Uninsured Veterans: A Stain on America’s Flag

Steffie Woolhandler, M.D., M.P.H.

Associate Professor of Medicine, Harvard Medical School
Co-Founder, Physicians for a National Health Program

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Dr. Woolhandler has not received any Federal government grants or contracts relevant to the subject matter of this testimony.
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 than 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 uninsured 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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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.
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

<table>
<thead>
<tr>
<th>Era of military service</th>
<th>Number of living veterans, total</th>
<th>Number lacking health coverage</th>
<th>Percent lacking health coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other (includes Gulf War)</td>
<td>8.60 million</td>
<td>1,105,891</td>
<td>12.9</td>
</tr>
<tr>
<td>Vietnam</td>
<td>7.56 million</td>
<td>645,628</td>
<td>8.5%</td>
</tr>
</tbody>
</table>


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

<table>
<thead>
<tr>
<th></th>
<th>Family members of veterans</th>
<th>Veterans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private coverage</td>
<td>73.2%</td>
<td>70.6%</td>
</tr>
<tr>
<td>Medicaid coverage</td>
<td>6.4%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Medicare coverage</td>
<td>19.1%</td>
<td>37.1%</td>
</tr>
<tr>
<td>Champus/Tricare/ChampusVA</td>
<td>5.5%</td>
<td>7.2%</td>
</tr>
<tr>
<td>Military /veterans’ medical care only</td>
<td>0.8%</td>
<td>6.3%</td>
</tr>
<tr>
<td><strong>Uninsured and no military/VHA Care</strong></td>
<td><strong>9.4%</strong></td>
<td><strong>7.4%</strong></td>
</tr>
</tbody>
</table>


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.

<table>
<thead>
<tr>
<th></th>
<th>Insured veterans</th>
<th>Uninsured veterans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>5.4%</td>
<td>7.4%</td>
</tr>
<tr>
<td>Age &lt;18</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>18-44</td>
<td>16.3%</td>
<td>44.5%</td>
</tr>
<tr>
<td>45-64</td>
<td>40.7%</td>
<td>55.2%</td>
</tr>
<tr>
<td>&gt; 64</td>
<td>43.0%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Income &lt;150% of poverty</td>
<td>11.4%</td>
<td>29.9%</td>
</tr>
<tr>
<td>Income &lt;250% of poverty</td>
<td>28.9%</td>
<td>53.3%</td>
</tr>
<tr>
<td>Currently employed</td>
<td>48.8%</td>
<td>64.3%</td>
</tr>
<tr>
<td>Currently unemployed or laid off</td>
<td>1.9%</td>
<td>8.7%</td>
</tr>
</tbody>
</table>

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.

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

<table>
<thead>
<tr>
<th>Fair or poor health (%)</th>
<th>Insured veterans (%)</th>
<th>Uninsured veterans (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 0-17</td>
<td>N/A.</td>
<td>N/A.</td>
</tr>
<tr>
<td>18-24</td>
<td>5.6</td>
<td>3.7*</td>
</tr>
<tr>
<td>25-44</td>
<td>7.7</td>
<td>7.9</td>
</tr>
<tr>
<td>45-64</td>
<td>18.8</td>
<td>19.1</td>
</tr>
<tr>
<td>&gt;64</td>
<td>30.3</td>
<td>NA</td>
</tr>
</tbody>
</table>

*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

<table>
<thead>
<tr>
<th>Problem</th>
<th>Insured veterans</th>
<th>Uninsured veterans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delayed care due to cost</td>
<td>6.6%</td>
<td>31.2%</td>
</tr>
<tr>
<td>Didn’t get needed care due to cost</td>
<td>4.3%</td>
<td>26.5%</td>
</tr>
<tr>
<td>Couldn’t afford medications</td>
<td>5.5%</td>
<td>25.1%</td>
</tr>
<tr>
<td>Couldn’t afford glasses</td>
<td>5.3%</td>
<td>20.8%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Insured veterans</th>
<th>Uninsured veterans</th>
</tr>
</thead>
<tbody>
<tr>
<td>No office visits, past year</td>
<td>15.5%</td>
<td>49.1%</td>
</tr>
<tr>
<td>Did not get preventive care anywhere</td>
<td>51.8%</td>
<td>66.4%</td>
</tr>
<tr>
<td>No contact with health professional in past year</td>
<td>14.9%</td>
<td>44.9%</td>
</tr>
<tr>
<td>No usual place to go when sick</td>
<td>8.9%</td>
<td>51.4%</td>
</tr>
</tbody>
</table>

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

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

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 disabiling

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
PART I: General Information

Date Prepared: April 25, 2007
Name: Stephanie J. (Steffie) Woolhandler, M.D., M.P.H., F.A.C.P.
Office Address: Department of Medicine, 1493 Cambridge St., Cambridge MA 02139
FAX: 617-665-1671
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:


54. Ira L. Mintzer, MD 1, Mark Eisenberg, MD2, Maria Terra, BA1, Casey MacVane, MD, MPH1, David U. Himmelstein, MD1 and Steffie Woolhandler, MD1 Treating Opioid Addiction With Buprenorphine-Naloxone in Community-Based Primary Care Settings. Annals of Family Medicine 2007: 5:146-150

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

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


Books and Monographs:


