].

#### Thus, the Plan: A just government ought to recognize an unconditional right of healthcare workers to strike.

#### The plan is effective – emergency duty workers stay and organizers will reveal flexibility and organization

Świątkowski 17 [Andrzej Marian Świątkowski. Polish lawyer, professor of legal sciences, full professor at the Jagiellonian University and the Ignatianum Academy in Krakow, specialist in the field of labor law. Pronounced “Swat-cow-ski”. December 20, 2017. “The Right To Strike in Health Service” [https://www.humanitas.edu.pl/resources/upload/dokumenty/Wydawnictwo/Roczniki%20AiP%20-%20pliki/Podzielone/Roczniki%20AiP%202017%20z2/RAiP\_2\_2017-303-314.pdf Accessed 10/28](https://www.humanitas.edu.pl/resources/upload/dokumenty/Wydawnictwo/Roczniki%20AiP%20-%20pliki/Podzielone/Roczniki%20AiP%202017%20z2/RAiP_2_2017-303-314.pdf%20Accessed%2010/28) //gord0]

SPECIFIC SITUATION OF THE MEDICAL PERSONNEL DURING A STRIKE The discussion on the ban on strike expressed in Art. 19 section 1 of the Act of 23.5.1991 should be illustrated by an example concerning a specific substantive strike of hospital staff - medical staff: doctors, nurses, laboratory technicians.8 In order to assess the situation about the compliance or unlawfulness of a specific strike organized in a hospital, the number of people striking in each of the three mentioned substantive groups of medical personnel is significant. Certainly, the general participation in the strike of all employees belonging to the hospital medical staff would pose a threat to the health or life of patients, because there would not be a single employee in the hospital who would be able to take and carry out the necessary medical activities in the case of an emergency situation. The common practice used by trade unions organizing strikes of medical staff in hospitals is to refrain from performing the work of medical personnel except those who perform “emergency duty” – they are on standby to take the necessary rescue procedures in sudden and unexpected situations. “Emergency duty” is a commonly used technique of caring for health and life of hospital patients on days and hours non-working for medical personnel. Then pre-planned medical procedures are not performed. A hospital is an institution which should guarantee its patients that the obligation of the treatment will be carried out. With reference to the above the organizer of the strike is under the obligation to decide how many employees who belong to the substantive medical staff must be excluded from the planned strike in each of the three above mentioned occupational categories (doctors, nurses, lab technicians) so that the intended strike could be carried out according to the law without endangering the health and life of those treated. The evaluation of this situation may change. The organizer of the strike must reveal flexibility, involving the exclusion from the category of strikers and including in the group a certain number of employees of the medical personnel necessary to enable the management to carry out both scheduled and emergency activities related to the protection of health and life of patients

. Most likely for these reasons in the Act of 5.12. 1996 on the professions of a doctor and a dentist9did not include the provisions on the right of doctors to strike. The Code of Medical Ethics passed in 1993, a set of ethical norms not recognized as the provisions of applicable law10 requires the striking doctor to provide the patient with professional assistance in a situation where failure to comply with a moral obligation could endanger health or life. Each physician, both strikers and those who perform work, have a moral duty to care for the well-being of the patient under their care. Doctors, nurses, laboratory technicians, staying with a hospital in an employment relationship or employed there on a different basis than a contract of employment, participating in a legal strike, are obliged to provide the employer with all necessary information about the patient’s situation, so that during their absence at work because of the strike, it was possible to ensure continuity of treatment without undue delay. According to labor law, the employee’s participation in a legal strike is a justified reason for the absence of an employee at work. Only few criminal lawyers share the above view of specialists in the field of labor law11. A different approach to the strike of medical staff is made by other lawyers dealing with criminal law. According to some of them, the striking doctor may be released from responsibility for deterioration of health, serious damage to health, death of the patient under his care after finding that the hospital manager had a real opportunity to provide proper care to patients12. Thus, it is not clear whether the participation of medical staff in a strike organized in accordance with the law is only treated as a case of exercising the right guaranteeing the strikers a release from the obligation to perform work, or also acts as an immunity that protects the doctor from criminal liability.

#### Strikes have already gotten off the ground in certain areas because they’re recognizing leverage, but are prohibited or conditioned in others, making the plan essential.

Al-Arshani 10/23 [Sarah Al-Arshani is a breaking news reporter for Insider. Before joining Insider, Sarah was an editorial intern with The Jordan Times. She graduated from the University of Connecticut in May 2019. October 23, 2021. “Over 500,000 healthcare workers quit in August and thousands more have gone on strike as the industry deals with burnout and staff shortages” [https://www.businessinsider.com/thousands-healthcare-workers-quitting-striking-burnout-grows-staff-shortages2021-10 Accessed 10/28](https://www.businessinsider.com/thousands-healthcare-workers-quitting-striking-burnout-grows-staff-shortages2021-10%20Accessed%2010/28) //gord0]

Over [500,000 healthcare workers quit in August](https://www.bls.gov/news.release/pdf/jolts.pdf), the most recent month figures are available for, and more than two dozen strikes amongst healthcare workers have taken place since the start of the year, according to reports.

A tracker from [Cornell University's School of Industrial and Labor Relations](https://striketracker.ilr.cornell.edu/) found there have been 35 strikes in the Healthcare and Social Assistance industry as of Friday.

Over the past four months, t[housands of workers at more than two dozen hospitals](https://www.businessinsider.com/california-hospital-workers-strike-over-critical-staffing-shortages-2021-10) in California have gone on strike. Earlier this month, close to 31,000 healthcare workers at [Kaiser Permanente voted to authorize a strike over wages.](https://www.businessinsider.com/kaiser-permanente-health-care-workers-vote-to-authorize-strike-2021-10)

Nurses at one hospital in Massachusetts have been on strike since March, [Masslive reported.](https://www.masslive.com/worcester/2021/10/striking-saint-vincent-hospital-nurses-no-longer-entitled-to-unemployment-some-may-have-to-repay-benefits-state-rules.html)

The strikes are occurring during a time of increased demand for patient care and a shortage of workers. In addition to the Delta variant, the US is also facing a rise in chronically ill patients who delayed care during the pandemic, [Politico](https://www.politico.com/news/2021/10/20/hospitals-labor-shortage-covid-delta-516303) reported.

Healthcare workers told Politico that while they know walking out may garner "scorn" from some, they wanted to use the attention they've recieved throughout the pandemic to demand better conditions.

"We're drowning here," Mike Pineda, a senior transport technician at Sutter Delta Medical Center in Antioch, California, told Politico. "The wear and tear on everyone got to the point where people became frustrated."

Jamie Lucas, the Executive Director of the Wisconsin Federation of Nurses and Health Professionals, told the outlet that the reasons to strike have always been there but that some healthcare workers, like many other industries [demanding better conditions across the country](https://www.businessinsider.com/what-is-striketober-kelloggs-john-deere-iatse-strike-labor-2021-10), are realizing they have some leverage.

Throughout the pandemic, healthcare workers have said they're burnt out. In May, Nikki Motta, a travel nurse who spent a year working with COVID-19 patients in understaffed hospitals across the East Coast [told Insider she was experiencing hair loss from the stress.](https://www.businessinsider.com/nurses-are-considering-leaving-the-profession-after-covid-19-pandemic-2021-5)

Liz Evans, another travel nurse, told Insider she was taking care of six patients at a time when in normal times, she might have two at most.

 A March 2021 [Trusted Health online survey](https://uploads-ssl.webflow.com/5c5b66e10b42f155662a8e9e/608304f3b9897b1589b14bee_mental-health-survey-2021.pdf) of over 1,000 travel nurses found that almost half said they were considering leaving the profession. Seven months, later a [ShiftMed survey found 49% of US nurses](https://www.businessinsider.com/nurse-shortage-labor-quit-healthcare-hospital-jobs-employment-shiftmed-survey-2021-10) said they may leave the profession within the next two years. More than 90% of respondents in the ShiftMed survey said staffing shortages were negatively impacting them.

Some of the other factors that have pushed healthcare professionals to consider leaving include the pandemic, low wages, and an increase in workload.

"I really started looking away from bedside over the last year, because the weight was really heavy of what I was doing, and I didn't feel like I was doing the job that I initially signed up for, which is to help people and make people feel better," Motta told Insider in May. "I feel like there are even more and more expectations for nurses, and nurses are the type of people who want to help and who want to do what is asked of them, but I think that is being taken advantage of in a lot of ways."

### Framing

#### Role of the Ballot is to vote for the debater who best debates the desirability of the plan.

#### Pleasure and pain are the starting point for moral reasoning—they’re our most baseline desires and the only things that explain the intrinsic value of objects or actions

Moen 16, Ole Martin (PhD, Research Fellow in Philosophy at University of Oslo). "An Argument for Hedonism." Journal of Value Inquiry 50.2 (2016): 267.

Let us start by observing, empirically, that a widely shared judgment about intrinsic value and disvalue is that pleasure is intrinsically valuable and pain is intrinsically disvaluable. On virtually any proposed list of intrinsic values and disvalues (we will look at some of them below), pleasure is included among the intrinsic values and pain among the intrinsic disvalues. This inclusion makes intuitive sense, moreover, for there is something undeniably good about the way pleasure feels and something undeniably bad about the way pain feels, and neither the goodness of pleasure nor the badness of pain seems to be exhausted by the further effects that these experiences might have. “Pleasure” and “pain” are here understood inclusively, as encompassing anything hedonically positive and anything hedonically negative. 2 The special value statuses of pleasure and pain are manifested in how we treat these experiences in our everyday reasoning about values. If you tell me that you are heading for the convenience store, I might ask: “What for?” This is a reasonable question, for when you go to the convenience store you usually do so, not merely for the sake of going to the convenience store, but for the sake of achieving something further that you deem to be valuable. You might answer, for example: “To buy soda.” This answer makes sense, for soda is a nice thing and you can get it at the convenience store. I might further inquire, however: “What is buying the soda good for?” This further question can also be a reasonable one, for it need not be obvious why you want the soda. You might answer: “Well, I want it for the pleasure of drinking it.” If I then proceed by asking “But what is the pleasure of drinking the soda good for?” the discussion is likely to reach an awkward end. The reason is that the pleasure is not good for anything further; it is simply that for which going to the convenience store and buying the soda is good. 3 As Aristotle observes: “We never ask [a man] what his end is in being pleased, because we assume that pleasure is choice worthy in itself.”4 Presumably, a similar story can be told in the case of pains, for if someone says “This is painful!” we never respond by asking: “And why is that a problem?” We take for granted that if something is painful, we have a sufficient explanation of why it is bad. If we are onto something in our everyday reasoning about values, it seems that pleasure and pain are both places where we reach the end of the line in matters of value. Although pleasure and pain thus seem to be good candidates for intrinsic value and disvalue, several objections have been raised against this suggestion: (1) that pleasure and pain have instrumental but not intrinsic value/disvalue; (2) that pleasure and pain gain their value/disvalue derivatively, in virtue of satisfying/frustrating our desires; (3) that there is a subset of pleasures that are not intrinsically valuable (so-called “evil pleasures”) and a subset of pains that are not intrinsically disvaluable (so-called “noble pains”), and (4) that pain asymbolia, masochism, and practices such as wiggling a loose tooth render it implausible that pain is intrinsically disvaluable. I shall argue that these objections fail. Though it is, of course, an open question whether other objections to P1 might be more successful, I shall assume that if (1)–(4) fail, we are justified in believing that P1 is true itself a paragon of freedom—there will always be some agents able to interfere substantially with one’s choices. The effective level of protection one enjoys, and hence one’s actual degree of freedom, will vary according to multiple factors: how powerful one is, how powerful individuals in one’s vicinity are, how frequent police patrols are, and so on. Now, we saw above that what makes a slave unfree on Pettit’s view is the fact that his master has the power to interfere arbitrarily with his choices; in other words, what makes the slave unfree is the power relation that obtains between his master and him. The difﬁculty is that, in light of the facts I just mentioned, there is no reason to think that this power relation will be unique. A similar relation could obtain between the master and someone other than the slave: absent perfect state control, the master may very well have enough power to interfere in the lives of countless individuals. Yet it would be wrong to infer that these individuals lack freedom in the way the slave does; if they lack anything, it seems to be security. A problematic power relation can also obtain between the slave and someone other than the master, since there may be citizens who are more powerful than the master and who can therefore interfere with the slave’s choices at their discretion. Once again, it would be wrong to infer that these individuals make the slave unfree in the same way that the master does. Something appears to be missing from Pettit’s view. If I live in a particularly nasty part of town, then it may turn out that, when all the relevant factors are taken into account, I am just as vulnerable to outside interference as are the slaves in the royal palace, yet it does not follow that our conditions are equivalent from the point of view of freedom. As a matter of fact, we may be equally vulnerable to outside interference, but as a matter of right, our standings could not be more different. I have legal recourse against anyone who interferes with my freedom; the recourse may not be very effective—presumably it is not, if my overall vulnerability to outside interference is comparable to that of a slave— but I still have full legal standing.68 By contrast, the slave lacks legal recourse against the interventions of one speciﬁc individual: his master. It is that fact, on a Kantian view—a fact about the legal relation in which a slave stands to his master—that sets slaves apart from freemen. The point may appear trivial, but it does get something right: whereas one cannot identify a power relation that obtains uniquely between a slave and his master, the legal relation between them is undeniably unique. A master’s right to interfere with respect to his slave does not extend to freemen, regardless of how vulnerable they might be as a matter of fact, and citizens other than the master do not have the right to order the slave around, regardless of how powerful they might be. This suggests that Kant is correct in thinking that the ideal of freedom is essentially linked to a person’s having full legal standing. More speciﬁcally, he is correct in holding that the importance of rights is not exhausted by their contribution to the level of protection that an individual enjoys, as it must be on an instrumental view like Pettit’s. Although it does matter that rights be enforced with reasonable effectiveness, the sheer fact that one has adequate legal rights is essential to one’s standing as a free citizen. In this respect, Kant stays faithful to the idea that freedom is primarily a matter of standing—a standing that the freeman has and that the slave lacks. Pettit himself frequently insists on the idea, but he fails to do it justice when he claims that freedom is simply a matter of being adequately (and reliably) shielded against the strength of others. As Kant recognizes, the standing of a free citizen is a more complex matter than that. One could perhaps worry that the idea of legal standing is something of a red herring here—that it must ultimately be reducible to a complex network of power relations and, hence, that the position I attribute to Kant differs only nominally from Pettit’s. That seems to me doubtful. Viewing legal standing as essential to freedom makes sense only if our conception of the former includes conceptions of what constitutes a fully adequate scheme of legal rights, appropriate legal recourse, justiﬁed punishment, and so on. Only if one believes that these notions all boil down to power relations will Kant’s position appear similar to Pettit’s. On any other view—and certainly that includes most views recently defended by philosophers—the notion of legal standing will outstrip the power relations that ground Pettit’s theory.

#### That justifies util – we must aggregate in order to determine how behaviors will be conducted based on what is most pleasurable. Anything else is arbitrary and always allows for exclusions, but aggregation solves because it allows us to determine what behaviors are most likely given relative evaluations of pleasure and pain.

#### Thus, the standard is maximizing expected well-being – prefer:

#### 1] Actor specificity

#### A] Governments must aggregate since every policy benefits some and harms others, which also means side constraints freeze action.

#### B] States lack wills or intentions since policies are collective actions. Actor-specificity comes first since different agents have different ethical standings. Link turns calc indites because the alt would be *no* action.

#### 2] **No act-omission distinction—governments are responsible for everything in the public sphere so inaction is implicit authorization of action: they have to yes/no bills, which means everything collapse to aggregation.**

#### 3] Only consequentialism explains degrees of wrongness—if I break a promise to meet up for lunch, that is not as bad as breaking a promise to take a dying person to the hospital via intuitions. Intuitions outweigh—they’re the foundational basis for any argument and theories that contradict our intuitions are most likely false even if we can’t deductively determine why.

#### 4] Existential threats independently outweigh – all life has infinite value and extinction eliminates the possibility for future generations

GPP 17 (Global Priorities Project, Future of Humanity Institute at the University of Oxford, Ministry for Foreign Affairs of Finland, “Existential Risk: Diplomacy and Governance,” Global Priorities Project, 2017, <https://www.fhi.ox.ac.uk/wp-content/uploads/Existential-Risks-2017-01-23.pdf>,

1.2. THE ETHICS OF EXISTENTIAL RISK In his book Reasons and Persons, Oxford philosopher Derek Parfit advanced an influential argument about the importance of avoiding extinction: I believe that if we destroy mankind, as we now can, this outcome will be much worse than most people think. Compare three outcomes: (1) Peace. (2) A nuclear war that kills 99% of the world’s existing population. (3) A nuclear war that kills 100%. (2) would be worse than (1), and (3) would be worse than (2). Which is the greater of these two differences? Most people believe that the greater difference is between (1) and (2). I believe that the difference between (2) and (3) is very much greater. ... The Earth will remain habitable for at least another billion years. Civilization began only a few thousand years ago. If we do not destroy mankind, these few thousand years may be only a tiny fraction of the whole of civilized human history. The difference between (2) and (3) may thus be the difference between this tiny fraction and all of the rest of this history. If we compare this possible history to a day, what has occurred so far is only a fraction of a second.65 In this argument, it seems that Parfit is assuming that the survivors of a nuclear war that kills 99% of the population would eventually be able to recover civilisation without long-term effect. As we have seen, this may not be a safe assumption – but for the purposes of this thought experiment, the point stands. What makes existential catastrophes especially bad is that they would “destroy the future,” as another Oxford philosopher, Nick Bostrom, puts it.66 This future could potentially be extremely long and full of flourishing, and would therefore have extremely large value. In standard risk analysis, when working out how to respond to risk, we work out the expected value of risk reduction, by weighing the probability that an action will prevent an adverse event against the severity of the event. Because the value of preventing existential catastrophe is so vast, even a tiny probability of prevention has huge expected value.67 Of course, there is persisting reasonable disagreement about ethics and there are a number of ways one might resist this conclusion.68 Therefore, it would be unjustified to be overconfident in Parfit and Bostrom’s argument. In some areas, government policy does give significant weight to future generations. For example, in assessing the risks of nuclear waste storage, governments have considered timeframes of thousands, hundreds of thousands, and even a million years.69 Justifications for this policy usually appeal to principles of intergenerational equity according to which future generations ought to get as much protection as current generations.70 Similarly, widely accepted norms of sustainable development require development that meets the needs of the current generation without compromising the ability of future generations to meet their own needs.71 However, when it comes to existential risk, it would seem that we fail to live up to principles of intergenerational equity. Existential catastrophe would not only give future generations less than the current generations; it would give them nothing. Indeed, reducing existential risk plausibly has a quite low cost for us in comparison with the huge expected value it has for future generations. In spite of this, relatively little is done to reduce existential risk. Unless we give up on norms of intergenerational equity, they give us a strong case for significantly increasing our efforts to reduce existential risks. 1.3. WHY EXISTENTIAL RISKS MAY BE SYSTEMATICALLY UNDERINVESTED IN, AND THE ROLE OF THE INTERNATIONAL COMMUNITY In spite of the importance of existential risk reduction, it probably receives less attention than is warranted. As a result, concerted international cooperation is required if we are to receive adequate protection from existential risks. 1.3.1. Why existential risks are likely to be underinvested in There are several reasons why existential risk reduction is likely to be underinvested in. Firstly, it is a global public good. Economic theory predicts that such goods tend to be underprovided. The benefits of existential risk reduction are widely and indivisibly dispersed around the globe from the countries responsible for taking action. Consequently, a country which reduces existential risk gains only a small portion of the benefits but bears the full brunt of the costs. Countries thus have strong incentives to free ride, receiving the benefits of risk reduction without contributing. As a result, too few do what is in the common interest. Secondly, as already suggested above, existential risk reduction is an intergenerational public good: most of the benefits are enjoyed by future generations who have no say in the political process. For these goods, the problem is temporal free riding: the current generation enjoys the benefits of inaction while future generations bear the costs. Thirdly, many existential risks, such as machine superintelligence, engineered pandemics, and solar geoengineering, pose an unprecedented and uncertain future threat. Consequently, it is hard to develop a satisfactory governance regime for them: there are few existing governance instruments which can be applied to these risks, and it is unclear what shape new instruments should take. In this way, our position with regard to these emerging risks is comparable to the one we faced when nuclear weapons first became available. Cognitive biases also lead people to underestimate existential risks. Since there have not been any catastrophes of this magnitude, these risks are not salient to politicians and the public.72 This is an example of the misapplication of the availability heuristic, a mental shortcut which assumes that something is important only if it can be readily recalled. Another cognitive bias affecting perceptions of existential risk is scope neglect. In a seminal 1992 study, three groups were asked how much they would be willing to pay to save 2,000, 20,000 or 200,000 birds from drowning in uncovered oil ponds. The groups answered $80, $78, and $88, respectively.73 In this case, the size of the benefits had little effect on the scale of the preferred response. People become numbed to the effect of saving lives when the numbers get too large. 74 Scope neglect is a particularly acute problem for existential risk because the numbers at stake are so large. Due to scope neglect, decision-makers are prone to treat existential risks in a similar way to problems which are less severe by many orders of magnitude. A wide range of other cognitive biases are likely to affect the evaluation of existential risks.75