I affirm,

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

I provide the following definitions for clarification in the round.

Webster defines guarantee as an assurance for the fulfillment of a condition.

Wikipedia defines Universal healthcare as a system of organized health-care systems built around the principle of universal coverage for all members of a society.

Value: My value is morality, the quality of being in accord with standards of good or right conduct. Because morality is defined as being in accord with good, and it is in harmony with good to provide universal healthcare, we must uphold.

Therefore, it follows that the standard is an ends based concept of health care. Their are three reasons why my criterion is preferable. First, it holds individuals accountable. Under deontological ethics an individual cannot be blamed for a bad consequence. Second, it solves for insolvable situations. For example a believer of a means based approach would never kill one person to save a thousand. Third, it allows you to advocate for solvency.

Contention 1- Universal health care prioritizes the well being of the most people

Subpoint a- Our current path work healthcare system causes us to spend more per capita than any other nation in the world. Only one uniform system can solve costs, a single payer system.

PNHP ‘7 (Physicians for National Health Program, ‘Single-Payer National Health Insurance’, http://www.pnhp.org/facts/single\_payer\_resources.php)

PNHP states, Currently, the U.S. health care system is outrageously expensive, yet inadequate. Despite spending more than twice as much as the rest of the industrialized nations ($7,129 per capita), the United States performs poorly in comparison on major health indicators such as life expectancy, infant mortality and immunization rates. Moreover, the other advanced nations provide comprehensive coverage to their entire populations, while the U.S. leaves 45.7 million completely uninsured and millions more inadequately covered. The reason we spend more and get less than the rest of the world is because we have a patchwork system of for-profit payers. Private insurers necessarily waste health dollars on things that have nothing to do with care: overhead, underwriting, billing, sales and marketing departments as well as huge profits and exorbitant executive pay. Doctors and hospitals must maintain costly administrative staffs to deal with the bureaucracy. Combined, this needless administration consumes one-third (31 percent) of Americans’ health dollars. Single-payer financing is the only way to recapture this wasted money. The potential savings on paperwork, more than $350 billion per year, are enough to provide comprehensive coverage to everyone without paying any more than we already do. Under a single-payer system, all Americans would be covered for all medically necessary services, including: doctor, hospital, preventive, long-term care, mental health, reproductive health care, dental, vision, prescription drug and medical supply costs. Patients would regain free choice of doctor and hospital, and doctors would regain autonomy over patient care. Physicians would be paid fee-for-service according to a negotiated formulary or receive salary from a hospital or nonprofit HMO / group practice. Hospitals would receive a global budget for operating expenses. Health facilities and expensive equipment purchases would be managed by regional health planning boards. A single-payer system would be financed by eliminating private insurers and recapturing their administrative waste. Modest new taxes would replace premiums and out-of-pocket payments currently paid by individuals and business. Costs would be controlled through negotiated fees, global budgeting and bulk purchasing.

Subpoint b- Global budgeting and reduced administrative expenses makes single-payer the most economically viable solution.

DeGrazia ’96 (David DeGrazia, Ph.D., is Assistant Professor of Philosophy, George Washington University, and a Senior Research Fellow at the Kennedy Institute of Ethics, Georgetown University, 1996, Kennedy Institute of Ethics Journal 6.2, ‘Why the United States Should adopt a Single-Payer Sytem of Health-Care’, http://muse.jhu.edu/

journals/kennedy\_institute\_of\_ethics\_journal/v006/6.2degrazia.html)

Degrazia says,Canada is able to get more for less chiefly because of (1) the vastly reduced administrative expenses made possible by the absence of a private insurance industry (competing payers) and (2) the economic controls afforded by global budgeting. While the U.S. spends an estimated 25 cents of every health care dollar on administration, Canada spends on the order of 13 cents (Woolhandler and Himmelstein 1991). The U.S. has more than 1,500 different payers. Most of them, as part of the private sector, must advertise, elaborate their unique restrictions on coverage, [End Page 148] determine patient eligibility, conduct patient-by-patient utilization reviews, bill patients individually, try to collect on bad debts, and the like--all while still seeking a profit. Nearly all of this frenetic activity is eliminated in Canada. Physicians submit simple, standardized forms--or disks--on which they check off the services rendered; they are then reimbursed by provincial governments. Global budgeting and other planning is also crucial in controlling costs. Canada pays physicians on the basis of standardized fees negotiated annually by medical and government representatives. Also negotiated annually are the global budgets for hospitals, which cover all expenses and therefore virtually eliminate the need to bill patients. In addition, Canada limits the number of specialty physicians, allocates the purchase of costly equipment, and restricts expensive procedures such as open-heart surgery to a few hospitals in major population centers (Iglehart 1989, p. 1767). Apparently, such macromanagement is far more cost-effective than the highly intensive micromanagement of the American system, with its myriad insurance companies scrutinizing decisions, patient eligibility, and so on, thereby creating mountains of paperwork for whole armies of administrators to climb. This claim of cost-effectiveness is supported by the fact that the systems of other industrial countries, including the single payers of the Scandinavian countries, France, Great Britain, and others, which have favored macromanagement, have had lower rates of health care inflation in recent decades than the U.S. has had. Not only does the U.S. currently spend more per capita than other countries, but the gap keeps growing (Schieber and Poullier 1989).

Subpoint C- Only single-payer healthcare can solve our systems cost problems while providing access to quality medical care for all.

Wirt ‘9 (Daniel P. Wirt, Pathologist, Houston, Texas and member of Health Care for All Texas and member of PhysiciansforaNationalHealthProgram,3/3/09, http://www.baltimorechronicle.com/2009/030509Wirt.shtml)

Wirt says, The data and evidence are clear: to a scientific certainty, only a single-payer “Medicare-for-All” system of health care financing will solve the serious cost and access problems and achieve good, affordable health care for all in the United States. As a scientist and physician, this is my conclusion after studying the data for years. The data are voluminous, stretching back to World War II, and come not only from the United States, but from all other industrialized countries. Except for the United States, all industrialized countries have some form of universal health care. Americans are increasingly afraid that they can’t afford to get sick, and with good reason. About half of all personal bankruptcies are caused by medical expenses, and 76 percent of these individuals had health insurance when they got sick or injured. Those of us with insurance are paying a greater share of the premium and more deductibles and co-pays as well. Thus, not only do we have 46 million Americans without health insurance, but at least an equal number who are seriously underinsured. With the recent economic downturn, the ranks of those who are uninsured and underinsured are growing. Many are faced with choosing between paying for medicine and needed health care and paying for food and housing. A typical story is: get sick or injured, lose your job, lose your health insurance, go bankrupt

Universal Healthcare CP Ext.- Quality

Subpoint D- Single-payer maintains patient choice while slashing overhead costs and improving care.

Wirt ‘9 (Daniel P. Wirt, Pathologist, Houston, Texas and member of Health Care for All Texas and member of PhysiciansforaNationalHealthProgram,3/3/09, http://www.baltimorechronicle.com/2009/030509Wirt.shtml)

Wirt says, Single-payer “Medicare-for-All” for financing health care is the right answer. It is right on choice: it provides free choice of doctor and hospital, the choice Americans want and value. In mandate plans, we lose those choices. It is right on efficiency and quality: single payer would slash administrative costs and promote efficient primary care. It would also enhance evidence-based quality assurance. It is right on accountability: it will be a public, nonprofit system that will respond to what doctors and their patients need, not what corporate executives and their stockholders want. The nation will pay about the same, while covering all Americans (no more exclusions based on “pre-existing conditions”). A modest increase in employer/employee payroll taxes would be offset by savings in out-of-pocket costs for insurance premiums, deductibles and co-payments, as well as by more comprehensive health services coverage. The single-payer program will cover all medically necessary services, including primary care, inpatient care, outpatient care, emergency care, prescription drugs, durable medical equipment, hearing services, long term care, mental health services, dentistry, eye care, chiropractic, and substance abuse treatment. Patients have their choice of physicians, providers, hospitals, clinics, and practices. No co-pays or deductibles are allowed. The program will negotiate reimbursement rates annually with physicians, allow for global budgets for hospitals, and negotiate prices for prescription drugs, medical supplies and equipment.

Subpoint E-A single-payer system is able to maintain a high quality healthcare system-Canada proves.

DeGrazia ’96 (David DeGrazia, Ph.D., is Assistant Professor of Philosophy, George Washington University, and a Senior Research Fellow at the Kennedy Institute of Ethics, Georgetown University, 1996, Kennedy Institute of Ethics Journal 6.2, ‘Why the United States Should adopt a Single-Payer Sytem of Health-Care’, http://muse.jhu.edu/journals/kennedy\_institute\_of\_ethics\_journal/v006/6.2degrazia.html)

Degrazia states, According to the reasoning described in the previous section, Canada's health care system has accomplished the impossible. First, Canada provides universal access to care and still controls costs sufficiently [End Page 147] to spend much less per capita than the U.S. does. In 1990, for example, the U.S. spent $2566 per citizen on health care while Canada--the world's second biggest spender--spent only $1770 per citizen, less than 70 percent as much (Schieber, Poullier, and Greenwald 1992). Equally surprising to many Americans, Canadians have access, not just to some "decent minimum" of health care, but to a very comprehensive set of benefits, including long-term and chronic care, as well as the services of psychiatrists and psychiatric hospitals. Commentators often state that the Canadian system provides "all medically necessary" services as determined by physicians (see, e.g., Iglehart 1990, p. 563), but the more modest claim that the health care benefits are very comprehensive is less likely to be contested. The quality of health care in Canada is generally considered high, and patient satisfaction is apparently higher than in the U.S. (Blendon et al. 1990; Barer and Evans 1992, p. 44). Equally impressive is the extensive freedom enjoyed by both providers and patients. Physicians are paid predominantly under a fee-for-service system, thereby avoiding, for example, the various kinds of restrictions imposed by American HMOs, such as limitations on the providers to whom patients can be referred and limits on the number of visits patients can make for, say, psychotherapy. In addition, Canadian physicians are undisturbed by the scrutiny and demands of insurance companies--since there are none--and they have very little administrative overhead, as explained below (Singer 1991, pp. 47-48). At the same time, patients enjoy the freedom to choose their physicians (something many Americans cannot do); 2 the freedom to receive appropriate medical care regardless of wealth, employment status, or pre-existing conditions; and the freedom from fear that such coverage allows. Patients also are free of copayments, deductibles, and the like, since, with rare exceptions, such as Quebec's $2 user fee for its drug plan subscribers, they are not charged for medical services. How are the achievements of Canada's health care system possible?

Subpoint F- Criticism of single-payer systems are wrong, system still maintains high tech and long waits for care are extremely rare.

DeGrazia ’96 (David DeGrazia, Ph.D., is Assistant Professor of Philosophy, George Washington University, and a Senior Research Fellow at the Kennedy Institute of Ethics, Georgetown University, 1996, Kennedy Institute of Ethics Journal 6.2, ‘Why the United States Should adopt a Single-Payer Sytem of Health-Care’, http://muse.jhu.edu/

journals/kennedy\_institute\_of\_ethics\_journal/v006/6.2degrazia.html)

Degrazia says, Despite its record of success on several counts, the Canadian single-payer system has provoked concerns and criticisms in the American discussion of health care reform. Two common, closely related concerns are (1) the specter of long waits for needed services and (2) a perception that high-technology services, such as hip replacements, open-heart surgery, and cataract operations, are in short supply. It is true that Canadians often have to wait in line and that high-technology services are in shorter supply in Canada than in the U.S. But it is worthwhile to put these facts into perspective. First, in nearly all cases the waits are for elective procedures; seriously ill or injured persons are prioritized, with very few slipping between the cracks (Farnsworth 1992). 4 Second, American patients in HMOs know that waits for services are not uncommon in the U.S. either. Third, the limited supply of high-technology services in Canada prevents problems associated with the duplication of those services, such as higher costs and mortality due to lower volume of use. Moreover, in the U.S. certain types of surgery and other specialized services are often performed when less invasive and costly alternatives are available but are not discussed with patients. 5 So the American usage rate of such services is hardly a gold standard. Finally, although it is well known that wealthy Canadians occasionally seek specialized care in the U.S., rather than waiting in Canada, patients flow north as well. Perhaps suggestively, a 1993 spot check of Ontario border hospitals revealed that 5 percent of the patients were Americans (Nelson 1994).