I affirm

Resolved: The United States ought to guarantee universal health care for its citizens.

Definitions:

Health Care: is the provision of services that helps individuals achieve an optimal state of well-being, in any settilllng or stage in the human life cycle.

- http://www.ihs.gov/nonmedicalprograms/chr/index.cfm?module=vocab

This definition means that the affirmative can advocate any action as long as it promotes the well being of humans, and is universal.

United States is understood to be the United States Federal Government.

United States government: the executive and legislative and judicial branches of the federal government of the United States

wordnetweb.princeton.edu/perl/webwn

The value is Political morality, as the resolution specifies a governmental actor. Governments must be held accountable for the well being of their citizens, so…

The criterion is Consequentialism. In a political scheme, evaluation by the consequences makes the most sense because…

1. It holds those in power accountable to their people
2. Allows for decision making in morally contradicting situations.
3. Allows us to evaluate the solvency, and thus, consider the benefits of an action

Thus, you evaluate the round on who does the most good or prevents the greatest harm to the citizens of the US,

Contention 1: Bioterror

1. Government Predicts Biological Attacks in 2013

Dave Bohon, <http://thenewamerican.com/usnews/politics/item/3164-government-panel-predicts-wmd-attack-by-2013>, July 19 2012

The official report from a blue-ribbon panel warns that terrorists with weapons of mass destruction (WMD) are likely to attack somewhere in the world in the next three years, and the United States could be a prime target. According to the Commission on the Prevention of Weapons of Mass Destruction Proliferation and Terrorism, the likelihood is high that by 2013 terrorists will use WMDs in an attack somewhere in the world, and while several nations with terrorist ties are now in a race to produce nuclear weapons, the commission’s report says that an attack using biological weapons is the more likely scenario, with potentially devastating consequences. Among its recommendations, the commission said it believes that “the U.S. government needs to move more aggressively to limit the proliferation of biological weapons and reduce the prospect of a bio-terror attack.” The commission, co-chaired by former U.S. Senators Bob Graham (D-Fla.) and Jim Talent (R-Mo.), originally reported its findings in December 2008. During a June 10 press conference to announce legislation aimed at addressing dangers from terrorism, members of the commission joined with members of the House Homeland Security Committee to address the commission’s findings. “The consequences of a biological attack are almost beyond comprehension,” said former Senator Graham. “It would be 9/11 times ten or a hundred in terms of the number of people who would be killed.” Noting the millions of Americans who died as a result of the epidemic flu virus of 1918, Graham predicted that a lab-generated biological agent in the hands of terrorists could prove far worse. “Today it is still in the laboratory,” he said, “but if it should get out and into the hands of scientists who knew how to use it for a violent purpose, we could have

1. We are not prepared to counter a bioterrorist attack. Only through acceptance of universal healthcare can we effectively counter bioterrorism.

Donald A. Henderson. The Looming Threat of Bioterrorism. Science 283, 1279 (1999

Of the weapons of mass destruction (nuclear, chemical, and biological), the biological ones are the most greatly feared (4), but the country is least well prepared to deal with them. Virtually all federal efforts in strategic planning and training have so far been directed toward crisis management after a chemical release or an explosion. Should such an event occur, fire, police, and emergency rescue workers would proceed to the scene and, with the FBI assuming lead responsibility, stabilize the situation, deal with casualties, decontaminate, and collect evidence for identification of a perpetrator. This exercise is not unfamiliar. Spills of hazardous materials, explosions, fires, and other civil emergencies are not uncommon events. The expected scenario after release of an aerosol cloud of a biological agent is entirely different (Table 1). The release could be silent and would almost certainly be undetected. The cloud would be invisible, odorless, and tasteless. It would behave much like a gas in penetrating interior areas. No one would know until days or weeks later that anyone had been infected (depending on the microbe). Then patients would begin appearing in emergency rooms and physicians’ offices with symptoms of a strange disease that few physicians had ever seen. Special measures would be needed for patient care and hospitalization, obtaining laboratory confirmation regarding the identity of microbes unknown to most laboratories, providing vaccine or antibiotics to large portions of the population, and identifying and possibly quarantining patients. Trained epidemiologists would be needed to identify where and when infection had occurred, so as to identify how and by whom it may have been spread. Public health administrators would be challenged to undertake emergency management of a problem alien to their experience and in a public environment where pestilential disease, let alone in epidemic form, has been unknown. The implicit assumption has frequently been that chemical and biological threats and the responses to them are so generically similar that they can be readily handled by a single “chembio” expert, usually a chemist. This is a serious misapprehension (Table 1). First responders to a biological weapons incident (in contrast to an explosion or chemical release) would be emergency room physicians and nurses, family physicians, [and etc.] infectious disease specialists, infection control practitioners, epidemiologists, hospital and public health administrators, and laboratory experts. Surprisingly, to date there has been little involvement of any of these groups in planning for appropriate responses or in training. One recent measure to address this deficit is the convening, by the Hopkins Center, of a national Working Group on Civilian Biodefense, which is composed of government and nongovernment experts. The principal goal of this group has been to identify which biological agents require priority attention and what should be the most appropriate response to each.

1. Bioweapons are easy to manufacture, and could have devastating impacts on the United states

Chris Holmes. Why Bioterrorism is America’s Greatest Threat. The Baltimore Chronicle and The Sentinel. 2003

Despite the recent spate of suicide bombings, biological terrorism is still the greatest threat. Conventional explosives, ‘dirty bombs’ and chemical weapons all stop at ground zero. But biological weapons could cause a nationwide epidemic. It’s not suicide bombers we should fear, but suicide coughers and sneezers.¶ Bioweapons are relatively easy to produce. Secret labs, say, in North Korea, Libya, Cuba or Iran could be manufacturing plague, anthrax and maybe smallpox right now. In 1999, the Defense Threat Reduction Agency gave a paltry $1.6 million to a handful of scientists and challenged them to set up a secret bioweapons lab. The team ordered equipment and supplies from the internet and within a year were producing two pounds of an anthrax simulant per week at a site in the Nevada desert. The FBI never detected it. Named Operation Bachus, the results were sobering. ¶ Bioweapons are easy to disperse, cause high numbers of casualties, and have high mortality rates. In 1970, WHO estimated that 50 kg. of anthrax released upwind of a city of 500,000 could produce 125,000 cases with 95,000 deaths. This is the same lethality as a nuclear weapon, but at a fraction of the cost. Plague and anthrax could be spread from crop dusters or pilotless drones, or dispersed through subway systems, the winds from the trains scattering the agent city wide.¶ More disruptive than actual casualties from a bioterrorist attack may be the psychological effects. The worried public would quickly clog the health care system. Cases of epidemic hysteria—which mimic the real thing but aren’t—would add further to the overload. Travel and commerce would grind to a halt. The fear from those anthrax-by-mail cases in 2001 (only 5 deaths from 23 cases) and this year’s SARS outbreak (zero U.S. deaths from about 300 cases) demonstrate how pyschologically unprepared we are to cope with bioterrorism. ¶ A greater risk may be bioweapons created by recombinant DNA technology. Imagine this nightmare scenario: a communicable form of anthrax—a germ with the infectiousness of SARS and the killing power of anthrax—is unleashed through infected air travelers. From these few cases, it spreads across the entire country. ¶ Is such a thing possible? Theoretically, it is, and research like it has already been done. For example, during their heyday, the Soviets used this technology to create antibiotic resistant strains of both anthrax and plague and were studying the feasibility of a weaponized Ebola-smallpox virus. An even greater horror were their plans to inject a neurological toxin into plague bacteria; a ‘supergerm’ which would cause the fever, rash and pneumonia of plague, and convulsions and paralysis from the neurotoxin. Finally, it’s possible our current antibiotics and vaccines would be ineffective against these recombinant germs. This is not science fiction. This technology is real. ¶ What are we to do? It is not hopeless, and we are not helpless. The same technology used to design new bioweapons can be used to overcome them, with new vaccines, antibiotics and protective devices. And time-tested public health measures—which contained the SARS epidemic—are still our best first line of defense against future outbreaks. The likelihood of another biological attack is high. We must be better prepared for the next one.

1. Only through universal healthcare can we effectively counter bioterrorism. Thus the United States should adopt universal health care in order to prevent

Shane K. Green. Bioterrorism and Health Care Reform: No Preparedness Without Access. Virtual Mentor. May 2004, Volume 6, Number 5.

But with the US presently engaged in a "war on terror," in which not only soldiers but also civilians are targets, a healthy fighting force is no longer enough to ensure national security; the time has come for this country to take up reforms that promote the health of all Americans.

Reassuringly, this is not a novel proposal. Reflecting upon statements made in 1944 by American medical historian Henry E. Sigerist, MD, concerning the power of external security threats to stimulate reform, a recent editorial in the American Journal of Public Health suggested that, "[t]his incendiary moment may be just the time for rekindling reform" [2]. Similarly, emergency physician and medical ethicist C. Griffin Trotter, MD, PhD, recently declared: "National security, I submit, is the new banner for health care reform" [3].

Consider the threat of bioterrorism: the potential use of biological weapons against this country raises the specter of a unique kind of war in which battles will be fought not against soldiers and artillery but against epidemics. Without significant reform to ensure access to health care for all Americans, the US will be unable to fight such battles effectively.

A nation's greatest defense against bioterrorism, both in preparation for and in response to an attack, is a population in which an introduced biological agent cannot get a foothold, ie, healthy people with easy access to health care.

Contention 2: Pandemic

1. Current countermeasures against pandemics are insufficient.

David S. Fedson. Preparing for Pandemic Vaccination: An International Policy Agenda for Vaccine Development. Journal of Public Health Policy, Vol. 26, No. 1 (2005), pp. 4-29

When the next pandemic virus emerges, it will replace the influenza viruses that have been circulating until then. Thus, a pandemic vaccine will need to contain only the pandemic virus; in other words, it will be a monovalent not trivalent vaccine. Given the current global production capacity of ~300 million doses of trivalent vaccine (and assuming a production cycle similar to that for current trivalent vaccines), it is theoretically possible that up to 900 million doses of same-strength (15 g HA) monovalent pandemic vaccine could be produced. Most if not all people will never have been infected with an influenza virus like the pandemic virus. As they will be immunologically naive, they will require two doses of vaccine to be fully protected (21). This means that only 450 million people could be vaccinated with two doses of a "same strength" monovalent vaccine. In many countries, public health officials will want to vaccinate everyone in their populations. For this reason, when a pandemic virus appears, government leaders in countries that have vaccine companies will probably "nationalize" their vaccine production facilities to ensure that there is enough vaccine to vaccinate their populations. This could mean that millions of people living in countries without vaccine companies will have to wait several months or more for supplies of pandemic vaccines. It also means that millions of people living in many "have not" countries that have traditionally been supplied with interpandemic vaccines will not be able to obtain any supplies of pandemic vaccines.

1. Another pandemic could spell disastrous consequences for humanity.

David S. Fedson. Preparing for Pandemic Vaccination: An International Policy Agenda for Vaccine Development. Journal of Public Health Policy, Vol. 26, No. 1 (2005), pp. 4-29

The influenza pandemic of I918 was one of the most significant disease outbreaks in all of recorded history (3). Within a two-year period, it killed an estimated 50-100 million people worldwide, 2.5 to 5% of the world's population (4). The number of people who died was far greater than the number who died in World War I. Two later pandemics-Asian influenza in 1957-1959 and Hong Kong influenza in 1968-were much milder, but nonetheless caused widespread social disruption and substantial excess mortality (3). In 1997, avian H5NI influenza appeared in the poultry markets of Hong Kong and infection spread to 18 people, six of whom died (5). Human cases of H5NI influenza reappeared in 1999 and again in early 2003. In late 200oo3 and early 2oo004, unprecedented outbreaks of avian H5Ni influenza swept through poultry flocks in many countries in East and Southeast Asia, leading to the deaths or culling of more than ioo million chickens. Again, human cases of H5NI infection occurred, and this time 24 (68%) of the 34 who were infected died (6). In autumn 2004, human cases of H5NI influenza reappeared, with similarly high fatality rates. Other regions of the world have also experienced human infections with avian influenza viruses. In early 2003, a highly pathogenic avian influenza H7N7 outbreak affected commercial poultry farms in the Netherlands and infection was transmitted to humans. As a result, more than 400 poultry workers and their family members developed conjunctivitis and influenza-like illness and one, a previously healthy veterinarian, died (7). This is not the only documented instance of the transmission of an avian influenza virus to mammals. In the early 198os, an H7N7 avian virus infected harbor seals on Cape Cod in New England, and within 2 months approximately 2zo% had died (8). The World Health Organization (WHO) and infectious disease experts throughout the world are concerned that events such as the recent avian influenza outbreaks in Asia could lead to a new human influenza pandemic. Given the more than three-fold increase in the world's population since 1918, a reappearance of a 1918-like pandemic could kill as many as 175 to 350 million people. This is greater than the number of people killed in all wars and by the most murderous governments throughout the twentieth century (9). Deaths from a flu pandemic would not be spread over 100 years but happen in one or two.

1. We can eradicate and prevent certain diseases from happening by use of herd immunity. Only through universal vaccination can we prevent and stop pandemic.

Robert I. Field and Arthur L. Caplan. A Proposed Ethical Framework for Vaccine Mandates: Competing Values and the Case of HPV. Kennedy Institute of Ethics Journal, Volume 18, Number 2, June 2008, pp. 111-124 (Article)

Much of the harm to society results from the loss of an effect known as “herd immunity.” Most infectious agents must reside in a sufficient number of susceptible individuals to maintain their presence. Eradication can occur when the proportion of the population that has been vaccinated is sufficiently large to deny the infectious agent such a reservoir of unimmunized hosts. For most diseases, herd immunity is achieved when the proportion of the population vaccinated is in the range of 90 percent. When the proportion of vaccine declinations exceeds this threshold, the infectious agent can lurk in the population to threaten not only those who are unvaccinated but also many who chose the vaccine but whose immune systems generate insufficient levels of antibodies to confer full protection (May and Silverman 2005). In this situation, a small number of vaccine declinations can have a devastating impact on a community, so the greatest medical benefit for the greatest number of people is achieved by requiring that everyone receive the vaccine. This is true regardless of whether a mandate is in the best interests of every individual or whether it ignores the interest in autonomy. It is an example of government coercion in the service of a competing ethical consideration. It also reflects an implicit hierarchy of public goods in which health takes precedence over rights. Justice calls for the fair, equitable, and appropriate distribution of scarce goods. It requires a reasoned system of allocating resources based on an underlying principle such as egalitarianism, fair opportunity, or underlying need. Health care is a scarce resource, so justice demands such a system for determining access. Under most analyses, relying solely on individual wealth to purchase access when life and well-being are at stake would not meet the requirements of fairness. Therefore, a program to encourage widespread use of a health care resource, such as a vaccine, whether through a mandate or otherwise, cannot be just if only those with financial means could comply. Justice requires an equitable means of access (see Daniels 1985; 2008; Daniels and Sabin 2002).

There are 2 implications:

1. We can prevent and stop pandemics from happening through vaccinations
2. We can only do so through herd immunity.

Thus, in order to prevent the impacts of bioterrorism, and to prevent future pandemic, I affirm.