PNHP
PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

PNHP Activist Update
January 2007

PHYSICIANS FOR A NATIONAL HEALTH PROGRAM » 29 E. MADISON, SUITE 602, CHICAGO, IL 60602 » WWW.PNHP.ORG » JANUARY 2007 ACTIVIST UPDATE

Legislative Update

Support for Single-Payer (HR 676) Doubles in Congress

Thanks to the efforts of the sponsors — and especially to Reps. Dennis Kucinich and John Conyers and their staffs — HR 676 finished the last Congress with more co-sponsors than any other health reform bill. The number of co-sponsors more than doubled last session from 38 in the 108th Congress to 79 in the 109th. A list of these sponsors can be found on page 3. Please let your representatives know that you appreciate (or urge) their support. The bill will be reintroduced this year.

The 2006 midterm elections added three new single-payer supporters to the US House of Representatives: John Yarmuth (KY-03), Dave Loebsack (IA-02), and Keith Ellison (MN-06). Loebsack made health reform a plank of his campaign and told reporters that supporting national health insurance is "one of the first things I will do" in Congress. Two HR 676 co-sponsors are moving to the Senate: Sherrod Brown (OH) and Bernard Sanders (VT).

Several single-payer supporters will chair key House committees related to health reform. John Conyers (MI) will chair the House Judiciary Committee, Charles Rangel (NY) will chair the Committee on Ways and Means, and Henry Waxman (CA) will chair the Government Reform Committee. Rep. Conyers has indicated interest in holding hearings on medical bankruptcy as a way to highlight the need for single-payer reform.

HR 676 Resources

What You Can Do

Join PNHP's Op-ed Campaign

A new effort by PNHP to help members publish op-eds in their local newspapers is off to a great start. It works like this: PNHP provides a "skeleton" op-ed, and physician activists fill in the rest with personal anecdotes from their practices and data specific to their communities for submission to their local papers.

Dr. Bill Wood, a resident in otolaryngology, published an op-ed supporting "Medicare for All" in the Pittsburgh Post-Gazette; Dr. Aaron Carroll's op-ed on the rising number of the uninsured appeared in the Indianapolis Star (reprinted on page 4); and Dr. Adam Tsai's op-ed on single payer and the Citizen's Health Care Working Group appeared in the Philadelphia Inquirer (reprinted on page 5). Thanks to PNHP's dedicated physician activists, op-eds appeared in at least 11 other major metropolitan newspapers around the country.

Those who have published op-eds are often gratified by the expressions of support from patients and colleagues who have seen their op-eds in the paper.

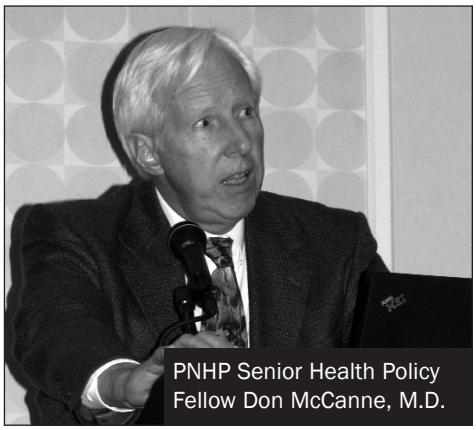
PNHP is seeking more activists to participate in these campaigns. To join the op-ed list, e-mail nick@pnhp.org.

Give Talks with the Updated PNHP Slide Show

2007 Version Released at Annual Meeting

More than 250 physicians and medical students attended PNHP's Annual Meeting in Cambridge in November 2006, including 81 who came a day early to participate in an intensive leadership training workshop. The slides and other presentation materials are available to members to download from the PNHP web site at www.pnhp.org.

This fall, PNHP'ers delivered more than 100 grand rounds presentations. Dr. Robert Zarr spoke to pediatricians at Georgetown, inspiring at least one faculty member to "go right back to her office and join PNHP online." PNHP'ers also gave hundreds of talks to non-physician audiences. Dr. Claudia Fegan spoke to a conference of oil industry CEOs and labor leaders in Houston; the program's other speakers included former Health and Human Services Secretary Gail Wilensky and Princeton economist Uwe Reinhardt.



PNHP Senior Health Policy Fellow Don McCanne, M.D.

Blog! Spread the Single-Payer Message in Cyberspace

Dr. Andy Coates in upstate New York has started a blog that functions as a website for the new Capital District PNHP (capitaldistrictPNHP.blogspot.com). Blogs are much simpler to set up than websites (see www.blogspot.com).

Dr. Don McCanne's online health policy "Quote of the Day" is reaching a wide audience, including some of the nation's top health reporters (archived at www.pnhp.org).

Daily Kos, a popular blog, is now featuring articles on single-payer on a regular basis by Dr. Steve Auerbach.

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Educate the 110th Congress on the US National Health Insurance Act (HR 676)

Both Houses of Congress have changed hands, but legislators and their staffs rely on PNHP member physician constituents to educate them about single-payer and remind them that national health insurance should be at the top of their agenda.

There are many ways to contact your legislators, but not all are created equal. A personal visit or phone conversation with a legislative health aide is much better than a written letter, and a written letter is much better than an e-mail. But even a quick e-mail can help! A sample letter (reprinted below) can serve as the basis for a letter or phone conversation.

Encourage Organizations to Pass a Resolution for HR 676

PNHP is launching a campaign to get organizations of all kinds (from city councils to county or state chapters of professional organizations) to pass resolutions in support of HR 676 (see sample resolution on page 3). PNHP is inspired by the success of Kay Tillow and the All Unions Committee for Single Payer, which has won endorsements from 212 union organizations with this strategy, including 16 AFL-CIO state federations.

The American Medical Student Association (AMSA) is the first organization to endorse PNHP's resolution in support of HR 676 (reprinted on page 3). Jay Bhatt, President of AMSA and a member of PNHP's Board of Directors, spearheaded the effort. Three representatives of the Student National Medical Association from PNHP's NY-Metro chapter attended PNHP's Annual Meeting and will be introducing the resolution to that important group. Dr. Rob Stone has already passed an endorsement in the Bloomington, Indiana city council.

PNHP'ers speaking to grassroots audiences should encourage those groups and their members to pass a resolution endorsing HR 676 as a way to get a dialogue started. Please be sure to notify the PNHP office when the resolution is passed and we'll add it to the list. You can find sample resolutions and report your endorsement at www.pnhp.org/resolution/.

Representatives John Conyers (MI) and Dennis Kucinich (OH).

Sample Letter to Legislators:

Use as is, or (better yet) add some details from your own experience and/or locale

Dear Senator / Representative,

I write as a constituent - and as a physician who serves our state - to express my support for single-payer national health insurance and to urge you to co-sponsor HR 676, the U.S. National Health Insurance Act.

As a physician, I see the results of our health care crisis every day. More than 46 million Americans are uninsured. Even for those lucky enough to have insurance, rising costs and deteriorating coverage cause more than one-in-four (28 percent) to go without needed care because they can't afford it. Indeed, of the one million Americans bankrupted by medical bills annually, more than three-quarters had insurance when they got sick.

Single-payer national health insurance would save enough on administrative paperwork - more than $300 billion per year - to provide comprehensive coverage to all Americans. It would provide full choice of doctor and hospital for patients, and unleash physicians from arbitrary corporate dictates over patient care. It would control the health expenses currently crippling our economy and provide for a wholesome revitalization of our democratic values.

Please join with the 70 percent of Americans who support such a system and co-sponsor HR 676.

Sincerely,

Resolution in Support of the United States National Health Insurance Act

Whereas everyone deserves access to affordable, quality healthcare.

Whereas the number of Americans without health insurance continues to rise and now exceeds 46 million.

Whereas tens of millions with insurance have coverage so inadequate that a major illness would lead to financial ruin, and medical illness and bills contribute to one-half of all bankruptcies.

Whereas proposals for "consumer-directed healthcare" would worsen this situation by penalizing the sick, discouraging prevention and saddling many working families with huge medical bills.

Whereas managed care and other market-based reforms have failed to contain healthcare costs.

Whereas HMO and insurance company overhead consumes over $100 billion annually.

Whereas U.S. hospitals spend 24.3% of their budgets on billing and administration while hospitals under Canada's single-payer system spend only 12.9%.

Whereas American physicians are inundated with bureaucratic tasks and costs that physicians in Canada and other nations with national health insurance avoid.

Whereas the U.S. Government Accountability Office has estimated the bureaucratic savings from converting to a single-payer system at 10% of health spending, $200 billion in 2006, which is enough to cover the uninsured and to improve coverage for all of those who now have only partial coverage

Whereas "consumer-directed healthcare" adds yet another expensive layer of bureaucrats - the financial firms that manage health savings accounts.

Whereas entrusting care to profit-oriented firms diverts billions of dollars to excessive incomes for CEOs and threatens the quality of care.

Whereas United States Representatives John Conyers and Dennis Kucinich have introduced H.R. 676, The United States National Health Insurance Act.

Whereas H.R. 676 would assure universal coverage of all medically necessary services under a non-profit single payer program, while containing costs by slashing bureaucracy.

Whereas H.R. 676 would protect the doctor patient relationship, assure patients a free choice of doctors, and allow physicians a free choice of practice settings.

Therefore _____ expresses its support for H.R. 676, The United States National Health Insurance Act.

In drafting a resolution, it's okay to change the "whereas" clauses.

LET US KNOW!

Go to **www.pnhp.org/resolution/** to let us know that your group has endorsed HR 676. You can find the above resolution along with other sample resolutions on our site.

Endorsed resolutions can also be sent to PNHP at:
29 E. Madison, Suite 602, Chicago, IL 60602 | or faxed to: (312) 782-6007.

HR 676 Co-Sponsors

(109th Congress Co-Sponsors)

Rep Abercrombie, Neil [HI-1]
Rep Baldwin, Tammy [WI-2]
Rep Becerra, Xavier [CA-31]
Rep Berman, Howard L. [CA-28]
Rep Bishop, Sanford D., Jr. [GA-2]
Rep Brady, Robert A. [PA-1]
Rep Brown, Corrine [FL-3]
Rep Brown, Sherrod [OH-13]
Rep Capuano, Michael E. [MA-8]
Rep Carson, Julia [IN-7]
Rep Christensen, Donna M. [VI]
Rep Clay, Wm. Lacy [MO-1]
Rep Conyers, John [MI-14]
Rep Cummings, Elijah E. [MD-7]
Rep Davis, Danny K. [IL-7]
Rep Delahunt, William D. [MA-10]
Rep Doyle, Michael F. [PA-14]
Rep Engel, Eliot L. [NY-17]
Rep Evans, Lane [IL-17]
Rep Farr, Sam [CA-17]
Rep Fattah, Chaka [PA-2]
Rep Filner, Bob [CA-51]
Rep Frank, Barney [MA-4]
Rep Green, Al [TX-9]
Rep Grijalva, Raul M. [AZ-7]
Rep Gutierrez, Luis V. [IL-4]
Rep Hastings, Alcee L. [FL-23]
Rep Hinchey, Maurice D. [NY-22]
Rep Honda, Michael M. [CA-15]
Rep Jackson, Jesse L., Jr. [IL-2]
Rep Jackson-Lee, Sheila [TX-18]
Rep Johnson, Eddie Bernice [TX-30]
Rep Jones, Stephanie Tubbs [OH-11]
Rep Kaptur, Marcy [OH-9]
Rep Kilpatrick, Carolyn C. [MI-13]
Rep Kucinich, Dennis J. [OH-10]
Rep Lantos, Tom [CA-12]
Rep Lee, Barbara [CA-9]
Rep Lewis, John [GA-5]
Rep Lynch, Stephen F. [MA-9]
Rep Maloney, Carolyn B. [NY-14]
Rep McDermott, Jim [WA-7]
Rep McGovern, James P. [MA-3]
Rep McKinney, Cynthia A. [GA-4]
Rep McNulty, Michael R. [NY-21]
Rep Meehan, Martin T. [MA-5]
Rep Miller, George [CA-7]
Rep Moore, Gwen [WI-4]
Rep Nadler, Jerrold [NY-8]
Rep Napolitano, Grace F. [CA-38]
Rep Norton, Eleanor Holmes [DC]
Rep Olver, John W. [MA-1]
Rep Owens, Major R. [NY-11]
Rep Pastor, Ed [AZ-4]
Rep Payne, Donald M. [NJ-10]
Rep Rangel, Charles B. [NY-15]
Rep Reyes, Silvestre [TX-16]
Rep Roybal-Allard, Lucille [CA-34]
Rep Rush, Bobby L. [IL-1]
Rep Sanchez, Linda T. [CA-39]
Rep Sanders, Bernard [VT]
Rep Schakowsky, Janice D. [IL-9]
Rep Scott, Robert C. [VA-3]
Rep Serrano, Jose E. [NY-16]
Rep Solis, Hilda L. [CA-32]
Rep Stark, Fortney Pete [CA-13]
Rep Thompson, Bennie G. [MS-2]
Rep Tierney, John F. [MA-6]
Rep Towns, Edolphus [NY-10]
Rep Udall, Tom [NM-3]
Rep Velazquez, Nydia M. [NY-12]
Rep Visclosky, Peter J. [IN-1]
Rep Waters, Maxine [CA-35]
Rep Watson, Diane E. [CA-33]
Rep Waxman, Henry A. [CA-30]
Rep Weiner, Anthony D. [NY-9]
Rep Wexler, Robert [FL-19]
Rep Woolsey, Lynn C. [CA-6]
Rep Wynn, Albert Russell [MD-4]

THE INDIANAPOLIS STAR

A GANNETT NEWSPAPER
★ INDYSTAR.COM ★

"Where the Spirit of the Lord is, there is Liberty" II Cor. 3:17

SEPTEMBER 08, 2006

CITY FINAL
★ 50 CENTS ★

The only health-care solution: single-payer system

MY VIEW

Aaron E. Carroll

The new uninsured statistics released recently by the U.S. Census provide a sobering reminder of the failures of the U.S. health-care system. In Indiana the number of uninsured has risen to 871,000: Nearly one of every seven residents lacks coverage. Even for those lucky enough to be insured, ever-skimpier private policies helped push an estimated 28,000 Indiana families into medical bankruptcy in 2001. As a physician who faces our state's health-care crisis day in and day out, I support a single-payer "Medicare for All" system for Indiana and for the nation.

Carroll is assistant professor of pediatrics and director of the Children's Health Services Research Fellowship at the Indiana University School of Medicine in Indianapolis.

Nearly everyone, regardless of ideology, agrees that reform to establish universal coverage is necessary. But the most important question is "how," and here not all proposals are created equal. Because our current non-system is based on insurance companies whose natural market behavior is to compete to cover healthy people while shunning the sick, proposals that preserve our reliance on them are destined for failure:

◆ "Individual Mandates" (like the much-celebrated Massachusetts plan) simply force the poor and near poor to buy overpriced policies that offer grossly inadequate coverage, guaranteeing an epidemic of medical bankruptcies.

◆ Reforms, which force employers to contribute more for coverage, encourage them to cut jobs, wages or other benefits.

◆ "Consumer-directed" health plans are nothing but a euphemism for substandard coverage, offering families no protection in the event of medical need.

Other countries have figured out how to provide higher-quality coverage to all their citizens for far less than we spend. Recent studies have detailed how Brits and Canadians have lower rates of nearly every chronic disease and enjoy superior access to care. An exhaustive 2004 study of 21 international health quality indicators in five countries found that — despite double the outlay on health care — the U.S. performed noticeably better on only two.

How can the U.S. spend so much more and get so much less? Anyone who has ever had to deal with the nightmarish paperwork of giant insurance companies already knows the answer: It's our reliance on private insurers.

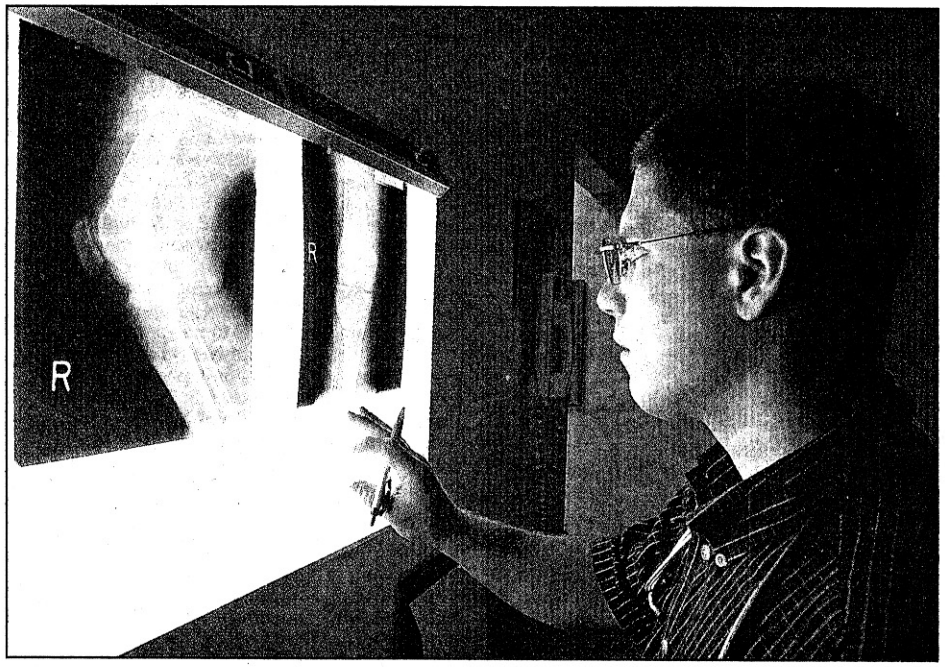
Insurance companies stay profitable by keeping those who actually need health care from getting it. To do this, they erect a giant, expensive bureaucracy whose only purpose is to fight claims, issue denials and screen out the sick. They consume care dollars, but produce only paperwork headaches. Doctors and hospitals must maintain costly staffs to deal with insurance hassles, and businesses are saddled with the burden of administering their own health benefits. In total, this administrative waste consumes nearly one-third of our health spending.

Research has shown that streamlining payment though a single public payer could save the U.S. more than $350 billion per year. Such a system could have saved Indiana $6 billion in 2003. That's $8,266 per uninsured resident, enough to provide high-quality coverage to everyone. Everybody would be covered for all doctor, hospital, long-term, mental health, dental and vision care, and prescription drugs. Patients would have free choice of doctor and hospital, and physicians would be unleashed from corporate dictates over patient care.

In the U.S., opponents resort to cries of "socialized medicine," but don't be fooled. In a "socialized" system (like the U.S. Veterans' Administration) the government employs the doctors and owns the hospitals. In a single-payer system, they stay private.

Similarly, much hysteria has been printed about alleged "rationing" of care in other nations. The truth is that the U.S. rations care more harshly than any other country. According to the Institute of Medicine's most conservative data, 18,000 Americans die every year due to lack of insurance. Millions more go without needed care due to cost. Now that's rationing. What's more, Canadians don't even wait very long for care. The median wait time for non-emergency, elective surgery was four weeks in 2005. Service was so fast that in a recent survey only 3.5 percent of Canadians reported feeling they waited too long for care. Considering we spend twice what they do, a U.S. system should be able to eliminate waits entirely.

Single-payer offers the only real solution for Indiana and for our nation. It's time for politicians to stand up to the insurance giants — as they have in California — in the interest of the public.



2006 Star file photo

SIGNS OF A PROBLEM: Dr. Eric Beachy reviews the X-rays of a patient at the Clay City Center for Family Medicine. Indiana has more than 800,000 uninsured residents.

The Philadelphia Inquirer

Friday, October 27, 2006

We deserve U.S. health care

Most citizens back national insurance. A bill in Congress would provide this

BY ADAM GILDEN TSAI

Imagine if Congress passed a bill requiring national public discussions regarding the state of health care in America. Then imagine that these discussions actually happened across our country, and that across the country there was actually a consensus that we need national health insurance to ensure that everyone has access to care. Finally, imagine that when the final report, to be presented to the President and Congress, is drafted, the report makes no mention of this consensus.

There is no need to imagine these things because they have actually happened. The same act that created the Medicare prescription-drug plan mandated the Citizens' Health Care Working Group (www.citizenshealthcare.gov). The group, which included people from medical and public-health backgrounds, held meetings in cities across the country this year. The questions asked (and voted on) at each meeting were the same, and fell into several categories: what health-care services are important; how health care should be delivered; how best to pay for care; and what trade-offs Americans are willing to make to ensure access to quality affordable health care.

I attended the Philadelphia meeting in April, and there was a range of opinions on some of the topics discussed. Some people voiced a need for better coverage of services such as eye and dental care; others wanted more comprehensive end-of-life care; and still others felt we needed a more rigorous system of health education. There also were differences of opinion on financing issues. For example, some people believe that only the most basic level of benefits should be covered and that everything else should be paid for out-of-pocket, while others felt that anything deemed effective by providers and patients should be covered.

One thing, however, on which there was strong consensus at the Philadelphia meeting, and across the country, was that we need a national health-care system to ensure that everyone has access to care. In fact, when given a choice of 10 reform options, participants in most cities clearly favored a national health program by a ratio of at least 3-1. At meetings where participants were asked to rank the 10 options, national health insurance was ranked first 16 of 19 times (Billings, Mont.; Denver; Des Moines, Iowa; Detroit; Eugene, Ore.; Indianapolis; Jackson, Miss.; Kansas City, Mo.; Memphis, Tenn.; Miami; New York; Philadelphia; Phoenix; Providence, R.I.; Sacramento, Calif.; and Seattle). At two meetings, participants were not polled and options were not ranked.

Despite the clear public mandate, the Citizens' Health Care Working Group's report makes no mention of the vast support for a national health program. Instead, the group's official recommendations include only generic suggestions such as promoting "efforts to improve quality of care and efficiency" and finding a way to protect "against very high health costs."

From my experience, most supporters of a national health program favor a single-payer system, which retains the private delivery of health care by physicians and hospitals, but organizes payment under a single public agency. A 2003 study in the New England Journal of Medicine found that a single-payer national health-insurance program would save enough on administrative costs - more than $300 billion per year - to cover all of the uninsured and provide full benefits for everyone else.

Public opinion polls show that Americans favor a system of tax-financed health insurance by a 2-1 ratio, as opposed to our current system linking coverage to employment. A May 2006 Keystone poll found that 66 percent of Pennsylvanians favor the U.S. government guaranteeing health insurance to its citizens even if it means raising taxes. The main obstacle to universal health care is the health-insurance industry, which has made a mint covering healthy people who don't use very much care while avoiding the sick patients who need coverage the most.

If our politicians are listening, they'll realize we don't need Wall Street-controlled health-insurance plans to provide us with health care. We need a streamlined system that can provide quality affordable health care for all. U.S. Rep. John Conyers of Michigan has introduced such a bill, the U.S. National Health Insurance Act, also known as House Resolution 676. We should all be pressuring our senators and representatives to support it.

Adam Gilden Tsai, MD, of Philadelphia, is a member of Physicians for a National Health Program (www.pnhp.org), a not-for-profit group that advocates for a tax-funded, privately delivered system of national health insurance.

The Boston Globe

SATURDAY, OCTOBER 28, 2006

Healthy Skepticism

By Dr. Michael Hochman and
Dr. Steffie Woolhandler

MASSACHUSETTS is in the midst of yet another healthcare experiment. By July, all residents will be legally required to have health insurance — a so-called "individual mandate." The bill's sponsors believe that the uninsured can buy their way out of their predicament.

As doctors in an urban hospital, we are not optimistic about this proposal. We care for uninsured and underinsured patients who often lack the resources to eat well or find proper child care, much less to buy insurance. The individual mandate is another ill-fated Band-Aid.

Under the new law, Massachusetts residents will continue to be covered by the existing patchy network of insurance groups. The options are complicated, and the costs are steep: a typical group policy in costs about $5,000 annually for an individual and more than $11,000 for a family. Many of the state's approximately 618,000 uninsured residents will still fall through the cracks.

The answer lies in an alternative proposal: single-payer national health insurance. Australia and Canada already use this approach. Under such a system, a public agency would finance universal healthcare. It would be an improved and expanded version of Medicare.

How would a single-payer system work? According to the proposal by the Physicians for a National Health Program — which holds its annual convention in Cambridge next weekend — all US residents would receive a healthcare card entitling them to all medically necessary services from their choice of doctors and hospitals.

The program would be funded by an increase in taxes. But the tax hike would be fully offset by savings from abolishing insurance premiums and many out-of-pocket healthcare costs.

The private insurance industry, the only major group that would be harmed, has been national health insurance's most vocal opponent. Industry lobbyists have thus far convinced legislators on Beacon Hill and Capitol Hill that a government-run system would be inefficient.

Yet insurance companies spend several times as much on administrative costs as public programs do. A 2003 study published in the New England Journal of Medicine found that the average overhead of US insurance companies is 11.7 percent, compared with 3.6 percent for Medicare and 1.3 percent for Canada's national health insurance program. Two studies commissioned by the Massachusetts Medical Society concluded that a single-payer system could save so much on paperwork that it would be more cost-effective than the present system.

Some worry that the quality of healthcare might decline. But there is no reason to suspect this would happen. Healthcare providers and hospitals would continue to have the same incentives they have now to provide high-quality care. For the most part, doctors and hospitals would continue to be paid as they have been, except that rather than submitting their bills to private insurance companies — a difficult and time-intensive process — they would send their bills to the national health insurance program.

And despite fears of long waits for life-saving services, that would be unlikely with appropriate funding. In countries such as Canada, where patients experience long waits, a much lower percentage of GDP is devoted to healthcare than in the United States.

A national insurance program also would not hurt medical research. Most basic research in the United States is publicly funded by grants from the National Institutes of Health (NIH). According to a recent book by a former editor of the New England Journal of Medicine, the vast majority of new classes of medications are discovered using NIH funding.

Single-payer healthcare is the only long-term answer to our ailing healthcare system. No other proposal — including a healthcare mandate — could provide health insurance to all Americans, cut costs, and simplify the healthcare system in one broad stroke.

Others feel this way as well. In a survey of more than 900 Massachusetts physicians published in the Archives of Internal Medicine in 2004, almost two-thirds supported single-payer healthcare.

Over the next few years, the nation will be watching the Massachusetts experiment closely. The silver lining may be that what we learn will move us closer to the universal, comprehensive single-payer system that Americans deserve.

Dr. Michael Hochman is an intern in internal medicine at Cambridge Hospital. Dr. Steffie Woolhandler is a co-founder of Physicians for a National Health Program and an internist at Cambridge Hospital.

Arizona Daily Star

WEDNESDAY, NOVEMBER 22, 2006

Canada's health care lauded by one who knows

By Sol Littman

Ever since my wife and I chose to leave Canada and settle in Tucson, we have been amazed and angered by the distortions and misrepresentations in the American media of Canada's government-funded, one-payer medical system. Among them is the recent op-ed article in the Arizona Daily Star by Dr. Jane M. Orient.

For most of my adult life, I worked as a journalist in Canada and took full advantage of Canada's health-care system. My wife, daughter and grandchildren were free to choose their own primary doctors and specialists. Service was consistently kindly, prompt and concerned. If something serious was suspected, we were tested, X-rayed and examined in a matter of days. Our physicians were highly trained and the hospital facilities modem and pleasant.

Thirty years ago, I had my gall bladder removed and had to spend three or four days in hospital. When I was discharged, I was presented with the bill — a total of $5.50 for the use of the television set in my semi-private room. The Ontario Hospital Insurance Plan paid the rest.

It is important for Americans to know that people in Canada tend to live a couple of years longer than their U.S. counterparts and that Canada's infant mortality rate is lower. This is attributed to the fact that everyone — young, old, working or unemployed — is covered for basic hospital and medical care in Canada without co-insurance or deductibles. This is in contrast to the United States, where there are more uninsured people (over 40 million) than Canadian inhabitants.

American critics of Canada's health care are quick to cite the fact that there are lengthy waiting lists for non-emergency medical procedures. It is also true that there is considerable overcrowding in some hospitals, but this is due to the fact that emergencies are treated immediately even if it means a lineup of gurneys in the hospital corridor — a situation I have found exists in American emergency wards as well.

The Canadian system does not rely on private insurance companies. The system is run by 10 provinces and two territories. They pay the bills and set the rules. Medicare, which services the American elderly, is the closest approximation to the Canadian one-payer system, but there are important differences.

In the United States, the government pays the bills but private insurance companies that are more wasteful than the government run the system. In addition, some of our American health-care dollars go to make the insurance companies rich and play no role in actual health care.

The waiting times for some procedures are longer in Canada than in the United States, but this problem is being actively tackled by the government in the wake of a Canada Supreme Court decision that "access to a waiting list is not access to health care." However, the decision did not abolish the one-payer system — in fact, it reinforced it by giving the Quebec government, which was the chief object of the lawsuit, 12 months to remedy the situation.

As a result, Quebec is working hard to catch up with the rest of Canada. The average wait for a hip replacement has been reduced to four to five weeks, and knee replacements usually take six to seven weeks. This may still be too long, but if you happen to be one of the 40 million uninsured Americans, you might have to wait forever.

Why have my wife and I chosen to spend our retirement years in Tucson? We did, in fact, worry about leaving behind our Canadian health care, but climate, the availability of year-round golf and relatively good health persuaded us to take the chance.

We have found medical services in Tucson excellent, but expensive and complicated. We don't like being at the mercy of an HMO and have yet to decipher the ins and outs of the new drug plan. We continue to long for the simplicity and efficiency of Canada's single-payer system.

Write to Sol Littman at solittman@aol.com.

Health Care Reform in the United States: Arguments for a Single Payer System

By Annette Ramirez de Arellano, DrPH and Sidney Wolfe, MD
Public Citizen's Health Research

The rationale for single-payer has become increasingly compelling right now, when US businesses are increasingly feeling the pinch of rising health care costs, the number of uninsured continues to rise, the nation is losing its comparative advantage in world markets, hospitals are eager to shed the burden of their "bad debt and charity" pool, and consumers are increasingly baffled by an array of insurers who offer confusion in the guise of 'choice.'

The arguments in favor of having a single payer are summarized below. These reasons are in addition to the most overwhelming reason, namely that such a system is the only way we can realistically afford to end the dangerous, 2 embarrassing, and worsening situation wherein about 45 million people in this country lack health insurance and tens of millions more are seriously uninsured.

Single Payer is good for business. Publicly financed but privately run health care for all would cost employers far less in taxes than their costs for insurance.[i] With universal coverage, employers would no longer have to pay for medical care as part of the compensation package offered to workers. And with health care outlays expected to increase between 14% and 18% between now and 2010, employers can expect no relief from the already unsustainable situation they are facing at present. A survey of senior-level executive in Detroit found that 75% consider employee health insurance "unaffordable," while the remaining 25% consider it "very unaffordable."

If the situation is untenable for individual employers, it is even worse for the economy as a whole. Increases in health care costs are a drag on economic growth: they thwart job growth, suppress increases for current workers, weaken the viability of pension funds, and depress the quality of jobs. Rising health care costs are also causing budgetary problems for federal and state governments, who are currently paying over 50% of the US health care bill.

Universal health coverage would also have a salutary effect on labor-management relations. Many if not most strikes in the past five years have involved conflicts over health benefits. Universal coverage would defuse this contentious issue, provide benefits independent of employment status, and allow business greater flexibility in whom to hire.

Single Payer will enhance the comparative position of the US in the global market. President Bush has repeatedly said that the United States is not reluctant to compete on the international market as long as there is an even playing field. At present, the lack of universal health insurance places the US at a disadvantage vis-Ã -vis other countries. Companies such as General Motors that have factories in both the US and other countries have learned this lesson well; for example, in 2003 the costs of manufacturing a midsize care in Canada were $1,400 less than that of manufacturing the identical car in the US, primarily because of much higher health costs in this country.[ii]

Single Payer builds on the existing experience. Those who fear that single payer is new and foreign, and therefore untested, need to be reminded that Medicare is, in essence, a single-payer system. For those who are eligible, Medicare is universal and identical, not means-tested, and administered by the government, which acts as a single-payer for hospital and outpatient physician services. Because it did not have to sift and sort the population or cope with a layer of insurers, the rollout of Medicare in 1966 was amazingly smooth.[iii] Practically overnight—and without computers—the program covered services 3 provided by 6,600 hospitals, 250,000 physicians, 1,300 home health agencies, and hundred of nursing homes. By the end of its first year, Medicare had enrolled more than 90% of eligible Americans, a feat that cemented its popularity and redeemed President Johnson's faith in the efficacy of government.

In contrast, Part D of Medicare, which departed from the single-payer model and introduced private insurers, encountered the wrath of consumers who were unable to maneuver the complicated choices required to obtain prescription drug benefits.

Single Payer has significantly lower administrative costs. Studies by both the Congressional Budget Office and the General Accounting Office have repeatedly shown that single-payer universal health care would save significant dollars in administrative costs. As early as 1991, the GAO concluded that if the universal coverage and single-payer features of the Canadian system had been applied in the United States that year, the total savings (then estimated at $66.9 billion) "would have been more than enough to finance insurance coverage for the millions of American who are currently uninsured."[iv] More recently, estimates published in the International Journal of Health Services conclude that "streamlining administrative overhead to Canadian levels would

save approximately $286 billion in 2002, $6,940 for each of the 41.2 million Americans who were insured as of 2001. This is substantially more than would be needed to provide full insurance coverage." [v] At present, the US spends 50% to 100% more on administration than countries with single-payer systems.

Single Payer facilitates quality control. Having a single-payer system would create for the United States a comprehensive, accurate, and timely national data base on health service utilization and health outcomes. This would provide information on gaps and disparities or duplication of care, thereby serving as valuable intelligence for decision-making and resource allocation. At present, the closest analogy to this is the Veterans Health Administration (VHA), which has been highly successful in containing costs while providing excellent care. The key to its success is that it is a universal, integrated system: "Because it covers all veterans, the system doesn't need to employ legions of administrative staff to check patients' coverage and demand payment from their insurance companies. Because it's integrated, providing all forms of medical care, it has been able to take the lead in electronic record-keeping and other innovations that reduce costs, ensure effective treatment and help prevent medical errors."[vi]

Single Payer gives the government greater leverage to control costs. A single payer would be able to take advantage of economies of scale and exert greater leverage in bargaining with providers, thereby controlling costs. Recent experiences with both the VHA system and that of Medicare Part D indicate the difference exerting such leverage can make. The Department of Veterans Affairs 4 uses its power as a major purchaser to negotiate prices with pharmaceutical makers. But when the legislation leading to the drug prescription plan (better known as Medicare Part D) was passed, Congress explicitly barred negotiating prices with drug makers. The results of this are now becoming evident: at present, the VA is paying 46% less for the most popular brand-name drugs than the average prices posted by the Medicare plans for the same drugs.[vii] Because Part D increased the effective demand for drugs without controlling costs, prescription drug prices have risen sharply: during the first quarter of 2006, prices for brand-name pharmaceuticals "jumped 3.9%, four times the general inflation rate ...and the largest quarterly price increase in six years."[viii]

If this trend is allowed to continue unchecked, it could jeopardize the fiscal viability of the Medicare drug program and seriously undermine whatever political and public support it now has. In addition, this could have significant repercussions on the program as a whole. In the words of economist Stephen W. Schondelmeyer, who specializes in drug industry issues, "Higher drug prices may lead to higher premiums next year, which may discourage enrollees from joining or staying in the program, and fewer enrollees could drive premiums even higher."[ix]

Single Payer promotes greater accountability to the public. One of the key features of the US health care system is its fragmentation. When every player is responsible for only part of the care of part of the population part of the time, there is no overall accountability for how the system functions as whole. Consumers are therefore left wondering who is in charge, and whom they can appeal to when their knowledge is incomplete or their care is inadequate. The most recent report to Congress of the Medicare Advisory Commission recognizes this: "...perverse payment system incentives, lack of information, and fragmented delivery systems are barriers for full accountability." [x]

The creation of a single payer would provide an opportunity for creating a system run by a public trust. Benefits and payments would be decided by the insurer which would be under the control of a diverse board representing consumers, providers, business and government.

Single Payer fosters transparency in coverage decisions. Single-payer plans have been criticized for "making all sorts of unbearable trade-offs explicit government policy, rather than obscuring them in complexities." Given finite resources, it may not be possible to cover every single treatment, device or pharmaceutical a patient may require or desire. Priorities must be set, and the criteria for these should be transparent and consistently applied.

The practice of "obscuring trade-offs" is irresponsible and demeaning to the American public. Medical care decisions are too important and affect everyone 5 too directly to be made surreptitiously. Moreover, forcing policy-makers to make decisions concerning what to cover will ensure their confronting issues of safety, efficacy, and value-for-money that are often circumvented or overlooked. Tradeoffs that are transparent to health care consumers will therefore be in the public's interest.

In sum, the reasons for supporting single payer are practical as well as principled, based on values of openness, equity, and social responsibility. We therefore urge the Citizens Health Care Working Group to adopt the creation of a single payer as an essential pillar without which the guiding values underpinning the Interim Recommendations will not be fulfilled.

Published July 18, 2006

i. Mintz, Morton. Single Payer: Good for Business. The Nation. November 15, 2004.

ii. Ibid.

iii. Friedman, Saul. A tale of two Medicare plan rollouts. Newsday, May 27, 2006.

iv. Quoted in Mintz, Op cit.

v. Himmelstein DU, Woolhander S, and Wolfe SM. "Administrative Waste in the US Health Care System in 2003: The Cost to the Nation, The States, and the District of Columbia, with State-Specific Estimates of Potential Savings. International Journal of Health Services. Vol. 34, No. 1, 2004: 79-86.

vi. Krugman Paul. "Health Care Confidential." The New York Times, January 27, 2006.

vii. Freudenheim M. "Drug Prices Up Sharply This Year." The New York Times, June 21, 2006.

viii. Ibid.

ix. Quoted in Ibid.

x . Report to the Congress: Increasing the Value of Medicare. Washington, DC: Medicare Payment Advisory Commission. June 2006: xv.

PNHP Chapter Reports - January 2007

PNHP's **California** chapter, the California Physicians' Alliance (CaPA), continues to lead physician advocacy, education, and media outreach in support of SB 840, a bill to create a statewide single-payer program. The bill passed the legislature last year but was vetoed by the governor. Working with labor, senior, consumer, and other groups, CaPA members appeared at press conferences, gave dozens of talks to lay and medical audiences, and met with legislators to advocate for single-payer. Thanks to everyone who participated in the effort. CaPA Co-Chair Dr. Bree Johnston and Dr. Richard Quint are also organizing outreach efforts in all 11 medical and osteopathic schools in California. PNHP Senior Health Policy Fellow Dr. Don McCanne frequently speaks at conferences and to the press; he also continues to build support for single-payer nationwide with his "Health Policy Quote of the Day" e-update. Subscribe by dropping a note to don@mccanne.org.

In **Colorado**, PNHP members are active in speaking, coalition building, and legislative outreach. Dr. Rocky White has made presentations on single-payer to business and professional groups and is working on updating the late Dr. Bob LeBow's book, "Health Care Meltdown," for publication in Spring, 2007. Dr. Howie Wolf and other PNHP'ers participated in the Citizens' Health Care Working Group meeting in Denver. Dr. Elinor Christiansen is working with consumer, union, and seniors' groups, and published a single-payer op-ed in the *Rocky Mountain News* with Dr. David Iverson. Contact Dr. White at whtfarms@fone.net

District of Columbia chapter members have presented grand rounds at Georgetown, George Washington (GW) and Howard Universities. Dr. Harvey Fernbach represented PNHP at the summer retreat of the House Progressive Caucus, where single-payer received an enthusiastic reception. Dr. Robert Zarr has been helping congressional efforts as well as organizing a PNHP student chapter and lecture series at GW. Dr. Jerry Earll is a frequent public speaker, most recently addressing the U.S. Women's Chamber of Commerce. The chapter recently hosted a media and speakers' training with PR staff from the American Automobile Association and plans more trainings in the future. Contact Dr. Robert Zarr at rlzarr@yahoo.com

In **Florida**, PNHP members have focused on public speaking to community, business and medical groups. In Tampa Bay, several members have organized presentations at local hospitals. Dr. Greg Silver debated the right-wing Cato Institute at a meeting of the Florida Human Resources Association. Dr. Carmine Luongo published a single-payer op-ed in the South Florida *Sun-Sentinel*. Chapter members also attended the Orlando meeting of the Citizens' Health Care Working Group, where they won praise from attendees for criticizing the group's exclusion of single-payer as an option. Contact Dr. Silver at drsilver@drsilver.net.

PNHP's **Indiana** chapter continues to gain widespread media and public attention for its efforts on behalf of single-payer. Drs. Aaron Carroll and Chris Stack were each featured in large articles in the Indianapolis press: an extensive interview with Dr. Stack was published in the weekly *Nuvo*, and the *Indianapolis Star* ran an op-ed by Dr. Carroll (reprinted on page 4). Dr. Rob Stone was a featured speaker at local political forums which were broadcast on television. The group plans to introduce a state single-payer bill soon. Contact Dr. Rob Stone at grostone@insightbb.com

Idaho PNHP'ers have been making progress in their socially conservative state by talking about the effects of the health crisis on small communities. Dr. Bill Woodhouse has been speaking to legislators and community groups about the benefits of single-payer for small business, school districts and local governments. Contact Dr. Woodhouse at wdhouse@fmed.isu.edu

Illinois PNHP'ers have been speaking to physicians, medical students and community groups. Chapter Chair Dr. Rob McKersie was quoted in the *Chicago Tribune*'s coverage of the uninsured, presented grand rounds to Children's Hospital, and spoke to the board of the Advocate hospital system. Dr. Basil Bradlow and Dr. John Rolland have spoken to students at universities around the Chicago area. Dr. Quentin Young also continues to be a frequently-requested speaker, most recently presenting grand rounds at Rush University. The chapter submitted a single-payer proposal to a state task force on health reform; the plan received the highest score of six submitted proposals in an evaluation by the state's independent consulting firm. Contact Dr. Rob McKersie at dejadog@hotmail.com

Kentucky PNHP'ers have been using legislative efforts to build a coalition for single-payer and earn extensive media coverage. Dr. Garrett Adams coordinated a physician-legislator meeting campaign which won 56 legislator endorsements and passed a single-payer endorsement out of the House's health committee. Their efforts also earned front-page coverage in the state's largest newspaper, The Louisville *Courier-Journal*. A special thanks to the chapter's medical student intern, Reesha Shah. The chapter also hosted Dr. Steffie Woolhandler for a talk to the Kentucky Medical Society. Members are speaking frequently to medical and community groups throughout the state. Contact Dr. Adams at kyhealthcare@aol.com

In **Maryland**, PNHP members have been bringing the single-payer message to national progressive and activist groups. Members spoke with attendees at the national meetings of the Spiritual Progressive Network, the Woman's National Democratic Club, and the Take Back America Conference. They also joined the D.C. chapter at a House Progressive Caucus retreat. Dr. David Rabin advised two pro-single-payer primary candidates (both lost), and appeared on a health reform panel at a D.C. business conference. He also gave a grand rounds to the Department of Family Medicine at Howard University.

PNHP's **Massachusetts** chapter has been using the flawed new state health law to raise awareness about the single-payer alternative. Passed in April 2006, the law modestly expands public coverage and mandates that the rest of the uninsured buy coverage from private insurers. A critique by Drs. Michael Hochman and Steffie Woolhandler appeared in the *Boston Globe* (reprinted on page 6), and Drs. Woolhandler and David Himmelstein also published critiques of the plan in the Atlanta *Journal-Constitution* and in The Hastings Center Report. The study they co-authored with Dr. Karen Lasser - showing Canadians are healthier and enjoy better access to care than Americans - was likewise covered in hundreds of newspapers and broadcast stations around the country. Drs. Julie Silverhart and Michael Hochman are spearheading an effort to build more physician and medical student activism. Contact Dr. Silverhart at jsilverh@bidmc.harvard.edu.

Michigan PNHP'ers have been bringing the single-payer message to medical and labor audiences. Dr. Susan Steigerwalt presented grand rounds at Michigan State University and to the Pediatrics Department at William Beaumont Hospital. Dr. David Apsey has been active in labor outreach, most recently giving the PNHP talk in support of HR 676 to 300 steelworkers at Local 600 in Dearborn. Contact Dr. Steigerwalt at spspnhp@aol.com.

New Hampshire's new PNHP chapter has enjoyed early success in attracting speaking engagements and media attention. Co-founder Dr. Marcosa Santiago convened the chapter's inaugural meeting, which attracted more than a dozen physicians and citizen activists. She recently spoke to the New Hampshire Medical Society, which asked for more presentations on the topic. The chapter also placed op-eds on the uninsured in three state newspapers. Contact Dr. Santiago at cosy@diacad.com.

New Jersey PNHP'ers have been bringing single-payer to the attention of the medical community through debates and grand rounds presentations. Dr. Wink Dillaway recently debated Dr. Eileen Moynihan of the NJ State Medical Society. The chapter co-sponsored a debate between PNHP-NYC Chair Dr. Oliver Fein and Dr. Peter Carmel of the AMA, and the chapter will be giving grand rounds at the Univ. of Medicine & Dentistry and Warren Hospital. Dr. Charles Granatir has been working with Gov. Corzine's staff to get single-payer represented on its health advisory board. Contact Dr. Dillaway at w.dillaway@umdnj.edu.

In **Upstate New York**, the Capital District PNHP chapter has been bringing single-payer to the airwaves, hosting four public forums on local radio. Chapter leaders Drs. Paul Sorum and Andrew Coates have presented to medical schools, county medical societies, local governments and labor groups around the state. In July, medical student member Katherine Baerwald organized a summer advocacy camp which attracted more than 50 participants for presentations from NY-Metro leaders. Dr. Richard Propp published an op-ed on single-payer and business in the Albany *Times Union*. Contact Dr. Coates and Dr. Sorum at pnhpalbany@verizon.net.

The **NYC Metro** PNHP chapter has continued its active medical, community, and student outreach efforts. The chapter recently hosted a public meeting attended by more than 500 people where *New York Times* columnist Paul Krugman made the case for single-payer. They've continued to build on the success of their monthly public forums and medical student activism. Their accomplished speakers bureau (including physicians Drs. Peter Barland, Olveen Carrasquillo, Mary O'Brien, Richard Pierson, and Peter Steinglass; and Profs. Martha Livingston and Len Rodberg) has reached hundreds of health and community venues. To get involved, contact Joanne Landy at jlandy@igc.org.

PNHP's **North Carolina** chapter has focused on coalition-building through an active speaking schedule. Chapter leader Dr. Jonathan Kotch has been spearheading collaboration efforts with the National Health Law Program and the "Healthy Durham" citizen group. He also presented a grand rounds at Forsyth Memorial Hospital in Winston-Salem. Contact Dr. Kotch at jonathan_kotch@unc.edu

Utah PNHP'ers are working on outreach and media through their group, the Utah Health Cooperative. Dr. Joseph Jarvis spoke to the Intermountain Pediatric Society in June on single-payer reform. Dr. Jarvis also ran as a Republican state senate candidate. A community forum in May attracted 100 local physicians. The group plans to bring the single-payer message to the business community next. Contact Dr. Jarvis at jqjarvis@ix.netcom.com.

Vermont PNHP leader Dr. Deborah Richter gave 21 talks this year. In addition to her constant outreach to the Vermont community, Dr. Richter spoke to the New Hampshire Medical Society and Academy of Family Physicians, and the New York Academy of Family Physicians. The chapter received substantial media attention for their criticism of an incremental health reform passed this year: an analysis by Dr. Richter appeared in four state newspapers and she was a guest on WAMC radio. Contact Dr. Richter at drdebvt@sover.net.

Members of PNHP's **Western Washington** chapter have been busy with organization building and speaking engagements. Dr. David McLanahan testified to the Governor's Commission on Health Care Access and Costs, and presented to the King County Academy of Family Physicians. He was also a guest on NPR's "All Things Considered" during that show's coverage of the Citizens' Health Care Working Group. Dr. John Geyman will present a grand rounds in Yakima, and his new book "The Corrosion of Medicine" will be available from Common Courage Press in April 2007. Contact Dr. David McLanahan at pnhp.westernwashington@comcast.net.

Wisconsin PNHP'ers have maintained an active speaking schedule, addressing labor, business and medical audiences. Drs. Gene and Linda Farley are leading this effort, with recent talks to the Wisconsin Nurses' Association, Rotary Clubs, and UW Medical School. They have also appeared numerous times on public radio and are frequent guests at statewide progressive health care forums. Contact Drs. Farley at esfarley@wisc.edu.

TRANSPARENCY OR FIG LEAF?

Helping the Sick Spend Money Will Not Cure National Health Care Ills

By Drs. Steffie Woolhandler and David Himmelstein

Nearly 47 million Americans are uninsured, and millions more have coverage so skimpy that a major illness would bankrupt them. Yet President Bush apparently thinks Americans are too well-insured.

He's pushing health savings accounts — a plan to make the sick pay thousands from their own pockets before insurance kicks in. And the fig leaf for his soak-the-sick scheme is "transparency." Just make hospitals and doctors post their prices, he says, and the market will magically cut health costs.

The president's scheme will drive millions more into medical poverty, but it won't hold down costs.

Insured Americans already pay bigger co-payments and deductibles than do people in any other nation. Yet our health costs are far higher than anywhere else.

Steep out-of-pocket costs have little impact on overall spending. They discourage preventive care such as immunizations but don't affect the real cost driver — expensive illnesses that afflict only 20% of Americans each year but account for 80% of spending.

A patient having a heart attack can't comparison shop among hospitals, bargain for discount clot-buster drugs, or second-guess the doctor's advice. And when steep deductibles make people delay care, the heart damage gets worse and the bill goes up.

Huge corporations like General Motors have tried for years to hold down health benefit costs by using their market muscle (and the kind of price and quality information Bush touts). They've failed. If GM can't bargain down costs, will Mrs. Smith succeed?

THE NATION'S NEWSPAPER
USA TODAY
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Transparency won't cut costs, but national health insurance would. A single-payer system could save $300 billion annually on health bureaucracy by eliminating paperwork and exorbitant CEO incomes. It could avoid the duplication of transplant facilities that raises costs and worsens quality. It would also reduce unnecessary surgery and other harmful procedures.

Most important, national health insurance would guarantee comprehensive coverage and close the health gap with Canada and other nations where people live longer than we do.

Drs. Steffie Woolhandler and David Himmelstein teach at Harvard Medical School and co-founded Physicians for a National Health Program.

Recruit your Colleagues to PNHP

Longtime PNHP member and outgoing American Psychiatric Association (APA) President Dr. Steven Sharfstein urged psychiatrists to "tirelessly advocate" for a single-payer, universal health care system during his address at APA's 2006 Annual Meeting. Child psychiatrist Dr. Audrey Newell hosted a PNHP exhibit at the meeting - as she has done annually for many years - and recruited 25 of her colleagues to join PNHP!

PNHP'er Dr. Caryl Heaton, President of the Society of Teachers of Family Medicine, also urged physicians to become advocates for single-payer at her group's conference. Dr. Ken Saffier and other PNHP'ers signed up more than 20 new members on the spot. PNHP will host a booth at STFM's 2007 meeting in Chicago.

Encourage your colleages to join PNHP online today at www.pnhp.org.

Updates from States in the News

Although this short publication is focused on the national scene, we'd be remiss if we didn't comment on three states receiving lots of attention this year. Legislation for single-payer (SB 840) passed the California legislature this fall. Although it was vetoed by the governor, the hard-won victory energized supporters and lead sponsor Sen. Sheila Kuehl plans to reintroduce the bill next year. An ill-conceived but highly-touted reform passed in Massachusetts. An op-ed by Dr. Michael Hochman on the Massachusetts bill appeared in the *Boston Globe* (reprinted on page 6). Hochman is an intern in internal medicine and one of several new activists in the Boston chapter of PNHP. Tireless activist Dr. Deb Richter reports that a similar situation transpired in Vermont this year, with a small coverage expansion being mistakenly hailed as a "breakthrough." For the real story, see www.pnhp.org/VT/.

2007 PNHP President

Ana Malinow, MD, is an Assistant Professor of Pediatrics at Baylor College of Medicine and co-founder of Health Care for All Texas. Dr. Malinow was born in Buenos Aires, Argentina, and earned her BA from the University of California, Davis and her MD from Case Western. She currently practices at the Pediatric Emergency Center at the Ben Taub General Hospital in Houston, where most of her patients are uninsured.