### Framework

#### I affirm the resolution, resolved: The United States ought to implement a single-payer universal healthcare system.

#### I value morality because the word ought in the resolution implies a moral obligation.

#### Thus, the value criterion must be maximizing well-being for everyone.

#### There are two main reasons for this:

#### Everyone does not like painful or emotionally harmful experiences, so naturally we should try to replace these things with good experiences.

#### Things like death and oppression are intuitively bad, and effect everyone, so we should try to prevent them.

#### Next, Single payer universal healthcare is defined by the National Health Care for the Homeless Council as

[National Health Care for the Homeless Council, "Single-Payer Health Care – National Health Care for the Homeless Council," No Publication, https://nhchc.org/policy-issues/single-payer-health-care-2/]

What is Single Payer?

Single-payer—or Medicare for All—is simply a streamlined financing mechanism where one entity administers the health care funding and payments. It expands the cost-effective and administratively efficient Medicare program to cover everyone in the United States.

#### The debate will break down simply: if I can show you that a universal healthcare system will have a good impact on the world, you should vote affirmative in today’s debate. The negative burden is to prove why universal healthcare won’t be good for the world.

### Our sole contention is Coverage

#### Current lack of healthcare coverage creates a widening gap in health equality – that results in disparities in access, system gaming, and death gaps

Himmelstein et al., MD, primary-care doctor in Cambridge, Massachusetts, who teaches at Harvard Medical School. He co-founded, with Steffie Woolhandler, Physicians for a National Health Program, ‘17

(David U., Inequality and the health-care system in the USA, Volume 389, No. 10077, p1431–1441, 8 April)

Inequality and the health-care system in the USA The health-care system could soften the effects of economic inequality by delivering high-quality care to all. Yet the institutions and financing patterns of the health-care system in the USA—by far the world's most expensive12–cause it to fall short of this ideal. Although inequalities exist to some extent in every health-care system, they are particularly stark in the USA. Unequal access to medical services is likely to contribute to disparities in health status, while rising costs (for both the insured and uninsured) reduce disposable incomes, particularly burdening low-income households. Many patients cannot afford the care they need, and often forgo medical care altogether. For example, 19% of non-elderly adults in the USA who received prescriptions in 2014 (after full implementation of the Affordable Care Act [ACA]) could not afford to fill them.13 Millions of middle-class families have been bankrupted by illness and medical bills.14 Meanwhile, very wealthy Americans are turning to so-called concierge practices that offer lengthy office visits and unfettered access to specialists. This Series paper examines how the health-care system in the USA contributes and responds to inequality. We focus our attention on the association between inequality and the medical care system. We first review how social position influences Americans' access to medical services and the quality of those services. The uninsured face the greatest barriers to care, but many insured Americans are also unable to afford medical care because of cost sharing. Although race-based disparities in quality are well documented, the low quality scores of doctors and hospitals serving poor communities might reflect patients' deprived social circumstances rather than their providers' performance. We also review how the health-care costs borne by households—in the form of insurance premiums, taxes, and out-of-pocket payments—exacerbate income inequality, forcing many Americans to cut back on food and other necessities, and contributing to most personal bankruptcies. We conclude by discussing the historical context for today's health-care inequalities, and propose options for reform. Inequality and access to care Income-related disparities in access to care are far wider in the USA than in other wealthy countries.15 Before the 2010 passage of the ACA, which progressively expanded health insurance coverage, 39% of Americans with below-average income reported not seeing a doctor for a medical problem because of cost, compared with 7% of low-income Canadians and 1% of those in the UK.16 Inequality in access to care is particularly stark in Southern states. For example, in Texas, Mississippi, and Florida, adults on a low income are more than twice as likely to face cost-related barriers to care as their counterparts in Maine (a relatively poor New England state) and Massachusetts.17 Disparities in access are largely due to high rates of uninsurance or inadequate health insurance among low-income Americans, although Americans with above-average incomes probably also have worse access to care than do their peers in other countries.16 Today, despite gains due to the ACA, 27 million Americans (down from 50 million before the passage of the ACA) remain uninsured. Most of the uninsured have annual incomes near or below the official poverty line ($11 770 for an individual in 2016). The uninsured are far more likely than the insured to forgo needed medical visits, tests, treatments, and medications because of cost. Cost barriers are especially severe for the millions of uninsured Americans with chronic conditions.18 For example, middle-aged adults with no coverage for eye care report difficulties in reading or recognising a friend across the street more frequently than do comparable individuals with coverage.19 Uninsured individuals with diabetes spend, on average, $1446 out of pocket for medical services each year, and more than **30% do not have a primary care provider**.20 Similarly, low-income and uninsured Americans with psychiatric disorders are far more likely than the insured and those on higher incomes are to experience difficulties obtaining care.21 For poor Americans, gaining insurance boosts access to care (although it does not fully close the gap between poor and affluent patients), leading to more visits for preventive screenings and greater satisfaction with care than before gaining coverage.22 Medicaid insurance for low-income Americans Medicaid, the public insurance programme that covers 58 million low-income Americans, improves health outcomes and access to care for its beneficiaries.23 Gaining Medicaid coverage reduces rates of clinical depression,24 financial problems due to illness,24 and mortality.23 The generosity of the Medicaid programme, which is largely controlled by state governments, is a key determinant of access-related disparities. Before the passage of the ACA, most states restricted Medicaid eligibility to poor children and pregnant women, disabled people, and the poorest adults with children. Childless adults and parents with incomes above stringent state-specific thresholds (eg, 10% of the poverty level in Alabama) were generally excluded. The ACA's expansion of Medicaid to all citizens with annual incomes at or below 138% ($16 643 for an individual in 2017) of the poverty level promised to cover millions of previously uninsured Americans. However, the US Supreme Court ruled in 2012 that states could opt out of the Medicaid expansion, and the Trump administration is likely to further erode or repeal it. As of 2016, 19 states (mostly in the South) have opted out, cutting the number of citizens who would otherwise have gained coverage by about 5 million. An additional 5–6 million undocumented immigrants do not have insurance because the ACA specifically excluded them from its coverage expansion,25 perpetuating major constraints on their access to care.26 Fortunately, the ACA increased funding for community health centres, which deliver much-needed care to millions of low-income Americans, and extended mental health parity regulations aimed at improving insurance coverage for mental health and addiction treatment. Although Medicaid improves access to care, specialist care is often unobtainable because the programme pays low fees to physicians,27 who are free to turn away Medicaid patients. For example, 76% of orthopaedists' offices in a nationwide audit study refused to offer an appointment to a Medicaid-insured child with a fracture, whereas only 18% refused a child with private insurance.28 Cost sharing and private insurance In the private insurance market, cost sharing by patients (ie, through user fees) has increased substantially since the 2000s.29 Many plans now impose co-payments of more than $30 for primary care and more than $45 for specialist visits.30 More than 80% of employer-based plans include an annual deductible (the amount a patient must pay before insurance covers additional costs), which averaged $1478 in 2016, an increase of 2·5 times since 2006.30 Cost sharing by patients is even higher in plans sold through the insurance exchanges created by the ACA. In mid-level, so-called silver tier plans (which account for about 70% of exchange coverage), deductibles averaged $3064 in 2016,30 although some subsidies were available to cushion the deductibles for enrollees with incomes 100–250% of the poverty level. Many private plans also reduce premium costs by restricting patients' choice of providers to narrow networks of doctors and hospitals, which often exclude academic and cancer referral centres.31 Enrollees who seek out-of-network care (either by choice or because of medical necessity) generally must pay the entire bill out of pocket. Predictably, patients' use of care declines as their cost-sharing obligation rises, and people with the worst health are most likely to cut back on care.32 Paradoxically, this reduction in care-seeking can fail to cut system-wide use, instead shifting care from the sick and poor to the healthy and wealthy. At least in some cases, when poor patients avoid care, doctors and hospitals fill the empty appointment slots and beds with patients who are less price-sensitive33—an example of supply-sensitive demand.34 Strikingly, the USA has the world's highest health-care expenditures despite extensive cost sharing by patients. Additionally, care forgone because of cost sharing might ultimately raise costs by increasing downstream health problems. When the Medicare programme (the public coverage for people aged 65 or older and those with long-term-disabilities) added new co-payments, outpatient visits decreased but hospital admissions increased.35 Among patients who developed a myocardial infarction, elimination of medication co-payments after the cardiac event increased compliance, and (for racial and ethnic minority patients) led to a 35% reduction in major vascular events and a 70% reduction in total health-care spending.36 Similarly, among children aged 5–18 years with asthma, those whose insurance required higher co-payments used fewer medications but had a 41% greater risk of asthma-related hospital admissions than did children with lower co-payments.37 For nearly a third of children with asthma from low-income families with high cost-sharing coverage through the Kaiser Health Plan, parents reported delaying or avoiding outpatients visits, and 14·8% reported non-adherence to medications because of cost; 15·6% of all parents (including those with higher incomes) reported borrowing money or cutting back on necessities to pay for their children's asthma care.38 Defining underinsurance *Rising deductibles* and other forms of cost sharing by patients have eroded the traditional definition of insurance: protection from the financial harms of illness. The term underinsurance describes this problem, but it does not have a standard definition. Some studies of underinsurance have focused on financial vulnerability (eg, measurement of deductibles as a fraction of income),39 others on out-of-pocket costs incurred (either in absolute dollars or relative to income),40 whereas others have highlighted barriers to care (because of cost or narrow insurance networks).41 No standard quantitative thresholds exist for these different concepts. The various definitions of underinsurance highlight two related but distinct problems: people with inadequate insurance risk financial harm when they receive medical services, and they are therefore less likely to obtain needed care. Despite the absence of consensus on the definition of underinsurance, it is clear that these problems affect many Americans with private coverage and have increased. Between 2004 and 2013, high rates of uninsurance, rising cost sharing (ie, underinsurance), and stagnant incomes all contributed to a decline in overall health-care consumption (as measured by the total amount spent by insurers and patients) for poor Americans, a trend that was reversed in 2014 when the major provisions of the ACA came into effect (figure 2).42 For the first time since the 1970s, per-capita medical expenditures for the poorest fifth of Americans (who are, on average, much sicker than the wealthiest 20%) dipped below those of the wealthiest 20%.42 In Canada, by contrast, the poorest citizens receive the most medical services, commensurate with their increased health needs.45 Meanwhile, health-care expenditures for the wealthiest 20% of Americans accelerated, raising their share of overall health-care consumption. The ACA, fully implemented in 2014, led to a surge in health-care expenditures for the bottom 20%, but expenditures for the middle class have flattened while health-care consumption by the wealthiest Americans continues to grow. Access problems Geography often affects access to care. Because physicians are concentrated in cities and affluent suburbs, many Americans living in rural areas find it difficult to obtain primary46 and specialty care.47 Many rural and Southern states also have a shortage of adequate family planning resources. Texas, for example, has imposed onerous regulations and funding cuts on family planning clinics, causing closure of many48 and a subsequent increase in unwanted pregnancies.49 Since the closure of the last local abortion clinic in 2013, women in Lubbock, Texas (population 244 000), are now more than 250 miles away from the nearest abortion provider. Women are also at a financial disadvantage because of their greater health-care needs (including reproductive care) than those of men. Although fewer women than men are uninsured, those with insurance have higher out-of-pocket costs. For example, among people with employer-sponsored coverage, women's out-of-pocket costs were $233 higher than men's in 2013;50 among Medicare enrollees, such costs were $640 higher for women than they were for men in 2011.51 These costs are especially burdensome because women's median incomes are 39% lower than those of men.52 Illness-based disparities are particularly stark for mental illness and substance abuse. Historically, a large share of psychiatric care was paid for out of pocket or provided in underfunded public institutions. Jails remain the largest so-called inpatient mental health facilities in the USA. Although the 2008 Mental Health Parity and Addiction Equity Act mandated that most insurance plans provide equivalent coverage for mental and physical illness, implementation of this requirement was delayed until 2015, and its enforcement has proven difficult.53 Moreover, most Medicaid programmes (which cover many people with mental disorders) are exempt from these regulations. Psychiatric—and particularly substance abuse—providers are in short supply on a national scale, especially in poor and rural areas;53 these areas have been particularly hard hit by the epidemic of drug overdoses and self harm, which pushed up the overall death rate in the USA in 2015. The ACA, which applied the parity requirement to the plans sold through the exchanges, increased access to mental health, but not to substance abuse treatment; substantial racial and ethnic disparities persist.54 Inequality and quality of care For many conditions, increased quality is implied by, and inseparable from, improved access to care. An increased frequency of primary care visits, for example, is associated with improved control of diabetes.55 Similarly, among patients who developed an acute myocardial infarction, the uninsured were 38% more likely (and the underinsured 21% more likely) than the well insured to delay seeking emergency care.56 Yet it is unclear whether income-related disparities in access to care are accompanied by other gaps in global quality, which are harder to measure. Poverty itself causes ill health, compromises non-medical social supports and resources that improve medical outcomes, and is associated with worse satisfaction with care.57 Hence, differences in the socioeconomic profile of patients, rather than true differences in quality of care, might explain why hospitals58 and physicians59 caring for poor patients score lower on some quality metrics than do health-care providers serving affluent areas. Assessment of quality differences is increasingly difficult because tying quality indicators to financial incentives can induce so-called gaming, which distorts measurement.60 Nonetheless, payers have implemented pay-for-performance schemes that reward providers on the basis of proxy measures of quality, and facilities serving poor patients have been disproportionately penalised. For example, safety-net hospitals have seen their payments reduced under Medicare's Hospital Readmission Reductions,61 Hospital-Acquired Condition Reduction,62 and Hospital Value-Based Purchasing programmes.63 Disturbingly, such programmes introduce perverse incentives to avoid poor patients, while shrinking funding for hospitals and physicians continuing to care for them. In view of the pitfalls of quality measurement, what can be said about the association between social disadvantage and the quality of medical services? A classic study of patients admitted to hospital in 1984 found that uninsured patients were at higher risk (odds ratio 2·35) of receiving substandard medical care than their insured counterparts.64 However, safety-net hospitals (and hospitals in the Veterans Administration [VA] system, which serves mostly non-affluent veterans) have risk-adjusted mortality rates for older patients similar to those of other hospitals. By contrast, small hospitals serving isolated rural areas appear to deliver a lower quality of care for medical conditions than other hospitals do, as measured by both process-of-care metrics and mortality.65 Studies of differences in surgical quality and safety are inconclusive,66 although risk-adjusted outcomes appear worse for poor patients across a range of surgical procedures.67 Poor patients are more likely than affluent patients to receive dangerous drugs: 27% of low-income Medicare beneficiaries with dementia, hip or pelvic fracture, or chronic renal failure received contraindicated medications compared with 16% of higher-income individuals.17 Poor Americans older than 50 years are also far less likely than their affluent counterparts to receive recommended influenza and pneumonia vaccinations, and cancer screening tests,17 although cost-related barriers might underlie these differences. There is strong evidence showing that quality of care is worse for racial and ethnic minorities,68 although racial disparities in the quality of hospital care **could have narrowed between 2005 and 2010** as a result of improvements among hospitals serving patients from minority backgrounds and more equitable care within all hospitals.69 Yet unequal access to care, along with institutional racism, remain important drivers of persistent disparities in health-care quality for racial and ethnic minorities. For example, although African-Americans tend to live closer than white patients to high-quality hospitals, they are less likely to have their surgeries there.70 The intersection of race, raci\sm, and the health-care system in the USA is reviewed elsewhere in this Series. Health-care financing inequality The USA finances medical care through a complex network of public and private insurance programmes, as well as substantial direct payments by patients. Figure 3 shows the proportion of Americans covered by the main insurance programmes, and the major sources that fund health care. Taken together, government insurance programmes—principally, Medicare, Medicaid, and military health care—account for 42% of personal health-care expenditures.72 Yet this figure substantially understates the government's share, because it excludes two large, tax-funded outlays for private insurance: government agencies' expenditures to purchase private insurance for public-sector employees (representing 28% of all employer payments for private coverage) and tax subsidies for private firms' purchase of insurance for their employees. Taking into account these two additional categories boosts the public share of total health funding in the USA to 65%.73 Total health-care expenditures by the government in the USA exceed the total public and private spending per head of any other country except for Switzerland.73 In light of this fact, the stark inequalities in health care faced by millions of Americans seem particularly unjust. The complexity of health-care financing in the USA obscures not only the magnitude of public funding but also the regressive pattern of who ultimately pays. In fact, health care takes a substantially larger share of income from the poor than from the wealthy, exacerbating inequalities in disposable income.74 Although comparative international studies are scarce and mostly old, financing schemes in other wealthy countries are generally less regressive (although cost sharing is rising in some European countries75). Health-care systems financed primarily through income taxes, as in Ireland, the UK, and Portugal, tend to be the most progressive, whereas those relying on private insurance and out-of-pocket payments, as in Switzerland and the USA, are more regressive.76 The redistributive effect of specific health-care financing programmes Direct out-of-pocket spending is the most regressive form of health-care financing. The uninsured (who are disproportionately poor) pay for much of their care out of pocket and, because they do not have insurers' negotiating leverage, are charged the highest prices.77 As noted previously, insured patients often bear a heavy (and regressive) out-of-pocket burden for deductibles, co-payments, and out-of-network care. Even older patients, almost all of whom are covered by Medicare, face high out-of-pocket costs for their share of the premiums, as well as co-payments and deductibles,78 a burden that falls most heavily on low-income senior citizens. For Medicare enrollees, out-of-pocket medical expenses consume 11•2% of income among those with incomes above 300% of the poverty level, and between 22•7% and 26•8% among those with incomes below 200% of the poverty level.51 In an effort to reduce the burden of catastrophic medical bills, the ACA imposed limits on out-of-pocket medical costs in private plans ($6850 per year for individual plans and $13 700 for families in 2016), Yet these limits, which do not apply to out-of-network and so-called non-essential services, vastly exceed most families' savings.79 Private insurance premiums are also regressive74 and have risen faster than earnings (figure 4); premiums for employer-based plans increased by approximately three times between 1999 and 2016.29 The poorest fifth of Americans spend, on average, 6% of their income on private insurance premiums, while the wealthiest fifth spend just 3•2%.74 Although employers typically make sizeable contributions to their employees' premium costs, economists believe that this expense is mostly passed on to employees in the form of lower wages. Medicaid is the most progressively redistributive health insurance programme in the USA. It requires little cost sharing by patients, is financed through federal and state taxes (with progressive income taxes providing the largest share),81 and most of the benefits go to poor citizens. Medicare is funded largely through federal general revenues and a payroll tax, which remains less progressive than Medicaid's funding base (despite the ACA's extension of the payroll tax to some investment income). Medicare covers both affluent and poor senior citizens, but its high and regressive cost-sharing requirements discourage many low-income beneficiaries from seeking care.82 Moreover, the growing gap in life expectancy between the rich and the poor means that wealthier Americans will, on average, live to enjoy many more years of publicly funded benefits after becoming eligible at the age of 65 years.83 As a result, among men born in 1960, lifetime Medicare outlays are expected to be 28% higher for the wealthiest fifth than for the poorest fifth, a reversal of the pattern 30 years earlier.83 Similarly, immigrants (especially the undocumented) collectively contribute billions more in taxes to Medicare each year than they receive in benefits.84 Medical bills and financial hardship The health-care financing system in the USA leaves millions of Americans facing medical bills that deplete their assets and drive them into debt. One in four non-elderly adults younger than 65 years (and one in three with annual household incomes <$50 000) reported difficulty paying medical bills in 2015; more than half of these individuals owe more than $2500.85 People with deductibles higher than $1500 (or families with deductibles >$3000) and worse health than the overall population are particularly at risk85,86 (figure 5), as are African-Americans and Hispanics.86 Medical bills are a major contributor to household debt and bankruptcy,14 comprising more than half of all unpaid personal debts sent to collection agencies87 (figure 6). One in ten families with medical bill problems has declared bankruptcy.88 Although the uninsured are at greater risk than the insured of declaring bankruptcy,39 most medical bankruptcies involve debtors who are insured.14 Financial hardship is especially common among people with serious illness.89 Among non-elderly adults with cancer, more than a third borrowed money or went into debt because of their treatment, and 3% filed for bankruptcy.90 Such financial catastrophe appears to increase mortality for treatable cancers,91 perhaps because it leads to forgone care. Medicare92 and Medicaid93 coverage provide better (although still imperfect) protection from financial hardship. Medical bills force families to make difficult choices: 34% of insured Americans with difficulty paying medical bills were unable to pay for food, heat, or housing, 15% took out high-interest payday loans,94 and 42% took on extra jobs or worked additional hours.85 Most people reporting problems with medical bills say they have skipped or delayed needed medical care.95 Moreover, defaulting on medical bills and medical bankruptcies often has long-term repercussions; these blemishes remain on credit reports for many years, compromising access to credit, insurance, housing, and employment. Although medical costs impoverish many Americans, this issue is not captured by the US Census Bureau's official measure of poverty. In response, the US Census Bureau has introduced alternative poverty measures that subtract medical costs and other mandatory expenses from income, and add non-cash government aid (eg, housing vouchers). These alternative measures indicate that more Americans experience poverty than are reflected in official statistics,96 with medical costs being the largest contributor to the difference between the official and alternative measures, pushing an additional 10 million Americans below the poverty line.97 The medical system in the USA also influences inequality as an employer of nearly 17 million Americans. Although physicians and nurses are generally well paid, many other health-care workers are not. The health-care system employs more than 20% of all black female workers; more than a quarter of these health-care workers subsist on family incomes below 150% of the poverty line, and 12•9% of them are uninsured (Himmelstein DU; unpublished analysis of the 2015 Current Population Survey).

#### In 2022, that trend continues – healthcare costs are delaying care and disproportionately harming minority groups

Montero et. al. in July finds that [Alex Montero, Audrey Kearney, Liz Hamel, and Mollyann Brodie, "Americans’ Challenges with Health Care Costs," KFF, <https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/>]

For many years, KFF polling has found that the high cost of health care is a burden on U.S. families, and that health care costs factor into decisions about insurance coverage and care seeking. These costs also rank as a top financial worry. This data note summarizes recent KFF polling on the public’s experiences with health care costs. Main takeaways include:

About **half** of U.S. adults say they have difficulty affording health care costs. About four in ten U.S. adults say they have **delayed or gone without medical care** in the last year due to cost, with dental services being the most common type of care adults report putting off due to cost.

Substantial shares of adults 65 or older report difficulty paying for various aspects of health care, especially services **not generally covered by Medicare**, such as hearing services, dental and prescription drug costs.

The cost of health care often prevents people **from getting needed care or filling prescriptions**. About a quarter of adults say they or family member in their household have not filled a prescription, cut pills in half, or skipped doses of medicine in the last year because of the cost, with larger shares of those in households with lower incomes, Black and Hispanic adults, and women reporting this.

High health care costs **disproportionately affect uninsured adults, Black and Hispanic adults, and those with lower incomes**. Larger shares of U.S. adults in each of these groups report difficulty affording various types of care and delaying or forgoing medical care due to the cost.

Those who are covered by health insurance are not immune to the burden of health care costs. About **one-third of insured** **adults** worry about affording their monthly health insurance premium, and 44% worry about affording their deductible before health insurance kicks in.

Health care debt is a burden for a large share of Americans. About **four in ten adults (41%) report having debt** due to medical or dental bills including debts owed to credit cards, collections agencies, family and friends, banks, and other lenders to pay for their health care costs, with **disproportionate shares** of Black and Hispanic adults, women, parents, those with low incomes, and uninsured adults saying they have health care debt.

Affording gasoline and transportation costs is now a top worry for Americans followed by unexpected medical bills. While worry over gasoline and transportation costs has risen markedly since 2020, significant shares of adults still say they are worried about affording medical costs such as unexpected bills, deductibles, and long-term care services for themselves or a family member.

#### And it won’t get better soon – exploding healthcare inflation, nursing shortages, and doctor burnouts make the current system unsustainable – only the single-payer healthcare revives the economy and regulates for-profit healthcare.

Pearl, former CEO of the largest medical group in America explains in August [Robert Pearl, M.D., 8-15-2022, (bro is the former CEO of The Permanente Medical Group (1999-2017), the nation’s largest medical group, and former president of The Mid-Atlantic Permanente Medical Group (2009-2017). In these roles he led 10,000 physicians, 38,000 staff and was responsible for the nationally recognized medical care of 5 million Kaiser Permanente members on the west and east coasts. Named one of Modern Healthcare’s 50 most influential physician leaders, Pearl is an advocate for the power of integrated, prepaid, technologically advanced and physician-led healthcare delivery.) "These 3 Healthcare Threats Will Do More Damage Than Covid-19," Forbes, <https://www.forbes.com/sites/robertpearl/2022/08/15/these-3-healthcare-threats-will-do-more-damage-than-covid-19/?sh=7faaf8465165>] Jet

For two years, the Covid-19 pandemic rattled financial markets, dominated news coverage and disrupted daily life in ways most Americans would never have predicted. But now, in year three, the coronavirus has been downgraded to a persistent yet manageable threat—on par with the flu. Thanks to some familiar medical solutions (vaccines, antiviral meds and public safety measures), three-quarters of Americans say the worst of Covid-19 is behind us. Now, a new disaster looms. American healthcare stands in direct path of the perfect storm. Forecasting disaster Doomsday predictions often prove wrong or overinflated. But, in 2004, a team of hurricane experts at Louisiana State University predicted “a catastrophe [is] right on the horizon.” They were right. Less than a year later, New Orleans was eleven feet under water. Hurricane Katrina killed 1,833 people and left thousands more homeless. How did the researchers know Katrina was coming? Using data-based computer simulations, they observed a confluence of potentially deadly forces—rising heat, weak levies, high wind speeds, transportation issues and more—that, when combined, would bring about certain destruction. A similar situation is unfolding in American healthcare. Decades of price escalation combined with eroding quality and misused technologies have made U.S. healthcare the “most expensive and least effective” system in the developed world. By themselves, these protracted healthcare issues are manageable and might have been tackled over time, using familiar fixes. However, that was before a trio of “mega forces” arrived that now threaten to create healthcare’s version of the perfect storm. Without urgent and radical solutions, these forces will combine to produce a massive medical disaster—one that will prove far more destructive and costly than Covid-19. Mega Force 1: Untamed Inflation In my 2021 book Uncaring, I predicted federal Covid-19 relief efforts, totaling in the trillions, would cause inflation to rise rapidly. However, I failed to anticipate that a series of global events—the war in Ukraine, an international oil shortage and a persistent supply-chain squeeze—would enter the picture and, together, **drive U.S. inflation to a 40-year high.** Without these added pressures, our country **may have had five to 10 years** to fix healthcare’s thorniest problems. Instead, the United States **no longer has the luxury** of tinkering with payment models or carrying out the long-term transformation of medical practice. Most public health officials and patients don’t realize that **healthcare prices are about to explode**. They **mistakenly compare** today’s soaring consumer prices with the relatively tame rate of healthcare inflation. But unlike gas, grocery and housing prices, healthcare prices **don’t adjust in real time**. Instead, the cost of everything from nursing salaries to bandages to Rx medications is set one to two years in advance and holds firm for 12 to 24 months. A when these contracts come up for renewal this fall, the piper will have to be paid. Labor in healthcare is **essential and increasingly expensive.** So are raw materials and supply-chain expenses. The same factors that have driven consumer prices up 8% to 9% are likely to drive up the price of healthcare to unaffordable levels for decades to come. Starting next year, the majority of U.S. health insurers plan to **increase employer premiums 10 to 15%** with American families likely to pay an even higher percentage for their share of healthcare costs. Mega Force 2: The Nursing Shortage Last Friday, my friend—a surgeon—called at 4 p.m. to cancel dinner plans. He told me one of his patients scheduled for surgery that morning was still waiting for his procedure. Since the patient wasn’t allowed to eat or drink anything since the night before, the doctor didn’t want to cancel the procedure and have to reschedule it. Surgical delays and cancellations are becoming increasingly common. A driving factor is a growing shortage of nurses. According to multiple studies, **one-third** of RNs plan to leave their current roles while **many intend to exit the workforce entirely**. More than 1 in 4 baby boomer RNs intend to retire within the year. This dwindling headcount poses a huge problem for patients. Hospitals literally can’t function without enough nurses. State regulators set minimal requirements for RN staffing on medical floors and in critical care units. The nursing shortage is especially pronounced in operating rooms, where **experienced nursing is essential** for optimal patient care. When hospitals can’t meet these numbers, care gets delayed and patients must be **turned away.** You might assume an easily solution would be to expand nursing-school enrollments and increase class sizes. But training nurses is **expensive and time-consuming**—it takes at least **five years** to get nursing students ready to deliver bedside care and even longer to train them for the operating room. Further complicating the issue is that **it takes a skilled** RN to teach nursing students the hands-on techniques of bedside patient care. And in the context of a nursing shortage, hospital administrations are **loath** to assign experienced RNs to educational roles rather than care delivery roles—even if the former is the best long-term choice. With the dual threats of inflation and nursing shortages, hospital administrators feel trapped in lose-lose situations. They know that aggressively raising wages to recruit and retain nurses will **drive costs through the roof** whereas holding salaries down to address ever higher costs **will lead to more nurses quitting.** Without immediate solutions, surgical backlogs will grow and even fully insured patients will find their surgeries delayed or postponed. The result will be progressively poorer outcomes, avoidable complications and even death. When my friend called me the next day, he said his patient finally underwent surgery at 2 a.m. Fortunately, the case went well. When I asked how the family reacted, he replied, “They’re still irate.” Mega Force #3: The Burnout Crisis Even before the pandemic, doctors were reporting burnout rates of 44% or more. Now, after two years of intensifying workplace demands and an endless parade of patient deaths, the **emotional trauma** on healthcare professionals **has reached a boiling point.** The shortage of nurses and support staff, combined with cost-cutting efforts from insurers and hospital administrators have only fueled the discontent. Doctors, who increasingly reject the word “burnout,” label the problem “moral injury,” a pain that comes from being unable to provide excellent medical care. Physicians say hospital administrators and insurance company executives are more concerned with profits than patients. Furthermore, doctors feel they don’t get the respect and appreciation they deserve for all their hard work. As a result, dissatisfied physicians are turning to **private equity firms** for better compensation and greater control over their day-to-day. Private equity leaders recognize this as a great financial opportunity. The PE approach is to first sign up as many community specialists as possible (with a particular eye on the kinds of doctors that hospitals need to stay in business: anesthesiologists, ER physicians, orthopedists, urologists and cardiologists). Then, having gained market control through consolidation, the PE firms demand **significantly higher physician reimbursements** from insurers and hospitals (25% or more). Between 2010 and 2019, private equity’s annual healthcare investments soared from $42 billion to $120 billion. Naturally, the last thing these companies want is to reduce reimbursement. And as burnout continues to intensify, more and more doctors will pursue this route, thus worsening healthcare’s cost crisis. As happened with Katrina, this vicious combination of forces, all hitting medical practice at once, will inflict massive damage. **Double-digit inflation, a major nursing shortage and monopolistic control** of physician specialists through private equity—on top of the ongoing healthcare problems that predate Covid-19—will produce **a mega disaster** unless we take urgent and bold action. The old solutions (i.e., financial incentives and assigning doctors and nurses ever-larger patient loads) simply won’t work. Try raising nursing salaries or acquiescing to private equity demands **and we’ll exacerbate healthcare inflation**. Try squeezing compensation or reducing headcount, **and we’ll worsen nurse and doctor dissatisfaction and compromise access.** Addressing all three mega forces together will require a radically different approach than in the past. The details of that solution will be the focus of my next article. To receive that story in your inbox, click the “FOLLOW” button at the top of this article.

#### The failures of for-profit healthcare creates unique risks for disease –

#### 1] Access – Lack of coverage increases disease risk and decimates the economy

Malloy et al. 16 — Liam Malloy, Associate Professor of Economics at the University of Rhode Island, Shanna Pearson-Merkowitz, Associate Professor in Political Science at the University of Rhode Island, Irwin Morris, Professor and Chair of the Department of Government and Politics at the University of Maryland, “State Sponsored Health Insurance and State Economic and Employment Growth” Politics & Policy, Volume 44, Issue 5 October 2016 Pages 945–975, http://digitalcommons.uri.edu/cgi/viewcontent.cgi?article=1004&context=ecn\_facpubs

Better overall health is associated with better macroeconomic performance for countries (see e.g., Murphy and Topel 2006). The cause of this relationship could be through innovation and productivity growth in the health care sector, or through the improvement in health of the labor force (or both). This, however, leaves open the question of whether or not extending health insurance coverage to a larger percentage of the population is good for economic growth. Covering more people may increase their health and allow them to enter the labor force or work more hours. Increased spending on health care could spur investment in innovative technologies. On the other hand, increased health insurance coverage, especially public coverage, may come at the cost of higher taxes that could slow economic growth (see e.g., Padovano and Galli 2007). In addition, increased health care spending may crowd out spending in other areas that could be more innovative, thus slowing growth (see e.g., Collins et al. 2012). The question of whether and to what extent health insurance coverage is related to economic growth became highlighted in the debate over whether to pass the Affordable Care Act (ACA). In their efforts to gain support for the bill, the Obama administration argued that the decline in health insurance coverage had significant negative effects on aggregate public health and the degradation of public health has significant national economic consequences (Council of Economic Advisors 2009). Specifically, the administration argued that GDP would be 4 percent higher by 2030 because reduced health care spending has the potential to increase national savings and investment and better health outcomes can increase the labor supply and make workers more productive. (Council of Economic Advisors 2009, 6-9). The literature supports the argument that better health increases labor supply and economic growth. Several studies suggest that increased health outcomes are “one of very few obust predictors of economic growth” (Suhrcke and Urban 2010). In one sense, the studies are clear: quality health insurance decreases the onset of avoidable illnesses, increases access to care for treatable illnesses, and can decrease the likelihood that relatively minor illnesses become severe—all of which decrease employment (see e.g., Bernstein, Chollet, and Peterson 2010). For example, not only has reducing the prevalence of particular conditions been shown to increase personal earnings by 15 to 20 percent, but poor health has also been found to be a primary reason people leave the workforce early (Hadley 2003) and file for social welfare programs, particularly disability for illnesses that could have been prevented had they had access to health insurance before their health problems worsened (Bernstein, Chollet, and Peterson 2010; Decker et al. 2012). Research also suggests that health improvements that occurred since the 1970s added approximately 3.2 trillion dollars per year to national wealth in the United States or almost half of GDP (Murphy and Topel 2006). In addition, there is evidence that increased public spending on health care leads to increased health outcomes. Mays and Smith (2011) find that higher public health spending is associated with lower rates of preventable deaths such as infant mortality, diabetes, and cancer. In a review of the literature, Singh (2014) concludes that higher public health spending is associated with better community health, although the path from one to the other is not always clear.1

#### 2] Pandemic preparation – Profit-driven healthcare cuts corners in quality care to raise revenue – for-profit means companies focus on reaction, not preparation

The California Nurses Association explains in 17 — California Nurses Association, approved by the California Board of Registered Nursing, Provider Number, Last Cited 2017, Date Accessed: 10-04-2017, “SARS, Ebola, And Zika: What Registered Nurses Need to Know About Emerging Infectious Diseases” California Nurses Association, http://nurses.3cdn.net/e4e2ba885fd853b85c\_07m6i2p32.pdf

CONCLUSION

We have discussed examples of emerging infectious diseases that do not occur exclusively in tropical, developing countries. Many diseases do emerge in these places — concentration of the population in slums, rapid deforestation and destruction of environment, effects of climate change, lack of healthcare and public health infra- structure all conspire to create conditions for new diseases to emerge or old diseases to re-emerge. But it is false to assume that residents of the United States and other developed countries are safe from these diseases. SARS traveled to Toronto and infected many healthcare workers and other patients in hospitals there. Ebola traveled to Texas and infected two healthcare workers. Zika has been brought to the United States in hundreds of travelers returning from areas with local transmis- sion, introducing it to local mosquitoes in Florida. The examples discussed also illustrate the potential for diseases to erupt in the US. SARS exploded in Toronto and it was just barely that Ebola was contained in Texas. Zika has not yet been fully contained in Florida, and the full impact of Zika is yet to be seen. The public health infrastructure in the United States is fragmented and underfunded. Healthcare workers are most often the first line of contact for infectious travelers. The lack of protections for healthcare workers was demonstrated clearly in the SARS and the Ebola epidemics. The profit-driven healthcare system typically reacts to infectious disease outbreaks rather than taking a precautionary approach to protect workers and patients. The US needs a single-payer system to reorder healthcare industry priorities from profit to care, economic and political reforms, the simultaneous funding of public health systems including vector control and emerging disease research and vaccine/diagnostics development. This systemic change is necessary to protect global health. The increasing income inequalities in the US and across the world are intimately tied to the forces that have led to increased urbanization. Many infectious disease outbreaks, like Zika and Ebola, have taken root in slums before exploding into full-blown epidemics regionally and even globally.

#### Reacting to pandemics fail – preventative measures have the best chance of containing disease – failure to respond kill millions and the economy

Samuel 19 [Sigal Samuel, 9-19-2019, "The next global pandemic could kill millions of us. Experts say we’re really not prepared.," Vox, https://www.vox.com/future-perfect/2019/9/19/20872366/global-pandemic-prevention-who-world-bank-report]

“There is a very real threat of a **rapidly moving, highly lethal pandemic** of a respiratory pathogen killing **50 to 80 million people**.” That’s from the opening paragraph of a major new report on our current state of pandemic preparedness. It doesn’t get much more optimistic from there. This is the first annual report authored by the Global Preparedness Monitoring Board, an independent panel of experts convened by the World Bank and the World Health Organization “to provide the most frank assessments and recommendations possible.” They very frankly warn that **the risk of a global pandemic is growing**. The next big one to hit us could be naturally occurring, deliberately created, or accidentally released. Although we’ve got new vaccines and drugs that previous generations didn’t have access to, we’ve also got new developments working against us. Scientific advances have made it possible for disease-causing microorganisms to be engineered or recreated in labs, or to escape labs when explosions and other accidents occur. Our robust transportation infrastructure makes it easy for travelers to pick up a disease in one country, fly across an ocean, and spread the disease to another country within hours. Increased urbanization and population growth also exacerbate the spread of disease. And then there’s climate change, which causes natural disasters that strain national health systems, weakening their ability to efficiently respond to outbreaks. Global warming is also expanding mosquito habitats, which means we’ll likely be seeing more mosquito-borne illnesses like Zika, dengue, and yellow fever — including in the US and Europe. The convergence of these trends is making us all more susceptible to what the report calls “global catastrophic biological risks.” **We’re not prepared** to handle them. To change that, the report states, we need to act decisively now. But there’s a lack of political will to do that. We need leaders to care about pandemics. That means we need to care, too. National leaders tend to respond to health crises only when the public expresses enough panic. Unfortunately, we’ve got a habit of paying attention to pandemics only when they’re actually upon us. “For too long, we have allowed a cycle of panic and **neglect** when it comes to pandemics: we ramp up efforts when there is a serious threat, then quickly forget about them when the threat subsides,” the report says. Our current approach is like waiting to fix a giant hole in your roof until a storm cloud actually breaks and rain starts pouring in. But in 2019, we really can’t afford to do that: The world is so interconnected that storm clouds are coming at us from all directions. Pandemics pose risks not only to our health but also to our economies. Consider the estimated costs of past outbreaks: a loss of over $40 billion in productivity from the 2003 SARS epidemic; a $53 billion loss from the economic and social impact of the 2014-2016 West Africa Ebola outbreak; and a $45-55 billion cost from the 2009 H1N1 influenza pandemic. If, tomorrow, we had a global influenza pandemic akin to the scale and virulence of the one that struck a century ago — in 1918, the Spanish flu killed around 50 million people — it would cost our modern economy an estimated $3 trillion. And, the report notes, “If a similar contagion occurred today with a population four times larger and travel times anywhere in the world less than 36 hours, 50-80 million people could perish.”

#### Single-payer healthcare lowers prices, increases the economy, and resolves inequities

Ansell, MD, MPH, The Michael E. Kelly, MD, Presidential Professor, Department of Internal Medicine, Rush Medical College, ‘17

(David A., *The Death Gap: How Inequality Kills*, University of Chicago Press, April, Ch. 7)

The most elegant, comprehensive, fairest, and lowest-cost solution to the health care crisis would have been to expand and improve the Medicare insurance plan to cover all Americans. 6 Medicare, enacted in 1965 as a single governmental payer system to provide health insurance for Americans 65 and older, has been well liked since its inception. Before Medicare, 48 percent of such Americans had no insurance; now only 2 percent are uninsured. In addition, before Medicare 56 percent of senior Americans paid out-of-pocket health care expenses, compared to 13 percent now. 7 Satisfaction with coverage is substantially higher among Medicare recipients than for those who have private insurance. Only 8 percent of Medicare enrollees report their experience as fair or poor, compared to 20 percent of those with typical employer-based health insurance coverage and 33 percent of those who purchased private insurance directly. 8 Moreover, the costs of administering the program are substantially lower than those of private insurance companies—only about 2 percent of the total cost for Medicare, compared to 12 percent for the least expensive insurance company’s overhead charges. 9 Most important, experts estimate that since its inception Medicare has added five years to the life expectancy of older Americans. 10 Polls have shown that universal government-sponsored health coverage is preferred by half of Americans. 11 And an improved Medicare would be an entitlement available to all Americans, with the exact same benefits for the wealthy and the poor. Medicare for all would achieve the goal of universal access to health care. As an entitlement for all US citizens (and extended to noncitizen residents), access to health care would be a right. This would contribute to the improvement of the life expectancy gap between rich and poor. Plus it would save an estimated $400 billion yearly by eliminating administrative waste. 12

#### Ansell furthers that

A Call for Single Payer I speak for many of my health care colleagues across the nation when I say that the Affordable Care Act is a disappointment. In contrast, an improved and expanded Medicare for All would achieve truly universal care, affordability, equity, and effective cost control. It would put the interests of our patients — and our nation’s health — first. By replacing multiple private insurers with a single nonprofit agency like Medicare that pays all medical bills, the United States would save approximately $400 billion annually. Administrative bloat in our current private-insurance-based system would be slashed. That waste would be redirected to clinical care. Copays, coinsurance, and deductibles would be eliminated. A single streamlined system would be able to rein in costs for medications and other supplies through the system’s strong bargaining clout— clout directed to benefit health, not profits. Finally, it would create an equitable system of care that would provide equal access to rich, poor, black, and white. As a result, life expectancy gaps between rich and poor would narrow. Hospitals that serve poor communities would have access to capital investment based on need. It has been done in other countries, and it can be done in the United States.

#### In the final analysis, we can see that the nature of a for-profit healthcare system results in insurance coverage disparities that disproportionately affects minorities. This lack of access creates breeding grounds for disease, where marginalized groups cannot get care for diseases, spreading it more.

## 1AR

### 1AR – Case

#### Currently, health insurance operates through private companies who represent the consumers. Since the nature of private companies is to gain profits, they charge consumer the most they can while giving them the lowest quality care.

#### This creates diseases in 2 ways:

#### 1] Access to healthcare – minority groups are hit the hardest by high costs since they usually can’t afford health insurance or are charged a higher premium. No healthcare for these people means no medicine for the sick, no vaccines for future pandemics, and no screening for current diseases. That creates a prime breeding ground for another global pandemic.

#### 2] Readiness – because it is more financially risky to invest in preparing for a future pandemic, companies only respond to pandemics when it really hits. That’s clearly been shown to be ineffective by how hard SARS, Ebola, and COVID hit the world – only shifting healthcare into the government’s hands can we ensure that we are more prepared for the next pandemic.

#### Uncontrolled pandemics kill millions and shut off international trade and supply lines, costing trillions.

### 1AR – Case – Short

#### Currently, health insurance operates through private companies. Since they are more interested in making a profit rather than actual healthcare, the quality of said healthcare plummets.

#### This creates diseases in 2 ways:

#### 1] Access to healthcare – minority groups are hit the hardest by high costs since they usually can’t afford insurance. No healthcare for these people means no medicine for the sick, vaccines, and screening for diseases, breeding pandemics.

#### 2] Readiness – companies only respond to pandemics than prepare beforehand to save money. That’s clearly been shown to be ineffective by how hard SARS, Ebola, and COVID hit the world – only by preparing beforehand with the government can prepare us.

#### Uncontrolled pandemics kill millions and shut off international trade and supply lines, costing trillions.

### 1AR – Innovation

#### 1] Remember what their impact is: pandemics. We have clearly won that increases in healthcare coverage both prevent future disease from forming and also allows for us to respond to them better – this means that we don’t need new drugs since new diseases are going to pop up less often

#### 2] Who cares about new drugs if we can’t afford them? Uninsured, marginalized groups can’t afford screening let alone drugs.

#### 3] Even research doesn’t support their ludicrous position – public funding and excessive profits means they have more than enough

Lanford explains in 2021 [Sarah Lanford, 3-8-2021, "Will Laws to Lower Drug Prices Harm Innovation? The Evidence Says No.," National Academy for State Health Policy, https://www.nashp.org/will-laws-to-lower-drug-prices-harm-innovation-the-evidence-says-no/]

Drug makers claim high prices are necessary to support new drug development and innovation, but research shows that public investment in drug research and development combined with large industry profits leaves manufacturers room to lower prices while continuing to innovate. Drug manufacturers have brought new vaccines to market in record speed to stop the spread of COVID-19. That notable achievement was made possible by massive financial investments from the public. More than $19 billion in government funding has been invested in the research, development, manufacturing, and distribution of COVID-19 vaccines. In total, the United States has guaranteed purchase of 900 million doses for a population of approximately 330 million and assumed financial risk so manufacturers don’t have to. Even companies that did not accept federal funding for research and development have benefited from previous taxpayer-funded research. The Pfizer vaccine contains a publicly-funded, government-developed spike protein technology that rapidly accelerated its development process. Taxpayer-funded research for each of the 356 drugs approved by the FDA in the last decade totals $230 billion. Despite taxpayers’ investments in drug development, manufacturers face few restrictions on what they can charge for these drugs in the United States. Public funding is not unique to vaccines though. The drug industry relies heavily on public funding for all forms of drug development. Taxpayer-funded research for each of the 356 drugs approved by the US Food and Drug Administration in the last decade totals $230 billion. Despite this level of public investment in drug development, manufacturers face few restrictions on what they can charge for their drugs in the United States despite taxpayers’ investments. As a result, drug prices are on average 2.5-times higher in the United States than comparable countries, even though those countries also contribute considerably to research and development (R&D) costs. High drug prices in the US market have generated substantial profits for the pharmaceutical industry. Between 2008 and 2018, the profitability of pharmaceutical companies was almost double that of other large, public companies. Despite the significant amount of taxpayer funding, pharmaceutical industry officials argue that high drug prices reflect the cost of R&D and the risk associated with developing a new drug. However, high US drug prices exceed what is necessary to fund R&D. For example, drug manufacturers Amgen, Biogen, Pfizer, and Teva generated more than double their global R&D budgets from excessive US prices, and three companies covered or nearly covered all of their research spending through high US prices on their top-selling products alone: AbbVie’s Humira (an immunosuppressant); Biogen’s Tecfidera (treats multiple sclerosis); and Teva’s Copaxone (an immunomodulator that treats multiple sclerosis). Two of these drugs – Humira and Tecfidera – appear on the Institute for Clinical and Economic Review’s 2020 list of drugs that have prices increases unsupported by new clinical evidence.

### 1AR – Econ

#### Our impact significantly outweighs economic growth:

#### 1] Jobs – the sick can’t work, decimating the labor force. Our Malloy evidence quantifies this effect, showing that health improvements are responsible for half of our GDP, not even counting COVID

#### 2] Spending – United State healthcare is the “most expensive and least effective” system in the developed world. Saving money on healthcare using single-payer and investing it in more cost-efficient places could add 4 percent to the GDP by 2030

#### 3] Savings – private insurance involves a whole bunch of actors, making administrative work costly. Single-payer healthcare eliminates that administrative cost, freeing up $400 billion.

#### 4] Pandemics – they shut down trade routes and supply lines, costing us as much as $3 trillion looking at past precedent.

### 1AR – Multipayer

#### While multipayer sounds like a good idea, it fails to stop the core of the issue – pandemics. There are a couple reasons why it fails - 1] Private companies existing will inevitably cause coverage gaps between our population and cause spreading of disease. Why would a doctor work for a public company over a private one? Unless we universally make healthcare public, there will be differences in care, which will hurt the overall impact and quality of care of universal care.2] Administrative costs. Private insurance has a lot of administrative fees – including paperwork, marketing, and overall efficiency through multiple complicated insurance companies. However, only universal healthcare will streamline healthcare, while a mixture of private and public will just complicate paperwork and cost the government money it needs to be. The proof is in the past – compared to private insurance, Medicaid saves a total of 400 billion dollars. 3] The profit incentive for private insurance. If private companies have the profit incentive, their overall quality of care would be worse than universal care. Private companies would never prepare for pandemics beforehand because it’s a losing bet – why spend money on something that might happen? Additionally, private insurance would increase exploitative costs like hidden fees in order to squeeze the most out of the customers that stay, which would leave customers bankrupt. However, universal care doesn’t care about profit, and therefore will focus on the quality, rather than making quick cash off of people.