Chapter 2
Pharmaceuticals, Hospitals, Nursing Homes, Drug Store Chains, and Pharmacy Benefit Manager/Insurer Integration

Introduction

“Healthcare mega-mergers dominate in 2017” claimed a *Modern Healthcare* article in December 2017—a clear reality for firms across the entire health sector, all trying to achieve greater scale for financial advantage for their executives and stockholders; further marketplace consolidation would lie ahead (Nash, 2018). The extent of mergers and acquisitions (M&As) marked 2017 as a “year of mergers”: horizontal, vertical, regional, national, and large and small scale (Kacik, 2017a). The opening of 2018 began a tumultuous consolidation of the market with the entry of Silicon Valley players.

This chapter will examine the continuing corporatization in the American healthcare system. First, the upsurge in consolidation is examined through the merger and acquisition activity of each segment of the industry: pharmaceutical firms, insurers, hospitals, and health systems, and the more recent intensely pharmacy benefit managers. Ongoing federal subsidizations now over 46% of total expenditures are revealed to provide the attractiveness for investment in health care for mighty lucrative returns. This incentive structure remains even while Republican efforts to restrain spending are chiefly targeting the indigent, seniors, and seriously ill (Pear, 2018). Employer reactions to persistent cost escalation are also examined with implications to workers’ benefits and further rationalization. In closing, the huge recent incursions by information technology firms suggest that the American healthcare system may be on the verge of a further corporate takeover, instead of resolving issues of access, quality, cost, and accountability through a progressive public health approach.
Merger Mania Amidst Policy Uncertainties

*The New York Times* Sunday Business post piece (Abelson & Creswell, 2018, p. 1) “Merger Medicine and the Disappearing Doctor” noted that 12,000 retail clinics formed by insurance companies and giant retailers were teaming up to dominate health care. Office visits to primary care doctors declined 18 percent from 2012 to 2016.

Meanwhile, Donald Trump and his Republican cohorts sought budget cutbacks amidst elimination of the Affordable Care Act, as well as the Medicaid program. By 2026, national health spending is predicted to reach 19.7% of the economy (Inserro, 2018a). “Americans used less care in 2016, but health costs still soared” headlined the Health Care Cost Institute (IHCCI) (Inserro, 2018b), which identified rising prices, “especially for prescription drugs, surgery, and ED visits.” Overall spending grew further than at any time in the last 5 years!

Prices rose, but who paid for such prices increasing so much? What does this mean about the introduction of value-based care (VBC)? It seems not to be going away—at least for the quality reporting requirements for doctors! (Sweeney, 2018). This IHCCI report noted that direct out-of-pocket patient spending increased every year. In the meanwhile, prices for professional services—fees to physicians—saw their lowest growth and lowest prices overall. Patients and physicians may have a mutual set of concerns over the evolving structure of the delivery system.

*The Kiplinger Letter* cautioned about the sizzling pace of M&A activity in the economy, up to 60% in the first quarter over 2016—a total of $1.2 trillion in tie-ups, still marching on for the remaining months of the year. Low interest rates—about to rise more—aid the debt-financed deals, along with the burgeoning corporate coffers, thanks to the Trump tax cuts. Several health firms—along with most IT firms—have been cash-rich, floating bond offerings so they can horde cash to buy up any firms that may get beaten up by market swings over the near future. Stock buybacks are common to boost values in preparation for takeovers. It should be noted that R&D investments do not hold as much guarantee for short-term gain as such corporate behaviors. Together these conditions foster a health system bent on placing profits over public health. Yet Kiplinger (2018, p. 1) comments that these activities may signal that companies aren’t able to grow their business from within and are instead relying on taking over competitors that may increase profits but at significant cost to the acquiring company.

These advisors maintain that these actions do not seem to be the case right now since “the US economy looks sound.” Corporate debt levels are high, but manageable, so far. Many companies pursuing deals are reportedly positioning themselves for longer-term growth, not a quick, one-time earning hike. Health care and consumer goods are predicted to remain among the most popular arenas for deal making. Kiplinger notes that Amazon, Walmart, and other retailers are being pressured to get a lot bigger so that they can compete more aggressively.

But getting bigger in a difficult environment caused by increasing interest rates may make it harder to finance deals, a bear stock market may sour investors,
worsening trade disputes will be provoked by Trump, and most of all antitrust rumblings from his Administration remain unclear. Can his Department of Justice reorient from its current fumbling over immigration to block future takeovers? The courts gave the go-ahead in June 2019 for the Time Warner/AT&T merger; so it is rumored that this approval will open up a huge new surge in M&As overall and especially in communications. Most of all in terms of uncertainty is the $316 billion annual cost by the US Treasury on interest payments that are financing the Republican tax cut. This future cloud of $15.3 trillion looms over the overall economy, as particularly health care with federal resources drained to pick up this debt tab. One must bring to mind the Trump budget deficit spending to build the military amidst his colossal tax cuts for the rich, and that preceded the business bailout of 2020 after COVID-19.

Beyond the merger mania, escalating drug prices reached a “boiling point.” From 2012 to 2016, drug costs rose 27%. Amidst a plethora of cybersecurity concerns from providers, there appeared a wide range of health-related smartphone apps, care moving more to community settings, and consumers becoming “money managers” to handle much higher deductibles and patient outlays (Gooch, 2015). Despite similar utilization rates for the United States compared to other nations, labor and goods (including pharmaceuticals) and administrative costs (including profits) are the major differences with health costs in America (Masterson, 2018). Beyond the growing and aging population, increased prices and the intensity and utilization of the costliest services are actually driving spending.

For seniors, Medicare healthcare costs remain a rising burden—they are expected to consume a larger share of their total income by 2030 (Cubanski, 2019). Medicare beneficiaries averaged out-of-pocket payment spending at 41% of the average Social Security income in 2013. As Republicans reduce funding for Medicare and Medicaid, this senior and indigent cost-sharing becomes highly problematic for them, especially for folks with debilitating chronic degenerative diseases. Over recent years, more attention seems being paid to these “high spenders” on costs rather than their access to improved quality care (Johnson, Brennan, Rodriguez, & Hargraves, 2018).

Substance abuse, chronic illnesses, and protections against infectious and foodborne illnesses, along with the socioeconomic determinants of health such as poverty, unemployment, and violence, are mere afterthoughts for those in charge of our healthcare policy:

> The new administration has also changed the health care landscape through the Food and Drug Administration, and its new commissioner, Scott Gottlieb, M.D.: Actions on high drug pricing, clearing orphan drug request backlogs, increasing drug review efficiency, and driving digital health technology and medical device innovation. (Vogenberg and Smart, 2018, p. 34)

In its first year, the corporate-pleasing Trump Administration became notorious for pulling all verbiage referring to climate change from federal websites, eliminating the Clean Power Plan, and withdrawing from the Paris Climate Accord, along with Scott Pruitt’s litany of EPA travesties, which are also likely to have
significant health consequences for people (Davenport, 2018; Talbot, 2018; Eilperin, Dennis, & Dawsey, 2018. The Children’s Health Insurance Program finally was passed in December 2017 but only given a temporary 3-month reprieve by Congress, along with a modicum of added funding for community health centers (CHCs) to support vital infrastructure. CHCs in the past have garnered bipartisan support since one CHC has been carefully situated in almost every Congressional district.

Nevertheless, major funding uncertainties defined public health in 2017 (Johnson, 2017), thanks to Trump and his Republican cohorts. Of concern to public health professionals has been the significant relaxation and elimination of regulations to allow the marketplace to thrive unfettered. Nevertheless, public health funding by federal, state, and municipal governments has historically stayed at 2% to 3% of total US health expenditures (Himmelstein, & Woolhandler, 2016).

As for corporate employers who are caught up on urging “cost management” on providers (Kalish, 2017), their influence ever grows as their climbing outlays propel forward high-deductible health savings plans (HSAs) for employees and greater risk-based contracting with providers. Larger corporations self-insure for their health benefit outlays. From time to time, certain employers have attempted stricter controls over what gets labeled as high costs, including their historically shifting a greater burden to employees (Young, 2005): fixed-sum health benefits to encourage workers to “shop efficiently”—a so-called “consumerism” approach in vogue of late. It is not well known what higher cost-sharing and reduced benefit coverage do for improved health and well-being of either their employee families or the overall population.

Corporate America lies behind the steady raising of co-pays and deductibles in the private insurance market—especially for drugs—to force employees to judiciously use services, like avoiding ERs, limiting doctor visits, and purchasing generics over brand drugs. Many firms have fallen into avoiding insurers through self-funding their health plans, with group stop-loss insurance in abeyance. The trend toward “direct contracting” with provider systems indicates employers supporting efforts for stricter “cost management” (Kalish, 2017). Direct contracting has been saving costs for some employers, but there are issues such as growing the network of providers and obtaining performance, constructing databases and developing analytics, and also conducting studies for good decision-making. Walmart is another firm that engages in direct contracting (Diamond, 2018), but one of the more prominent American corporations to go down this path was General Motors. Twenty-four thousand of its 180,000 workforce were placed in a 5-year direct contracting program with the Henry Ford Health System, circumventing insurance companies. Boeing also contracts in California for its employees. Plans provide discounts to employees who participate, but educating them to choose wisely for the “best doctors” and hospitals can be problematic. Integrating care among the set of providers takes effort, especially if they are not already formed into systems.

Saving on next year’s employee benefit outlays has been the HR executives’ goal for decades, seizing upon what can be cut out. Evermore such decisions are sought, backed up courtesy of Big Data extracted from provider performance. While
analytics work has been reaching some precision, it does not always lead to the “best” benefit decision-making, nor what workers particularly need or want. Across the 2018 midterm election cycle, it became clear that health care dominates as a major issue to the overall public.

Overall benefit costs for employers have risen more than 24% in the last 2–4 years (Kalish, 2017), the same 24% rise as was for 2000 to 2004. Per capita growth in employee cost is driven by specialty drugs (Toich, 2017a, 2017b). Trump’s recent repeal of the individual mandate under the ACA has caused anxiety among employers who fear potential adverse selection among their employee plans. In this context, policies and practices promoting these marketplace dynamics have been sustained by Republican Party-based ideology.

Chapter Purpose

This chapter will expand upon the previous chapter with the advances in corporatization across all segments of the American healthcare system. It will be seen that rather than merely a trend, there is a huge upswing in the amalgamation of providers and suppliers as profit-taking surges in the marketplace. Federal subsidization of specific areas is highlighted as about 50% of funding comes from government sources. Policy actions by not just Republicans when in power but also the Obama Administration’s ACA favoring the private sector growth without much acknowledgment for its natural tendencies for greed with concerns for equity in health services get downplayed. Each private segment of the overall system discussed below from pharmaceuticals and pharmacy benefit managers to hospital and healthcare systems has done well and increasingly so. Privatization in the capitalist system seems to favor private entities so we see that nursing homes, prisons, higher education, and more succumb to similar moves for profit opportunities to transform them, resulting in what might be said numerous questionable outcomes. Chain drug stores rose to challenge ambulatory physician practices in the 1980s, again being the march of private corporate takeover. This chapter concludes with a lament that the population’s health care remains solidly under corporate auspice, which presents many barriers to raising the public’s overall health status.

Ongoing Corporate Federal Subsidizations

In almost all circles of payers and providers, a deep pervasive frustration bubbles over the current payment system—repeatedly said to be broken—with continuous attempts to contain cost inflation, many futile. Physicians are said to be moving toward single-payer Medicare for all (opinion favored by over 50% of doctors). Pressures toward “value-based payments” are not really seen as the best prospect in some quarters (Gittlen, 2017). Ascertaining value is very complex and politically
holds a series of landmines for many parties, so we see fits and starts on this strongly intended direction.

It is undeniably true that Medicare and Medicaid bailed out health providers for the two groups, previously uncovered seniors and indigent, who paid out of pocket when they could to get care. This can be viewed as a social development with many people receiving needed services, and surely these funds boosted employment in the economy. These federal programs begat significant gains in financial access for millions of Americans; seniors and the poor were brought into health care in a wonderful way, but it came from an initial federal Medicare cost of over $3 billion in 1966 now growing to 2016 expenditures over $685.3 billion for Medicare and even higher for Medicaid of federal $344.4 billion; the states’ share is about an equal additional amount (HHS.gov, 2016). Private parties benefited greatly under the huge federal funding from the mid-1960s fashioned after the Blue Cross Blue Shield deal of fee-for-service and cost-reimbursed hospital care. Medicare Part A was fashioned after Blue Cross, with its required stepdown accounting sheets prepared by the hospital administration to essentially receive cost-plus payments that of course ballooned over the years. Blue Shield was the model for Medicare Part B, paying doctors piecemeal for services previously either discounted for certain patients or provided free for the elderly. Thus, federal largess bailed out the healthcare system for seniors and the indigent and began an economic boom for all the vested parties that came to feed on the trough, i.e., the medical-industrial complex (MIC).

Historical review of the heavy cost inflation under fee-for-service medicine, the excessive inappropriate care, high administrative costs, and issues of questionable quality have been documented in health services research over time. This federal largess essentially invited in the host of proprietary firms documented in Chap. 1. All of this uncontrolled expenditure has provided ammunition to cost-cutting conservatives, who are currently intent upon dramatically scaling back its 14% of total federal spending, mainly because the aged and indigent are simply not worth it—to the Republican Right, which seeks budget program cuts, nor to Corporate America, which considers their expense to productivity for the overall economy.

An obvious government creation of corporate medicine was the End-Stage Renal Disease Program (ESRD) adopted under Medicare Part C by Nixon in 1973. Nowadays persons with chronic kidney disease do not face the horrendous access and cost barriers to get their blood dialyzed three times a week to forestall their death and perhaps wait for a transplanted kidney. In an article entitled, “God help you. You’re on dialysis,” The Atlantic Monthly (2010) reported that the US fatality rate was one of the worst in the industrialized world and costs more than anywhere else. Yet, this federal program, which covers any citizen diagnosed with kidney failure under Part C, regardless of age or income, piles huge sums of money into a mere handful of highly profitable corporate dialysis chains; in 2016, the ESRD program cost taxpayers $32.9 billion—considerably more than its initial projected price tag of $135 million.

In essence, this End-Stage Renal Dialysis Program yielded an entire corporate industry of nationwide and regional dialysis firms, which have grown wildly (e.g., Fresenius, DaVita, US Rural Care, American Renal Associates, and Satellite...
Healthcare, among a few others). Academic medical centers still do some dialysis, but not for chronic care. The top two listed for-profit firms served 383,464 patients of the 477,476 in the program in 2014, that is, 80% of persons receiving dialysis; both firms have spread overseas too. Incidents of noted substandard care have been newsworthy (Atlantic, 2010; Oliver, 2017). A midterm election proposition in California sought to curtail ESRD firms’ excess profits and address quality issues, but it was strongly opposed and defeated by the industry. Critics of the ESRD industry state that these for-profit clinics are seen as low-quality care and that performance is often hidden by the government from the patients and families who use that service (Atlantic, 2010). Medicare does not set staffing ratios, and “hundreds of clinics were cited for infection-control breaches.” Even with such lax oversight, for-profit share of revenues in 2016 was 93% among dialysis providers. In contrast, Italy’s public hospitals provide more than three quarters of the care (Atlantic, 2010). Marketplace medicine absent adequate federal oversight can be expected to hinder cost and quality issues for consumers.

During the 1990s, George H. W. Bush substantially buoyed the nascent pharmacy benefit managers (PBMs) with his Medicare Modernization Act simultaneously taking care of his friends in the pharmaceutical industry with the promise of no cost controls over drugs. Coverage of drug therapies was long overdue from 1965 Act and surely remains completely necessary to senior health care. This Act for the first time subsidized much of seniors’ pharmaceutical costs with Medicare Part D. One hundred and eight billion again was given over right away to the pharmaceutical industry. Bush overnight spurred forth phenomenal growth and power in the private PBM industry, now enrolling 43 million plus Americans. This direct subsidization created the price escalation of drug prices, becoming a critical political economic dilemma now across this decade.

Again, marketplace medicine prevailed. The deal forestalled in legislation forever no drug price regulation on pharmaceuticals, leaving an escalation of prices to become a critical unabated political economic dilemma reaching to this day. It also remains remarkable that a fledgling industry from the early 1990s with a handful of firms today now has the largest pharmacy benefit managers dwarfing a number of long-established pharmaceutical firms, and these PBMs remain more profitable, setting them up as targets for the ongoing M&A fervor by insurers, now attracting Silicon Valley firms in 2018.

Not to be outdone with outright federal subsidization of corporate health, Barack Obama and the Democratic Congress dropped over $600 billion into the coffers of the private insurance industry with the Affordable Care Act, even after a strident critique of their crass practices of discriminating against sick and disabled patients and their families. Like the above provider groups, insurance firms have recently become dissatisfied without greatly increasing annually the federal largess.

As with most federal programs, it need not be said that some people indeed did benefit with new access to services. Beyond being intended to sway voting constituencies with the ACA, it can be pointed out that perhaps a different design for a public option might have curtailed the driving force away from its major corporate beneficence; states might have been able to conduct their own public plans, as was
suggested, but dismissed by the Democrats. In contrast to what was passed, health infrastructural development could have been more substantial, going beyond the limited funds for designated safety net hospitals, risk corridors, and community health centers. Cost controls and quality improvements were downplayed as “regulatory” to quell the insurance and pharmaceutical industries, and provider antagonisms, though grievances from these vested interests emerged when the Republicans ranted “repeal and replace.” Unlike the Bill Clinton days, corporate opposition had given way to Obama’s accommodation strategy to reap marketplace advancement with heavy government support sans much strict oversight and regulation.

In the ACA, pharma was continued to guarantee no federal price controls; insurers expanded their market share with bountiful subsidized customers; so both vested industries decided not to oppose the ACA (as historically had been the case with almost all previous federal insurance extensions). Wonderfully, 20 million Americans received access to insurance coverage (but absent greater support for infrastructural improvements), not necessarily access to proper continuous physician care! Now with Trump reversing any and all of Obama’s legacy, most of these folks appear vulnerable to losing it. Witness Congressional attempts to rid the Medicaid program in its entirety, not just its ACA expansion by Mitch McConnell’s Senate attempt!

In 2016, 28.1 million Americans were still uninsured (8.8% of the population). This represented a slight decrease despite ongoing Trump attempts to repeal all of the ACA. Those maintaining coverage—many who still cannot afford care due to the high cost-sharing requirements—seem better off since a strongly disproportionate burden of uninsurance fell upon minorities. Lower-income Americans still have significant problems in obtaining adequate medical care, since income is so crucial to decent access and social determinants lead to ill health. Inequality continues to be a marked feature of American society; in recent decades, poorer Americans have borne more of a tax burden, while richer Americans pay less, especially after the Republican tax cut in 2017 (Himmelstein, Woolhandler, Almberg, & Fauke, 2018).

Such repeated historical federal largess with its mindful flow of funds to the medical-industrial complex, however, has tended over time to undermine what should be the social purpose of the American healthcare enterprise: to advance the overall health status of all Americans. Of note, during the George H. W. Bush and Clinton administrations, the health sector became a motor force for rise in employment, thus GDP growth. Nevertheless, the maldistribution of both health status and afterward healthcare resources has never been given top funding priority over feeding the beasts in the MIC. In the final analysis, the lobbying parties, who influence these federal programs and then support their funding, are the very ones who reap the spoils within the corporate health sector.

True, many citizens did clinically benefit from every of the above policy actions; such remains the key ideological selling point to the general public for each program’s continued tax fund flow. The corporate welfare aspects usually remain unspoken, and often hidden, as does suggestions for closer monitoring of potential and real abuses.
Accountability has never been a hallmark of American health policy. Witness the estimated cost of fraud and abuse at about 3% of the near $4 trillion spent on health care. At the same time, all of these policy actions propelled a burgeoning health cost conundrum for the entire nation. An ever-expanding expenditure—coupled with declining standards of healthcare delivery—still poses uncertain outcomes for the population across this century without progressive policy remediation.

It should be pointed out that never has there been a national policy debate over whether such a corporate health system was the best way to organize Americans’ health care, nor was there a debate over whether the American people knew much about the corporate takeover, nor more importantly whether they actually wanted such profit-driven arrangements over their health.

Notwithstanding, our nation surely needs to engage in popular debate to investigate the overall corporate consequences to health and health care. This should happen now as a national debate over “Whose healthcare system is it?” along with the rallying for “Medicare for All.” The key question is: “Whom does it serve? People or profits?” More and more people today in all walks of life are coming to the conclusion that marketplace forces or the billionaire class cannot fix a broken healthcare system (Master, 2017).

The Pharmaceutical Industry

When one thinks of corporate health care in America, it is likely that the pharmaceutical industry first comes to mind. The industry has dramatically expanded and prospered long from early entrepreneurship origins at the turn of the last century with the likes of Merck Sharp & Dohme, Eli Lilly, Abbott, and Upjohn Brothers selling nostrums from covered wagons that traveled from town to town. Its presence is now negatively known from newsworthy portrayals of price gouging and its ubiquitous direct-to-consumer (DTC) TV advertising reaching $6 billion annually. Moreover, an ever-increasing percentage of Americans are consuming multiple drug products and experiencing growing out-of-pocket outlays (Dusetzina, Keating, & Huskamp, 2019; Terhune, 2016).

Recently, in addition to a heightened awareness of the costs of various drugs, there have been mounting doubts about drug safety and efficacy (Carcinoma-causing ingredients found in Zantac, 2019; Silverman, 2019a, 2019b; Dangerous contamination, 2019). At the same time, some firms have reported newsworthy zooming profits, political influence, and multiple miscreant behaviors (Opioid deaths taking a quarter Americans’ lives; Data show a “tsunami” of overprescribed opioids across U.S. as death toll rose in 2019; Crow, 2018; Billionaire Sackler family owns second opioid drug maker, 2018; About the epidemic, 2018). Johnson & Johnson, a firm with a past prided reputation, became tarnished by association with the El Chapo-Sackler Family at Purdue Pharma in the opioid crisis (Economist: Big Pharma in Court, 2018).
The populace has also been introduced to the world’s disease burden through news coverage of profit-taking from developing countries, particularly the Southern Hemisphere (RNCOS Global Vaccine Market Forecasts to 2017, 2013; Wechsler, 2020; IQVIA Global Medical Spending and Usage Trends, 2020).

Relief from double-digit inflationary drug costs, plus knowledge of fellow American citizens who cannot afford to buy needed medications, is now an emergent domestic political issue (Roland & Loftus, 2016). The Pharmaceutical Research and Manufacturers Association responded to these criticisms with a TV campaign blitz and more intense lobbying (Scott, 2017). House Speaker Nancy Pelosi’s drug pricing bill following the impeachment inquiry does not hold any promise of passing, even if compromises ever come from Trump (Cunningham, 2019). Members from both parties remain at fault. Democrats and Republicans have taken plenty of cash campaign contributions from PhRMA (Facher, 2020).

New perspectives from payers and providers are additionally provoking demands for better pharmacovigilance due to drug mishaps and noted ineffectiveness (Pharmacovigilance & pharmacoepidemiology, 2019). A greater push may come from European drug policy standards, which according to STAT raise a huge question for US charities and NIH funding. Why don’t our tax-exempt charities insist on reasonable pricing to protect access to the medicines they make? Why does the NIH refuse to enforce the contractual obligations in funding agreements (Love, 2019) related to the $1.2 million treatment of Zulema?

Perhaps, given all of this today, the pharmaceutical industry faces its most profound period of change since the turn of the last century when it was corporatized. It has been said that the collision of technology, business, politics, and culture has contributed to one of the most divisive times in US history. The pharmaceutical industry displays all such tensions. Nevertheless, it remains problematic in how the global pharmaceutical industry gets conceptualized. It is indeed much more than just brand drugs produced by multinational giants (now rebranding itself as the “life sciences industry”), along with generic houses in almost every nation of the world, the bulk coming from Israel, Brazil, Russia, India, and China. These BRIC nations each has a thriving industry making off-patent entities and shipping approved pharmaceutical ingredients (APIs), which are added to many US and European brand entities (PR Newswire, 2020). Sophistication in API development and manufacture has become serious; the bulk come from abroad and must be thoroughly tested for safety precautions after several highly publicized incidents and drug recalls.

Then there are thousands of firms contracted for equipment, glassware, parts and supplies, packaging, and added ingredients for production (Rowland, 2020). Additionally, firms assist in outsourced manufacturing, clinical trials, and an array of administrative services (Outsourcing Resources, 2019). Moreover, there is the plethora of firms which surround and feed off the industry, such as consultants, regulatory affairs and compliance, analytic, lawyers and lobbying, IT firms, and marketing firms. While much is described for consumption by industry sources (and generally unavailable due to huge prices for their insider publications), there has
been little critique of ongoing drug marketing practices, clinical trial developments, and the rapid consolidation of the industry in the academic literature.

What may prohibit any new price controls or further regulatory attempts are the numerous vested allies of the pharmaceutical industry. Allies on Wall Street and Madison Avenue, Congress (Facher, 2020), Academia, and elsewhere have historically benefited from the largess of pharmaceutical companies. Moreover, “America’s biggest charities are owned by pharmaceutical companies” (2019) so claimed by an *Economist* article. The industry is extant in its spread of influence, and it has truly mastered exerting political prowess over time.

It should be noted that the bulk of the world’s almost eight billion inhabitants use alternatives to pharmaceuticals (herbals, Ayurveda and Chinese traditional medicines, other Latin and African nostrums, and a variety of over-the-counter substances). High costs, unavailability, and cultural preferences account for this preference (Salmon, 1985; Kleinman, 1984).

The corporate pharmaceutical industry has advanced mightily to address numerous health conditions in our nation and worldwide. Nevertheless, in pursuit of new profit opportunities, and to placate fears (for the new realities of global pandemics, with a burgeoning vaccine market, along with remedies promised for chronic disease cures and now, for the sales benefit, drugs for prevention); all this goes hand in hand in a continual public relation blitz full of hype and hopes (Wechsler, 2018).

Today, this industry is multinational, extremely profitable, and very ideologically political and powerful. But it is still a relatively small capital compared to giants like Walmart, General Motors, Microsoft, Apple, Amazon, and other titans of American capitalism (Fortune, 2020). The pharmaceutical industry has been noted as being one of the least transparent parts of the US healthcare system, yet its set of ongoing issues has brought it into the popular and political spotlight this decade. Due to public disapproval of the industry (Bulik, 2020), firms have been attempting a rebranding of sorts advertised as “life sciences businesses,” with attempted diversifications. Seizing the opportunity to wear a big white hat after coming up with an effective vaccine against COVID-19, its declining drug industry image may be able to be redeemed.

Emerging technologies make up several small research-focused private biotech firms aimed at a specific tech platform, a mechanism of action, or a few early-stage compounds, not yet with revenue streams, but awaiting an IPO to enlarge richly, and/or for an eventual takeover by a big firm (Deloitte, 2018a). Few of the largest brand companies have produced blockbuster discoveries—like those in the 1980s—but they now buy entities through acquisitions, which have trended with a big surge in this century.

In this age of deregulation, one can easily identify a critical need for greater market oversight by governments. In an article entitled, “The Biotech-Industrial Complex gets ready to define what is human,” Newman (2019, p. 2) writes that newly approved human-animal chimera procedures, although by scientifically and ethically questionable techniques, may be soft-pedaled by panels of experts influenced by financially motivated bio-entrepreneurs.
Mergers and acquisitions (M&As) have become a major characteristic of late-stage capitalism. All over the world, business entities are joining together with the sole purpose of increasing their market share and reaping higher revenues and profits. In numerous countries, much of the merger activity looks like swashbuckling. The allures of combinations are heralded as major economic steps forward. International combinations allow for cross-border transactions, and even within a single country, a merger could be a keyway to enter new markets, often seen in the pharmaceutical industry when a biotech firm is gobbled up to just obtain a single new product (Mergers and Acquisitions Take Center Stage, 2019).

Finance capital loves M&As because enormous bankers’ fees are reaped, plus there is the ideological support for basically touting promised economic growth. Nevertheless, some mergers and acquisitions do not seem to work out; frequently, by 2 years down the line, when plants get close, worker layoffs result, and corporate culture clashes become difficult to resolve. Additionally, promises for the sale or takeover do not fully delight Wall Street. In the era of globalization, blurring lines between industries and the increasing technological disruption, M&As continued to flourish. If not actual takeovers and/or coming together, many firms seek subsidiaries in the form of joint ventures, which is like “friends with benefits.” Such, along with licensing entities, may make sense for less risk and allow a better chance to get to know each other. However, the Federal Trade Commission is being pressured to examine the steady increase in Pharma M&A, noting the AbbVie/Allegan merger and the Pfizer combos (Lawmakers ask FTC, 2010). Reuters reported that the FTC later responded by asking for more information on the $63 billion deal (FTC requests AbbVie, Allegan, 2019). Consumer groups and unions are lining up to block this drug amalgamation now (Silverman, 2019c).

The largest drug company, Pfizer ($52 billion in revenues), is known less and less as an R&D research manufacturer. The Chicago Tribune noted that the firm went on a range of chronic acquiring (Johnson, 2016): $14 billion to buy Medivation, another $495 million for Bamboo Therapeutics, and $5.2 billion spent for Anacor Pharmaceuticals in 2016 alone (Pierson & Banerjee, 2016; Rockoff & Stevens, 2017). Pfizer’s abortive deal with Allegan in 2016—a $160 billion failure—was essentially a tax avoidance scheme to relocate to Ireland (Growing Pains, 2016; Grant, 2017). Allegan ($16 billion), hurt some by the Pfizer mishap, later went with Allegiance in a strategic partnership to sell its products across Europe, Africa, and the Middle East. Abbott, now just drugs as AbbVie ($28 billion), tried to get out of a messy deal with Alere because the target had misrepresented its attractiveness (Schnecker, 2016). Back in the 1990s, eight of the blockbusters sold by Pfizer came from acquisitions as further evidence that drug firms are not intensely trying to discover new products from their own research.

The purchase of new products from other firms spurs much competition within the industry. Grocer (2019) points out that the hunt for finding new entities has been driving up the cost of takeovers. Over $146 billion was expended in the first few months of 2019 (Rockoff & Stevens, 2017). Pharma managements do not always make astute decisions, and with the industry under more intense watch, such decisions get
amplified through the business and popular press. Within virology, as well as with chronic diseases, the repurposing of older drug entities has come into vogue.

Many firms are concerned for their public image. Recently, Novartis ($49 billion in revenues) was nailed for manipulating clinical trial data to get a faster FDA approval (Thomas, 2019). Witness Johnson & Johnson’s sinking PR from its opioid involvement (Hoffman, 2019). Giving great publicity was one of the worst corporate decisions of late: Bayer of Germany ($49 billion) in its frenzied acquisition of Monsanto, the agribusiness company, in a $63 billion buyout. This is now seen as highly regrettable given the 13,000 court cases against the dangerous use of Monsanto fertilizers; the stock price of Bayer fell 40%, the kind of drop that leads to significant stockholder discontent (Bender, 2019).

The year 2017 was predicted to see a decline in M&A fervor (M&As driving chemicals, 2017). Yet, it should be remembered the strong M&A market is very pleasing to Wall Street bankers who arrange deals and profit for themselves handsomely. The coronavirus outbreak and resultant recession significantly derailed consolidations in 2020. Yet, large cash balances in some firms may restart takeovers, but not likely as much as past surges. Remember, some industries were bolstered by the huge Republican tax cut and with earlier increasing profits, but even with the low interest rate for borrowing, M&As will be selective. This economic environment will not spur deal making and other collaborative strategies across many business sectors.

Notwithstanding for the pharmaceutical industry, will the eyeing of Gilead by AstraZeneca stimulate new fervor among drug companies to consolidate (Lauerman, Ring, & Hammond, 2020)? A few companies are using the moment of the epidemic to “go lean” and may launch new efforts along the trends described above. Overall, the economy is facing unprecedented, near-term difficulties, which may give future-oriented firms time to assess core activities, competition, and a changing post-COVID-19 culture.

In a STAT article, “Pharmaceutical mergers and megamergers stifle innovation,” Milani (2019, p. 1) stated that the industry puts profits over people with a huge percentage of all Americans believing that drugs cost too much and lowering them should be foremost on legislators’ to-do lists. In the absence of Trump and the Republicans doing anything, several states are taking more than a glance at drugs with new policy initiatives (What other states can learn, 2014). Will state governments feel reinvigorated as they learn to cope with heavy post-virus fiscal burdens amidst damaged economies?

Such behaviors also yield the ups and downs of the biotech market, pressuring pharma more since their R&D expenditures have recently produced poor drug pipelines (Grant, 2017); thus, firms must resort to the acquisition of new products. In this climate, particularly in 2016—a high deal volume year—the biotech bubble came upon the industry (Grant, 2017). Another factor pushing this forward is patent losses that lead to seeking specific replacement entities. An example is Roche ($54 billion) outbidding for the biotech Spark for $4.8 billion (Massoudi et al., 2019). The synergy of acquiring products that work with the existing product line and/or what may be in the pipeline is key in many cases for success (Schencker, 2016).
Melding different corporate cultures, besides the technical nuances of bringing scientific endeavors in line, is always problematic; firms find results that do not work out to be how they were parlayed at first love.

Patent loss particularly hits the highly priced biologics (more difficult to make larger molecule drugs usually administered by injection or intravenous fusion in the doctor’s office). These entities in oncology, rheumatology, and endocrinology are part of the specialty pharmacy category that is ballooning drug expenditures for employers and the Medicare Part D program. The global biosimilar market is estimated to grow by 6% by 2025, heralded by the top seven manufacturers ($7.7 billion in the United States in 2019) (Global Report Store, 2019). New generic biosimilars when eventually on the market may save up to $250 billion over the next decade. Over 125 biologics are under brand protection with entrenched company barriers in place, so few biosimilars are ready to be approved by the FDA (Public Citizen highlights efforts by biologics industry to maintain monopolies, 2015). While this issue remains a contentious policy direction, it is vital to resolve since specialty drugs now represent 45.4% of the total pharmacy spending ($218.6 billion), including orphan drugs for relatively few people with rare disease conditions. The federal government subsidizes companies for their orphan drug development. The increasingly stricter formulary management schemes by PBMs urged by employers don’t lend themselves to the same tactics that seem to work on traditional medicines (Vela, 2019).

Financial Times in an article “Case of buyer’s remorse over Pharma deals from 2015-16” pointed out that the frenzy for growth did not always work out the best for investors, nor obviously for the public’s health. The perpetual hunt for new medicines to replenish dry pipelines to achieve higher revenues from drugs falling off the “patent cliff” was tempered in these few following years. Some multibillion-dollar deals do not appear to be well founded in hindsight. Again, the increased scrutiny by Wall Street over the drug industry makes managements subject to more critique than they have ever seen before.

There has been an internal industry discussion (as well as from Wall Street) about the wisdom of large conglomerate diversified firms versus the “pure play” drug firms that focus just on discovering innovative medicines. Financial Times raised the question that some firms may be too big to succeed, much akin to the behemoths in the information technology sector thought to be too big for expected growth. We have witnessed the shedding of [assets] by several drug companies, particularly in consumer medicines. GSK ($49 billion) broke off its over-the-counter brands into a joint venture with Pfizer (Roland, 2018; Reuters, 2019).

The Economist delved into the debate over whether diversified drug firms should break themselves up into more specialized units. Diversified firms are those that typically have consumer health divisions that offer low-margin products versus the “pure-play” with innovative medicines that usually command higher margins.

In the first camp are Johnson & Johnson, GSK, and Novartis each considering splitting off parts since investor believes they will be worth more. Pfizer dumped its consumer product division to J&J in 2006, and Merck divested its consumer unit in 2014 (Growing Pains, 2016).
Yet the *Economist* continues to point out that even a firm that publicly professes a desire to slim down is likely to buy others. Firms may be looking for new drugs to sell or to enter different geographical regions. The axiom from the industry is that drug pipelines matter enormously and Pharma bosses and investors may debate the merits of focus versus diversification, but doing deals will continue (Growing Pains, 2016, p. 62).

This direction has been ongoing through numerous years, along with reconsidering the maintenance of generic houses inside a firm. Under the weight of an acquisition, Teva ($22 billion), based in Israel, saw its shares tumble 24% in a day during the summer of 2017 (Scheer & Rabinovitch, 2017). Teva is the biggest seller of generic drugs (one in every seven generics worldwide).

Certain biotechnology firms have in the meanwhile advanced as major formidable players. Frost and Sullivan studied the biotechnology sector noting that Amgen, Chiron, Genentech, and Genzyme will lead the market, with licensing deals and risk management connections with most of Big Pharma. The Rise of Biotech Pressurises Pharma report in 2005 said high returns in biotech stocks will sustain investor interest in the industry to maintain R&D projects. The top ten US biotechnology companies have 186 products in the pipeline, nearly 20% in phase 3 to substantially impact market growth in the short term (Rise of Biotech Pressurises Pharma, 2005).

As with the entire concentrating health sector, there is also a set of medical technology firms seeking larger market shares from M&As; *Fierce CEO* reports on the top companies in this segment, who face the same terrain of changing partners to secure better positions amidst the uncertainty in the current dynamics (The Top Companies in Med Tech, 2017).

Housed in only seven advanced Western nations, multinational brand manufacturers discover new expensive novel therapies (or buy them by gobbling up smaller firms). An additional key industry segment is the decentralized global generics market that chiefly supplies pharmacy benefit managers (PBM) in the United States. Many developing nations get much lower cost off-patent drugs, including APIs (approved pharmaceutical ingredients) that also get poured into branded entities made in the United States (Salmon, 2017a). The high potency API market is projected to reach $27 billion by 2023 (Active Pharmaceuticals Ingredients market size, 2018). Additionally, an abundance of over-the-counter (OTC) products (including analgesics, digestive agents, dietary substances, vitamins, minerals, and all kinds of herbal remedies) is readily consumed by people at out-of-pocket costs (Liu & Salmon, 2010). Worldwide counterfeit medicines that threaten the globe are a direct result of the unaffordable costs of needed drugs in most Southern Hemisphere nations.

Inflation in US drug expenditures for many years has far outpaced other medical expenditures (doctors, hospitals, nursing homes, etc.) despite efforts by managed care pharmacists to keep costs contained (CVS Health, 2017). Popularly used brand drugs for the elderly, as well most generic drugs, have seen continuous double-digit annual price climbs (Silverman 2016). Many long term generic drugs required by many diabetics to live, have seen unjustifiable price increases and shortages (Roland
A rash of drug price climbs became notable during the 2016 election campaign drawing both Presidential candidates’ commentary, for example, EPI-pens rose in a huge hike (Skapinker, 2018). Other examples were noted in the press to provoke public ire. Thus, never have drug costs become a hot political topic in America and across the world.

Trump’s campaign stumps spoke to drug price gouging to appeal to his working-class base and even found the mainstream media universally welcoming his promise to negotiate prices for the federal government. In *The New York Times* op-ed, Wu noted Trump’s missed opportunity to back up his populist criticisms of pharmaceutical price gougers and be cheered on by everyone (Wu, 2017). Wu suggested beginning with the ten most outrageous incidences of excessive pricing, but Trump quelled his rhetoric from the White House as he met with Pharma leaders and later appointed a drug company executive as his Health and Human Services Secretary. Remember back that Trump ran as an economic populist to confront the pharmaceutical industry. Over 3.5 years, however, the price gouging business model remains in effect. The Trump Administration essentially has done little policy change here.

Spectacular investor returns make pharma stocks a favorite of Wall Street, hedge funds, pension plans, and individual investors, along with advertising firms loving the pharma money flowing richly to them (Deloitte, 2018b). Thus, the pharma industry’s political allies are extensively implanted deep within the capitalist economy worldwide.

The remarkable rise of this unique industrial organization has often been cloaked as the major contributor to the world’s health advances, though such is disputable. This assertion, however, has tended to grant pharma firms special privileges. In contrast, demographic research has indicated that declining death rates in populations overtime have much more to do with rising standards of income, as well as numerous public health measures (Powles, 1973; McKeown, 1971; McKinlay & McKinlay, 1977, 1979). Nevertheless, the industry repeatedly takes credit for their products, which indeed may aid many patients clinically, but not so much for overall populations.

The vaccine segment of the industry is foremost in its assurances for better world health, though policy researchers might ask for prior cost-benefit evidence before any developing nation spends countless billions on mere possibilities in prevention for its people, now including promises for eradication of several chronic ailments (BBC Research Global Cancer Vaccine Market, 2014; Adult Vaccines Market Analysis, 2014).

The manufacturing and sale of pharmaceuticals in America are highly regulated for purposes of assuring product and patient safety (Fincham & Wertheimer, 1991), as well as a result due to historic public outrage over past drug mishaps (Wolfe, Coley & Health Research Group, 1981). Regulatory policies became enacted after a historic series of calamities in drug use in our population for impure, unsafe, and non-efficacious ingredients, unsanitary production facilities and processes, fraudulent claims for effectiveness, and a huge host of marketing abuses. The US Food and Drug Administration (FDA) was founded and strengthened over time to address some issues, but not all such matters, and often insufficiently addressed according
to some observers. While the industry complains that it is already overregulated and that the FDA is often cumbersome in reviews, others claim that regulatory science could be vastly improved and strengthened and that the FDA could do more in tightening up drug reviews and oversight of certain players and practices, particularly for safety purposes (Edlavitch & Salmon, 2006). Some critics ask for broader scrutiny over marketing practices too.

Additionally, the current ongoing concern for the federal government to address unbridled price climbs, amidst broader scrutiny over firms’ marketing practices, has provoked a few states to step up for policymaking as Trump has substantially wavered and caved to industry largess (Salmon, 2017a, 2017b). In the absence of federal actions, numerous states have moved on drug pricing fixing and other confrontational issues with manufacturers (Ollove, 2019). Trump’s major drug price pronouncement in May 2018 actually spiked drug stocks to indicate all will be well ahead for the industry.

The Bush subsidization of the 2006 Medicare Part D program today faces a huge surge due to the high costs, and more frequent use, of newer specialty drugs (Andrews, 2019). With the ACA “donut hole” going away, more elderly are entering the catastrophic coverage benefit period. Since this will greatly propel Medicare outlays, the Trump Administration has been considering spending caps for specialty drug use, which would increase beneficiaries’ out-of-pocket costs. Biosimilar development by generic firms is unlikely to stem this drug expenditure climb by very much, given utilization trends (Biosimilar Drug Development, 2019).

Worldwide drug sales are projected to reach $1.5 trillion by 2021, up $370 billion from 2016 (Berkrot, 2016). US drug spending was $485 billion in 2017, expected to grow up to $655 by 2023 (Philippidis, 2019). Despite smaller capitalization in the US economy next to financial institutions and other manufacturers, as well as corporate giants from Silicon Valley, Pharma firms have achieved disproportional political power through huge bipartisan lobbying. Given a 3:1 ratio of its lobbyists to every Congressman, plus ample campaign donations to both parties’ candidates, this industry has done very well to stem criticisms. There has been an industry/federal “revolving door” where politicians and bureaucrats float back and forth, maintaining the ideology of “wonderfulness of the industry.” Academic medical centers have been richly funded, and health professionals have been lavished with bountiful generosity in their practices and professional organizations. Now that greater numbers of nurse practitioners and physician assistants prescribe drugs, pharma gift giving (meals, fees, grants, and other goodies) are being bestowed upon them also (Silverman, 2017). (See Retail Clinics section below).

All of this has been successfully strategic for decades. The public is daily swayed to consume drug products in the over $5 billion spent on direct-to-consumer (DTC) persuasive advertising. Few other nations of the world tolerate DTC ads. Scientific endeavors can be costly, though R&D outlays differ among firms, some of whom place marketing expenditures well ahead of drug discovery outlays.

Single entities can generate billions in revenues, most with double-digit sales gains year after year. The top 15 selling drugs range from $15 billion Lyrica (by Pfizer) to Humira’s almost $20 billion (by AbbVie) (Philippidis, 2019). Trump and
the Republicans may talk about restraining drug prices, but no direct policy actions have been taken through 2020. Generic drugs saw some entity prices triple with the General Accounting Office identifying more than 20% of generics increasing over 100% from 2010 to 2015 (Morgenson, 2017).

The pharmaceutical industry has mastered the same tactic that Trump has become famous for: John Oliver called the technique “Whataboutism?” (Oliver, 2017)—abruptly changing the subject to distract folks from a difficult or uncomfortable topic. When industry spokesmen are asked about price gouging, their commentary for distraction focuses on all the great drugs in their pipelines that cost a lot to produce (claimed to be a billion dollars or more each). This argument flies in the face of many firms which have promotion expenses far in excess over their R&D outlays.

In other words, advertising to sway prescribers and constant direct-to-consumer TV ads take a greater portion of revenue than what their executives think about in terms of disease scourges and unmet clinical needs in populations—especially internationally. After botching the industry’s response to fight the HIV/AIDS epidemic by restricting the availability of drugs, certain firms may now be attempting to approach international health differently. Of course, the white-hatted good guys are out there publicizing their efforts for COVID-19 vaccines and cures; commentators are asking if the epidemic will possibly assure the industry image improvement.

When critiqued about their marketing abuses, the “pay to play” blocking of generics onto the market, stock manipulations, and clinical trials gone awry, amidst other transgressions, industry defenders change the subject and retort a list of “whataboutisms”: recent approvals in precision medicine, discovering genetic risks, genomic medicines and epigenetics, firms searching to understand the microbiome role in numerous conditions, molecular diagnostics in personalized medicine, and CRISPR, CAR-T, and RNA editing, amidst a continuing alphabet soup of new innovations, including vaccines.

This is not to suggest that significant findings may indeed come from such efforts, as already seems to be the case with cancer genetics knowledge (Cutting edge, 2018), but of late each firm’s public affairs office seems to work overtime with press releases to inform us of how great they are to stem criticisms.

But what about industry’s contributions in harnessing infectious microbes to prevent more social epidemics, like Ebola, Zika, SARS, drug-resistant malaria, and the rise of yet-known unforeseen diseases across the Southern Hemisphere that may spread fear to the United States and Europe? Granted, dozens of innovations in processes, production, and distribution arise from inside the industry (i.e., see industry newsletters and magazines: R&D, MM&M Weekly, Pharmaceutical Executive, STAT Pharmalot, BioPharma Dive, Drug Discovery and Development, among others).

Nevertheless, justifications of climbing prices and high profit margins at times disturb other domestic manufacturing executives (who may unequivocally struggle only to obtain lower margins), while all employers, large and small, confront constantly zooming employee benefit costs, with highest cost specialty drugs a formidable culprit (Terhune, 2016) and this drug component being unbridled. The industry caters to Wall Street analysts, who conduct in-depth regular financial
reviews. Hedge funds give more attention to pharma firms, venture capitalists, and large healthcare investment banks that lend and invest heavily within the health sector (Modern Healthcare, 2018a, 2018b, 2018c, 2018d, 2018e, p. 34); they pay very close attention to what pharma firms research and their returns, as well as do pension funds and individual investors who have historically appreciated the constant climbs in drug stock price rises. 2017 saw health private equity investments totaling $83 billion, the only sector in the economy to receive more private equity over 2016 (Button, 2018). Money invested and made in pharma stocks is key to enhancing the industry’s prowess.

Such financial tie-ins across the economy raise the stakes against any progressive political reform, but these very tie-ins also heighten the society-wide visibility for pharma and other parties. The latter scrutiny may eventually make for a new era for the industry longer term. Thus, the industry’s embeddedness economically and politically makes change not very likely, especially given the Trump Administration’s cozy dealings with pharma firms. Coupled with large donations to key representatives and senators, one can see that paying homage to the pharmaceutical industry will continue with corrective policy change difficult, if not impossible, to enact. Watch how individual firms seek to curry favor during the coronavirus epidemic while the desperate public yearns for the magic bullet of a vaccine.

While the above listing is a mere inkling of what pharmaceutical firms may have on their scientific agendas, many of their costliest products heralded from industry organs (which get catapulted by their public affairs staff early on into the popular press) contain measures of hope, and hype, that belies the fuller story of these promises for very costly entities: multinational drug firms historically have a poor track record across the globe in disease containment since profit always determines production pursuits. For example, Financial Times estimates the new gene therapies may cost $1 million per patient (Gene therapy, 2017)—a tough distribution even across insured middle-class Americans, let alone the less fortunate, especially internationally.

In all, pharmaceutical firms continue to reap extremely high profits compared to other industries; they remain a formidable force in public policymaking and have a very persuasive public presence, though lately their image has been doubtful in many consumers’ eyes (Cubanski, 2019). Pharma rarely loses a political battle in Congress with only occasional setbacks from the FDA. The industry’s constantly surging drug prices will not likely face price controls for a predictable time under Republican rule, but both party’s stalwarts lately give voice to the issue because it sounds good in the news. Certain firms have lately restrained the huge hikes as seen in 2016–2017, but a 2020 surge was made evident. The United States has by far the largest dollar drug market in the world (nearly a half trillion dollars), understandably since almost every other nation negotiates lower drug prices for their populations and healthcare systems and many nations also restrain over prescribing much better.

For decades, pharma firms have been singing the same song, praising their requirement for high profits to maintain R&D to fight disease threats, but at
whatever prices, firms choose to charge. From the 1980s, mass marketed *blockbuster drugs* that most middle-aged and seniors get prescribed *for their lifetimes* (i.e., statins, antihypertensives, diabetes scripts, antidepressants, and more); this was *the major goal* of many manufacturers, not curing diseases! Nowadays, niche drugs and more federally subsidized orphan drugs with lesser patient numbers are being targeted, along with new specialty discoveries with the hope of forestalling any diminution in profit streams: the largest manufacturers don’t appear to be bringing out many entities, but prefer purchasing firms and products. While blockbuster sales had often reach annually into multibillions, PBMs, payers, and employers have termed them *budget busters* and have begun to fight back some in an internecine blame game for drug costs.

The 2017 Republican corporate tax cut and the repatriation of profits from overseas predictably add to the ongoing Pharma M&A fervor; as in the past, it may lead to plant closings and worker layoffs—not an employment expansion. More so, in the pharmaceutical industry, those funds will be used for greater monopolization. We may also witness huge stock buybacks, which aid executives for their quarterly bonuses and investors with the buoying of their stocks.

In sum, while US firms in the past have generated some of the most innovative pharmaceutical products, other international firms in Japan, Switzerland, etc. have *lately led with outstanding new drug introductions*, even given foreign firms facing their homeland price controls, with mostly lower profit margins and less remuneration for their execs (Salmon & Gutkin, 2021).

**Hospitals and Healthcare Systems**

The US healthcare system was historically constructed as doctor-dominated, hospital-centric, disease-oriented, and curative in approach with much end-staged medicine. However, these “old ways” developed under fee-for-service medicine and cost-reimbursed hospital care are gradually being revised in the ongoing push for greater value and quality improvement. The escalating cost spiral, amidst growing ineffectiveness, has as much to do with the kind of medicine historically embedded, as it does *who has come to own and control the American healthcare enterprise*. Managed care will be more fully addressed later along with Accountable Care Organizations, but the discussion here pertains to large hospital chains and healthcare systems, sometimes called integrated health systems (IHSs), which all demonstrate the mixed and amalgamating collectivity of clinical entities operating within the American delivery system.

American hospitals were originally founded by religious groups and municipal governments to service surrounding communities. Their “not-for-profit” status indicated a bygone charitable impulse to serve all comers in need, particularly addressing infectious epidemic diseases. Over time with healthcare modernization and scientific advancement, quality was vastly improved. The early for-profit medical schools and hospitals prior to the Flexner Report in 1910 were all pretty much
eliminated by the 1930s. Notwithstanding in the recent space of 50 so years, after the Nixon Administration legitimized money-making as the objective to both health maintenance organizations and later hospital services, ongoing disruptions now reveal an emergent new structural arrangement for American medicine: the push for the so-called value-based services is being heralded to intentionally alter provider incentives and behaviors, but importantly to establish monitoring and greater accountability, over practitioners. The implications for physicians and other professionals are becoming clearer with information technology and the changing agency relationship (Feinglass & Salmon, 1994; White, Salmon, & Feinglass, 1994).

It was shortly after the HMO strategy that for-profit hospital chains arrived on the scene with the “not-for-profits” facing stiff competition to their traditional inefficient ways. Hospitals consumed over 40% of healthcare expenditures, and doctors continued to use hospitals as their workshop, but not in the same way as previously. The culture of medicine was about to be changed, and the predominant kind of medicine that was practiced provided the foothold for the medical-industrial complex to benefit handsomely (McKinlay, 1984; Salmon, 1985).

The strengthened centralized administration over these scaled-up complex multi-hospitals became championed by the for-profits; they achieved much in local competitive battles given multiple advantages (access to capital reserves, newer facilities, locational superiority, economies of scale, consultancies, contract discounts, selective marketing, etc.). Over time, a transformation of most hospital services witnessed Quentin Young’s vampire effect (for-profits biting the so-called not-for-profits who became just like them in character) for converging behaviors in most institutions (Young, 1997). Again, the marketplace often determines the overall orientation, plus the increase of administrative control over professionals was taking hold. Over time, a transformation of most hospital services witnessed Quentin Young’s vampire effect, that is, for-profits biting the so-called not-for-profits who became just like them in character which resulted in a convergence of profit seeking behaviors in most institutions.

It still remains to be seen what impact the Accountable Care Organizations (ACOs) will have on the overall hospital industry; notwithstanding by the 1990s, HMOs had hit traditional hospital functioning hard (which will be covered later). Today the multi-hospital for-profit systems face notable management mess-ups at Community Health Systems and Tenet, among others (Ellison, 2019). The industry faces notable challenges with its current changing landscape, including the “not-for-profits” rapidly consolidating even more.

Tighter reimbursement issues and lost revenue during the epidemic will plague all firms as hospitalization costs remain hard to control, along with value-based care (VBC) being demanded by payers and elective money-making procedures postponed. It is uncertain how COVID-19 may affect the push for VBC (Livingston, 2020), but the pandemic looks like more hospitals may breach debt covenants due to the estimated well over $200 billion lost revenues (Bannow, 2002).

The large-chain hospitals expanded recklessly in their thirst for market share and ever-increasing profit margins. As Hoy and Gray pointed out in their 1986 book, most growth of the six largest for-profit hospital chains up to 1984 had occurred through acquisition of existing entities. Most of the hospitals acquired were
previously for profit, but roughly 20 percent were non-profit. The acquisition of these hospitals created additional churning in ownership with some changing hands up to five additional times (Hoy & Gray, 1986).

By this current century, rising pressures make it difficult to grow as rapidly. Managing existing inventories of facilities, as recent news reports indicate, confronts Community Health Systems ($18.4 billion), which was the largest for-profit chain, since 2016 retrenching some (Evans, 2016a). It ran into significant management challenges, including disgruntled investors demanding spinning off a series of hospitals that did not meet required desired metrics. Shortly thereafter, Tenet Hospital System ($20.6 billion) arose in reports of spinning off a number of their facilities due to financial difficulties (Kacik, 2017b; Barkholz, 2017a, 2017b). These systems often provided the backbone of health care in many rural and smaller city areas but also represented significant portions of urban locales, such as Philadelphia and Chicago where Tenet hospitals have been recently sold (Schorsch, 2017; Cramer, 2020).

Management muck-ups are not confined just to the greedy for-profit chains (Chaffee, 2016). Despite high administrative overheads (which tend to soar in multi-hospitals), many systems face difficulties managing off-site facilities since their size indicates complex varying regional characteristics across a consolidated industry segment. Compensation patterns have been climbing dramatically for CEOs with multimillion-dollar pay packages not uncommon (Barkholz, 2016)—not a bad job that pays up to over $100 million! A reported 33% average bonus awaits a successful hospital executive. Remember that a hierarchy below the CEO also gets paid very well and there are hordes of subordinates in management. Yet these jobs are tough, so turnover is quite high. Becker’s Hospital Review routinely reports multiple hospital CEOs departing their jobs weekly, perhaps for not making system-wide metrics given intense scrutiny over imposed standards of quality and patient satisfaction (the latter called “clinical transformation”) (Gooch, 2020). Exiting a job may also be for better pay or burnout from brutal pressures. Indeed, it is tough to move such complex operations toward value-based care and still reap the desired profit levels. For proprietaries, outside investors seek greater returns on their stocks; they watch financials closely so that challenges to management are becoming commonplace. The Modern Healthcare survey of executive compensation (Kacik, 2017c) stated that as corporations acquire more hospitals and physician practices, they grow market share, but at the same time, they need to ensure that their services are best aligned to improve outcomes and more importantly generate returns on that investment (p. 19). As these organizations took on more risk, they responded with Accountable Care Organizations (ACOs), started their own health plans, and in general expanded services that required increasing administrative control which necessitated ever-increasing financial incentives to acquire sufficient executive talent to manage these new entities (p. 21).

Of note, seven out of ten of the most profitable hospitals are the so-called not-for-profits (Johnson, 2016), who since 2015–2016 are adjusting their strategies to draw in investors (Evans, 2016b). The top ten of these largest systems reached $10 to $60
billion in revenues with many obtaining outside private equity investments (Modern Healthcare’s 2016; Hospital System’s Survey, 2016; Modern Healthcare Systems Financial Database, 2020).

The hospital sector is taking a beating with COVID-19 with many failing institutions, which is extremely problematic in denying access to vulnerable urban communities and small rural towns. It will be prudent from a policy perspective to reinstate federal, regional, and state planning mechanisms to rebuild a proper distribution of medical resources rather than leave it to marketplace madness.

Corporatization Spreads: Nursing Homes, Prisons, and Education

Market ideology is so ingrained in American society that it is often automatically suggested that privatization is the preferred “solution” to numerous sectors, including public water system infrastructure (Ivory, Protess, & Palmer, 2016) and other municipal activities. Reaching out to Big Tech for help, post-epidemic should heed cautionary notes also (Klein, 2020). This “private sector can do it well” thinking is so pervasive that not much thought is given when turning over huge sectors of government and non-profits to corporate operators; too often contracts are not tight for performance measures and accountability, and enforcement tend to be weak. The result is often a changed nature to the entire enterprise: witness the nursing home industry, prisons, universities, and much more.

The phenomenon of corporatization ranges from hospitals to the nursing home industry (which has been predominantly for-profit ownership). The earliest hospital chains, Hospital Corporation of America and Humana, came out of nursing homes. Beyond the concentrating hospital industry nowadays, the increasing nursing home consolidation is solidly for-profit (about 11,000 out of 15,640 nursing homes are for-profit) (IQVIA, 2018a, 2018b). MedPage Today (Wynn, 2017) reports on the rate of complaints in nursing homes going up more than 37%, with increased severity too. More than half were characterized as “immediate jeopardy” or “high priority,” the most serious types of cases. Findings by the HHS Office of Inspector General on state investigations into complaints at nursing homes usually do not bring change.

This discussion on the warehousing of our nation’s elderly takes on special meaning as we observe the mass deaths in long-term facilities exceeding 50,000 from COVID-19 by June 2020, 40+ percent of the nation’s almost 200,000 deaths (Kamp, 2020). Nevertheless, the common notion has held that both hospitals and nursing homes require “management,” so private investment was naturally thought to be preferred. Proprietary hospital chains actually originated out of for-profit nursing homes (like private prisons both used “hotel services”). This occurs when some federal and state payments became available. The model of corporate ownership was from the likes of Hospital Corporation of America and Humana. Not as
profitable as market, it was easy to jump into nursing homes, so several chains saw an aging population in middle and working class as a market with some government subsidy plus ability to pay from savings; thus more bodies in beds enlarged their supply chains, so expansions ensued.

As the coronavirus outbreak swept the nation, it was initially seen that the squalid conditions in any congregate living arrangements for the elderly were figuratively petri dishes for its spread. Historically, state agencies were reported not to respond well to patient and family complaints. Nursing homes have had high staff vacancy rates as well as high turnovers, due to low-paid salaries, with often scant professional supervision. Federal data has shown most nursing homes overstate their numbers of nurses and caretaking staff to the government. Therefore, fluctuations and gaps in care are common, affecting health code compliance, residents’ meals, and medication regimens. Of those 14,000 nursing homes, 7 in 10 reported lower staffing levels based on the evaluation with an average drop of 12% (The Health 202: Medicare For All, 2019, p. 1). Such poor conditions of labor yield high profits for investors or even provide for staying financially viable for the so-called “not-for-profit” nursing homes, given persistent historically low State Medicaid reimbursements, which vary by region.

Beyond these conditions, lax scrutiny over abuses of residents means many cases go unreported, estimated to be over two million annually, according to Lawyers.com (Chant, 2019). Types of abuses in nursing homes include a range of physical abuses (cuts, bruises, torn or bloody clothing, pulled out hair, broken bones), plus emotional abuses, including intimidation, humiliation, isolating the patient from family and other residents, mocking, or terrorizing the patient, along with outright neglect; signs of neglect include malnourishment, dehydration, unwashed clothing or bed linens, and failure to administer medication properly (Chant, 2019). These cases of abuse go unnoticed, even by caring staff since as Rau has noted being like “ghost towns.” He notes underreporting to the government on staff patterns, which bolsters family suspicions of inadequate staffing (Rau, 2018, p. 1).

The poor situation of how our elderly and disabled are treated in long-term care facilities has been developing for a long time; it is mighty complex, which will make it difficult to remedy unless there is determined public outrage in certain states over the virus revelations. Designing workable regulatory policy remains challenging, but all that may be needed is a few state reform models. Many targeting efforts in the past have not been corrected due to the ownership issue, their influence on state governments, and their outright seeking profits, amidst the low reimbursement climate by Medicaid. With ensuing lawsuits and the reality of folks not trusting these facilities to be safe, it just may come that investors pull out of this line of business, especially if regulatory oversight comes to pass.

The size of a nursing home facility can reach 1000 beds. The top 50 nursing home chains that own as many as 426 facilities in the largest chain, so nursing homes vary in size by individual facility and by the largeness of network-owned chains (Flessner, 2019).

*The New York Times* article “Nursing Home Industry Wins as Penalties are Relaxed” noted that the Trump Administration scaled back fines against nursing
homes that harm residents or place them in grave danger of injury—part of a broader regulatory relaxation under Trump. Rau calculates that nearly 6500 nursing homes—4 of every 10—receive a citation at least once for a serious violation (Rau, 2018, p. 1). Another article in The New York Times entitled “Care Suffers as Profits Rise” reports that complaints are higher at nursing homes that feed money to their owners’ other firms. Caring for the increasingly elderly population in America who need competent caring in nursing homes has been compromised by sinister capitalist arrangements, an increasingly common business arrangement where owners outsource a variety of goods and services to companies where they have a financial interest or control. More than 11,000, or nearly 75% of nursing homes in the United States, have business dealings known as related property transactions, according to an analysis of nursing homes’ financial records by Kaiser Health News (Rau, 2017). Some homes even contract out basic functions like management or rent their own building from a sister corporation claiming this is an efficient way of running their business and can help minimize taxes (Rau, 2018, p. 5).

This financial gaming is commonplace to marketplace medicine across the industry, among multiple creative means to rake in greater profits. In another The New York Times piece, “Care Suffers as More Nursing Homes Feed Money into Corporate Webs” claims that contracts with related companies accounted for $11 billion of nursing home spending in 2015—a tenth of their costs—according to financial disclosures submitted to Medicare. Investigations, such as these superb The New York Times articles have been replicated by cub reporters from local newspapers across America for decades, recognizing and responding to patients’ families’ concerns. Mostly all conclude the nursing home industry is raft with corruption and financial craziness to benefit owners rather than the very patients they are supposed to serve. Nursing home presented conditions that allowed deaths to mount from the recent virus simply because residents’ lives have been neglected. It has been noted that nursing homes with related companies received fines 22% more often for serious health violations than independent homes, with penalties averaging almost $25,000 (7%) higher.

Most of these were for-profit entities that solely existed for the enhancement of investors. In a section entitled “Piercing the corporate veil,” the article maintained that utilizing separate limited liability corporations and partnerships gained popularity just as the industry consolidated by publicly traded companies, private investors, and private equity firms. This above article cites a 2003 piece in the Journal of Health Law (Casson & McMillen, 2003) that encouraged owners to separate their nursing home businesses into detached entities to protect themselves if governments ever tried to recuperate overpayments or if juries levied large, negligent judgments (Rau, 2018, p. 6).

Again, it should be clear that the care for our nation’s elderly has long been placed in jeopardy by such financial shenanigans. Investigations and lawsuits following the mass negligence after COVID-19 infections will likely uncover much corruption. An article entitled “At Many Homes, More Profit and Less Nursing” claimed a typical nursing home acquired by a large investment company before 2006 was scored worse in national rates using indicators to track ailments of
long-term residents (Duhigg, 2007). Those included bed sores, usually preventable infections, as well as the need to be restrained. Before they were acquired by private investors, many homes scored at or above national averages in similar measurements. Private investment companies have made succeeding in court difficult for plaintiffs, and for regulators, it is hard to levy chain-wide fines since such complex corporate structures obscure control of the nursing home. It should be noted large chains owned by investment companies earned $1700 a resident, according to reports filed by the facilities. Those homes, on average, were 41% more profitable than the average facility (Duhigg, 2007, p. 2). The way firms earned greater profits is that managers cut clinical registered nurses sometimes far below levels required by law. For-profit homes were seen to put profits first, so the epidemic brought these practices to greater light (Goldstein, Silver-Greenberg, & Gebeloff, 2020). In The Washington Post piece entitled “As nursing home residents died, new COVID-19 protections shielded companies from lawsuits,” Cenziper, Whoriskey, Mulcahy, and Jacobs (2020) explain how Governors gave immunity to protect the nursing homes and their owners, plus appeals to Health and Human Services Secretary Alex Azar and Mitch McConnell went for naught. Families may have little recourse.

At the state level, rules and regulations over nursing home operations tend to be lax, and several states have more lenient surveillance and enforcement than others, typically drawing widespread criticisms. Our 50 states vary greatly in the quality of nursing home care under their supervision. In regulatory statues, definitions of “abuse and neglect” are usually insufficient. Staffing patterns and training issues of nursing assistants, who take care of patients’ daily needs, are pervasively poor, so personal care standards are easily compromised. Beyond the training and supervision of these very low-paid staff is the turnover issue, which often split state agency regulation that does not adequately address. For example, in Illinois, the Department of Public Health provides for licensure, but the Illinois Department of Public Aid handles reimbursement. Coordination between state agencies can be problematic beyond interagency work with a Department of Mental Health also. This situation may be replicated across many states where licensure and certification and inspections are different from the financing issues, even while they are usually poorly reimbursed, or not adequately examined. Thus, legal problems notoriously arise over “informed consent” and families being notified of what happens to their relative.

The virus has devastated nursing homes across the country, before staff were regularly tested and given PPE, and visitors were prohibited (Healy, Richtel, & Baker, 2020). Chances for infection of their relatives became the main worry of families in the understaffed and underfunded homes (Reilly, 2020). This worry and the horror of deaths will likely lead into widespread lawsuits through 2021. Look for a withdrawal of investment dollars as facilities close and go bankrupt, particularly where severe occurrences in Nebraska, Wisconsin, Washington State, Illinois, and New York made headlines. In April 2020, The Washington Post claimed that one in ten nursing homes nationwide reported coronavirus cases (Cenziper, Jacobs, & Mulcahy, 2020). The Wall Street Journal said deaths topped 10,000 that same month in nursing homes (Kamp & Mathews, 2020).
It became apparent that the elderly, especially with underlying chronic disease, are highly vulnerable to death from the virus (Cavendish, 2020). Such should have been suspected with prompt preventive actions taken. Without professional quick response, which is generally lacking in this industry, along with limited testing by the federal government, it is reasonable that staff were likely bringing in the virus. Same goes for homes for the disabled and other social service agencies indicating just how badly the US healthcare system was prepared for the outbreak and how bad the national leadership was!

Obviously, states were not policing homes (Chicago Tribune Editorial Board, 2020b). Ornstein and Sanders (2020) maintain nursing homes allowed the virus to explode when they violated basic health standards like isolation, use of PPE, and failure to maintain social distancing. Thus, it was no surprise nursing homes turned into disaster zones. Will stricter regulation and enforcement now ensue (Yin, 2020; Kacik, 2020a, 2020b)? Perhaps a few states will step up as models, but reform of this industry segment will be formidable.

For sure, the impact on staff has been devastating, since nursing assistants and support staff are poorly paid with few decent benefits. An SEIU union in Chicago threatened a strike (Editorial: A Nursing Assistant Strike during COVID-19) seeking pay raises, sick pay, training, and prevention protections (Chicago Tribune Editorial Board, 2020a). Previously, CMS had intervened with nursing home penalties and cracking down on inspections (Castellucci, 2018; Brady, 2019). Change has come very slowly to nursing home reforms simply due to few state and federal priorities and the industry’s power to resist. So most past attempts at change over time seem futile up to this present moment of crisis. In September 2019, CMS considered rewarding SNFs for outcome-based care in its Payment Driven Payment Model, which may in theory eliminate unnecessary therapy services designed to build profits (Kacik, 2019). This was intended for system change away from Medicare fee for service—a side effect is the imposed data sharing with hospitals. Nursing home professional staff will need to discover what is “clinically appropriate care” with this costly change. After hospital discharge, patients’ needs today are more complicated, so facilities must gear up for complex cases by hiring additional nursing staff, which is costly, as payments get restricted. Such tinkering with reimbursements usually does not have adequate policy follow-up for neglectful practices in this segment of health care.

Financial watchdogs rarely pursue this industry except in one case in 2019: the US DOJ prosecuted Illinois and Florida nursing home operator Philip Esformes guilty of Medicaid fraud (Jackson & Ariza, 2019) for $1.3 billion. The judge in the case called the operator orchestrating a fraud unseen by anyone prior (Jackson & Ariza, 2019, p. 4).

If nursing homes had been thought of as “God’s waiting room,” they might after COVID-19 actually have morphed into Sarah Pain’s vision of death panels!
Prisons and Immigrant Detention Camps

The phenomenon of corporatization is so prevalent across American society that it has spread from hospitals and the nursing home industries to the privatization of prisons, immigrant roundups, and for-profit universities.

Additionally, the coronavirus outbreak exposed the sad conditions in congregate living arrangements for prisoners and detainees before revealing the overall social injustice within minority communities, the police, courts, and criminal justice systems that are being protested and examined. Several prison systems were quickly highlighted as incubators for the virus as detainees found overcrowded and were not properly protected. Some jurisdictions released many merely recognizing the backlogs in the courts (those arrested who could not post bond, minor offenses, older at-risk prisoners, etc.). Cook County Jail in Chicago became a national top hot spot with 350 confirmed cases (Ivory & Williams, 2020) due to overcrowding of suspects.

Worldwide prisons (Coyne, 2020) quickly considered inmate release, sanitary cleanup, visitor bans, and other containment measures to quell prison powder kegs for rapid spread (Mancini, Cocco, & Shubber, 2020). Most prisons domestically historically have poor medical care, so coping with the outbreak proved impossible. As Ivory (2020) pointed out, these facilities are not hospitals able in any way to care for those infected, as attention focused nationally from the realm of local dilemmas, the plight of the Trump Administration’s ongoing incarceration of immigrants by the Border Patrol. Most of these facilities for the “illegals” are contracted out to private entities at huge costs, which were never well-equipped to render sufficient medical attention before COVID-19.

Nationwide overall testing was so poorly conducted by the Trump Administration so it would not be expected to prioritize all at-risk groups in nursing homes, prisons, jails, and detention centers. Just on the basis of crowding in such facilities should have given reason to mobilize much greater efforts.

Social distancing in crowded prisons and immigrant detention centers, along with improper sanitation, lack of PPE, and medical capabilities placed these populations at very great risk. It was predictable that rates of infection would zoom disproportionately, and they did. The United States had 1.5 million citizens in state and federal prisons in 2016 (Gotsch & Basti, 2018). That makes 8.5% in private detention. States with the most private prisons are California, Florida, Louisiana, Mississippi, Oklahoma, Wisconsin, and of course Texas, with its high of 13,985 but down from 20,000 in 2008.

The Trump Administration placed 73% of immigrants in privately run facilities. Attorney General Sessions reversed the Obama Administration directive to phase out private prisons. From 2000 to the present, a boom in private prisons saw five times increase in people going to private prisons (Gotsch & Basti, 2018).

Factors for such an increase were the driving quest of profit and the tendency of federal and state officials to favor privatization schemes, along with how the war on drugs, mandatory sentencing, minimum sentences, and tougher policing expanded America’s prison population beginning in the 1980s. One in 12 convicts receives a
private placement, a 47% jump since 2000, while the total population increased by 9%. The two largest corporations are CoreCivic and GeoGroup that run private prisons with contracts exceeding $3.5 billion in 2015. Lesser offenders, not necessarily major felons, get housed in private places since security costs tend to be lower for them.

Over 26,000 immigrants are detained in privately run facilities. Contracts by U.S. Immigration and Customs Enforcement (ICE) are for beds even if not filled. There has been a 442% increase since 2000 into over 200 immigrant prisons and jails in the United States (Gotsch & Basti, 2018). Average length of detention can run as high as 100 days. Some facilities force work upon the detainees paying $1 per day. A heightened political issue with full press coverage has centered on separation of families and the poor conditions for women and children and lack of medical care (Gotsch & Basti, 2018).

Proponents for privatization of prisons argue cost-savings, but some research casts doubt on the validity of this line of thinking (Private prisons, 2020). The promise may not have materialized according to the US Bureau of Justice Statistics. So controversy continues as privatization remains an international phenomenon across many nations.

As to the effect from the epidemic, one would hope local, state, and federal enforcement would emerge with better quality performance measures and see that they are met transparently so that private contracting proves its so-called cost-savings. The ideology of privatization where for-profit entities take over formerly public functions must be fought on the basis of evidence, which Gotsch and Basti say is lacking. Known for lower staffing levels, correction officers in private prisons earn considerably less than public facility counterparts who receive superior training. Quality and performance concerns persist. Since for-profit prison growth trended with growing crime rates and tougher sentencing patterns, it may be hopeful to believe that the ongoing street protests for police and criminal justice reforms may eventually lead to an examination of this notion of letting the “free market” rule in private prisons.

**Universities**

The COVID-19 epidemic had an abrupt impact on higher education and may just provide a lasting transformation to the sector. University administrators were among the first to act as students were returning from spring break by shutting down classrooms and dormitory life to prevent the virus spread. Classes were cancelled, and students dismissed (Green, 2020a); colleges had their money for tuition, fees, and dorm rentals, so most colleges thought hastily assembled online courses a la Trump University might suffice for the end of the semester. Many faculties were insufficiently prepared for online learning, and students found growing frustration from not seeing friends and having a campus experience. Senior health science students needing rotations, science majors missing lab settings, and theatre arts and music
students requiring interaction, among others, find online courses not decent substitutions, and surely not worth the costs (Minhaj, 2020).

Students and parents thought the replacement of classroom learning and the campus experience somehow was not worth the $30 to $60 thousand or more. In truth, universities faced a hard lesson (Jack & Smyth, 2020); they began to lose their constituencies. Parents at DePaul University in Chicago demanded their money back (Cherney, 2020). Other colleges will face lawsuits as folks are drawing up class action suits. Who knows how many international students, whom many institutions depend upon for their much higher payments, will return upset for being outright dismissed and/or for fear of the continued epidemic spread?

Then many students may just not return for the fall semester (Anderson, 2020; Hubler, 2020) believing downgraded University of Phoenix-type degrees will not be useful to a future job search. An estimate of 15% dropout has been made (Minhaj, 2020). College used to be aspirational as a mechanism for social mobility. The general public has now begun to assess what value a degree may have as costs are sure to rise. The virus requires continual testing (for the virus and not what students learn), eliminates lecture halls and sports events, and imposes social distancing, masks, single-room dorms, and other restrictions college students may not take to.

Recently, examinations of high administrative costs, use of endowments, expenses for sports activities, overall budget allocations, and other aspects of universities are now in play. For sure, fiscally strapped states will be unable to pony up extra funding for public universities; many may be in jeopardy for cuts if not closure. Since universities have been corporatizing over the last few decades, queries into administrative decision-making and priorities in operations will likely discover many points of critique. Over the years administrators have wrung profits from bookstores, sporting events, parking lots, dining facilities, etc. Yet, it is estimated that 1/5 of colleges are at risk financially, so along with the questionable fate of public universities which have become more dependent on tuition (Carey, 2020), a period of consolidation may be on the horizon for US universities. The shift will deepen from academic to corporate.

With college shutdowns this past spring, the online for-profit colleges saw an opportunity to snare students through renewed advertising campaigns (Kolodner & Burtrymowicz, 2020) though this segment of education still faces a tarnished image due to several firms leaving graduates with huge debt and questionable learning. As state budgets slowed and higher education saw cuts and stagnation in the early part of this decade, this for-profit segment grew. Like for-profit hospital chains, certain firms became darlings of Wall Street. Internet offerings were attractive especially to full-time workers. Large institutional investors swept into this industry, but concerns for quality saw enrollments drop from the heydays of 2010–2013 along with lower student loan repayment rates and lower graduation rates. For-profit higher education corporations received $32 billion in Title IV funding, approximately 70% of their funds. America’s largest university, University of Phoenix, enrolled nearly a half million students in 2010 with revenues approaching $5 billion to demonstrate the advertising and political connects count.
As in primary and secondary education with US Education Secretary Betsy DeVos trending toward privatization, political revamping will have profound effects (Green, 2020b). For sure, the Big Tech firms have become entrenched in both hardware and software, strengthening their grip with the stay-at-home schooling orders. Google for Education, Apple, and Microsoft have long had major involvement in education, though critics feel much is not meeting the high expectations (MSNBC, 2020). Over the past few years, Google Educator has gained entry into many school districts to sell Chromebooks and to promote reliance on its search engine, Google DOCS, and drive. Teacher resources are also provided. Its dominance not only defeats competitors but also extinguishes the possibility that competition may occur, besides engraining a certain system dependence over time, according to Duhigg (2018). Likely the school market for online instruction from IT firms exploded after the epidemic led to school shutdowns, and individual families who are home schooling can be customers too.

With the ongoing economic turndown, the job market for the 3.9 million spring college grads appears uninviting (Weaver, 2020). As with the 2008 global financial crisis, a generation of young people, debt-ridden from their education expenses, will face tough life prospects, and so it may be for a few years for the current enrolled group of students given the state of the economy.

This entire social situation demands astute minds to consider progressive man/woman power planning for this generation for a productive future, and not rely upon an erratic market scramble for chaotic guidance. If the Trump Administration should try to resolve issues in the education sector, Betsy DeVos’ outright support of for-profit schools can give indication of the policy drift (Dayen, 2019).

### Drug Store Retail Clinics

HMOs were sporadically resisted by the medical profession; certain doctors found the competition shrunk their practices by siphoning off paying patients after the 1973 dual-choice HMO mandate fell into the hands of employer HR offices. The HMO effort proved to be less encompassing of the profession as practices became bought up by hospitals to feed their specialists and admissions. Greater numbers of doctors began the trend toward employment contracts, now approaching 50%.

Not really anticipated by the profession was the fast diversification of chain drug stores that spread all across the nation in huge numbers. There are now an estimated 3000 in-store clinics, 14 times an increase over 10 years to 2018 (Retail Bus Tour, 2014, Statista, 2018). Additionally, there are 7.639 urgent care centers, now itself an $18 billion segment of health care, offering perhaps a higher acuity service with corporate physician staffing (Japsen, 2018). For cost concerns, this ambulatorization of medicine seemed to be heralded, along with surgicenters and MRI units, but they became mainly corporate in sponsorship over time, usually shifting doctors out of hospitals (Lovrien & Peterson 2016a, 2016b).
Pharmacies had begun to morph beyond just dispensing prescriptions into more clinical services to complement their general store functions in many neighborhoods. Walmart and other big-box firms, many chain food stores, and the Walgreens, CVS, Rite Aid, Target, Health Mart, Rexall, Kroger, and the like pharmacy industry identified the opportunity in being the “most accessible healthcare resource.” Their general store function provided front-end consumer products to attract customers, so why not design retail clinic space?

With the purported demand for primary care and consumers seeking better access to convenient care, store managements set out to hire nurse practitioners and physician assistants from their ample supply to directly compete with family medicine and pediatrics, whose patients seem to prefer shopping while waiting for their appointment, as well as getting the prescription right from the pharmacy in the next aisle. Retail clinics began to handle minor medical needs, well childcare, vaccinations, and preventive care. Several have moved into chronic care management and lifestyle change strategies for reimbursements and out-of-pocket payments.

Moreover, it was the lower cost of care over physicians, free parking, and most of all easy and convenient care that consumers tend to like, supportive of the “consumer-centric” rhetoric that has become common in the healthcare system. Besides, one can pick up drugs, groceries, and other sundries afterward or while waiting—reportedly always less time than hanging at the doctor’s office with sick people. Moreover, there is a huge rack of magazines in the store to choose from, since some patients have complained about old used reading materials in doctors’ offices, besides other historic gripes. This last comment is intended to point out that consumerism is not always that great.

Retail clinic visits are to the dismay of local medical practitioners who get to hear favorable satisfied reports from their patients, who regularly prefer retail clinics and tell their doctor if not records having transferred. Some areas of the country saw a doctor backlash as editorials in medical journals questioned their quality management or sought to besmirch nurse practitioners. Research from RAND has shown that retail clinics do not necessarily reduce ER use and may actually be contributing to higher overall spending. Records are not readily shared unless a hospital system connection has been established. Many hospitals have recently begun to affiliate with a number of retail clinics to establish referral mechanisms and to actually participate in this rapidly developing change in medical care delivery.

**Pharmacy Benefit Managers**

Rising like a phoenix in the desert, pharmacy benefit managers (PBMs) have ballooned as gigantic newcomers to corporate health in a very short time. Several PBMs now have greater revenues and even higher profit margins than the largest pharmaceutical firms—remarkable since PBMs have only been around since the early 1990s. In the late 1980s, their predecessor third-party administrators (TPAs) organized to pay prescription bills to pharmacies. Since many pharmacies had
already computerized to maintain their growing inventories and conduct online ordering from drug distributors, it became possible later on for online claims adjudication and eventually to direct pharmacists for clinical oversight, beyond just payment collection.

Thus, PBMs represent the quintessential opportunity for quickly amassing huge revenues and profits in the American healthcare market, which incidentally makes them valuable takeover targets of late. They piled up significant political power when President George W. Bush designated them as the handlers of the Medicare Part D drug program; they serve private insurance firms who carve out their drug benefit and self-insured corporate employers too—they perform a necessary overall administrative function for handling the over five billion prescriptions written every year. Again, the rapid industrialization of the healthcare sector brings such kinds of administrative oversight in all phases of health care.

The early and evolving PBMs were pharmacy card system (PCS) and diversified prescription system (DPS), both fast growing and later absorbed by pharmaceutical companies Eli Lilly and SmithKline Beecham, respectively. Pharmacists in stores liked this model that allowed them to maintain their customer base and get paid, stores being then mainly independently owned while the big store chains began to grow.

The potential for industrialization of drug distribution became evident as more drug entities came onto the market and prescribing zoomed. The upgraded industry expansion was found to lie in mail order pharmacies, where the RX was electronically transmitted from the prescriber and then shipped out from gigantic automated dispensing warehouses to patients’ homes. Bulk purchasing of generics from overseas became commonplace; automation allowed a robot to fill up to 50,000 scripts per day, which enabled employer demands for cheaper generic substitutions to be met. Fewer professional pharmacists were left in the community.

Nevertheless, the industrial model for centralized dispensing (MEDCO, a PBM later acquired by Merck) had provoked the ire of practicing pharmacists in independent operations; their customers no longer came to the pharmacy for their prescriptions, nor to buy various dry goods and sundries. With mail order pharmacies now dominant today (between 80% and 90% of the total United States’ 5.4 billion scripts are handled by all PBMs), PBMs get rich on volume dispensing so—like with Trump, the argument of *no collusion*—between PBMs with Pharma seems like thin gruel. PBMs sought special relationships with pharmaceutical firms who pay them for preferred brand status on their formularies; they jointly conduct disease state management programs to push preferred entities, and PBMs sell their valuable data to drug firms if not producing bountiful health services research from their data warehouses (Dedhiya & Salmon, 1998). Notwithstanding, in the “blame game” over drug pricing, greater antagonisms between the two are emerging with recent public attention to increasing drug prices.

More so, an aging cohort of BS-trained burgermeister pharmacists was retiring, so thousands of small stores closed per year in the 1990s. As a result, pharmacy wastelands arose in rural and inner-city neighborhoods (Qato et al., 2014), with no
infrastructural relief other than big-box Walmart mushrooming across the land—an additional factor driving out small community pharmacies. Pharmacies were never under federal health planning (CHPs or HSAs) guidelines; business owner pharmacists were never involved partly due to the professional socialization for business owner pharmacists. Such massive closures over this decade were not necessarily merely managed care-driven per se, but complicated by the rapid expansion of chain drug stores, several of which had started their own PBMs. Again, demonstration of health marketplace disruption and destruction was clearly witnessed, with professionals at most risk ceding to more powerful corporate entities.

As corporate chain drug stores ballooned (Walgreens, CVS, Rite Aid, Kroger, Albertsons, Kmart, and more), the top ones garnered between 2000 and up to over 7000 locations, expanding beyond regional to nationwide operations. PBMs added to their lines of business when George W. Bush rewarded them with Medicare Part D; profits for both chains and PBMs grew quite handsomely.

PBMs make money processing each prescription Rx claim and using profitable mail service that allows generic substitutions. They also sell usage data to pharmaceutical companies, who also discount their brand cost for preferred formulary status. Commonplace today are tiers for co-pays to incentivize patients to buy cheaper generics, prior authorizations to push prescribing away from costlier entities, and directed clinical interventions at the pharmacy counter toward practitioners for patients and both now part of the more invasive modern PBM. Some PBMs have even broken down the silo of medical and pharmacy benefit data integration to promote some coordinated care, particularly at the request of larger employers for cost savings. Each administrative “innovation” may be beneficial in ways for patient care. Nevertheless, highly profitable PBMs remain essentially unregulated in the ongoing marketization of drug benefits, which are becoming highly complex and often undiscernible to even insiders.

Then at the end of 2017, the business press was ablaze about pointed developments related to pharmacy benefit management, but existing firms became more and more alarmed by the new competition while their stocks plummeted, when IT industry firms even mentioned, let alone actually stepped in (Schencker, 2018). Earlier in 2017, insurer Anthem initiated a shake-up by ditching the number one PBM, Express Scripts (a not-so-uncommon industry practice of changing partners), following legal suits and countersuits. Anthem reportedly sought “complete control over its formulary,” meaning an attempt to lower outlays to keep more money for itself.

Given the historical trend of divorces within the PBM industry, consumers might still need to adjust to new benefits, different drugs, new pharmacy sites, higher copayments, and deductibles—as drug prices will surely continually rise. Modern Healthcare (2017, p. 17) has highlighted this trend when they noted that PBMs are under a consolidation trend with insurers opening their own PBMs to more effectively control costs, as well as gain them access to more patients and physicians.

As consolidation continues, a Becker’s Hospital Review article (Haefner, 2018) stated that OptumCare is employing a huge amount of all employed doctors and scaring both Kaiser and hospitals in general. Insurer United is said to direct its...
insured customers toward its acquired physicians. So, it can be seen that insuring populations corporately controlled leads to greater administrative control over physician behaviors, along with their prescribing, all adding more layers of cost.

PBMs control prescription drug benefits for employers, insurers, and the CMS. Since their early stages, firms have sought to negotiate discounts with pharmaceutical companies and establish pharmacy networks in order to implement their own created drug benefit plans. Lately with the societal concern over exorbitant drug price escalations, the “blame game” has drawn greater attention to PBMs for not doing more to restrain pharmaceutical manufacturer prices. Trump recognized the PBM political vulnerability and chose to leave his friends in the drug industry less culpable for high prices. Needless to say, PBMs’ activities and their extra profits do create a greater patient burden from every consumed drug after the PBM pockets any discounted savings and then adds administrative overhead, which policymakers should find embarrassing for the United States compared to all other nations. Criticisms are now levied that PBMs have not done much over 20 years to restrain the consumer drug price climb, so as with many Trumpisms, it seems implausible to believe that “There is no collusion.”

The healthcare industry is now awash with discontent between and among PBMs, manufacturers, hospital systems, insurers, specialty pharmacies, wholesale distributors, and chain drug stores all pointing fingers at each other over horribly high costs in the midst of their collective richly lucrative business model; this business model based upon increasing profits appears to ultimately not benefit consumers, nor many employers for that! Partly the long persisting “silo effect” has precluded coordination in the delivery system (fragmented doctors disconnected from pharmacies unconnected to other clinical facilities). This outmoded structure may now be giving way with industry vertical integrations. Many thinkers may see integration as the answer to the cost and quality problems, but we should ask in what ways and importantly under whose auspices and for what purposes. Integration does not by itself yield the key care coordination.

The year 2017 initiated a tidal wave of changes across the health sector. Express Scripts allegedly overcharged Anthem over several years, leading the insurer to end its outsourcing to an external PBM (Matthews, 2017). A number of new permutations in the consolidation process are rapidly proceeding—all under the banner of providing better service for less money and improved efficiency (Spitzer, 2018c). Noted from the above comment, should disbelief be warranted in more “whataboutisms”?

Anthem’s deal with its IngenioRx, with CVS arranging for distribution, is said to save Anthem $4 billion annually (Haefner, 2017a, 2017b, 2017c). Firms’ moves to consolidate for their own interests can be seen in the example of constructing “preferred pharmacy networks.” For 2018, 99% of Medicare Part D pharmacy drug plans (PDPs) are distributed through “narrow networks” that incentivize filling of scripts at certain chosen pharmacies contracted within the network. Five giant insurers and two dominant PBMs control these networks, a corporate consolidation that again reflects taking advantage of federal Medicare funding (Fein, 2017). Restricted networks restrain pharmacist-owned stores that have historically complained that
managed care arrangements are squeezing them out, while larger chain stores have gradually taken over the bulk of the ambulatory prescription market share. PBM middlemen select drugs and negotiate discounts with manufacturers and then set rates for what pharmacies are selected to be part of their networks.

The current crop of PBMs has been enlarging over time with a flurry of previous M&As and some integration. Trace back any larger company to see a history of industry amalgamations usually with support by employers, insurers, and the federal government under the Part D program. However, these earlier happenings were by no means the biggest developments to shake ups in the PBM industry; the PBM industry’s current fluidity appears to be a consideration by Amazon to enter the field based upon the ongoing trajectory of this lucrative enterprise (Bond, 2018).

As the giant IT firms of US capitalism jump into health care, it is probable that their individual and collective impact will be momentous. Amazon is the “new kid on the block”—much bigger, much more powerful, and with greater ability to reshape the PBM industry due to its size, scale, and past behavior—Amazon has established pharmacy business Pill Pack as an adjunct to its e-retailing business. Existing players who realize hundreds of billions of dollars are at risk for a reinvention of the industry (Martino, 2017). Drug store stocks plummeted in June 2018 with Amazon’s acquisition of PillPack after rivals had voiced fears of its entry (Kim, 2018). The adjunctive Buffett-Amazon-Dimon ("BAD") collaboration adds still the unknown unknowns since this business of health care and drugs is indeed very complicated. Remember Trump’s point: “Nobody knew health care could be so complicated.”

Nevertheless, the strong national brand image of Amazon, and its generational following among younger online buyers (92% of online shoppers have bought from Amazon) makes entry of competitors all but impossible. Vartorella (2018) maintains Amazon has forced established PBMs toward “bolder decisions” to rethink the value proposition in the PBM industry, according to Martino. Customer service à la Amazon will be quite a challenge for a more compelling assessment of value (Martino, 2017). Its first move into pharmaceutical distribution to hospitals was labeled “disruptive,” even before the final decision was made by the company to buy PillPack to directly sell drugs to consumers. Both announcements dropped stock prices of chain drug stores and had most innovating trying to move toward improved customer service, since Amazon’s entry will hit bottom lines hard and maybe remove some of their customer bases. Amazon took steps to obtain pharmacy licensing in multiple states to sell drugs online, as well as open 450 whole food pharmacies. PillPack already has those state licenses. The total market for prescription drug distribution currently is around $560 billion a year, which will give the mega Silicon Valley firm plenty of business to siphon off. The Amazon entry to become a major hospital supplier (Paavola, 2018) represents the growing hegemony of the corporate tech industry over multiple facets of American life, now analogous (but much more pervasive) to the auto industry’s reshaping the society, along with American culture in the twentieth century.

Nevertheless, as a new entrant, Amazon will find that the prescription distribution market is highly complex with a huge varied number of entities in the insurance, hospital, nursing home segments, as well as 56,000 nationwide chain pharmacies (Sharif, 2017). For sure in the American retail marketplace, a cultural change has been taking place, where consumers are seemingly more demanding for
quality and service, and they are armed by the Internet with much more information about products and prices. The Amazon transformation of the PBM industry would not eliminate brick and mortar stores by the chains since they can design customer experiences beyond mere mail order, so they will likely survive in some new form, particularly with their retail clinics. Yet, the might of Amazon is amazing; 354 million different products are under its warehousing, so adding 8 to 10 thousand drug entities may be easy. Moreover, Amazon is known as a highly competitive company going for scale to drive down prices (as seen in groceries), so what it does in drugs remains to be seen. Amazon is also working with Chase Bank and Berkshire Hathaway on their direct contracting scheme. Its potential entry into drug distribution may have also provoked CVS and its deal makings with Aetna, with more predictable overall changes to come.

After the failure of the Aetna-Humana combination in 2015, this large insurer waited as CVS took a long time to go for its $240 billion market combination. CVS is the number one drug store in the country with its Caremark PBM arm. The CVS/Aetna arrangement will have greater leverage over reducing Pharma prices. If the merger goes through, it will be the biggest deal of 2017: $66 billion in sales where CVS is offering a 25% premium on the stock price of Aetna. Higher drug costs have been said to be a contributing factor in this arrangement (Terlep, Matthews, & Cimilluca, 2017).

Successful PBM/insurer amalgamations can be seen in UnitedHealthcare/ OptumRX with other insurers considering owning in-house PBMs rather than outsourcing (Sorkin, De la Merced, & Tsang, 2017; Grant, 2017). UnitedHealthcare, the largest insurer, has also been exploring partnering with a pharmaceutical firm. United made $50.3 billion in its third quarter, which was up to 9%, with its PBM profits reaching $1.7 billion, up to 15.7%. CVS gets more customers for its PBM out of the deal and can strengthen its retail clinics and other store activities. It represents, as several have stated, companies climbing up the “healthcare food chain” to integrate in order to grab a larger market share. Many big companies are rushing to integrate different business lines for cost efficiencies to achieve dominance in the market (Mattioli, Terlep, & Mathews, 2017).

Recently, drug stores have seen declining sales in their non-pharmacy retail operations, so the pharmacy and drug sales remain a higher percentage of their revenue (estimated up to 75% for some firms and growing lately). Of course, when customers walk in to pick up their prescriptions (rather than using mail order), they grab a shopping cart to buy sundries on the way to the back of the store. The Federal Trade Commission (FTC) intervention against horizontal mergers led Walgreens/Boots to buy only half of the Rite Aid stores across the country; this was the largest and most controversial M&A of late. Other integrated drug chain stores may now be explored and not necessarily be FTC opposed. The CVS/Aetna combination is thought to be better able to face off against not just pharmaceutical manufacturers but also the powerful giant hospital systems, both of which are on their own seeking to merge, integrate, and expand.

Humana, the $37 billion insurer heavy in the Medicare space, was unable to consummate its horizontal deal with Cigna (U.S. District Court, 2017). So Walmart ($500 billion revenues) is seeking to forge another profound shake-up in the benefit
industry (Mayer, 2018). Never a paragon for its workers’ health care, the giant retailer may seek to leverage its 4700 nationwide stores to provide primary care for both employees and the general public (Tracer & Hammond, 2018). By owning Humana and bypassing other insurers, Walmart can remove the middleman and deliver directly to consumers while at the same time use its massive bargaining power to lower prices (Bloomberg, 2018a, 2018b, p. 2). With the highest revenue corporation in the world, Walmart’s profit fell 42.1% in the 4th quarter 2017 year over year. This mammoth is moving from merely big box to delivery of products during COVID-19, now requiring masks 6 weeks after the beginning of the outbreak.

The business press, along with the healthcare press, has lit up over all of these “disruptions” with Modern Healthcare declaring it “has reached its tipping point” (Disrupted, 2018). Much of the business coverage accepts the corporate line of great things to come for lower costs and improved services, though it might be advisable to remain skeptical at this point in time. Indeed, the flurry of corporate consolidation is unprecedented with the new configuration yet hard to imagine. All of these nascent marketplace developments rest essentially at the announcement stage and wait to be achieved; none at this stage appears to be easy going, given the detail of the study to mount each effort amidst complicated market dynamics, besides the regulatory oversight, though rather weak if may currently be.

Back to the PBM industry, it should be noted that these firms perform a socially necessary function in administratively handling over five billion scripts annually written by physicians and other prescribers; it surely beats the workflow inefficiency and minimizes the mistakes of pharmacist dispensing in the community setting. Given that more powerful and dangerous pharmaceuticals are regularly dispensed lately and greater numbers of patients are consuming numerous entities at the same time, PBMS have corrected or rather eased a few of the potential mishaps.

Nevertheless, the facts are that PBMs are profit-based, essentially unregulated and have tended to serve little or no outright public health functions—this undergirds a clear policy mistake under the Bush Administration for neglecting how the states might together had designed a decentralized R model in the 1990s following their history of Medicaid script processing to conduct a similar function—though publicly performed and accountable. Providers may snicker at this given the way the Medicaid program addresses drugs, but little cleanup of this Medicaid payer system has ever received adequate policy attention. All the Republican rhetoric of devolution to the states and strengthening their role in health care to be closer to people seemed not to be considered in the policy debates over Part D. But instead Bush promoted the corporate takeover of Medicare Part D drug distribution. Federal grants to upgrade the states likely would have socially cost much less than the profit streams of existing private PBMs! A large public database for pharmaco-epidemiology would have been a public health researcher’s dream to improve drug usage in patients, thus potentially improving the health of the American population. Or we can wait for Amazon.

Private PBMs compete and rarely cooperate on much (except lobbying), particularly addressing the issues of rampant drug misadventuring in American society (Commonwealth Fund, 2019). The gigantic data warehouses they have amassed
have not been fully utilized in research for the most part; academic researchers rarely get privy to their proprietary data to publish in peer-reviewed journals. Volume-driven by making money for every script processed, only their strong generic substitution has restrained drug expenditures in the past from escalating even more; deals with manufacturers to push certain pharmaceuticals on preferred lists bridged ethical lines at times. A few firms have, however, sought interventions to improve pharmaceutical care among their enrollees.

Notwithstanding, the difficulty in critically assessing this profit-driven segment in health care rests in the overall corruption of overmedicating Americans with many tie-ins to what PBMs could be doing differently. The huge uptick in the cultural medicalization of everyday life and social problems (Illich, 1976) contributes heavily to this phenomenon, but when profits lead, criticism, let alone insider awareness, tends to remain absent. Consider over drugging with many drug categories—amidst the current opioid epidemic—that have created a catastrophic public health crisis among school children, incarcerated minors, prisoners, and especially the elderly in nursing homes.

**Summary Thoughts**

When considering any assessment of a national healthcare system, it is important to distinguish between the micro and macro levels, given that most health professionals have little or no preparatory course work in health policy analysis in their education, nor much orientation through their professional associations. Nor has there been much in-depth coverage to the complexity of macro-level issues in their journals (until just recently in a select few). It is easy, therefore, to understand the lag in consciousness among professionals; many physicians have not seen clearly and thus misinterpreted much over the last couple of decades.

The corporate takeover differs from the meddling by government that always seems to create antagonisms, though the federal government often serves as an instrument for vested financial powers in health care as depicted above.

At the micro level, one can detect functioning of provider organizations, where the clinical work of practitioners takes place and involves them deeply. Questioning management actions is on this level, though not often viewed in a larger political economic context. Physicians’ concern is understandably for patients and community needs—which those who seek care. But they tend to see care at the level of the individual patient’s presenting symptoms. Few tend to examine the larger picture of the public health realm from which patients collectively rise, though a new awareness has been provoked with COVID-19 for sure. Nor has the profession done well in assessing federal actions beyond a narrow self-interest, falling into the trap of little critique of the large medical marketplace (Sidel & Sidel, 1977).

Our nation has neglected for a long time, even given well-meaning attempts, to effectively address the greater unmet needs of the poor, minorities, LGBTQ, disabled, and other special populations despite numerous reports. In a market-based
system, the indigent with often complex cases brings little of value to the transaction; thus, they are often ignored, except by the dedicated though underfunded and overwhelmed public hospitals and clinics, community health centers, and maybe select academic medical centers. By focusing on the micro level, one can however, become cognizant of the multitude of variations in our complex delivery system—from the maldistribution of resources to the diversity of population groups; such critical differences in the nature of care delivery systems are to be noted, though greater understanding derives from analytically viewing such developments from the larger macro level.

In contrast, this larger level is determined by the societal character; in turn, it affects all the nuances of the unique healthcare structure and the social policies that evolved historically. Service capacities can be assessed, along with the history of health policies at the national and state levels. The social epidemiology (the population’s objective health needs) can be discerned to shed light to both the nature and effectiveness of health policies, the services delivered, and the overall societal character.

Here also at this level are advances in medicine, the forces of science and technology, and the roles of supply industries (in the United States, determined in the political economy of the medical-industrial complex), academic medical centers, the National Institutes of Health, Food and Drug Administration, Centers for Disease Control and Prevention, Centers for Medicare & Medicaid, philanthropic foundations, and policy research centers. Each should be examined in light of its ability to stand and serve the public’s true health interests, rather than be influenced by the market structure, its corporate parties, or the political party in power. Unfortunately, individuals among this collectivity may harbor critical views of marketplace medicine, though they mostly accept the overall situation as given and immutable. Case in point is the Centers for Disease Control and Prevention under Trump!

But it is crucial to note that looking at the macro level provides us with a broader understanding of the major players and their power and influence, exerted not just in everyday life of the healthcare workforce and provider institutions but also in the setting of the tone, purpose, and direction of public policy.

Roemer’s (1990) description points out that there are unique characteristics of each and every national health system across the globe. All of them struggle with resolving problems of access, cost, quality, and accountability to advance their population’s health. Assessing overall system trends is important to grasping the micro and macro dynamics over time. The mode of financing health care and the share of public and private funds supporting resource allocations are important to recognize. The resolution of problems that crops up in the US healthcare system, whether concerning costs or the general effectiveness of the overall system, may depend upon popular demands for specific policy remediation. Redirections depend upon their orientation (market development vs. public health), as well as levels of sophistication, informed by critical health services research in the public interests.
To that end, we are witnessing in the national debate renewed efforts to uncover a more detailed comprehension of what has been happening. The level of health information technology has the potential to identify population disease patterns and design proper utilization of services to not only better treat but to prevent disease occurrences. Notwithstanding, it is crucial to note who controls this technology and for whom. In the United States and worldwide, the growing attention to analytics is crucial, both in terms of capabilities to examine sufficient Big Data for decision-making, including differentiating social determinants and demographics which remain lagging. Most importantly, who controls the analytics work, the metrics chosen by whom, and how they will be used for whose purposes? Vested corporate health interests are excited about Big Data, which should give pause to those concerned about the large public’s health or, for that matter, your own health.

All across the world, information technology is entering healthcare systems to illuminate issues that were only vaguely understood. Today though, a major problem arises when American multinationals swoop down on new foreign markets with suggested national policy changes to entrench their own interests (Human Development Network, 1993). Thus, the paramount issue becomes who owns and controls the chosen analytics, for specifically questioning institutions that facilitate the influence of multinational health corporations present on new markets after privatization schemes gets encouraged to various governments.

The United States remains the largest and richest national health system; it has perhaps the highest level of science and technology across many fields. Yet, the United States will spend $4 trillion in 2020 (now approaching 20% of GNP). Its profit-based system continues to have the highest inflation rate year after year over any other nation of the world. The difference between Canada and Germany (the next highest spenders after the United States) and yet the former two provide universal coverage to their respective populations, which are healthier, but at a cost about 40% lower of what the United States spends per capita. Federal estimates of our projected growth are now being recalculated with the Trump Administration and Republican control over the Senate. Still over $10,000 dollars are spent per capita with more than 12% of Americans lacking coverage (even after Obama’s ACA enrolled 20 million of the uninsured). This makes this expenditure highly problematic to government, businesses, and consumers alike. The ballooning costs affect the federal and state budgets who need to put in place austerity measures. Corporate employers have constrained their outlays for employee health and seem to have few clear options ahead.

Rather than examining the international community for ideas to develop a decent system that is more sensible, equitable, and cost-effective and move to achieve universal access, the authors believe that the Trump Administration and GOP Congress will double down on private market initiatives to “fix” what they think ails the US system, first aiming, however, to disenfranchise the indigent and then on to seniors—both considered unproductive segments of the economy. We can predict an explosion in an already bloated expenditure, as well as reduced access to more Americans. For those with current coverage, they may expect being subject to sometimes substandard, ever more expensive, and often unnecessary services while at the same
time facing iatrogenic care induced by an unregulated market system tending to medicalize all that appears wrong with us. This is not a hopeful scenario.

**Conclusion**

Health care in America is solidly corporate; most Americans may agree that profit seems to drive the healthcare delivery system, including providers, insurance companies, PBMs, chain drug stores, and peripheral supply firms, such as the pharmaceutical industry. Their collective purpose appears not to be enhancing the entire populace’s health by assuring access to needed services, nor especially concerned with raising the larger public health condition through other measures. This is not so easy to state since most physicians and practitioners have devoted their careers to serving their patients and many provider institutions do seek to perform to their utmost under challenging circumstances to serve their communities. Notwithstanding, corporate dominance in American health care and trends in public policy often act against the interests of health professionals (e.g., MACRA) with policies that greatly influence behaviors.

In the 1860s, Marx made the point that today remains critical: production thus produces consumption. When we examine modern medicine, it is important to note that true health needs in the population are grossly obscured by mere medical care utilization; here, Illich’s conception of social iatrogenesis appears crucial. What has evolved institutionally with the offered commodified form of medical services does not truly address a patient’s health and well-being, nor a population’s health. The definition of health has been argued and debated over time as the content of modern medicine has been critiqued (Kelman, 1975; Illich, 1976; Zola, 1972; Salmon, 1985).

We wish readers to ponder a newer broader concept of public health as they examine our writing: the sustenance of well-being among the entire population—apart from the clinical condition of a single individual patient’s designated services. This assumes the social, political, economic, and ecological contexts of life for varying cohorts in our society and across the world; thus, a strong commitment to health and health care as a basic human right is fundamental.

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