

## **B3 | HEALTHCARE IN THE USA: UNDERSTANDING THE MEDICAL-INDUSTRIAL COMPLEX**

### **Introduction**

In the mid-1960s a group of progressively-minded New York activists came together to found the Health Policy Advisory Center or Health/PAC as it came to be called. It was a time of intense activism in New York as poor communities took to the streets demanding improved services and were emboldened to actually take over Lincoln Hospital in the Bronx (known locally as ‘the butcher shop’).<sup>1</sup>

Following a 1967 ‘exposé-analysis’ written by one of the authors of this chapter (Robb Burlage), Health/PAC began publishing a monthly bulletin offering a ‘New Left’ perspective on health. Three years later in 1970, John and Barbara Ehrenreich published a book-length critique of US healthcare based on the Health/PAC article, titled *The American Health Empire*.

### **The medical–industrial complex**

In November 1969, Health/PAC first used the phrase ‘medical–industrial complex’ (MIC) as a way of characterizing the US health system. The term was a spin-off from President Eisenhower’s farewell address in 1961, during which he discussed the dangers of the “military–industrial complex”.

Health/PAC’s use of the term ‘MIC’ incorporated the perception that healthcare was moving away from a system built on individual doctors and small community hospitals; healthcare was becoming more and more the ‘business’ of large academic centres that Health/PAC characterized as medical empires. These medical empires were constructed around a central (private, academic) hospital and outlying satellite (city) hospitals, serving mainly poor communities. The idea of a medical empire incorporated the understanding that the healthcare system had a colonial nature. The satellite hospitals’ role was to service the evolving Academic Medical Centers.

*The utility of a concept* Most analyses of the US healthcare system attribute its failures to one of two problems. Either the US system is portrayed as an over-regulated market that escapes ‘market discipline’ or it is presented as a fragmented ‘non-system’. *The American Health Empire* offered an alternative explanation: The problems of US healthcare were due to its focus on profit: “Health is no more a priority of the American health system than safe, cheap, efficient, pollution-free transportation is a priority of the American automobile

industry.” (Ehrenreich B and Ehrenreich J, 1970) This was a key insight for two reasons: First, it pointed out that the essential problem with the health system was the commodification of health and the idea that health was an economic good. Second, true reform would have to dismantle this model. Decades of modest reforms did little to improve poor performance on the part of the overall system.

*Parsing out President Eisenhower’s speech on the military–industrial complex* In his 1961 speech, President Eisenhower first introduced the concept of the military–industrial complex with these words: “In the councils of government, we must guard against the acquisition of unwarranted influence, whether sought or unsought, by the military industrial complex. The potential for the disastrous rise of misplaced power exists and will persist<sup>2</sup>.”

Eisenhower’s speech was essentially concerned with the threat to government posed by the enormous power of the defence industry and the military. He discussed three entities: the military (an organ of the state), the defence industry (private corporations) and the councils of government (the US Congress).

Eisenhower’s concern – the co-optation of the state for private ends – was similar to that of *regulatory capture*, which occurs when “a regulatory agency, created to act in the public interest, instead advances the commercial or political concerns of special interest groups that dominate the industry or sector it is charged with regulating”<sup>3</sup>.

*A ‘market-driven’ healthcare system* During the early days of the Trump administration, the Republicans sought (unsuccessfully) to sell their idea of a ‘market-driven’ healthcare system. Markets, they argued, would bring down costs and improve quality. In the words of Republican Speaker Paul Ryan: “The ‘Patients’ Choice Act of 2009’ transforms healthcare in America by strengthening the relationship between the patient and the doctor; using choice and competition rather than rationing and restrictions to contain costs; and ensuring universal, affordable healthcare for all Americans<sup>37</sup>”. As we examine the US healthcare system, it will become clear that the idea that markets (choice and competition) improve healthcare is not based on any ‘really existing’ experience.

*A conservative critique of the MIC* Although Health/PAC had conceived the concept of a medical–industrial complex, mainstream outlets typically associate this idea with the late Dr Arnold Relman, who wrote an article in the *New England Journal of Medicine (NEJM)* in 1980 called “The new medical–industrial complex”. Relman came from an aristocratic Boston medical culture and was not primarily interested in radical change in the healthcare system. But he was concerned about the “large and growing network of private corporations engaged in the business of supplying health services to patients for a profit—services

heretofore provided by non-profit institutions or individual practitioners”. Relman was concerned that the increase in ‘for-profit’ activities within medicine posed difficult conflicts of interest for individual physicians, while polluting the rational scientific independence of health research. (Relman, 1980).

Relman also offered a cogent critique of the ‘healthcare marketplace’. First, he noted that for many people health was a human right and not a ‘good’ that could be bought and sold in a market. Second, he argued that most people who needed care were insured either by their employers or the government; this meant they did not directly pay for care and were thus insulated from the real costs. Thus, “the classic laws of supply and demand do not operate because health-care consumers do not have the usual incentives to be prudent, discriminating purchasers”. Finally, he pointed out that most healthcare decisions were actually made by doctors whose decisions could involve real conflicts of interest, such as a tendency to do unnecessary testing in a fee-for-service system (ibid).

Relman did not mention one of the key practical problems with market-based health systems: their lack of transparency. Currently, US hospital charges are hard to find, difficult to interpret and seem to follow no particular logic (Brill, 2013). There is little chance this will change in the near future.

These critiques are important for those of us who wish to de-commodify human health and suffering, but they held little force in a healthcare system that was expanding rapidly. Yet we can see how all the problems mentioned by Relman are manifest in our current healthcare ‘marketplace’.

### **Meet the MIC: major players**

We can use these ideas to better understand the current system and its problems, in terms of the main players of the healthcare industry and parts of the government involved in the provision of healthcare.

According to statistics from the Organization for Economic Cooperation and Development (OECD), from 2015 the USA has been spending approximately US\$ 9,451 per capita on health, representing some 16.9 per cent of the US GDP (OECD, 2017). Most countries spend far less. On average, OECD countries spend about 8.9 per cent of the GDP on health, so that US expenditures (in terms of GDP percentage) is *nearly double the OECD average*. It is not the case that US healthcare outcomes (which are largely dependent on social and economic conditions) are better than those of other countries. Furthermore, even after the implementation of the Affordable Care Act, millions of Americans were unable to afford health insurance and/or healthcare.

The large amount we pay for healthcare reflects the role of profit within the healthcare system and we can identify the big players here by following the money. They include, among others, the health insurance companies, the pharmaceutical companies, the government players, for-profit long-term care services and the medical elites.

*The insurance industry* Health insurance companies collected some US\$ 635 billion in 2015 (Insurance Information Institute 2017). Yet many have questioned exactly what social benefit these companies provide. In theory, a robust insurance market will drive down costs and improve quality. But it is not clear that this is happening. Instead we see the insurance market consolidating via mega-mergers into a small group of ‘too big to fail’ health companies. Much of what the Affordable Care Act did was subsidize the private insurance system.

By 2014, 83 per cent of health insurance was provided by one of four companies: Cigna, Aetna, United Healthcare and Anthem (The Commonwealth Fund 2017). Subsequently, the field attempted further consolidation. United Healthcare merged with Humana (and adopted its name). Aetna then attempted to purchase the resulting company. Cigna and Anthem then announced a merger plan, which was stopped by the courts on anti-trust grounds.

Such mergers exemplify what happens in open markets. Rather than competing, companies find it safer to merge with competitors. The end result is a few very big companies who have no interest in a price war. This is just the opposite of the supposed benefits of the market.

*The pharmaceutical industry: legal extortion* In 2016 US pharmaceutical sales reached US\$ 425 billion (Bloomberg, 2016). Current estimates are that the pharmaceutical industry will have international sales of US\$ 1.4 trillion by 2020 (IMS Institute for Healthcare Informatics, 2015). In the past few years we have seen a new model of pharmaceutical sales that verges on extortion; it is a part of what some have called ‘the flagrant-extortion economy’ (Chocano, 2017).

This transformation is illustrated by Valeant Pharmaceuticals. The story begins in 2004 when activist-investor Bill Ackman teamed up with the CEO of Valeant Pharmaceuticals, J. Michael Pearson. Pearson argued that most of the money spent on research and development (R&D) would ultimately not result in a useable drug. He suggested a different strategy. First, they would slash Valeant’s R&D department, purchase patents from other pharmaceutical companies (or merge with them), and hike up the prices on the newly acquired medications which had patent protection. He also came up with an idea to incorporate Valeant as a Canadian firm; this would allow them to avoid high US corporate tax rates.

The result was massive increases in the prices charged for Valeant drugs. Glumetza (a diabetes drug) saw a price jump from US\$ 520 to US\$ 4,600. Other companies took advantage of Pearson’s strategy and also raised their prices. The result is that patented drugs have seen astonishing price increases; prices for patented drugs are estimated to have increased 18 per cent each year since 2010 (Kacik, 2017).

This strategy turned the idea of a healthcare market in the USA on its head. The market now became a vehicle for using a monopoly to accumulate riches. Rather than respond to this crisis by regulating prices – something

the US government could legally do – the Obama administration criticized the industry but took no action. Valeant would ultimately fail because it overextended itself. As noted by James Surowieki (2016) writing in *New Yorker Magazine*, “Valeant has been less like a drug company than like a super-aggressive hedge fund that just happened to specialize in pharmaceuticals.” We don’t know how many people died because they could not afford the exorbitant costs of their drugs.

But this lack of price protection for patients is nothing exceptional. The Medicare programme, which accounts for about 30 per cent of all national healthcare spending, is *specifically prohibited* from negotiating prices with the drug companies.<sup>5</sup> This prohibition (called the ‘non-interference clause’) reflects the power of the pharmaceutical companies as well as Republican arguments that price negotiations would ‘expand the role of government’ (Cubanski and Neuman, 2017).

There may be more mundane reasons why the Congress has not allowed Medicare to negotiate prices with Big Pharma. Big Pharma is one of the largest lobbies in Washington, DC. Data provided by OpenSecrets.org (2016) shows that in 2016 companies that produced pharmaceutical and health products spent US\$ 246 million on lobbying. This largesse was spent on 315 clients by some 1,125 lobbyists; there are only 534 members of Congress. In 2016 Paul Ryan alone would benefit from US\$ 395,000 in lobbying gifts.<sup>6</sup>

In addition to receiving lobbying money, many representatives hold large investments in healthcare companies and thus have a direct financial interest in reducing taxes and fees for the pharmaceutical industry. Unfortunately, under current congressional rules this is entirely legal (Glawe, 2017). As Mark Twain said, “We have the best Congress money can buy.”

*Academic Medical Centers* Columbia University was the model used by Health/PAC for its concept of a medical empire, and the centre of the empire was a large academic hospital. It utilized ‘colonized’ city hospitals as a source of profit and ‘teaching material’ (that is, patients who could be used for teaching or research purposes). The division between ‘centre’ and ‘periphery’ (to use the language of colonialism) was reflected in the colour of the patients – mainly white at Columbia’s Presbyterian Hospital and mainly black at Harlem Hospital. It is worth pointing out that nearly five decades after Heath/PAC raised this as an issue, New York’s elite hospitals continue to cater to white clientele with private insurance (PNHP, 2017). In 2016, Columbia reported US\$ 5.2 billion in total revenues of which US\$ 100 million went to charity care; this all the while being tax-exempt as a ‘not-for-profit’.

Columbia Presbyterian has received major funding from the state (primarily to conduct research and teaching) as well as from philanthropy and private industry. The hospital also exercises significant political power. In 2010, this power allowed the university to profit from the state’s right of eminent domain

to evict an entire community that stood in the way of a planned university expansion (Bagli, 2010).

In a de-industrialized New York City, economic activity centres on the so-called FIRE economy (finance, insurance and real estate). Elite representatives of the FIRE economy – particularly finance – make up the Universities Board of Trustees and place it centrally within a nexus of power in New York (Columbia University, 2017).

Academic Medical Centers have been central, particularly in metropolitan areas, in the creation in the last decade or so, of so-called ‘health systems’ as hospitals merge and morph into ‘networks’. The NYC metro-region, encompassing more than 10 million people, has about a half-dozen of these ‘health systems’.

*Public hospitals* In many large US cities, there is typically one municipal hospital, which is responsible for providing ‘charity’ care to those in need. They are essentially the provider of last resort for those patients who do not have insurance. New York City runs 11 public hospitals under a federal administration that is hostile to them. They operate in a system that is deeply fiscally challenged. Nonetheless, these public hospitals are an important source of care, particularly for the half-million ‘undocumented immigrants’ who live in New York City.

*The healthcare workforce* The healthcare workforce is represented by a variety of professional societies. These would include the American Academy of Pediatrics, the American Medical Association, the American Academy of Family Practice, the Society of General Internal Medicine and the American Public Health Association (to name just a few). These organizations are often (but not always) somewhat conservative; after all, they represent individuals who are privileged in American society. This has led to patterns of thought and behaviour that were quite inadequate to respond to the recent Republican attack on the healthcare system.

Many of them are victim to something akin to ‘regulatory capture’, by partnering with private entities who dwarf them in size and do not work in favour of the public’s health. For example, for many years the website of the American Academy of Family Practice (AAFP) offered educational material with the Coca-Cola logo; this has now been removed, but the AAFP remains largely dependent on funding from Pharma (AAFP, 2016).

*Unions* Healthcare unions – particularly nurses’ unions such as the New York State Nursing Association and the California Nurses Association/National Nurses United – have been in the forefront of progressive activism, showing a far more sophisticated approach to political advocacy than most professional medical societies. Medical schools tend to inculcate values of hierarchy and

an avoidance of social issues, which are seen as ‘political’. Physicians’ unions are relatively rare and often represent doctors associated with a particular institution or public hospitals.

*Major governmental players* The US government is heavily involved at various levels, both in providing direct healthcare services and in healthcare research. Much of this activity involves interaction with other areas of the MIC.

*CMS: Centers for Medicare and Medicaid Services:* The CMS was created in 1977 to manage Medicare (primarily services for the elderly and disabled) and Medicaid (a joint federal state programme to provide healthcare to the poor). It later assumed control of the Children’s Health Insurance Program (CHIP), which provides insurance for children up to age 18. Thus, CMMS touches people at all stages of life.

Medicare has been one of the great successes of the US healthcare policy. Currently, Medicare covers 55 million Americans (about 15 per cent of the population), is widely popular and has administrative costs of only 2 per cent (Archer, 2011). Private insurance companies, in contrast, are mandated to keep administrative costs to less than 20 per cent! Unfortunately, this creates a perverse incentive for the insurance companies to inflate prices. A hospital bill for US\$ 100 allows for overhead expenses of US\$ 20. If the bill is US\$ 200, the insurance company can now pocket US\$ 40 in overheads.

Medicare faces a number of challenges as the US population ages. It is under attack from conservative Republicans who just don’t like the idea of federal financing for healthcare and would like to see Medicare turned into a voucher programme. In response to these pressures, Medicare has been mandated to provide supplemental insurance (sometimes called Medi-Gap or Medicare Advantage) policies to people who can afford them. The experience of these private programmes has not been good. They have used a variety of strategies to cherry-pick the healthiest Medicare recipients and work to channel off resources from the larger system.

The Medicare Advantage programme has also been plagued by fraud on the part of the insurance companies. Recent allegations from a whistleblower suggest that United Health Group overbilled Medicare Advantage to the tune of ‘hundreds of millions’ or even ‘billions of dollars’ (Walsh, 2017). In short, the USA loses enormous sums of money to failed privatization programmes and to the grossly inflated overhead costs of the private insurers.

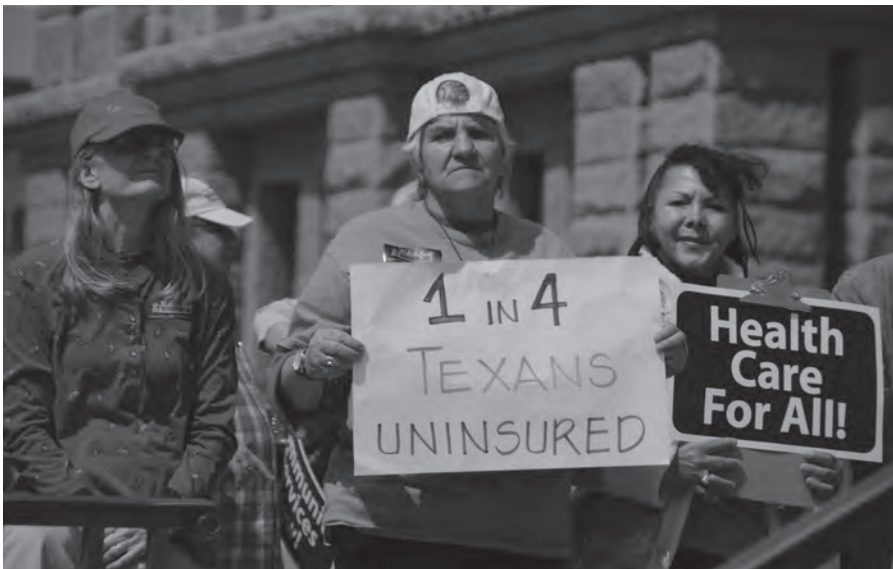
*Military health care and Veterans’ Administration:* The military health system in the USA has two major programmes for civilians. One, originally called CHAMPUS and now referred to as TRICARE, was primarily for the families of soldiers and covered between 2.6 to 9 million people (Harvard University, 2007). An additional 8.9 million veterans are served by the Veterans’ Administration (VA) system, which includes 150 hospitals and 820 community-based outpatient clinics (Alba, 2014).

The VA is unique in America in that it represents a truly socialized health system in which care is delivered by a government entity at no charge. During the early 2000s the VA was seen as one of the best run hospital systems in the country, due in part to a national electronic medical record. More recently, there have been scandals related to fraudulent reporting by clinical directors under pressure to meet appointment deadlines.

Some have argued that when one puts together all the different groups receiving some form of government subsidy for their healthcare, more than half of healthcare dollars are coming from the federal government. A variety of sources suggest that eliminating the private insurance system would free up resources now spent on bureaucracy and allow for healthcare to be provided to all Americans without increasing taxes or fees (PNHP, 2016).

*The National Institutes of Health:* The National Institutes of Health (NIH) is the premier medical research centre in the USA. It is composed of 27 specialized institutes and centres. In the past two decades, the NIH budget has been a contested topic in Washington. The current budget is US\$ 34 billion. But this is the result of a 22 per cent drop in NIH funding from 2003 to 2015. The Trump administration had proposed an additional US\$ 1.2 billion cut this year and a further US\$ 5.8 billion reduction for 2018.

*For profit and not-for-profit: is there really a difference?* One of the striking features of the current MIC is the way in which the lines between ‘for-profit’ and ‘not-for profit’ have become blurred. John Ehrenreich (2016) has noted



**Image B3.1** Participants in rally in support of Medicaid in Texas ([www.flickr.com/photos/26672416@Noo/8532545606](https://www.flickr.com/photos/26672416@Noo/8532545606) by 'Texasimpact'; License: CC BY-SA 2.0, <https://creativecommons.org/licenses/by-sa/2.0/>)



that “Non-profit organizations [have become] larger...now some 10 [per cent] of the American population is working for a non-profit—but the non-profits behave more and more like for-profit businesses.”

Becoming a not-for-profit allows institutions to avoid taxes and yet continue to operate as businesses.<sup>7</sup> Given the generous tax breaks afforded to not-for-profits, corporations see profit and not-for-profit as two complementary forms of doing business.

*The medical elites and the MIC* We can see the MIC personified in a group of elite physicians who serve multiple roles in the MIC. We will take the example of Dr Victor Dzau to illustrate the role played by these elite doctors.

Dr Victor Dzau is chairman of the National Academy of Medicine (NAM), part of the National Academy of Sciences. The NAM is a private, non-governmental organization, which advises the US government on health-related matters. The NAM reports are important documents, which are generally well respected. Dzau, himself, is a graduate of McGill Medical School, was on the faculty at Harvard Medical School, conducted important research in cardiology and was an advisor to the NIH and its directors.

In 2004 he took a position as president and chief executive officer of the Duke University Health System (DUHS). Questions then began to emerge about his compensation. In 2010 a group of Divinity students at Duke protested the high salaries paid to the Duke leadership. They singled out Dzau who had received a US\$ 983,654 bonus on top of his salary; his final compensation was US\$ 2.2 million (Health Care Renewal, 2010). By 2014, his salary was reported to be US\$ 8 million (Cai, 2016).

If this seems to be a lot of money, it's because it is. Particularly, for a university that is nominally a non-profit.<sup>8</sup> But it is also in line with the salaries paid to other heads of health systems; in New York City multi-million dollar salaries seem to be the norm (Vincent and Klein 2015).

After he was tapped for the position to head the National Academy of Medicine, it would emerge that Dzau had sources of income beyond his university salary. He sat on the board of directors of three health-related companies: Medtronics, Alnylam Pharmaceutical and Genzyme. More disturbing yet was that he also sat on the Pepsi Board. These board positions provided Dzau with an additional US\$ 1 million in compensation in 2009.

These board positions pose difficult questions in terms of professional ethics. By being on the board he was supposed to defend the interests of the Pepsi stockholders. What about his responsibilities to the patients at Duke? Why was he making such an exorbitant salary at a nominally ‘not-for-profit institution’? Before joining the NAM, Dzau would resign from these board positions but the troubling questions remain: Who is he working for at the NAM? The public's health? The Pepsi stockholders? Or simply himself?

This ability to move between the business world and medicine is not unique to Dzau. A study published in the *British Medical Journal* in 2015 examined 446 US healthcare corporations traded on NASDAQ during 2013. Of these, 41 per cent reported at least one director affiliated with academic medical and research institutions. These ‘dual’ directors received a median compensation of US\$ 193,000 annually and owned a median of 50,699 corporate shares (Anderson, Good and Gellad, 2015).

## Conclusions

*International ramifications:* The MIC is not limited to the USA. Pharmaceutical companies are well distributed internationally and US insurance companies have made some inroads into overseas markets. There are now international hospital chains. Much of the battle internationally is over who controls the World Health Organization (WHO) and what its role should be (see chapter D1). In this battle, we see the international expression of the trends and tactics described in this chapter (ARTE, 2016).

*The US experience as a cautionary tale:* Despite all claims to the contrary healthcare does not make a good commodity and ‘market place solutions’ have been a failure in the USA. This is not a viable model for a robust, efficient healthcare system that protects the public’s health. Privatization does not make things better: it just parasitizes the public systems.

*How we think about things matters:* We constantly hear that the USA has a ‘non-system’. But the MIC concept allows us to take the big view and to understand how the profit motive corrupts the healthcare system. It needs to be understood as a systemic problem, not one of corrupt individuals and bad government. (Although there is plenty of both around.)

If one thinks that healthcare is primarily about health, changing the system becomes a nightmare. Understanding that it is primarily about profit provides a far richer approach. Remember the adage: Follow the money.

*Unions matter:* Many (if not most) healthcare workers are motivated by a desire to help others and are frustrated by the barriers of our current system. Healthcare unions have played an important role in progressive change in the USA and they should be supported.

*It’s not about the money, stupid!:* Because profit is at the heart of our healthcare system, healthcare reform is all about money and financing. But money and financing are only part of healthcare and they obscure other important matters. How do we deal with racial disparities in health and healthcare? How do we create a vibrant primary care system? How can we reduce the cost of iatrogenesis? Some things are simply more important than money and they should not be ignored.

## Notes

1 This chapter is based in part on an article titled 'The Medical industrial complex in the age of financialization', to be published by Monthly Review Press in the fall of 2017 as part of a book on the healthcare system. We note that many members of Health/PAC remain active in teaching and mentoring a new generation of activists in New York.

2 See text of speech: [http://avalon.law.yale.edu/20th\\_century/eisenhower001.asp](http://avalon.law.yale.edu/20th_century/eisenhower001.asp)

3 See: Regulatory capture: [https://en.wikipedia.org/wiki/Regulatory\\_capture](https://en.wikipedia.org/wiki/Regulatory_capture)

4 See: Patients' Choice Act 2009, <http://paulryan.house.gov/healthcare/pca.htm#sthash.jOpScqzV.dpuf/>

5 Other federal programmes, such as Medicaid and the Veterans' Administration, are allowed to negotiate with the drug companies.

6 It is interesting to note that Hillary Clinton received US\$ 2 million from health lobbyists; this was far more than any other member of Congress.

7 See the example of the American Shipping Bureau (NPR, 2012).

8 People remark that the two highest paid university employees are the basketball coach and the head of the University Medical Center.

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