Chapter 7
Conclusion: Progressive Directions

Ideas, concepts, and strategies can be found among American progressive health voices dating back to Henry Sigerist (Fee & Brown, 1997; Sigerist, 1960) and before, in Germany, Rudolph Virchow (McNeely, 2002). Such broader perspectives that embody health and health care for all citizens represent an idealism that never seemed to take hold firmly in the American healthcare system.

Many cultural and economic forces stand against a collective sense of popular health, partly due to the episodic piecemeal reimbursement for medical practitioners but more to the focusing on high-margin activities (e.g., elective procedures and surgeries). The social medicine perspective that recognizes that individual health lies in social groupings was not persuasive under American individualism (Waitzkin & Waterman, 1974; Waitzkin, 2000). Social epidemiologists repeatedly have demonstrated that people do get sick in groups; they share many clinical and social demographic characteristics in common (Cwikel, 2006; Salmon, 2008). Therefore, it makes imminent sense to address disease patterns in targeted population groups through community-based interventions and not as individuals unrelated to the people and places they interact with on a regular basis (McKeown, 1965; Roemer, 1956).

Biomedicine’s grip remains doctor-centered, symptomatic- and disease-focused, episodic, and hospital-based with its technology fetish. In brief, it has made lots of money for providers and the medical industrial complex. Preventive medicine never took hold, and health promotion for populations never was developed. Moreover, there was not much money to be made in it, either.

Nevertheless, in certain academic medical centers, particularly beginning with the War on Poverty and Great Society policies, discussions in public health circles led to several designs and implementations from a social medicine perspective. Examples implemented were Neighborhood Health Centers, Comprehensive Health Planning, Regional Medical Programs, and a few more from when Public Health Service Commission Corps members were socially minded. These more forward-looking beginning attempts, unfortunately, did not advance widely due to prevailing forces of capitalism and subsequent Republican dismantling, as well as
complacency within the House of American medicine. The dominance of the structural payment arrangement of fee-for-service medicine and cost-reimbursed hospital care was profoundly influential in defeating alternative visions of healthcare delivery.

Observations Elsewhere

Thus, the United States never experienced a collective sense of health like what began in Europe, neither at the time of Bismarck’s Social Insurance Sickness Funds after 1890 nor the establishment of the National Health Service in post-World War Britain following the Beveridge Report of 1947. Social democratic policies have allowed Europe’s universalist health systems to do better on access and cost, even as every citizen gets coverage. America has ignored the social epidemiological lens except by some determined scholars (Berkman et al., 2014; Braverman & Gottlieb, 2014).

Clearly, American capitalist development provided plenty of empirical observations of the social, occupational, and ecological causations of disease patterns and its failure to address much causations except the most grievous and publicized one. Business was constantly externalizing their production costs to workers, and to the environment, but always sought to deny or cover it up. Even with Nixon’s establishment of the Occupational Safety and Health Administration (OSHA) and the Environmental Protection Agency (EPA), huge potential advances in developing a social epidemiological lens were neglected to examine broader health (Diez-Roux, 1998; Krieger, 2001).

Yet, investigations were branded as lackluster or “nonscientific” endeavors, and they were politically squashed (Daum, 1973; Stellman, 1973). Fringe progressive elements within medicine were noted academicians and those in public service at each level of government, but they never received enough attention, funding, nor broad support to effectuate remedial actions on the scale needed, nor much system even philosophical reorientation to attune to the fuller context of health.

Earlier on, certain prepaid group practices held a few potentialities in its managed care principles for population health (Roemer, 1978), yet organized medicine vilified the idea as anti-American “socialism” and unnecessary interference in the sacrosanct physician-patient relationship. As time progressed, more corporate influences were drawn into the medical industrial complex by the increased federal backing, with the practices of managed care corrupted with the Nixon-type profit-seeking HMOs (Salmon, 1978). Meanwhile, Medicaid for the states’ indigent was never developed from a social medicine perspective, nor even much of a community medicine thrust; each program was a revenue stream for providers (Brown, 1983):

Additionally, social medicine successes from overseas never broke through the American arrogance that “the USA has the best healthcare system in the world” misbelief. Amazingly, at each point of national health reform debate in America from Democrats Bill Clinton through Barack Obama, few analyses of elsewhere internationally ever entered our domestic debates. In general, when considering
changes in our own healthcare system, there is little examination of other nations that may suggest new ideas, programmatic approaches, and/or even mistakes to enlighten our national public policy formulation. This would be so crucial as implementations result in significant stumbling blocks, as clearly seen in Obamacare with plan cancellations in the Fall of 2013. Republicans have also misread the strong public concerns against narrower networks and for pre-existing conditions being held sacrosanct. The obvious rebuke to Republicans as the Party of no ideas on health (just repeal but no replace) was the 2018 election where the House flipped to the Democrats and voters in four states favored expansion of their Medicaid programs under the ACA (Armour, 2018).

Marketplace Medicine Dominates

Marketplace medicine has achieved such a strong ideological grip on our national consciousness, especially within the ranks of the health professions. Vested interests have been very persuasive in their propaganda against systems in other nations. Canada’s universal national health insurance model is maligned continually as unworkable here in the United States, even though our own Medicare system borrowed both its name and some structure from the Canadian national system—just without becoming universal for everyone!

Americans do not realize how much of their money is wasted in this corporate healthcare system on overly priced, tax-supported care, coupled with such climbing out-of-pocket personal payments for their families for this corporate healthcare system. Especially compared to other nations, the United States is spending twice per capita than the universal plans in Canada and Germany with the next highest national outlays. Only lately have Democratic presidential candidates Bernie Sanders and Elizabeth Warren brought to light the huge profits in the insurance and pharmaceutical industries (Martin, 2019), when advocating a Medicare-for-All solution to deal with them. Given the near death of the Trump “repeal and replace,” Medicaid expansion referendums in 2016 indicated public favor in states where Republican governors and legislatures had turned down the ACA generous support (Mulvihill & Alonso-Zaldivar, 2018).

For too long, many citizens have faced dire financial stress over their health care. Private insurance has indentured workers to depend upon jobs they may not like; they may lose family coverage if they leave a job or as ongoing reality reveals lose health coverage with the huge unemployment. Before the ongoing massive unemployment and loss of insurance caused by the COVID-19 Pandemic, some polls seemed to indicate many people were satisfied with their private coverage, a reality surely not guaranteed now in 2020. Hospitals sue patients for unpaid medical bills and garnish their wages; unpaid bills even before became the single greatest cause of bankruptcies for American families. The American Hospital Association takes no official position on this issue, but instead funneled millions of dollars worth of ads opposing single-payer insurance. The American Medical Association dropped out of the Partnership for America’s Health Care Future, begun by the pharmaceutical industry and the
for-profit hospital group (Diamond & Cancryn, 2019). Nevertheless, forces for corporatization that prefer the status quo of marketplace medicine continue to resist progressive thinking and any changes except that which benefits them.

What Direction Now?

To regain a moral compass in health policy, there needs to be much greater clarity over, and charity for, the plight of the uninsured and medically underserved; health professionals witness the unnecessary suffering of these minions who have lacked access over decades; without access, they do not get better, but just suffer needlessly and then cost much more to treat downstream for their chronic illnesses when they usually end up in the public sector. Surely, the high death rate of minorities from COVID-19 has revealed the long-standing inequities embedded in our health system structure (Dean, 2020); their health status emanates from underlying social conditions (Case & Deaton, 2020). Historically, the US Surgeon General’s reports have annually delineated populations and disease conditions that, in a socially just and humane society, should have been significantly targeted to reduce the widespread health inequities in this richest nation of the world. Richardson (2017) has argued that Democrats must seize a historic opportunity not to make the rich richer. Yet Democrats must dislodge Mitch McConnell’s Senate grip in service to Donald Trump so legislation can be passed (Editorial: Burns & Martin, 2017).

Completely absent of any compassion, the Trump Administration considers compassion in health as a sorrowfully nonexistent commodity. In the COVID-19 outbreak, testing was restrained and not widely available to the high-risk groups of elderly, prisoners, or detainees, though a few states and counties later targeted minority communities and began to address, though tragically late, nursing homes. Supply chain arrangements over essential testing supplies, personal protective equipment (PPE), ventilators, etc. were poorly coordinated and corrupt (McSwane, 2020). Witness his May 2020 trip to Michigan extolling his made-up “man of the year award” while never mentioning the folks harmed by two power dam breaks that flooded many Michiganders’ homes and businesses a few days right before (Karni, 2020). Nor has Trump himself sadly shown much knowledge of the plight of minorities, immigrants, protestors, or anyone criticizing him. His attacks on opponents have been said to disgrace the Office of the Presidency and proven to embarrass our nation on the world stage. Thus, despite campaign promises on expanded health coverage, lower drug prices, and almost all healthcare reform ideas, there has been nothing! (Hamblin, 2019).

Unpreparedness on Several Counts

The “repeal and replace” cry lessened most emphasis in health care, even as Title X funding was cut from Planned Parenthood amidst Trump’s remaking of women’s health policy (Alonzo-Zaldivar & Crary, 2018; Luthi, 2018). The GOP healthcare
bill in 2017 sliced the Centers for Disease Control and Prevention’s budget (Facher, 2017), as well as closed down the White House’s National Security Council Directorate for Global Health Security and Biodefense (Cameron, 2020), two ominous actions that left the nation less prepared for the COVID-19 pandemic. How terrible present health and economic conditions became for the working and middle class was displayed in Trump’s incompetent handling of the supply chain distribution, given urban health systems collapsing and the resultant massive societal unemployment, reaching 42 million by June 2020 (Cox, 2020). For employers, outlays for health coverage shrunk, so bottom lines benefited some, despite slacking production. The unemployed—now expanding Medicaid roles by 20% to 30%—will bring greater profits to drug store chains and pharmacy benefit managers (PBMs), though at the expense of their losing more lucrative employer-sponsored participants (Fein, 2020). Whether under fee-for-service or managed care, volume dispensing is key to these pharmacy players.

In today’s economy, the question to ask now is: Do the 170 some million Americans really like their employment-based private insurance, versus what Medicare single payer could be for them as a needed shield in these bad times? Republicans have recently proffered short-term, limited duration plans during the epidemic to compete with the Obama exchange plans; insurers may deny based on preexisting conditions, which the ACA had made illegal (Cohrs, 2020).

Depictions in the news media often present human-interest stories, but without further notice or indictment of those who perpetuate perverse conditions. In general, the establishment and corporate media downplayed both Sanders and Warren’s universal Medicare and their outright criticisms of the insurance and pharmaceutical industries while favoring Centrist Democrats’ criticisms of Medicare for All (Pedersen, 2019). Greater depth of analyses must forcefully be put forward for restructuring strategies for change and to help rid profit-taking from the healthcare system.

The pandemic has been said to present a turning point in health care due to its unprecedented impact domestically and worldwide; however, it is not just a need for data science conducted under the auspice of Silicon Valley (Aitken, 2020). It was surely a wake-up call on unpreparedness and inequalities. Several advocacy groups have remarked that out the ashes of COVID-19, a Medicare-for-All movement should arise (Abrams, 2020). To achieve such a national policy, its proponents must lead the public to see and understand how much the broader context of corporate health has to do with system corruption that created the mass vulnerability to the virus (PNHP, 2020). As progressives should readily realize, a financing solution alone is clearly insufficient, even if providers acknowledge and try to address social determinants of diseases. Overhauling the dominant players, restraining egregious profits, and restructuring care patterns across the system must be at the forefront of progressive policymaking. Greater increased funding for new enrollees would be welcomed by the forces of greed, but without regulatory restraint to strive for ethical efficiencies, a newly constructed healthcare system may be unlikely.

Broad structural reorganization must be planned in phases to move toward equity in health and to gradually rid corporate profit-taking throughout health care (Eyer, 1984). Greater numbers of individual patients and families themselves now ponder the overall post-COVID-19 condition, when they face vastly delimited quality
care—and cannot afford it. Folks may realize how much single-payer ideas are now worthy of consideration for benefiting themselves and everyone. Notwithstanding, Americans should never settle for a stripped down Medicaid-for-All mechanism that compromises care benefits. For those who are able purchase add-on private coverage, will it be enough to revitalize the medical industrial complex?

So, messages for positive progressive principles must be shared to fend off Centrist Democrats spouting their similar corporate/Republican talking points to preserve the status quo or at best merely tinker on the margins of reform like a state-by-state public option. Thinking about how to reorganize the overall delivery system and to advocate for a new equitable public policy for all of the American people may have to reach beyond the average person’s grasp; as Trump himself once said, “Nobody knew health care could be so complicated.” Such an educational strategy necessitates clear articulation of what visionary reforms might concretely mean for families, communities, and the entire population—so necessary during the 2020 election campaign beyond merely “building on the ACA.”

Republican health policies historically have been so focused on special interests at the expense of the public’s health, that it was worth the review in Chaps. 1 and 2 to see how vested interests benefitted from past administrations, notwithstanding the Democrats who also failed to enact more progressive policies, instead merely feeding the corporate monster. Even with the Affordable Care Act decreasing George W. Bush’s number of uninsured by 41% in 2017, some 20+ million still were kept out of insurance coverage after 6 years of its passage—a legacy that prevailed into Trump’s rule.

Remember again that giving someone an insurance card is not in reality guaranteeing access to care. Access means assuring timely availability of affordable, comprehensive, quality care that is continuous by lowering social and cultural barriers to that care for a given population (Gulliford et al., 2002). This means guaranteeing substantial infrastructural improvement so that physicians are there in all communities for relationships with patients and families. The ACA did not do this!

The Current Crisis

Minorities and the poor have borne the greatest burden with class and race mostly accounting for the structural discrimination over why universal care has not been established here. News accounts demonstrate that minorities, the homeless, the aged in nursing homes and homes for the disabled, prisoners, and the poor have been most gravely stricken by COVID-19; these are groups that right-wing factions may consider as Charles Dickens’s “surplus population” of the unproductive. To some degree, knowing much earlier these people were most at risk for infection, it may be assumed that a planned biological and economic genocide might have been orchestrated, since too little, too late, or no federal policies were enacted.

Ongoing, this may demonstrate systemic social injustice and just may account for Trump’s sinister delay in rolling out faster widespread virus testing with a
supply chain to ensure adequate distribution (Callahan & Botella, 2020; McSwane & Gabrielson, 2020). Incompetence in managing supply lines might have been overcome had the Administration been dedicated to different values and concerns for clearly those groups who were forgotten in the outbreak.

For sure, a persistent ongoing financial crisis in health care is ahead for providers (Barnett, Mehrotra, & Landon, 2020). Value-based care will require reconceptualization with telemedicine taking hold: Will the finance powers that be provoke a “renaissance” for value-based insurance? (Olmstead, 2020). Many agree the pandemic will not preserve much of the same (The pandemic will recast the health-care industrial complex, 2020).

It remains certain that corporate domination over the American healthcare system will never cease with both the Democratic and Republican parties still under sway of the corporate grip; business lobbies were able to direct legislative and executive actions before the coronavirus outbreak and are gearing up for more federal largess post-COVID-19. Apple and Google have proceeded with their tracking devices under government subsidization and medical record advances during the epidemic, even with skeptics and concerns over privacy (Apple, Google debut major effort to help people track if they’ve come in contact with coronavirus, 2020; The pandemic has spawned a new way to study medical records, 2020; The Economist, 2020a). Dumaine (2020) claims Amazon was built for the pandemic, becoming bigger and stronger. If the politicians and public swallow the belief in Big Data, greater largess will flow into their coffers as they forge further control over policymaking. Adding to the persuasiveness of this line of thinking is that clinicians and most citizens now recognize strengthening the public health infrastructure must come in preparedness for the next disease disaster. IT firms see large steady profit streams and improved public popularity for solving the COVID-19 crisis as well as future epidemics, in addition to their already addressing health system dysfunctions.

The New England Journal of Medicine Catalyst (Barnett et al., 2020) surveyed clinicians to uncover:

1. Many providers will be financially devastated, with perhaps significant staffing shortages.
2. Feelings of expendability may be sensed “when being directed by ignorant administrators with little clinical understanding” (Barnett et al., 2020).
3. Inventory management with proper logistical coordination will be better maintained, especially for personal protective equipment (PPE), ventilators and drug supplies, etc.
4. Should the coronavirus remain endemic, or its curve flattened, or cases diminish, cross-training may become a routine.
5. Telemedicine will grow with enhanced technologies.
6. Burnout will likely be better understood with more interventions commonplace.
7. Delivery of services will become more diverse and efficient.
8. Independent rural hospital closings, plus clinics.
9. Hopefully increased understandings of population needs.
10. Clinical leadership roles will be strengthened.
11. At point of inflection, will systems learn from the lessons of the pandemic?

Many hospitals face a precarious future given the coronavirus impact: margins will shrink, strategies and restructuring will come, staff may leave or die as was the case in hotspot areas, closings will be likely concentrated in red states, and unless financing can be assured, amalgamations will decline.

The CARES Act of 2020

The Congressional bailout paid billions to the wealthiest hospital chains, just as big hospitals got richer off Obamacare, forsaking many struggling health providers (Drucker et al., 2020). Last year, the pharmaceutical industry spent $295 million on lobbying, more than any other industry (Accountable.US, 2020). This industry seems to be trying to redeem itself (Gordon, 2020) in the public’s mind with high-speed coronavirus treatments and a vaccine (Thomas & Grady, 2020). The IT industry already has numerous inroads in health care as discussed earlier, and many big firms are planning their “solutions” to the present system chaos, without privacy controls or other oversight. The pandemic will likely recast the entire healthcare industrial complex (The Economist, 2020b); McKinsey claims the virus recovery will be digital as IT firms beef up their growing extensions into health care (McKinsey & Company, 2020).

Infrastructural development and added federal economic stimulus will likely flow mainly into corporate coffers (as was seen with the Boeing bailout, airline subsidization, and channeling Small Business Administration loans through the biggest banks). Unless strong popular resistance is mounted and the Trump Administration is brought to justice, Democrats must take much different stands on the economic recovery, or the more powerful will win in negotiations for future subsidizations. Historians, beyond the scathing flow of media reviews to Trump’s response to the COVID-19 epidemic, will have much to pour through.

In the midst of Trump’s first 3 years of uncertainty and policy confusion, the insurance industry seemed to do fine (Luthi & Dickson, 2017), particularly on Medicare advantage plans (Livingston, 2018). In 2019, health profits boosted CEO salaries by 15.7%, with the head of CVS pocketing $36.5 million. Articles in the trade magazines tried to explain the impact of COVID-19, which was that with healthcare organizations cancelling all elective procedures because of the huge increase in pandemic patients entering their hospitals, their outlay for these procedures is way down (Liss, 2020; Livingston, 2020). And insurance companies were given a boost when the Supreme Court upheld the ACA’s “risk corridors” extra payments to insurers if sicker patients had signed up on their roles—a $12 billion infusion of cash that Republicans in Congress had unfunded in their continuing repeal of the ACA (Liptak, 2020).

Note that the massive decrease in elective procedures and surgeries, and an epidemic of diagnoses and their too often cascade iatrogenesis (Welch et al., 2007), can present phenomenal outlays for insurers; unemployed workers are not having
premiums paid for them anymore, but at best Medicaid may be picking up the tab for the costly repair work now during the layoff. In the second Congressional Heroes Act appropriations bill under consideration, House Speaker Nancy Pelosi favored health insurers by providing subsidized 9 months’ coverage for furloughed workers and the unemployed using COBRA for continued insurance coverage (Lacy & Walker, 2020). It is key to note that not all health care is hurting; health insurers are thriving with the diminished utilization (Johnson, 2020), but will they cut premiums and co-pays as some auto insurers have? Not much hope resides for insurers to step up to demonstrate their commitment to the nation’s health (Navathe & Emanuel, 2020).

The booming federal deficit in trillions, and the tendency by Trump and the Republicans to distribute funding in their way to business, may leave fewer funds for health and social spending over several coming years. Schneider in the New England Journal of Medicine points out the tragic data gap that continues to undermine the US response even as this country tallies the most cases and deaths in the world (Schneider, 2020), yet with little clarity, as the nation watches second and third waves of the virus after Trump’s churches returning and rallies beginning in the “reopening of the economy.” Lack of faith in Washington given the handling of the COVID-19 crisis (Tavernise, 2020), as well as the state and local conduct toward the summer protests, may cement negative views toward politicians and public policy that may delimit progressive possibilities. Atkins (2020) argues we need a renewed Party that tells the truth and represents working Americans. It remains to be seen even under a winning Democratic Administration whether regulatory regress will return to the political environment as before 2016. As Lilla wrote in The New York Times, a state of radical uncertainty awaits the nation and world: Does anyone really know what’s going to happen? (Lilla, 2020). Given the Minneapolis cop killing George Floyd and the subsequent protests and rioting across the nation, profound clouds may hang over our nation’s future up until the election.

Future Role of Labor Unions

One must recognize that the history of American medical care is intricately intertwined with the American Labor Movement, which was highly instrumental in bringing out positive changes in health coverage and in public policy. Union membership has substantially lessened, though since the Reagan years, will under current circumstances, lead unions to re-emerge as a stronger voice in national policymaking. After the Second World War, unions embraced employment-based coverage but tended to abandon broader population advocacy. Yet today with new organizing campaigns, issues look different since the working class has growing minority representation, and they are truly hurting and vocal. Employment-based coverage has been presented by Centrist Democrats as a huge obstacle against the adoption of single-payer health insurance for all—nevertheless, with up to 60
million jobs lost and no coverage solutions for them in 2020, people may now feel much differently, especially about the role of private insurance.

American unions had earlier on sought to address the very conditions of life, including health insurance as a benefit for families, workers’ compensation, occupational health, child and maternal health care, and more benefit additions over time. Labor must now get behind such policy concerns and fight hard for universalist social democratic policy changes (Atkins, 2020).

An Expanded Corporatization?

Nevertheless, the interests, objectives, and behaviors of corporate entities that were centralizing in health care fought against Labor’s efforts and supported the shift to private ownership in the healthcare system. This different healthcare power structure brought along changes in traditions, philosophies, and the way history is being interpreted. The greater complexity and increased size of the health sector led to changes in the relative size of its different components (pharmaceuticals and hospitals vs. physicians) and the change in the position of the health sector in society in general (both parties’ administrations have recognized health services as boosting economic growth). It was under these circumstances that proprietary health services took root both in the medical care sector (HMOs, ambulatory care, etc.) and in hospitals, along with the rise of powerful administrators replacing physicians in command. Will the American Labor movement get behind our critique of corporate health care? Given these developments, the position of “the physician” is subject to alteration. Will the profession be granted the evidence and relative power to meet clinical and financial goals? How will Labor respond to Medicine’s current quandary?

Clearly, information technology can and will make substantial contributions to help solve the data dilemmas in health care; however, such directions should proceed with oversight and multiple cautions. Understanding the origins of the American healthcare system before and after the viral outbreak will be more illuminating to rebuild it for more equitable distribution of services to all our citizenry. The trillion dollar IT behemoths are positioned to seize new opening opportunities with their huge cash buckets (McKinsey & Company, 2020) under the seemingly prevailing mood that they can “solve” our healthcare problems. Most of their activity stays under the public radar; meanwhile, their corporate public affair offices maintain vigil over popular favor for most of what they do, despite critics more dismayed by notable specific unsavory business behaviors. The well-cited discussion in Chap. 5 should provoke caution in addition to worries.

Public policy has never truly addressed the issue of what should be the nature of the relationship between health services within a profit-based economy: What is the proper role for profit-oriented firms in the supply, provider functions, and insurance segment? How should their roles be assessed and at what costs and control are they permitted? What safeguards should be instituted to preserve a more appropriate and
popularly desired balance? What is the necessary regulatory oversight for maintaining accountability?

More importantly, is the structure and control over what we have now the best and the only way to organize healthcare services for the benefit of the American people and for their health promotion and well-being in the whole population? Do we want a system designed and run by those with huge financial interests in the system?

References

Abrams, A. (2020). For organizer Ady Barkan, COVID-19 is yet another reason to pass medicare for all. Available at: https://time.com/5810489/medicare-for-all-coronavirus-2/. Accessed on October 13, 2020.

Accountable.US. (2020). Lobbying spending in 2019 nears all-time high as health sector smashes records. Available at: https://www.accountable.us/news/bigpharma-earnings-season-record-profits-from-patients-being-poured-into-windfall-earnings-for-lobbyists/. Accessed 13 Oct 2020.

Aitken, M. (2020). COVID-19 as a positive turning point in healthcare. https://www.iqvia.com/insights/the-iqvia-institute/covid-19/covid-19-as-a-positive-turning-point-in-healthcare. Accessed July 25, 2020.

Alonzo-Zaldívar, R., & Crary, D. (2018). Trump remaking federal policy on women’s reproductive health. Available at: https://apnews.com/article/0a165e54c0a94600871539472ba82ba1. Accessed 13 Oct 2020.

Armour, S. (2018, October 22). Votes in red states to test support for Medicaid expansion. Wall Street Journal. p. A3.

Atkins, J. B. (2020). We need a party that tells the truth and represents workers. Portside. Available via DIALOG. https://portside.org/2020-05-26/we-need-party-tells-truth-and-represents-workers. Accessed June 2, 2020.

Barnett, M. L., Mehrotra, A., & Landon, B. E. (2020). COVID-19 and the upcoming financial crisis in healthcare. NEJM Catalyst. Available via DIALOG. https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0153. Accessed June 4, 2020.

Berkman, L. F., Kawachi, I., & Glymour, M. M. (2014). Social epidemiology. Oxford, UK: Oxford University Press.

Braveman, P., & Gottlieb, L. (2014). The social determinants of health: It’s time to consider the causes of the causes. Public Health Reports (Washington, D.C.: 1974), 129(Suppl 2), 19–31.

Brown, E. R. (1983). Medicare and medicaid: The process, value, and limits of health care reforms. Journal of Health Policy, 4(3), 335–366.

Burns, A., & Martin, J. (2017). McConnell, in private, doubts if Trump can save presidency. Available at: https://www.nytimes.com/2017/08/22/us/politics/mitchmcconnell-trump.html. Accessed 13 Oct 2020.

Callahan, P., & Botella, S. (2020, August 7). The White House paid up to $500 million Too Much for these ventilators, Congressional Investigators say. ProPublica.

Cameron, B. (2020). I ran the White House pandemic office. Trump closed it. The Washington Post. Available via DIALOG. https://www.washingtonpost.com/outlook/nsc-pandemic-office-trump-closed/2020/03/13/a70de09c-6491-11ea-acc4-80c2e6bee96f_story.html. Accessed June 11, 2020.

Case, A., & Deaton, A. (2020). America can afford a world-class health system. Why don’t we have one? Available on: https://www.nytimes.com/2020/04/14/opinion/sunday/covid-inequality-health-care.html. Accessed 13 Oct 2020.
Cohrs, R. (2020). Appeals court weighs legality of limited health plans amid COVID-19 crisis. *Modern Healthcare*. Available via DIALOG. [https://www.modernhealthcare.com/legal/appeals-court-weighs-legality-junk-insurance-plans-amid-covid-19-outbreak](https://www.modernhealthcare.com/legal/appeals-court-weighs-legality-junk-insurance-plans-amid-covid-19-outbreak). Accessed June 3, 2020.

Cox, J. (2020). Coronavirus job losses could total 47 million, unemployment rate may hit 32%, Fed estimates. Available at: [https://www.cnbc.com/2020/03/30/coronavirus-job-losses-could-total-47-million-unemployment-rate-of-32percent-fed-says.html](https://www.cnbc.com/2020/03/30/coronavirus-job-losses-could-total-47-million-unemployment-rate-of-32percent-fed-says.html). Accessed 13 Oct 2020.

Cwikel, J. G. (2006). *Social epidemiology: Strategies for public health activism*. New York, NY: Columbia University Press.

Daum, S. (1973). *Work is dangerous to your health*. New York, NY: Vintage.

Dean, L. (2020). The pandemic has exposed health disparities; we need to act on these painful lessons. *Modern Healthcare*. Available via DIALOG. [https://www.modernhealthcare.com/opinion-editorial/pandemic-has-exposed-health-disparities-we-need-act-these-painful-lessons](https://www.modernhealthcare.com/opinion-editorial/pandemic-has-exposed-health-disparities-we-need-act-these-painful-lessons). Accessed June 3, 2020.

Diamond, D., & Cancryn, A. (2019). AMA drops out of industry coalition opposed to Medicare expansion. *Politico*. Available via DIALOG. [https://www.politico.com/story/2019/08/15/ama-drops-out-of-industry-coalition-opposed-to-medicare-expansion-1664604](https://www.politico.com/story/2019/08/15/ama-drops-out-of-industry-coalition-opposed-to-medicare-expansion-1664604). Accessed June 3, 2020.

Diez-Roux, A. V. (1998). Bringing context back into epidemiology: Variables and fallacies in multilevel analysis. *American Journal of Public Health, 88*(2), 216–222.

Drucker, J., Silver-Greenberg, J., & Kliff, S. (2020). Wealthiest hospitals got billions in bailout for struggling health providers. Available at: [https://www.nytimes.com/2020/05/25/business/coronavirus-hospitals-bailout.html](https://www.nytimes.com/2020/05/25/business/coronavirus-hospitals-bailout.html). Accessed 11 Oct 2020.

Dumaine, B. (2020). *Amazon was built for the pandemic—and will likely emerge from it stronger than ever*. Available at: [https://fortune.com/2020/05/18/amazonbusiness-jeff-bezos-amzn-sales-revenue-coronavirus-pandemic/](https://fortune.com/2020/05/18/amazonbusiness-jeff-bezos-amzn-sales-revenue-coronavirus-pandemic/). Accessed 13 Oct 2020.

Eyer, J. (1984). Capital, health, and illness. In J. McKinlay (Ed.), *Issues in the political economy of health*. New York, NY: Tavistock.

Facher, L. (2017). Obamacare repeal and Trump’s spending plan put CDC budget in peril. *STAT News*. Available via DIALOG. [https://www.statnews.com/2017/03/07/cdc-budget-obamacare-repeal/](https://www.statnews.com/2017/03/07/cdc-budget-obamacare-repeal/). Accessed June 11, 2020.

Fein, A. J. (2020). *Four unexpected ways that the COVID-19 medicaid boom will affect PMB and pharmacy profits*. Available at: [https://www.drugchannels.net/2020/04/four-unexpected-ways-that-covid-19.html](https://www.drugchannels.net/2020/04/four-unexpected-ways-that-covid-19.html); for Single-Payer Health Care Reform. Available at: [https://pnhp.org/what-is-single-payer/physicians-proposal/](https://pnhp.org/what-is-single-payer/physicians-proposal/). Accessed 13 Oct 2020.

Gordon, J. (2020). ‘After Covid pharma no longer looks like a big oil or tobacco.’ *City Wire*. Available via DIALOG. [https://citywire.co.uk/investment-trust-insider/news/after-covid-pharma-no-longer-looks-like-big-oil-or-tobacco/a1357550](https://citywire.co.uk/investment-trust-insider/news/after-covid-pharma-no-longer-looks-like-big-oil-or-tobacco/a1357550). Accessed June 2, 2020.

Gulliford, M., Figueroa, J. I., Morgan, M., Hughes, D., Gibson, B., Beech, R., & Hudson, M. (2002). What does “access to health care” mean? *Journal of Health Services Research & Policy, 7*(3), 186–188.

Hamblin, J. (2019). Has Trump actually done anything about drug prices? *The Atlantic*. Available via DIALOG: [https://www.theatlantic.com/health/archive/2019/05/trump-actually-decreasing-drug-prices/589096/](https://www.theatlantic.com/health/archive/2019/05/trump-actually-decreasing-drug-prices/589096/). Accessed July 25, 2020.

Johnson, J. (2020). Thriving during a pandemic: UnitedHealth group posts surge in profits as millions lose insurance and thousands die. *Common Dreams*. Available via DIALOG. [https://www.commondreams.org/news/2020/04/16/thriving-during-pandemic-unitedhealth-group-posts-surge-profits-millions-lose](https://www.commondreams.org/news/2020/04/16/thriving-during-pandemic-unitedhealth-group-posts-surge-profits-millions-lose). Accessed June 4, 2020.

Karni, A. (2020). *In Michigan visit, Trump forgoes criticism and talks about the economy and the flood*. Available at: [https://www.nytimes.com/2020/05/21/us/politics/trump-michigan-visit.html](https://www.nytimes.com/2020/05/21/us/politics/trump-michigan-visit.html). Accessed 13 Oct 2020.

Krieger, N. (2001). The ostrich, the albatross, and public health: An ecosocial perspective—or why an explicit focus on health consequences of discrimination and deprivation is vital for good science and public health practice. *Public Health Reports (Washington, D.C.: 1974), 116*(5), 419–423.
Lacy, A., & Walker, J. (2020). Heroes act delivers a win to the health insurance industry. The Intercept. Available via DIALOG. https://theintercept.com/2020/05/12/heroes-act-coronavirus-health-insurance-industry/. Accessed June 4, 2020.

Lilla, M. (2020). No one knows what’s going to happen. The New York Times. Available via DIALOG. https://www.nytimes.com/2020/05/22/opinion/sunday/coronavirus-prediction-future.html. Accessed June 4, 2020.

Liptak, A. (2020). Supreme Court rules for insurers in $12 billion Obamacare case. New York Times. Available via DIALOG: https://www.nytimes.com/2020/04/27/us/supreme-court-obamacare-insurance.html. Accessed July 25, 2020.

Liss, S. (2020). Despite the pandemic, insurers seem cautiously optimistic about 2020. Here’s why. Available via DIALOG: https://www.healthcaredive.com/news/despite-the-pandemic-insurers-seem-cautiously-optimistic-about-2020-here/577511/. Accessed July 25, 2020.

Livingston, S. (2018). Insurers profit from Medicare Advantage’s incentive to add coding that boosts reimbursement. Modern Healthcare. Available via DIALOG. https://www.modernhealthcare.com/article/20180901/NEWS/180839977/insurers-profit-from-medicare-advantage-s-incentive-to-add-coding-that-boosts-reimbursement. Accessed June 4, 2020.

Livingston, S. (2020). Large Health Insurers Appear Immune to COVID-19. Modern Healthcare. Available via DIALOG. https://www.modernhealthcare.com/insurance/large-health-insurers-appear-immune-covid-19. Accessed July 25, 2020.

Luthi, S. (2018). Trump could ban Title X funding for Planned Parenthood. Available at: https://www.modernhealthcare.com/article/20180426/NEWS/180429923/trump-could-ban-title-x-funding-for-planned-parenthood. Accessed 13 Oct 2020.

Luthi, S., & Dickson, V. (2017). 2018 Outlook on politics and policy: Insurers will come out ahead. Available at: https://www.modernhealthcare.com/article/20171230/NEWS/171239990/2018-outlook-on-politics-and-policy-insurers-will-come-out-ahead. Accessed 13 Oct 2020.

Martin, J. (2019). Elizabeth Warren and Bernie Sanders have a problem: Each other. Available on: https://www.nytimes.com/2019/12/16/us/politics/elizabethwarren-bernie-sanders-democrats-2020.html. Accessed 13 Oct 2020.

McKeown, T. (1965). Medicine in modern society. London, UK: George, Allen and Unwin.

McKinsey & Company. (2020). The next normal: The recovery will be digital. Available at: https://www.mckinsey.com/~/media/McKinsey/Business%20Functions/McKinsey%20Digital/Our%20Insights/How%20six%20companies%20are%20using%20technology%20and%20data%20to%20transform%20themselves/The-next-normal-the-recovery-will-be-digital.pdf. Accessed 13 Oct 2020.

McSwane, J. D. (2020). The secret, absurd world of coronavirus mask traders and middlemen trying to get rich off government money. Available at: https://www.propublica.org/article/the-secret-absurd-world-of-coronavirus-mask-traders-and-middlemen-trying-to-get-rich-off-government-money. Accessed 13 Oct 2020.

McSwane, J. D., & Gabrielson, R. (2020, June 18). The Trump administration paid millions for test tubes—and got unusable mini soda bottles. ProPublica.

Mulvihill, G., & Alonso-Zaldivar, R. (2018). ACA big issue on voter agenda. Chicago Tribune. 11 October. Sec 2 p. 1.

Navathe, A. S., & Emanuel, E. J. (2020). Health insurers as heroes? The New York Times. Available via DIALOG. https://www.nytimes.com/2020/05/06/opinion/coronavirus-insurance.html. Accessed June 4, 2020.

Olmstead, R. (2020). Is a value-based insurance design experiencing a renaissance? Employee Benefit Adviser. Available via DIALOG. https://www.employeebenefitadviser.com/opinion/is-value-based-insurance-design-experiencing-a-renaissance. Accessed June 4, 2020.

Pedersen, B. (2019). Medicare for all: Promise and perils. Incremental reforms are more likely than a complete overhaul. Kiplinger's Personal Finance. Available via DIALOG. https://www.kiplinger.com/article/insurance/T027-C000-S002-medicare-for-all-promise-and-perils.html. Accessed June 11, 2020.

PNHP. (2020). Physicians’ Proposal - Beyond the Affordable Care Act: A Physicians’ Proposal for Single-Payer Health Care Reform. Available at: https://pnhp.org/what-is-single-payer/physicians-proposal/. Accessed on October 13, 2020.
Richardson, H. C. (2017). Democrats have a historic opportunity. They must not make the rich richer. Available at: https://www.theguardian.com/commentisfree/2017/aug/03/democrats-trump-better-deal-income-inequality. Accessed 13 Oct 2020.

Roemer, M. I. (1956). Medical care in relation to public health: A study of relationships between preventive and curative health services throughout the world. Geneva, Switzerland: World Health Organization.

Roemer, M. I. (1978). Social medicine: The advance of organized health services in America. Springer Series on Health Care and Society, 3, 1–560.

Salmon, J. W. (1978). Corporate attempts to reorganize the American health care system. Unpublished thesis at Cornell University, Ithaca, NY.

Salmon, J. W. (2008). Review essay: Cwikel, J. G. Social epidemiology: Strategies for public health activism. International Journal of Global Social Work Practice, (1), Fall.

Schneider, E. C. (2020). Failing the test- The tragic data gap undermining the U.S. pandemic response. The New England Journal of Medicine. Available via DIALOG. https://www.nejm.org/doi/full/10.1056/NEJMp2014836. Accessed June 4, 2020.

Stellman, J. M. (1973). Work is dangerous to your health: A handbook of health hazards in the workplace and what you can do about them. New York, NY: Pantheon Books.

Tavernise, S. (2020). Will this crisis cement Americans’ lack of faith in Washington? The New York Times. Available via DIALOG. https://www.nytimes.com/2020/05/23/us/coronavirus-government-trust.html. Accessed June 4, 2020.

The Economist. (2020a). The pandemic has spawned a new way to study medical records. Available at: https://www.economist.com/science-andtechnology/2020/05/14/the-pandemic-has-spawned-a-new-way-to-study-medical-records. Accessed 13 Oct 2020.

The Economist. (2020b). The pandemic will recast America’s health-care industrial complex. The Economist. Available via DIALOG. https://www.economist.com/business/2020/05/09/the-pandemic-will-recast-americas-health-care-industrial-complex. Accessed June 4, 2020.

Thomas, K., & Grady, D. (2020). How upbeat vaccine news fueled a stock surge, and an uproar. Available at: https://www.nytimes.com/2020/05/23/health/coronavirus-vaccine-moderna.html. Accessed 13 Oct 2020.

Waitzkin, H. (2000). The second sickness: Contradictions of capitalist healthcare. Lanham, MD: Rowman & Littlefield Publishers, Inc.

Waitzkin, H., & Waterman, B. (1974). The exploitation of illness in capitalist society. Indianapolis, IN: MacMillan.