**Letter to the Editor: Why Medicare for all is the best plan**
Published in The Washington Post, February 1, 2016

Regarding the Jan. 29 editorial “[The real problem with Mr. Sanders](https://www.washingtonpost.com/opinions/mr-sanderss-ideas-are-not-too-bold-they-are-too-facile/2016/01/28/e7125bca-c60a-11e5-9693-933a4d31bcc8_story.html) ”:

Single-payer expanded and improved Medicare for all would provide universality, affordability and cost containment. Single-payer would allow doctors to focus on their patients’ health needs, rather than on patients’ ability to pay. What Americans want is choice of doctor, not choice of health insurance. Americans want comprehensive, lifelong insurance that assures them they will get the care they deserve.

Although it may seem fantastical to provide more care to more people for less money, there is a preponderance of scientific data to support this claim. In the United States, [we waste $375 billion a year](http://www.cnbc.com/2015/01/13/health-insurance-paperwork-wastes-375-billion.html) on billing and insurance-related bureaucracy, and not a dime of it goes toward a doctor’s visit, vaccination, procedure or medication. In contrast with private insurance with double-digit administrative overhead, Medicare runs at less than 3 percent. The vast majority of Americans and physicians favor expanding and improving Medicare.

So what’s stopping us? Certainly not the facts, because the facts are on our side.

Robert Zarr, Washington

The writer is president of Physicians for a National Health Program.

**Letter to the Editor: Better in Canada**
Published in The Chicago Tribune, January 20, 2015

I strongly disagree with the editorial board’s opinion in the Tuesday editorial “Sanders’ lavish ‘Medicare for All.’” Some argue that his plan has no chance of passing Congress, and therefore he should give up on the idea of universal health care. The same argument could be made about reforming gun control, gay marriage or Citizens United. Just because something doesn’t seem easy at first doesn’t mean that we can’t consider the idea. There are many examples in history of ideas that may not ever have seemed possible, but by logically examining the facts and data surrounding the issue, the collective conscience of the American people has changed.

I spent two years living and working in Canada and was covered by its national health care system. Each time I used it, I thought it worked flawlessly; my problems were quickly taken care of with solid after-care plans. From my experience as a health care patient in Canada and the U.S., there is no question that a national single-payer health care system is far more efficient than the fractured for-profit system we have in the U.S.

As a doctor, I have often thought about immigrating to Canada to escape our broken health care system, which treats patients like a commodity. For now I will continue to practice in America, with the hope that as president, Bernie Sanders can help fix our broken health care system.

Mark Neahring, psychiatry resident, University of Chicago Medical Center

**Letter to the Editor: Libby Medicare for Flint**

Daily Kos, Jan. 27, 2016

There is a precedent for expanding Medicare to a region suffering from a public health disaster.

Montana Senator Max Baucus tucked into the Affordable Care Act a special section that expands Medicare to the people of Libby and the surrounding area who were poisoned by W. R. Grace's deadly mine causing mesothelioma and asbestos-related disease.

Shouldn't the people of Flint, all of them not just the children, have Medicare also for life?  We must do much more, but, at least, we can start here.

Kay Tillow, Coordinator

[All Unions Committee for Single Payer Health Care--HR 676](http://unionsforsinglepayer.org/)

# Letters to the Editor: Is a Single-Payer Health Insurance Program Feasible? The New York Times, Letters, Jan. 21, 2016Re “Health Reform Realities” (column, Jan. 18):

I’m glad to see that Paul Krugman acknowledges that “if we could start from scratch, many, perhaps most, health economists would recommend single-payer, a Medicare-type program covering everyone.” His argument that we should not work for it now is unconvincing.

Just because private insurers are powerful doesn’t mean a concerted national campaign can’t overcome their well-funded opposition. Already a majority of the general public (58 percent in a recent Kaiser poll) supports single-payer. Cost will never be controlled until we do away with the bloated administrative expenses of our hopelessly complex financing arrangements and for-profit medicine.

And while the Affordable Care Act has indeed been a great help for many seeking health insurance, it has left over one-fourth of Americans ages 18 to 64 with problems paying their medical bills. As you have reported, that can be the case even for those with insurance (“Medical Debt Often Crushing Even for Insured,” The Upshot, Jan. 5).

We can do better, as every other developed nation has demonstrated.

ALAN MEYERS

Dr. Alan Meyers resides in Boston. He is a professor of pediatrics at Boston University School of Medicine and a founding member of Physicians for a National Health Program

Paul Krugman argues that perhaps the “most important” reason not to pursue single-payer health care financing is that it “would impose a lot of disruption on tens of millions of families who currently have good coverage through their employers.”

As a physician who happens also to be an employee of a large Boston-area human services agency, I can tell you from personal experience, as well as from the (frequently desperate) experiences of my patients, that “good” is not how any of us would describe our coverage.

Premiums are jaw-droppingly high (and projected to increase anywhere from 6.8 to 16.5 percent this year); high-deductible and other “Swiss cheese” insurance policies have become the norm, resulting in increasing out-of-pocket co-pays and deductibles; and obstacles to care, from arbitrary “prior authorization” requirements to restricted panels, regularly prevent people from receiving the care they need. Along with so many of my patients and colleagues, I am convinced that single-payer is right for us, right now.

JIM RECHT

Dr. Jim Recht resides in Cambridge, Mass. He is an an assistant professor of psychiatry at Harvard Medical School.

**Op-Ed: Medicare for all would solve many health problems**

Published in The Tennessean. *3:49 p.m. CDT October 19, 2015*

Just over a year ago, Sharon, a fast food worker from Middle Tennessee, walked into the Vanderbilt emergency department in the worst pain of her life.

Stones had formed in her gallbladder. Fortunately, this common and excruciatingly painful condition can be easily treated with surgery. Sharon, however, did not have health insurance and could not afford the surgery.

A few weeks ago, Sharon reappeared in the emergency department with worsening pain and vomiting. This time, her doctors found cancer in her gallbladder that had spread to her stomach and liver. There is no cure for her cancer.

Untreated gallstones are a major risk factor for this type of cancer. If Sharon had insurance and could afford the surgery, removing her gallbladder would have saved her life.

Sadly, Sharon’s story is in no way unique.

Sharon is one of [90,000 American](http://www.commonwealthfund.org/~/media/files/publications/fund-report/2011/oct/1500_wntb_natl_scorecard_2011_web_v2.pdf)s who will die this year because she does not have access to affordable health care. That so many Americans die unnecessarily is a profound failure to our fellow citizens.

Despite the Affordable Care Act, 33 million Americans, including [750,000 Tennesseans](http://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-253.pdf), remain uninsured. Over 30 percent of the uninsured in Tennessee would be covered were it not for the senseless [refusal to expand Medicaid](http://www.tennessean.com/story/money/industries/health-care/2015/06/04/study-insure-tennessee-defeat-carries-economic-health-impacts/28452349/).

Even people with health insurance often face crippling medical expenses. In December 2014, [almost half of Americans](http://www.nytimes.com/interactive/2014/12/18/health/cost-of-health-care-poll.html?_r=0) reported that acquiring basic medical care was a significant financial hardship — a 10 percent increase over the previous year. Health care is the leading cause of personal bankruptcy in this country, and [70 percent](http://kff.org/health-costs/perspective/medical-debt-among-insured-consumers-the-role-of-cost-sharing-transparency-and-consumer-assistance/) of those with medical debt have health insurance.

These outrageous costs and preventable deaths are not a problem in other developed countries. Out of 16 industrialized nations, the [U.S. ranks first in cost and last in medically preventable death](http://www.commonwealthfund.org/~/media/files/publications/fund-report/2011/oct/1500_wntb_natl_scorecard_2011_web_v2.pdf)s — 68 percent higher than the best-performing countries.

As medical students, we understand that we cannot protect our patients from illness with the power of medical science alone. We strongly believe that the only sustainable way to save health care from itself would be to expand Medicare to all Americans.

In a Medicare-for-all system, every citizen would automatically receive health care coverage regardless of income. No American would ever need to forgo treatment because they could not afford the exorbitant costs of modern medicine.

More than half of physicians support Medicare-for-all. Economists and politicians understand that a Medicare-for-all system is the only way to control costs in the long run while providing quality medical care to every American.

Expanding Medicare would actually reduce health care spending. A Medicare-for-all insurance program would create a streamlined nonprofit system with reduced overhead, no marketing expenses and reduced drug costs through increased purchasing power. Together these effects would reduce health care spending by up to[$500 billion per year](http://www.pnhp.org/sites/default/files/Funding%20HR%20676_Friedman_7.31.13_proofed.pdf). Under a Medicare-for-all system, 95 percent of Americans would pay less than they currently do for health care.

By expanding Medicare, tens of millions of ordinary Americans would gain access to quality, affordable health care, and not a single dollar would be added to the deficit.

Students from six universities in Tennessee and Kentucky (UT-Memphis, Louisville, Vanderbilt, East Tennessee State, DeBusk, and Meharry) are reaching out to their communities to bring attention to the problems and the future of American healthcare.

As physicians-in-training we understand that it is not enough to provide the best care possible to our patients. Our experiences with people like Sharon remind us that health reform is not behind us. It is a necessary part of our future.

Without significant policy changes, the fundamental problems of our health care system will never be solved. [HR 676](https://www.congress.gov/bill/113th-congress/house-bill/676), the Expanded & Improved Medicare for All Act, would provide these changes. Despite 63 cosponsors and considerable public support, this bill remains stalled in Congress.

Expanding Medicare to every American would ensure that we never again have to witness anyone struggle like Sharon.We are at a critical moment in the history of American health care. Costs continue to skyrocket, and Americans continue to suffer. There is no better time to act.

*Monisha Bhatia, Margaret Axelrod, Emily Holmes, Mitchell Hayes and Connor Beebout, Vanderbilt University School of Medicine Chapter of Students for a National Health Program and Meharry Medical College Chapter of Students for a National Health Program.*

# Op-Ed: Single-payer health plan wouldn't cost U.S. moreSteffie Woolhandler and David HimmelsteinPOSTED: February 06, 2016 on philly.com

# In our "read my lips/over my dead body" political culture, the threat of tax increases usually shuts down proposals for single-payer national health insurance. Lately, conservative pundits - and even liberals like Hillary Clinton - have been repeating the mantra that single-payer insurance would break the bank.

Never mind that Canadians, Australians, and Western Europeans spend about half what we do on health care, enjoy universal coverage, and are healthier. Their health-care taxes are higher.

Or are they? According to our study in the current issue of the American Journal of Public Health, American taxpayers picked up 65 percent of the total health-care tab last year - a figure that will soon rise to 67 percent.

We paid $2.1 trillion in taxes to fund health care - $6,560 per person. That's more per capita than Canadians or people in any other nation pay. Indeed, our tax-financed health-care bill is higher than total health spending (private as well as public) in any other nation except Switzerland.

Official accounts from agencies like the Department of Health and Human Services peg taxpayers' share of U.S. health spending at about 45 percent, a figure that includes Medicare, Medicaid, the Centers for Disease Control and Prevention, and Veterans Affairs. However, this kind of tally omits two important items.

First, it leaves out government spending to buy private health coverage for public employees like teachers, firefighters, and members of Congress. Indeed, government employers account for 28 percent of all employer health spending.

Second, it excludes tax subsidies for private employer-paid plans and other privately paid care - $326 billion last year - that mainly benefit affluent families.

Omitting these government expenditures from the official health-spending tabulations obscures the fact that our health-care system is already about two-thirds publicly funded. In contrast, the Office of Management and Budget, not to mention most health-policy experts, considers tax subsidies for private insurance to be tax expenditures.

Even many uninsured families pay thousands of dollars in taxes for the health care of others.

More than one-third of these tax dollars meander through private insurers on the way to the bedside. These private insurers siphon off 12 percent for their overhead and profits (vs. 2 percent in the Medicare program) and also inflict huge paperwork costs on doctors and hospitals. A shift to single-payer national health insurance would save at least $400 billion annually on paperwork alone, enough to cover all of the uninsured and eliminate co-payments and deductibles for the rest of us.

That means a national single-payer plan wouldn't cost Americans any more than we're currently spending. Moreover, the taxes to pay for it would be fully offset by the savings from eliminating private insurance premiums.

Moving from our current level of tax financing, 65 percent, to Canada's 70.7 percent would mean a tax increase of about $185 billion per year. But Americans would save at least that much on premiums. The vast majority of American households would come out ahead financially, and everyone would be covered.

Drug and insurance firms that would lose billions under single-payer health coverage generously fund its detractors (including Clinton, who has gotten more health-industry dollars than any other presidential candidate). These naysayers suggest that a single-payer plan (or "Medicare for all," as Bernie Sanders likes to call it) would downgrade Americans' coverage, and they also raise the specter of big tax increases.

But a national single-payer plan would give all Americans the first-dollar coverage enjoyed by Canadians and Brits, and guarantee them a free choice of doctors and hospitals - a choice that private insurers currently deny to many of us.

Surprisingly, American taxpayers already pay enough to fund national health insurance. We just don't get it.

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**Blog Post:** [**“This Is My Child”: A Religious Perspective on Health Care for All**](http://student.pnhp.org/post/124511134275/this-is-my-child-a-religious-perspective-on)
Emily Kirchner, Published on student.pnhp.org on 19 July, 2015

In my faith tradition, we have a story about Jesus’ baptism. At this point in his life, Jesus has not started his ministry – no sick people have been healed, no one has walked on water, five thousand people have yet to be fed with loaves and fishes. Before any of his work challenging the brutal economic and military oppression of his people by the Roman Empire, Jesus goes to his cousin, John, and is baptized in the Jordan River. The heavens open up and the voice of God says: “This is my child, with whom I am well pleased.”

As a child, I thought that the voice of God was warning everybody: “Yo – this is my kid, don’t mess with him. This kid is gonna do some impressive stuff. Watch out.” Now my understanding of God is different, my understanding of oppression is different, and my own hope in the redemptive message of this story is greater. Today, my faith guides me to hear God calling each human a beautiful, valuable creation. Before a career is chosen, an income earned, an insurance status achieved, each person has worth.

I used to imagine a voice thundering: “This is my child.” Now I hear a voice cracking with pride and love: “This is my child.”

Many Christian communities retell this story and recreate this ritual with their members. My church practices infant baptism and when we baptize a baby, we remind ourselves that each child is beloved, not only by us, but by something greater than us, and that we are responsible for caring for each other.

I am not asking you to share my faith, but I invite you to share this vision of life, which holds that all people are equal, that each person is valuable, and that society is responsible for all. And I encourage you to consider what moral values or political ideals may come from that vision of life.

I have been thinking about what it means that King v. Burwell (the latest Supreme Court case upholding the ACA) and Obergefell v. Hodge (the Supreme Court enabling marriage equality) were released in the same week. I can’t help but think that each of these rulings would be unnecessary if our country truly considered each of its citizens and residents valuable, deserving of respect, dignity, and fullness of life.

The ability to marry whom you choose is a right for everyone, but I question the way that wealth, access to health care, and societal acceptance is extended to married people, and whether the ability to care for our loved ones, utilize government services, and share financial resources ought to lie with a marriage license issued by the state.

Similarly, the court held up the Affordable Care Act, which adds ounces of gasoline to the tank of a health care system that is sputtering. Why should I be thankful for a few more miles on an outdated, gas-guzzling jalopy when we know there is a model that allows us to care for each other efficiently? Each person deserves quality health care and right now, our system leaves out too many. We are not caring for each other when so many of us are still uninsured or underinsured, despite the measures of the ACA.

For anyone concerned about mixing religion with medicine, do not worry. I am not taking up Jesus’ prescription for blindness, which involved a paste of spit and dirt and a nice bath. The stories in my faith tradition inspire and require me to find connections with this world and the people in it, to work towards justice, and to act mercifully. I find myself in a time, place, and career where justice and mercy have been forgotten in lieu of profits and power.

“This is my child,” the voice is still saying. Let us remember the innate worth of each person and better care for one another. A good start is Medicare for All: health care for everyone regardless of income, employment, or marriage status.

Emily Kirchner is a medical student at the Temple University School of Medicine.

# Huff Post Blog: Medicare's History Belies Claim That Medicare-for-All Would Disrupt Care

# Steffie Woolhandler and David Himmelstein, The Huffington Post, February 16, 2016

Hillary Clinton and others charge that Bernie Sanders' Medicare-for-All plan would disrupt and threaten Americans' health care. But the smooth rollout of Medicare-for-Seniors in 1965 -- which many had also predicted would bring chaos -- belies that charge.

Medicare, signed into law on July 30, 1965, went live just 11 months later. By then, 18.9 million seniors had signed up, 99 percent of those eligible.

To accomplish this feat (largely without computers) the Social Security Administration mailed an information leaflet and sign-up cards preprinted with each individual's name and Social Security number (see example below) to seniors on the Social Security and railroad retirement rolls, as well as Civil Service annuitants and a million other seniors identified through IRS records.

To contact hard-to-reach seniors, the federal government reached out to nursing and retirement homes, employers, unions and civic organizations offering to help people apply; organized hundreds of local information meetings; and enlisted postal workers, forest rangers and agricultural representatives to help locate residents of remote areas. The Office for Economic Opportunity hired 5,000 low-income seniors who went door-to-door in their neighborhoods.

All told, Medicare's overhead costs for the first year totaled only $120 million (equivalent to $882 million in 2015). By comparison, setting up the insurance exchanges for private coverage under Obamacare cost more than $6 billion -- about seven times as much. But even the modest figure for Medicare's start-up costs is an overstatement since it includes the cost of processing six months' worth of medical bills, not just the enrollment costs. Moreover, Medicare and Medicaid (which was passed at the same time) displaced several smaller federal health assistance programs, saving about $383 million (in 2015 dollars) on their overhead costs.

Even as it became clear that Medicare enrollment was proceeding smoothly, many saw disruption ahead. The Association of American Physicians and Surgeons (AAPS), a group to the right of the American Medical Association (AMA), threatened that 50,000 doctors would boycott Medicare. (Today, the AAPS is sounding the alarm that Medicare-for-All would take away "what remains of your doctor's liberty.") Wall Street Journal headlines warned that "Most MDs Won't Cooperate," and foresaw a "Patient Pileup," as "flocks of Medicare beneficiaries ... suddenly clog the nation's 7,200 hospitals."

None of this came to pass. Doctors continued to care for elderly patients, mostly accepted Medicare payment, and soon came to rely on Medicare as an economic pillar of their practices. Even the AMA, which had spent millions fighting Medicare's passage (including an infamous ad campaign featuring then-actor Ronald Reagan) cooperated in the program's implementation. Hospitals ran smoothly, with only a handful reporting more than minor of problems.

But Medicare did cause a major disruption, it disrupted Jim Crow hospital care.

The 1964 Civil Rights Act banned racial discrimination in facilities receiving federal funds (which included most hospitals), but enforcement was lax until Medicare.Many hospitals, particularly in the South, still refused to care for black patients at all, while others relegated them to separate entrances and shabby basement wards. Black physicians were often barred from hospital staffs, and in many locales ambulance services were separate, and distinctly unequal.

With Medicare on the horizon, federal officials made it clear to hospitals that segregated hospitals would be excluded from the program. In the spring of 1966, three months before Medicare took effect, 51 percent of American hospitals were still segregated. By August of that year, 99.5 percent had desegregated.

While Medicare ended overt racial segregation in hospitals, segregation by insurance remains legal and common -- and often perpetrates de facto racial segregation. Most of New York City's prestigious academic medical centers -- and many hospitals elsewhere -- maintain separate clinic systems, and even separate wards, for Medicaid patients (the 33 million uninsured need not apply).

Medicare-for-All would give all Americans complete and equal coverage, completing the disruption of hospital segregation that Medicare began a half century ago.

Aside from that welcome disruption, Medicare-for-All would greatly simplify life for hospitals and doctors. Instead of the laborious and expensive task of billing patients and their insurers for each Band-Aid and aspirin tablet, hospitals would receive a lump-sum budget, much as we pay for a fire station. Doctors would bill one plan, using one billing form instead of the dozens of complex billing schemes -- each with its own rules and redundant documentation requirements -- that we face today.

Most important, Medicare-for-All would end many of the disruptions that our patchwork coverage system currently inflicts on patients. All Americans would, for the first time enjoy a free choice of doctor and hospital, and would never again be forced to change doctors merely because their insurance changed, or their doctor was dumped from their insurer's network. And patients' lives would no longer be disrupted by financial ruin from medical bills.

Drs. Steffie Woolhandler and David U. Himmelstein, professors of health policy and management at the City University of New York School of Public Health at Hunter College and Lecturers in Medicine at Harvard Medical School, co-founded Physicians for a National Health Program, a nonpartisan organization. The opinions expressed do not necessarily reflect those organizations'.