Chapter 1
History of the Corporatization of American Medicine: The Market Paradigm Reigns

Introduction

Economic systems have been analyzed and debated by economists and governmental leaders for centuries. Historically, economic systems have been assessed by the products and techniques of production and how they are distributed, today with capitalism predominant and with mounting inequality within every society (Piketty, 2016). Under global capitalism, ownership of land and productive capital is chiefly in private hands, with the role of the state fiercely debated with continual attempts seeking to restrain its oversight (O’Connor, 1973). Social justice in more liberal advanced societies has been championed over time, but the rise of finance capital and its presence in corporate-dominated economies has emerged with a massive concentration of ownership in almost every sector of the American economy. With its tendency toward managerial and administrative quantifications to fix existing flaws in the system, neoclassical economics has prevailed; few alternative or opposing perspectives rarely get debated. Thus, the overall structure is taken as a given and immutable (Hunt & Schwartz, 1972). Global efforts toward privatization and monopolization mark the current stage of development.

When analyzing the United States, one observes that almost every sector of the economy—industrial, financial, construction, agriculture, communications and media, and even services—is dominated by just a few large national, if not multinational, firms (Baran & Sweezy, 1966; O’Connor, 1973, 1974; Barnet & Muller, 1974; Hermann, 1981). This monopolization has been ongoing over the last century. However, today there is an incredible degree of concentration and centralization of capital, which is an indicator of the strong political influence that large corporations exert on public policy at all levels of government: federal, state, and local.

Therefore, it is not difficult to realize that the American healthcare system would eventually reflect this larger concentrated economy. Health care is not alone, as this phenomenon is also seen in higher education, private prison management, and, under President Donald J. Trump, immigration detention camps. Given current
political trends, we may see upswings among other public and “not-for-profit” services becoming targets for further privatization, usually masked as being for increased “cost control” and “efficiency” and always with the epitaph that “the private sector can do it better.”

This book’s analytic perspective is broad, seeking to define the overall structure to delineate the changing context of medical practice under which costly medical malpractice reigns within a profit-based medical-industrial complex functions. Grasping the dominant social relationships that compose the healthcare system requires a political economic lens to reduce the overriding ideology of the marketplace and to discern its underlying dynamics.

Ushered in during the Reagan Administration, the heightened fetish for cost containment in health care reflects the Republican disdain over the distribution of healthcare expenditures, not just by the federal government, but within the entire economy. It was the time when economists rose to prominence in health policy discussions (Fox, 1979), the majority of whom seemed much less focused on access to care and more on providing improving amenities to their well-heeled clients. It is not a surprise that cost containment often went together with disenfranchisement of the poor, disabled, and minorities, who had previously secured some access through federal programs, but basically excluded many other vulnerable population groups in need.

Nelson (2018, p.2) critiques the economics profession as vulnerable to group-think, along with its lack of diversity, especially at the highest echelons of economic policymaking. Such is the case that provides the lack of attention to issues that address minorities in economic research to macroeconomic models used in public policy decisions. In effect, the profession has less chance to serve the public effectively and remains a tool of those in power; this became obvious from the 1980s on with health policy. Critics have chimed in on the dismal cost of economics’ lack of racial diversity that surely has affected what questions get asked and what issues get readily dismissed for lack of “scientific study.”

Privatization has been rampant across the developed capitalist world for decades as many governments divest themselves. Prime Minister Margaret Thatcher privatized public utilities, healthcare facilities, and much more without necessary oversight to prevent thereafter exploitation (Ford & Plimmer, 2018). President Emmanuel Macron in France has sought privatization schemes to fund infrastructure projects; many transactions are complicated with murky implications (Kegshaw, 2018). Even space exploration is being privatized (Pasztor, 2020).

Since President Ronald Reagan’s first inaugural address in 1981 when he proclaimed, “Government is not the solution, it is the problem,” the very thought of reforming the public sector has faded from the general consciousness. Consider, after a number of veterans Administration (VA) hospital scandals over access and quality from the George W. Bush years through Trump, the federal budget was seen as bountiful for subsidizing private entities for care of our veterans and military, and perhaps to entirely transition to private insurance coverage. While local news media had reported extensively on the VA for years to enumerate multiple issues, many Democrats and most veterans groups oppose such a move to privatize care.
(Bhagwati, 2019). ProPublica reported that Trump’s “private care program gave companies billions and Vets longer waits” including higher overhead (Arnsdorf and Greenberg, 2018).

Opening access may shorten waits, provide more choices, and perhaps lessen co-pays, although switching vast numbers of veterans to private hospitals (a massive endeavor itself) may actually strain care in parts of the private sector (Steinhauser & Philipps, 2019; Meyer, 2019). Even before this dramatic policy change, the Government Accountability Office (GAO) examination of one of the nation’s largest health systems found a crucial need for improved oversight and greater clarity over roles and responsibilities (GAO, 2019b)—the operative word is oversight! The VA was previously charged with grievously not reviewing credentialing of practitioners (GAO, 2019a), keeping on doctors despite misconduct allegations (Luthi, 2019).

At the same time, the VA and the US Department of Defense (DoD) are together attempting to create a new electronic health record (EHR) system, which could transition active duty servicemen to local VA care. A huge government contract will be awarded to a private firm (likely, Cerner) for its development. In 2019 McKesson Technologies was awarded a $400 million contract for the Department of Defense digital imaging network picture archiving and communications health IT system. In many cases, governments lack the expertise to carry out functions to greatly advance their agency; the issue then becomes assuring performance-based contracting and avoiding the typical cost overruns, where excess private profit can be gained—particularly given the outlandish history of DoD military outsourcing.

Thus, privatization is widely overtaking multiple aspects of the American healthcare system, as the corporate for-profit basis of reorganizing our citizenry’s health care seems substantially entrenched at huge taxpayer costs. The Trump Administration is also planning to privatize Fannie Mae and Freddie Mac, the core of American housing finance; they hold nearly half the total outstanding in America (The Economist, 2019b). More such moves will likely spread under the Trump Administration, since awards of taxpayer’s money to private firms—like huge corporate tax cuts—provide the cycle of reelection campaign donations. This direction goes hand in hand with his massive deregulation efforts.

There are surely better ways to proceed. Lessons can be learned from abroad, as noted by the political and cultural differences seen in Japan’s privatizing its railways versus the slack, highly unpopular British railway privatization under Thatcher. The much-criticized franchise system in Britain has endured a catastrophically botched timetable change, major delays and cancellations at the worst level in a decade, and a passenger usage decline; ticket prices have risen twice as fast as wages since 2010 (How rising rail fares and falling punctuality, 2019). Unreliable service due to poor performance by the British rails became symbolic of the broader discontent with privatization and neoliberal economics since Thatcher. In contrast, Harding (2019, p. 7) reports in the Financial Times that Japan’s private enterprise has a robust system of regulation, and rail companies feel a responsibility to society; they also operate on consumer payments without public subsidy.
Reich (2018) points out that privatization boosting efficiency and reducing taxes is a myth; rather privatization often only boosts corporate bottom lines. He warns “don’t privatize when the purpose of the service is to bring us together—reinforcing our communities” to connect across class and race, “linking up Americans who’d otherwise be isolated or marginalized… don’t privatize when the people who are supposed to get the services have no power to complain when services are poor” or maybe cannot recognize their poor quality (2018, p. 2). These are surely apropos to health care for Americans.

Chapter Purpose

This chapter will provide an overview of the historical development of American health care from its nineteenth-century cottage system to the onset of its now dominant corporate for-profit form. The main characteristic of private ownership with public subsidy reveals the lack of moral national commitment to health care for all citizens. Interventions by powerful economic forces have been key from reorganizing medical education through business sources arranging for financing strategies for the hospital industry to the current encroachment by the IT industry firms. The chapter traces the beginning concentration of capital in the medical-industrial complex (MIC) through various social interventions that allowed profit-making to emerge. Actions by capitalist philanthropic foundations at the turn of the twentieth century reorganized medical education to promote scientific medicine which greatly advanced productive health resources. As the delivery system started to industrialize, the Committee on the Costs of Medical Care (CCMC) in the late 1920s proposed hospitals to become the employment center for physicians and other professionals to deliver organized care for populations, but its ideas were staunchly defeated by the medical profession.

As an alternative, solo fee-for-service medical practice was preserved so hospitals sought their own cost-plus reimbursement through employment-based voluntary insurance. This model supported by Blue Cross persisted with broad support until the 1960s when the federal government grafted on Medicare and Medicaid with a similar payment mechanism. As a result, costs exploded to warrant President Richard M. Nixon’s healthcare crisis declaration in 1968. The genesis of corporatization came with his health maintenance organization strategy, which in effect unleashed market forces for the advancement of profit-making in multiple segments of the healthcare industry. This chapter spells out the rise to supremacy of marketplace medicine with the emergence of the proprietary hospital chains, the growth of the medical-industrial complex, and the societal confrontation over access, cost, quality, and accountability issues up against progressive calls for universal coverage for all Americans. The chapter will reveal that historically the private sector’s pursuit of profit in health care with heavy public subsidization leaves less than desirable outcomes for the public’s health. The commoditization of health needs runs opposite to consideration of a collective public health.
Historical Background

The corporate consolidation of American medicine came rapidly (Gray, 1983; Institute of Medicine, 1986; Brown & McCool, 1986). Today several giants dominate the production of health services (Light, 1986) with a handful of nationwide insurance firms continually passing through a merger and acquisition (M&A) activity of their own. The mighty Anthem-Cigna and Aetna-Humana horizontal combinations were defeated in 2015–2017 by the Federal Trade Commission (Dranove, 2017), but a new stage witnesses these players, among many others, seeking out partners in vertically integrated lines of business, as well as with pharmacy benefit managers, chain drug stores, and now information technology firms (see Chaps. 2 and 5). Greater permeations of smaller insurance mergers are likely under Trump’s executive order for cross-border insurance (Jopson & Sevastropulo, 2017). Republican tax-cutting actions and support for repatriation of overseas profits are spurring stock buybacks and a much larger M&A furor among all parties in the “medical-industrial complex” (MIC).

Box 1.1 $3.8 Trillion Fuels the Medical-Industrial Complex

Profit margins for health providers and the corporate supply firms have become huge, including pharmaceutical biotechnology, medical diagnostics, and biomedical research and development; medical, dental, and optical hardware or services; construction of facilities; real estate investment trusts for health facility holdings; provision of legal, accounting and consulting services; computers, software, and information technology; analytics firms, among other products to assist providers in their treating patients. Entities in the medical-industrial complex have been the motor force of development and chiefly responsible for the cost spiral.

Phenomenal inappropriate services, rampant administrative overhead, excessive executive salaries, “drug misadventuring,” and more fraud and waste are characteristic, which do not promote the public health.

New England Journal of Medicine editor Arnold Relman (1980) decried the new medical-industrial complex: investor-owned hospital and nursing home chains, home care, dialysis centers, health maintenance organizations (HMOs), and now pharmacy benefit managers (PBMs), Accountable Care Organizations (ACOs), and drug store retail clinics. All of these segments have reaped bountiful returns on their investments by stiffly challenging traditional “not-for-profit” and public providers, who are left to primarily serve the less fortunate populations, including the uninsured and many Medicaid patients. For-profit corporate drug store clinics also now compete against practicing physicians in many communities. The ongoing consolidation of PBM/insurers portends an even greater threat to the playing field of existing providers.
Of note, mergers and acquisitions (M&As) are almost always disruptive; they lead to layoffs, which may provoke union unrest—as with the 2018 Dignity and Catholic Health Initiatives (CHI) example below (Gooch, 2018), closing of offices and plants, significant community impacts, and geographical dislocations, even while stockholders don’t always benefit, but the top executives, including those in the so-called not-for profits, who manage the process, clearly do!

Merging the Dignity-CHI “not-for-profit” systems faced an unfavorable “moral analysis” from the National Catholic Bioethics Center. Later organized reviews by the local archbishops, other bioethicists, respective state attorney generals, and the Vatican then pushed this Catholic/secular merger forward as CommonSpirit with 150,000 employees (AnyDay: nearly 2 years in the making, 2018). The combined system of 139 hospitals and 25,000 physicians in 21 states will reap almost $30 billion in revenues annually (Meyer & Bannow, 2018), but it’s no overlap in service areas presents obstacles to coordinating and standardizing care (Kacik & Bannow, 2017). Its co-CEO leadership structure (Kacik & Bannow, 2017) may face a few financial challenges, while they figure out integration, people, and cultures. Both systems had huge operating losses in 2017, but Dignity bounced back in 2018, with the new CommonSpirit Health rivaling its Catholic competitor, Ascension, in total hospitals, and with revenue just below Kaiser Permanente’s $72.7 billion in 2017.

*Kaiser Health News* asked if Catholic-run systems will tie doctors’ hands by prohibiting previous policies on contraception services, abortions, in vitro fertilizations, and physician-assisted death (Gold, 2019). Advocates for women’s health and the LGBTQ community fear their concerns could be a casualty of Dignity taking over the University of California San Francisco Hospital, a public entity with a long-standing commitment on liberal health issues. One in six acute care hospital beds in the United States are in Catholic systems, with such hospital ownership increasing 22% from 2001 to 2016 (Gold, 2019).

This trend of rapid consolidation in both horizontal and vertical mergers is based on the assumption that large scale is needed to lower costs, although the evidence points to a different reality of higher prices for consumers (Kacik & Bannow, 2017, p. 5). The year 2015 was record-breaking for M&As, with the following year seeing continued adaptations to the evolving financial landscape.

With M&As that climbed from 38 in 2003 to 115 in 2017, economists and the American Hospital Association debated whether consolidation typically raises prices, often does not produce expected savings, and can diminish quality (Kacik, 2019a, 2019b). Owens has commented on an American Hospital Association (AHA) report which claimed that mergers resulted in better care and savings, but all other studies point to the outcomes of less competition and higher prices for patients (Owens, 2019, p. 1).

Analyses that focus on costs and not prices skew all conclusions. Mergers can beget greater capital and clinical expertise, which may mean wider use of “best
practices.” Yet hospitals joining together seems in part to be a response to rising information technology (IT) costs, among other cost trends (see Chaps. 2 and 5). The cost burden in the executive suite usually becomes an issue in that already high salaries tend to balloon. It is important to point out that consolidation is *not* the same as integration of services (Owens, 2019). For example, a local hospital chain here in Chicago, almost a decade after merging, still cannot transfer medical records from the flagship to an affiliate in the suburbs. Knowles reports that when institutions merge and competition declines, mortality rates and adverse health outcomes increase (2019, p. 91).

Beyond changing historic hospital names, local disruptions occur, which altered the range of services residents have been used to providing, e.g., women’s health when Catholics chains absorb, HIV/AIDS care cuts, closing ERs and OPDs, and elimination of other not-so-profitable services. Research has shown that closures take a huge toll on a local economy, besides the surrounding community (McLafferty, 1986; Whiteis, 2000; Rich, 1982; Sager, 1983; Oloroso, 1988, 1989; Friedman, 1978; Dranove & White, 1997). Community characteristics often determine payor mix and thus financial stability; overtime viability of the hospital puts poorer folks most at risk. Hospital competition under the uneven playing field and M&As are both chiefly responsible for the decimation of many local community hospitals from the 1980s through today. The marketplace for hospitals has been highly unstable for decades, where today 1 in 5 rural hospitals remain at high risk for closing (Gooch, 2019).

*Modern Healthcare* annually publishes its *Resource Guide*, a listing of the firms in each line of health business, from management consulting, law, electronic health records (EHRs), investment banks, outsourcing vendors, to professional membership organizations, among others (*Modern Healthcare*, 2018a, 2018b, 2018c). This is a valuable tool for recognizing the concentration that parallels every segment of the healthcare industry. The larger proprietary and “not-for-profit” chains are delineated (see Chap. 2).

In recent years, the wide range of corporate health entities has been caught up in a frenzy of amalgamations, including the so-called “not-for-profit” hospital systems, the pharmaceutical industry, managed health care, pharmacy benefit managers, specialty pharmacy groups, health information technology firms, and chain drug stores and retail clinics. This has resulted in a few firms dominating in most of these arenas, also including facility construction, consulting, and legal and accountancy firms, and other firms specializing in the health sector. Marketplace medicine yields a plethora of entrepreneurial startups in multiple areas to grab what they can get with innovative spins (just witness exhibitors at any health professional meeting and trade show). Ideological support can be garnered from the powerful charitable foundations that have long been influential across the healthcare system.
Making a Business off of Sick Folks

With handsome returns on investment to be made, achieving greater market size has become the modus operandi. A prominent example of health sector transformation is the distorted growth of health expenditures directed toward medical marketing reaching $30 billion in 2016 (Tanner, 2019). Among the top 20 firms grossing over $40 million listed by Modern Healthcare (2018a, 2018b, 2018c, p. 42) was Omnicom Health Group with $739 million in revenues in 2017. Such “health” expenditures add to the per capita cost of care (sic) for every American.

Often in response to the strengthened market power they must confront, physician groups have gotten larger as well. IQVIA’s review finds 50 largest medical group parents that own and manage about 20,757 medical group locations, employing an estimated 102,600 physicians (Schember, 2018).

Likewise, there will be no letup in M&As across all segments of health care given Republican policies for healthcare market “reform.” Of late, vertical integration appears to be more prevalent than horizontal mergers—combining separate business lines, as in the CVS-Aetna and other pharmacy benefit management arrangements (Japsen, 2018). Such amalgamations challenge organizational theorists for conceptualizing sets of complex functions across the rapidly changing field (Etzioni, 1961).

In addition, the host of large corporate firms, long constituting the medical-industrial complex (MIC) to supply providers for services provision (Box 1.1), has substantially grown given generous pass-through providers from employer and federal/state funding. Several of the economy’s largest corporate giants (including Amazon, Buffett’s Berkshire Hathaway, Morgan Stanley, Apple, Google, Microsoft, IBM, and General Electric, among numerous other Fortune 500 firms) are staking out new much larger investments in health care. Their strategies in health appear to be ripe for both innovations and exploitation. Is a new wave of corporate transformation of American health care underway as the technology-driven invasion by behemoth IT entities swoops into the health sector? (see Chap. 5).

McKinlay (1984) offers an excellent class analysis of what has been happening in the structural development of our American health care as it has spread across the globe. His main point is that the US medical-industrial complex (MIC) tied in with other Northern global powers, yielding a worldwide MIC. This is properly understood mainly by seeing how multinational corporations in general as a class develop and preside over new markets much as they wield their power inside the United States. It is believed that innovation drives deep changes in the structure of economies. This predicted larger corporate involvement follows the pattern that truly transformative effects are still mostly concentrated in specific sectors (Donay, 2018). But is this a prelude to “better things to come,” as techno-optimists may have us believe?

McKinlay points out that the “types of health services research that dominate the health field around the world” are “much atheoretical, frequently ahistorical,
usually apolitical, and usually defensive of the status quo, and normally dominated by managerialism.” To understand the true dynamics, he suggests a structural analysis of political economic forces that influence the shape and the content of medicine and its institutions to evidence the broad corporate involvements. It is much broader than interactions of merely professionals and provider institutions (Navarro, 1976). The actual MIC expansion in size and power over several decades is reflective of the larger capitalist society. McKinlay states:

The phenomenal and uncontrolled expansion of the Medical Industrial Complex over the last 50 years has paralleled the now uncontrollable requirements of advanced capitalism. … In order to explain why the ideologies and institutions comprising the health care complex have developed as they have, we require first, some understanding of the logic, pressures, and contradictions with which capitalism is beset; and second, an awareness of the reasons why predatory corporations had penetrated and now dominate health-related activities around the world. … The term “predatory” is employed here to characterize the rapinous activities of large-scale capitalist institutions (mainly banks, insurance companies, and industrial corporations): the act of invading, exploiting, and ultimately despoiling a field of endeavor -- with no necessary humane commitment to it -- in order to seize and carry away an acceptable level of profit. (McKinlay, p. 2)

In McKinlay’s same volume, Bodenheimer (1984) examines transnational corporate plans to operate on a global scale, particularly given the pharmaceutical industry’s near 20-year patents where they hold a monopoly on each compound. This monopoly allows the shifting of product lines to other industrial activities, as well as many developing economies, to gain footholds to guarantee profit flows transnationally. Through our book here, the authors will lay out numerous data points to demonstrate how this structural approach is preferable to other examinations of American medicine that ignore or discount power and wealth (Navarro, 1976).

Borrowing heavily from McKinlay, the logic of this expansionary activity can be applied to the corporate provider entry into healthcare provision and the subsequent changes wrought since the mid-1960s. Some forms of competition led to expansion of the total productive services output, yet questions may be raised over the “use value” of what was, and is being, produced, i.e., inappropriate care, huge administrative waste, plus fraud and abuse—estimated to reach $272 billion in 2014 (The $272 billion swindle, 2014). Trump’s preoccupied Department of Justice is reported to have recovered only $2.5 billion in fraud and false claims in 2018 (Boggs, 2019).

All of these production downsides tend to characterize the recent functioning of providers. If the aim of production is to primarily result in expanded profits, which are then reinvested in more enterprises and more technologically efficient production this might conceivably improve delivery of health services. However, this has led to creation of a commodity fetish promulgated by deceptive advertising for even higher utilization. Kennedy examined the significant impact of for-profit organizations on voluntary and public hospitals by the mid-1980s to find reduced overall access and rising costs resulted while professional standards were lessened (Kennedy, 1985).
More attention becomes directed at foreign markets when regulatory constraints develop domestically (Bell, 1996); multinational expansions seek even higher returns on their investment (ROI) amidst likely less regulation abroad, though social and cultural barriers can be challenging (Perez-Stable, 1999). The ideological sales program for US health care has been that it is far superior to any other nations and that American medicine and technology (and its capital sponsors) are unsurpassed (Human Development Network, 1997). Multinational health corporations sped into other nations’ markets (Berliner & Burlage, 1990; Maier & Engelberts, 1986; Berliner & Regan, 1987). Witness American proprietary hospitals in Latin America, Asia, England, and Europe (Euro-Fiet, 1987; Milmo, 1987; Hagland, 1998; Berliner & Regan, 1990; Salmon, 1984); HMOs across Latin America and elsewhere (Snow, 1996; Ham, 1995; Hensley, 1999; Bosch, 2000); academic medical centers in the Middle East and Asia (Marquee Brand, 2016); clinical trials outsourcing across Asia and the Caribbean; and a variety of PBMs all over (Navarro, 1995a, 1995b, 1998; Hotchkiss & Jacobalis, 1999; Stocker, Iriart, & Waitzkin, 1999). Some of this overseas investment is tied into the widespread private profit-based medical tourism industry (Medical Tourism, 2013; Salmon & Aruru, 2019).

In several national healthcare systems, these advanced for-profit organizational forms may make some innovative contributions in addressing their current cost, access, and quality problems (Meyer, 1997). Unfortunately, innovative and/or advanced services usually stay confined to multinational employees, well-insured upper-class residents, and medical tourists—not the bulk of ordinary citizens. More lately, a McKinsey executive, among other corporate spokesmen, report American systems and Big Pharma lie in wait while building sales and R&D infrastructures to move into developing private insurance markets in places like India and China (Carroll, 2012). Ongoing and longer-term effects are diminishing existing public health sectors through privatization schemes that open foreign markets to American multinationals (COM, 2002; DeGroote et al., 2008; Alvarez, Salmon, & Swartzman, 2011).

Writing in Modern Healthcare, about corporate managed care making money off the state Medicaid, Terhune in a piece “As billions in tax dollars flow to private Medicaid plans, who’s minding the store?” notes that these privately managed Medicaid plans do not provide sufficient oversight of patient care and the quality of that care to the 54 million people now on Medicaid managed care. The expansion of Medicaid managed care now consumes $300 billion annually, and yet we have little information as to what we are getting for the money (Terhune, 2018, p. 14).

In another Modern Healthcare article, Terhune (2019, p. 1) explores how the legion of private subcontractors control crucial decisions over care denials of services for the millions of low-income Americans on Medicaid managed care.

Dr. Arnold Relman clearly saw mounting consequences arising from unfettered marketplace medicine (Relman in Salmon & Todd, 1988). It is important to reiterate that Relman (1980) noted the emergence of a “new medical-industrial complex” that arose from the late 1960s to capture a part of the influx of federal largess; it was
also positioned to capture benefits from the Democratic-constructed Affordable Care Act of 2018, which failed to safeguard against such practices.

For-profit care is subjected to management control from distant centers accountable to stockholders, not communities, nor in fact to patients themselves when safeguards against such practices interfere with care patterns. The growing variety of corporate entities today reap handsome returns on their investments, by selectively choosing locations and patient groups, still highly subsidized from the public trough.

In conclusion, public policymaking remains largely shaped by powerful firms to satisfy their vested interests, which are often at odds with the overall public’s health. Regulatory constraints imposed by government to redirect efforts to address the public’s health are stiffly resisted in this medical marketplace. Thus, the quest for financial gain underlies the passion to forge larger more powerful, diversified, and integrated entities to gain, and try to dominate, market share. Their grip on policymaking comes from their lobbying strength, and the widespread acceptance that this corporate healthcare system seems to be the one the American people supposedly want. The populous remains uniformed of the most crucial issues and unfortunately can be easily manipulated by prevailing ideology.

**Background to Corporate Involvement**

Following business support for urban sanitation measures in the 1890s, interventions by the Carnegie and Rockefeller Foundations post Flexner Report in 1910 marked the first major phase of business involvement in American health care (Salmon, 1978). The Rockefeller Foundation’s huge funding of scientific medical schools, and its infectious disease programs through 1914, in effect reshaped medical education (Ludmerer, 1985) and transformed the entire healthcare delivery system by changing the nature of doctoring (Salmon, 1990, 1994). The medical profession became principally upper middle-class white males thereafter (Brown, 1976; Berliner, 1984). In the 1960s a beginning feminization of medicine began with more women admitted to medical schools, with sporadic minority physician numbers up too, many being foreign medical graduates, growing now to about 20% today (see Chap. 3).

Ironically, for-profit medical schools lost out with the Flexnerian reforms after 1910 after the Carnegie and Rockefeller Foundations reorganized medical education to a 4-year, university-based curricula to professionalize medicine. The advent of scientific medicine eventually improved the quality of doctoring, the specialties emerged in academic medical centers, and hospitals modernized to no longer be “places to die” (LeFanu, 1999). Most US hospitals then were religiously sponsored, traditionally non-profit, and charitable to serve their communities. In the late 1920s, the privately funded Committee on the Cost of Medical Care sought to set in place the concept of an industrialized hospital system. Government had established urban public health facilities to control epidemic diseases; the need for public hospitals during the Great Depression led to widespread building under the federal Works
Progress Administration (WPA) to open access to poorer areas and for the unemployed across the nation. This public effort continued with subsidization of private non-profits with the Hill-Burton Hospital Construction Act of 1947 (Stevens, 1999; Starr, 1982). By the 1960s overbedding (the high ratio of beds to community residents) was established, so hospital costs zoomed since a “bed built was a bed filled” (Roemer’s Law) (Roemer & Shain, 1959).

Thus, the predominant configuration of the delivery system and its reimbursement increased access while ballooning costs primarily within inpatient care, generally disregarding ambulatory care until higher profit margins began to be mined in later decades. With care centered in hospitals, the MIC found a growing market for medical supplies and technology, etc. Undertaken without proper population-based health planning, the necessity for better outcomes now for Americans has led marketplace medicine to begin to craft its “new solutions” to cost control (e.g., prospective payment, health savings accounts, vertical integration, narrower networks, value-based care, outright disenfranchisement of certain population segments, etc.), but unfortunately such solutions come under the auspice of private gain.

These early interventions occurred against the backdrop of successive stages in the organizational and technological transformation of American healthcare delivery. It is important to grasp the transitions from cottage industry through small-scale competitive entrepreneurship to the now emerging corporate monopolization stages (Kelman, 1971). Each stage can be demarcated by imbalances between larger societal productive forces and the existing social organization of health services (Dreitzel, 1971). The nineteenth-century guild-like petty commodity production under the cottage system gave way to the beginning of the modern hospital as medical education was substantially upgraded to 4-year laboratory-based university training. A new division of labor under the hospital administrator was established with physicians over other health worker categories, as well as with the specialization of medicine (Stevens, 1971). Each health worker category, in its self-interest, sought a respective professionalization on its own to help advance the productive health forces.

With modernization, the hospital’s earlier role changed as an institution of social control, particularly in urban areas to house the deviant and undesirable: the insane, criminal, handicapped, and orphaned, including the sick (Goffman, 1961). Scientific discoveries and new medical breakthroughs greatly improved hospital care and altered its purpose and organization. Anesthesia, the contributions of Pasteur and Lister in antisepsis, and pharmaceutical advancement contributed to more sophisticated care and efficacious surgery and more. The germ theory of disease amidst Rudolf Virchow’s laboratory discoveries on cellular structure, along with improvements in laboratory medicine and pathology techniques, led to refinements for more effective patient and population interventions (Rosen, 1958). Along with radiology, such advances massively changed diagnostic and treatment procedures.

The glamour of rapid change in hospital care left behind the image of the “place to die.” These advances attracted greater religious group sponsorship and upper-class charity to build more and larger hospitals, as well as upgrade existing ones.
Public institutions advanced as well, with federal public health service hospitals at ports and municipal-sponsored hospitals, addressing infectious outbreaks.

Medicine as a social institution thus legitimized itself, which in turn provided the material basis for industry growth through the vast funding that subsequently followed. Medical specialties came to dominate the larger urban hospitals, mainly in a non-wage-contract relationship as they were outside private practitioners. In addition to practicing in homes and community agencies, nurses made up almost the entire waged hospital workforce, some of whom began to resist their “handmaiden” status to the doctor (Moccia, 1994). Hospitals had established formal schools of nursing to exploit the unpaid labor of students, as well as to secure their employment upon graduation for their increasing technical labor needs. Nurses were almost exclusively female and white working class, while medical school entrants post-Flexnerian reforms increasingly came from white wealthier ranks (Berliner, 1984). Professional nursing began with the advancement of the hospital, with its nursing elite attempting to upgrade the discipline by establishing RN registration upon completion of accredited schooling and passing state boards (Reverby, 1994). As with medicine, adherence to nursing practice standards was to raise quality of care.

Other health professional categories followed similar paths to attempt semiprofessional identity and some self-regulation, e.g., social workers, physical therapists, laboratory and radiological technicians, nutritionists, etc. (Friedson, 1973, 1974). Professionalization among these various “semiprofessions” under medicine (Friedson, 1971) at times led to challenges to the white male-dominated upper middle-class status of the doctor, but such challenges have yet to break down the class, gender, and racial hierarchy that prevails in American health care through today (Navarro, 2017). Even with rising demands for women’s rights across society, doctors continue to rule over the generally female nursing ranks and still mostly dominate in clinical decision-making (Donbek, 2003). The role of nurses being the so-called handmaiden to the physician was altered over time as middle-class women chose nursing careers with their professional rank forging new avenues of expertise in credentialed advanced practice roles (Price, 2013). Masters and doctoral-prepared nurses came from upgraded curricula, with greater independence sought. Nurses had been at the forefront of public health in the community in public health departments, visiting nurse associations, and community health centers in the 1960s. Many gains coincided with the societal women’s movement evolving as medicine itself became feminized with greater medical school enrollments of women. More collaborative team functioning has been sought that blurred traditional roles too.

Recently, the Institute of Medicine (IOM) has recognized the valuable role of the three million nurses in the frontlines of patient care (Institute of Medicine, 2011). Advances in nursing education and everyday practice eroded past images of the nurse, all feeding into improved interprofessional relations. As perceptions and expectations of work life altered, stereotypes among the public changed as patients came to appreciate and rely upon nurses for clinical care and guidance.
Nurses became respected in and out of the hospital setting for their knowledge, skills, as well as greater time spent with patients. Similarly, this response has been fueling the rise of the chain drug store clinics where nurse practitioners handle primary care, and now chronic care conditions, among the populace. The IOM urges bachelor’s degree BSN curriculum to prepare more technically competent graduates and urges the preparation of more nursing doctorates, as colleges of nursing are doing along with residencies for more students. While remuneration of advanced nurses has climbed, their pay has never come close to physicians and especially well behind administrators.

It is interesting to note how the ideas of industrial capitalism did come to permeate medicine in not so subtle ways. While the delivery system moved rather haphazardly, an industrial model influenced doctors who relayed to the public an explanation of the human body in mechanistic terms: the heart was a pump; the lungs were bellows; the kidneys were filters; and later the brain became conceived as a computer.

Such a mechanistic and materialist representation of the body and one’s health neglects or downplays a broader sense of self that includes the human mind and spirit (Frank, 1963; Frankl, 1955; Hastings, Fadiman, & Gordon, 1980; Ferguson, 1978; Krippner & Villoldo, 1976; Pelletier, 1976). From the 1970s onward, the rise of the holistic health movement (Berliner & Salmon, 1980; Salmon & Berliner, 1980) and its entrepreneurial practitioners have capitalized on the limitations of modern medicine with an expanded notion of human existence and healing (Salmon, 1984). More among the world’s populations exclaim, as the German alternative health movement has, that “Gesundheit ist mehr,” which translates to “health is more” than just medical care (Salmon & Gallo, 1985; Salmon & Goepel, 1990). On a sadder note, social media has fueled diverse notions of alternative medicines in a generally unregulated marketplace (Liu & Salmon, 2010) of nostrums with dubious value that tend to confuse peoples’ minds. Despite reasonable due skepticism, the anti-vaccine movement has eroded needed institutional trust for addressing twenty-first-century global health problems.

The larger context of the health sector development was the society’s rapid industrialization in most spheres across the twentieth century’s economy, particularly in the urbanized Northeast and Midwest. Both industrialization and urbanization brought migration and sped up the economy, which eventually demanded a more highly trained, specialized workforce for its expanding division of labor. This reality edged in becoming recognized as needed for more rapid capitalist development. In 1890 Germany, Chancellor Otto von Bismarck enacted national health insurance for workers to essentially prepare for Germany’s industrialization and later European armed aggression.

In modern societies, formal education has taught necessary skills, as well as how to get up and go to work, properly behave, and relate to authority and competition (Aronowitz & Giroux, 1985; DiLeo, Giroux, McClennan, & Saltman, 2013). Certain segments of US industrial capital came to realize that their labor force also required greater protection from infectious diseases, as well as the ravages of the production processes themselves; issues of frail population health began to be seen as delimiting the rate of capital accumulation and fomenting underlying social unrest, as Bismarck had understood: replacement of valued
skilled, professional, and managerial workers due to disease was disruptive to production and very costly. European capital amidst the relative strength of their labor unions seems to have made note that government and their own investments in population health is integral to economic development; thus universal health coverage was implemented earlier in Europe, unlike no path chosen by US corporations (Navarro, 1975).

In the United States, business interests started to see that improvements beyond the workplace might also be necessary for social development. George Rosen (1975, p. 10) reported:

Concern with the relation of environmental conditions to ill health was not limited to industrial workers. It was recognized that the health of the worker in the plants could not be compartmentalized. Conditions of life in the home, as well as conditions in the factory, could deleteriously affect the worker’s health so that effective prevention required action along several interrelated lines.

The Federal Commission on the Conservation of Natural Resources, established by President Theodore Roosevelt, recognized the value of a healthier labor force to production and for overall economic development. Federal, state, and municipal governments were urged to protect people from diseases and conserve this “basic natural resource.” The elites of the society were more mindful that interventions into the social sphere of the individual and community life accrued benefits to the business class as a whole (Fisher, I., Committee of One Hundred on National Health., United States. National Conservation Commission, 1909).

Roosevelt faced what historian Gabriel Kolko (1963) describes as a dominant tendency in the American economy toward growing competition with economic decentralization rather than increasing monopolization of industry and finance. Therefore, “many leaders of big business became the chief imitators of progressive legislation to maintain existing social and power relations in a new economic context.” This was a time when banking regulation, a Federal Trade Commission, meat inspection, and other vital aspects of “progressivism” came as a surprise to many, but the regulatory agencies became essentially captured by powerful economic interests, which we observe continuing to this day (Kolko, 1963, book cover).

O’Toole, a biographer of Theodore Roosevelt, claims that TR was able to persuade Congress to pass the Meat Inspection Act and the Pure Food and Drug Act. He succeeded by seizing on public outrage over the putrid disease-causing conditions described in Upton Sinclair’s bestselling novel, The Jungle, which exposed the stomach-turning conditions in Chicago’s meatpacking plants. Both laws, enacted on the same day in 1906, were considered huge achievements in improving the health and well-being of Americans (O’Toole, 2019, A23).

The ideas behind the Roosevelt agenda or “ostensible goals” were economic, but its mandate also called for flood control, soil reclamation, and pollution abatement, all boons to the public health regarding his Natural Parks and Waterways Commission. When Roosevelt later ran for the national Progressive Party’s ticket, his platform called for universal health insurance; a national public health service; insurance for the elderly, the unemployed, and the disabled; the end of child labor; the abolition of the 7-day work week; and a living wage.
The point to be realized from these past times in America is that government leaders, with tacit going along by the business sector, reflected views long gone as part of the Trump era policymaking. TR’s perspective, as well as later his relative President Franklin Delano Roosevelt, offered a different political economic vision for America than that we find expressed today.

Significantly, the Carnegie and Rockefeller Foundations’ interventions in the beginning of the twentieth century had virtually rebuilt the entire medical care system by endowing research institutes and select medical schools (Brown, 1976). This funding cleaned up the inadequate situation of poor-quality medical education, leading many private for-profit schools to close (Berliner, 1977). It can be interpreted that the organization of medical practice under the previous cottage industry had then come into conflict with the aims of industrial capitalists. The developing delivery system was ripening for change, and groups began a process of reimaging health services, much as we may be witnessing this decade.

**The Committee on the Costs of Medical Care**

By the 1920s, the Committee on the Costs of Medical Care (CCMC) became perhaps the most significant historical attempt to mold a new organization form for American health services delivery (Salmon, 1978). Funded by eight philanthropic foundations, the CCMC assembled a host of health providers with insurance and banking representatives from the private sector. Staff issued 28 major reports from extensive investigation into the “economics of medical care and prevention of illness.” In 1929, health expenditures were at $3.5 billion, merely 4% of the gross national product (GNP). Approximately 30% of this amount, however, was allocated directly to private physicians, which was then considered exorbitant for the perceived safety and quality of care. Consumers paid 79% of their healthcare costs directly out of pocket. Philanthropy and local government operations were present, but these would be quelled with the oncoming Great Depression.

The suggested major restructuring was to create large-scale production to reduce the cost of its “unit product,” the worker (Salmon, 1978). The final volume of the CCMC published in 1933 recommended that:

…medical service should be furnished largely by organized groups of physicians, dentists, nurses, and pharmacists and other associated personnel. Such groups should be organized around a hospital for rendering complete home, office, and hospital care. The form of organization should encourage the maintenance of high standards and the development of preservation of a personal relationship between patient and physicians. (Committee on the Costs of Medical Care, 1932, p. 109)

Thus, the CCMC endorsed an industrial model of group medical practices under the control of the hospital factory to be financed by prepaid group insurance for defined enrolled populations. This proposal aimed to consolidate a more rational division of medical labor to maximize productivity with voluntary insurance to cover costs equally distributed over the enrollee group and over periods of time.
Doctors and hospitals would be assured more stable financing, while consumers would be required to pay for their medical care through fixed prepayment, supplemented by employers. This required insertion of middlemen, which adds to the administrative overhead.

It is not difficult to grasp why the medical profession, full of rugged individualists, opposed the design espoused by the Committee. Traditionally, doctors were supposed to “hang out a shingle” and mostly practice from their homes or a small office; this ethos continued for the next forty-some years. By the time the work of the Committee ended, general practitioners in private practice had been hit hard by the Depression. They organized to combat most of the ideas expressed in the reports; this reform was labeled erroneously as “socialized medicine.”

The power of hospitals in no way matched that of organized medicine; the outcome was that essentially doctors resisted their losing private practice status to become hospital captured employees, i.e., proletarians. Organized medicine would keep up the mantra “no interference to the private practice of medicine,” preserving the sanctity of the “doctor-patient relationship.” Later the American Medical Association (AMA) opposed the Franklin Roosevelt Administration leading to the elimination of health insurance from the Social Security Act in 1935. Yet, the medical profession was not really united as a whole, for some physicians in certain locales chose group practices of the prepayment sort, for example, Ross-Loos in Los Angeles, among several union-sponsored plans in major cities; physicians also joined group practices based on the fee-for-service model as seen in Mayo, Cleveland, and Guthrie Clinics (Rorem, 1931). Besides regional divisions, the varying medical sects of homeopathy, naturopathy, osteopathy, and eclecticism separated from the allopathic membership of the AMA and eventually lost importance (Shryock, 1936).

Nevertheless, the general instability and insecurity endured by all of society during the Great Depression hindered the implementation of all the Committee’s recommendations. Financing group practices remained tenuous, but certain models in different locales found physicians who preferred group practice over solo practice. In addition, a wide variety of payers (unions certain employers, coops), along with consumers, preferred the advantages from this type of medical practice (MacColl, 1966).

The most noteworthy prepaid group practice began with the Kaiser Permanente medical care program, a corporate initiative by the mining, aluminum, and shipbuilding magnate Henry J. Kaiser. In the early 1930s, Kaiser workers at isolated construction sites had no access to doctors and hospitals until the company leadership brought services to places where the employees lived and worked (Saward & Fleming, 1980). Industrial and family medicine integration was then seen worthwhile for assuring labor productivity (Spencer, 1973). Other sites across the West were built on this model in competition to fee-for-service practice.

During the Great Depression, hospitals saw charity donations wither, with unemployed and poor patients having no money for their care. In the absence of financing for health care, the voluntary hospital insurance movement arose on a number of local fronts, bringing about self-interested hospital insurance-only plans that eventually united under the Blue Cross Association in Chicago in the late 1930s.
(Anderson, 2005). The structural arrangement of solo fee-for-service physician practice and the cost reimbursement of hospital care then became entrenched with the advent of provider-controlled Blue Cross and subsequently Blue Shield payments.

The prepaid group practice (PPGP) model had been conceptualized, advocated, and operationalized under traditional not-for-profit designations (Saward, 1980). Yet it did not take widespread root across the country, but only established in isolated locations. Just as hospitals became aware of their key role in the advancement of scientific medicine, many institutions faced bankruptcy due to occupancy declines and an inability to collect from patients with little or no income. Most hospitals barely staved off bankruptcy through local charity support since income-depleted upper-class patrons and religious groups no longer could subsidize their communities’ care.

**Blue Cross Blue Shield Plans Take Off Nationwide**

Blue Cross plans began to sell hospital coverage for select employer groups usually under community-rated (i.e., one price for everyone, collectively sharing costs of care). The plans secured their financial base as the major player; employment-based voluntary insurance became the alternative that ruled out consideration of national health insurance. Of note, most hospitals were “not-for-profit,” and the Blue Cross Blue Shield plans were established in this same vein. Hospital administrators and local employers (who were usually hospital board members) ran the Blue Cross plans (Anderson, 2005; Miller, 1992). With cost reimbursement, hospitals were able to expand their services and facilities, to increase their workforces, and to cover any overhead from research and teaching activities, plus some bad debt expenses or charity care. By 1938, the American Hospital Association (AHA) was officially approving Blue Cross plans; this incestuous relationship between the national Blue Cross of America and the AHA would last through the 1970s when conflicts over cost containment between insurers and hospitals were exacerbated.

Likewise, state and county medical associations initiated Blue Shield organizations to remunerate certain medical services by, at first, hospital-based physicians, such as radiologists and pathologists, and for doctors who practiced on hospitalized patients under fee-for-service. Blue Shield plans provided an alternative to any federal proposals for national health insurance. The doctor-patient relationship, ideologically considered sacrosanct, had resisted “third-party” interference until medical society-controlled Blue Shield plans set up a suitable payment program to pay themselves well—but at least it was not government money!

When industrial unions under John L. Lewis won medical coverage as a fringe benefit during the Roosevelt Administration wage-frozen war years (Alinsky, 1950), the dominant position of Blue Cross Blue Shield in the insurance market chiefly became secured during the 1940s. The removal of the patient from this equation created a moral hazard for insured groups who were insulated from the full cost of
care; thus they tended not to be concerned with what was being charged by providers. The strong belief in health insurance has, however, begun to erode across the past few decades with increased burden from ever-rising premiums, deductibles, co-pays, and exclusions. Both consumers and some payers have differing perspectives on provider behavior today. Consumers were not aware of the true care costs, except their out-of-pocket spending, which today has become fully understood due to very high co-pays. The resultant burgeoning cost dilemma and the parties who benefit will be addressed in Chap. 2.

To sum up this earlier history, healthcare providers established a financing mechanism that separated physician practice and hospital care. Medical professionals and hospital interests maintained complete control over their respective activities, that is, the physician stayed independent and not employed by the hospital itself. With costs covered, hospital worker categories were elaborated to include pharmacists, medical social workers, physiotherapists, occupational therapists, laboratory technicians, dieticians, as well as a stratified hierarchy of nursing personnel. Services became commoditized and billable. The hospital workers in these roles—while not paid by physicians—served their admitted patients under physicians’ supervision.

Outside of the hospital setting, dentists, optometrists, podiatrists, chiropractors, and a few other categories remained independent, like physicians, as fee-for-service private practitioners. They usually collected from self-pay patients until commercial insurance companies broadened benefit coverage to undercut the local Blue Cross monopolies. The desire of the CCMC to industrialize the entire medical care operation was never achieved. The corporate vision of business rationality through the prepaid group practice model attached to the hospital factory was yet to be realized.

Financing medical care in United States was thus imbedded with solo fee-for-service medicine and cost-plus reimbursed hospital care, a structural arrangement that was inherently inflationary, with financial incentives to yield significant inappropriate care, increasing huge administrative overhead, in addition to fraud and abuse. There has been demonstrated ineffectiveness, with employers starting to see this arrangement as costly expenses—rather than investment in workers’ health, or a worthwhile investment for the general population!

This payment structure, however, was so acceptable to providers and insurers that later in the 1960s, both Medicare and Medicaid were crafted with the same reimbursement, even though the several prepaid group practices that did evolve seemed superior in performance for cost, effectiveness, and consumer acceptability (Brindle, 1969; MacColl, 1966; Saward, 1969a, 1969b; Prussian, 1972). Provider political strength at the time of legislative passage foreclosed the debate that later surfaced with justification for the Nixon’s health maintenance organization strategy in the late 1960s.

The crucial policy issues remain about the longer-term solvency of the Medicare trust fund and the strain on federal general revenues that fund the care for both seniors and the disabled (Munnell, 1985). Ongoing debates across decades for tighter cost controls recognize the demographic shift of more elderly people needing greater cash to cover costs, with less labor force participants paying taxes. The
search for new or restricted payments remains contentious in order to get costs under better control; prepayment is considered in various ways. Health maintenance organizations helped some, along with diagnostic-related groupings reimbursement, and now value-based care. Nevertheless, considerable controversy persists over the terms for altering the health cost trend with a spectrum of philosophical differences and vested interests behind each step. There remain feasible ways to save funds to pay for care, but most will involve cutting provider incomes and pushing more burden on patients. Solving the long-term Medicare financing will need to be addressed given aging cohorts and now with calls for “Medicare for All.” The method and level of payments to providers will affect both beneficiaries and the health system as a whole far beyond the immediate transactions at the cash nexus (Vladek, 1985). Republican market-based policies for cost controls seek cuts to providers and more cost-sharing by patients, whose origins and continuation began in the Nixon/Reagan/Bush administrations and now Trump.

The Health Maintenance Organization Strategy

The passage of Medicare and Medicaid for the aged and indigent drove overall health expenditures upward from 1965, along with other Great Society programs (Brown, 1983). The subsequent Nixon Administration sought to eliminate programs through cutbacks and rescissions to curtail outlays, as all subsequent Republican administrations seek to undo previous Democrat established programs. Total health expenditures had grown to reach $69.2 billion and 7.2% of GDP (Salmon, 1978, p. 136). Yet, the opening of access for the two large uninsured populations of aged and indigent greatly pleased providers, besides all in the medical-industrial complex, which had grown to attract new powerful players. After Medicare, Blue Cross Blue Shield plans began to lose market dominance to giant commercial insurance companies (Aetna, Metropolitan, Prudential, Travelers, Cigna, etc.); the latter competitors packaged health benefits into their other insurance product lines sold to large corporations, to undercut rates by the non-profits who lost rapidly in many locales. Blue Cross of Philadelphia was said to see its 90% market share fall precipitously to the commercial firms. Blue Cross negotiated friendly cost-plus contracts, while the commercial plans paid hospital charges for each item of service. Thus, while generally less ill, commercial patients brought more profits to hospitals.

At the same time, the sector’s largess and potential returns began to entice investment capital into proprietary hospital and nursing home firms to explore profit-making opportunities in the delivery of services (Salmon, 1990). The Nixon Administration planners sought out their business friends, who also witnessed huge increases in employee health outlays, so employers came to believe in the health maintenance organization (HMO) as a favored model (Morgan Guaranty Survey, 1972; Conference Board, 1972). Nixon’s proclaimed in his “healthcare crisis” speech in 1971 that it was chiefly the concern with costs: costs in the economy, costs to the corporate class as employers, and costs to the government for
Medicare/Medicaid recipients. He ambitiously declared HMOs to be the cornerstone of his restructuring of the *entire* healthcare system.

A totally new configuration was being shaped through his HMO strategy, along with added proposals for Health Systems Agencies (HSAs), Area Health Education Centers (AHECs), Professional Standards Review Organizations (PSROs), and Nixon’s own national health insurance plan. These newly designed federal interventions were intended to revamp the entire sector (i.e., health planning, professional education, quality assessment, and financing) (Salmon, 1978). Dr. Paul Ellwood, known as the “father of the HMO,” essentially took the CCMC recommendations for prepaid group practices and reformulated them into the HMO concept, only updated for corporate bottom-line pursuits. In essence, the HMO was intended to embody a *group practice of physicians* as part of a *coordinated delivery system* to offer a *benefit package* to an *enrollee group* that *prepays the fixed premiums* for care (Ellwood, 1971, 1973).

Nixon was faced with escalating expenditures under federal and state health programs, while his Vietnam War effort remained unabated and very expensive. He also heard from his friends among the corporate class who were alarmed by their rising outlays for workers’ health insurance during a tough economy. Several corporate planning bodies issued widely publicized major reports (e.g., Washington Business Group on Health, Business Roundtable, Conference Board, US Chamber of Commerce, among others). At the same time, dozens of conservative ideological entrepreneurs urged health policy restructuring to favor their class interests; essentially a chorus broke out all singing the same song for HMO restructuring to contain costs (Salmon, 1977). A burgeoning business literature also carried forth, along with a popular press, to foment widespread HMO support (Rothfeld, 1973; Salmon, 1984).

Being from California, Nixon was enamored with the Kaiser Permanente system—corporate-initiated private large-scale group practice of medicine (Saward, 1970; Saward, Blank, & Greenlick, 1968; Fleming, 1971; Williams, 1971, 1972). So Ellwood envisioned a thousand Kaiser-like giant HMOs across the United States to reduce costs and improve care to the working population while tightening up services to the aged and poor—which were considered by businesses to be a “social drag” on the economy. This was part of the agenda to bring government beneficiaries into organized systems of care to get a grip on their overutilization (Schneider & Stern, 1975).

The very structure of the HMO was designed for profit-taking: costs for providing services under the benefit package contract would be deducted from prepaid revenues, yielding the profit margin, which would become *the measure of success*. Taking care of patients would later be termed “medical loss ratio” as greed became evidenced in many fast-buck HMOs or the poorly managed plans:

According to Ellwood, the HMO strategy will strengthen the role of “competition” by introducing “economic incentives” and minimize the need for “regulation” by relying upon “market mechanisms.” The promise of a rational, well-organized delivery system of HMOs sounds convincing to cost conscious employers who purchase the bulk of health insurance for their employees, and to individual consumers who face problems of cost, quality, accessibility, and availability of services. As Alford [1972] points out, those pro-
posing “solutions” of corporate rationalization gained support from consumers who are hard pressed for improved health care services. (Salmon, 1990, p. 86)

Profitability was introduced to the picture as the key to HMO growth and survival; this legitimation of profits in health care would propel the corporate takeover of American medicine our nation faces in the twenty-first century. Ellwood invited private corporations to lend their “industrial know-how” because they are experienced in “the application of modern management” and had the ability to generate effectively used capital resources. The Nixon Administration was intent on attracting private capital to invest; corporate takeover mechanisms were designed to entice commercial insurance companies, industrial employers, and workplace integration of industrial medicine with family medical care (MacLeod & Prussin, 1973; Salmon, 1975). By 1974, a flurry of activity in the marketplace saw 177 operational HMOs, 204 in the “formational” stage and 88 in the “planning” stage. About seven million people were actually covered in HMOs by this time, which was not considered an impressive number. Quite a number had been in the earlier prepaid group practices. Almost all newly initiated HMOs were for profit, while by the 1990s, several of the earlier managed care plans would come to a “biblical conversion” like Paul on the road to Damascus. Blue Cross plans (e.g., Anthem, WellPoint, among others) reorganized as for-profit corporations, a kind of “why doth thou not pursue huge profits when one can?” By this time, marketplace ideology had become so ingrained in the healthcare consciousness. Surely executives would reap greater bounty for themselves, which they in fact did!

Contextual developments in the larger society had much to do with this policy failure. The economic recession occasioned from the OPEC (Organization of the Petroleum Exporting Countries) crisis resulted in an abrupt rise in the price of oil with the long waits in gas station lines. This, in turn, spun the world economy into recession amidst troublesome inflation. Additionally, on the political front, the Watergate scandal led to Nixon’s downfall, massively disrupting the District of Columbia bureaucracy and subsequently eroded Republican health reform effort after his resignation. Federal funds for HMO development had been limited, often taken from other agencies’ budgets (Bauman, 1976). Private capital found other investment alternatives during the recession; so, this was a disappointing response to the cheerleading of the Nixon and later Ford administrations.

Federal health policy under the Ford Administration carried forth enactment of Professional Standards Review Organizations (PSROs) for quality monitoring and Health Systems Agencies (HSAs) for local health planning. HSAs incidentally grew more corporate over the Great Society’s Comprehensive Health Planning Agencies, which had been filled with inner city activists (Health Information and Action Group, 1975). The dozen or more proposals for extending national health insurance all died in Congress. Of note, most major players in the health sector had a submitted proposal to suit their vested interests, including Nixon’s own in anticipation of its enactment, opposing that of Senator Ted Kennedy’s liberal standard.

By 1974 the idea of making explicit profits in health care did, however, firmly take hold. Several large Fortune 500 firms began to explore developing their own in-house clinics for their employees. The concept of integrating industrial medicine
with family medical care was being tested out by certain firms because they recognized assuring employee health might lead to enhancing their labor productivity, along with getting control over climbing expenses. Moreover, replacement costs of managerial, technical, and highly skilled personnel (particularly in tight labor markets) run high; to this day, recruitment remains a difficult task for HR departments in many industries due to the unavailability of specialized employee pools.

This industrial medicine model has occasionally surfaced in business circles up until today. Corporate planning bodies, which had “discovered” the need for “efficiencies” in healthcare delivery, widely publicized their major policy reports and began to lobby in new ways for policy changes (Rothfeld, 1973; Salmon, 1976). This phase of corporate involvement in health care, however, witnessed many twists and turns, which represents the interconnected complexity of “health reform,” the huge learning curve to grasp our dynamic health sector, as well as divisions among vested interests that persist until today. Revenue seeking by all parties comes up against imposed cost constraints, which have been stiffly resisted. Oppositions can usually forestall forward movement.

Still, the vision and direction of the Nixon Administration HMO planners was never quite embraced. Private investors in HMOs had been explicitly encouraged for healthcare profit-taking by Nixon officials (Salmon, 1984), so it became a natural outcome that other health endeavors would be seen similarly for lucrative returns. Dr. Charles Edwards, Under Secretary of Health, Education and Welfare, had been recruited from Booz Allen and Hamilton, a corporate consulting group, so past Democratic Public Health Service Commissioned Corps officers were replaced by business-oriented staffers with a larger corporate orientation and connections.

The HMO movement engendered by the bipartisan HMO Act of 1973 mandated the dual option where employees were to be offered a prepaid plan versus a fee-for-service plan, which the employer both decided, while simultaneously the feds spurred on Medicare and Medicaid managed care (Bauman, 1976). An influx of commercial insurance companies, employers, and hospital systems, among other providers, slowly adopted this new prepaid delivery arrangement, which significantly began to impact the culture of medicine (Young, 2013).

While staff model HMOs employed doctors, private practitioners defensively banded together in prepaid independent practice associations (IPAs) to keep their patient base from being syphoned off by local HMOs. Physicians around this time started to see the lessening of their autonomy and feel the erosion of their independence. Also, there were some observable differences between for-profit and the more traditional HMOs (Schlesinger, Blumenthal, & Schlesinger, 1986), but such began to ease over the decade as competitive behaviors converged.

**Rise of For-Profit Hospital Chains**

Profit was becoming the accepted underlying motor force for the sector development, with investment capital coming in, spurring more job creation, and boosting the entire economy (Fuchs, 2013; Healthcare is going gangbusters for the economy, 2018). Concentration and centralization in the delivery of health services proceeded
with pursuit of ever-larger revenues with higher margins becoming central. After a while, the outmoded “not-for-profit” designation became camouflaged and blurred. The delivery system was now officially businesses competing for their economic growth under a changing reimbursement environment. The marketplace became a struggle for gain, or, in some cases, survival. As a Catholic nun administrator aptly stated to the author while researching hospital closures in Chicago: “No margin, no mission” (Whiteis & Salmon, 1990a). Convergence of organizational behaviors had come to no longer distinguish the two camps.

While HMOs nationally failed to attain the market penetration previously predicted, almost a dozen investor-owned for-profit hospital chains arose and rapidly advanced during this time in the 1970s (e.g., the earliest entrants, Humana, Hospital Corporation of America, National Medical Enterprises, American Medical International, Universal, among several others). Across the next two decades, more firms joined the proprietaries as new business line combinations, takeovers, and mergers ensued and continued lasting until today’s ridiculously consolidated and integrating stage.

From out of this, Wall Street became enthralled. Backed by investment capital acquired from hedge funds and the stock and bond markets, such proprietary chains initially built smaller modern facilities in growing well-insured middle-class communities. Later the chains strategically absorbed certain hospitals and then started bringing endangered institutions under their management contracts, but the latter without any capital outlay for ownership. This added revenue to the lucrative supply chains from bulk purchasing pharmaceuticals to using sophisticated information technology. The chains attracted physicians by financially incentivizing them to hospitalize their patients there. The concept of an organization conducting a patient “wallet biopsy” was put into effect so that top-flight insurance and cash-rich patients filled their beds to boost bottom lines; profits were reinvested for greater growth and more takeovers. The uninsured and Medicaid patients were screened out and “dumped” to the public sector or to nearby “not-for-profit” hospitals that still were able to maintain a little charitable impulse to serve their surrounding communities, or could not easily turn them away.

Objective measurement of the extent of this tragedy across the nation was difficult to assess by the US Inspector General in 1988 since no record keeping was required. The US Commission on Civil Rights told President Barack Obama many years later in 2014 that lack of enforcement of the Emergency Medical Treatment and Active Labor Act (EMTALA), which had been signed by Reagan to prevent patient dumping, had not stopped this practice of refusing needy patients (Commission on Civil Rights, 2014). The law failed to provide financing its mandate, so violations were common by providers (Meyer, 2016). Estimates of hospitals believed to experience acts of dumping at least once a month was 45%—after President Bill Clinton again signed COBRA in 1993. The political stand for prohibiting the practice was by Dr. Ron Anderson at Parkland Hospital in Dallas, Texas (Hudson, 1986; Kutscher; 2014). Enforcement across Texas was exemplary for eventually provoking the COBRA action by President Clinton for a national prohibition. But policies that are not strictly enforced usually do not mean much.
Working out a methodology to monitor dumping patients, studies at Cook County Hospital in Chicago (Schiff et al., 1986) were absolutely key to such “wallet biopsies” that risked death and/or deterioration of clinical status in such unwarranted transfers. Patient dumping is thought to continue today as bottom-line dictates have continued to prevail (Can a hospital emergency room delay or refuse care, 2017).

Dr. Quentin Young, founder of the Physicians for a National Health Program, made the observation of the “vampire effect” (Young, 1995): once bitten, the so-called “not-for-profit” providers became just like the for-profits—the only difference they don’t pay taxes! In a short while, it became difficult to distinguish the two camps within the uneven playing field; a series of convergent behaviors were becoming apparent as reimbursements tightened. Multihospital systems were grabbing up doctors’ practices as smaller well-situated institutions in most urban areas became engulfed into larger entities (Salmon in Ginzberg et al., 1993); other hospitals added to the hospital closure trend, 15 in Chicago alone in the 1980s (Whiteis, 1992).

The far distant corporate chain management presiding over dozens of scattered hospitals lent itself to the preference for contracting out services over actual building or buying hospitals; this proved much less risky and more profitable since any acquisition under the management contract enriched returns from the corporate bulk purchase supply chain. Multihospital systems also became prominent in the so-called “not-for-profit” sphere as well; all sector parties saw an amazing surge in M&A fervor to better compete, as numerous hospital closures became more evident (Whiteis, 1992):

Between 1974–77, eighty-five public hospitals closed. Twenty-one county hospitals in California were closed or sold during the last six years of the [1980s]. In New York City alone, twenty-nine hospitals were closed between 1976 and 1980, seventeen were considered “financially distressed” in 1982 along with a total of 160 hospitals nationwide according to the U.S. Department of Health and Human Services. (Salmon, 1990, p.61)

In the better-off proprietaries, centralization took form in aspects, such as combined dietary, laundry, and housekeeping services; bulk purchasing of pharmaceuticals, medical equipment, and supplies; and health information technology. This centralization achieved real profit enhancements as more hospitals were engulfed into the chain orbit without substantial investment. Not uncommon with takeovers were lower-level workers losing jobs to enhance the chain’s profit levels. Hospital cutbacks also restricted emergency services and former outpatient departments affecting the greater size communities they had supported (Salmon, 1993). Independent doctor offices were acquired by hospitals, and new clinical buildings attracted specialists, who could be fed by the primary care physicians. Understand Andre Gunder Frank’s development in the face of underdevelopment contradiction (Whiteis & Salmon, 1990a). Using systems theory, Frank analyzed within interregional global capitalism that certain sectors advance, but often at the expense of other sectors that lag behind. In brief, they tend to go hand in hand but structured for the advantage of the dominant.

The proprietary chains slowed their acquisition of failing hospitals to morph more toward hospital management contracting strategically to enrich their size
without high capital outlays. Smaller public hospitals in rural areas and failing urban institutions were gobbled up in large numbers without much effort; these could be abandoned if corporate metrics were not achieved in a few years. These changing partners in the hospital industry dance led to many geographic relocations across the nation as large chains sought to maintain their profit levels from their glory days, at the expense of the communities they served (Whiteis, 2000). Significant care access issues ensued with abandonments and economic misery with loss of jobs in rural and inner-city areas.

Saint Anne’s Hospital in the Austin community of Chicago, a 400+ bed facility—the largest hospital closing to date then—majorly impacted its residential area beyond the denial of health services. Doctors, nurses, pharmacists, and other professionals could obtain jobs elsewhere; however, lower-paid staff, who lived in the surrounding community, would eventually face neighborhood business failures, deteriorating housing stock, and policing reductions for a crime surge. Local stores that once thrived abruptly closed with no more hospital visitors and staff customers; property values plummeted, insurance costs increased, and more, until noticeable change in social support came when community activists mobilized replacement of health and human services to preserve a safety net. Several agencies restored the ambulatory building and attracted a CVS drug store—no more pharmacy wasteland! Black community leadership then was strong, with some charitable and academic help, to create a success story. Nonetheless, across the country many closed facilities remain abandoned as dead capital.

Around this time, outsourcing by many hospitals became a standard practice of the privatization trend (Ginzberg et al., 1993). Many hospital administrations found hazards in contracting out due to a lack of due diligence. DeGroote, Paepe, and Unger (2005) note conditions to be met to avoid potential calamities: (1) real competition must exist between competent and substantial private providers and suppliers; (2) adequate capacity must be present to assess needs and negotiate and monitor contract terms; (3) a legal and political environment must exist to enforce regulations and resist patronization and corruption (Mills, 1998). Such conditions are most critical for public systems in developing nations where privatization ran rampant. Careful watch was not always adhered to, as some US hospitals became shells with a variety of private entities from consultants to clinical services taking operational and clinical responsibilities off premises. Nursing homes are notorious for such outsourcing practices (see Chap. 2).

The Broader Transformation

Over time, the American healthcare system—which had previously been based upon thousands of practitioner entrepreneurs and smaller-scale provider organizations except large firms in the peripheral supply role—began to be transformed in structure, control, purpose, and ethics, partly due to the tightening umbilical cord from the US Treasury (Young, 1999). Overall, professional altruism and the charitable impulse of community hospitals waned. All sector parties saw an amazing
amount of M&As to expand their size to better compete. Outpatient departments and Emergency Rooms were scaled back, while private physician practices were acquired by hospitals in the quest to fill beds with paying patients and for better control over the means of medical production. Community cutbacks were deemed necessary to restrict unprofitable patients and clinical services. Such combinations and cutbacks were forged for “economies of scale” and “cost-efficiency” but were always sold under the banner of “serving the public better.”

Other business ideas and behaviors crept into a broad swath of provider management as highly paid MBAs took the reins. By the late 1960s through the 1980s, at the operational level, a new breed of financial and marketing managers found employment supposedly to handle new complex issues, create “efficiencies,” and enlarge the now defined “customer base.” These managers over time tended to displace medical professionals in key decision-making roles.

In particular, proprietary firms set off heavy marketing campaigns to advertise their “superiority” as modern. They had newer facilities built in areas near the well-insured populations instead of being hospitalized in well-worn urban institutions placed near poorly insured areas. This was the age of roadside billboards and TV spots to advertise firms with what was to hopefully entice patients into changing providers. It was also the time of increasing managerial buildups in hospital ranks for the added sophistication needed to compete in a rapidly changing and challenging marketplace and to handle the complex financial conditions. Larger amalgamations, however, led to much higher administrative overheads, which in the calculation meant less money given to caregivers. Higher overheads included expanding their profit margins markedly; subsequently, this allowed certain firms to branch out internationally (Salmon, 1984, 1990).

Thus, the new medical-industrial complex (MIC) arose as a vigorous and varied group of investor-owned entities to serve those able to pay. Patients became “customers” who could sustain their growth for continued profit levels; Wall Street loved these rising stars as the new American wave of health care. This is the very expanse that Relman designated as “the most important recent development in American health care.” (Relman, 1980, p. 963). The rapid growth of for-profit providers included investor-owned hospital and nursing home corporations, diagnostic labs, mental health and home care agencies, hemodialysis centers, freestanding ambulatory, surgicenters, MRI units, and emergency centers and a variety of other services. This grouping soon produced between $35 and $40 billion dollars (25% of personal health expenses) in 1979, a percentage much greater today. In 2018, the American Hospital Association listed 1035 investor-owned entities or 21% of hospitals accounting for the $902,891,035 expenditure (AHA, 2017).

Outside contractors in the supply side ballooned (especially administrative, consulting, and information technology) during the restructuring, alongside physicians and hospital executives witnessing administration becoming vastly dense. Modern Healthcare (2017a, 2017b) lists the largest management consultant firms making billions in health care (#1 Deloitte taking in $2.6 billion annually from 12,000 contracts) and the largest public relations and marketing agencies again with contract revenues in billions (#1 Omnicom Health Group billing $808 million in 2016).
Medicare and Medicaid initially had made little change in the actual delivery system beyond bestowing a massive provider subsidization under the fee-for-service and cost reimbursed financing mechanism. These market improvements did grant better access as millions of Americans received needed care; however, inflationary pressures with little price accountability created problems for both government, employers, and consumers. Importantly, the government largess invited a plethora of firms to jump on the healthcare bandwagon, which they did in droves with sales to providers. This collectivity joined all the other MIC firms to feed off the constant federal funding.

In effect, Medicare and Medicaid accelerated and aggravated both federal and state policy problems, to reveal major structural defects in the system. Neither federal financing program challenged the historic provider-preferred premise of underwriting virtually any expenditure physicians chose for patient care. It was the public and private funding largess, amidst a lack of regulatory oversight, that attracted the host of investors, including fast-buck operators.

The *more is better* philosophy had taken firm root in the system with *more* service utilization, *more* technology, *more* growth, *more* layers of management, and assuredly *more* profits. This perversion was accompanied also by *more* admissions, *more* unnecessary surgery, *more* inappropriate prescribing, *more* diagnostic testing, *more* fraud and abuse, *more* days in the hospital, *more* readmissions, and *more* of whatever made *more* money. Such were the results of the now fading structural arrangement for financing.

While the private market during this period provided many innovative changes that advanced care for some Americans, the direction did not seem to contribute to the public’s overall health (McKinlay, McKinlay, & Beaglehole, 1989). Many Americans continued to face significant access barriers as the price of care continued to spiral out of control. Moreover, the overall medical measures of mortality and morbidity were found not to be declining (McKinlay, McKinlay, & Beaglehole, 1989). Yet, the medical marketplace remained heralded for all its attributed splendor by those who were richly benefiting.

**The Reagan Era of the 1980s**

The one-term Ford and Carter administrations launched few health policies of much significance. President Gerald Ford implemented Nixon’s PSROs and signed the health planning legislation to establish Health Systems Agencies (HSAs), replacing the former Democrat-passed community-based Comprehensive Health Planning Agencies, which ceded influence over local health planning to more corporate entities (Health Information & Action Group, 1975). Some block granting for Medicaid to the states was also established (Ford, 2017). President Jimmy Carter’s Voluntary Effort (VE) failed to impact hospital cost inflation, since the private sector went back to business as usual right when constraints were lifted after 1 year (Carter, 1977). The explosion of federal and employer budget costs later provoked the
Reagan fetish for cost controls and cutbacks. Economists saw their star rise, while concerns for access and quality took a back seat in policy discussions; again, huge policy reversals were set in place for market-driven ideology after Democrat Carter left office.

Health care as a percentage of GDP nearly doubled from 1965 to 10.5% by 1980. So it became clear to federal policymakers—and their corporate class sponsors—that not just the inflationary spiral but the allocation of those dollars and their outcomes deserved stronger policy attention. During the Reagan Administration, the Health Care Financing Administration (HCFA) began to wield enormous power, as did the Office of Management and Budget (OMB) (Etheredge, 1983). The former conducted utilization review, but in subsequent years, the agency morphed into utilization management; the latter review challenged provider behaviors. As the clinical decision-makers on patient care, doctors tended to be targeted as cost drivers (Schlesinger, Blumenthal, & Schlesinger, 1986). Victim-blaming patients for lifestyle behaviors and noncompliance for therapies and their subsequent utilization became prevalent (Ryan, 1976: Knowles, 1977; Crawford, 1977, 1978, 1979, 1980).

It might be recognized that HMOs were not easy to establish due to needed upfront funding and technical expertise which came at a high cost. Many existing providers shied away from the challenges presented with a break from the fee-for-service market. Thus, the superiority of organized systems did not hold up as an argument necessarily against the lucrative and entrenched vested interests at that time. Additionally, the conservative antipathy to extending any more access to the poor, disabled, elderly, women, and children kept alive the fetish for cost control in federal outlays. Profound economic shifts over time became evident.

As HMOs engulfed greater portions of fee-for-service markets across the country (Mechanic, 1991), preferred provider organizations (PPOs) by commercial insurance firms emerged, taking aim at the doctor-sponsored independent practice associations (IPAs), which had been physicians’ preferred model to mitigate patient migration toward HMOs. Employees usually had a choice between a few options, but it was the employers deciding on what local insurance plans would be chosen, their benefits, and amounts of patient cost-sharing. IPAs faced a competitive disadvantage against PPOs, which had larger networks of hospitals and providers. As a result, PPOs became the instruments of hospital chains and insurance companies.

As premiums rose, benefit packages with greater consumer cost-sharing shifted the burden from government and corporations at a time of declining living standards. An insufficient number of health professionals spoke out about consumer health cost controls under the Reagan Administration and its class nature (Navarro, 2017). Policies emphasizing cheaper front-end ambulatory services were not regarded as a health improvement if the price was the sacrifice of necessary hospital, rehabilitation, and end-stage care for certain patient segments. The bulk of private investment was situated in the higher-cost multihospital systems and academic medical centers. Case in point, the HIV/AIDS crisis arose in the early 1980s, and Reagan simply denied its existence (Cohen, 1985).
As Reagan led a huge buildup in military expenditures, the Economic Recovery Tax Act of 1981 coincided with a sharp increase in revenues by the four major hospital management companies. Investor capital flooded into these companies and other proprietary ventures while their stocks climbed.

Nascent health information technology (HIT) enabled hospital financial executives to examine specific departmental costs to carry out greater rationalization of the labor process and to reduce expenditures within hospital operations. Across the globe, computerized systems continue to be developed in the rush to build “Big Data” to gain control over healthcare activities and to further scrutinize the appropriateness of services and practitioners’ output (The 2019–2014 World Outlook for Internet, 2018). This burgeoning segment of American health information technology, today concentrated into four- or five nation-wide firms, began to play a critical role in tracking physician performance. The Obama Administration’s Medicare Access and Children’s Health Insurance Program Reauthorization Act (MACRA) of 2010 later further extended such monitoring (Feinglass & Salmon, 1994; Glassman et al., 1996; Hyans et al., 1996). Malpractice investigations took on greater meaning with HIT advances (Perna, 2018), with physician resistance to such electronic health records being a factor (Wigger, 1996).

HIT systems have come a long way over this past decade, and with greater big IT firms bringing greater sophistication into health care, it remains to be seen how such HIT systems may evolve: who designs and controls the metrics for what chosen analytics, for what purposes, and what directions. Whether the Trump Administration moves more aggressively on the MACRA implementation may be in doubt; CMS seems at times to rely upon private sector initiatives setting directions. Certainly, today’s Accountable Care Organizations (ACOs) are using their own performance monitoring of costs and quality in varying ways, as will later be explored.

By the time Reagan introduced diagnostic-related group (DRG) reimbursement for Medicare, expenditures had climbed substantially. DRG categories established set amounts for diagnosis upon admission, and hospitals sought their profit by minimizing services, or as many consulting firms helped them to benefit through various managerial techniques. Hospitals sought contracts with a burgeoning array of consultants that sprung up to populate health trade shows and professional meetings. This demand for expertise led to a burgeoning healthcare management consulting industry, sporting firms like Deloitte, Optum, and Navigant, among a couple dozen others, raking in as high as $3 billion per year (Largest healthcare management, 2018, p. 34). DRGs supported widespread profit-seeking within the hospital industry.

Even with cost reductions in certain spheres, the fundamental belief in the private market for the bottom line remained the primary sign of “success.” Each diagnostic group received a fixed payment for an admission with generally multihospital systems and larger hospitals able to maximize payment excesses. As a result, larger firms with specialized internal staff or outside private consultants won out by gaming the system. State Medicaid plans and private insurers followed suit with prospective payment soon thereafter, greatly complicating hospital reimbursement
across the 1980s. Rearranging incentives, however, does not necessarily reduce overall cost outlays.

Certain clinical services were driven out of the hospital setting—a loss to physicians not jumping on the ambulatory bandwagon. Physician and corporate-sponsored surgicenters and diagnostic centers sprung up all over, completely unregulated and causing much local disruption. Any Medicare Part A DRG hospital budget “savings” were soon gobbled up under Medicare Part B physician payments. This is where the “vampire effect” became much more noticeable in many urban centers where so-called not-for-profits came up against the proprietary chains (Ginzberg et al., 1993).

Across the 1980s, for-profit hospital systems owned about 20% of nongovernment acute general hospital beds and more than 50% of nongovernment psychiatric beds. Yet this “development” went together with an “underdevelopment” of the less fortunate hospitals in poorer communities, as economist Andre Gunder Frank has said characterizes the capitalist system (1967). The 1970s growth in facilities and bed numbers in the proprietary sector contrasts dramatically to the contraction in the “not-for-profit” volutaries and government segments of the industry who were left to serve the poor, minorities, and uninsured. Two major and interconnected issues became public and voluntary hospital failure in the face of the rapid encroachment by the for-profit sector (Whiteis & Salmon, 1990b).

A Modern Healthcare survey revealed a 15% increase in the total beds owned, leased, or managed by investor-owned multihospital chains between 1982 and 1983 and a similar 15.1% increase between 1983 and 1984, where the profits of investor-owned chains rose 28.5%. This continued trend had shown a 37.7% profit increase between 1982 and 1983 (Modern Healthcare, 1990, p. 66).

This examination of hospitals reveals the financial crisis among those unable to tap into capital reserves, as well as compete for better-paying privately insured patients. Financing their futures, many larger non-profit systems pursued tax-exempt bonds to expand to compete. However, 156 community hospitals closed between 1980 and 1984, with the single greatest concentration of closings (almost 30%) being in large metropolitan areas with populations over 1.5 million, the areas with the greatest health needs. These hospitals that closed tended not to be part of multihospital systems (Whiteis & Salmon, 1994). Underdevelopment was seen in the huge losses by public hospital systems, which recorded a $360 million deficit for 1984, 57.2% greater than the $229 million deficit in the year before.

In this era of cost cutting and retrenchment under Reagan policies (McKenzie, 1994), many hospitals and their served communities remained in jeopardy. Federal policy exacerbated the financial damages on hospitals that were most at risk. Restrictions on access for the uninsured and Medicaid patients, and the later impact of “dumping” patients on already overcrowded financially burdened public institutions, were noted in studies (Schiff et al., 1986).

Corporate concentration—under the guise of competition—led to a rapid and insidious trend, with insufficient policy concern for the massive disruption across the entire health system, including its profound impact on the culture of medicine (Stoeckle, 1994). As Whiteis and Salmon (1990a, p. 119) summed up:
In the wake of this push toward corporate consolidation, those left behind -- the working poor, the unemployed, racial minorities, many elderly women, and children [were] gradually being denied access to the vital resources needed to participate actively in their own health and the health of their communities. … the structure of the health care industry, its long history of technological-intensive intervention, and the current trends toward for-profit care with the removal of services to those left behind in the wake of the corporate siphoning of public resources are all of a piece. They are signs and symptoms of the larger illness, the underdevelopment of public resources under corporate development.

This corporate takeover of health care coincided with the huge growth in the ranks of the uninsured, which rose dramatically during the Reagan years of neglect, continuing to balloon to 47 million Americans under the second George W. Bush Administration. Simultaneously, the number of underinsured (those with chronic diseases with poor coverage) has been estimated to be about equal in number. In addition, from the Reagan through George H.W. Bush years, economic crisis and hospital closure among institutions serving the poor and minority populations in major US cities created an access dilemma unaddressed by any public policy until the Affordable Care Act gave insurance coverage to some 20+ million.

The national health insurance failure by the Clintons in 1993 (Starr, 2011) stood beside the initiation of the Children’s Health Insurance Program, which has aided some families with sick kids, but again became a subsidization to private insurance firms that had long neglected this cohort as unprofitable without federal largess. Clinton’s approved health plans, while settled in the private sector, came with federal oversight that the insurance and pharmaceutical firms decided were not palatable. They chose to go on their own ways with the market.

Community hospital failures during the 1980s had multiple impacts to declining communities; closures displaced many unskilled and semiskilled workers who lived in adjacent neighborhoods delivering a double whammy to many urban and rural communities (Whiteis, 2000). Doctors, nurses, pharmacists, and other professionals could find jobs elsewhere, but unskilled workers did not easily regain employment. An accompanying disruption was the small businesses formerly sustained by the hospital traffic that closed, as the surrounding housing stock faced disintegration as well (Whiteis, 1992).

Globally, the move toward privatization in health care as well as for public services led to the removal of many state-guaranteed public services and instead provided private services across many nations (Navarro, 1984). Often inspired by the US and international financial institutions (Alvarez, Salmon, & Swartzman, 2011; DeGroote, 2005), the ideology of marketplace medicine was majorly exported and fostered multitiered healthcare systems in several nations, being shaped where larger social policies and processes were promulgated by increasing multinational corporate power and economic consolidation (Homedes, Ugalde, & Rovira 2005). The ideological significance lies in the accompanying decrease in the provision of human services and economic support to those considered “unproductive” segments of the population and their respective communities.

With the growth of corporate hospital profits, these firms moved into related areas of care. The sector saw a continuum of investor activity popping up in diversified areas of freestanding health centers, surgical, MRI and other diagnostic centers,
and home healthcare agencies. Despite the contraction of services at the bottom layer of health institutions serving the less fortunate, services sold to well-off insured patients became money making enterprises. Retail store eye and dental centers, ambulance services and other profit-seeking entities filled the vacuum once provided by hospitals.

More recently, chain drug stores diversified into primary care clinics—an entry which blindsided community physicians (see Chap. 2). Today these clinics pose significant threats to primary care physicians and represent another intrusion of “marketplace competition” which has long been heralded by conservatives and investors as an example of innovation and improvement that can only be possible in a free market health system (Woodson, 2017) (sic).

Physicians then began to realize that their own remuneration was to be similarly subjected to conserving by both government and private insurance monies: “incentivizing” by the resource-based relative value scale (RBRVS) reimbursement began to set physician fees. RBRVS is based upon predetermined resource costs to provide various services, with the policy intention to stabilize the payment system while continuously trying to constrain outlays. This doctor reimbursement was Reagan’s Centers for Medicare & Medicaid Services (CMS) new way to reduce doctor income. Physicians over time adapted to this regulatory constraint, but further restricted payments would lie ahead in the Medicare Part B reimbursement changes and then Obama’s MACRA further tightening.

In their heyday, “free market” health economists (Fox, 1997) carried out studies to appeal to the corporate and governmental focus for cost containment. Advocacy and critique took a backstage to policy journals’ focus on articles about provider reductions and higher consumer out-of-pocket payments as attempts to curtail expenditure growth. The President of the Federation of American Hospitals, the lobbying arm for the proprietary hospital chains, explained:

…an administration opposed to government regulation of our industry, opposed to comprehensive national health insurance, opposed to cost controls, opposed to planning, and receptive to new ideas… we have never been in a better position in our history. (Federation of American Hospitals, 1981, p. 2)

The vampire effect was clearly in full swing with most “not-for-profits” obviously choosing bottom-line oriented strategies. Operating surpluses instead of profits are produced by so-called “not-for-profit” voluntary hospitals, which are manifested in higher executive salaries and expense accounts for administrative personnel, trustees, and their business associates who may furnish services or products to the hospital and, indirectly, the medical staff. Modern Healthcare’s executive compensation survey in 2019 (Kacik, 2019a, 2019b) revealed average pay for hospital administrators above a half million dollars, with larger systems’ CEOs making well into tens of millions in payments per year, all increasing by 6.8% annually—far surpassing the average hospital worker’s increases. As mentioned previously, the medical-industrial complex suppliers, who benefit by the pass-through federal/state and private funds, hyped up the purchase of new fancy equipment and supplies supposedly for competition’s sake (McKinlay, 1984).
Thus, provider competition, and tougher reimbursement for patient care, created a climate that tended to lessen the enhancement of the population’s health in their surrounding communities. What was more apparent was selective marketing to more desirable patients, and “demarketing” to others, along with efforts to build larger systems through diversification schemes. The rhetoric was for a “cost-effective, business-like basis” often with physicians being blamed for high utilization decisions for their patients. The object was to provide greater billable service to those patients who may likely not need more care, but who possessed good coverage for reimbursement and then provide less to those who may very well need more care, but possessed little or no reimbursements.

Further Implications

The magnitude of this proprietary presence and its rapid growth in a new realm of ambulatory entities remains completely unique to the US healthcare system. No other national health system across the globe has such a large and powerful medical-industrial complex with such a heavy corporate provider presence. Nowhere else is profit the main driving force in health care, though this may be changing in several nations. Other nations have traditionally constructed public healthcare and/or not-for-profit systems, though many nations are now privatizing often with the same collection of American health corporations currently making inroads into international markets (Berliner and Burlage, 1994).

With a change in values and purpose of the overall healthcare enterprise, corporate forces abandoned a public health orientation while directing the entire system to their commodity production purposes. Similar ideologies brought along employers who bought the arguments for HMOs, deregulation, and no national health insurance. Across this time, the industrialization of the sector seems directed more toward delimiting the allocation of resources to certain population segments. Individualistic solutions took precedence over communal approaches toward public health; the admonitions favoring social medicine fell on deaf ears among the professions. Corporatization has altered the nature of doctoring and will continue in the future in more dramatic ways (Stoeckle, 1994).

In our healthcare system today, profits subsidized from public funds (which amounts to almost 50% of total US expenditures) give ample reason for these powerful entities to exert influence over policymaking; their proposals are often at odds with the overall public’s health. Regulatory constraints imposed by the government to redirect efforts to address public health is stiffly resisted in this medical marketplace, estimated to be around 2–3% of total health expenditures. Thus, the mission of underfunded healthcare entities to further the public’s health will continue to erode substantially.

One might pose the question: How did this corporate transformation of US health care occur so fast? Not long ago, the medical profession was considered to be the dominant power in US health care; almost all hospitals were “not-for-profit,” as was
the largest insurer, Blue Cross Blue Shield, and the largest health maintenance organization, Kaiser Permanente.

Fading of late, the ethics of professionalism spoke to a calling to public service for physicians, nurses, and other practitioners while maintaining a caring purpose to alleviate suffering from disease in their patients and their communities. In the halcyon days of the 1950s, physicians were once “the captain of the ship” and used to be their own agents, with personal relationships with their patients, who used to come from communities of which they were both apart. Patients were patients—not considered “customers.” Such an agency relationship has been fundamentally altered today (White, Salmon, & Feinglass, 1994).

Back then, insurance under Blue Cross Blue Shield did not interfere in those doctor-patient relationships, nor much in hospital dealings. In fact, payments worked to the clear benefit of providers who were generally happy with the relationship and their funding. Hospitals were paid cost-plus by Blue Cross, and when Medicare and Medicaid came into being in the mid-1960s, reimbursement was similarly designed. Doctors got fee-for-service crafted with hospital payments under the creed that “more is better”—“whatever it takes for patient care.” Clearly more in this case meant free reign for getting higher provider revenues. The overriding paradigm was that services were always indicated if a physician ordered them, and they surely did so; use of facilities and newer technologies in greater quantities naturally exploded costs.

Nonetheless, this structural payment arrangement proved to be highly inflationary and packed full of unnecessary and inappropriate utilization, as well as documented iatrogenesis (doctor- or health system-caused disease) both clinical and social (Illich, 1976). Social iatrogenesis addresses the widespread medicalization of social problems and the created dependency on pharmaceuticals and medical care; over 90% of physician visits result in prescriptions. Federal and state governments felt the burden of exploding costs, and employers became upset over their uncontrollable outlays for workers’ benefits with little gains in improved productivity, nor in overall population health (Salmon, 1973). Consumers constantly face higher and higher premiums, co-pays, and deductibles, still wildly escalating under both the Obama and Trump administrations.

While stronger cost controls appeared highly needed, the system’s excesses and inefficiencies mounted, while excess greed prevailed and was increasingly identified but rarely addressed. The United States has not sought strong pathways for social prevention for broader occupational and environmental actions; these were opposite to the Republican policy agenda. Therefore, the ongoing corporate transformation spread rapidly as marketplace ideology heralded private interests; health sector corporations became powerfully involved in policymaking across all segments of the sector and then shaped it to their own self interests.

Physicians seem to have been slow to grasp implications from their loss of authority, but recent conditions and the surging burnout make it more evident, maybe to spur a new consciousness (see Chap. 6). The anti-government sentiments, historically expressed by organized medicine, may have tended to obscure threats from the encroaching corporate players. The profession can be characterized as
highly fragmented. It now finds itself divided into dwindling private practitioners, paid employees (over 50% of the total practicing), as well as specific segmented divisions: primary care, specialty care, subspecialties, contract physicians, and an administrative class. Its professional elite in leadership roles has often wavered more in narrow self-interest than advocacy stands for the entire population’s health and well-being.

Many physicians feel bewildered as they watch mega-corporate health groups and the insurance industry gather performance data to evaluate their clinical decision-making about their now insurer-owned customers—not longer doctors’ patients (Feinglass & Salmon, 1994). Physician professional groups like the American Medical Association remain acutely disturbed by governmental actions into their professional affairs; nevertheless, they appeared to have been blindsided by the encroachment of private administrative entities over the practice of medicine. Relman foresaw the emergence of explicitly for-profit entities, but his voice and a few others failed to echo across the wider profession. Bitten by the vampire for-profit providers in the competitive struggle, the “not-for-profits” began to emulate them with convergent marketplace behaviors: creating patient barriers to entry, scaling back on not-so-profitable community-based services, building service lines that yielded attractive returns on investment, eliminating unprofitable service lines, and dumping patients who were unfunded or underfunded.

These overall conditions were promulgated by government policies, and part of the unplanned marketplace medicine left to the desires of numerous vested interests. The uneven playing field gave way to common bottom-line practices that mimicked across all provider systems. Moreover, administrative functions have now greatly expanded, so physicians find their autonomy more at risk (White, Salmon, & Feinglass, 1994).

From Obamacare to Trump’s No Care

The above highlights prevailing conditions and issues before the election of Barack Obama: marketplace medicine was advancing, while 47 million Americans went uninsured, with many denied services; perhaps an equal number were underinsured due to high out-of-pocket outlays; insurance company practices were blatantly discriminatory; and many more health providers became financially at risk. Despite their substantial subsidization by George W. Bush’s Medicare Part D, drug company price increases were seen as even more outrageous.

Forces of corporatization had grown steadily since the defeat of the Clinton reforms back in 1993, but the Democrats under Obama now seemed willing to deal and to use massive subsidization for a segment of the uninsured. Obama spoke to the national need to extend coverage while campaigning against insurance company practices. Waitzkin and Hellander (2016), however, note that:

With funding from the insurance industry and financial corporations linked to Wall Street, Obama became the first presidential candidate in history able to turn down government funds for his campaign.
One wonders where his campaign funding came from other than the many small donors who flocked to his campaign of hope. Subsequently, the Obama Administration would obtain both insurance and pharmaceutical industry support for the Affordable Care Act by providing over $600 billion in funds to the insurance industry, with a continuation of Bush’s promise not to regulate drug prices. The marketplace would benefit with new federal funds and minimal regulation. While Obama inherited an economy in shambles, his Administration dumped an additional $700 billion bailout of Wall Street and the banking industry, as Bush had previously performed such a stimulus of a similar amount.

There remains little ideological difference on each party’s support for corporate health care even given Republican hostilities toward Obama. On health matters, both parties have generally been centrist since the liberal days of President Lyndon Johnson with his passage of Medicare and Medicaid in 1965. Neither party has supported universal health coverage, preferring incremental and minor adjustments to extending access, which tended to serve certain vested interests (see Chap. 2). Corporate health parties backed many financing modifications so that more government dollars flowed into the medical-industrial complex while consistently preventing regulatory oversight and resisting the push for insurance for everyone.

Coming after the Johnson Administration, Republican policies changed from administrative reform giving way to budget cuts, deregulation, and tax credits: from practical insights on how to improve operations to cutbacks (which Nixon called “rescissions”). Administrative science parlayed in business schools at this time was not prevalent in health care. Agency history, mission, constituency, and ideology were changing with a different party in control. Republicans followed a tendency that rejected the character and competency of the past Democratic direction to extend access to new groups in need; they fell into managerialism as seen in Nixon’s new restructuring. The role of policy in the larger political economy was constrained by the Executive Branch, Congress, and the courts, so proposing that health services merely required better management was rather simplistic. Nevertheless, Republican’s cynical ideological support for all things in the medical marketplace does not restrain costs as it is increasingly witnessing that price increases across the sector are the major culprit. Neither party will likely choose to tackle price controls in hospitals, pharmaceuticals, and every other health expenditure partially as the result of relying on campaign funding from these very industries. Thus, leaving the status quo in place means growing expenditures and a shift of costs to employees and consumers.

Republicans have heralded the status quo for private interests in health care; there was a continuum of shifts back and forth without much harmonious agreements between the parties on policies. Much of the dispute centered on entitlement programs in the Great Society health and social programs; diametrically opposed policy goals existed over any extension of access. Since their enactment Medicare and Medicaid both boomed to consume greater federal dollars, considered expenses for “unproductive groups” versus investment for workers’ health. Some in Democratic circles held a value orientation for providing greater coverage, but they also responded to traditional health providers lobbying for more subsidization, plus
being aware of ways to solidify their voter base through advocacy, if not legislative passage.

The Nixon Administration’s emphasis on restructuring and managerialism gave way to Reagan’s stricter cost controls. Both facilitated economists to gain prominence in health circles to formulate technocratic “solutions” in service to Republican Party market-oriented policies. With provider largess under fee-for-service discredited, prepayment incentives were championed. HMOs and DRGs demanded boosting analytical capabilities developed by business types whom Nixon brought into the bureaucracy, along with academic economists and consultants who festered over climbing costs in their reports and studies.

The aging of the population and the pent-up demand from historic lack of access amidst poor social conditions led to the realization that the scope of chronic disease and their future costs in current health care delivery was never taken into account by the government planners. There were a series of failures to hold the line on utilization until Reagan’s bargaining with providers to curtail reimbursements. Unfortunately, once the providers found what would be paid for expenditures just shifted from Medicare Part A to the medical side Part B as for-profit ambulatory services increased substantially. Given this cost obsession, imperfect analytic capabilities along with a bottom-line mentality forsook greater focus on quality and hindered care coordination which is so key in chronic disease treatment and control. Overall, Reagan’s cost control fetish became the rationale for prohibiting extension of health care access to all Americans, but allowed for vested health care interests to benefit handsomely. Republican health policies have historically been slanted toward market-based solutions with heavy investment into private corporations; it is worthwhile to point toward the brief review in Chap. 2 to see how special vested interests have advanced during past administrations.

In brief, Republicans have been recycling failed ideas for a long time. Now an untested promise of Big Data on steroids is being promulgated within the medical marketplace (see Chap. 5). This comes amidst compassion fatigue across the society for those left behind—over 23 million and growing under Trump. Buried deep in the House of Medicine’s reductionism and fetish for the cellular bits and body parts, the medical profession can no longer identify the social and environmental causations of disease in population groups. Confusion persists among health professionals who need to awaken to their changing social context and return to being a noble profession in the Oslerian tradition of early last century—seeing and talking to patients to know them beyond their disease (Osler, 2008). This lineage of the Johns Hopkins University Professor of Medicine, William Osler, who urged physicians to be utmost devoted to their patient as a person and the populace was lost (Bliss, 1999; Silverman et al., 2008).

Notwithstanding Republican opposition, the Democrats and the Obama Administration failed to enact more progressive health policies (Medicare for All, public option, infrastructure development, etc.) when they held the majority of Congress and ultimately fed the corporate monster. Even with the Affordable Care Act decreasing the number of uninsured by 41% in 2017, some 20+ million remained uninsured, many without access to health insurance at any cost.
To reiterate, the ACA giving someone an insurance card is not in reality granting access. Access to care means assuring availability of affordable, comprehensive, quality care that is continuous by lowering social and cultural barriers to that care. This means guaranteeing substantial infrastructural improvements in communities so that physicians are there for relationships with patients and families, which the ACA did not do! Even while some funds for community health centers were made available with the disproportionate share hospital (DSH) monies, only small segments of the populace received improved health services.

Reflecting on the Affordable Care Act a decade later, it is important to understand the ambitious effort that was carved out during venomous Republican opposition aiming at its voluminous details. Many aspects of the Affordable Care Act needed to be launched at the same time upon an already complex and dynamic healthcare system; this made it difficult to coordinate the changes being implemented and gave the law’s opponents fodder to attack government incompetency (Blumenthal & Abrams, 2020).

The ACA did solidify a commitment for what employers wanted: introducing value-based payment to change incentives from fee-for-service medical practice; the idea linking physician compensation to monitored performance by using information technology received broad acceptance. As an attempt to reduce costs by targeting quality of care, hospitals—the largest expenditure of any medical care component—got particular attention. Under the historic Medicare and Medicaid programs, cost reimbursement (or rather cost-plus reimbursement) had been the basis of payment, obviously being highly inflationary over decades. The ACA reduced payments to hospitals in various ways.

Medicare Advantage Plans run by private insurers saw reduced payments. The idea that got the hospital buy-in to ACA was that some 20 million of the uninsured would be brought into the system, thus reducing uncompensated care. The downside was that the federal government would begin to look at quality of care through the Hospital Readmissions Reduction Program which intended to have hospitals take responsibility for patients unduly readmitted for their clinical conditions soon after discharge. Wide variations in Medicare readmissions had been found (as high as 24.7% among patients with certain conditions). Identified hospitals with above-average risk-adjusted rates of readmission within 30 days were found unable to quickly alter their practices, so they received federal penalties, estimated to be 50% of the nation’s hospitals the following year—an indicator of how difficult redirecting engrained practices are for quality improvement!

Another area of concern was hospital-acquired conditions; its program sought to identify how to measure and limit those conditions in groups of people occurring disproportionately. Hospital safety has been improving under the ACA, but it is unclear if the law actually produced such improvement or other factors contributed (Blumenthal & Abrams, 2020). Much more over the future needs to be done in hospital safety, with better studies to guide directions too (See Chap. 4).
Accountable Care Organizations

The major significant introduction of the ACA was Accountable Care Organizations (ACOs) which were designed to measure and reward physician practices based upon much greater scrutiny over physician decision-making with particular attention to costs and quality. Fifteen hundred ACOs were begun by hospitals and physician groups resulting in enrolling 44 million Medicare patients. While getting these public and private organizations off the ground from a policy perspective, as well as operationally, seemed formidable, the Trump Administration has not followed through with CMS emphasis as was the intent of Obama. Yet, as ACOs yield different performance with their control over quality and finances, questions remain whether many of their innovations will be proven worthwhile after assessment by good health services research and what it will take to replicate the worthwhile ones in other settings. In this era of Big Data with improved analytics, will the colossal IT firms sweep in with capabilities that will be used to serve consumers to lower costs and advance their health literacy? Or will marketplace disruptions locally, regionally, and nationally mount with lesser providers losing out? Will national health policy attempt to make health services available to all citizens? Will the nation be able to advance health promotion and protection for the whole population? Social, occupational, and environmental conditions for healthier communities need to be fully recognized, researched, and addressed beyond just cost-efficiencies in medical care, which is only part of improved population health.

For the most part, ACOs have modest net savings in the different types of ACOs, likely due to nuances of their design features and the sponsoring operational management. Physicians and hospitals also found the high-cost questionable quality procedures addressed through the Bundled Payments for Care Improvement Program, the idea being that providers would receive a single prospective payment for treatment of a medical or surgical condition and could retain savings or absorb excess costs in order to meet imposed quality criteria. Over a thousand hospitals and physician groups participated in this, again having mixed results, but some surgical procedure expenditures (such as hip and knee replacements) saw some cost restraint; while most of the program “was less promising with more chronic conditions” (Joynt Maddox, Oray, Zheng, & Epstein, 2019).

The ACA also looked to improve performance by strengthening the nation’s primary care infrastructure. Increased monies were channeled into community health centers, and further support for hospitals came with the DSH initiative; designated safety net hospitals received enhanced reimbursement for taking care of more uninsured people. The Comprehensive Primary Care initiative sought increased payments from both public and private sources in order to reduce emergency department visits. Approximately 15,000 primary care practitioners were given enhanced payments, but the results of this remain to be determined (Peikes, Dale, & Ghosh, 2018).

Obama’s goal of remaking the healthcare system (Pear, 2009) was beset by an ailing economy that exacerbated concerns over its eventual costs and stern opposition from the Republicans. His predecessor George W. Bush had poured $700
billion into Wall Street, and Obama repeated the transaction for another $700 billion to save the banking industry. For the ACA, health providers remained skeptical of new “efficiencies” that supposedly would help to control costs, though the ACA really did not have much in cost and quality controls, nor stiff regulation. The “46 million uninsured” was not a rallying cry that could dampen the ominous Republican opposition, who formed themselves into the Tea Party Caucus to express its bitter dismay over government intrusion into the healthcare market. Republicans in Congress stood as “deficit hawks” seeking to cut the federal debt and limit Executive power. The now evolved albeit diluted Freedom Caucus clowns now have had their wings clipped under Trump’s military buildup and huge tax cuts, leading to the biggest federal deficits in history. The bailout bills to get the “economy back” ballooned the deficit even more with the CARES Act following the COVID-19 pandemic lasting through 2020.

The ACA implementation did not balloon costs in a huge way, yet the Republican budget hawks always objected to Obama spending. Increased spending and deficits under President Trump apparently don’t stir the same dire warnings as we heard back during the Obama Administration. In fact, there was a modest increase in total health expenditures between 2010 and now before COVID-19 took hold. Employer-sponsored benefit spending also did not jump in a great way, partly because benefit packages were changed, less uncompensated care costs shifted to the private sector, and the health insurance exchanges took over some employees.

Besides the overall complexity of the ACA law, sad mistakes in its startup (especially with the website used to apply for coverage), and its slow implementation, the ACA proposed a federal “marketplace” to be run by the government for roughly 2/3 of the states, offering a set of benefit plans by private insurers (bronze, silver, and gold levels) with three added silver options for people qualified for cost-sharing reductions based on their income. The federal outlay was estimated to be over $650 billion. States were to receive extra funds to sign up their uninsured citizens plus a few years of federal subsidization in their Medicaid programs; several Republican-held states refused this Medicaid expansion. Private insurers were not required to offer standardized plans on the federal and the individual state marketplaces, an obscenity which tended to baffle consumers. Republicans seized upon talking points that revolved around taking your private health insurance away and not being able to keep your doctor. Alaskan Governor and then Vice-Presidential candidate Sarah Palin’s fictitious “death panels” took hold with notions of killing grandma all in the service of the Affordable Care Act mandates. The Administration’s promises of no changes in Americans’ usual health care proved to be a stretch, so the opposition seized on that false claim.

Regardless of these missteps, 20 million of the 47 million received some access to coverage, even if the ACA popularity was tarnished by its inability to cover more and the determined opponents who continue to seek the law’s “repeal and replace.” Through the spectrum of these previous events, one can witness that the popular mandate for health reforms from the late 1980s through the early 1990s had called for an overall restructuring of the entire system (Sommers, Maylone, Blendon, Oray, & Epstein, 2017). Nevertheless, criticisms of the ACA were able to turn the
tide during its complex implementation. This was aided by its slowness to deliver what was promised and its widely felt startup problems and confusion. The original federal website for signups failed at first. The exchanges proved to be too difficult to comprehend, were often misunderstood and that was if you were able to get through to the actual website. One major outcome was that low-income adults benefited well after a few years (Sommers, Maylone, Blendon, Oray, & Epstein, 2017).

Awareness of price increases by providers, insurers, and drug companies did emerge during this period of cost containment. Now it appears widely acknowledged as a key cost push in the overall expenditure. Constraints to ease into value-based reimbursement are a trend. Experimentation with these different programs and the ACOs has created an altered condition for payment practices. Quality appears to no longer just be rhetoric, with designs being put in place to bring about serious discussions with some concerted interventions. To its partial credit, the ACA brought necessary attention to evidence-based medical practice with its series of attempted cleanups. Comparative effectiveness for drug evaluations are now seen as so necessary built upon real-world data. Whether routing out the non-useful and harmful results in drug therapies, and how fast, remains to be seen in the current insurer/PBM industry. Tools are on the way to aid physicians and pharmacists in this clinical decision-making, so that practitioners can make better informed choices without being bludgeoned by administrators!

Existing patterns of testing and treatment can be scrutinized through electronic health records (EHRs) with new information technology capabilities and analytics—depending upon who controls these new tools. It is not clear if medical experts will prevail, or merely cost-cutting corporate administrators stay in charge of this direction; nevertheless, it is absolutely necessary that protocols receive sufficient physician participation in their development and give feedback on their utility for quality improvements. Practitioners should not be dictated to! Maintaining such dialogues will be critical if we are to see a system-wide reduction in the dramatic variations in medical practice and find better strategies for chronic disease control.

The authors, as academicians ourselves, would prefer studies by health services researchers that get peer reviewed, rather than leave observations and “studies” at the whim of the marketplace. Clinical practice must be balanced with practitioners, obtaining better understandings of evidence generated on solid scientific foundation—not by some newly designed corporate AI system. Surely, comparative effectiveness for pharmaceuticals cannot be left to the pharmaceutical firms.

A new policy perspective should reach awareness that powerful economic actors must be held in check so that society heads toward more progressive directions toward social justice and health equity. Demanding new accountability by the vested interests is a step toward breaking up the monopolies that have so controlled medical practice and medical science itself. Drug therapies should be scrutinized in ways that the pharmacy benefit managers have never chosen because of their profit-taking. Millions of Americans are on a multitude of drugs that may not really be helping them as much as they have been told, and in fact in many cases could be harming them. The ACA urged outcome studies which must be developed and funded with new trends for designing overall system performance.
Had the ACA not received such staunch Republican resistance and undermining, the Obama Administration may have been able to move forward on some of these activities in a better and clearer way. For sure, the issue of accountability is more pronounced policymaking debates. The recent explosion of many urban health conditions due to the coronavirus may provoke new demands for improvement in new accountable forms also.

To its partial credit, the ACA brought attention to evidence-based medical practice with its series of attempted cleanups. Comparative effectiveness for drug evaluations are now seen as so necessary to rout out the non-useful and harmful. Tools are on the way to aid physicians and pharmacists in this clinical decision-making, so that practitioners can make better informed choices. The outside power of the pharmaceutical industry may be required to be curtailed for real progressive reforms.

Existing patterns of testing and treatment can be scrutinized through EHRs and new information technology capabilities and analytics—depending upon who controls these new directions. It is not clear if medical experts and professionals are in charge of medical care usage instead of cost-cutting corporate administrators. It will be necessary that protocols receive sufficient physician participation and feedback so that there is buy-in and practitioners who will use the tool will not feel dictated to. Maintaining dialogues between providers and payers are critical if we are to see a systemic end to, or reductions, in significant variations in medical practice.

Demanding new accountability by the vested interests may be a step toward breaking up the monopolies that have so controlled medical practice and medical science itself. Drug therapies should be scrutinized in ways that the pharmacy benefit managers have never chosen because of their profit-taking. Millions of Americans are on polypharmacy that may not really be helping them, and in fact in many cases is harming them (Manasse, 1989). The ACA urged outcome studies to be developed and funded with new trends for designing overall system performance.

**Trump’s Divide**

The 45th President caused many Americans to disbelieve and distrust the institution of the Presidency. For some Americans, it began with the actual election and followed by inauguration and later for many who may have voted for him but gradually came after continuous shenanigans. Indicators point to his incompetence in addressing the COVID-19 pandemic and an economy in free fall only to be compounded by protests after the George Floyd killing by Minneapolis Police in late May 2020. Trump’s election to the Presidency dismayed a huge portion of the American population.

As president, Trump continues to secure and support his base versus an ever-enlarging defined enemy of Democrats, “establishment elites,” including the media, intelligence community, and everything done within the past Obama Administration.
It has been reported he does fail to read many reports coming across his desk, nor does he seek advice from his advisors and cabinet. In the absence of a coherent governing strategy, Trump has consistently continued to campaign and has never pivoted from that to running the government as the chief executive. After FBI Director James Comey told him of Russian influence over the American elections (and all top intelligence agencies confirmed the interference), Trump reacted against the intelligence community and the media by promoting the idea of a “deep state” and haranguing about “fake news” and “very dishonest people.” His performance led to much skepticism and criticism by the public that has in some ways allowed him to get away with it by maintaining what was called “America’s Great Divide” (Frontline: America’s Great Divide, 2020).

In his inaugural address, Trump appealed to his base, the forgotten men and women, aka the “deplorables” to begin to continue to accentuate the divide between them and everyone else. The largest protests in American history came shortly after his inauguration with women in the hundreds of thousands protesting in early 2017. Here was when the idea of “alternative facts” emerged, which presents us with an Orwellian sense of a dangerous and unstable environment that may allow a person to believe whatever one wants to believe in the Great Divide. Nothing gets accepted at face value; thus the Trump Administration rescinded nearly 200 Obama executive orders on the ACA, the environment, immigration, and whatever else President Obama had done. In his ongoing efforts to roll back all aspects of the ACA with an eye upon his base, his Administration took away transgender protections allowing doctors and hospitals to discriminate citing religious reasons (Armour, 2020). The first acts against the Affordable Care Act were designed to strip it of its powers.

His prime directive was to keep immigrants out of the United States by building the border wall and fighting Hispanics on the immigration issue; restricting DACA students; and going after Muslim “terrorists” by blocking seven Muslim nations with a travel ban. In response to the Charlottesville “Unite the Right” rally in 2017 which wound up with a right-wing supporter killing a protester with his car, the President merely dismissed the violence as there were many “good people on both sides.” And his crude and mostly unsuccessful trade dealings with China, Europe, Mexico, and Canada have perpetually gyrated the financial markets. And yet for some reason his base remains loyal, supportive, and are very vocal, and the corporate sector enjoyed the tax cuts and easing regulations.

The Trump Administration has not followed through with Obamacare’s emphasis on ACOs; instead he has singularly sought to totally dismantle the ACA. Sixty-five attempts by the Republican Congress to end Obamacare and two Supreme Court decisions, plus Trump’s own executive orders, greatly interfered with its implementation over time, but to date the Affordable Care Act remains albeit with growing appreciation.

Nevertheless, when it became time for Republican legislation to “remove and replace,” there were no ideas for the “replace” part. The GOP game plan was merely to repeal a somewhat popular entitlement that a Democratic Congress and President had enacted with zero plans by the opposition to replace. Their idea was simply to
revert to the system that existed in 2010 that would throw millions of people off the health insurance rolls.

So after Trump had continually boasted he would deliver the “a wonderful plan,” “the best care,” and “for every American,” Trump and the Republicans (proved this time to be the Party of no ideas) pressed on to strip the Medicaid expansion away from the several states who have signed on (Eilperin & Goldstein, 2017). Most Americans will remember the infamous John McCain’s fateful Senate “thumbs down” vote that defeated Senate Majority Leader Mitch McConnell’s attempt to repeal the ACA. In his second year of office, Trump slashed outreach efforts for navigators to enroll more eligible persons to help the ACA to “implode” (Sullivan, 2017). Hard-pressed folks would still sign up, though in small numbers.

**COVID-19 Pandemic**

The veniality of Trump has been exacerbated by his poor response and incompetence to the COVID-19 pandemic. Was it clear to the White House the virus would cull the ranks of minorities, the aged and disabled, the homeless, Native Americans, and prisoners? Or were they holding back widespread testing and their supply chain mismanagement after it was seen who was dying? Or did they just not care believing ultimately that they were dealing with “just the flu” and that this outbreak would run its course like the seasonal flu? Historians will hopefully delve into this clash of politics and public health.

During the Trump Administration, under both Secretary Price and Alex Azar, CMS made a wide range of temporary adjustments to Medicare and Medicaid, with exceptions for value-based services and delaying the MIPS incentive payments (Brady, 2020). ACOs will benefit from these CMS actions. The first CARES Act bailout law gave a $175 billion package for hospitals. The Trump Administration proceeded to distribute the funds—not to the neediest facilities facing the luge of coronavirus patients—but to wealthier hospital chains (Drucker, Silver-Greenberg, & Kliff, 2020). Regrettably, hospitals serving low-income patients did not fare well against the wealthiest who benefited; most of the former hospitals have insufficient cash on hand to finance operations during the epidemic (Cohrs, 2020). A high number are at risk for closure. Laid off workers who lost their coverage face a 60-day sign-up for Obamacare or Medicaid if eligible (Alonso-Zaldivardo, 2020). More folks quickly obtaining coverage may keep certain hospitals afloat.

Up until the Minneapolis Police murder of George Floyd in May of 2020, and the death of 100,000 Americans from the COVID-19 virus, Trump’s approval rating stayed in the 30 to 40 percent range. Now Democratic Presidential nominee Joe Biden is leading in the polls based on anti-Trump sentiment as seen by the nationwide protests in almost every city, with some rioting and new calls for defunding police over a series of racist actions that resulted in multiple deaths, which have lessened Trump’s approval rating, putting his reelection in jeopardy.
The recent implosion of several urban health conditions and ravaging state budgets (Mervosh & Harmon, 2020; Kelton, 2020) due to the coronavirus points out the paucity of analysis as Trump’s basis of what to do. Delays, improper supply chain actions, and untimely travel bans may have actually compounded his Administration’s response to COVID-19. His playbook that wasn’t revealed a systematically dismantled pandemic preparation commission and then subsequent cuts to the National Institutes of Health and Centers for Disease Control and Prevention budgets, along with his antagonisms to the World Health Organization. He also failed to act more quickly on travel bans, with little decent national management over testing, and the supply chain for masks, gloves, swabs, and other medical personal protective gear. It is clear that the increased potential death and case rates can be laid squarely at the feet of President Trump and his Administration and his response, or more accurately lack of response, were criticized widely (Media Outlets Examine Trump Response to COVID-19 Pandemic, 2020). His continued push to restart and reopen the economy driven by his reelection campaign is likely to backfire with states in the south and west that saw little in the way of COVID-19 cases and deaths, but now are starting to show large increases in both. Reopening the economy before the pandemic was under better control in a number of states likely accounts for a second wave of infections and maybe reach the 200,000 death mark before the election (Stacey & Crow, 2020; Kuchler, 2020). It’s ironic that many of the states that had lax “stay-at-home” and no required mask orders, plus an earlier opening, have faced the fastest spread of the coronavirus. And these are Trump states of Florida, Arizona, and Texas, among others (Masson, 2020). Ironically it seems this desperate push to reopen the economy, decrease unemployment, buoy the stock market, and bounce consumer confidence may actually wind up costing the President the very voters he was counting on to get reelected.

What is clear is that we will never see a progressive national health policy agenda ever arise under these sordid conditions of crisis. The calamity of a pandemic, Depression-era unemployment, widespread national protests, and a clueless Administration can only mean more hardship for the already hard-hit population. How will all of this be debated over the election campaign remains to be seen with facts, reasonable analyses, understanding, and reconciling of divergent perspectives. This is an expectation of a decent civil campaign.

Locally, Governors and Mayors are greatly perplexed over strategies, not just to address the popular health conditions but also for funding dilemmas that obviously delimits their ability to resolve their impending respective health crises in 2021. The resulting double whammy of the economic effect of the pandemic coupled with systemic community disinvestment (Harrison, 2020), give these communities cause to remain very angry. Coupled with spending on the pandemic, states have little room to address any other issues in their already strained economic situation. The opening of schools is an especially disheartening management decision for local areas.

Marketplace players, however, are planning to sweep in to explore the multitude of new opportunities, from state database constructions to software for contact tracing. Yamey and Jamison (2020) calculate the US death rate is a hundred times
greater than it is in China. Other nations that acted early and effectively on available information avoided their worst-case scenarios; however, the Trump Administration still lingers well behind for improved public health programming to address the epidemic and financial assistance to providers. Americans justifiably have psychological uncertainty over the society in which we live.

Despite campaign promises to replace with the “best,” “everyone covered,” and “pre-existing conditions protected,” no alternative plan was ever suggested. His vilifying China for his economic problems and other Twitter rants mean Trump needs issues for a comeback, even perhaps to maintain his loyal Republican ranks. This is key given how central health has become in the American consciousness. While the GOP and the Trump Administration have never actually had an idea for replacing the ACA, or reforming it in any ways other than vindictive rhetoric, the recent events of both the COVID-19 pandemic, the huge unemployment and loss of insurance coverage, and the protests surrounding the George Floyd killing may eventually renew interest in concerted healthcare reform. Let us see what the Presidential campaign reveals in the near term.

Conclusion

Today’s mega-mergers of insurers, PBMs, and the sight of other large-scale cross-corporate amalgamations cannot help but provoke new deeper ponderings on the future of medical practice over the twenty-first century (McKinlay & Stoeckle, 1994). Beyond the entry of for-profit corporations into the delivery of care, other forces were endemic to the overall health system leading into the transformation of the sector. Corporate entities from pharmaceuticals and hospital equipment and supplies through accounting and legal firms had secured a strong foothold. All sought to enrich themselves to maintain the supply function to the delivery of health care. It remains all of the same piece.

In the 1860s Karl Marx made the point (O’Connor, 1981) which remains critical today for health care: production thus produces consumption. When we examine modern medicine, it is important to note that true objective health needs are hidden by mere medical care utilization, which is how the system defines as health. Here is where Illich’s conception of social iatrogenesis becomes crucial. What has evolved over time is what has been offered in its commodified form of services; does utilization truly reflect either a patient’s or the population’s health and well-being? An ongoing critique of modern medicine in its current form has displayed many aspects, and it is worthwhile to ponder its questioning (Cousins, 1976; Carlson, 1976; Bishop, 1977, 1980, 1981; Waitzkin, 1978).

The definition of health has been argued and debated over time as the ideology and content of modern medicine has been critiqued (McNeely, 2002; Roemer, 1956, 1978; Waitzkin, 1978; Szasz, 1977; Kelman, 1984; Illich et al., 1977; Zola, 1972; Geiger, 1976; Thomas, 1976; Anderson, Smith, & Sidel, 2005; Dossey, 1982; Salmon, 1984).
The authors believe in a broader conception of public health, and we hope to contribute insights into overall healthcare system dynamics so people might begin to question its purpose and organization; we believe such an approach can assist making better choices for policy changes toward the sustenance of well-being of the entire population—apart from merely the clinical condition of an individual patient’s doctor-designated services. This includes the broader social, political economic, and ecological context in a given society for varying cohorts, as well as the societal commitment to health care as a basic human right.

Since the 1970s corporate health care has been reorganizing the production of health services, yielding new production techniques, producing many new products and services, and reaping bountiful profits, some extracted by executives and investors, others reinvested. All of this is changing relationships between patients and health professionals. Through these processes, different expectations and new needs have arisen. These processes also create additional needs that production in a variety of ways attempts to satisfy, if profits can be made; nevertheless, these new discovered needs may be manufactured and not be helpful for advancing true public health for the entire population. They instead are designed to be suitable as more high-tech costly procedures to feed the medical-industrial complex.

The profit-based means to satisfy designed health needs are always changing, but a few constants remain. Medicine continues to seek out advancements to prolong life and supposedly improve quality of life. In a perverse way, it seems that American Health Care in particular is engaged in a desperate search for a cure for death and is willing to spend any amount of money to achieve it. So, is the nation ready to spend whatever is necessary to keep death at bay? Without a doubt, the medical-industrial complex stands ready to do those things for people provided the funds are given to pay for them. Availability of new technologies multiplies production possibilities and further offers commoditized versions of what is to be consumed, usually with explosive costs. For example, a new drug introduction onto the market can become a blockbuster, leading to often billions of new expenditures in a few years. Rarely are pharmacoeconomic studies performed to demonstrate any other downstream system savings: Should this be an FDA requirement even after the introduction, let alone, before it becomes embedded as standard care? Technology assessments need to become standard fare especially given the history and makeup of the MIC.

The pharmaceutical industry has come up with a plethora of drugs to address unwanted adverse drug reactions (or combo drugs that fuse two older drugs of shown ineffectiveness and more recently add-on drugs when the earlier ones don’t work that well as the DTC ads reveal), which are created by use of other prescribed drugs. Firms advertise entities directly to consumers to stimulate demand often around restrictive PBM formularies. Such production and promotion require many people to buy into the constructed system rather unquestioningly (O’Connor, 1974). In a convoluted manner, the market and financing determine what gets produced, while at the same time, what gets produced has usually received payment to benefit providers and suppliers.

The impact on costs for bringing in large numbers of uninsured has been notable. Healthcare costs rose phenomenally from 2007 to 2015 with certain components
doing better. Drug costs rose 15.8% in 2015 alone with existing brand drugs seeing new price increases to bring healthcare expenditures up to 19.2% of GDP. Back in 2015, a family of four was estimated to be spending $25,826 dollars per year for health care. For 2020, overall expenditures for health care in the United States reached $4 trillion annually, which may jump considerably with COVID-19, going beyond a fifth of the gross domestic product.

This sum remains a significant “expense” to the larger economy, which conservatives feel is burdensome on employers for competitiveness abroad, all government budgets, and their wealthy donors. Beyond the weight upon consumers themselves, corporate employers have dealt with increasing health expenses. Republicans seeking entitlement reductions propose cuts in Medicaid, Medicare, and other health programs. They are crafting coverage schemes (e.g., health savings accounts, narrow networks, short-term and skinny benefit plans, etc., along with changing disproportionate share hospital payments) to limit benefits and impose large caps, as was their agenda in the rollback of the ACA. Most of such ideas are unlikely to be well-received by the working and middle class and completely unmindful for the less fortunate among us.

The object of these policy directions is rooted in the belief that people should be responsible for their own health and if one wants something, then just go out and earn the necessary funds to pay for it; otherwise, the person is likely to be deemed undeserving of help from the rest of us. This victim-blaming perspective is anathema to the premise of health as a fundamental human right with universal coverage!

Capital flooding into any sector of the economy tends to create bubbles, which typically suddenly deflate when better opportunities for investment arise elsewhere. Renewed attempts to keep the present system intact appear to many as both untenable and unsustainable. Policymakers beyond the “slash and burn” ultraconservatives may come up with a twisted option, instead of that of progressive Democratic Presidential candidates “Medicare4All,” but perhaps a vastly limited legislated Medicaid for All form may evolve—such may have the CMS contract with insurers to handle back end functions of insurance and payment much like many private insurance firms do now under Medicare contracting.

The current Democratic presidential nominee Joe Biden does not seem to be on board the single-payer bandwagon, so the articulation of the design and its implementation of something new beyond “build upon the ACA” has a very long way to go. Do the Congressional Democrats have the wherewithal to come up with a winnable legislative set of real solutions and to resist compromise in such a manner as mentioned above?

A fear should arise that such a compromise arrangement to gain feasible passage would likely be designed to remove risk from insurance companies, whereas finance capital might end up dictating more restricted conditions for health providers. Rate setting, along with other mechanisms, could be established at state levels, supposedly favored by Republicans (i.e., work requirements for Medicaid recipients). Other ideas should be explored to oppose the more draconian reforms led by the Trump Administration, like “skimpier health plans” pushed by US Secretary of Health and Human Services Azar (Armour, 2018).
In the final analysis, the authors here believe that our nation should guard against what may lie ahead as conservative health policies that favor those who wish to privatize the gain and give the public the losses—while Medicaid recipients and uninsured cohorts may go with limited options for the interim, particularly in states that didn’t expand Medicaid.

However, popularity for the ACA has never been higher as witnessed in voters choosing Medicaid additions last election in 2016. In short, well-connected private entities that are better-managed and connected stand to do well financially, while many other providers may face closure (Goldsmith, 1985). In the meanwhile, patient cohorts can expect increased outlays, restricted access, and worsening health outcomes.

Health care in America has become solidly more corporate as the next chapter will demonstrate, with many Americans agreeing that profit seems to drive most aspects of the healthcare delivery system, including providers, PBMs and insurance companies, retail clinics, and peripheral supply firms, such as the pharmaceutical industry. Their purpose appears not to be enhancing the entire population’s health and assuring access to needed services, nor especially raising the larger public health. This is not so easy to state since most physician 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. 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. What has evolved institutionally with the offered commodified form of medical services does not truly reflect a patient’s, nor a population’s, health and well-being.

We wish readers to ponder a new 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, economic, political economic, and ecological contexts of life for varying cohorts in our society and the world; thus, a strong commitment to health and health care as a basic human right is fundamental.

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