#### CP Text: The member nations of the World Trade Organization should establish a global system that provides universal healthcare to all of those nations’ citizens. This system should centrally purchase medicines in accordance with all IP rights and laws and should then universally distribute that medicine, with funds from the richest and healthiest going to subsidize the care of the poorest and sickest as per recommendations made by the CP evidence.

2) In order for universal healthcare to be achieved for all citizens, the system has to be global so that inequity between countries (not just within countries) may be resolved.

Faulkner, 19 - ("Global Universal Healthcare: Is It Within Reach?," Middletown Media, 5-4-2019, https://muncievoice.com/22657/global-universal-healthcare-is-it-within-reach/)//va

One of the biggest questions about global healthcare is how the costs will be distributed. In developed countries, raising taxes is a valid answer, but in some poorer nations, there is little room for tax reform on an already underprivileged population. So what can be done about it? ¶ For global universal healthcare to work, costs must be shared globally. This may mean [charity in third-world nations](https://borgenproject.org/fighting-poverty-developing-countries/), and more public and private partnerships in those areas. In other cases, global organizations can be formed, and surrounding nations that are more prosperous will need to help share the burden of costs with their neighbors. ¶ The biggest key with global universal healthcare is a shift in mentality from [selfishness and nationalism](https://www.muncievoice.com/11582/gop-just-trying-derail-affordable-health-care/) to a worldwide perspective on healthcare and the welfare of world citizens. No one entity can do it alone. ¶ Is [global universal healthcare within reach](https://www.economist.com/leaders/2018/04/26/universal-health-care-worldwide-is-within-reach)? With modern technology and communication and the innovations we have seen in healthcare, the answer is yes. The question then becomes: “Will we reach for it together?” ¶

3) Most people lack access to quality basic healthcare even though they spend shocking amounts of money trying to get it – a global universal healthcare system would pool resources to ensure everyone’s access at a much more efficient price and would solve better than the money currently spent on aid because it would establish infrastructure and employ rural community health workers

Guardian, 18 - ("Universal health care, worldwide, is within reach," Economist, 4-26-2018, https://www.economist.com/leaders/2018/04/26/universal-health-care-worldwide-is-within-reach)//va

BY MANY measures the world has never been in better health. Since 2000 the number of children who die before they are five has fallen by almost half, to 5.6m. Life expectancy has reached 71, a gain of five years. More children than ever are vaccinated. Malaria, TB and HIV/AIDS are in retreat. ¶ Yet the gap between this progress and the still greater potential that medicine offers has perhaps never been wider. At least half the world is without access to what the World Health Organisation deems essential, including antenatal care, insecticide-treated bednets, screening for cervical cancer and vaccinations against diphtheria, tetanus and whooping cough. Safe, basic surgery is out of reach for 5bn people. ¶ Those who can get to see a doctor often pay a crippling price. More than 800m people spend over 10% of their annual household income on medical expenses; nearly 180m spend over 25%. The quality of what they get in return is often woeful. In studies of consultations in rural Indian and Chinese clinics, just 12-26% of patients received a correct diagnosis. ¶ That is a terrible waste. As this week’s special report shows, the goal of universal basic health care is sensible, affordable and practical, even in poor countries. Without it, the potential of modern medicine will be squandered. ¶ How the other half dies Universal basic health care is sensible in the way that, say, universal basic education is sensible—because it yields benefits to society as well as to individuals. In some quarters the very idea leads to a dangerous elevation of the blood pressure, because it suggests paternalism, coercion or worse. There is no hiding that public health-insurance schemes require the rich to subsidise the poor, the young to subsidise the old and the healthy to underwrite the sick. And universal schemes must have a way of forcing people to pay, through taxes, say, or by mandating that they buy insurance. ¶ But there is a principled, liberal case for universal health care. Good health is something everyone can reasonably be assumed to want in order to realise their full individual potential. Universal care is a way of providing it that is pro-growth. The costs of inaccessible, expensive and abject treatment are enormous. The sick struggle to get an education or to be productive at work. Land cannot be developed if it is full of disease-carrying parasites. According to several studies, confidence about health makes people more likely to set up their own businesses. ¶ Universal basic health care is also affordable. A country need not wait to be rich before it can have comprehensive, if rudimentary, treatment. Health care is a labour-intensive industry, and community health workers, paid relatively little compared with doctors and nurses, can make a big difference in poor countries. There is also already a lot of spending on health in poor countries, but it is often inefficient. In India and Nigeria, for example, more than 60% of health spending is through out-of-pocket payments. More services could be provided if that money—and the risk of falling ill—were pooled. ¶ The evidence for the feasibility of universal health care goes beyond theories jotted on the back of prescription pads. It is supported by several pioneering examples. Chile and Costa Rica spend about an eighth of what America does per person on health and have similar life expectancies. Thailand spends $220 per person a year on health, and yet has outcomes nearly as good as in the OECD. Its rate of deaths related to pregnancy, for example, is just over half that of African-American mothers. Rwanda has introduced ultrabasic health insurance for more than 90% of its people; infant mortality has fallen from 120 per 1,000 live births in 2000 to under 30 last year. ¶ And universal health care is practical. It is a way to prevent free-riders from passing on the costs of not being covered to others, for example by clogging up emergency rooms or by spreading contagious diseases. It does not have to mean big government. Private insurers and providers can still play an important role. ¶ Indeed such a practical approach is just what the low-cost revolution needs. Take, for instance, the design of health-insurance schemes. Many countries start by making a small group of people eligible for a large number of benefits, in the expectation that other groups will be added later. (Civil servants are, mysteriously, common beneficiaries.) This is not only unfair and inefficient, but also risks creating a constituency opposed to extending insurance to others. The better option is to cover as many people as possible, even if the services available are sparse, as under Mexico’s Seguro Popular scheme. ¶ Small amounts of spending can go a long way. Research led by Dean Jamison, a health economist, has identified over 200 effective interventions, including immunisations and neglected procedures such as basic surgery. In total, these would cost poor countries about an extra $1 per week per person and cut the number of premature deaths there by more than a quarter. Around half that funding would go to primary health centres, not city hospitals, which today receive more than their fair share of the money. ¶ The health of nations Consider, too, the $37bn spent each year on health aid. Since 2000, this has helped save millions from infectious diseases. But international health organisations can distort domestic institutions, for example by setting up parallel programmes or by diverting health workers into pet projects. A better approach, seen in Rwanda, is when programmes targeting a particular disease bring broader benefits. One example is the way that the Global Fund to Fight AIDS, Tuberculosis and Malaria finances community health workers who treat patients with HIV but also those with other diseases. ¶ Europeans have long wondered why the United States shuns the efficiencies and health gains from universal care, but its potential in developing countries is less understood. So long as half the world goes without essential treatment, the fruits of centuries of medical science will be wasted. Universal basic health care can help realise its promise. ¶

4**)** The body responsible for medicine acquisition would be able to negotiate lower prices from pharma firms without violating IPR – having seven billion customers at a lower price is better than the status quo, so innovation ramps UP because there’s a guaranteed market. This is especially true for diseases like malaria that still haven’t been cured because it’s not profitable – the system is prepared to buy those medicines on a massive scale.

5) Public-private partnerships are key to universal health care systems & have been successful in the real world. The CP spills over to investment in education, sanitation, housing, and other public goods because countries have an incentive to pay less for emergency health care.

Guardian, 17 - ("How to make global universal healthcare a reality," 7-7-2017, <https://www.theguardian.com/global-development-professionals-network/2017/jul/07/how-to-make-global-universal-healthcare-a-reality)//va>

[Siddharth Chatterjee, resident coordinator to Kenya, United Nations, Nairobi, Kenya [@sidchat1](https://twitter.com/sidchat1) [@UNDPKenya](https://twitter.com/UNDPKenya)  
Siddharth is leading efforts with the Ministry of Health to leapfrog primary health coverage through PPP initiatives in Kenya. Previously he worked for the Red Cross.

Priya Balasubramaniam, senior public health scientist and director, PHFI-RNE Universal Health Initiative, [Public Health Foundation of India](http://www.phfi.org/),New Delhi, India  
Priya directs one of India’s seminal health policy exercises on health system reform and co-authored the government’s recommendations on universal health coverage as part of the country’s 12th Five Year Plan.

Cicely Thomas, senior program officer, [Results for Development](http://www.r4d.org/), Washington DC, USA [@results4dev](https://twitter.com/results4dev) [@cicelysimone](https://twitter.com/cicelysimone)  
Cicely has over 10 years experience providing technical support for health system strengthening in LMICs. She is, along with Priya, also a coordinating committee member of the [Health Systems Global Private Sector](http://www.healthsystemsglobal.org/twg-group/3/The-Private-Sector-in-Health/) in Health Thematic Working Group.

Jolene Skordis, director, [UCL Centre for Global Health Economics](http://www.ighe.org/), London, UK [@JSkordis](https://twitter.com/JSkordis)  
Jolene is an economist working to improve the effectiveness and efficiency of global health systems.

Agnes Soucat, director, health financing and governance, [World Health Organisation](http://www.who.int/en/), Geneva, Switzerland [@asoucat](https://twitter.com/asoucat) [@WHO](https://twitter.com/WHO)  
Agnes has over 25 years of experience in health and poverty reduction, and has previously worked at the World Bank and the African Development Bank.

Anand Reddi, corporate and medical affairs, [Gilead Sciences Inc,](https://www.theguardian.com/us) San Francisco, USA [@ReddiAnand](https://twitter.com/ReddiAnand) [@GileadSciences](https://twitter.com/GileadSciences)  
Anand’s work for Gilead Sciences focuses on HIV and viral hepatitis in resource-limited settings.

Helen Hamilton, policy advisor for health, [Sightsavers](http://www.sightsavers.org/), Haywards Heath, UK [@HelenCHamilton](https://twitter.com/HelenCHamilton) [@Sightsavers\_Pol](https://twitter.com/Sightsavers_Pol)  
Helen leads health policy work on increasing access to health services for people with disabilities, neglected tropical diseases and eye illnesses]

1 | Accept there’s no such thing as a ‘perfect healthcare model’ All healthcare models have their challenges in terms of systems capacity, fiscal space and good governance. I think the progress of countries like Thailand and Sri Lanka towards universal health is certainly laudable, but they each have different approaches to getting there. Thailand’s journey began incrementally and over the years through consistent investment in Primary Health Care (PHC). Meanwhile, India is more focused on achieving Universal Health Care (UHC) through mixed health markets featuring both public and private sector players. Priya Balasubramaniam, senior public health scientist and director, PHFI-RNE Universal Health Initiative,[Public Health Foundation of India](http://www.phfi.org/), New Delhi, India ¶ 2 | Have the same healthcare provider for the rich and the poor If we have dual systems with the “national service” caring for the poor and the private sector caring for the rich, quality will be an afterthought. We need the rich and poor to be cared for by the same provider – this ensures that high quality will be a political priority as those with voting influence are directly affected by the quality of services provided. Jolene Skordis, director,[UCL Centre for Global Health Economics](http://www.ighe.org/), London, UK[@JSkordis](https://twitter.com/JSkordis) ¶3 | Give public-private partnerships serious consideration The PPP model needs to be taken to scale in PHC in order to achieve UHC in a planned time frame. I have worked in many parts of the developing world and in general governments have not been able to step up. Now is the time to test new models as the old system is not working. We need a blended service delivery mechanism. We have to open up the insurance space and governments must push for universal insurance cover for all citizens. This is what we’re trying to do in [Kenya](http://www.huffingtonpost.com/siddharth-chatterjee/kenyas-health-sector-chal_b_11503202.html?ncid=engmodushpmg00000004). Siddharth Chatterjee, resident coordinator to Kenya, United Nations, Nairobi, Kenya[@sidchat1](https://twitter.com/sidchat1)[@UNDPKenya](https://twitter.com/UNDPKenya) ¶4 | Learn from the places getting it right Ghana’s health system isn’t the best I’ve seen but they’ve got some very fundamental things right and have been continually improving over many years. Some of the fundamentals are a commitment to all Ghanaians getting quality, affordable healthcare, and trying to create a national-level risk pool – so the healthier and wealthier subsidise the sicker and poorer. From small-scale experimentation with community-based health insurance, they scaled up to national health insurance, and are now working through the tough challenges of purchasing health services more strategically and sustainably for everyone. The private sector plays a significant role in Ghana’s healthcare provision – a recent World Bank study of Ghana’s private sector noted that Ghanaians access care from private sources more than half of the time. Cicely Thomas, senior programme officer,[Results for Development](http://www.r4d.org/), Washington DC, US [@results4dev](https://twitter.com/results4dev)[@cicelysimone](https://twitter.com/cicelysimone) ¶5 | Raise taxes to reach the poorestIn the majority of developed countries, health services are mostly private. But they are publicly regulated and financed. What we have learned over time is that an equitable system always relies on cross-subsidy, from rich to poor and from healthy to sick. Progressive taxation and public subsidy to ensure access to services is the essence if we want to reach universality of access to health services. Agnes Soucat, director, health financing and governance,[World Health Organisation](http://www.who.int/en/), Geneva, Switzerland[@asoucat](https://twitter.com/asoucat)[@WHO](https://twitter.com/WHO) ¶6 | Don’t focus on arbitrary targets for health spending The Abuja declaration expects African governments to spend 15% of GDP on healthcare. That’s not easy to do – and is not essential. Singapore spends about 5% of GDP on healthcare and has done a fantastic job in ensuring every citizen has access to a good quality service. Sri Lanka spends between 3%–5% and India is pushing for 2.5%. But the question should be about what can you do best with what you can afford to spend. There is no magic GDP number that will deliver UHC since every country has varied resources. Ultimately it is not only about more money, but also how you end up spending your existing health budget that matters. Resources are often misspent in the health sector with an inordinate focus towards hospital care. Siddharth Chatterjee and Priya Balasubramaniam ¶7 | Invest more in preventing people getting sick Health is not just the remit of health ministries – sanitation, housing, welfare and education are just a few of the bedrocks of improving population health. We shouldn’t think of healthcare as a pill or a hospital or programme to treat a single disease. Healthcare is clean water and a diet that does not place you at risk of diabetes or stunting. Healthcare is the education you need to find work and pay for a safe and warm home for your family. Healthcare is delaying early marriage and early pregnancy for vulnerable girls. Prevention has been relatively neglected in our policy priorities. Perhaps because prevention activities can seldom be charged for and people are not yet sick so it can be hard to convince both the public and policymakers of the benefits of preventative measures, even though prevention is usually the most cost-effective way to address disease. Jolene Skordis ¶8 | Make tackling individual diseases have a wider impact In resource-limited settings, what health initiatives can catalyse overall healthcare systems strengthening? Vertical initiatives anchored to one disease, such as the focus on HIV through PEPFAR and Global Fund, have led to broader health-system strengthening by alleviating the HIV burden as well as increasing outcomes in mother-to-child transmission. Anand Reddi, corporate and medical affairs, Gilead Sciences Inc, San Francisco, US[@ReddiAnand](https://twitter.com/ReddiAnand)[@GileadSciences](https://twitter.com/GileadSciences) ¶9 | Focus on equity, not just the number of people reached If we look back at the millennium development goals it is clear that the focus on reaching big numbers has had a detrimental effect on equity. Too often, national policies do not specifically address how marginalised groups will be reached by development programmes in order to benefit from the new facilities and services provided. This problem is often made worse in low-income areas where the services are offered on a cost recovery basis. Helen Hamilton, policy adviser for health,[Sightsavers](http://www.sightsavers.org/), Haywards Heath, UK[@HelenCHamilton](https://twitter.com/HelenCHamilton)[@Sightsavers\_Pol](https://twitter.com/Sightsavers_Pol) ¶10 | Be honest about how money shapes healthcare decisions India’s case (and that of South Africa, Brazil and the US) proves how users of a health services are often not the best judge of health services. We rely on doctors to tell us what care we need. If doctors can profit from giving us incorrect advice, they may well do so – particularly if there is little harm likely to be done (eg sending paying patients for extra, unneeded tests or procedures). This results in the cost of care increasing rapidly in the private sector, to the point where even the middle classes can’t afford health insurance in South Africa and the US. We need to remove the profit motive from healthcare if we want efficiency and effectiveness. Jolene Skordis ¶