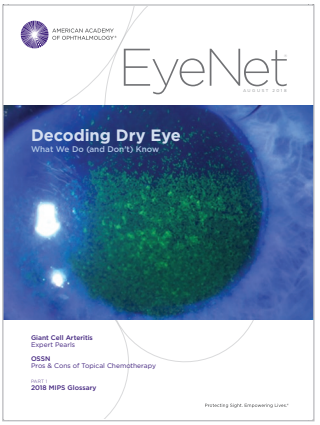
# Letters

## Single-Payer Health Care: The Next Logical Step

Reading "Single-Payer Health Care: Of Canada and California" (Current Perspective, August), I was struck by its alarmist tone.




Single-payer health care is suddenly looking attractive to Americans because of the failure of for-profit, private insurance–centered health care. Before the Affordable Care Act (ACA) was implemented in 2010, insurance prices were increasing exponentially; 15% (and quickly rising) of Americans were uninsured; medical bills caused most bankruptcies; quality remained the worst among comparable countries; and health care was reaching 20% of the federal budget and gross domestic product.[1]

With the ACA, we attempted a market-based approach. It stabilized prices, but its complexity and continued reliance on private insurance has doomed it. The Republican Party is dismantling ACA without any workable replacement.[2]

The type of single-payer coverage gaining most support is an improved "Medicare for all." Yes, taxes will go up, but Americans will no longer pay private insurance premiums, deductibles, copays, and coinsurance. Drug prices will fall.[1] People will pay about one-third less for health care overall.[1] Doctors and hospitals will enjoy a drop in administrative costs and malpractice insurance prices.[2] Medical students will pay much less for schooling and avoid the crush of student loans. Best of all, Americans will gain access to a higher quality of care, improving outcomes while decreasing costs.

Private insurance is just a middleman that moves money from the patient to the provider. Its real point is to make profits for shareholders, yet we are paying 30 cents of every health care dollar for administrative costs and insurance company profits instead of improving health.[1]

The single-payer form of universal coverage will come to the United States, as it remains the cheapest way to cover everyone. We see it succeeding in nearly every developed country of the world, and in the United States as Medicare, the government's most beloved program. Expanding Medicare to cover everyone is the next logical step.

*Chandak Ghosh, MD, MPH*
*New York*

1 Gaffney A. *J Policy Anal Manag.* 2018;37(3):188-195.
2 Woolhandler A, Himmelstein D. *Ann Intern Med.* 2017;166(8):587-588.


**THE ACADEMY NEEDS YOUR INPUT.** Sending a letter to *EyeNet* is just one of many ways to be heard. You also can contact your state, subspecialty, and specialized interest society's representative(s) on the Academy Council, which presents membership concerns to the Board of Trustees. Academy members also can register to attend the Oct. 28 Fall Council Meeting in Chicago.

**To see a Council roster or register for the Fall Council Meeting,** visit aao.org/council.

## Progress for Inclusivity

"Cultivating Diversity in Ophthalmology" (Opinion, July) was very inspiring and I'm glad that it was shared throughout the Academy. Oftentimes underrepresented students are discouraged from applying to competitive specialties because they feel like it is an unattainable goal. Unfortunately, there is unconscious bias in the workforce in how minorities are represented. Preconceived notions often taint our awareness and beliefs toward other cultures and races. The opportunity for education in ophthalmology for minorities at Howard University is wonderful and definitely a step in the right direction for equal opportunity in employment.

*Adriana H. Jones, BS*
*Plainfield, N.J.*

## Correction

In "Drug Update: Vyzulta and Rhopressa" (Clinical Update, September), it should be noted that Rhopressa's primary mechanism of action is lowering resistance to outflow through the trabecular meshwork. The article should have stated that Rhopressa "decreases [rather than promotes] actin-myosin contraction and reduces [rather than increases] actin stress fibers and focal adhesions in the trabecular meshwork to improve the outflow of aqueous humor."