FALL 2016

Missourians for Single Payer Health Care

438 N. Skinker Blvd., St. Louis, MO 63130 ~ Ph: 314.862.5735 ~ www.mosp.us

President's message: Medicare is dead...

Medicare is dead unless we stop its demise. We let our politicians destroy Medicare a piece at a time. Politicians from both major parties have privatized Medicare, from Part C to Part D to the ACA. Politicians have robbed our Medicare trust fund for health care, squandering our tax money on experimental for-profit programs in which wealthy corporations benefit. What motivates our politicians to destroy Medicare?

Better health for Americans was the motivation for Medicare, passed in 1965. **Traditional U.S. Medicare is a single payer social insurance program that works.** In return for the contributions we make through payroll taxes during our working years, we receive earned, guaranteed health benefits. Medicare, a model of fairness and equality, is one of two universally cherished social safety nets.

Everyone needs health care. Health care alleviates pain and suffering, cures illness, and saves lives in critical situations. Without health care, we suffer more and die sooner. Because we will pay whatever we can for our survival and that of our children, corporations raise prices to increase their profits. When health care is a mere commodity, health will be an exclusive privilege of affluent Americans.

This is our nation's path, through privatization of public hospitals and clinics, privatization of the Veterans Administration, and privatization of Medicare, our single payer program. Destroy Medicare, and you destroy single payer.

We can stop the killing of our Medicare, but we must now demand, as individuals and groups, that our elected politicians protect and preserve traditional Medicare. In a representational democracy such as ours, the will of the people and the benefit of our society can prevail, but only if we demand it.

—Mimi Signor, RN

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www.mosp.us

We do not need magic to change the world, we carry all the power we need inside ourselves already: we have the power to imagine better.

—J.K Rowling

U.S. Health Care System and Big Pharma

MaryJane Schutzius

First came great increases in HIV/AIDS medication prices, followed by a large increase in medication for life-threatening allergic-reactions. The same pharmaceutical company then announced that a generic form would soon be available at half the increased price. Research into prices charged by drug companies confirmed that cost is not based on research and development or scarcity of ingredients, but by "what the market will bear."

In an op-ed in the Sept. 23 Post-Dispatch, Pamela Hosler, R.N. wrote that until 1981, "research and medicines that were developed with public funds were either put into the public domain or were owned by the federal agency that had supported the research." This was changed by the Bayh-Dole Act, which included two provisions for corporations to purchase patent rights: the federal agency that funded the research may issue a license to a generic manufacturer if the patent holder is not making the federally-supported drug available to the public on reasonable terms; and a royalty-free license to the US government to manufacture the patented invention or license someone else to do so, without paying any royalty fee, as long as the product is for government use, for example, the VA, Medicare, Medicaid.

"Not once, in the past 35 years, has the National Institutes of Health or the Department of Health and Human Services approved requests for generic medicine manufacture of medications. Taxpayers funded medicine research for treatment of HIV/AIDS, leukemia, glaucoma, Fabry's disease and cancer; each time the agency director turned down the request." The NIH director was quoted in one case as saying approving manufacture of a generic drug "would harm the agency's relationship with the drug companies."

Some system.

The current CEO of the drug company producing EpiPen, the medication for allergic reactions, Heather Bresch, is the daughter of Sen. Joe Machin III (D-W.VA.) and was a lobbyist for the pharmaceutical company, Mylan, before becoming CEO. She lobbied to pass the 2003 Medicare prescription drug bill, while her father was Secretary of State in W. Virginia. (Machin was governor of the state before winning the special election in 2010 to fill the seat of Sen. Robert Byrd, who died in office.)

Joe Machin III got his daughter a job at Mylan in 1992. She stayed with the company, got an MBA from WVU without completing course work (which caused the university president to lose his job), was appointed President of Mylan in 2009 and joined the Board of Directors in March 2011. She took the position of CEO in January 2012. Her lobbying achieved several more laws promoting EpiPen. In Feb. 2015 Mylan's headquarters were moved to the Netherlands, where business taxes are lower. From 2007 to 2015, Bresch's compensation rose from $2,453,456 to $18,931,068, a 671% increase, far more than the increase in the cost of EpiPen.

Some system.

—-Mary Jane Schutzius

Your Gift of MoSP

Consider Missourians for Single Payer, a non-profit, non-partisan advocacy organization, when you make your tax-deductible end of the year donations to charities. A $20 membership can be a meaningful gift for those on your hard-to-buy-for gift list.

"Rats and roaches live by the laws of supply and demand. It is the privilege of human beings to live under the laws of justice and mercy."

—Wendell Berry

"The world is changed by your example, not by your opinion."

Advocate Dr. Fred Rottnek: Looking back and moving forward (excerpts)

Fred Rottnek, MD

Friday, September 30, 2016, is the end of my 15 year and 4-month sentence as a provider in Corrections Medicine.

I will, however, remain active with my student task forces and electives at Juvenile Detention. And I imagine we'll have projects to work on in the future—particularly regarding reentry planning for our patients. I look forward to continue working in Correctional Health Care in the region as well as nationally.

I started working with Saint Louis County in June of 2000. I came to Corrections Medicine in June of 2001. This work has allowed me to combine my professional training, my educational interests, and my personal values. I have grown as a physician and as a human being in working with colleagues and in working with patients who never aspired to be in jail. My views of human nature and criminal justice have been challenged; they have evolved. I am a better human being today due to my time behind bars.

My future holds three new projects as I remain Director of Community Medicine in the Department of Family and Community Medicine at Saint Louis University.

1. Working with Concordance Academy of Leadership to build out the health services portion of their reentry model;
2. Working with Saint Louis Effort for AIDS to create a primary care clinic (plus HIV, HCV, Medication-Assisted Therapy services for Substance Use Disorders);
3. Investigating the possibility of building an Addiction Medicine Fellowship at SLU.

And, of course, I'll still be teaching in the Interprofessional Education Program and working with students in longitudinal service, and sundry other projects in Medicine as well as in Mission and Identity at Saint Louis University and in the community. I will also continue to serve on the corporate board of Criminal Justice Ministry and contribute to the growing programs at SLU to educate and support people whose lives are entwined with the criminal justice system.

I look forward to working with you in the future.

Fred Rottnek, MD, MAHCM

Solution for our Mental Health Crisis

The state of mental health treatment in the U.S. is deplorable! The United States has the highest mortality rate for mental health and substance abuse disorders of any industrialized nation. 18% of all American have a mental, behavioral or emotional disorder and 30% with serious mental illness are not receiving any treatment.

In a new briefing paper, the National Union of Healthcare Workers (NUHW) discusses **how a Medicare for All single payer healthcare system could ease the mental health crisis.** NUHW members are in the front lines of this crisis. It represents over 3,000 mental health clinicians who fight every day to provide adequate treatment for their patients. Profit-driven healthcare undermines their efforts to care for some of the most vulnerable and fragile patients in the U.S.

healthcare system.

Our system of private insurance systematically denies patients access to the care they need. NUHW supports a Medicare for All healthcare system because it will ensure that care will be based on the judgement of the clinician rather than the profit motive of the insurance company. Single payer would allow for comprehensive treatment, planning and data gathering, eliminate waste and sustain a high quality workforce.

We all have a stake in a society where everyone in crisis has full access to mental and substance abuse treatment. Download the NUHW briefing paper here. Share it with your union members and neighbors and then ask them to take the pledge to join the fight for healthcare for all.

—-Mark Dudzic, National Coordinator, for the National Advisory Board and Steering Committee, The Labor Campaign for Single-Payer, www.LaborForSinglePayer.org

System Fails Mentally Ill

Conclusions by Dr. Henry Nasrallah, editor in chief of ***Current Psychiatry***

Consequences of mental illness, especially untreated mental illness, can be deadly in the U.S. The U.S. Centers for Disease Control and Prevention report that between 1999 and 2014, the suicide rate in the United States increased by 24 percent. In 2014, there were 42,773 suicides in the U.S. Suicide is the second most common cause of death for those ages 15-24. Suicides are increasing for girls between the ages of 10 and 14. The rate of suicides among veterans continues to climb.

Leading reasons for these appalling increases:

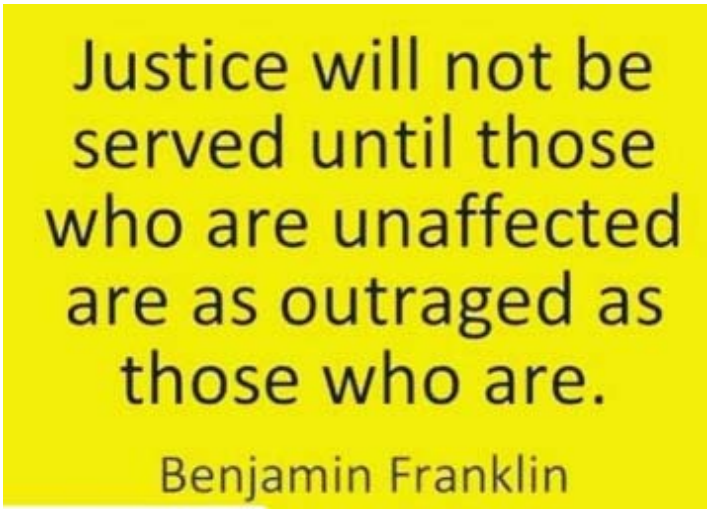
1. There is a lack of compassion for the mentally ill. People with severe mental illness, such as schizophrenia or bipolar disorder, do not receive the compassion or empathy as those suffering for other neurological disorders such as epilepsy, Parkinson's disease or multiple sclerosis.

2. There remains a lack of accessible and affordable mental health treatment. With private and ACA plans, people cannot afford high deductibles, as high as $10,000 annually. Private, high-deductible and ACA plans cost $600 to $1,200 a month in premiums.

3. There is a shortage of publicly funded mental health programs.

4. We are transforming the mentally ill into felons. It is hard to get into a psychiatric hospital, but not hard to get into jail or prison for acts committed when psychotic. Admission to psychiatric hospitals requires that one be found dangerous to self or others or gravely disabled. Many who are psychotic are sent away from ER's.

5. Untreated psychosis and depression have deleterious effects on the brain. The longer that treatment is delayed, the more serious are the ramifications for the patient and for society.



"People don't care how much you know until they know how much you care."

Philanthropies' Impact on Social Equity

During this season of giving, consider the larger social concerns that require charity and philanthropy to help address inequalities that arise, in part, from a free-market system.

Our current tax system — presumably an instrument to ameliorate inequality, but which, in fact, probably contributes to it. While the federal income tax is progressive in principle, in practice the dizzying provisions of the tax code make it less transparent, less efficient and probably regressive.

Most other taxes — from Social Security and payroll taxes to sales taxes — are regressive and thus undergird greater income inequality. Major tax reform could do more than all our philanthropies combined to address this problem. Such reform would include a simplification of the tax code, a broadening of the tax base through the elimination of many if not all tax deductions (which in sum favor the rich), and a decrease in the favored treatment of income from capital as opposed to wages.

Addressing the tax code can make philanthropic leaders uncomfortable because their entire business model rests largely on the tax-deductibility of charitable donations. But this business model encourages a few to amass great wealth and then give it away, with the unspoken presumption that the rich and highly educated understand how to address poverty and other public concerns better than elected government.

Without tackling this fundamental cause of income and wealth disparities, philanthropies can include as many voices of those affected by the injustice as they want, but the impact on social equity will be minimal.

—-Alec Ian Gershberg, New York

Essay from a letter to the editor published in the New York Times, December 2015. The writer is chairman of the Urban Policy Analysis and Management Program at the Milano School of International Affairs, Management and Urban Policy at the New School.

Uninsured rate drops, but out of pocket medical expenses still drag millions into poverty: The Supplemental Poverty Measure, 2015

The Supplemental Poverty Measure (SPM) released by the U.S. Census Bureau, with support from the Bureau of Labor Statistics (BLS): The SPM extends the official poverty measure by taking account of the government programs designed to assist low-income families and individuals that are not included in the current official poverty measure.

In 2015, 45.7 million people were poor using the SPM definition of poverty, more than the 43.5 million using the official definition of poverty.

The SPM and the Effect of Cash and Noncash Transfers, Taxes, and Other Nondiscretionary Expenses: (Excerpt): Without subtracting MOOP (Medical Out-of-Pocket) expenses from income, the SPM rate would have been 3.5 percentage points lower. In numbers, 11.2 million fewer people would have been classified as poor.
https://www.census.gov/content/dam/Census/library/publications/2016/demo/p60-258.pdf

by Trudi Renwick and Liana Fox, United Census Bureau, September 2016

Healthcare-NOW Single Payer National Strategy Conference in NY

Time is running out to register for the Single Payer National Strategy Conference, January 13-15, 2017 in New York City. There couldn't be a more urgent time for healthcare justice advocates to come together and begin to craft a common strategy. Registration is open until December 31 but there are a limited number of hotel rooms available. So don't wait. Register today.

Here are 10 good reasons why you should come to New York City this January 13-15:

1. The onslaught continues and will only get worse. The attacks on workers' hard won healthcare benefits continue unabated. Union health plans are in crisis.

2. The Affordable Care Act will be repealed. We need to plan ways to re-invigorate state and national single-payer campaigns to provide an alternative to a failing healthcare system.

3. They want to kill Medicare. We have a plan to expand it to everyone. Tom Price, the nominee for Secretary of Health and Human Services, has vowed to gut Medicare by turning it into a voucher program.

4. Medicaid is under the gun. How can we defend it while paving the way for single payer? The proposed director of Medicare and Medicaid services, Seema Verma, has a track record of helping states design Medicaid programs that restrict poor people's access to healthcare. We will discuss ways to make this fight a central part of the struggle to make healthcare a right for everyone in America.

5. States can lead the way forward. In New York, California and beyond, strong grassroots movements continue to build momentum to establish state-based single-payer style health plans. Victory in one or more key states will help rebuild the national Medicare for All movement. We will learn some important lessons from campaigns in Colorado, Vermont and elsewhere and apply them to our ongoing organizing.

6. Healthcare Justice and Racial Justice go hand in hand. We will discuss how healthcare disparities drive inequality and the need to build a powerful coalition to fight for healthcare justice.

7. Women and the LGBTQ Community are about to lose important access to health services. Inequities are built into our current, for-profit system. A Medicare for All system could begin to fix these problems.

8. Defending immigrants includes defending their right to healthcare. Our vision of an "everybody in" health system requires their inclusion.

9. Healthcare for All includes the right to clean water and a healthy environment. From Flint, Michigan to the Standing Rock Sioux Reservation, people are waging desperate fights against powerful corporate interests for the right to live in a community that promotes good health. We will hear about these struggles and what we can do to build a united movement for healthcare justice.

10. Medicare for All needs to be part of the plan to save the labor movement. Labor faces an administration that will extinguish public employee bargaining rights and institute a national right to workregime. Labor must learn how taking healthcare off the bargaining table by making it a right for everyone in America can be a powerful tool in rebuilding a labor movement that speaks on behalf of the entire working class.

This national strategy conference can launch a powerful resistance movement that will use healthcare for all as a unifying theme to bring together all of those struggling for justice and equality. **Be part of the resistance.** Register today!

—-Mark Dudzic, National Coordinator

Healthcare-NOW! is a grassroots organization that fights to end the health insurance crisis by educating and advocating for improved Medicare-for-all legislation, such as HR676.

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(specific programming and expenses)

_____ I'm unable to pay dues at this time, but I will support and promote MoSP among relatives, friends, colleagues, acquaintances, however I can. Please continue to send me the newsletter. Please call on me for volunteer help.