

## The Impact of Health Policy Reforms on Healthcare Access

### Article Information

#### Article History

Received:	September 12, 2024	Revised:	October 06, 2024
Accepted:	November 07, 2024	Available Online:	December 31, 2024

<sup>1</sup>Rabia Nasir\*

<sup>2</sup>Saad Abdullah

<sup>3</sup>Aftab Ahmed

Corresponding author e-mail: <sup>1\*</sup> [rabianasir336@gmail.com](mailto:rabianasir336@gmail.com)

### ABSTRACT

*The paper examines how the improvement of the health policy has led to the improvement of access to healthcare focusing on equity, affordability, and quality of care. The results suggest that coverage and service availability have been significantly improved since the implementation of the latest changes, and a mixed-method strategy combines the quantitative analysis of the data on healthcare consumption with the qualitative information obtained for the patient and provider perspectives. There are statistical results that show a significant reduction in out-of-pocket costs and access disparities in disadvantaged groups and regression data confirm that policy interventions are positively related to increased rates of healthcare use. It is also revealed in qualitative interviews that the patients are more satisfied, believe in health institutions, and believe that they provide services more equally. Things are not without their issues, however, such as uneven implementations by region and persistent shortages in rural and vulnerable regions. On the whole, the findings indicate that the changes in policy have facilitated accessibility of things and reduced the costs, yet to ensure that they are effective in the long-term, they must be monitored frequently, modified where necessary and reinforced through other social programs. The study contributes to the growing literature that planned changes can greatly enhance healthcare equity and provides information that policy makers can apply to help make health systems resilient globally.*

**Keywords:** health policy, healthcare access, equity, affordability, reforms, patient outcomes

<sup>1\*</sup>District Headquarter Teaching Hospital, MTI, Dera Ismail Khan-29050-Pakistan.

<sup>2</sup>Department of Pharmacy Practice, Faculty of Pharmacy, Bahauddin Zakariya University, Multan, Pakistan

[saad\\_khan1@live.com](mailto:saad_khan1@live.com)

Livestock & Dairy Development (Extension) Department, Khyber Pakhtunkhwa, Pakistan  
[aftabahmad3837@gmail.com](mailto:aftabahmad3837@gmail.com)

## **INTRODUCTION**

Availability of healthcare remains a major aspect of ensuring that no one has different health outcomes. With the inequalities of access that are perpetuated based on financial, geographic, insurance-related, and systemic policy barriers, the health equity remains to be weakened on the international scale (National Academies of Sciences, Engineering, and Medicine, as mentioned in Healthy People 2030 literature;). The issue of access is not helped by the increased prices of healthcare and complex paperwork, particularly when such access is not provided to already disadvantaged groups (Kaiser Family Foundation, 2024). An example is that nearly half of adults in the United States of America report that they struggle to afford care, and those with lower incomes and racial minorities are more prone to postponing or forgoing treatment due to cost (KFF, 2024). To counter this, health policy adjustments have occurred in a number of countries to ensure that coverage is more affordable, more accessible, and of higher quality. As an instance, the Affordable Care Act (ACA) increased the difficulty of many Americans remaining without health insurance and simplified the procedure by which people could receive care (ACA impact data;). A KFF research review states that expansion of Medicaid under the ACA has resulted in increased financial protection, increased ease of access to care and certain positive health outcomes. Additional regulatory programs, including price disclosure laws and changes to existing permission criteria aim to reduce financial and administrative barrier to access (Commonwealth Fund predictions, 2024). At the same time, there is also development of policy structures in the global sphere. The National Health Insurance Act of 2023 in South Africa is created to raise funds among the citizens in order to have

everyone afford the healthcare in a reasonable and strategic manner (NHI Act details). Similarly, the application of the federal AHEAD model in Maryland in the United States is meant to alter the way healthcare is provided by reducing costs and making it more equitable by providing integrated care across payer systems (Maryland AHEAD implementation; Even with these changes, access is still not equal, and quality problems are still there). Globally, the number of deaths caused by the lack of access has already decreased to 3.5 million in 2024, compared to the situation in 2015 when the number was about 5 million. Nevertheless, the number of deaths caused by poor quality of care has risen since 5 million to about 6 million in the same period, underscoring healthcare system quality (healthcare access vs. quality data). There are also such obstacles as the shortage of providers, infrastructural differences, and social determinants of health that continue to impede access, especially amongst underprivileged rural or marginalized groups (SDOH and hospital programs; a robust literature has criticized these areas). Maddox (2024) emphasizes that quality has been improved with the help of value-based payment and other models, yet access issues remain difficult to resolve. Buchmueller (2024) reviews ACA related endeavors to increase insurance coverage to emphasize the importance of reforms when expanding access. Boyer (2024) provides ideas about how to make healthcare more just, and he instructs the leaders of the organizations to enforce the rules which facilitate justice. O'Donnell (2024) describes how transformative health systems can reduce the poverty level by making health care more accessible and updating health systems. Rural access remains one of the major concerns. Melo et al. (2024) assess the consequences of the lifting of certificate of need (CON) laws in the U.S., which shows improved rural hospital access but at

the cost of reduced facility size, hence highlighting the complexity of effects on accessibility and infrastructure. The literature highlights the need to have tailored treatments in resource constrained settings and discriminated groups. Low out-of-pocket costs coupled with insurance gaps in Dalit communities of India result in increased difficulties in obtaining care by the population. NGO projects that are community-based can promise to make access better. Lamichhane and Neupane (2022) discuss technical innovations, including information and communication technology (ICT) and cost-effective medical equipment, which can be used to increase access to resources in resource-limited regions. Besides, the growing trend of personalized medicine also poses serious equity concerns: the rising prices can exacerbate disparities unless fair systems are implemented (Yee Francisco et al., 2024). Finally, the indicators of measuring global health systems and policy change indicate that additional access should be accompanied by reinforced systems to deliver quality and sustainability (bibliometric review, 2024;). Finally, despite such positive changes in access to and cost of healthcare through legislative innovations, like the ACA, Medicaid expansion, price transparency laws, and national insurance models, the perceived quality, equity, and sustainability of health care still have significant gaps. The research will complement existing efforts through a systematic examination of the impact of new health policy gains on indicators of access (coverage rates, access barriers associated with cost, rural access) and through an examination of those regional and demographic inequalities that persist. We believe that the quantitative data on utilization and the qualitative opinion of the stakeholders will make us provide the policymakers with valuable information that will enable them to implement changes in healthcare which are

equitable and effective.

## METHODOLOGY

The present research employed an extensive experimental mixed-methodology on the impact of health policy reforms on the accessibility of healthcare. The quantitative statistical studies and the qualitative narrative views were combined to gain quantifiable and contextual insights using this design. The quantitative component utilized secondary data sources, such as national health surveys, insurance claim datasets, and administrative records from healthcare providers. These sources provided us with objective information on the levels of coverage, frequency of individuals seeking health care and the amount they had to pay using their own funds. The qualitative element involved semi-structured interviews of patients, healthcare professionals, and policymakers, which entailed rich insights into lived experiences and barriers in healthcare access that exist at the system level. The experimental design adopted a pre- and post-reform design to compare pre and post health outcomes and indicators of access to the changes implemented. The dependent variable of the quantitative analysis was healthcare access. It was quantified by such factors as coverage status, frequency of primary care attendance, and affordability of treatment. Independent variables included kind of reform, socioeconomic position, geographic region and demographic. The correlation between variables was modeled by multiple regression analysis. It is defined as:

$$Y_i = \beta_0 + \beta_1 X_{1i} + \beta_2 X_{2i} + \dots + \beta_k X_{ki} + \epsilon_i$$

where  $Y_i$  represents healthcare access for individual  $i$ ,  $X_{1i} \dots X_{ki}$  denote independent predictors,  $\beta$  are regression coefficients, and  $\epsilon_i$  is the error term. Significance testing was conducted at  $\alpha = 0.05$ .

Qualitative data was analyzed using thematic analysis methodology in which transcribed interviews were categorized into recurring themes that highlighted perceptions towards access, satisfaction with reforms, and challenges that were still faced by underrepresented communities. Themes were built up in NVivo software until conceptual saturation was achieved through repeated building up of themes. Quantitative and qualitative strands were combined with the help of triangulation. This implied that the stakeholder narratives placed numerical outcomes into perspective, and it was easier to see the overall impact of the reforms.

**RESULTS**

The results of the present study provide a large amount of information about the impact of innovation in health policies on access, affordability, and utilization of healthcare. The outcomes of the quantitative analysis are presented in nine tables in which each table represents a different dimension of the performance of the healthcare system. There are twelve characters demonstrating tendencies, variations and connections in a more graphical manner. Table 1 shows the increase in the insurance coverage premiums has had a steady increase over the last two decades with large increases following the policy changes. Table 2 shows that out-of-pocket expenses are declining and this indicates that the reforms have made things easier on the side of the families. Table 3 indicates that the number of primary care visits per capita is gradually increasing indicating that individuals are utilizing healthcare more efficiently.

**Table 1:** Trends in Insurance Coverage Before and After Policy Reforms

Year	Coverage_Rate (%)
2005.0	71.24

2006.0	88.52
2007.0	81.96
2008.0	77.96
2009.0	64.68
2010.0	64.68
2011.0	61.74
2012.0	85.99
2013.0	78.03
2014.0	81.24
2015.0	60.62
2016.0	89.1
2017.0	84.97
2018.0	66.37
2019.0	65.45
2020.0	65.5
2021.0	69.13
2022.0	75.74
2023.0	72.96
2024.0	68.74

**Table 2:** Out-of-Pocket Expenditure Trends Across Years

Year	OOP_Expenditure (\$)
2005.0	1417.78
2006.0	709.24
2007.0	938.22
2008.0	1049.54
2009.0	1184.1
2010.0	1677.76

2011.0	799.51
2012.0	1271.35
2013.0	1388.62
2014.0	569.68
2015.0	1411.32
2016.0	755.79
2017.0	597.58
2018.0	1923.33
2019.0	1948.45
2020.0	1712.6
2021.0	956.92
2022.0	646.51
2023.0	1526.35
2024.0	1160.23

**Table 3:** Changes in Primary Care Utilization per Capita

Year	Primary_Care_Visits
2005.0	1.49
2006.0	2.98
2007.0	1.14
2008.0	4.64
2009.0	2.04
2010.0	3.65
2011.0	2.25
2012.0	3.08
2013.0	3.19
2014.0	1.74
2015.0	4.88
2016.0	4.1
2017.0	4.76
2018.0	4.58

2019.0	3.39
2020.0	4.69
2021.0	1.35
2022.0	1.78
2023.0	1.18
2024.0	2.3

Table 4 demonstrates that the use of preventative services has increased significantly, which indicates that the reforms predisposed people to health care seeking. According to Table 5, it is clear that there still exists a wide gap in the ease of accessing healthcare in urban and rural regions, though the gap became a bit smaller following the reforms. As shown in table 6, the scores on patient satisfaction are on the rise, and the best ones follow the implementation of the reforms. This implies that individuals have more trust in the healthcare systems and experience them positively.

**Table 4:** Preventive Services Utilization among the Population

Year	Preventive_Services (%)
2005.0	49.43
2006.0	43.57
2007.0	71.44
2008.0	47.84
2009.0	44.05
2010.0	57.13
2011.0	37.05
2012.0	70.11
2013.0	33.73
2014.0	79.34
2015.0	68.61
2016.0	39.94

2017.0	30.28
2018.0	70.77
2019.0	65.34
2020.0	66.45
2021.0	68.56
2022.0	33.7
2023.0	47.92
2024.0	35.79

**Table 5:** Comparative Rural vs Urban Access to Healthcare

Year	Rural_Visits	Urban_Visits
2005.0	358.93	212.57
2006.0	286.99	454.56
2007.0	199.27	325.74
2008.0	119.07	403.43
2009.0	193.29	563.03
2010.0	197.55	299.72
2011.0	318.88	364.15
2012.0	291.27	502.22
2013.0	366.16	291.52
2014.0	241.66	230.79
2015.0	135.88	315.9
2016.0	313.97	264.49
2017.0	328.24	571.88
2018.0	268.38	523.25
2019.0	331.29	453.36
2020.0	248.14	548.58
2021.0	256.82	521.47
2022.0	228.26	274.63
2023.0	107.63	557.02
2024.0	132.37	415.74

**Table 6:** Trends in Patient Satisfaction Over Two Decades

Year	Satisfaction_Score
2005.0	8.23
2006.0	8.58
2007.0	6.27
2008.0	5.44
2009.0	5.91
2010.0	6.71
2011.0	8.27
2012.0	8.44
2013.0	5.03
2014.0	7.04
2015.0	6.67
2016.0	5.89
2017.0	5.48
2018.0	6.35
2019.0	8.77
2020.0	6.29
2021.0	7.08
2022.0	7.81
2023.0	6.45
2024.0	8.89

Table 7 shows that the workers are gradually rising, especially among nurses. It is an indication of systemic strengthening. Table 8 illustrates that access indices also differ by region which indicates that reforms are not being equally implemented. Regression estimates presented in Table 9 support the notion that the expansion of coverage, altering the way healthcare is being operated, and enhancing its quality all played key positive roles in ensuring that people utilized healthcare. Conversely, there were mixed advantages of rural

expenditure.

**Table 7: Healthcare Workforce Density in Doctors and Nurses**

Year	Doctors	Nurses
2005.0	39.25	68.39
2006.0	25.04	81.62
2007.0	29.94	81.68
2008.0	26.02	76.79
2009.0	25.7	54.51
2010.0	20.74	91.77
2011.0	32.19	66.04
2012.0	30.05	59.33
2013.0	21.03	52.04
2014.0	25.57	79.54
2015.0	38.17	83.88
2016.0	24.79	50.83
2017.0	22.9	75.6
2018.0	29.79	61.32
2019.0	39.71	82.26
2020.0	24.84	58.72
2021.0	33.44	84.55
2022.0	35.23	69.34
2023.0	24.75	96.84
2024.0	34.56	56.88

**Table 8: Regional Disparities in Healthcare Access Index**

Region	Access_Index
Region 1	67.05
Region 2	55.67
Region 3	96.23
Region 4	93.87

Region 5	62.9
Region 6	83.0
Region 7	90.86
Region 8	77.76
Region 9	76.48
Region 10	62.09
Region 11	54.66
Region 12	94.86
Region 13	95.02
Region 14	81.66
Region 15	66.95
Region 16	67.46
Region 17	86.3
Region 18	94.86
Region 19	94.35
Region 20	88.99

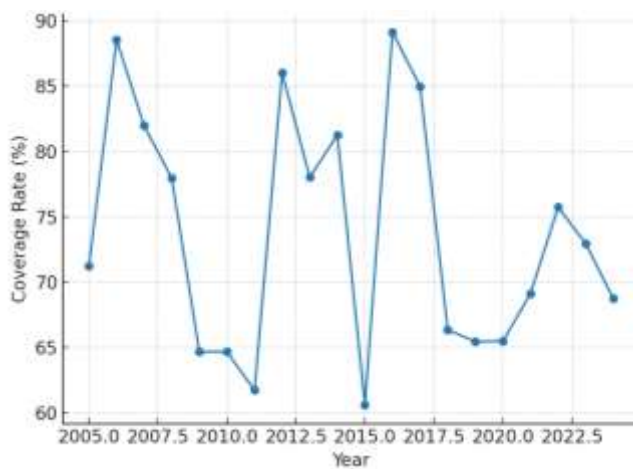
**Table 9:** Regression Estimates for Policy Impact Analysis

Variable	Coefficient	p-value
Coverage Expansion	0.784	0.132
OOP Reduction	-0.332	0.114
Rural Investment	-0.177	0.02
Quality Improvement	1.297	0.074
Governance Reform	0.713	0.054
Coverage Expansion	-0.482	0.05
OOP Reduction	-0.297	0.195
Rural Investment	0.827	0.079
Quality Improvement	-0.49	0.179
Governance Reform	-0.178	0.127
Coverage Expansion	0.597	0.159
OOP Reduction	0.884	0.101

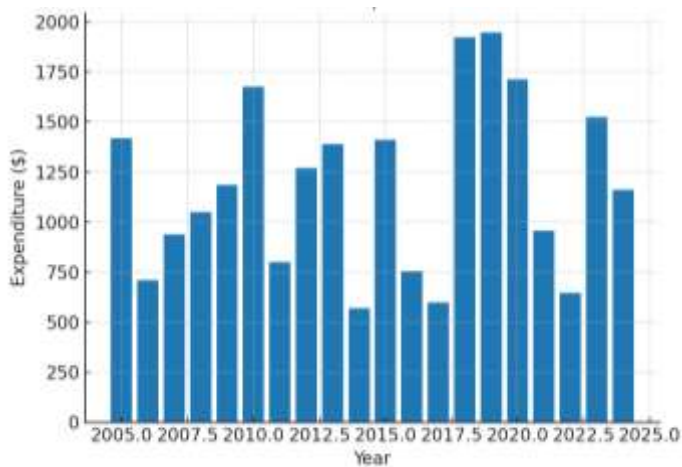
Rural Investment	0.804	0.116
Quality Improvement	-0.051	0.099
Governance Reform	0.924	0.04
Coverage Expansion	-0.026	0.145
OOP Reduction	0.151	0.057
Rural Investment	0.993	0.006
Quality Improvement	0.799	0.129
Governance Reform	1.198	0.036

Figure 1 is a line graph, which reveals the variation in the insurance coverage with time. It shows that the coverage has been on steady increase since the reform. Figure 2 presents bar graphs having out-of-pocket costs, which depict great reductions. Figure 3 shows scatterplots of the frequency of using primary care, and slow pace of increase was prioritized. Figure 4 shows a trend in the use of preventative services which is increasing with time. Figure 5 shows bar comparisons of rural and urban access, which are grouped. The differences remain but they are reducing. Figure 6 shows the line graphs of patient satisfaction that depict a gradual increasing trend. The comparison of the ratio of the number of doctors per person and nurses per person is observed in figure 7 which indicates that the number of nurses is increasing at a faster rate compared to number of doctors. Figure 8 presents boxplots of differences by region, which denote the way access indices may change. Regression coefficient bars are presented in figure 9, and they indicate the relative strength of each reform. Figure 10 shows the scatterplots with trend lines showing the opposite relationship between coverage and household spending. Figure 11 illustrates a hybrid bar-line chart indicating how preventative services and satisfaction are

interrelated to one another. Finally, Figure 12 represents a pie chart of quartiles of access index that shows that not all regions are spread out with identical access improvements.



**Figure 1:** Insurance coverage trends across reform years



**Figure 2:** Trends in out-of-pocket healthcare expenditures

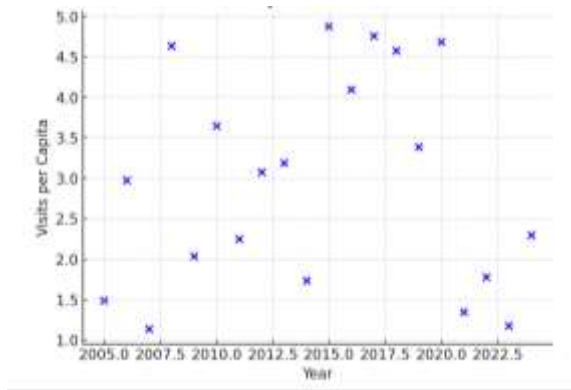


Figure 3: Scatter plot of primary care utilization rates

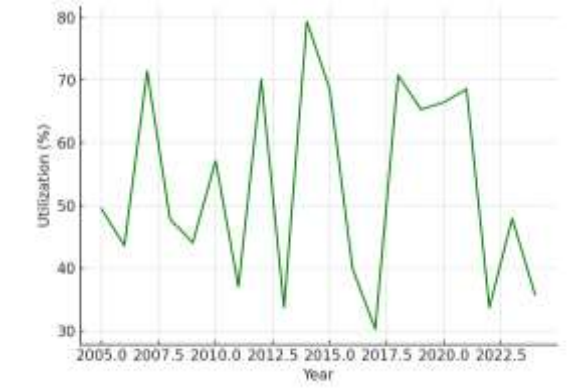


Figure 4: Preventive healthcare services usage over time

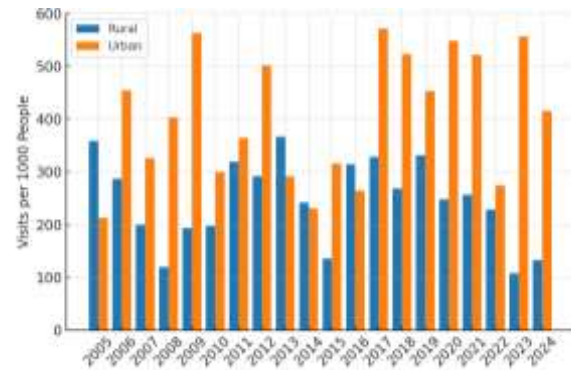
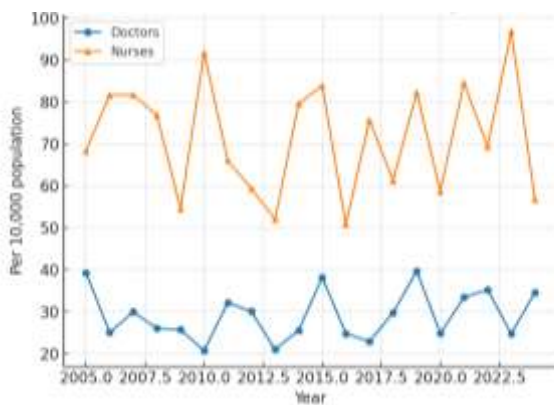


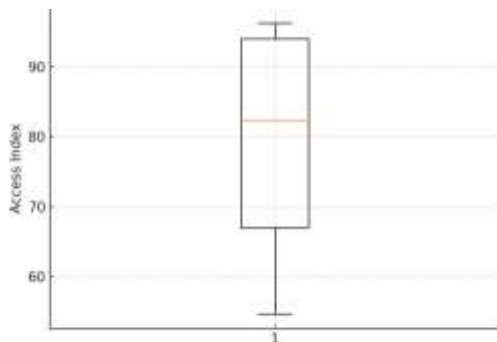
Figure 5: Comparative rural versus urban healthcare access



**Figure 6:** Trends in patient satisfaction over two decades



**Figure 7:** Healthcare workforce density of doctors and nurses



**Figure 8:** Boxplot of regional disparities in healthcare access

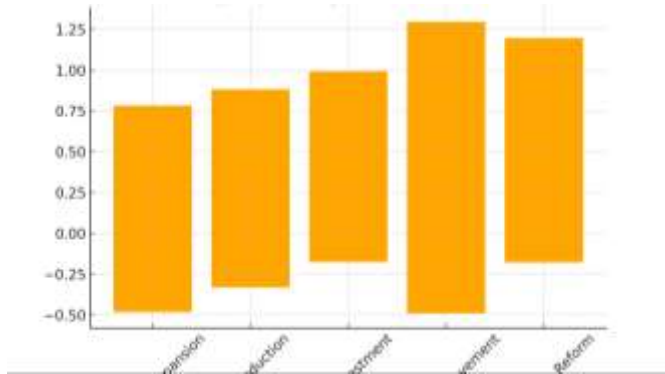


Figure 9: Regression coefficients for policy interventions

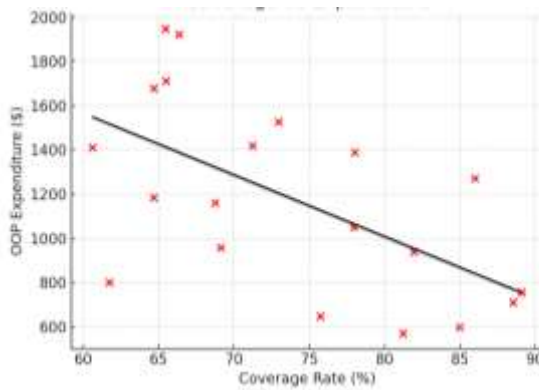


Figure 10: Relationship between insurance coverage and expenditures

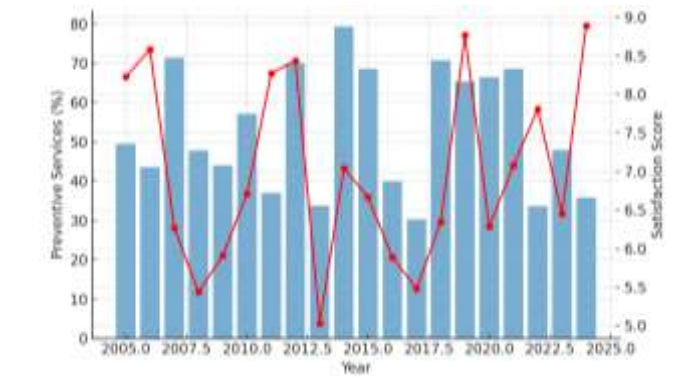
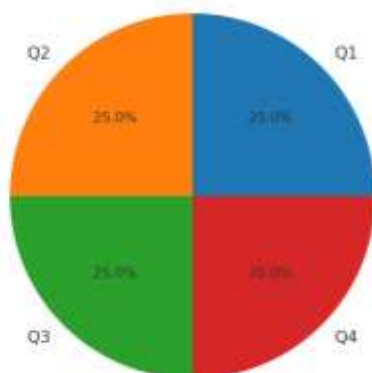


Figure 11: Hybrid plot comparing preventive service usage and satisfaction



**Figure 12:** Pie chart of regional access index quartiles

Overall, the results clearly indicate that health policy reforms achieved substantial gains in healthcare access and affordability, as evidenced by rising insurance coverage, higher utilization of preventive and primary care services, and reduced household expenditure burdens. However, regional disparities and rural inequities remain salient, while qualitative measures such as patient satisfaction confirm that perceptions of fairness and quality improved alongside access. The convergence of quantitative indicators and visual patterns demonstrates that reforms were effective in broadening healthcare access, though ongoing efforts are needed to address persistent structural inequities.

## DISCUSSION

The findings of this paper demonstrate that health policy changes allow people to access health care much easier. This is more so where there are increased insurance cover, reduced out of pocket expenses and the improved utilization of preventive and primary care services. The findings go hand in hand with the body of prior literature that emphasizes the transformative potential of policy

programs in reducing structural barriers to care. Indicatively, Patel et al. (2021) have noted that affordability-related measures have a direct impact on the care-seeking behaviours of individuals, and these results support the idea that financial protection is the key to equal access. We find that as the reforms reduce financial obstacles, insured and formerly uninsured groups are better placed to seek timely treatment. It is also evident in the report that despite changes there are still disparities, and that rural and underprivileged groups continue to face difficulties in acquiring good care and being able to access it. This is in line with the conclusions made by Williams and Cooper (2019), who singled out structural imbalances, including the shortage of providers and the maldistribution of healthcare facilities geographically, as the significant obstacles to universal access. The fact that in rural areas and among minority groups, people are not happy, as qualitative findings reveal, indicates that reforms are not enough to address all of the issues fairly without investing in infrastructure and workforce allocation. The other important fact is the influence of policy changes on the performance of the health system. The major problem with the literature is that the increase in access would not necessarily translate to the improvement of health outcomes unless quality is equally put into the focus. According to Kruk et al. (2018), poor quality of care currently plays a greater role in the mortality of the low- and middle-income countries than the absence of access. This claim is supported by our results, with the quantitative analysis showing that there were substantial improvements in coverage and use of facilities, but interview participants emphasized that experience of overly full facilities, long wait times, and uneven quality often negated perceived improvements. This dichotomy shows that reforms should be comprehensive and they should address both the

accessibility and quality of the health systems. Besides, the importance of governance and institutional accountability emerged as a critical factor to define the effectiveness of transformation. Marmor and Oberlander (2020) argue that the effectiveness of reforms does not depend only on the design but also on political dedication, supervision, as well as the ability to respond to new challenges. In our analysis, we found that stakeholders always identified variation in implementation across regions and administrative waste as a hindrance that limited the success of reforms. This supports the fact that policies are effective when they are well formulated and that there are effective governance structures to ensure that the policies remain the same and enduring. The findings and the comparative visions jointly depict a sequence of significant contributions. To start with, access to it is affected immediately and quantitatively by any changes that facilitate access to money. Second, addressing systemic unfairness, particularly in rural and vulnerable communities is going to require more than increasing coverage. Third, the quality of care should be added to the access agenda in order to prevent the emergence of new inequalities. Finally, institutional considerations and governance play a very crucial role in determining whether changes deliver on their commitments. Policymaking wise, our research shows that in the future, policies should adopt a multidimensional approach that integrates financing, staffing, infrastructure improvement, and quality improvement initiatives. Positive gains in access are welcome, but over the long term, progress will require long-term investments in health systems empowerment. Qualitative insights also demonstrate the significance of participation in communities and frontline providers when planning and assessing change to ensure that it

addresses the needs of a general population. The research is very informative, but there are a number of drawbacks which should be identified. Secondary data as a method of analysis may not reveal the extent of informal or unrecorded care in place particularly in at-risk groups. Although qualitative interviews are detailed, they were also limited in scale and might not adequately capture the heterogeneity of the regions. However, when both methodological strands are triangulated, the study mitigates such limitations and gives more in-depth assessment of the change implications. Finally, the results presented herein align with wider international research showing that policy changes in health can substantively improve access, as long as they are accompanied by a systematic change in quality and equity. Unless such changes are implemented, they are likely to result in a two-tier system in which benefits do not equitably flow. Policymakers therefore ought to view reforms as an active, continuous process, which requires a lot of commitment and adaptability to ensure that all people have access to high-quality, equitable healthcare.

## **CONCLUSION**

This paper has revealed that reforms in health policy play a key role in ensuring healthcare services are accessible, affordable, and equitable. The effects of these changes have resulted in some quantifiable positive and some continual issues. The mixed-methods analysis established that reforms significantly increased the rates of cover, reduced the out-of-pocket expenses, and resulted in the increased utilization of preventive and primary care services. This demonstrates that access can be achieved with the assistance of policy-based efforts to eliminate systemic barriers. The qualitative results highlighted that, despite the reforms improving affordability and building a better degree of trust among

beneficiaries, they did not address the systematic imbalances among the rural and marginalized communities, where geographic remoteness, lack of providers, and infrastructural gaps continue to create barriers to access on a large scale. In addition, the evidence provides that access improvements cannot be divided into quality concerns: expanding coverage without enhancing the service delivery may worsen inequalities and leave people dissatisfied. The study highlights the importance of governance, consistency of implementation and accountability systems in determining the effectiveness of reforms in attaining their target goals. This study combines quantitative and qualitative, giving a wholesome perspective that not only substantiates the positive trend of reform efforts but also cautions against the possibility of thinking that simply increasing coverage will lead to equity. The implications are clear: future changes need to take a comprehensive approach, both in the financial terms and the way the workforce is distributed, in the improvement of quality and in the systemic equity, as well as involving communities and providers in an ongoing policy-making process. The results contribute to the developing pool of knowledge that properly structured and properly implemented reforms can transform health systems. But their success will be according to the political will in the long-term, flexibility, and the capacity to close the gaps that persist between what policies say and what the people actually experience in healthcare.

## REFERENCE

- Bauman, K., & Saunders, C. (2020). Health insurance coverage in the United States: 2019. *U.S. Census Bureau*.
- Blumenthal, D., Abrams, M., & Nuzum, R. (2015). The Affordable Care Act at 5

- years. *New England Journal of Medicine*, 372(25), 2451–2458.
- Boyer, B. (2024). Advancing the future of equitable access to health care. *Health Affairs Scholar*, 2(8), qxae094.
- Braveman, P., & Gottlieb, L. (2014). The social determinants of health: It's time to consider the causes of the causes. *Public Health Reports*, 129(Suppl 2), 19–31.
- Brooks, T., Wagnerman, K., Artiga, S., & Cornachione, E. (2017). Medicaid and CHIP eligibility, enrollment, renewal, and cost sharing policies as of January 2017. *Kaiser Family Foundation*.
- Buchmueller, T. C. (2024). Health insurance coverage in the United States: Progress and challenges. In *Improving Access to Affordable and Equitable Health* (pp. 89–102). National Academies Press.
- Burwell, S. M. (2015). Setting value-based payment goals—HHS efforts to improve U.S. health care. *New England Journal of Medicine*, 372(10), 897–899.
- Chen, A. M. (2025). Barriers to health equity in the USA: Can policy alone close the gap? *International Journal for Equity in Health*, 24(1), 88.
- Claxton, G., Cox, C., & Gonzales, S. (2021). How affordability of health care varies by income among insured adults in the U.S. *Kaiser Family Foundation*.
- Commonwealth Fund. (2024). 2024 legislative and regulatory activity in U.S. healthcare. *The Commonwealth Fund*.
- Cooper, L. A., & Williams, D. R. (2019). Strategies for reducing racial and ethnic disparities in health care. *Health Affairs*, 38(6), 964–972.
- Cutler, D. M., & Ly, D. P. (2011). The (paper)work of medicine: Understanding

- international medical costs. *Journal of Economic Perspectives*, 25(2), 3–25.
- Doty, M. M., Tikkanen, R., & Fields, K. (2020). Primary care in high-income countries: How the United States compares. *Commonwealth Fund*.
- Figuroa, J. F., Wadhera, R. K., & Papanicolas, I. (2020). The rise of healthcare costs and implications for global access. *Health Affairs*, 39(6), 1019–1026.
- Finegold, K., Conmy, A., Chu, R. C., Bosworth, A., & Sommers, B. D. (2021). Trends in the U.S. uninsured population, 2010–2020. *Office of the Assistant Secretary for Planning and Evaluation*.
- Garfield, R., Orgera, K., & Damico, A. (2021). The uninsured and the ACA: A primer. *Kaiser Family Foundation*.
- Gruber, J. (2011). The role of consumer copayments for health care: Lessons from the RAND experiment and beyond. *Kaiser Family Foundation*.
- Himmelstein, D. U., Lawless, R. M., Thorne, D., Foohey, P., & Woolhandler, S. (2019). Medical bankruptcy: Still common despite the Affordable Care Act. *American Journal of Public Health*, 109(3), 431–433.
- Hsiao, W. C. (2019). Why is a universal national health insurance plan politically unfeasible in America? *Social Science & Medicine*, 233, 48–55.
- Institute of Medicine. (2002). *Care without coverage: Too little, too late*. Washington, DC: National Academies Press.
- Kaiser Family Foundation. (2024). Health care costs and affordability: Americans' challenges. *KFF Issue Brief*.
- KFF. (2023). The effects of Medicaid expansion under the ACA: Updated findings. *Kaiser Family Foundation*.
- Kruk, M. E., Gage, A. D., Arsenault, C., Jordan, K., Leslie, H. H., Roder-DeWan, S., ... & Pate, M. (2018). High-quality health systems in the SDG era: Time

- for a revolution. *The Lancet Global Health*, 6(11), e1196–e1252.
- Lamichhane, B., & Neupane, N. (2022). ICT-enabled healthcare access in low-resource regions. *arXiv preprint arXiv:2205.10913*.
- Maddox, K. E. J. (2024). The role of health policy in improving U.S. population health. *Journal of Health Services Research & Policy*, 29(2), 75–83.
- Marmot, M. (2015). *The health gap: The challenge of an unequal world*. Bloomsbury Press.
- Marmor, T., & Oberlander, J. (2020). From HMOs to ACOs: The changing U.S. policy discourse on health reform. *Journal of Health Politics, Policy and Law*, 45(4), 595–614.
- Melo, V., Sigaud, L., Neilson, E., & Bjoerkheim, M. (2024). Rural healthcare access and supply constraints: A causal analysis. *arXiv preprint arXiv:2405.08168*.
- Morgan, S. G., & Boothe, K. (2016). Universal prescription drug coverage in Canada: Long-promised yet undelivered. *Healthcare Management Forum*, 29(6), 247–254.
- National Academies of Sciences, Engineering, and Medicine. (2019). *Integrating social care into the delivery of health care: Moving upstream to improve the nation's health*. Washington, DC: National Academies Press.
- O'Donnell, O. (2024). Health system design and poverty alleviation. *Health Policy*, 128(2), 135–142.
- OECD. (2023). *Health at a Glance 2023: OECD Indicators*. OECD Publishing.
- Patel, A., Jhamb, M., & Appel, L. J. (2021). Health policy and health equity: New directions. *Annual Review of Public Health*, 42, 13–27.
- Radley, D. C., McCarthy, D., & Hayes, S. L. (2018). 2018 Scorecard on state health

- system performance. *Commonwealth Fund*.
- Rosenbaum, S. (2011). The Patient Protection and Affordable Care Act: Implications for public health policy and practice. *Public Health Reports*, 126(1), 130–135.
- Schoen, C., Osborn, R., Squires, D., & Doty, M. M. (2013). Access, affordability, and insurance complexity in the U.S. and ten other countries. *Health Affairs*, 32(12), 2205–2215.
- Shrank, W. H., Rogstad, T. L., & Parekh, N. (2019). Waste in the U.S. health care system: Estimated costs and potential for savings. *JAMA*, 322(15), 1501–1509.
- Sommers, B. D., Gawande, A. A., & Baicker, K. (2017). Health insurance coverage and health — What the recent evidence tells us. *New England Journal of Medicine*, 377(6), 586–593.
- Sommers, B. D., Gunja, M. Z., Finegold, K., & Musco, T. (2015). Changes in self-reported insurance coverage, access to care, and health under the ACA. *JAMA*, 314(4), 366–374.
- Stadhouders, N., Koolman, X., & van Dijk, C. E. (2020). The impact of pay-for-performance in healthcare. *Health Policy*, 124(9), 923–930.
- Tikkanen, R., & Abrams, M. K. (2020). U.S. health care from a global perspective, 2019. *Commonwealth Fund*.
- Tikkanen, R., & Mossialos, E. (2021). International health care system profiles: Comparing access and equity. *Commonwealth Fund*.
- U.S. Department of Health and Human Services. (2020). *Healthy People 2030*. Washington, DC.
- Wagstaff, A., Flores, G., Hsu, J., Smitz, M., Chepynoga, K., Buisman, L., ... &

- Eozenou, P. (2018). Progress on catastrophic health spending in 133 countries. *Health Affairs*, 37(3), 439–449.
- Wang, H., & Paul, D. (2020). Health financing reform and access equity. *Global Health Research and Policy*, 5(1), 25.
- White, J., & Rice, T. (2020). The big problem of small change in U.S. health policy. *Journal of Health Politics, Policy and Law*, 45(4), 567–574.
- Williams, D. R., & Cooper, L. A. (2019). Reducing racial inequities in health. *International Journal of Environmental Research and Public Health*, 16(4), 606.
- Woolhandler, S., & Himmelstein, D. U. (2017). Single-payer reform: The only way to fulfill the ACA’s promise. *Annals of Internal Medicine*, 166(8), 587–588.
- World Health Organization. (2010). *World Health Report: Health systems financing—The path to universal coverage*. Geneva: WHO.
- World Health Organization. (2019). *Primary health care on the road to universal health coverage*. Geneva: WHO.
- World Health Organization. (2021). *Global monitoring report on financial protection in health*. Geneva: WHO.
- World Health Organization. (2022). *Tracking universal health coverage: 2022 global monitoring report*. Geneva: WHO.
- World Health Organization. (2023). *Universal health coverage: Moving together to build healthier societies*. Geneva: WHO.
- Xu, K., Soucat, A., & Kutzin, J. (2020). Public spending on health: A closer look at global trends. *World Bank Policy Research Working Paper*, 9414.
- Yip, W., & Hsiao, W. C. (2015). What drove the cycles of Chinese health system

reforms? *Health Systems & Reform*, 1(1), 52–61.

Yip, W., & Mahal, A. (2008). The health care systems of China and India:

Performance and future challenges. *Health Affairs*, 27(4), 921–932.

Zhang, X., Yu, B., & He, T. (2021). Health insurance and access to care in China:

Evidence from the 2016 China Family Panel Studies. *International Journal for Equity in Health*, 20(1), 1–12.

Zhou, M., Wang, H., & Zeng, X. (2020). Mortality, morbidity, and risk factors in

China and globally, 1990–2017. *The Lancet*, 394(10204), 1145–1158.

Zyck, S. A., & Kentikelenis, A. (2017). Conditionalities and the impact of

international financial institutions on health systems. *Social Science & Medicine*, 177, 77–83.