Uninsured Veterans:
A Stain on America's Flag

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Summary/Oral Testimony

In my written testimony I present detailed information on the health insurance coverage and problems in access to health care of America's veterans, based on analyses of multiple years of data from two annual national surveys carried out by the government: The Current Population Survey and the National Health Interview Survey.

I will address two questions: (1) How many veterans are currently uninsured? And (2) Do uninsured veterans suffer problems in access to care – similar to other Americans who are uninsured?

In 2004, 1.8 million military veterans neither had health insurance nor received ongoing care at Veterans Health Administration (VHA) hospitals. Note that the surveys asked veterans if they had health insurance, and if they had veterans or military health care. We counted them as uninsured only if they answered no to both questions. The number of uninsured veterans has increased by 290,000 since 2000. The proportion of non-elderly veterans who were uninsured rose from less then one in ten (9.9%) in 2000 to more than one in eight (12.7%) in 2004.

An additional 3.8 million members of veterans' households were also uninsured and ineligible for VHA care.

Virtually all Korean War and World War II veterans are over age 65 and hence covered by Medicare. However, 645,628 Vietnam-era veterans were uninsured (8.5% of the 7.56 million Vietnam-era vets). Among the 8.6 million veterans who served during "other eras" including the Persian Gulf War, 12.9% (1,105,891) lacked health coverage.

Almost two-thirds (64.3%) of uninsured veterans were employed and nearly nine out of ten (86.4%) had worked within the past year. Most uninsured veterans, like other uninsured Americans were in working families. Many earned too little to afford health insurance, but too much to qualify for free care under Medicaid or VA means testing.

Uninsured veterans have the same problems getting the care they need as do other unsinsured Americans. Moreover, many uninsured veterans have serious illnesses requiring extensive care. Among uninsured veterans older than 45 years, nearly one in five (19.1%) were in fair or poor health. Nearly one in three uninsured veterans (of all ages) reported at least one chronic condition that limited their daily function.

A disturbingly high number of uninsured veterans reported needing medical care and not being able to get it within the past year. More than a quarter (26.5%) of uninsured veterans failed to get needed care due to costs; 31.2% had delayed care due to costs. Among uninsured veterans, 44.1% had not seen a doctor or nurse within the past year, and two-thirds failed to receive preventive care. By almost any measure, uninsured veterans had as much trouble getting medical care as other uninsured persons.

The VHA is a rare success story in our health care system. The VHA offers more equitable care[1] and higher quality[2] [3] [4] care than the average care in the private-sector, and has become a medical leader in research, primary care, and computerization.

While we support opening VHA enrollment to all veteran, this would still leave many veterans unable to access care because they live far from VHA facilities. Moreover, even complete coverage of veterans would leave 3.8 million of their family members uninsured. Hence, my colleagues and I support a universal national health insurance program that would work with and learn from the VHA system in covering all Americans.

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[1] Jha AK, Shlipak MG, Hosmer W, Frances CD, Browner WS. Racial differences in mortality among men hospitalized in the Veterans Affairs health care system.
JAMA. 2001;285:297-303.

[2] Asch SM, McGlynn EA, Hogan MM et al. Comparison of quality of care for patients in the Veterans Health Administration and patients in a national sample. Ann Int Med 2004; 141: 938-945.

[3] Petersen LA, Normand S-LT, Leape LL, McNeil BJ. Comparison of use of medications after acute myocardial infarction in the Veterans Health Administration and Medicare. Circulation 2001; 104:2898

[4] Kerr EA, Gerzoff RB, Krein SL et al. Diabetes care quality in the Veterans Affairs health care system and commercial managed care: The TRIAD Study. Ann Intern Med 2004;141:272.

Additional Written Testimony

Background

Forty-five million Americans were uninsured in 2005, the latest year for which reliable data are available. While the Census Bureau's annual survey on health insurance includes questions about previous military services, the Bureau's report on coverage does not include tabulations of veterans' coverage. In addition to the sources of health coverage available to other Americans – Medicare, Medicaid and private coverage - some military veterans obtain care through the network of hospitals and clinics run by the Veterans Health Administration (VHA).

While many Americans believe that all veterans can get care from the VHA, even combat veterans may not be able to obtain VHA care. The 1996 Veterans Health Care Reform Act expanded eligibility for VHA care to all veterans, but instructed the VHA to develop priority categories for enrollment. The VHA priority list includes eight priority categories, with veterans offered care based on their priority status and the resources available (Appendix).

As a rule, VHA facilities provide care for any veteran who is disabled by a condition connected to his/her military service, and care for specific medical conditions acquired during military service. Any veteran who passes a means test is eligible for care in VHA facilities but has lower priority status (Priority 5 or Priority 7, depending upon income level) and is enrolled on a space-available basis. Veterans without service-connected illnesses or disabilities, and with incomes above 80% of the median income in their area are classified in the lowest priority group, Priority 8.

In the 7 years after the passage of the Veterans Healthcare Reform Act, VHA enrollment grew 141%, from 2.9 million to 7.0 million. However, funding increased by only 60%. Because VHA funding did not keep pace with the demand for care, long waiting lists developed at many VHA facilities. By 2002, there were almost 300,000 veterans either placed on waiting lists for enrollment or forced to wait for 6 months or more in order to receive an appointment for necessary care (Memorandum from Department of Veterans Affairs to Chairs and Ranking Members of Senate and House Veterans' Committees and VA-HUD Appropriations Sub-Committees, July 2002).

In January 2003, President Bush's Secretary of Veterans Affairs halted enrollment of Priority 8 veterans. Since that time these veterans have remained ineligible for VHA enrollment.

VHA analysts have estimated that about three-quarters of VHA-enrolled veterans have other health coverage such as Medicare or private insurance, and that 1.013 million VHA patients were uninsured in 1999 (Donald Stockford et al. Uninsured Veterans and Veterans Health Administration Enrollment System, 2003. Department of Veterans Affairs, April 2003.). The 2001 National Survey of Veterans (NSV) found that 10.0% of veterans – 2.52 million vets – were uninsured, 0.9 million of whom used VHA hospital,

outpatient or emergency care (2001 National Survey of Veterans: Final Report and supplemental tabulations, available at: http://www.VHA.gov/vetdata/SurveyResults/). Thus, the NSV data indicate that more than 1.6 million veterans had neither health insurance nor VHA care in 2001.

This report uses data from two large, recent surveys of the U.S. population to examine two related questions: (1) How many veterans and their family members lacked any health coverage in 2005 (i.e. they had neither insurance nor VHA care)?; and (2) What problems in access to health care did these uncovered veterans and their families experience?

Methods

Our principal analysis used data from two large surveys of the U.S. population: the Current Population Survey Annual Social and Economic Supplement (CPS) for multiple years (most recently March, 2005), and the 2002 and 2004 National Health Interview Survey (NHIS).

The CPS is the standard source for estimates of health insurance coverage in the U.S. We used weights supplied by the Census Bureau to extrapolate the findings to the entire U.S. population. The CPS asks only about prior U.S. military service. Hence, both honorably-discharged and other veterans are included under the rubric "veteran". We considered a person insured if they had any private insurance, Medicaid, SChip, Medicare, other insurance, or were "covered by Champus, veterans or military health care". Thus, persons enrolled in VHA (or military) healthcare were classified as insured even if they had no other coverage. We considered a person to be a veteran's family member if they resided in a household with a veteran. Because the CPS is considered the standard source for data on health insurance coverage, we based most of our analyses of veterans' insurance coverage on these data.

Because the NHIS includes more detailed health care access and utilization measures than the CPS, we used the NHIS for analyses of these issues. This survey is conducted annually by the National Center for Health Statistics of the U.S. Department of Health and Human Services. We used the NHIS to analyze health status and health care utilization – questions that are not asked in the CPS. The NHIS asks if subjects have been "honorably discharged" from the armed forces, and hence identifies slightly fewer persons as veterans than does the CPS. Because the NHIS is specifically designed to assess health and health care issues, its questions are generally more specific than those on the CPS. For instance, the NHIS survey allows differentiation of persons who have only "veterans or military health care" from those who have military-paid insurance plans such as Champus, "Champus-VA", or Tri-Care. NHIS also contains information on specific medical conditions, access to medical care and use of health care services.

Data were analyzed using SAS statistical software.

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Lack of Health Coverage is Common Among Veterans

1.77 million American veterans were uninsured in 2004, according to the CPS data, including 12.7% of all non-elderly (age <65) veterans. In this survey, veterans with "Champus, Tricare, veterans or military health care" were categorized as having health coverage. Hence, the 1.77 million figure represents persons with neither health insurance nor ongoing access to VHA medical facilities.

As expected, because of their age, virtually all World War II and Korean War veterans had Medicare coverage. However, many veterans with more recent military service were uninsured. Among the 7.56 million Vietnam-era veterans, 646,000 (8.5%) lacked any coverage. Among the 8.6 million veterans who served during "other eras," including the Persian Gulf War, one in eight was uninsured.

Table 1 -Number and Percentage of Uninsured Veterans for Recent Veterans, by Service Era, 2004

Era of military service	Number of living veterans, total	Number lacking health coverage	Percent lacking health coverage
Other (includes Gulf War)	8.60 million	1,105,891	12.9
Vietnam	7,56 million	645,628	8.5%

Source: Analysis of Current Population Survey, March 2005 Supplement

The 2004 figures represent an increase of 290,000 in the number of uninsured veterans since 2000. In 2000, 9.9% of veterans under the age of 65 were uninsured, rising to 12.7% in 2004.

In addition to the 1.77 million uninsured veterans in 2004, 3.8 million members of veterans' families lacked coverage

Veterans Without Health Coverage are not Currently Receiving VHA Care

According to the NHIS, 1,670,410 honorably-discharged veterans had neither health insurance nor "military or veterans' health care" in 2002. This number is statistically indistinguishable from the CPS-based estimate of uninsured veterans for that years. In

the NHIS, an additional 1,426,897 veterans indicated that they had military or veterans' health care but no other coverage.

Table 2 – Health Insurance of Veterans and their Family Members - 2002

	Family members of veterans	Veterans
Private coverage	73.2%	70.6%
Medicaid coverage	6.4%	2.3%
Medicare coverage	19.1%	37.1%
Champus/Tricare/ChampusVA	5.5%	7.2%
Military /veterans' medical care only	0.8%	6.3%
Uninsured and no military/VHA Care	**9.4%**	**7.4%**

Source: Analysis of National Health Interview Survey, 2002. Public Use Data Release, December, 2003

Note: Individuals may have more than one type of coverage

Which Veterans are Uninsured?

The typical uninsured veteran was an employed male in his late forties living with one or two family members. Compared to the uninsured non-veteran population, uninsured veterans were older, and more often employed, male and high school graduates (data not shown).

Compared to veterans with health coverage, uninsured veterans were younger, more likely to be working, and had lower incomes. 64.3% of uninsured veterans were working at the time of the survey, and 8.7% were in the labor force but currently unemployed or laid off. 70.1% of uninsured veterans had family incomes at or above 150% of the Federal poverty level, and 46.7% had incomes above 250% of poverty (a level that would likely place them above the income threshold for Priority Group 7, leaving them ineligible for VHA enrollment).

Table 3 – Veterans' Demographic and Employment Characteristics, by Insurance Status - 2004.

	Insured veterans	**Uninsured veterans**
Female	5.4%	**7.4%**
Age <18	0%	**0%**
18-44	16.3%	**44.5%**
45-64	40.7%	**55.2%**
> 64	43.0%	**1.3%**
Income <150% of poverty	11.4%	**29.9%**
Income <250% of poverty	28.9%	**53.3%**
Currently employed	48.8%	**64.3%**
Currently unemployed or laid off	1.9%	**8.7%**

Source: Analysis of Current Population Survey, March 2005

Veterans Lacking Health Coverage Are Not in Good Health

Many uninsured veterans had serious health problems. When asked to rate their health as "excellent", "very good", "good", "fair" or "poor", less than one-quarter of uninsured veterans indicated that they were in excellent health; one in six had a disabling chronic illness.

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Table 4–Share of Veterans in Fair or Poor Health, by Age and Insurance Status – 2004

	Insured veterans (%)	**Uninsured veterans (%)**
Fair or poor health (%)		
Age 0-17	N/A.	**N/A.**
18-24	5.6	**3.7***
25-44	7.7	**7.9**
45-64	18.8	**19.1**
>64	30.3	**NA**

*Based on small numbers of respondents – note almost all persons over 65 are covered by Medicare

Source: CPS March 2005 Supplement. Respondents were asked to rate their health as excellent, very good, good, fair or poor.

Uninsured Veterans and Family Members Forego Needed Health Care Due to Cost

Uninsured veterans indicated that they faced major barriers to obtaining medical care. Among veterans age 18-64, those without coverage were five times more likely than insured veterans to delay care because of costs, five times more likely to forego medications because of costs, and six times more likely to forego medical care because of costs than those with insurance (Table 5).

Table 5– Health Care Access Problems During the Past 12 Months of Veterans and Family Members 18-64 Years Old - 2004

	Insured veterans	**Uninsured veterans**
Delayed care due to cost	6.6%	**31.2%**
Didn't get needed care due to cost	4.3%	**26.5%**
Couldn't afford medications	5.5%	**25.1%**
Couldn't afford glasses	5.3	**20.8%**

Source: Analysis of the National Health Interview Survey, 2004.

Uninsured Veterans Use Less Health Care

Our analyses of the amount of care actually used by uninsured veterans and their families confirmed that they, indeed, lacked access to care. Two thirds of uninsured veterans did not get any preventive care. Nearly half of uninsured veterans had not made **any** office visits to any health professional in the past year, and a similar number had **no** usual place to go when they got sick (Table 6).

Table 6 - Healthcare Access and Utilization of Veterans and Family Members under Age 65, by insurance status – 2004

	Insured veterans	**Uninsured veterans**
No office visits, past year	15.5%	**49.1%**
Did not get preventive care anywhere	51.8%	**66.4%**
No contact with health professional in past year	14.9%	**44.9%**
No usual place to go when sick	8.9%	**51.4%**

Source: Analysis of National Health Interview Survey, 2004

Uninsured Veterans' Access is No Better, and in Most Respects Worse, Than That of Other Uninsured People

Indicators of access to care for uninsured veterans were strikingly similar, and in some cases worse, than those for other uninsured individuals (Table 7). This indicates that VHA care did little or nothing to fill the gaps for uninsured veterans.

Table 7 - Healthcare Access and Utilization of Uninsured Veterans Compared to Other Uninsured People, Age 18-64

	Other Uninsured Persons	**Uninsured veterans**
No contact with health professional, past year	42.3%	**44.9%**
Doesn't get preventive care anywhere	69.8%	**66.4%**
No usual place to go when sick	48.9%	**51.4%**
Delayed care due to cost	26.3%	**31.2%**
Didn't get needed care due to cost	22.1%	**26.5%**
Couldn't afford medications	23.9%	**25.1%**
Couldn't afford glasses	17.5%	**20.8%**

Source: Analysis of National Health Interview Survey, 2004.

Discussion

Almost 5.6 million American veterans and members of veterans' families are uninsured and not receiving care in the VHA system. They account for 1 out of 8 uninsured people in our nation. Like other uninsured adults, most of the uninsured veterans were working; many had two jobs. All Americans deserve access to high quality, affordable health care. Yet it is especially troubling that many who have made sacrifices and often placed themselves in harm's way are later denied the health care they need.

Were the veterans who were classified as uninsured in the surveys we analyzed truly denied access to the care they need? Several pieces of evidence suggest that the doors to medical care – including the VHA system – are effectively closed to most of this group.

First, both surveys we analyzed asked respondents if they had "veterans or military health care" and considered anyone answering "yes" as insured. The National Health Interview Survey was highly specific in this regard. We considered all veterans reporting veterans or military health care to have coverage. Hence, veterans who lacked insurance but were enrolled in the VHA system would be considered insured in our analysis. The data suggest that the VHA currently cares for only about 45% of the more than 3 million veterans without any other coverage.

Second, the veterans we identified as lacking coverage had substantial problems in gaining access to health care. Like other uninsured people, they were often unable to afford care, had low rates of health care utilization, and frequently went without needed services. Indeed, for virtually every measure of access to care, uninsured veterans were indistinguishable from other uninsured persons, and they fared much worse than insured veterans. Even if some of these uninsured veterans are theoretically eligible for VHA care, their real-world access to health care is just as bad as – and by some measures worse than - that of other uninsured people.

Finally, about half of the uninsured veterans had incomes that would make them completely ineligible for VHA enrollment (priority 8). For many others (Priority 7), care would only be available with substantial co-payments (e.g. $50 for specialty care). Moreover, low-priority veterans are generally ineligible for free transportation to VHA facilities, leaving care inaccessible to many vets.

Appendix

Priority Groups for VHA Healthcare Enrollment

Priority 1
Service-connected disability rated 50 percent or more disabling

Priority 2
Service-connected disability rated 30 percent or 40 percent disabling

Priority 3
Former POWs
Purple Heart recipients
Discharged for a disability that was incurred or aggravated in the line of duty
Service-connected disability rated 10 percent or 20 percent disabling
Special-eligibility classification under "benefits for individuals disabled by treatment or vocational rehabilitation"

Priority 4
Veterans who are receiving aid and attendance or household benefits
Veterans who have been determined by the VHA to be catastrophically disabled

Priority 5
Income and net worth below VHA Means Test threshold
Receiving VA pension benefits
Eligible for Medicaid benefits

Priority 6
World War I veterans
Mexican Border War veterans
Veterans solely seeking care for disorders associated with:

* Exposure to herbicides while serving in Vietnam
* Exposure to ionizing radiation during atmospheric testing or during the occupation of Hiroshima or Nagasaki
* Disorders associated with service in the Gulf War
* Any illness associated with service in combat in a war after the Gulf War or during any period of hostility after November 11, 1998

Priority 7
Veterans who agree to pay co-payments with income and/or net worth above the VHA Means Test threshold and income below the HUD geographic index

Priority 8 (Not currently eligible for enrollment)
Veterans who agree to pay specified co-payments with income and/or net worth above the VHA Means Test Threshold and the HUD geographic index

CURRICULUM VITAE

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PART I: General Information

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Office Address:	Department of Medicine, 1493 Cambridge St., Cambridge MA 02139
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Place of Birth:	Shreveport, Louisiana

Education:

1975 B.A.	Stanford University, Stanford, CA
1979 M.D.	Louisiana State University, New Orleans, LA
1981 M.P.H.	University of California, Berkeley

Postdoctoral Training:

Internship and Residencies:

1979-1980	Intern in Family Practice, San Francisco General Hospital/University of California at San Francisco
1981-1982	Medical Resident, Highland General Hospital/University of California at San Francisco, Oakland, CA
1984-1986	Medical Resident, The Cambridge Hospital/Harvard Medical School, Cambridge, MA

Research Fellowships:

1986-1987	National Health Services Research Fellow in General Internal Medicine, Harvard Medical School, Cambridge Hospital

Licensure and Certification:

1982	Massachusetts Medical License
1986	Board Certified, American Board of Internal Medicine

Academic Appointments:

1983-1985	Adjunct Assistant Professor of Public Health, Boston University School of Medicine

1985	Visiting Associate Professor, University of Zagreb Medical School, Yugoslavia
1985-1998	Adjunct Associate Professor of Public Health, Boston University School of Medicine
1987-1989	Instructor in Medicine, Harvard Medical School
1989-1994	Assistant Professor of Medicine, Harvard Medical School
1994-present	Associate Professor of Medicine, Harvard Medical School

Hospital Appointments:

1986-present	Staff Physician, Department of Medicine, The Cambridge Hospital (now Cambridge Health Alliance).
1996-2003	Clinical Associate in Medicine, The Massachusetts General Hospital
2007-	Clinical Associate in Medicine (Bigelow Attending), Massachusetts General Hospital

Other Professional Positions and Major Visiting Appointments:

1985	Exchange Health Scientist, John E. Fogarty International Center, National Institutes of Health
1990-1991	Robert Wood Johnson Health Policy Fellow, Institute of Medicine, National Academy of Sciences
1991-	Research preceptor, Harvard General Medicine Faculty Development Fellowship Program
2000-	Co-Director, Harvard General Medicine Faculty Development Fellowship Program and site-director at Cambridge Health Alliance

Hospital and Health Care Organization Service Responsibilities:

1986-present	Attending Physician, Medical Service, The Cambridge Hospital
1986-1998	Attending Physician, Medical Consultation Service, The Cambridge Hospital, with occasional Attending responsibilities ongoing to present
1986-present	Out-patient Primary Care Physician, The Cambridge Hospital

Major Administrative Responsibilities:

1987-1999	Director of Inpatient Services, Department of Medicine, The Cambridge Hospital
1989-present	Quality Assurance Coordinator, Department of Medicine, The Cambridge Hospital
2001-present	Director for Academic Promotions and Faculty Development, Department of Medicine, Cambridge Health Alliance

Major Committee Assignments, Harvard Medical School:

2003-present	Joint Committee on the Status of Women, Member

Major Committee Assignments, Cambridge Hospital:

1988-1990	Morbidity and Mortality Monitoring Committee, The Cambridge Hospital
1989-1996	Patient Care Evaluation Committee, The Cambridge Hospital
1992-1993	Medical Executive Committee, The Cambridge Hospital
1994-present	Academic Promotions Committee, Department of Medicine, The Cambridge Hospital, Chair 2000-present

1996-2000	Adult Service Line Committee, The Cambridge Hospital Inpatient Leadership Committee, The Cambridge Hospital
2000-present	Cambridge Health Alliance Quality Assurance Committee

Professional Societies:

1982-present	American Public Health Association
1984-present	Society for General Internal Medicine
1986-present	Founder and Treasurer, Physicians for a National Health Program
1987-present	American College of Physicians, Fellow 1991
1992-present	Fellow, National Academy of Social Insurance
1997-2002	Founder and Board Member, Ad Hoc Committee to Defend Health Care

Community Service Related to Professional Work:

1986-present	I regularly address community groups such as the League of Women Voters, churches, synagogues, labor unions and senior citizens' organizations on issues related to health and public health policy. I also brief members of Congress, and Congressional and Presidential candidates (of any party) when invited to do so, and have spoken to several congressional conferences and committee meetings.

Editorial Boards:

1988-present	Editor, Physicians for a National Health Program Newsletter (circulation 13,000; approximately quarterly)
1986-present	Ad Hoc Reviewer, New England Journal of Medicine
1989-present	Ad Hoc Reviewer, JAMA
1990- present	Ad Hoc Reviewer. American Journal of Public Health
1999-present	Ad Hoc Reviewer, Annals of Internal Medicine
2004-present	Ad Hoc Reviewer, Health Affairs

Awards and Honors:

1974,1975	Phi Beta Kappa
1978,1979	Alpha Omega Alpha
1984,1985	Teacher of the Year Award, Boston University School of Public Health
1994	Barsky Award, Physicians Forum
1996	Humanist of the Year, Ethical Culture Society
2000	Quentin Young Award, Physicians for a National Health Program
2002	Benjamin Gill Award for Health Activism, Single Payer Research and Education Foundation
2004	Featured as an outstanding American female physician in exhibit by National Library of Medicine "The Changing Face of Medicine." –one of only six Harvard faculty members so honored
2007	Honorary fellow, University of Edinburgh, Edinburgh Scotland

Publications

Original Articles:

1. Himmelstein DU, Woolhandler S, Jones A. Hypernatremia in nursing home patients: An indicator of neglect. J Am Geriatrics Soc 1983; 31:466-471.

2. Woolhandler S, Himmelstein DU, Silber R, et al. Public money private control: a case study of hospital financing in Oakland and Berkeley, California. Am J Public Hlth 1983; 73:584-587.

3. Himmelstein DU, Woolhandler S. Free care, cholestyramine, and health policy. N Engl J Med 1984;311:1511-14.

4. Himmelstein DU, Woolhandler S, Adler RD. Elevated SGOT/SGPT ratio in alcoholics with acetaminophen hepatotoxicity. Am J Gastroenterology 1984; 79:718-720.

5. Himmelstein DU, Woolhandler S, Harnly M, et al. Patient transfers: medical practice as social triage. Am J Public Hlth 1984; 74:494-497.

6. Woolhandler S, Himmelstein DU, Silber R et al. Medical care and mortality: racial differences in preventable deaths. Int J Health Services 1985; 15:1-22.

7. Woolhandler S, Himmelstein DU. Militarism and mortality: an international analysis. The Lancet 1985; i: 1375-1378.

8. Himmelstein DU, Woolhandler S. Cost without benefit: administrative waste in U.S. health care. N Engl J Med 1986; 314:441-445.

9. Woolhandler S, Himmelstein DU, Labar B, Lang, S. Transplanted technology: first world science and third world options. N Engl J Med 1987; 317:504-6.

10. Woolhandler S, Himmelstein DU. Free care: A quantitative analysis of the costs and benefits of a national health program for the United States. Int J Health Services. 1988; 18:393-9.

11. Himmelstein DU, Woolhandler S, Bor D. Will cost-effectiveness analysis worsen the cost effectiveness of health care? Int J Health Services 1988; 18:1-9.

12. Woolhandler S, Himmelstein DU. Reverse targeting of preventive services due to lack of health insurance. JAMA 1988; 259:2872-2874.

13. Pels R, Bor DH, Woolhandler S, Himmelstein DU, Lawrence RS. Dipstick urinalysis screening of asymptomatic adults for urinary tract disorders. 2. Bacteriuria and pyuria. JAMA 1989; 262:1221-4.

14. Woolhandler S. Himmelstein DU. Ideology in medical science; class in the clinic. Soc Sci Med 1989; 28:1205-9.

15. Woolhandler S, Pels R, Bor DH, Himmelstein DU, Lawrence RS. Dipstick urinalysis screening of asymptomatic adults for urinary tract disorders. 1. Hematuria and proteinuria. JAMA 1989; 262:1215-9.

16. Himmelstein DU, Woolhandler S, et al. A national health program for the United States: A physicians' proposal. N Engl J Med 1989;320:102-108.

17. Himmelstein DU, Levins R, Woolhandler S. Beyond our means: patterns of variability of human physiologic traits. Int J Health Services 1990; 20:115-124.

18. Himmelstein DU, Woolhandler S. Who cares for the caregivers? Lack of health insurance among health care and insurance industry personnel. JAMA 1991; 266:399-401.

19. Harrington C, Cassell C, Estes CL, Woolhandler S, Himmelstein DU. A caring vision: a national long term care program for the United States. JAMA, 1991; 266:3023-3029.

20. Grumbach K, Bodenheimer T, Woolhandler S, Himmelstein DU. Liberal benefits, conservative spending: the Physicians for a National Health Program Proposal. JAMA 1991; 265:2549-2554.

21. Woolhandler S., Himmelstein DU. The deteriorating administrative efficiency of U.S. health care. N Engl J Med 1991; 324:1253-1258.

22. Himmelstein DU, Woolhandler S, Wolfe SM. The vanishing health care safety net: new data on uninsured Americans. Int J Health Services 1992; 22:381-96.

23. Woolhandler S, Himmelstein DU, Lewontin JP. Administrative costs in U.S. hospitals. N Engl J Med 1993; 329:400-3.

24. Willcox SM, Himmelstein DU, Woolhandler S. Inappropriate drug prescribing for America's elderly. JAMA 1994; 272:292-296.

25 Himmelstein, DU, Woolhandler A. Care denied: patients unable to get needed medical care. Am J Public Health 1995; 83:341-344.

26. Hellander I, Moloo J, Himmelstein DU, Woolhandler S, Wolfe S. The growing epidemic of un-insurance: new data on the health insurance coverage of Americans. Int J Health Services 1995; 25:377-92.

27. Boyd JW, Himmelstein DU, Woolhandler, S. The tobacco/health insurance connection. Lancet 1995; 346:64.

28. Himmelstein DU, Lewontin JP, Woolhandler S. Who administer? Who cares? Medical administrative and clinical employment in the United States and Canada. Am J Public Health 1996; 86:172-8.

29. Himmelstein DU, Lewontin JP, Woolhandler S. Medical care employment in the United States, 1968-1993: the importance of health sector jobs for African Americans and women. Am J Public Health 1996; 86:525-8.

30. Tyrance PH, Himmelstein DU, Woolhandler S. U.S. emergency department costs: no emergency. Am J Public Health 1996; 86:1527-31.

31. Woolhandler S, Himmelstein DU. Costs of care and administration at for-profit and other hospitals in the United States. N Engl J Med 1997; 336:769-74.

32. Carrasquillo O, Himmelstein DU, Woolhandler S, Bor DH. Can Medicaid managed care provide continuity of care to new Medicaid enrollees? An analysis of tenure on Medicaid. Am J Pub Health 1998; 88:464-6.

33. Carrasquillo O, Himmelstein DU, Woolhandler S, Bor DH. Going bare: trends in health insurance coverage, 1989 through 1996. Am J Pub Health 1999; 89:36-42.

34. Carrasquillo O, Himmelstein DU, Woolhandler S, Bor DH. A Reappraisal of private employers' role in providing health insurance. N Engl J Med 1999; 340:109-14.

35. Himmelstein DU, Woolhandler S, Hellander I, Wolfe SM. Quality of care in investor-owned vs not-for-profit HMOs. JAMA 1999; 282:159-63.

36. Lasser K, Boyd JW, Woolhandler S, Himmelstein DU, Mccormick D, Bor DH. Smoking and mental illness: a population-based prevalence study. JAMA 2000; 284:2606-2610.

37. Harrington C, Woolhandler S, Mullan J, Carrillo H, Himmelstein DU. Does investor ownership of nursing homes compromise the quality of care? Am J Public Health 2001; 91:1452-55.

38. Case BG. Himmelstein DU. Woolhandler S. No care for the caregivers: declining health insurance coverage for health care personnel and their children, 1988-1998. American Journal of Public Health. 2002; 92:404-8.

39. Lasser KE, Allen PD, Woolhandler SJ, Himmelstein DU, Wolfe SM, Bor DH. Timing of new black box warnings and withdrawals for prescription medications. JAMA 2002 287:2215-2220.

40. Woolhandler S, Himmelstein DU. Paying for national health insurance - and not getting it: taxes pay for a larger share of U.S. health care than most Americans think they do. Health Aff 2002; 21 (4):88-98.

41. Harrington C, Woolhandler S, Mullan J, Carrillo H, Himmelstein DU. Does investor ownership of nursing homes compromise the quality of care? Int J Health Services 2002; 32:315-25.

42. McCormick D, Himmelstein DU, Woolhandler S, Wolfe SM, Bor DH. Relationship between low quality-of-care scores and HMOs' subsequent public disclosure of quality of care scores. JAMA 2002; 288:1484-90.

43. Lasser KE, Himmelstein DU, Woolhandler S, McCormick D, Bor DH. Do minorities in the United States receive fewer mental health services than whites? Int J Health Services 2002; 32:567-78.

44. Himmelstein DU, Woolhandler S. Taking care of business: HMOs that spend more on administration deliver lower-quality care. Int J Health Services 2002; 32:657-67.

45. Woolhandler S, Campbell T, Himmelstein DU. Health care administration costs in the U.S. and Canada. New England Journal of Medicine 2003; 349: 768-775

46. McCormick D, Himmelstein DU, Woolhandler S, Bor DH. Single-Payer national health insurance: Physicians' views. Arch Internal Medicine 2004; 164:300-304.

47. Himmelstein DU, Woolhandler S, Wolfe SM. Administrative Waste in the U.S. Health Care System in 2003: The Cost to the Nation, The States and the District of Columbia, with State-Specific Estimates of Potential Savings. Int J Public Health 2004;34:79-86

48. Mohanty SA, Woolhandler S, Himmelstein DU, Pati S, Canasquillo O, Bor DH. Health Care Expenditures of Immigrants in the United States: A Nationally Representative Sample. Am J Public Health 2005; 95(6).

49. Himmelstein, DU, Warren E, Thorne D, Woolhandler S. Illness and Medical Bills as Contributors to Personal Bankruptcy. Health Aff 2005; Web Exclusive: February 2, 2005.

50. Woohandler S, Himmelstein DU, Distajo R, Lasser KE, McCormick D, Bor DH, Wolfe SM. American's Neglected Veterans: 1.7 Million Who Served Have No Health Coverage. Int J Health Services 2005. 35:313-323

51. Mohanty SA, Woolhandler S, Himmelstein DU, Bor DH. Diabetes and Cardiovascular Disease Among Asian Indians in the United States. Journal of General Internal Medicine, 2005. 20:474

52. King WD, Woolhandler SJ, Brown AF et al. Influenza Vaccination and Health Care Workers in the United States. J Gen Intern Med 2006. 21:181

53. Lasser KE, Himmelstein DU, Woolhandler S, Access to Care, Health Status, and Health Disparities in the United States and Canada; Results of a Cross-National Population Based Survey. Am J Public Health 2006. 96:1300-7.

54. Ira L. Mintzer, MD[1], Mark Eisenberg, MD[2], Maria Terra, BA[1], Casey MacVane, MD, MPH[2], David U. Himmelstein, MD[1] and Steffie Woolhandler, MD[1] Treating Opioid Addiction With Buprenorphine-Naloxone in Community-Based Primary Care Settings. Annals of Family Medicine 2007: 5:146-150

55. Woolhandler S, Lasser KE, McCormick D, Bor DH, Boyd JW, Himmelstein DU. Lack of Health Coverage Among U.S. Veterans, 1987-2004. Am J Public Health 2007, In press.

Reviews, Chapters, and Editorials:

1. Lang S, Woolhandler S, Himmelstein DU. The development of the Yugoslav health care system. World Health Organization Forum 1982; 3:407-408.

2. Woolhandler S. Toxic injury to male reproduction. Occupational Health and Safety, February 1983:24-28.

3. Himmelstein DU, Woolhandler S. Medicine as industry: the health sector in the U.S. Monthly Review 1984; 35,11:13-25.

5. Woolhandler S, Himmelstein DU. Terms of endowment: prospective hospital reimbursement in Massachusetts. Health/PAC Bulletin 1984; 15,2:13-16.

6. Lang S, Woolhandler S, Bantic S, Himmelstein DU. Medical ethics in Yugoslavia. Hastings Center Reports 1984; 14 (6): 26-27.

7. Himmelstein DU, Woolhandler S. Pitfalls of private medicine: healthcare in the U.S. The Lancet 1984; ii: 391-394.

8. Himmelstein DU, Woolhandler S. Free Care, Cholestyramine, and Health Policy, in Aiken LH and Kehrer BH (eds). Evaluation Studies Review Annual, Vol. 10. Beverly Hills: Sage, 1985.

9. Woolhandler S, Himmelstein DU. Physicians for a National Health Program. Int J Health Services 1987; 17:703-6.

10. Woolhandler S, Himmelstein DU: Aiming so low we hit our own feet: The limits of incrementalism. Health/PAC Bulletin; 1988; 18(2):20-1.

11. Himmelstein DU, Woolhandler S. The corporate compromise: a marxist view of health maintenance organizations and prospective payment. Annals of Intern Med 1988; 109:494-500.

12. Woolhandler S, Himmelstein DU. A National health program: Northern light at the end of the tunnel. JAMA 1989; 262-2136-7.

13. Woolhandler S, Himmelstein DR, Silber R, et., Medical Care and Mortality: Racial Differences in Preventable Deaths, in Brown P (ed). Perspectives in Medical Sociology. Belmont, CA: Wadsworth, 1989.

14. Himmelstein DU, Woolhandler S. Things to come: 15 leaders project the future of medicine and health. The New Physician. 1990; 39(2):32-3.
15. Woolhandler S, Himmelstein DU - Editorial - MD Computing. 1990; 7:276-7.

16. Woolhandler S, Pels RJ, Bor DH, Himmelstein DU, Lawrence RS: Hematuria and proteinuria, In Goldbloom RB, Lawrence RS (eds). Preventing Disease: Beyond the Rhetoric. New York: Springer-Verlag, 1990.

17. Pels RJ, Bor DH, Woolhandler S, Himmelstein DU, Lawrence RS: Bacteriuria, In Goldbloom RB, Lawrence RS (eds). Preventing Disease: Beyond the Rhetoric. New York: Springer-Verlag, 1990.

18. Woolhandler S, Himmelstein DU: Resolving the cost/access conflict: The case for a national health program. J Gen Intern Med 1989;4:54-60. Reprinted in the Journal of the National Medical Association 1991; 83:1049-1056.

19. Himmelstein DU, Wolfe SM, Woolhandler S. Commentary: invitation to hospitals: join the push for a single-payer, waste-avoiding health system. Modern Healthcare May 13, 1991:22.

20. Himmelstein DU, Woolhandler S. Who lives? Who dies? Ethical Criteria in Patient Selection. Book review. The Lancet 1991; i:1400.

21. Woolhandler S. The case for a National Health Program, in Hamner JE (ed) Universal Health Care Coverage in the U.S. Memphis, TN: Univ. of Tennessee, 1991.

22. Woolhandler S, Himmelstein DU. Free Care: A Quantitative Analysis of Health and Cost Effects of a National Health Program for the United States, in Navarro V (ed). Why the United States Does Not Have a National Health Program. Amityville, NY: Baywood, 1992.

23. Navarro V, Himmelstein DU, Woolhandler S. The Jackson National Health Program, in Navarro V (ed). Why the United States Does Not Have a National Health Program. Amityville, NY: Baywood, 1992.

24. Himmelstein DU, Woolhandler S. Socialized Medicine: A Solution to the Cost Crisis in Health Care in the United States, in Navarro V (ed). Why the United States Does Not Have a National Health Program. Amityville, NY: Baywood, 1992.

25. Himmelstein DU, Wolfe SM, Woolhandler S. Mangled Competition. The American Prospect 1993; 13:116-121.

26. Clancy CM, Himmelstein DU, Woolhandler S. Questions and answers about managed competition. Int J Health Services. 1993; 23:213-218, reprinted in J Mass Dental Soc 1993; 42:81-4.

27. Woolhandler S, Himmelstein DU, Young Q. High noon for U.S. health care reform. Int J Health Services. 1993; 23:193-211.

28. Woolhandler S, Himmelstein DU. Clinton's health plan: Prudential's choice. Int J Health Services 1994; 24:583-92.

29. Himmelstein DU, Woolhandler S. Do Chefs Run McDonald's? Nation 1994; 259:265-68.

30. Woolhandler S, Himmelstein DU. Resolving the Cost-Access Conflict: The case for a National Health Program, in Lemco J. (ed) National Health Care: Lessons for the United States and Canada. Ann Arbor: University of Michigan Press, 1994.

31. Grumbach K, Bodenheimer T, Woolhandler S, Himmelstein DU. Liberal Benefits, Conservative Spending: The Physicians for a National Health Program Proposal, in McKenzie NF. (ed) Beyond Crisis: Confronting Health Care in the United States. New York: Meridian, 1994.

32. Woolhandler S, Himmelstein DU. Understanding Health Care Reform and Medicine's Dilemmas: Infinite Needs Versus Finite Resources. Book Review. N Engl J Med 1994; 331:1779.

33. Woolhandler S, Himmelstein DU. Extreme risk: the new corporate proposition for physicians [editorial]. N Engl J Med 1995: 333:1706-8.

34. Woolhandler S, Himmelstein DU. Patients on the auction block [editorial]. Am J Public Health 1996; 86:1699-1700..

35. Woolhandler S. Women's Health: The Commonwealth Fund Survey. Book Review. JAMA 1997; 277:599.

36. Woolhandler S. Managed care and women's health [editorial]. J Am Med Women's Assoc 1997;52(2):50.

37. Woolhandler S, Himmelstein DU. For patients, not profits. The Nation December 22, 1997:6-7.

38. Himmelstein DU, Woolhandler S. Bound to gag [editorial]. Arch Intern Med 1997; 157:2033.

39. Ad Hoc Committee to Defend Health Care (Co-chair, Writing Committee) - A call to action. JAMA 1997; 278:1733-8.

40. Himmelstein DU, Woolhandler S. Care denied: U.S. residents who are unable to obtain needed medical services, in Harrington C, Estes CL (eds). Health Policy and Nursing. Boston: Jones and Bartlett, 1997.

41. Hellander I, Himmelstein DU, Woolhandler S, Wolfe S. Health care paperchase, 1993: the cost to the nation, the states, and the District of Columbia, in Harrington C, Estes CL (eds). Health Policy and Nursing. Boston: Jones and Bartlett, 1997.

42. Woolhandler S, Himmelstein DU. Extreme risk - the new corporate proposition for physicians, in Harrington C, Estes CL (eds). Health Policy and Nursing. Boston: Jones and Bartlett, 1997.

43. Himmelstein DU, Woolhandler S, et al. A national health program for the United States: A physicians' proposal, in Harrington C, Estes CL (eds). Health Policy and Nursing. Boston: Jones and Bartlett, 1997.

44. Harrington C, Cassell C, Estes CL, Woolhandler S, Himmelstein DU. A national long term care program for the United States: a caring vision, in Harrington C, Estes CL (eds). Health Policy and Nursing. Boston: Jones and Bartlett, 1997.

45. Himmelstein DU, Woolhandler S, Wolfe SM. The vanishing health care safety net: new data on uninsured Americans, in Chernomas R, Sepehari A (eds). How to Choose? A Comparison of the U.S. and Canadian Health Care Systems. Amityville, NY: Baywood, 1998.

46. Himmelstein DU, Woolhandler S. Canada's national health program, in Chernomas R, Sepehari A (eds). How to Choose? A Comparison of the U.S. and Canadian Health Care Systems. Amityville, NY: Baywood, 1998.

47. Himmelstein DU, Woolhandler S. Public opinion on health care reform, in Chernomas R, Sepehari A (eds). How to Choose? A Comparison of the U.S. and Canadian Health Care Systems. Amityville, NY: Baywood, 1998.

48. Himmelstein DU, Woolhandler S. The silence of the doctors: fifty years after Nuremberg [editorial]. J Gen Intern Med 1998; 13:422-3.

49. Himmelstein Du, Woolhandler S. NHS at 50: an American view (Invited editorial). The Lancet 1998; 352:54-5.

50. Himmelstein DU, Woolhandler S. Race and infant mortality, in Charmaz K, Paterniti DA (eds). Health, Illness, and Healing. Los Angeles: Roxbury, 1999.

51. Himmelstein DU, Woolhandler S. Respect, satisfaction, and health care: Canada and the U.S., in Charmaz K, Paterniti DA (eds). Health, Illness, and Healing. Los Angeles: Roxbury, 1999.

52. Himmelstein DU, Woolhandler S. The Canadian system, in Charmaz K, Paterniti DA (eds). Health, Illness, and Healing. Los Angeles: Roxbury, 1999.

53. Himmelstein DU, Woolhandler S. The rising costs of health care, in Charmaz K, Paterniti DA (eds). Health, Illness, and Healing. Los Angeles: Roxbury, 1999.

54. Woolhandler S, Himmelstein DU. When money is the mission: the high costs of investor-owned care (Invited editorial). N Engl J Med 1999; 341:444-6.

55. Carrasquillo O, Woolhandler S, Himmelstein DU, Bor DH. Going Bare: Trends in health insurance coverage, 1989 through 1996, in Harrington C, Estes C (eds) Health Policy: Crisis and Reform in the U.S. Health Care Delivery System. Boston MA: Jones and Bartlett, 2000.

56. Woolhandler S, Himmelstein DU. When money is the mission: the high costs of investor-owned care. in Harrington C, Estes C (eds) Health Policy: Crisis and Reform in the U.S. Health Care Delivery System. Boston MA: Jones and Bartlett, 2000.

57. Himmelstein DU, Lewontin JP, Woolhandler S. Medical care employment in the United States, 1968-1993. in Harrington C, Estes C (eds) Health Policy: Crisis and Reform in the U.S. Health Care Delivery System. Boston MA: Jones and Bartlett, 2000.

58. Himmelstein DU, Woolhandler S, Hellander I, Wolfe SM. Quality of care in investor-owned vs not-for-profit HMOs. in Harrington C, Estes C (eds) Health Policy: Crisis and Reform in the U.S. Health Care Delivery System. Boston MA: Jones and Bartlett, 2000.

59. Himmelstein DU, Woolhandler S, et al. A national health program for the United States: A physicians' proposal. in Harrington C, Estes C (eds) Health Policy: Crisis and Reform in the U.S. Health Care Delivery System. Boston MA: Jones and Bartlett, 2000.

60. Woolhandler S, Himmelstein D. Lost in translation. in Daniels N, Kennedy B, Kawachi I (eds) Is Inequality Bad for Your Health? Boston MA: Beacon, 2000.

61. Woolhandler S, Himmelstein D. New Democracy Forum: Lost in translation. Boston Review 2000; 25(1):17-18.

62. Woolhandler S, Himmelstein DU. National health insurance: liberal benefits, conservative spending. Arch Int Med 2002; 973-975.

63. Woolhandler S, Himmelstein DU, Angell M, Young QD. Proposal of the Physicians' Working Group for Single-Payer National Health Insurance. JAMA 2003;290:798-805.

64. Himmelstein DU, Woolhandler S. National Health Insurance or Incremental Reform? Aim High, or at Our Feet? Am J Public Health 2003; 93:102-5.

65. Woolhandler S. The sad experience of corporate health care in the U.S.A. in Sen K (ed) Restructuring Health Services. London: European Commission/Zed Books, 2003.

66. Woolhandler S., Himmelstein DU. National Health Insurance Falling Expectations and the Safety Net. Medical Care 2004; 42:403-5

67. Woolhandler S, Himmelstein DU, The High Costs of for-profit care. Canadian Medical Association Journal, 2004;170:18145

68. Himmelstein DU, Woolhandler S. Market Driven Medicine: Inflated Prices, Inferior Care. Health Matters (UK) 2004;57:12-13.

69. Himmelstein DU, Woolhandler S. Utilization Management: A Bad Review. Am J Med, 2004; 117:629-35.

70. Woolhandler S. American Pie. Harvard Medical Alumni Bulletin. Summer, 2004:28-31.

71. Himmelstein DU, Woolhandler S. Mayhem in the Medical Market Place. Monthly Review, 2005.

72. Woolhandler S, Himmelstein DU. Uninsured in America (Book Review) JAMA 2005: 293;2539-9

73. Himmelstein DU, Woolhandler S. Hope and Hype: Predicting the Impact of Electronic Medical Records: Health Affairs. 2005. 24:1121-1123

74. Himmelstein DU, Warren E, Thorne D, Woolhandler S, Discounting the Debtors will not make Medical Bankruptcy Disappear. Health Affairs 2006: 20:w74-83

75 Woolhandler S, Himmelstein DU. One Step Forward, Two Steps Back: The Massachusetts Health Reform Bill Hastings Center Reports September-October 2006 (3):19-21.

76 Woolhandler S, Himmelstein DU. Consumer Directed Health Care, Except for the Healthy and Wealthy, It's Unwise. Journal of General Internal Medicine, July 2007. Released on the web March 30, 200

Books and Monographs:

1. Himmelstein DU, Woolhandler S (eds). Science, technology, and capitalism. Monthly Review 1986; 38 (3):1-128.

2. Himmelstein DU, Woolhandler S. The National Health Program Chartbook. Cambridge, MA: Center for National Health Program Studies, 1992.

3. Himmelstein DU, Woolhandler S. The National Health Program Book. Monroe ME: Common Courage Press, 1993.

4. Canham-Clyne J, Woolhandler S, Himmelstein DU. The Rational Option for a National Health Program. Stony Creek CT: Pamphleteer's Press, 1995.

5. Woolhandler S, Himmelstein DU. For Our Patients, Not for Profits: A Call to Action - Chartbook. Cambridge, MA: Center for National Health Program Studies, 1998.

6. Himmelstein DU, Woolhandler S, Hellander I (eds). The National Health Program Reader. Cambridge, MA: Center for National Health Program Studies, 1998.

7. Himmelstein DU, Woolhandler S (with Hellander I). Bleeding the Patient. Monroe ME: Common Courage Press, 2000.