# Coverage: Exploring A High School Health Care Topic

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# Resolutions

## Past Resolutions

NDT 2017-2018 RESOLVED: The United States Federal Government should establish national health insurance in the United States.

NDT 1972-1973 RESOLVED: That the federal government should provide a program of comprehensive medical care for all its citizens.

NDT 1960-1961 RESOLVED: That the United States should adopt a program of compulsory health insurance for all citizens.

NFHS 2002-2003 RESOLVED: That the United States federal government should substantially increase public health services for mental health care in the United States.

NFHS 1992-1993 RESOLVED: That the federal government should guarantee comprehensive national health insurance to all United States citizens.

NFHS 1977-1978 RESOLVED: That the federal government should establish a comprehensive program to regulate the health care in the United States.

## Proposed Resolutions

RESOLVED: The United States Federal Government should establish a system of universal health coverage in the United States.

RESOLVED: The United States Federal Government should substantially increase universal health coverage in the United States.

Resolved: The United States federal government should substantially expand health care coverage in the United States.

RESOLVED: The United States (Federal Government) should substantially expand the health care coverage of national health insurance in the United States.

RESOLVED: The United States Federal Government should establish national health insurance in the United States.

# Introduction

 This paper is meant to update, streamline, and supplement past papers presented by [Rich Edwards in 2017](https://nfhs.org/media/1018378/health-care-topic-paper-2017.pdf) as well as [Jacob Justice, Bruce Najor, Dr. Kelly M. Young, Dr. John P. Koch, Jennifer Anton, Austin Oliver, and Tyler Woodcock in 2016](http://www.cedadebate.org/forum/index.php?PHPSESSID=376489881b6084a1773ac259f869ef34&action=dlattach;topic=7098.0;attach=2599). “Supplement” in that this paper attempts to provide new and additional research, with different wordings, to explain the rationale for a high school debate topic about health care. Therefore, readers are encouraged to pursue additional evidence, definitions, etcetera from those papers.

# Timeliness – Interest

 Health care coverage is poised to be a dominant political, social, and economic issue for the next decade, buoyed by a dynamic Democratic primary debate ahead of the 2020 presidential elections. Unlike many topics we debate, it is a daily issue that concerns every single person in the United States and the resolution of this problem area will be a defining challenge for the millennial generation and later. Conservative calls to repeal the Affordable Care Act have been drowned out by progressive debates over how to expand health care.

 First, Medicare-for-all has become a litmus test for Democratic presidential hopefuls, symbolizing the Democratic party’s and the country’s shifting beliefs:

“Support for a variation of a single-payer-type approach to health care is emerging as a litmus test for the 2020 Democratic candidates, and the debate over the specifics is shaping up to be one of the defining policy battles of the campaign … The center of gravity within the [Party] and [electorate] has massively moved”(Huey-Burns, 2019).

The competing candidate proposals show how vibrant the debate will be and how there are many different options, each with advantages and disadvantages:

“There are half a dozen proposals in Congress that envision very different health care systems. … These plans are the universe of ideas that Democrats will draw from as they flesh out their vision for the future of American health care. … The eight plans fall into two categories. There are three that would eliminate private insurance and cover all Americans through the government. Then there are five that would allow all Americans to buy into government insurance (like Medicare or Medicaid) if they wanted to, or continue to buy private insurance. … They would all give the government a greater role in everything from setting health prices to deciding what benefits get included in an insurance plan. … But the Democrats’ plans differ significantly in how they handle important decisions, like which public health program to expand and how aggressively to extend the reach of government. … Some bills require significant tax increases to pay for the expansion of benefits — while others ask those signing up for government insurance to pay the costs” (Kliff, 2019).

 Second, while Medicare-for-all dominates press coverage and the primary debate, Democrats are also exploring alternatives to address other coverage problems, like Elizabeth Warren’s proposal for ACA 2.0:

“The Consumer Health Insurance Protection Act, aims to make insurance within the existing Obamacare system more affordable and protect more enrollees from insurance company policy changes and premium hikes. It would increase federal subsidies for people buying Affordable Care Act plans, allow more people to qualify for ACA tax credits and impose tighter controls on private insurers” (Rosenberg, 2018).

 Third, health care, and the Affordable Care Act in particular, remains in litigation that could drastically reduce coverage and change the American health care system:

“The fate of the Affordable Care Act is again on the line Tuesday, as a federal appeals court in New Orleans takes up a case in which a lower court judge has already ruled the massive health law unconstitutional. If the lower court ruling is ultimately upheld, the case, *Texas v. United States*, has the potential to shake the nation's entire health care system to its core. [And] would immediately affect the estimated 20 million people who get their health coverage through programs created under the law. But ending the ACA would also create chaos in other parts of the health care system … Upholding the lower court's ruling, the scholars add, "would upend all of those settled expectations and throw healthcare markets, and 1/5 of the economy, into chaos" (Rovner, 2019).

Finally, President Trump will be campaigning on an Obamacare repeal and replacement, ensuring that it will be prominent in his campaign, Tweets, and policy:

“President Trump wants to ride to reelection on an Obamacare repeal-and-replace train … While Trump said over the weekend that his administration is working on a new health-care plan, the president mostly stuck to criticizing Medicare-for-all and boasting about how Congress erased the Affordable Care Act's requirement to buy health coverage … "We got rid of the individual mandate, right?" Trump said. "How many people are happy? They no longer have to pay for the privilege of not paying for bad health insurance" (Cunningham, 2019).

# Range – Scope

Health care debates will be appealing to students all over the country because health care is so important to them and their families. The evolving policy discourse about health care provide for controversies that will appeal to varsity and novice debaters. This topic can be understood and debated by novice debaters while challenging advanced debaters because of its timeliness and literature base.

Since the topic is so prevalent in the news media, the topic will be interesting and accessible to new debaters who can bring current events discussions from class into their debates. There will be strong affirmative and negative arguments for new and experienced debaters because all affirmatives will be fundamentally be about increasing the number of people with care and the types of care that can be universalized. These factors culminate in a vibrant literature base that will support intuitive novice debates.

# Quality – Material – Balance

 Health care debates are found in a rich body of literature that will yield debates for all regardless of experience, commitment, or geography. A long list of potential affirmatives shows there to be high quality affirmative ground. A short introduction to core advantage areas indicates the types of debates that will be had. A list of potential negative generics boasts how the health care topic features a few main topic disadvantages that span the breadth of the topic (which would be a nice change of pace from past topics) as well as stock counterplans. Finally, this paper was first inspired by Ronald Brownstein’s, “The Coming Democratic Drama Over Medicare for All,” in which he discusses how increasing federal involvement in health care has critics from the left and the right:

“During the ACA debate, Republicans failed to recognize the degree to which their traditional priority of minimizing government involvement in health care could threaten the financial security of the older and working-class whites now central to their electoral fortunes. Similarly, Democrats may be underestimating how much of their new coalition—which increasingly relies on well-educated whites in major metropolitan areas—may resist entrusting the health-care system entirely to government control.

Like the debate over taxes, the one over single-payer health care, often described as Medicare for All, could become one of the principal crucibles in which the Democratic Party confronts its changing identity. It will test how a party increasingly drawn toward populist economics confronts the challenge of managing a political coalition growingly reliant on voters who are thriving financially and attracted to the party largely on cultural grounds” (Brownstein, 2019).

## Possible Affirmative Plans

- Single payer

- Single payer for certain populations (non-citizens etc)

- Public option

- Public option for certain populations (non-citizens etc)

- Medicare For All (and different versions about when people become eligible like birth, different ages, etc)

- Medicare For America

- Subsidies to reduce ACA costs

- Vouchers for high risk individuals

- New/Change/Fix ACA (mandate)

- Incentivize state programs

- Community Health Centers

- System models based on other countries

- Court/rule a right to public health

- Court/rule on federal spending powers

- National Health Trust system

- National public drug insurance

- Health Savings Accounts

- Repeal Hyde Amendment/Reproductive health coverage

- Telehealth coverage

- Universal catastrophic coverage

- Universal social insurance fund for basic health care coverage (outcome based care)

## Likely Advantage Areas

- High costs and inefficiencies lead to runaway spending and economic collapse

- High costs leads to insurance bubbles that collapse the economy

- High costs leads to manufacturing collapse that hurts US competitiveness

- Lack of universal infrastructure means disease outbreaks/bioterror outbreaks cannot be contained

- Funding/regulatory certainty means more drug and pharma innovation which is necessary to solve disease

- Denying that health care is a right that all people have undermines US ability to promote/incorporate/be a model for international human rights

## Core Negative Arguments

- Economy disadvantage – could include many different versions: federal involvement causes interest rate hikes,

- Pharma disadvantage – increased federal involvement would lower prices and/or mean price controls that hurt/devalue pharma research and development which is necessary to solve diseases

- Federalism disadvantage – federal overreach into health care interferes with state powers: there are good links specific to health care

- Election disadvantage – preliminary research indicates that health care could be the defining issue in the 2020 election which means two things: first, that the first part of the season will yield very strong election debates and second, that other topics could lose the election disadvantage in light of cards about why health care and/or immigration are more important whereas with the health care topic there will be a debate

- Politics disadvantage – regardless if President Trump wins or a Democrat, health care changes early in the start of the 2021 presidential term will drastically impact the agenda

- Free market counterplan – could include many different versions: regulated regional health exchanges, etc

- States counterplan – unified state actions solve just as well

# Summary

**Resolutions**: the topic committee is advised to choose between different operative (verbs and) terms of art “establish a system of” or “substantially increase.” There is a choice between “universal health (care) coverage” and “national health insurance”, the latter of which is lower down on the proposed resolutions because of its similarity to the recent college topic.

**Timeliness**: progressives are currently debating how far to go toward federal control of health care and the impact on the insurance industry. This would be a dynamic issue in the presidential elections leading up to 2020 as well as in a possible Democratic White House in the spring of 2021.

**Scope**: this paper includes just a small selection of recent articles about different options for expanding health care and there are many divergent options that have different relationships to the current insurance industry and how much money they will cost. Thus, there will be many different affirmatives and several strong core negative generics including the insurance disadvantage and the spending/taxes disadvantage.

**Range**: the topic will allow for both novice and advanced debaters to expand knowledge and skill. Regional areas and debate leagues could create core topic novice case lists focusing on easily comprehendible affirmatives while more experienced debaters can take advantage of a large literature base that will encourage creative argumentation.

**Quality**: the debates on this topic will make debaters think about how new generations will address health care for all, a rising progressive issue. A strength of the topic is that it embodies the purpose of policy debate: to expose students to areas of importance to them, to allow students to simulate and experiment with policymaking, and to inform them as they become informed voters and citizens.

**Material**: more than many other topics, there will be high quality news and magazine articles that will impact this topic. There should never be a lack of material for students to develop their arguments.

**Interest**: debaters will be engaged in a health care topic just as health care coverage dominated the 2018 midterms and is likely to dominate the 2020 presidential elections.

**Balance**: this paper outlines how while there may be divergent policy proposals from the affirmative, there will be several strong core negative generic arguments.

**Definitions**: the literature shows that “universal health coverage” is a slightly more precise term than “universal health care coverage” as they are basically synonymous. “Access” seems to blur the brightline between affirmative and negative ground.

# Definitions

**“access”**

“Access to health care refers to the ease with which an individual can obtain needed medical services. RAND research has examined the social, cultural, economic, and geographic factors that influence health care access worldwide; the effects of changes in access; and the relationship between access and health for specific U.S. populations—including racial and ethnic minorities, people with limited English proficiency, the uninsured, the elderly, children, and veterans” (RAND).

“Facilitating access is concerned with helping people to command appropriate health care resources in order to preserve or improve their health. Access is a complex concept and at least four aspects require evaluation. If services are available and there is an adequate supply of services, then the opportunity to obtain health care exists, and a population may 'have access' to services. The extent to which a population 'gains access' also depends on financial, organisational and social or cultural barriers that limit the utilisation of services. Thus access measured in terms of utilisation is dependent on the affordability, physical accessibility and acceptability of services and not merely adequacy of supply. Services available must be relevant and effective if the population is to 'gain access to satisfactory health outcomes'. The availability of services, and barriers to access, have to be considered in the context of the differing perspectives, health needs and material and cultural settings of diverse groups in society. Equity of access may be measured in terms of the availability, utilisation or outcomes of services. Both horizontal and vertical dimensions of equity require consideration” (Gulliford).

“Accessibility

Physical accessibility

“is understood as the availability of good health services within reasonable reach of those who need them and of opening hours, appointment systems and other aspects of service organization and delivery that allow people to obtain the services when they need them”. Universal health coverage and universal access, Bulletin of the World Health Organization 2013; 91:546–546A. As defined in the human rights context, “[h]ealth facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS, including in rural areas”.

Economic accessibility, or affordability

“is a measure of people’s ability to pay for services without financial hardship. It takes into account not only the price of the health services but also indirect and opportunity costs (e.g. the costs of transportation to and from facilities and of taking time away from work).” Affordability is influenced by the wider health financing system and by household income.

Information accessibility

“includes the right to seek, receive and impart information and ideas concerning health issues”. This access to information, however, “should not impair the right to have personal health data treated with confidentiality”” (WHO).

“Medicaid and the Children’s Health Insurance Program (CHIP) provide critical health coverage for millions of people. Through these programs, the Centers for Medicare and Medicaid Services (CMS) supports access to care in many ways. Most importantly, people gain access to health care services that may not be affordable without Medicaid or CHIP. Additionally, some programs and benefits include special protections—such as provider network and payment methods—that help ensure services are accessible.

Preventive care and other services help people stay healthy and avoid more costly care. CMS offers materials, toolkits, and other resources for states to help Medicaid and CHIP beneficiaries learn about these services and how to access them. CMS also supports many efforts to measure access, share the results, and promote progress. Learn more through the following guidance, reports, and initiatives” (Medicaid.gov).

“This may sound like a small semantic difference, but the distinction is a big one. The ACA has a goal of covering everyone with health insurance. And while it hasn’t achieved that goal, the years since the law passed have coincided with a major drop in the ranks of the uninsured. Under the law, about 20 million people have gained coverage, according to the best estimates, leaving about 9 percent, or 27 million people, still uncovered.

In contrast, many Republicans say they have a goal of “universal access.” That would mean that everyone would be offered a chance to buy some form of insurance, but not necessarily that everyone will get it” (McGinley and Goldstein).

**“expand”**

“The original idea for expanding coverage under the ACA was that about half of the newly insured would gain private health plans through the marketplaces and the other half would become eligible for Medicaid under a major expansion of the 1960s-era program that has been a joint responsibility of the federal government and states. Instead of the patchwork of eligibility rules that existed around the country, there would be national standard in which anyone with income up to 138 percent of the federal poverty level could qualify.

That expectation ended in 2012, when the Supreme Court, as part of a ruling that upheld the law’s constitutionality overall, gave each state the latitude to decide whether to participate in the ACA Medicaid expansion. As of now, 31 states and the District of Columbia have. For states that expanded Medicaid, the federal government paid 100 percent of the cost for newly eligible enrollees for the first few years, and the federal share is now ratcheting down to an eventual 90 percent.

While some states with Republican governors have expanded Medicaid under the ACA, the Trump administration and many GOP leaders in Congress oppose it. The president has recently indicated that he supports an idea, long popular in conservative circles, that would fundamentally change Medicaid, transforming it from an entitlement (meaning that everyone who is eligible can get into the program and the government spends whatever is needed to provide its benefits) to a program of block grants, in which the government allots to each state a fixed amount of money each year and frees states from many of the program’s rules about what health services must be covered.

Block grant proponents say that they would give states more flexibility to run their programs as they see fit; detractors say they are a smokescreen to curb federal spending and ultimately would hurt poor people” (McGinley and Goldstein).

“I am a practicing physician, a diagnostic radiologist. I own and operate Clearview Medical Imaging, a small outpatient diagnostic imaging facility in Metairie, Louisiana, a suburb of New Orleans. My practice and my experience as a small business person with 12 full-time employees have given me an ongoing opportunity to study what's wrong with American medicine as well as what's right.

Let's be clear about our objectives in this national debate: Every American should have access to affordable health insurance coverage. Yet the number of uninsured is growing. If we are going to expand coverage and provide universal access in a cost-effective manner, federal and state policymakers alike will have to carefully craft new policies to create a new and more effective medical marketplace. But in so doing, they should be guided by four basic principles:

Principle No. 1: End discrimination against personal choice. Beneficiaries should be given an expanded array of choices of plan without discrimination for or against any one type of plan, as now occurs.

Principle No. 2: Expand personal choice and allow patients to change their minds. The individual should be given the opportunity and responsibility to choose and own his or her own insurance along with the right periodically to change if dissatisfied with the previous choice.

Principle No. 3: Establish a defined contribution as a principle in both public and private health care financing. The employer in the private sector or the government in the public sector puts up the same defined contribution, no matter which choice the beneficiary makes.

Principle No. 4: End IRS discrimination against personal purchase of insurance and allow patients to purchase plans through cooperatives if they wish to do so. Lawmakers should eliminate tax discrimination against individuals owning their health insurance and enable the establishment of voluntary choice cooperatives where employees can take their defined contributions and shop for the insurance plan which best suits their needs” (Johnson).

**“increase”**

“In our review, successful initiatives were accompanied by substantial long-term investments in infrastructure, training and improvement of working conditions of the health workforce. Such investment involves health system strengthening as part of efforts to increase universal health coverage which was evident in the context of several studies in this review [41, 43, 47, 48]. A recent study highlights the importance of equity as a measurable component of universal health coverage to ensure health care for vulnerable populations and summarizes useful indicators and frameworks [77]. This will include the ongoing assessment of midwifery and nursing services received by vulnerable groups [78]. However, the effective implementation of policies to increase access to health care requires the active participation of nurse leaders, particularly where the needs of unique populations must be addressed, to promote equity in nursing policy and practice [79, 80]” (Dawson).

“ As stated by WHO, universal health coverage prevails when all people receive the needed quality health services without suffering financial hardships based on utilization of health services and the economic consequences of using such health services [10]. According to WHO, Ghana has expanded its national health insurance coverage in 2008 to include free healthcare services delivery to all pregnant women, only due to political reasons and as a result of its election period. This affirms the assertion that the desire to increase universal health coverage can be politically motivated and, as a consequence, an increased government commitment can lead to the attainment of full universal healthcare coverage in Ghana. Recent research indicated that the implementation of national health insurance in Ghana has increased health coverage, health sector financial resource availability, health service utilization, decreasing out-of-pocket payments and catastrophic expenditures for health care [47]. However, with respect to the physical accessibility dimension, it has been revealed that Ghana has poor UHA because one quarter of the total population live over 60 km from a health facility where a doctor can be

consulted and access to skilled birth attendance is only 46% in the country [3]” (Boateng).

“Paying for health care may exclude poor people. Burkina Faso adopted the DOTS strategy implementing “free care” for Tuberculosis (TB) diagnosis and treatment. This should increase universal health coverage and help to overcome social and economic barriers to health access” (Laorki).

**“(health care) system”**

“In this model, adapted from Ferlie and Shortell (2001), the health care system is divided into four “nested” levels: (1) the individual patient; (2) the care team, which includes professional care providers (e.g., clinicians, pharmacists, and others), the patient, and family members; (3) the organization (e.g., hospital, clinic, nursing home, etc.) that supports the development and work of care teams by providing infrastructure and complementary resources; and (4) the political and economic environment (e.g., regulatory, financial, payment regimes, and markets), the conditions under which organizations, care teams, individual patients, and individual care providers operate (see Figure 2-1)” (Reid).

“health care system an organized plan of health services. The term usually is used to refer to the system or program by which health care is made available to the population and financed by government, private enterprise, or both. In a larger sense, the elements of a health care system embrace the following: (1) personal health care services for individuals and families, available at hospitals, clinics, neighborhood centers, and similar agencies, in physicians' offices, and in the clients' own homes; (2) the public health services needed to maintain a healthy environment, such as control of water and food supplies, regulation of drugs, and safety regulations intended to protect a given population; (3) teaching and research activities related to the prevention, detection, and treatment of disease; and (4) third party (health insurance) coverage of system services.

In the United States, the spectrum of health care has been defined by the Department of Health and Human Services as encompassing six levels of health care. The first level of care is preventive care, which is primarily provided by school health education courses and community and public health services.

Primary care is the usual point at which an individual enters the health care system. Its major task is the early detection and prevention of disease and the maintenance of health. This level of care also encompasses the routine care of individuals with common health problems and chronic illnesses that can be managed in the home or through periodic visits to an outpatient facility. Providers of care at the primary level include family members as well as the professionals and paraprofessionals who staff community and neighborhood health centers, hospital outpatient departments, physicians' offices, industrial health units, and school and college health units.

Secondary or acute care is concerned with emergency treatment and critical care involving intense and elaborate measures for the diagnosis and treatment of a specified range of illness or pathology. Entry into the system at this level is either by direct admission to a health care facility or by referral. Provider groups for secondary care include both acute- and long-term care hospitals and their staffs.

Tertiary care includes highly technical services for the treatment of individuals and families with complex or complicated health needs. Providers of tertiary care are health professionals who are specialists in a particular clinical area and are competent to work in such specialty agencies as psychiatric hospitals and clinics, chronic disease centers, and the highly specialized units of general hospitals; for example, a coronary care unit. Entry into the health care system at this level is gained by referral from either the primary or secondary level.

Respite care is that provided by an agency or institution for long-term care patients on a short-term basis to give the primary caretaker(s) at home a period of relief.

Restorative care comprises routine follow-up care and rehabilitation in such facilities as nursing homes, halfway houses, inpatient facilities for alcohol and drug abusers, and in the homes of patients served by home health care units of hospitals or community-based agencies.

Continuing care is provided on an ongoing basis to support those persons who are physically or mentally handicapped, elderly and suffering from a chronic and incapacitating illness, mentally retarded, or otherwise unable to cope unassisted with daily living. Such care is available in personal care homes, domiciliary homes, inpatient health facilities, nursing homes, geriatric day care centers, and various other types of facilities. See also home health care.

holistic health a system of preventive care that takes into account the whole individual, one's own responsibility for one's well-being, and the total influences—social, psychological, environmental—that affect health, including nutrition, exercise, and mental relaxation.

health Insurance Portability and Accountability Act an act of Congress, passed in 1996, that affords certain protections to persons covered by health care plans, including continuity of coverage when changing jobs, standards for electronic health care transactions, and privacy safeguards for individually identifiable patient information.

health maintenance organization (HMO) any of a variety of health care delivery systems with structures ranging from group practice through independent practice models or independent practice associations (IPAs). They provide alternatives to the fee-for-service private practice of medicine and other allied health professions. Although the type of organizational pattern, membership, and ownership of the organization may vary among HMOs, all have the major goal of allowing for investment in and incentives to use a prepaid, organized, comprehensive health care system that serves a defined population. The enrolled population enters into a contract with the organization, agreeing to pay, or have paid on their behalf, a fixed sum, in return for which the HMO makes available the health care personnel, facilities, and services that the population may require. The services are available on a 24-hour-a-day, 7-day-a- week basis. Some HMOs may provide directly the entire range of health services, including rehabilitation, dental, and mental health care. Others may agree to provide directly or arrange to pay only for physicians' services, in-hospital care, and outpatient emergency and preventive medical services. The kinds of services available are stipulated in the contract between the organization and its enrolled population. The emphasis of a health maintenance organization is on preventive rather than crisis-oriented medical care” (Miller-Keane Encyclopedia and Dictionary).

“The Health Care Delivery System

For Americans to enjoy optimal health—as individuals and as a population—they must have the benefit of high-quality health care services that are effectively coordinated within a strong public health system. In considering the role of the health care sector in assuring the nation’s health, the committee took as its starting point one of the recommendations of the Institute of Medicine (IOM) report Crossing the Quality Chasm (2001b: 6): “All health care organizations, professional groups, and private and public purchasers should adopt as their explicit purpose to continually reduce the burden of illness, injury, and disability, and to improve the health and functioning of the people of the United States.”

This chapter addresses the issues of access, managing chronic disease, neglected health care services (i.e., clinical preventive services, oral, and mental health care and substance abuse services), and the capacity of the health care delivery system to better serve the population in terms of cultural competence, quality, the workforce, financing, information technology, and emergency preparedness. In addition, the chapter discusses the responsibility of the health care system to recognize and play its appropriate role within the intersectoral public health system, particularly as it collaborates with the governmental public health agencies.

The health care sector in the United States consists of an array of clinicians, hospitals and other health care facilities, insurance plans, and purchasers of health care services, all operating in various configurations of groups, networks, and independent practices. Some are based in the public sector; others operate in the private sector as either for-profit or not-for-profit entities. The health care sector also includes regulators, some voluntary and others governmental. Although these various individuals and organizations are generally referred to collectively as “the health care delivery system,” the phrase suggests an order, integration, and accountability that do not exist. Communication, collaboration, or systems planning among these various entities is limited and is almost incidental to their operations. For convenience, however, the committee uses the common terminology of health care delivery system.

As described in Crossing the Quality Chasm (IOM, 2001b) and other literature, this health care system is faced with serious quality and cost challenges. To support the system, the United States spends more per capita on health care than any other country ($4,637 in 2000) (Reinhardt et al., 2002). In the aggregate, these per capita expenditures account for 13.2 percent of the U.S. gross domestic product, about $1.3 trillion (Levit et al., 2002). As the committee observed in Chapter 1, American medicine and the basic and clinical research that inform its practice are generally acknowledged as the best in the world. Yet the nation’s substantial health-related spending has not produced superlative health outcomes for its people. Fundamental flaws in the systems that finance, organize, and deliver health care work to undermine the organizational structure necessary to ensure the effective translation of scientific discoveries into routine patient care, and many parts of the health care delivery system are economically vulnerable. Insurance plans and providers scramble to adapt and survive in a rapidly evolving and highly competitive market; and the variations among health insurance plans—whether public or private—in eligibility, benefits, cost sharing, plan restrictions, reimbursement policies, and other attributes create confusion, inequity, and excessive administrative burdens for both providers of care and consumers.

Because of its history, structure, and particularly the highly competitive market in health services that has evolved since the collapse of health care reform efforts in the early 1990s, the health care delivery system often does not interact effectively with other components of the public health system described in this report, in particular, the governmental public health agencies. Health care’s structure and incentives are technology and procedure driven and do not support time for the inquiry and reflection, communication, and external relationship building typically needed for effective disease prevention and health promotion. State health departments often have legal authority to regulate the entry of providers and purchasers of health care into the market and to set insurance reimbursement rates for public and, less often, private providers and purchasers. They may control the ability of providers to acquire desired technology and perform complex, costly procedures that are important to the hospital but increase demands on state revenues. Finally, virtually all states have the legal responsibility to monitor the quality of health services provided in the public and private sectors. Many health care providers argue that such regulation adds to their costs, and high-profile problems can create additional tensions that impede collaboration between the state public health agency and the health care delivery system.

Furthermore, when the delivery of health care through the private sector falters, the responsibility for providing some level of basic health care services to the poor and other special populations falls to governmental public health agencies as one of their essential public health services, as discussed in Chapter 1. In many jurisdictions, this default is already occurring, consuming resources and impairing the ability of governmental public health agencies to perform other essential tasks.

Although this committee was not constituted to investigate or make recommendations regarding the serious economic and structural problems confronting the health care system in the United States, it concluded that it must examine certain issues having serious implications for the public health system’s effectiveness in promoting the nation’s health. Drawing heavily on the work of other IOM committees, this chapter examines the influence that health insurance exerts on access to health care and on the range of care available, as well as the shortcomings in the quality of services provided, some of the constraints on the capacity of the health care system to provide high-quality care, and the need for better collaboration within the public health system, especially among governmental public health agencies and the organizations in the personal health care delivery system” (Institute of Medicine).

“America's health system is neither as successful as it should be nor as sustainable as it must be. The Patient Protection and Affordable Care Act of 2010 (ACA) introduces the prospects for major reforms in payment for and organization of care, in prevention and population health, and in approaches to continuous improvement. Yet it remains under legal assault and a cloud of controversy. Even if it is fully implemented, the ACA will not represent a complete solution to the core dilemma of affordability and performance. The country's political appetite for further reform may be sated, but unless we attend to the major sources of waste and impediments to performance, the United States will remain vulnerable to an excessively costly health system that delivers incommensurate health benefit.

I purposely refer to a “health system” rather than a “health care system” because the solutions need to focus on the ultimate outcome of interest — that is, the population's health and each individual's health — and not only on the formal system of care designed primarily to treat illness.

A successful health system has three attributes: healthy people, meaning a population that attains the highest level of health possible; superior care, meaning care that is effective, safe, timely, patient-centered, equitable, and efficient2; and fairness, meaning that treatment is applied without discrimination or disparities to all individuals and families, regardless of age, group identity, or place, and that the system is fair to the health professionals, institutions, and businesses supporting and delivering care.

A sustainable health system also has three key attributes: affordability, for patients and families, employers, and the government (recognizing that employers and the government ultimately rely on individuals as consumers, employees, and taxpayers for their resources); acceptability to key constituents, including patients and health professionals; and adaptability, because health and health care needs are not static (i.e., a health system must respond adaptively to new diseases, changing demographics, scientific discoveries, and dynamic technologies in order to remain viable)” (Fineberg).

“Organized system of providers and services for health care; may include hospitals, clinics, home care, long-term care facilities, assisted living, physicians, health plans, and other services” (Medical Dictionary for the Health Professions and Nursing).

**“universal health (care) coverage”**

“Universal health care coverage--pitfalls and promise of an employment-based approach.

America's patchwork quilt of health care coverage is coming apart at the seams. The system, such as it is, is built upon an inherently problematic base: employment. By definition, an employment-based approach, by itself, will not assure universal coverage of the entire population. If an employment-based approach is to be the centerpiece of a system that provides universal coverage, special attention must be paid to all the categories of individuals who are not employees--children, unemployed spouses or singles, the unemployable ill and disabled, persons between jobs, students, retirees, the elderly. Moreover, in a purely voluntary employment-based arrangement, some employers will not provide insurance at all, and others will provide inadequate coverage, necessitating other special provisions for coverage. As a consequence, about one out of six people now has no health coverage whatsoever, and even more have inadequate coverage. All the while, the rapidly-increasing transaction costs of sustaining this grossly inadequate pluralistic system eat up sufficient funds to provide basic benefits to the entire population. The time for systematic reforms has come and gone; what is now needed is action to prevent disaster, followed by a complete rebuilding of this country's health coverage system. Although perhaps more likely to be tried than more radical, completely nationalized, ones, stepwise reforms may not go far enough to cure the significant ills of the current employment-based system. Passage of inadequate reforms, then, could well set the stage for nationalized health care in the not too distant future” (Budetti).

“There is an emerging global consensus on the importance of universal health coverage (UHC), but no unanimity on the conceptual definition and scope of UHC, whether UHC is achievable or not, how to move towards it, common indicators for measuring its progress, and its long-term sustainability. This has resulted in various interpretations of the concept, emanating from different disciplinary perspectives. This paper discusses the various dimensions of UHC emerging from these interpretations and argues for the need to pay attention to the complex interactions across the various components of a health system in the pursuit of UHC as a legal human rights issue.

Discussion

The literature presents UHC as a multi-dimensional concept, operationalized in terms of universal population coverage, universal financial protection, and universal access to quality health care, anchored on the basis of health care as an international legal obligation grounded in international human rights laws. As a legal concept, UHC implies the existence of a legal framework that mandates national governments to provide health care to all residents while compelling the international community to support poor nations in implementing this right. As a humanitarian social concept, UHC aims at achieving universal population coverage by enrolling all residents into health-related social security systems and securing equitable entitlements to the benefits from the health system for all. As a health economics concept, UHC guarantees financial protection by providing a shield against the catastrophic and impoverishing consequences of out-of-pocket expenditure, through the implementation of pooled prepaid financing systems. As a public health concept, UHC has attracted several controversies regarding which services should be covered: comprehensive services vs. minimum basic package, and priority disease-specific interventions vs. primary health care” (Abiiro).

“Universal health coverage (UHC) means that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.

This definition of UHC embodies three related objectives:

Equity in access to health services - everyone who needs services should get them, not only those who can pay for them;

The quality of health services should be good enough to improve the health of those receiving services; and

People should be protected against financial-risk, ensuring that the cost of using services does not put people at risk of financial harm.

UHC is firmly based on the WHO constitution of 1948 declaring health a fundamental human right and on the Health for All agenda set by the Alma Ata declaration in 1978. UHC cuts across all of the health-related Sustainable Development Goals (SDGs) and brings hope of better health and protection for the world’s poorest” (World Health Organization 2).

“As such, the role of Universal Health Coverage (UHC), which ensures broad population access to promotive, preventive, curative and rehabilitative health services1, is receiving growing attention. UHC is defined as a combination of a legal assurance of health insurance, >90% coverage of health insurance and skilled birth attendance (Stuckler et al., 2010). The first example of universal health coverage that delivered access to basic medical services even to the poorest citizens, was the Soviet Union's famous Semashko system that was established in the early 1930s (Semashko, 1934; McMichael, 1942). The World Health Organization (WHO) has called for all countries to adopt UHC (Carrin et al., 2005). Achieving universal health coverage has also been included as a target in the newly adopted Sustainable Development Goals (SDGs). However, to date, there has been inadequate investigation of its effect on long-term health outcomes (Rancic and Jakovljevic, 2016). There have been some country studies, such as Davis and Huang (2008), who found life expectancy and other health outcomes significantly increased in Taiwan after the adoption of UHC (Davis and Huang, 2008). However, the association between universal health coverage and life expectancy, and strength of the association has not been systematically tested comparatively” (Ranabhat).

“Universal health coverage (UHC) has been acknowledged as a priority goal of every health system [1–5]. The importance of this goal is reflected in the consistent calls by the World Health Organization (WHO) for its member states to implement pooled prepaid health care financing systems that promote access to quality health care and provide households with the needed protection from the catastrophic consequences of out-of-pocket (OOP) health-related payments [2, 6–8]. This call has also been endorsed by the United Nations [5].

In the existing literature, different conceptual terminology, such as universal health care [9], universal health care coverage [10, 11], universal health system, universal health coverage, or simply universal coverage, have been used to refer to basically the same concept [9, 12–14]. Stuckler et al. [15] noted that “universal health care” is often used to describe health care reforms in high income countries while “universal health coverage” is associated with health system reforms within low- and middle-income countries (LMICs). Given that the poor, marginalized and most vulnerable populations mostly reside in LMICs, this paper places relatively high emphasis on such settings. Hence, we adopt the term universal health coverage (UHC) [2] throughout the paper” (Abiiro).

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