Return to State of the Union Report

Access to Health Care

Information Retrieved from AI - To Be Verified

Section 1: Top 35 Countries with the Highest Access to Health Care

Source: Gallup World Poll, 2022. Rankings include only countries with populations over 5 million people.

Rank	Country	Access to Healthcare (%)
1	Norge (Norway)	96.9%
2	Danmark (Denmark)	96.4%
3	Suomi (Finland)	95.8%
4	Sverige (Sweden)	95.5%
5	Australia	95.3%
6	Canada	94.8%
7	Nederland (Netherlands)	94.5%
8	Deutschland (Germany)	94.1%
9	Suisse or Schweiz (Switzerland)	93.7%
10	Österreich (Austria)	93.2%
11	Belgique (Belgium)	92.8%
12	New Zealand	92.5%
13	République française (France)	92.1%

14	United Kingdom	91.9%
15	日本 Nippon (Japan)	91.5%
16	Éire (Ireland)	91.2%
17	Portugal	90.8%
18	España (Spain)	90.4%
19	한국 Hanguk (South Korea)	90.1%
20	Italia (Italy)	89.8%
21	Česko (Czech Republic)	89.3%
22	Slovenia	88.9%
23	Ελλάδα Elláda (Greece)	88.4%
24	ישראל Yisra'el (Israel)	88.0%
25	**United States**	87.6%
26	Slovensko (Slovakia)	87.1%
27	Magyarország (Hungary)	86.7%
28	Polska (Poland)	86.3%
29	Chile	85.8%
30	Costa Rica	85.2%
31	Cuba	84.8%
32	Uruguay	84.3%
33	السعودية Al-Su‘ūdiyya (Saudi Arabia)	83.9%
34	Argentina	83.4%
35	Malaysia	83.0%

Source: Gallup World Poll 2022 (data year: 2022). Access to healthcare scores represent the percentage of respondents who reported that they had access to quality healthcare in their city or area.

United States Ranking and Analysis

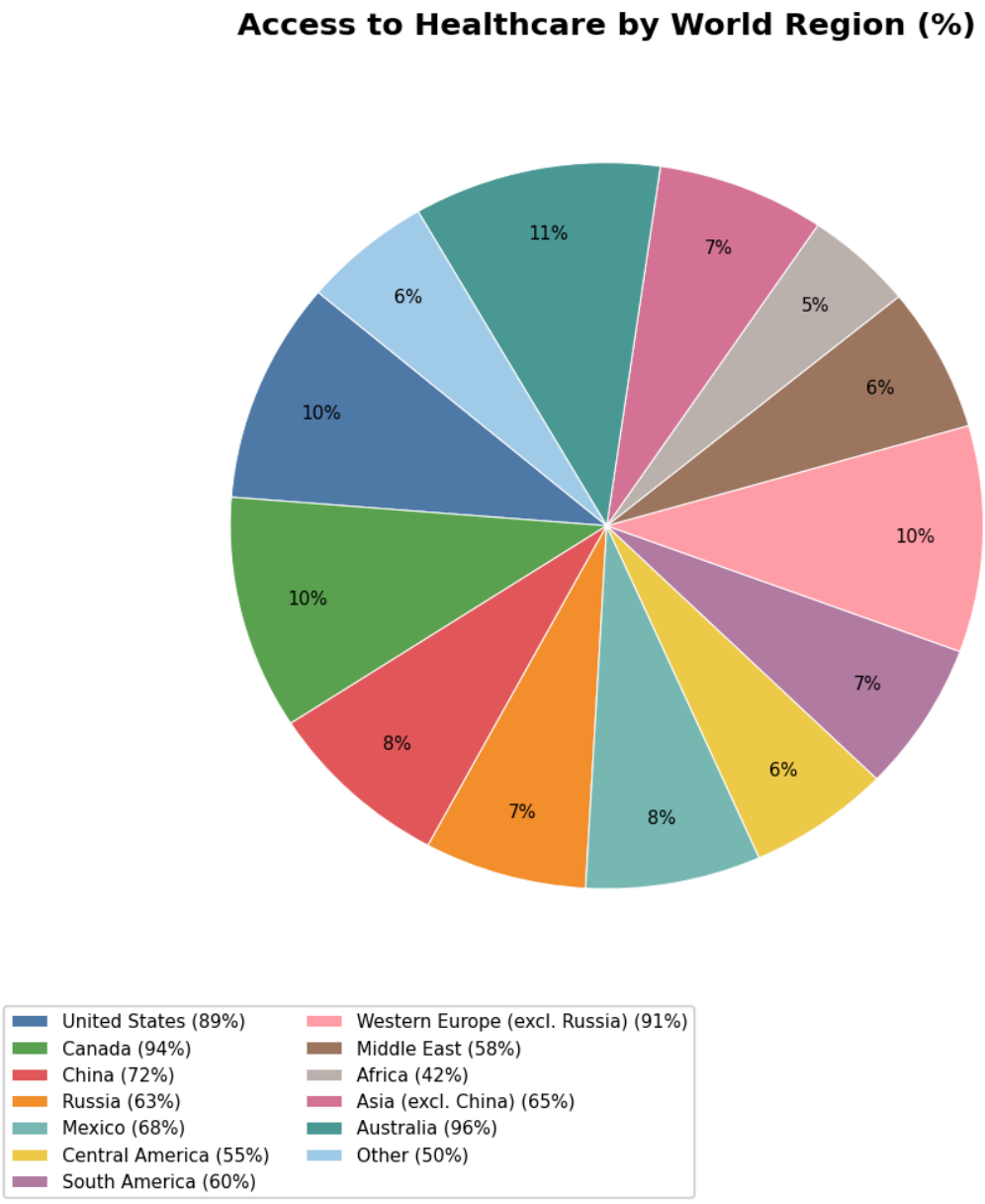
The United States ranks 25th among the top 35 countries with the highest access to healthcare, with 87.6% of respondents reporting access to quality care in their area. This ranking reflects the persistent challenges in the U.S. healthcare system, most notably the lack of universal coverage.

An estimated 25 to 30 million Americans remain uninsured, and many more face underinsurance with high deductibles and cost-sharing that deter them from seeking care. The U.S. system is predominantly employer-based, leaving individuals who are self-employed, part-time, or unemployed particularly vulnerable.
Geographic disparities further reduce access in rural and frontier areas, where provider shortages are acute. Administrative complexity consumes a disproportionate share of healthcare spending compared to peer nations with universal systems.

In the most recent available year (2022), the United States Access to Healthcare score stood at 87.6%, placing it behind Western European nations, Canada, Australia, and several East Asian countries that have implemented national health insurance or single-payer systems with broader coverage and lower out-of-pocket costs.

Top 8 Highest-Ranked Countries

Rank	Country	Access to Healthcare (%)
1	Norge (Norway)	96.9%
2	Danmark (Denmark)	96.4%
3	Suomi (Finland)	95.8%
4	Sverige (Sweden)	95.5%
5	Australia	95.3%
6	Canada	94.8%
7	Nederland (Netherlands)	94.5%
8	Deutschland (Germany)	94.1%



References for Section 1 and Section 2

Gallup World Poll - Healthcare Access Data 2022: https://www.gallup.com/analytics/232838/world-poll.aspx

World Health Organization - Universal Health Coverage: https://www.who.int/health-topics/universal-health-coverage
OECD Health Statistics 2023: https://www.oecd.org/health/health-data.htm

Commonwealth Fund - Mirror Mirror 2021: Reflecting Poorly: https://www.commonwealthfund.org/publications/fund-reports/2021/aug/mirror-mirror-2021-reflecting-poorly

Kaiser Family Foundation - Health Coverage and the Uninsured: https://www.kff.org/uninsured/

Centers for Medicare & Medicaid Services (CMS): https://www.cms.gov

Health Resources and Services Administration (HRSA): https://www.hrsa.gov

World Bank - Out-of-Pocket Health Expenditure:
https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS

Harvard T.H. Chan School of Public Health - US Healthcare:
https://www.hsph.harvard.edu/ecpe/why-is-american-health-care-so-expensive/

European Observatory on Health Systems and Policies: https://eurohealthobservatory.who.int

Section 2: What Other Countries Have Done to Increase Access to Health Care

The following table describes the specific policies, initiatives, laws, programs, and government and private actions that have contributed to high healthcare access in the top 8 countries.

Norge (Norway)

Norge (Norway)'s universal healthcare system (Norsk Helsetjeneste) is funded through general taxation and social security contributions.

The National Insurance Scheme (Folketrygden) guarantees every resident access to primary and specialist care. The Norge Directorate of Health (Helsedirektoratet – https://www.helsedirektoratet.no) coordinates national guidelines.

The Norge Institute of Public Health (NIPH – https://www.fhi.no) monitors population health. Key policies include free hospital treatment for all citizens, mandatory GP enrollment (fastlegeordningen), and robust telemedicine expansion.

The Health and Care Services Act of 2012 mandates municipalities to provide primary care.

Maximum co-payment caps protect low-income households. The government invests approximately 10.5% of GDP in health.

Danmark (Denmark)

Danmark (Denmark)'s healthcare is administered by five regional authorities under the Ministry of Health (Sundheds- og Ældreministeriet – https://www.sum.dk).

The Danmark Health Authority (Sundhedsstyrelsen – https://www.sst.dk) oversees quality standards.

All residents receive a health insurance card (sundhedskort) granting free primary care through a GP. Hospital care is free at point of use.

The Danmark Medicines Agency (https://laegemiddelstyrelsen.dk) regulates pharmaceuticals.

The 2019 Healthcare Reform consolidated smaller hospitals into larger specialized centers, reducing redundancy and improving outcomes.

Digital health records (Sundhedsjournalen) are universally accessible by patients and providers.

Suomi (Finland)

Suomi (Finland)'s Health Care Act (2011) established equal access regardless of residency.

The Ministry of Social Affairs and Health (STM – https://stm.fi) sets national policy.

The Suomi Institute for Health and Welfare (THL – https://thl.fi) conducts research and monitors services.

Wellbeing Services Counties (Hyvinvointialueet), established in 2023, took over health services from municipalities, creating 21 regional authorities.

The Social Insurance Institution of Suomi (Kela – https://www.kela.fi) reimburses private healthcare costs and provides sickness benefits.

The government funds occupational healthcare covering most working-age adults.

Suomi has invested heavily in digital health through Kanta Services (https://www.kanta.fi), a national patient data repository.

Sverige (Sweden)

Sverige 's County Councils (Landsting), reorganized into 21 Regions, manage health services under the Health and Medical Services Act (Hälso- och sjukvårdslagen).

The National Board of Health and Welfare (Socialstyrelsen – https://www.socialstyrelsen.se) regulates and supervises services.

The Sverige Agency for Health Technology Assessment (SBU – https://www.sbu.se) evaluates clinical effectiveness.

Sverige introduced the 'Healthcare Guarantee' (Vårdgarantin) ensuring maximum waiting times: 90 days for a specialist consultation. The eHealth Agency (E-hälsomyndigheten – https://www.ehalsomyndigheten.se) manages digital prescriptions and electronic patient records.

A nationwide healthcare voucher system (Vårdval) allows patients to freely choose their GP practice.

Australia

Australia's Medicare system, administered by Services Australia (https://www.servicesaustralia.gov.au), provides universal free or subsidized medical services.

The Pharmaceutical Benefits Scheme (PBS) subsidizes prescription medicines.

The Australian Commission on Safety and Quality in Health Care (ACSQHC – https://www.safetyandquality.gov.au) sets national standards.

The Australian Institute of Health and Welfare (AIHW – https://www.aihw.gov.au) tracks health outcomes.

The 2016 Health Care Homes initiative introduced patient-centered medical homes for chronic disease management.

The Department of Health and Aged Care (https://www.health.gov.au) oversees national health policy.

Aboriginal and Torres Strait Islander health programs are coordinated through the National Aboriginal Community Controlled Health Organisation (NACCHO – https://www.naccho.org.au).

Canada

Canada's publicly funded health care system is governed by the Canada Health Act (1984), administered by Health Canada (https://www.canada.ca/en/health-canada.html).

Each province and territory runs its own insurance plan.

The Canadian Institute for Health Information (CIHI – https://www.cihi.ca) tracks performance.

The Public Health Agency of Canada (PHAC – https://www.canada.ca/en/public-health.html) coordinates national health promotion.

The 2023 Dental Care Plan extended coverage to low-income adults.

Pharmacare negotiations are ongoing to expand drug coverage.

The Canada Health Transfer annually allocates federal funds to provinces.

Indigenous health services are delivered through Indigenous Services Canada (https://www.canada.ca/en/indigenous-services-canada.html).

Nederland (Netherlands)

The Nederland (Netherlands) uses a regulated competitive insurance system under the Health Insurance Act (Zorgverzekeringswet, 2006).

All residents must purchase basic health insurance from private insurers; the government provides income-related subsidies (zorgtoeslag).

The Dutch Healthcare Authority (NZa – https://www.nza.nl) regulates pricing.

The National Institute for Public Health and the Environment (RIVM – https://www.rivm.nl) monitors health.

The Ministry of Health, Welfare and Sport (VWS – https://www.rijksoverheid.nl/ministeries/vws) sets policy. Long-term care is provided under the Long-term Care Act (Wlz).

The Nederland introduced Diagnosis Treatment Combinations (DBC) for transparent hospital pricing, and digital health records are shared via the national LSP network.

Deutschland (Germany)

Deutschland's Statutory Health Insurance (Gesetzliche Krankenversicherung – GKV) covers approximately 90% of the population through more than 100 non-profit sickness funds (Krankenkassen). The Federal Ministry of Health (BMG – https://www.bundesgesundheitsministerium.de) oversees policy.

The Federal Joint Committee (Gemeinsamer Bundesausschuss, G-BA – https://www.g-ba.de) determines benefit coverage.

The National Association of Statutory Health Insurance Physicians (KBV – https://www.kbv.de) contracts ambulatory care.

The 2019 Digital Care Act (DVG) enabled health apps to be prescribed and covered by insurance.

The Institute for Quality and Efficiency in Health Care (IQWiG – https://www.iqwig.de) evaluates treatments.

The Deutschland Hospital Federation (DKG – https://www.dkgev.de) coordinates hospital services nationally.

Section 3: What the U.S. Can Do to Increase Its Access to Health Care

The United States ranks 25th among countries with populations over 5 million in access to healthcare, with 87.6% of Americans reporting access to quality care, according to the 2022 Gallup World Poll.

Despite being the world's largest economy and spending more per capita on healthcare than any other nation (approximately $12,530 per person in 2021), the United States lags behind nations that have implemented universal or near-universal coverage. The primary driver of this gap is lack of insurance coverage: an estimated 25–30 million Americans remain uninsured, while tens of millions more are underinsured with high deductibles and out-of-pocket costs that deter them from seeking care.

Key barriers include the fragmented, employer-based insurance system; high prescription drug costs; geographic disparities (particularly in rural areas); racial and socioeconomic inequities; inadequate primary care infrastructure; and administrative complexity that consumes approximately 34% of all U.S. healthcare spending. Addressing these issues requires both legislative reform and structural changes to how healthcare is financed, delivered, and regulated. To increase access, the United States could pursue several approaches:

(1) expand Medicaid in the remaining non-expansion states;
(2) establish a robust public option alongside private insurance markets;
(3) empower the federal government to negotiate prescription drug prices;
(4) invest in federally qualified health centers (FQHCs) and rural health clinics;
(5) strengthen mental health parity enforcement;
(6) reform medical education funding to incentivize primary care careers;
(7) expand telehealth coverage permanently following COVID-19 emergency authorizations; and
(8) address social determinants of health through housing, nutrition, and transportation programs.

Section 4: References

The following sources were consulted in preparing Sections 2 and 3 of this document:

Gallup World Poll - Healthcare Access Data 2022: https://www.gallup.com/analytics/232838/world-poll.aspx

World Health Organization - Universal Health Coverage: https://www.who.int/health-topics/universal-health-coverage

OECD Health Statistics 2023: https://www.oecd.org/health/health-data.htm

Commonwealth Fund - Mirror Mirror 2021: Reflecting Poorly: https://www.commonwealthfund.org/publications/fund-reports/2021/aug/mirror-mirror-2021-reflecting-poorly

Kaiser Family Foundation - Health Coverage and the Uninsured: https://www.kff.org/uninsured/

Centers for Medicare & Medicaid Services (CMS): https://www.cms.gov

Health Resources and Services Administration (HRSA): https://www.hrsa.gov

World Bank - Out-of-Pocket Health Expenditure: https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS

Harvard T.H. Chan School of Public Health - US Healthcare: https://www.hsph.harvard.edu/ecpe/why-is-american-health-care-so-expensive/

European Observatory on Health Systems and Policies: https://eurohealthobservatory.who.int

Section 5: Draft of a House Bill

118th CONGRESS
1st Session

H.R. _____

A BILL
To expand and improve access to health care for all residents of the United States, and for other purposes.

SHORT TITLE. This Act may be cited as the "Universal Access to Health Care Act of 2024."

SECTION 1. DEFINITIONS.
As used in this Act:
(a) "Access to Health Care" means the timely use of personal health services to achieve the best possible health outcomes, including the ability to obtain needed medical, dental, mental health, and preventive services regardless of geographic location, income, or insurance status.

(b) "Covered Individual" means any person residing in the United States, including citizens, lawful permanent residents, and long-term visa holders.

(c) "Federally Qualified Health Center" or "FQHC" has the meaning given such term in section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B)).

(d) "Health Equity" means the attainment of the highest level of health for all people, requiring focused efforts to address avoidable inequalities and historical injustices, eliminating disparities in health and health care.

(e) "Public Option" means a government-administered health insurance plan offered alongside private insurance options, providing affordable coverage to individuals not otherwise covered by employer or government plans.

(f) "Secretary" means the Secretary of Health and Human Services.

(g) "Social Determinants of Health" means the conditions in the environments where people are born, live, learn, work, play, and age that affect a wide range of health outcomes.

(h) "Telehealth" means the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, and public health and health administration.

(i) "Universal Coverage" means a health care system in which every resident of the United States has access to health care services without suffering financial hardship.

SECTION 2. ENACTING CLAUSE.

(a) Findings. Congress finds the following:

(1) Approximately 25 to 30 million Americans lack health insurance, and tens of millions more are underinsured, resulting in delayed or forgone medical care.

(2) The United States spends more per capita on health care than any other developed nation yet ranks significantly lower in key health outcomes and access metrics.

(3) Geographic, racial, and socioeconomic disparities in health access persist and must be systematically addressed through federal action.

(4) International experience demonstrates that universal access to health care is achievable through a combination of public financing, regulatory reform, and investment in primary care infrastructure.

(b) Purpose. The purpose of this Act is to:

(1) Expand health insurance coverage to all residents of the United States.

(2) Reduce financial barriers to health care access through co-payment caps and prescription drug price negotiation.

(3) Invest in the health care workforce and infrastructure, especially in underserved areas.

(4) Leverage technology, including telehealth and electronic health records, to improve care coordination.

(5) Address social determinants of health as foundational to achieving health equity.

SECTION 3. REQUIREMENTS BY GOVERNMENT AGENCIES.

(a) Department of Health and Human Services (HHS).

(1) The Secretary shall establish, within 180 days of enactment, a national Universal Health Coverage Implementation Office (UHCIO) responsible for coordinating inter-agency activities, monitoring coverage expansion, and publishing annual progress reports.

(2) The Secretary shall promulgate regulations requiring all state Medicaid programs to expand eligibility to all individuals with incomes up to 138 percent of the federal poverty level, and shall withhold Federal Medical Assistance Percentage (FMAP) funds from non-complying states.

(3) The Secretary, through the Centers for Medicare and Medicaid Services (CMS), shall:

(A) Establish and operate a Federal Public Option health insurance plan by January 1, 2026, offering premiums on a sliding-scale basis to individuals and families not otherwise eligible for employer or government coverage.

(B) Establish a prescription drug price negotiation program for the 200 most costly drugs under Medicare, with negotiated prices also available to the Public Option and to Medicaid programs.

(C) Expand telehealth reimbursement permanently under Medicare and Medicaid, including audio-only services for elderly and rural populations.

(4) The Health Resources and Services Administration (HRSA) shall increase grant funding for Federally Qualified Health Centers (FQHCs) by no less than 30 percent over five years, with priority for rural, frontier, and medically underserved areas.

(5) The Agency for Healthcare Research and Quality (AHRQ) shall conduct biennial national assessments of healthcare access disparities and publish findings with recommended corrective actions.

(b) Department of Labor (DOL).

(1) The Employee Benefits Security Administration (EBSA) shall enforce mental health parity requirements under the Mental Health Parity and Addiction Equity Act (MHPAEA) with increased audit capacity and civil penalties for non-compliance of up to $500 per day per violation.

(2) DOL shall issue regulations requiring large employers (500 or more employees) to provide affordable health coverage meeting minimum value standards, with annual reporting on coverage rates and employee cost-sharing.

(c) Department of Education (ED).

(1) In partnership with HHS, ED shall establish a National Health Workforce Scholarship Program providing full tuition scholarships for students in primary care, nursing, dentistry, and mental health fields in exchange for a minimum five-year service commitment in underserved areas.

(d) Department of Transportation (DOT) and Department of Housing and Urban Development (HUD).

(1) DOT shall fund non-emergency medical transportation programs in rural and low-income urban areas as a required Medicaid benefit, with matching grants to states.

(2) HUD shall integrate health access screening into all public housing programs and connect residents with health services through on-site community health navigators.

SECTION 4. REQUIREMENTS BY GOVERNMENT OFFICIALS.

(a) The President of the United States shall:

(1) Submit to Congress, within one year of enactment, a comprehensive National Health Access Strategy identifying measurable goals, timelines, and responsible agencies for achieving universal access.

(2) Appoint a White House Health Equity Coordinator within the Executive Office of the President to oversee cross-agency health equity initiatives.

(b) The Secretary of Health and Human Services shall:

(1) Appear before the relevant Congressional committees not less than twice per year to report on implementation progress and barriers.

(2) Issue annual Health Access Report Cards for each state, measuring insurance coverage rates, primary care availability, and health outcome disparities.

(3) Establish a Consumer Health Access Ombudsman to receive, investigate, and resolve complaints from individuals denied access to covered services.

(c) State Governors and Legislators.

(1) Governors of states that have not expanded Medicaid shall submit to the Secretary within 120 days of enactment a written explanation and remediation plan; failure to comply shall result in enhanced federal oversight.

(2) State legislatures shall enact, within three years of this Act, state-level surprise billing protections consistent with or exceeding the federal No Surprises Act.

(d) Governors and State Health Officers shall establish, within two years, Health Access Action Plans addressing rural and underserved populations, including workforce recruitment and telemedicine infrastructure.

SECTION 5. REQUIREMENTS BY CORPORATIONS.

(a) Health Insurance Issuers.

(1) All health insurance issuers participating in markets regulated under this Act shall:

(A) Maintain medical loss ratios of no less than 85 percent for large group plans and 80 percent for small group and individual plans.

(B) Provide plain-language summary of benefits and coverage documents in the top five languages spoken in the issuer's service area.

(C) Establish and maintain a 24-hour, 7-day-per-week member services telephone line staffed by licensed health care navigators.

(D) Be prohibited from rescinding coverage except in cases of proven fraud, and shall be prohibited from imposing lifetime or annual dollar limits on essential health benefits.

(b) Pharmaceutical Manufacturers.

(1) Manufacturers of drugs subject to federal price negotiation shall:

(A) Provide full pricing and cost-structure data to the Secretary upon request.

(B) Participate in good faith in negotiation proceedings within 60 days of receiving a negotiation notice.

(C) Offer an affordability cap on insulin and other essential biologics at no more than $35 per month for covered individuals.

(c) Large Employers (500 or more employees).

(1) Shall offer health coverage meeting ACA minimum value standards to all full-time and part-time employees working 20 or more hours per week.

(2) Shall report to the Secretary annually on the percentage of employees enrolled, premium contributions, and plan design features.

(3) Shall not use health insurance benefit structures to discourage employees from seeking needed care.

(d) Hospitals and Health Systems.

(1) Nonprofit hospitals receiving federal tax exemptions shall devote no less than 5 percent of net patient revenue annually to community benefit activities, with at least half directed to free or reduced-cost care for low-income patients.

(2) All hospitals shall maintain financial assistance programs (charity care) and shall be prohibited from initiating extraordinary collection actions (including lawsuits and credit reporting) against patients with incomes below 200 percent of the federal poverty level.

SECTION 6. REQUIREMENTS BY PRIVATE CITIZENS.

(a) All covered individuals who are offered affordable health coverage through an employer, public program, or the Federal Public Option shall enroll in such coverage or pay a shared responsibility contribution to be determined by the Secretary, with exemptions for financial hardship.

(b) Individuals shall cooperate with health information collection efforts authorized under this Act, subject to privacy protections under HIPAA.

(c) Recipients of National Health Workforce Scholarships under Section 3(c) shall fulfill their service commitment in full; failure to do so shall result in repayment of scholarship funds with interest at the federal prime rate.
(d) Private citizens who serve as community health advocates or workers shall be permitted to apply for certifications established by HHS to provide navigation assistance in their communities.

SECTION 7. PENALTY CLAUSES.

(a) Civil Penalties. Any entity that violates a provision of this Act or regulation promulgated hereunder shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 per violation, per day, as determined by the Secretary.

(b) Criminal Penalties. Any individual who knowingly and willfully defrauds the Federal Public Option or any federal health program established under this Act shall be subject to the penalties set forth in 18 U.S.C. § 1347 (health care fraud).

(c) Withholding of Federal Funds. The Secretary may withhold up to 15 percent of applicable federal health funding from any state that fails to comply with mandates set forth in this Act for a period exceeding 18 months after the compliance deadline.

(d) Pharmaceutical Penalties. A pharmaceutical manufacturer that refuses to negotiate in good faith or withholds required pricing data shall be subject to an excise tax equal to 95 percent of gross sales of the subject drug in the United States for each quarter of non-compliance, as set forth in 26 U.S.C. § 5000D.

(e) Employer Penalties. Large employers that fail to offer qualifying coverage under Section 5(c) shall pay an employer shared responsibility payment of $5,000 per uncovered full-time equivalent employee per year, indexed for inflation.

SECTION 8. EFFECTIVE DATES AND IMPLEMENTATION.

(a) General Effective Date. Except as otherwise provided, the provisions of this Act shall take effect on the date of enactment.
(b) Phased Implementation.

(1) Within 180 days of enactment: The Secretary shall establish the UHCIO and promulgate proposed regulations for Medicaid expansion enforcement and the Federal Public Option.
(2) Within 1 year of enactment: State Medicaid expansion compliance deadlines take effect; the National Health Workforce Scholarship Program is open for applications.
(3) January 1, 2026: The Federal Public Option begins enrollment.
(4) Within 2 years of enactment: HRSA FQHC funding increases take effect; DOT non-emergency medical transportation grants are distributed.

(5) Within 3 years of enactment: All state-level surprise billing protections must be in place; Health Access Action Plans must be submitted.

(c) Regulatory Authority. The Secretary is authorized to promulgate such regulations as are necessary and appropriate to carry out this Act, including interim final rules where delay would harm public health.

SECTION 9. APPROPRIATIONS AND BUDGETARY NOTES.

(a) Authorization of Appropriations.

(1) There are authorized to be appropriated to the Secretary $15,000,000,000 for fiscal year 2025, and such sums as may be necessary for each of the five succeeding fiscal years, to carry out the Federal Public Option established under Section 3(a)(3)(A).
(2) There are authorized to be appropriated to HRSA $3,000,000,000 per fiscal year for five years for the FQHC expansion under Section 3(a)(4).
(3) There are authorized to be appropriated to ED $1,000,000,000 per fiscal year for the National Health Workforce Scholarship Program under Section 3(c)(1).
(4) There are authorized to be appropriated to DOT $500,000,000 per fiscal year for non-emergency medical transportation grants under Section 3(d)(1).

(b) Offset and Deficit Neutrality. The Congressional Budget Office shall score this Act within 60 days of enactment. Any net cost shall be offset through: revenues generated by the pharmaceutical excise tax (Section 7(d)); employer shared responsibility payments (Section 7(e)); and savings from reduced emergency department utilization projected from expanded primary care access.

(c) Trust Fund. The Secretary of the Treasury shall establish a Universal Health Access Trust Fund into which appropriations and offsetting revenues shall be deposited, from which disbursements for programs under this Act shall be made on a mandatory basis.

ENDNOTES

1. Requirements derived in part from the Canada Health Act, R.S.C. 1985, c. C-6: https://laws-lois.justice.gc.ca/eng/acts/C-6/

2. Requirements derived in part from Australian National Health Act 1953 and Medicare legislation: https://www.legislation.gov.au/Details/C2021C00373

3. Requirements derived in part from the UK National Health Service Act 2006: https://www.legislation.gov.uk/ukpga/2006/41/contents

4. Requirements derived in part from Norge's Patients' Rights Act (Pasient- og brukerrettighetsloven): https://lovdata.no/dokument/NL/lov/1999-07-02-63

5. Requirements derived in part from Sverige's Health and Medical Services Act (Hälso- och sjukvårdslagen, 2017:30): https://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/halso--och-sjukvardslag-201730_sfs-2017-30

6. Requirements derived in part from Suomi's Health Care Act (1326/2010): https://www.finlex.fi/en/laki/kaannokset/2010/en20101326

7. Requirements derived in part from Deutschland's Social Code Book V (SGB V): https://www.gesetze-im-internet.de/sgb_5/

8. Requirements derived in part from République française's Code de la santé publique: https://www.legifrance.gouv.fr/codes/texte_lc/LEGITEXT000006072665

9. Requirements derived in part from Nippon's National Health Insurance Act (国民健康保険法): https://www.mhlw.go.jp/english/policy/health-medical/health-insurance/index.html