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US HEALTHCARE SYSTEM IN CRISIS:
Spends Doubly More Than Peer Countries,
But Falling Behind in Life Expectancy

People Increasingly Hard-Pressed
to Pay Medical Bills

by Jon Hellevig

An Awara Accounting Economic Study:

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Introduction

The US healthcare system is in a deep crisis – with a worsening trend. This Awara Accounting report examines the crisis and its roots.

The United States runs the by far biggest and most bloated healthcare sector in the world when measured as a share of the total economy. Its annual value in 2018 was $3.7 trillion, amounting to 17.9% of GDP. That is nearly double the average of developed Western countries (as a share of GDP). Yet, this does not buy the Americans any better health, far from it.

The problems with the ever increasing US healthcare costs is not about better access, better quality or even overutilization, quite the opposite, it is a case of monopoly pricing of a system ran amok.

Drug prices in the US are the highest in the world, American prices for prescription drugs being two to six times higher than those of the rest of the world

On the already astronomic markups of drug makers, hospitals add their own yet much more insane margins.

More and more Americans struggle without a health insurance or with inadequate insurance (aka “junk or discount insurance”) which does not buy the needed medical care when hospitalized. The share of people with employer-sponsored insurance has declined over the past 20 years from 67% in 1999 to 58.4% in 2017. About 10 % of Americans – 27 million people – are not covered by a health insurance at all. Among the formally insured, it is estimated that 45% of US working age adults are inadequately insured. There is also an increased age gap between insured and uninsured people as the share of young college graduates who have employer-sponsored health insurance coverage fell from 61% in 1989 to 31% by 2012.

Even having a health insurance is no longer a guarantee of adequate access to health services as medical debt is increasingly crushing Americans. According to a 2016 report, two-thirds of Americans are not able to afford a $500 emergency cost of any sort.

Insurances are no longer adequate as their quality has in the last two decades been steadily deteriorating with rising deductibles, copays, coinsurances, and annual or even life-time limits on what is covered. Pre-existing conditions could deny insurance altogether. What happens is that you could have an insurance on which you pay regular premiums, but which then is refused by the hospital when you need it for an emergency. Average deductibles have quadrupled in the past twelve years as nearly half of all people with employer-based insurance now have high-deductible plans. With rising deductibles, copays have also risen or been replaced with coinsurance, which places a higher burden on the consumer.

This Awara Accounting study shows that in addition to the original sin of corporate greed, the exorbitant costs of the US healthcare system stem from layers upon layers of distortions with which the system is infested. Each part of the healthcare industry contributes to what is a giant monopoly: the pharmaceutical companies, medical equipment manufacturers, drug wholesalers, drug stores, group purchasing organizations, health insurance companies, doctors, clinics and hospitals, and what should be impartial university research. And on top of that, the government acts as a giant enabler of it all.

At the very core of the US healthcare crisis, is the American ideological precept that healthcare must be a private corporate for-profit business. But the experience from the wider civilized world has proven that delivery of universal healthcare through a mixed model with emphasis on public government produced healthcare service and government funding is the most efficient model in terms of both health outcomes and cost. In a European style system all citizens have nearly equal access to general health services without having to incur financial hardship in a medical emergency. Global comparisons of life expectancy, other health outcome parameters, and total health expenditure of nations have shown that the countries, which run a universal healthcare system (with mixed elements) bring the best results and at far lower costs than the US does.

A functioning system is not only a question of government funding but also of delivery of the medical service through both public not-for-profit and private institutions. Hereby it is crucial that hospitals are generally publicly owned. Public hospitals offers the only solution for preventing the curse of monopolistic pricing by corporate entities and to remove the cancer of profit motive from healthcare. Private hospitals and clinics should be there to add a competition impulse and provide a better service for those who wish to pay more through their private insurances or directly to the hospital.

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US Healthcare Expenditure Astronomical – Results Not So

The United States runs the by far biggest and most bloated health care sector in the world when measured as a share of the total economy. Its annual value was $3.7 trillion, amounting to 17.9% of GDP (2018).[1] That is nearly double the average of developed Western countries (as a share of GDP).

This also means that on average the US healthcare spending *per person* is double the expenditure in peer countries. But the vastly higher expenditure does not mean that the Americans would actually use more healthcare services, or have a better health outcome, for that matter. On the contrary, studies show that residents of European countries like Germany see doctors more, spend more days in hospital and undergo medical procedures at similar rates like Americans.[2] At the same time the US deploys fewer healthcare resources: fewer doctors and nurses, fewer medical school graduates, and fewer hospital beds.[3] The problems, then, with the ever increasing US healthcare costs is not about better access, better quality or even overutilization, quite the opposite, it is a case of monopoly pricing of a system ran amok. A lot of the cost also represent an increasing volume of redundant tests, unnecessary surgeries, and other forms of overtreatment that don't improve health. The thing is that this enormous expense does not buy Americans any

better health than the Europeans get for half the price – on the contrary American health outcomes are falling behind

While spending superbly more than any other country, the United States ranked only 27th in the world for its levels of health care according to a University of Washington study.[4] A common measure for a global ranking of healthcare systems is the country's life expectancy. On this parameter, the United States ranks only 33rd in the world. And worse yet, while the trend is globally improving, US life expectancy has been falling for the past three years.[5]

Global comparison of life expectancy and healthcare expenditure

The below table ranks countries by life expectancy with indication of their respective total healthcare expenditure as a share of GDP, private and public spending in total.

Country Ranking on Life Expectancy with Health Expenditure
Selected Countries (2017)

Ranking	Country	Life Expectancy Years	Health Expenditure Share of GDP	Ranking	Country	Life Expectancy Years	Health Expenditure Share of GDP
1	Hong Kong SAR, China	85	5.8%	13	Canada	82	10.5%
2	Japan	84	10.9%	20	Finland	81	9.4%
3	Switzerland	84	12.2%	23	United Kingdom	81	9.7%
4	Spain	83	8.9%	26	Germany	81	11.1%
5	Italy	83	8.9%		European Union	81	9.9%
6	Singapore	83	4.4%	32	Cuba	79	12.2%
7	South Korea	83	7.3%	33	United States	79	17.9%
8	Israel	83	7.3%	34	Albania	78	6.7%
9	France	83	11.5%	35	Panama	78	7.3%
10	Norway	83	10.5%	36	Poland	78	6.5%
11	Australia	82	9.2%	42	Turkey	77	4.3%
12	Sweden	82	10.9%	45	Thailand	77	3.7%

Source: World Bank and Awara Accounting

Note: Mini-states and small countries without a representative sample of natural native population have been removed from the count on rankings.

The higher life expectancy among the top ranking countries – achieved at much lower cost than in the US – testifies to the success of their mainly public universal healthcare systems. The total health care spending (as referenced above) of the top countries was at the level of 9-10% of GDP, while the US spending was nearly the double at 17.9%.

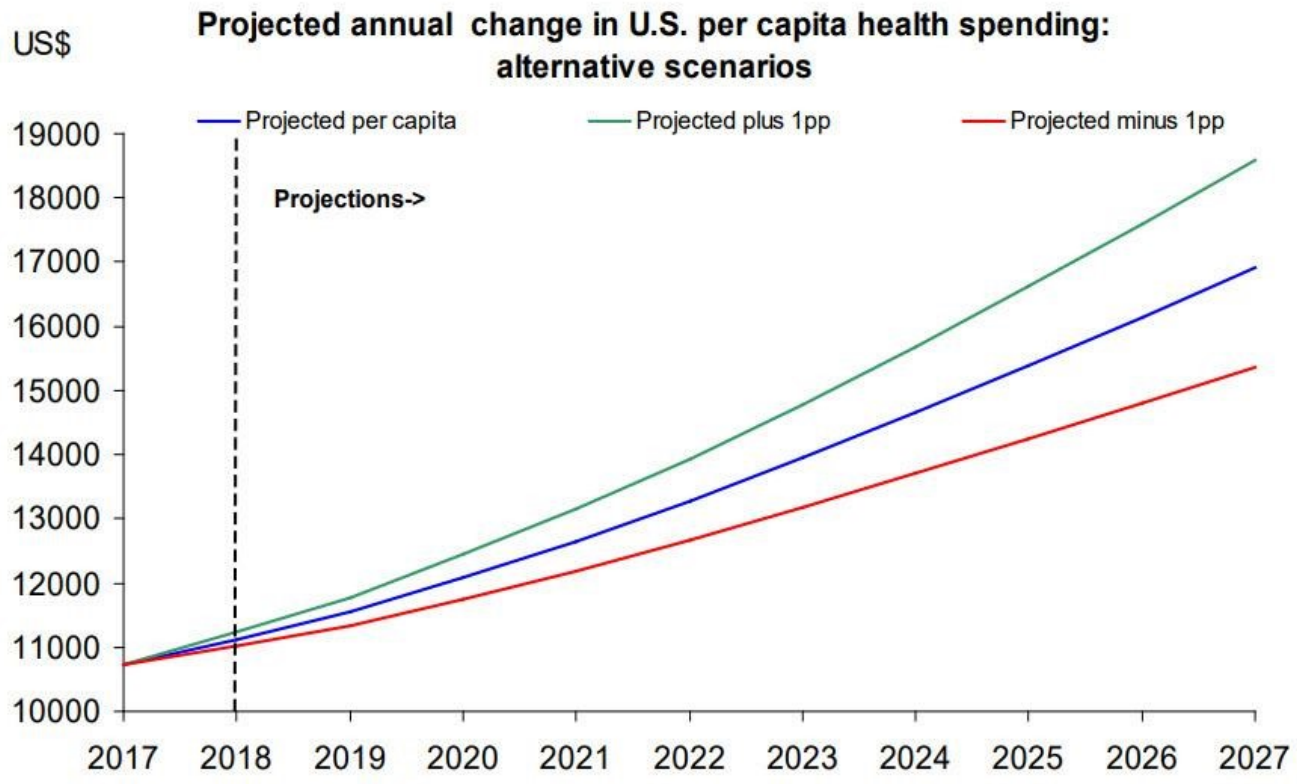
But there are also some countries, which are clear outliers from the prevailing tendency, managing impressive results in the longevity ranking but with yet much less total spending. Foremost, South Korea, Singapore and Hong Kong spring to mind. South Korea ranked 7th with a spending of only 7.3% of GDP. With a spending of 4.5%, Singapore spent least of all the countries but anyway achieved a life expectancy of 83 years, ranking 6th. The first spot in the ranking was taken by the

special administrative region of China, Hong Kong. Life expectancy in Hong Kong was 85 years, while the spending was 5.8%.

The high life expectancy reached in the leading countries, testifies to the success of their mainly public universal health care systems. In life expectancy, Spain ranks 2nd in the world with an estimated average life span of 83.3 years (2017), while Finland places 21st with 81.4. This compares with the 33rd place of the United States, which further saw life expectancy sink to 78.5 in 2018. Strikingly, we note that even communist Cuba managed an average life expectancy of 79 ranking 32nd just above the US. By 2018, Cuba had reached 80 years. Spain has reached its impressive results with an annual healthcare expenditure of only 9% of the GDP, which is roughly half of the 17.9% the US spends. Finland's annual expenditure was 9.5% as a share of GDP.

More generally it is obvious that life expectancy is not only a question of the formal healthcare system but of many other factors, too, foremost food and lifestyle habits.

China's healthcare spending was 4.98% of GDP (2016) and with that it reached in 2017 an average life expectancy of 76.5 with a growing trend. With its present ambitious investment plans, China is set to overtake the US within a decade on most of the key national health measures.[6] There is no end in sight for the ordeal, as healthcare costs are predicted to continue their precipitous rise, as shown in below table.[7]



Source: NHEA, Kaiser Family Foundation, DB Global Research

Glaring differences in longevity within the United States

Furthermore, there are immense differences between the US states. According to a study based on 2016 data[8], Hawaii had the highest life expectancy at birth (81.3 years) and Mississippi the lowest (74.7 years), a 6.6-year difference. Minnesota had the highest *healthy* life expectancy at birth (70.3 years), and West Virginia the lowest (63.8 years), a 6.5-year difference. In male life expectancy, the differences were yet bigger, Minnesota having the highest male life expectancy at 78.7 years and Mississippi the lowest at 71.8.

There are also big differences in life expectancy between ethnicities. In 2014, Asian Americans lived the longest at 86.7, 10% longer than White Americans at 79.1. Somewhat surprisingly the Hispanic population at 82.9 were also way ahead of Whites. African Americans scored a life expectancy of 75.5.[9]

Global Experience has Demonstrated that Publicly Funded Universal Healthcare With Public Hospitals Offers the Best Solution

At the very core of the US healthcare crisis, is the American ideological precept that healthcare must be a private corporate for-profit business. But the experience from the wider civilized world has proven that delivery of universal healthcare through a mixed model with emphasis on public government produced healthcare service and government funding is the most efficient model in terms of both health outcome and cost. In a European style system all citizens have nearly equal access to general health services without having to incur financial hardship in a medical emergency.

A functioning system is not only a question of government funding but also of delivery of the medical service through both public not-for-profit and private institutions. Hereby it is crucial that hospitals are generally publicly owned. Public hospitals offers the only solution for preventing the curse of monopolistic pricing by corporate entities and to remove the cancer of profit motive from healthcare. Private hospitals and clinics should be there to add a competition impulse and provide a better service for those who wish to pay more through their private insurances or directly to the hospital.

Below we will quickly take a look at a couple of the world's successful universal health care models.

Finland provides a model of a European functioning universal healthcare system based on public financing and public hospitals and clinics supplemented by optional private insurance and private service. The system framework is set by laws of the country's parliament while the delivery of the medical services are largely decentralized as a responsibility of local government (municipalities), which pool resources on larger regional levels.

The public funding comes through state and municipal taxes as well as compulsory national health insurance. The latter is similar to the US social security contributions charged from payroll.

The provision of health care, medical consultation, treatment, hospitalization and medicine are charged to the patient at a fraction of the real cost or sometimes just delivered for free, while the majority of the costs are financed by universal taxation. There is no fee for a doctor's visit for medical consultation but for treatment and therapy a charge of around $50 could possibly apply, while for continuous treatment it would drop to $10 per session. (As applicable in the capital city Helsinki in 2018). Surgery would cost $120 and hospitalization $60 per day (less for long-term). There is an out-of-pocket maximum limit for the patient for all the medical services of approximately $750 per year after which the service is delivered for free (except for long-term institutional care). Hereby the treatment of a multitude of chronic diseases and preventive medicine are free of charge to start with.

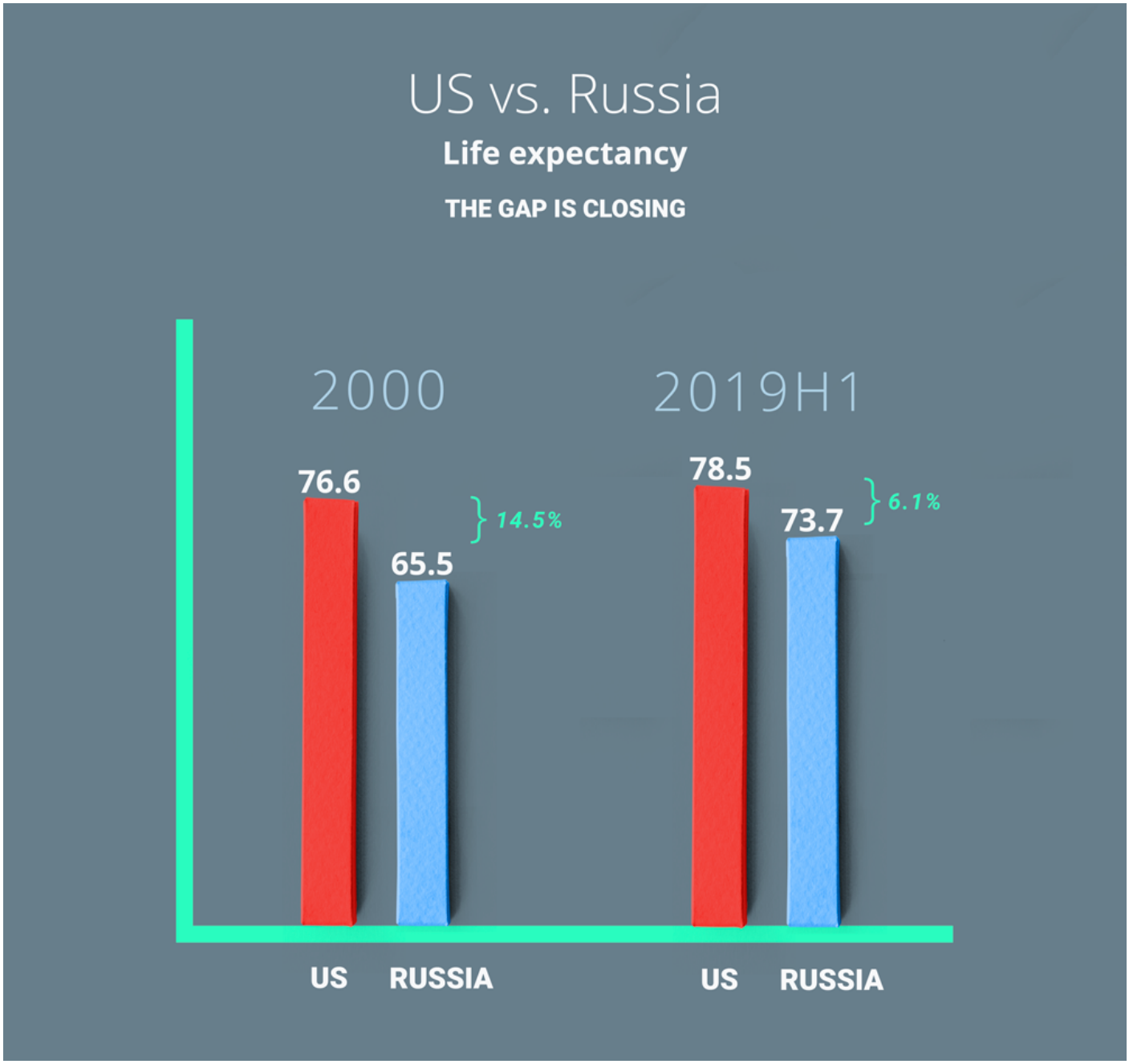
Prescription drugs are also subsidized on rates depending on the disease and the patient's personal circumstances. These, too, are free after reaching another $750 limit.

The public system is complemented by private sector clinics and hospitals and corresponding voluntary private health insurances. These are important as far as they offer the freedom of choice and allow those who can afford to use providers that may offer a better customer service. The private sector medical service also helps to improve the public service as it frees up resources. So, this public-private mix really gives the best of both worlds. It is estimated that 1.2 million (out of a total of 5.5 million residents) have procured a private health insurance. Typically the cost would be $300 dollars per year for a young adult and $400 for a 50-year-old.

Spain is another European country which maintains a strong public healthcare system with virtually free of charge service supplemented by voluntary health insurance and a private sector. Some 30% of the population are covered by some form of private insurance, many of them of a supplementary nature, while bulk services would still be delivered by the public sector.[10]

The Russian health care system of today basically works in the same lines as the Spanish and Finnish systems, with a public funding and delivery of healthcare services supplemented by a private option. Russia's total healthcare expenditure is very low in an international comparison with only 5.3% of GDP (2016), but nevertheless it delivers impressive results when measured by the improvements during the last two decades. After the fall of the communist system in 1991 and the ensuing liberal anarchy, the Russian healthcare system was in shambles. By the time Vladimir Putin became president in the early 2000s, the life expectancy of Russians had plunged to 65 years. But with political stability, economic growth and improved security under Putin and thanks to concentrated efforts by successive Putin governments, Russian longevity has steadily recovered and grown to reach the historic record of 74 years in 2019. Russian women now have an average expected life span of 78 years and men 68. That's a ten-year gap between the sexes. But the situation back in 2000 was especially extremely dire for men, who then had an average life expectancy of only 59 years. That means a 16% improvement by now. In the same period, women have seen their odds go up by 8%, so the gap is indeed closing.[11]

How remarkable this improvement is can best be gleaned from comparing Russia's situation with that of other countries. In below chart we juxtaposed Russia with the United States.



In 2000, the difference in life expectancy between the two countries was 11.1 years or 14.5% in favor of the US. But by 2019, the difference had shrunk to only 4.8 years or 6.1%. In the national strategic development programs Putin ordered to be implemented in connection with resuming presidency in 2018, there is a goal to push life expectancy up to 78 years by 2024 and further to 80 by 2030. Looking at the tremendous trend, that seems feasible for Russia to achieve, and when we also consider that the US is actually regressing on this measure, it is indeed to be likely that by 2024 the two rivaling countries have the same life expectancy score. By reaching the rate of 80 according on the 2030 plan, Russia would actually overtake America. That would of course be sort of a miracle, taking into account how really awfully bad things were in Russia in the 1980s and 1990s and how strong the American economy is supposed to be.[12]

Big Pharma Addicted on Raising Drug Prices

Drug prices in the US are the highest in the world, American prices for prescription drugs being two to six times higher than those of the rest of the world.[13] For example, in Britain the world's 20 top-selling medicines are three times cheaper than in the US.[14] The per capita spending for prescription drugs in the US were $1,443, while that figure in other high-income nations ranged from $466 to $939.[15]

The situation is yet much worse in the case of many crucially important medicines. For example:

– Gleevec (a cancer treatment) costs $6,214 (per month) in the US compared to $1,141 in Canada and $2,697 in England.

– Humira (for rheumatoid arthritis): $2,246 in the US, $881 in Switzerland and $1,102 in England.

– Cymbalta (for depression): $194 in the United States, $46 in England and $52 in the Netherlands.[16]

But there doesn't seem to be any end in sight of the ordeal of the American consumer as brand-name prescription drug prices in the US have increased nearly 100% in only the past six years.[17] Elsewhere, a US Senate committee report found that prices for the top 20 most-prescribed brand-name drugs for seniors increased at nearly ten times the cost of inflation from 2012 to 2017. Twelve of them increased in that period by 50%, six by 100% and one by 477%.[18] In the first half of 2019, pharmaceutical companies again raised the prices of more than 3,400 drugs. The average price hike was 10.5% – five times the (official) inflation – but about 40 drugs increased by more than 100%. A generic version of the antidepressant Prozac soared by 879%.[19] Before that, between 1997 and 2007, drug prices had already tripled.[20] That means a 200% drug price inflation, whereas the consumer prices according to the Bureau of Labor Statistics grew only by a cumulative 29.2% in the same period.[21]

The problem is that without government control of drug pricing, pharmaceutical companies can set prices which are in no relation to the actual costs on manufacturing and research and development, and charge as much as they think that the market will bear. Because of the dominant private health insurance system – and prohibition of government to negotiate prices for Medicare – price increases are in most cases passed on to the insurance companies. But inevitably, at the end of the day that cost is borne by the consumer, and the national economy as a whole in form of the least cost-efficient health system in the world.

Examples of drug price gouging

After Turing Pharmaceuticals acquired the American marketing rights to Daraprim, a 62-year-old drug to treat a parasitic infection it raised the cost of one pill to $750 from $13.50. That brought the cost of a course of treatment for some patients up to hundreds of thousands of dollars.[22]

In 2015, Valeant Pharmaceuticals – exploiting a pernicious monopoly business model – hiked prices on drugs for diabetes, acid reflux and serious heart conditions, in some cases by more than 500%. In particular, it raised the prices of Cuprimine and Syprine (drugs to treat Wilson disease) from about $500 to about $24,000 for a 30-day supply.[23]

Eli Lilly priced its new lung cancer drug, Portrazza, at $11,430 a month, a price six times the $1,870 price that leading oncologists had stated would be the fair price.[24]

Pfizer set the price for Ibrance, a drug to treat a form of advanced breast cancer, at $9,850 a month.[25]

Mylan Pharmaceuticals has since 2004 raised the price of its Epipen by 450% exploiting its 90% market share monopoly.[26] It could cost $600 to buy that pen for treating acute allergic emergency although the manufacturing cost could be as low as $1.[27]

Gilead came under scrutiny because of the extremely high price for its Sofosbuvir (brand name, Sovaldi), a medication used for the treatment of hepatitis C. The drug was sold in the US for $1,000 per pill, amounting to $84,000 for a full 12-week regime. The full extent of the price gouging became evident when it turned out that the same pill was produced by a Gilead licensed company in India and sold there for just $4 in India.[28] In 2018, a Brazilian court showed how to deal with such monopoly abuse of markets and patients by ruling to strip the patent protection of this drug in Brazil paving the way for fair-price generics of the same medicine to be produced locally.[29] One wonders what prevents US courts from challenging the nation's monopolies in a similar fashion.

These examples are typical of the American pharma market and the list of these scandalous examples of price gouging could go on and on.[30], [31]

The Insulin Racket

We will close this review of the extremely high drug prices with a look at the Insulin Racket. Affordability of insulin has become a big issue in America lately. Although insulin is a 100-year-old drug, its wholesale price has tripled in ten years[32] and doubled in just last 5 years.[33] The situation has become so dire that patients have been forced to attempt rationing their monthly insulin supply, often with lethal consequences.[34] The history of the insulin racket reads like a case study explaining everything what is wrong with America's broken pharma market. The insulin market was an early victim of the broader neoliberal turn in US politics and economy which transformed the pharmaceutical industry into a crony capitalist hothouse. As a combination of monopolization, unrestrained marketing and patent and exclusivity abuse of technological improvements, Big Pharma turned the insulin market into a money machine.

According to the above referenced story, a person in the US would have to pay $1,300 for a month's worth of insulin supplies, if not covered by insurance. (Even with insurance, deductibles and

copays would leave a significant cost to cover by the patient). One patient estimated that the cost of her monthly stay-alive insulin was $3,000 without insurance coverage.[35]

We may compare that with the price of insulin in Russia. Obviously, the monthly needs for different people under different circumstances vary, but this would serve to give an idea. Typically, you would have to pay 3,000 rubles for the monthly insulin need, that is $50. Residents would, however, receive the medicine for free paid by the government's social security system. The situation is similar in all European countries. We also have information that the monthly insulin supply, would cost $100 in Thailand, where residents also get it for free.

The 25 times cheaper price for the insulin in Russia than in the US should really set off alarm bells in Washington. How come the supposedly greatest economy in the world, cannot even produce and sell essential life-saving medicines at affordable costs anywhere near the levels of what a country like Russia can do?

Marketing and promotion expense possibly as much or more than R&D

Big Pharma lobbyists justify America's record high drug prices by the supposed high cost of innovation. We already saw from above what a hollow argument this is, in reality the US price of drugs is entirely based on market speculation, whatever the pharma executives think the rigged market can bear, that's the price.[36] And exactly in line with this counterargument, there are reports that Big Pharma actually spends as much on marketing as on R&D.[37]

It is hard to determine how much exactly companies spend on R&D and marketing due to the opaque reporting practices of Big Pharma and often purposely obfuscating media reporting sponsored by lobbyists. What seems to be quite well established, though, is that the (official) R&D spending of pharmaceutical companies amount to 17% of total revenues.[38], [39], [40]

That's the official story, in reality the actual R&D spending could be much less. It is well-known that Wall Street corporations employ very creative accounting practices in order to embellish their figures and boost their show-off profitability. There is therefore no reason at all to take at face value what Big Pharma reports as their R&D costs. R&D spending entitles tax breaks and, in many cases, a favorable accounting treatment and investor appeal. Besides, a lot of what is recorded in R&D actually are lawyers and lobbyists fees. Often the quality of the actual research is dubious, too, as pharma companies devote a lot of research spending to developing minor variations in drugs and packaging that will boost marketing and help to evergreen patents without any qualitative effects on patients' health.[41] Therefore, all too often, new drug launches are nothing but marketing gimmicks masquerading as innovation. A 2014 study found, that nearly half of the drugs approved by the FDA between 2005 and 2011 lacked any tangible incremental health benefits, such as prolonging life or relieving symptoms[42]

A study by Light and Warburton dissected the claims of pharma interest groups that the average cost of bringing a new drug to market would be $1.32 billion. At the end of their meticulous analysis, the researchers showed that the true cost was more likely to be $59 million.[43]

Among other things, the scholars pointed out that the industry claim had included the cost of the first research stage in company expenses although 84% of those are funded by government and universities. Light and Warburton estimate that in actual fact industry devotes as little as 1.2 % of sales revenue to their basic research effort. The industry calculations were also shown to include R&D on a gross basis without the subtraction of the savings thanks to their tax breaks, which the research team estimated would lower net costs by 39%. A further major problem with the inflated drug development cost was that it unwarrantedly included cost of capital as an alternative cost, as if the alternative cost of a pharma company was the lost revenue on asset bubble speculation.

On the other hand, it is estimated that Big Pharma spends approximately $30 billion on marketing and promotion, of which two thirds goes to persuading doctors and other medical professionals to favor one drug over another.[44], [45]

Considering that the combined pharma manufacturing revenue in 2016 was $323 billion[46], the above referenced 17% spending on R&D would amount to approximately $60 billion. That is twice the marketing cost on a primary basis but considering the above presented analysis on what could be the actual costs, we may conclude that there is merit to the claim that Big Pharma spends as much on marketing as on research and development. Having said that, I must note that some analysts would actually conclude that pharma companies spent 19 times more on marketing and promotion than basic research.[47], [48]

In fact, the number of new drugs approved each year has declined since the 1960s. The drop-off has been particularly steep since 1996, when 54 new drugs were launched, compared to only 30 in recent years.[49] As a result of the Fed fueled virtually interest-free financing bonanza drug companies have turned to mergers and acquisitions to make up for their lack of innovation and the tedious and costly process of developing new groundbreaking drugs; acquiring competitors and firms with established drugs, whose prices have the potential for enormous price hikes. Acquisitions also offer drug companies opportunities for creative accounting and capitalization of costs.[50], [51]

Clinical trials are often fake research

Even the actual research work is often fake and non-transparent as Big Pharma uses its financial and regulatory muscles to produce the research reports that support their profit margins instead of consumer health. Each year, the government – in form of the National Institutes of Health (NIH) – provides for proportionally less money to fund clinical trials as the share of Big Pharma correspondingly grows.[52] Having formerly been relatively uncommon, it is now estimated that 60% of biomedical research and development is privately funded by pharmaceutical corporations.

In 2011, the pharmaceutical industry spent $39 billion on research in the United States while the NIH spent $31 billion. Having formed "science hubs" in the universities to promote biomedical innovation, Big Pharma has solidified its grip on academic institutions, essentially converting them to their subsidiaries.[53]

With its financial clout, Big Pharma's influence over clinical trials has grown in a number of ways, including outright designing the trials and handpicking trial results. The most common method of Big Pharma to skew the research results is to publish only those studies which seem to support their commercial objectives and withhold studies with negative – or even neutral – results. Even when the research goal has been carefully crafted and the company has hired the best research team money can buy, the results most often don't come out as hoped for, therefore there is the need to suppress the awkward results. This practice of selective publishing is referred to as **publication bias**.[54], [55]Independent studies have shown the enormous and growing extent of publication bias.[56]

An increasing number of whistleblowers have started to speak out against the medical research scam. Dr. John P.A. **Ioannidis**, a professor of disease prevention at Stanford University, published a study entitled **Why Most Published Research Findings Are False**. Dr. Ioannidis highlighted the corrupting influence of Big Pharma concluding that: "There is increasing concern that most current published research findings are false … it is more likely for a research claim to be false than true."[57] The above referenced article – Most Scientific Research of Western Medicine Untrustable & Fraudulent, Say Insiders and Experts – serves as an eye-opener to the enormous extent of medical research fraud. In there, we read how whistleblower Dr. Peter Rost, former vice president of Pfizer, revealed how the game works: "Universities, health organizations, everybody that I have encountered … are out there …. begging for money. [Big Pharma corporations] use that money to basically buy influence … [Big Pharma provides] grants for various kinds of research … make sure they [scientific researchers] became beholden … Everyone obviously knows this is how things work. // "They [scientific researchers] are not going to continue to get money unless they're saying what you [i.e. Big Pharma] want them to say. They know it, you know it, and it's only maybe the public that doesn't know it."

The fraudulent medical research reports form part of the bigger problem of bias, corruption and fraud in all science reporting, as detailed in this article: Peer Reviewed:" Science Losing Credibility As Large Amounts Of Research Shown To Be False.[58]

There is increasing evidence that Big Pharma and big grocery retailers are using governments and media to crack down on those medical doctors who dare to question their drugs and raise health concerns about their processed food. **Dr. Mercola** – in an article exposing the statin scam – brings up the case of Finnish medical doctor **Antti Heikkilä**. Heikkilä is being persecuted by the Finnish government, its Big Pharma and retail monopoly sponsors, and their media mouthpieces. Heikkilä's "crime" is that he advocates a healthy and balanced diet with inclusion of red meat (keto diet). The ruling circles of Finland are furious for Heikkilä daring to tell the people that with a correct and

natural diet and by avoiding unnecessary drugs and processed food you can live a healthier and longer life.[59]

The Opioid Crisis

Fraudulent marketing of drugs has reached such lethal consequences and unprecedented levels that US courts have actually proceeded to punish pharmaceuticals for fueling the crisis. In August 2019, an Oklahoma court fined Johnson & Johnson $572 million for fueling the opioid epidemic.[60]

The opioid crisis – the epidemic of over-prescription of addictive drugs – is a direct result of the free-for-all drug marketing, regulatory vacuum and Wall Street speculation. The overdosing of prescription pain killers and synthetic opioids such as, Dilaudid, OxyContin, Fentanyl, opiates and other drugs derived from opium including morphine itself. Every day, more than 130 people in the United States die after overdosing on opioids.[61] In 2018, more than 68,000 Americans died from drug overdoses and 47,000 of them involved some kind of opioid. Even though heroin, prescription opioids and synthetic opioids such as fentanyl are receiving the most attention, deaths from other drugs such as methamphetamines and cocaine are rising.[62]

According to a 2011 survey conducted by the Kaiser Family Foundation, Americans aged 19-64 were prescribed an average of 11.9 prescriptions, and those aged 65 and more received an average of 28 prescriptions. The Kaiser Foundation study also found, that while the United States makes up only 5 percent of the world's population it consumes 80 percent of the world's painkillers.[63]

According to the U.S. Centers for Disease Control and Prevention, overdose deaths linked to prescription opioids have killed more than 218,000 Americans since the late 1990s.[64] At the same time, just one of this substances, the painkiller Oxycontin generated billions in profits for the drug maker Purdue Pharma.

Of these formally legal prescription drugs Fentanyl, depending on the dosage, can be 25 to 50 times stronger than heroin.[65] As the overdose death rate for heroin is decreasing, the rate of death due to fentanyl abuse is increasing. Many addicts are not sure if they are getting heroin or fentanyl from street dealers.

Purdue Pharma is another of the killer corporations for whom pay-back time has arrived. In 1995, the Food and Drug Administration gave approval to Purdue Pharma to produce OxyContin (the brand name of a generic form of oxycodone, a semisynthetic opioid). In just one year OxyContin generated $45 million in sales. By the beginning of the following decade, sales passed $1 billion; by the end of that decade, sales passed $3 billion. Aided by highly dubious marketing practices, by 2010, Purdue Pharma owned one-third of the painkiller market in the United States, all thanks to OxyContin.[66] Eventually the Purdue OxyContin scandal grew too big even for the American standards and pay-back time arrived. According to news from September 2019, the Sackler family

who own Purdue Pharma are willing to give up ownership of the company and pay additional $3 to $4.5 billion from their personal wealth to settle more than 2,000 lawsuits accusing the drug maker of fueling the opioid crisis.[67]

Already in 2007, the Department of Justice had initiated proceedings against Purdue in federal court, on charges of misleading doctors and patients by claiming that OxyContin was less likely to be abused than other forms of narcotics. Back then, Purdue admitted that they misbranded OxyContin as "abuse resistant" and paid $600 million in fines – an amount that *Pacific Standard* magazine says "would have little effect on the company's revenue." But that did not hinder the company from continuing making $3 billion every year on OxyContin.[68]

The fraudulent prescriptions of OxyContin and other opioids and the skyrocketing prices eventually led people taking to traditional narcotics. "The National Institute on Drug Abuse reported that in 2001, around 2,000 people overdosed on heroin across the United States. By 2013, heroin claimed about 8,000 lives. As the trade and death count of heroin increased, so too did the number of deaths related to overdosing on prescription opioids, like Purdue Pharma's OxyContin. There were 6,000 such fatalities in 2001; by 2013, there were 15,000. The National Survey on Drug Use and Health discovered that 80 percent of heroin users had started out on prescriptions opioids.[69]

Regulatory Capture

Patents in essence are a monopoly rights granted by the government. The original idea in US law was to stimulate R&D and innovation by granting a patent monopoly for a limited time to the drug innovator. Following the oligarch turn in US politics since the 1970s, the idea of patents has been turned on its head. Patents are now handed out on preciously little evidence of innovation. After 1982 the number of patents granted increased by an astounding 416% by 2014.[70] Today, the monopoly power created by copyright and patent protection encourages industry concentration and price gouging. In particular, this has been the case in the pharmaceutical industry, which has been granted endless extensions to patents through bogus reformulation of drugs, packaging, and minor modifications to the methods of delivery.[71] One trick has been to abuse the Orphan Drug Act, intended to encourage spending on developing cures for rare diseases. In reality, though, this act has been used as a cover to extend unwarranted protection for drugs which are not rare at all. 44% of new drugs approved in 2014 had received this status, most of them on spurious grounds.[72]

What is important to note here is that big business, in our case Big Pharma, loves regulations and bureaucracy, because the regulatory capture helps to keep prospective competitors out.[73] Today, government regulations and bureaucracy pose an ever more formidable challenge to competition. For example, the FDA purposefully puts obstacles in the approval of generics so as to protect the profit margins of Big Pharma.[74]

The revolving door

The abuse of patent law doesn't happen just like that, the system is designed for the perversion. The FDA has been taken over by Big Pharma, who place their operatives in top positions in the agency in order to look after their interests. Experts conclude that the FDA has become little more than **a revolving door** for the pharmaceutical industry for the purpose of rigging the system in favor of the industry and to continually grant itself special privilege while harassing would-be competition.[75] The symbiosis between the FDA and Big Pharma can be seen as a classic case of regulatory capture, when the regulatory agency, intended to safeguard the public interest, instead advances the business interests of the corporations that dominate the industry it is formally put in charge of.

A 2016 study found that more than a quarter of the FDA employees who approved cancer and hematology drugs from 2001 through 2010 left the agency to work or consult for the pharmaceutical companies that produced those drugs.[76]

Over the past decades, at least seven high-ranking employees in the FDA were drawn from the ranks of Monsanto.[77] A case in point is Michael R. Taylor, the current deputy commissioner of the FDA Office of Foods. He was also the deputy commissioner for Policy within the FDA in the mid '90s. In between those positions, Taylor was employed by Monsanto as Vice President of Public Policy. It is precisely from these kind of suspicious carrier moves, that the practice is referred to as *the revolving door* between government and corporations.[78]

A quote from Edward Bonnette will show what kind of corrupt practices are involved in these appointments: "During his employment with Monsanto, the company was developing rBGH, a type of beef growth hormone. Mr. Taylor advised the company on the possible legal implications of using the hormone on cattle that could reach beef markets for human consumption. However, when Taylor left Monsanto for the FDA, he became one of the main authorities behind the FDA's rBGH labeling guidelines with potential conflicts of interest."[79]

That the revolving door is in full swing is shown by the July 2019 appointment of former FDA commissioner Scott Gottlieb to a new position on the board of the pharmaceutical giant Pfizer a corporation, which Gottlieb had been responsible for regulating prior to his appointment.[80] During his tenure as commissioner, Gottlieb had been forced to formally recuse himself from making decisions involving nearly 20 pharmaceutical companies with whom he had relationships, including Vertex Pharmaceuticals, GlaxoSmithKline, and Bristol-Myers Squibb, among others. In keeping with the tenets of the revolving door, it should not come as a surprise that Gottlieb had already worked for Pfizer prior to becoming commissioner.

Another example of this revolving door is FDA member, Milton Packer who chairs the Cardiovascular and Renal Drugs Advisory Committee. As Matt Agorist reported: "Packer, who reviews applications for drugs submitted for FDA approval, is financed by Novartis and actually

spoke on its behalf to the advisory board he chaired."[81] "According to the Wall Street Journal," Agorist continues, "Packer also appeared before the Cardiovascular and Renal Drugs Advisory Committee involved speaking on behalf of Bristol-Myers Squibb in 2002; acted as a consultant and speaker for GlaxoSmithKline in 2003; appeared as a speaker for NitroMed in 2005; appeared as a speaker for Sanofi in 2009 and acted as a consultant on behalf of Pfizer in 2010."

In the latest episode of this crooked carousel, Trump's nominee to be the Director of the U.S. Fish and Wildlife Service (FWS) is Aurelia Skipwith, a former employee of Monsanto.[82]

The revolving door clearly raises questions about transparency. This naturally gives rise to the suspicion that landing a lucrative job at the corporations, that a government official has previously regulated amounts to a form of deferred bribes. Similar concerns have risen in connection with Bill and Hillary Clinton having become multimillionaires after leaving office, among other things by way of being paid by Wall Street banks and corporations astronomical fees for their speeches.[83] Same goes for Barack Obama's payday, who is now reported to rake in $400,000 to $600,000 per speech from the Wall Street banks he generously bailed-out and failed to prosecute while in office.[84], [85]

The health racket has solidified its hold on the US political system by influencing members of Congress by multimillion lobbying activities and **campaign contributions**. Pharmaceutical companies are among the biggest spenders on political corruption, having poured close to $2.5bn into these activities over the past decade. It has been reported that, nine out of 10 members of the House of Representatives, from both parties, and all but three of the US's 100 senators have taken campaign contributions from pharmaceutical and other health industry companies seeking to affect legislation on everything from the cost of drugs to how new medicines are approved.[86]

The Chicago School's Snake Oil Ideology

Today's rigged and monopoly-infested healthcare and pharma markets are of relatively recent origin. Up till the 1970s – after which the gradual perversion of the system really kicked in – the United States still had an efficient healthcare market geared toward protecting public interests and fostering healthy competition. The turn for the worse in healthcare coincided with the general pushback against government regulation and the abandonment of antitrust enforcement in the wake of the neoliberal Chicago School free market ideology capturing the minds of economists, lawyers and policymakers.

Due to the influence of the prominent Chicago School economist George Stigler, pharma became the forerunner industry which was totally remade in the model of the new neoliberal ideology.[87] Stigler had been in particular fixated with the regulatory burden that the pharmaceutical industry faced and the opportunities to commercialize the emerging biomedical science of the late 1960s. He championed the so-called 'capture theory' which held that big business support and encourage government regulations of their respective markets. This they would do for various reasons, among which figure prominently the aim to block new entrants from the market by way of

excessive regulatory hurdles. Regulation would also be directed towards establishing standards and rules mandating the purchase of goods and services provided by the relevant business interests. Although that is certainly true to a big extent, it is not yet the whole story. Some government control and regulation is certainly needed, but Stigler – completely in line with the simplistic mindset of the Chicago School – argued that regulation *never* benefits the public and called for a total elimination of all regulation.[88]

At the root of the Chicago Schools anti-regulation ideology had been their opposition to government granted monopolies. But in their warped way of thinking they identified one of the causes for monopoly, government regulation, as the bigger evil than the actual monopolies. At the end of their convoluted reasoning and the hatred of government that it had led to, the Chicago School then instead embraced monopolies of the type which had (supposedly) come about without government intervention, through the agency of the proverbial "free market."

Immediate victims of the new all-permeating neoliberal ideas were patent law, regulation, and antitrust and competition policy, which were rigged in favor of corporations first tentatively under the Carter administration and then by force under the Reagan presidency, after that followed up by both the two republican president Bushes and the democrats Clinton and Obama.

Specifically concerning pharma, Stigler organized in 1972 an event called "The Conference on the Regulation of the Introduction of New Pharmaceuticals." This conference – financed by drug makers like Pfizer and Upjohn – established the methods and ideological talking points that Big Pharma was to use ever since in order to serve their unfettered corporate power.[89] Their subsequent propaganda message is crystalized in the meme that high drug prices are simply the "price of progress," a supposed necessary condition for finding new and innovative cures for our ailments.

In earlier history, pharma and health care used to be regulated in public interest

In the early 20th century, pharma became tightly regulated by the government in keeping with the then popular anti-trust ideology. The 19th century the United States had seen an epidemy of fake patent medicine been sold to the public. A famous case of this was the widespread marketing of so-called snake oil, a petroleum-based mineral oil that was sold as a cure-all elixir. To combat this dangerous fraud, Congress and President Theodore Roosevelt passed the Food and Drugs Act of 1906, creating the Bureau of Chemistry, the precursor to the Food and Drug Administration. In a 1916 case, the chemistry bureau successfully fined Clark Stanley for falsely and fraudulently marketing a snake oil liniment.[90]

The bipartisan adherence to government regulation and opposition to monopoly lasted until the 1970s, up to the time when the Chicago School invented and started to disseminate its snake oil economic theories. Until then, government policies had fostered competition by limiting the length of patent monopolies. Even more efficiently, government regulators had forced drug companies to

license their patents to other manufacturers to ensure that competition kept prices down. At the same time, a real threat of both civil and criminal antitrust suits kept drug companies from forming cartels and combining and colluding against the public.[91]

The market for antibiotics provides a successful example of the efficiency of those government regulations. The antibiotic Penicillin had seen its price fall thanks to these efforts from $3,995 to $282 in the years from 1945 to 1950. But the pharmaceutical industry tried to strike back with renewed coordinated price hikes in the 1950s. However, these cartels were successfully rolled back by the anti-trust authority, the Federal Trade Commission (FTC). In 1958, the FTC released a report in which it found that a handful of companies had cornered the market and kept prices high for tetracycline, a broadly useful antibiotic. The report led to a blowback against the cartel and the FTC being successful in forcing the companies to license out tetracycline at a low price.[92]

The insulin market provides a later example of the totally opposite development. Since 2010 – well into the time when the US government had skewed the regulation in favor of corporations and abandoned anti-trust enforcement – the three American manufacturers of the drug have all raised their prices by 168 percent, 169 percent, and 325 percent, respectively.[93] Before that the price of insulin had stayed relatively affordable for US patients for nearly a half-century.

The retreat from antitrust regulation of the pharma market

With the spread of the snake oil Chicago ideology, the US started to move away from the policies that had fostered an open market for pharmaceuticals. The retreat from antitrust enforcement led to increased concentration of the industry. Between 1995 and 2015, 60 of the biggest pharmaceutical companies merged into just 10.[94] In these years, Congress and the courts also began a series of changes to patent policy and practice, that eroded the achievements of the previous half a century and lead to monopolization, higher prices, and less innovation.

A huge blow to the insulin and the whole drug market was dealt by the revival of the Institutional Patent Agreement program introduced by the National Institutes of Health in 1968 and the Bayh-Dole Act of 1980, as these enabled private entities to patent and commercialize publicly funded research.[95]

In 1947, the policy had still been to strictly maintain government control over patents. US Attorney General Samuel Biddle had argued, that that would serve to advance science, public health, and competition and prevent "undue concentration of economic power in the hands of a few large corporations."[96] Fast-forward to 1968, the NIH's general counsel, Norman Latker, on the back of the incipient free market ideology spearheaded the revival and expansion of the Institutional Patent Agreement program. This program effectively circumvented the rules which had been in place since the 1940s to prevent patent monopolies. Most detrimentally it assigned away government funded research results to private corporations by way of allowing the universities to patent them and then turn around to license the patents to corporations.

Before this fatal turn for the worse in 1968, the rule was that inventors were required to assign any inventions made with NIH funding back over to the federal government.[97] In 1980, Congress – pushed by the Carter administration – passed the Bayh-Dole Act, which codified the practice allowing universities and research institutions to privatize the results of public investment in scientific research by way of patent monopolies (expanding it beyond NIH funding to that of all government agencies).[98] The Act also expanded the rights of NIH contractors by assigning them new powers over the ownership and licensing of government science, including a right to issue 17-year life-of-patent monopolies.[99]

Interestingly – and most incriminatingly – the subsequent presidential administrations of all colors have chosen to ignore the vital public interest provisions of the Bayh-Dole Act. The Act clearly states that the utilization and benefits of science developed with public funds must be made "available to the public on reasonable terms."[100] The government had thus been handed a clear authority – as well as an obligation – to examine whether granting patents and exclusivity is in public interest. Experts therefore argue that, the law grants powers to the government to restrict the use of exclusive licenses on such inventions.[101] According to the referenced article, the law also gives government the crucially right to control drug prices including the power to reduce prices on existing drugs. The article also makes the point that government has willfully abdicated this right due to ideological considerations.

Jamie Love, an activist for affordable medicines and for curtailing Big Pharma abuse, notes that, in addition to the provisions of Bayh-Dole, the government could invoke US patent law to drive down cost of drugs (Title 28 Section 1498 of the US Code). This law grants the government power to break patents and license generic competition in the public interest in return of reasonable compensation.[102]

The ideologically driven patent craze got a further boost when the Supreme Court in 1980 decided that a GE scientist named Ananda Chakrabarty could patent genes and genetically engineered organisms. This led to a veritable gold rush in biotech investments as the *Chakrabarty* decision had provided the protection Wall Street and the venture capitalists required for opening the money spigots for pharma speculation. [103]

Presidential administrations from Reagan through Clinton continued to push Wall Street friendly pharma legislation of which the 1983 Orphan Drug Act is an example. This act provided extended licenses and tax waivers on drugs targeting rare and genetic diseases. As reported above, its provisions have since been abused by way of claiming orphan status for drugs which are not such. Furthermore, a 1986 tech transfer bill established "Cooperative Research Centers" that gave industry a direct presence in federal labs, and established offices to assist in transferring the fruit of these labs to their new commercial partners. A huge victory for Big Pharma came with Clinton's 1997 Food and Drug Administration Modernization Act, which opened the era of blatantly deceptive television advertisements on drugs.[104]

By the early 1990s, the Chicago snake oil ideology and its enablers in all the presidential administrations from Carter to Clinton had fully created the Big Pharma and health care scam monster. It was now a "business focused narrowly on predatory value extraction: scooping up government-funded science, gaming the system to extend licenses and delay generic competition, and aggressively seeking short-term stock boosts through maximum pricing, mergers, acquisitions and takeovers."[105]

Big Pharma – Corporate Welfare

Big Pharma motivates their huge profit margins and rip-off patents and FDA exclusivity protection with the free market ideology, price-gouging and patents are supposedly the pre-requisites for innovation. In reality, though, the American pharmaceutical industry is largely socialized, especially what it comes to basic research in drug development. What happens is that Big Pharma sponges off government investment in medical research. For example, of 210 medicines approved by the FDA between 2010 and 2016, every single one originated in research conducted in government laboratories or in university labs funded in large part by the National Institutes of Health.[106] This is why it is so important to understand what is wrong with the above referenced Bayh-Dole Act but also the powers that the US laws in actual fact gives to the government to restrict exclusivity and lower drug prices. At the end of the analysis, the benefits from public spending on drug research flow into the deep pockets of pharma executives and major shareholders. Between 2006 and 2015 – in a study focusing on the 18 largest pharma companies – these two groups raked in 99% of the profits, totaling more than $500 billion.[107] One way by which Big Pharma executives transfer the corporate profits into their own pockets is by way of share buybacks. Drug companies have spent the vast majority of their profits in recent years on share buybacks that maximize immediate share value. Donald Trump's 2017 tax bill, for example, allowed drug makers to repatriate more than $175 billion banked offshore at giveaway rates. Most of this money, including $10 billion by Pfizer alone, was spent on buybacks and cash dividends to public shareholders. Meanwhile, R&D expenditures stayed flat or fell across the industry.[108]

Generics – The suppressed relief

One major form of market abuse the drug companies have brought about by their regulatory capture and lobbying is to block competition from generic drugs. (A generic drug is a drug that contains the same chemical substance as a patented drug, but whose patent has expired).

The FDA is prone to extend drug exclusivity protection on existing drugs and delay approvals on competing generics on sham pretexts.[109], [110] In fact, the US runs a dual system, where the drug manufacturer needs to get a patent from the United States Patent and Trademark Office separately and exclusivity and approval from the FDA separately. It is the FDA process, which is extremely cumbersome, expensive and unpredictable. It is rare for a drug to pass all the hurdles that the FDA

puts in its way, the success ratio is somewhere between 5,000 and 10,00 to 1. With this ratio, in 2016, only 22 medicines were cleared for sale, down from 45 in 2015.[111]

To keep generics out from the market, Big Pharma spends untold amounts on legally and morally dubious advertisement, use their leverage on the distribution system, and even pay generic drugmakers not to bring their cheaper medicines to the market (pay-for-delay).[112] Pharma companies are also known to resort to outright cartels and price fixing in order to maintain high prices on generic drugs and thus deny the economy to consumers. A lawsuit brought by 44 states alleged that top pharmaceutical companies, including Teva, Pfizer, Novartis and Mylan, conspired to inflate the prices of over 100 generic drugs by as much as 1000%.[113]

One of the FDA's devious ways to protect the price margins of Big Pharma is to outright ban imports of cheaper drugs, which it has repeatedly done in relation to Indian manufacturers.[114], [115]

Malpractice suits further pump up healthcare costs

The skewed US justice system which has fueled the mania for suing people and businesses also raises healthcare cost by adding its layer of unwarranted costs in form of medical malpractice suits.[116] Because of the virtual epidemy of suits and the judges willingly playing the game, the availability of medical malpractice insurance is diminishing; insurance premiums are soaring; insurance carriers are going bankrupt or refusing to write malpractice insurance policies.[117]

Because of the prohibitive cost of malpractice insurance, physicians are increasingly leaving medicine. According to the Association of American Medical Colleges, the U.S. is currently experiencing a shortage of at least 13,000 doctors. Unfortunately, that shortage is expected to grow to 130,000 doctors over the next 10 years. Fearing the US health scare system young people do not want to study medicine, therefore by now already 40% of all US doctors are 55 years of older.[118]

US Government Not Allowed to Negotiate Drug Prices

In European countries, the governments tightly control drug markets, not only for safety but for availability and prices, too. Most governments cap the prices with maximum permissible prices that drug companies can charge. The European governments also wield market power in their capacity of the biggest medicine buyers by negotiating prices. While price caps are not even considered on the US market, the Congress has in a further effort to protect the oligarchy outright prohibited the government from negotiating prices in the one field there would be plenty of reason to do it, in its capacity of administering the federal government run Medicare prescription drug plans, which accounts for 29 % of all spending on prescription medicines.[119] Also by denying the possibility of negotiated rebates this legislation amounts to nothing else than a flagrant subsidization by the government of Big Pharma on the cost of the patient.[120]

The self-imposed ban on negotiating drug prices was codified in connection with the Congress approving and President George W. Bush signing into law in 2003 an otherwise crucially important reform program – known as Medicare Part D – to help seniors get access to prescription drug. The caveat that the federal government was barred from negotiating cheaper prices was justified by the snake oil free-market ideology but in actual fact done exclusively to pump up the profit margins of Big Pharma.[121] At the time of the signing, the speechwriters of President Bush wanted to record down for history a totally opposite version of the animus of the law, the President saying: "These reforms are the act of a vibrant and compassionate government. We show our concern for the dignity of our seniors by giving them quality healthcare. We show our respect for seniors by giving them more choices and more control over their decision making. We're putting individuals in charge of their healthcare decisions…"[122] When President Barack Obama pushed through the healthcare reform known as Affordable Care Act (aka Obamacare), he – toadying to the Big Pharma lobby – effectively confirmed the government's self-imposed ban to negotiate drug prices.[123]

Below (in "Medicare's Restraining Influence on Hospital Price Gouging") we will look at how Medicare regularly manages to dramatically cut hospital bills – even by magnitudes of 8 to 12 times – applying its cost-plus principles. We can therefore see why Big Pharma was horrified about government interfering with their robber markups in drug prices, too.

We saw above in section "The retreat from antitrust regulation of the pharma market" that the US law would grant a lot of leverage for the government to regulate the drug market and affordability, but that the government has willfully abdicated these rights.

The Failing Private Health Insurance System

The skyrocketing cost of the monopolized US health care system is hitting ever harder on the US consumer. According to the Milliman Medical Index, a standard measure of health care costs, a typical family of four has seen its health care expenditure rise from 18 to 35% between 2002 and 2014. For workers with employer-provided health insurance, those conclusions were drawn by considering the alternative lost income in foregone wages, pensions, and other benefits, as the employer has been transferring a proportionally bigger part of the rising insurance cost to employees.[124]

Insurances are no longer adequate as their quality has in the last two decades been steadily deteriorating with rising deductibles, copays, coinsurances, and annual or even life-time limits on what is covered. Pre-existing conditions could deny insurance altogether. What happens is that you could have an insurance which you pay regular premiums, but which then is refused by the hospital when you need it for an emergency. Average deductibles have quadrupled in the past twelve years as nearly half of all people with employer-based insurance now have high-deductible plans. With

rising deductibles, copays have also risen or been replaced with coinsurance, which places a higher burden on the consumer.[125]

Insurance or not, healthcare costs of families precipitously rising

To give an idea of how defunct some health insurance coverage has become, consider the case of Sean and Stephanie Recchi. Because, the couple had recently started their own small technology business, they were unable to buy comprehensive health insurance. For $469 a month, or about 20% of their income, they had been able to get only a policy that covered just $2,000 per day of any hospital costs.[126] Probably in every country in the world except in the United States, the $2,000 per day coverage would have been more than enough, but the administrator at the hospital Sean Recchi turned to informed point-blank: "We don't take that kind of discount insurance." Being denied the coverage the Recchis had already paid for they had to cough up $83,900 upfront for the entire treatment $83,900 upfront.

Insurances are no longer adequate as their quality has in the last two decades been steadily deteriorating with rising deductibles, copays, coinsurances, and annual or even life-time limits on what is covered. Pre-existing conditions could deny insurance altogether, or it could seem that the person has a health insurance, while the person is denied treatment for that essential disease. What happens is that you could have an insurance which you pay regular premiums, but which then is refused by the hospital when you need it for an emergency.

Another couple, Rebecca and Scott S. had an annual payout limit of $200,000 had an annual payout limit of $200,000 – not a small sum anywhere in the normal world – but still they were told they owed $402,955 for Scott's treatment after the payment from their insurance policy was deducted. (Scott had been in the hospital for 32 days pneumonia).[127]

The problems with health insurance are only getting worse. According to economist Martin Gaynor workers' health insurance premiums increased by 242 percent from 1999 to 2016, whereas over the same period nominal wages increased only by 60%.[128]

The main source of financing of the US healthcare system is employer-sponsored health insurance. The employer-sponsored insurance system covers 56% percent of the US population under age 65.

The share of people with employer-sponsored insurance has declined over the past 20 years, from 67% in 1999 to 58.4% in 2017.[129], [130] Other working-age people rely on private market plans, private health insurance, which they purchase directly on the market without the involvement of an employer. Such direct-purchase private marketplace insurance covered 16% of the working-age population.[131] (The figures between marketplace and employer-sponsored insurance are partially overlapping).

People in retirement age, 65 and older, are eligible for the government sponsored Medicare insurance program. These insurance systems are complemented by federal and state government sponsored Medicaid. Medicare is a US government sponsored social health insurance system. In general, all persons 65 years or older who have been legal residents of the United States for at least five years are eligible for Medicare. Medicare covers hospitalization and medical treatment as well as prescription drugs. Unlike Medicare, Medicaid is a means-tested, needs-based social welfare or social protection program for people with low income rather than a social insurance program. Eligibility is determined largely by income. The main criterion for Medicaid eligibility is limited income and financial resources, a criterion which plays no role in determining Medicare coverage. Medicaid covers a wider range of health care services than Medicare. Medicaid is a program that is not solely funded at the federal level, while states provide up to half of the funding for the Medicaid program. In some states, counties also contribute funds. In 2017, 74 million people, 23% of Americans, received some sort of health service through the system. Medicaid payments currently assist nearly 60 percent of all nursing home residents and about 37 percent of all childbirths in the United States. The federal government pays on average 57 percent of Medicaid expenses.

About 10 % of Americans – 27 million people – are not covered by a health insurance and must rely on occasional assistance through access to Medicaid or a charity.[132] Among the formally insured, it is estimated that 45% of US adults (ages 19 to 64) are inadequately insured.[133] Another study puts the number of Americans without adequate health insurance as high as 52 million.[134]

There is also an increasing age gap in insured employees.[135] Recent college graduates have been less and less able to find jobs that provide health insurance. The share of young college graduates who have employer-sponsored health insurance coverage fell from 61% in 1989 to 31% by 2012.[136]

The problem is that an ever-increasing number of Americans are stuck in a cycle of low-wage work, which do not provide health insurance, or merely something very inadequate. According to a recent Brookings Institution report 53 million Americans, or about 44% of all US workers are considered low-wage and low-skilled. This category of workers – often in the so-called gig economy – make approximately $10.22 per hour, and they bring home less than $20,000 per year.[137]

Still in the 1960s, health care cost was an incidental expense to most American families with a yearly average cost of $197 per person.[138] Back then an average worker had to work for 78 hours to cover the healthcare cost for the whole family. By 2012, with the tremendous cost hikes, the worker would have to put in 452 hours of labor to receive the same level of family health care coverage at an average cost of $8,915.

The total annual health care cost – including insurance premiums and out-of-pocket costs – for a typical family of four covered by an employer-sponsored plan is now $28,386 (2019).[139] The employer's contribution would be on average 59% of the total cost, which would leave an annual

$11,600 for the employee to pay. Already as such it makes a big dent in the family budget, but as soon as there is an emergency it can entail financial ruin.

But the above calculations do not actually represent the total average individual cost on health care as there is also the Medicare tax at the rate of 2.9%, split even between employer and employee.

Two-thirds of Americans are not able to afford a $500 unexpected cost

As reported above, even having a health insurance is no longer a guarantee of adequate access to health services as medical debt is increasingly crushing Americans. According to a 2016 report, two-thirds of Americans are not able to afford a $500 emergency cost of any sort.[140] A recent study found that only 29% of workers earning up to $40,000 annually could pay right away a surprise medical invoice of $500 for acute treatment. Still with an income between $40,000 and $75,000 only 49% could cope with it. Even with an income in excess of $75,000, 30% could not handle it.[141] Medical bills are therefore more and more often the proverbial straw that breaks the camel's back. This was confirmed by a shocking 2019 study by researchers from the American Cancer Society discovered that 137.1 million Americans suffered medical financial hardship in 2018."[142] Americans had to resort to borrow a total of $88 billion in 2018 only to cover medical costs.[143] And when credit runs dry, the risk of bankruptcy emerges. Medical bills are now the primary factor in two-thirds of all personal bankruptcies in the United States.[144], [145], [146]

A report by the J.P. Morgan Chase Institute found that about 40 percent median-income households (those who make around $57,000 a year) and older families faced an extraordinary expense of $1,500 or more due to a medical expense, taxes, or a car problem during a 12-month period.[147]

The market for health insurance is extremely oligopolistic

All the market distortions that we have detailed in this report contribute to the high health insurance premiums and the actual health care costs after out-pocket-costs when deductibles, copays, coinsurances, and annual limits are factored in. But there is also a very direct monopoly causation for the high cost insofar as the health insurance market is among the most monopolized in the country.

The market for health insurance is "extremely oligopolistic," according to author Jonathan Tepper, who tells that only four companies – United Healthcare, Aetna, Cigna and Blue Cross Blue Shield Association – control the health insurance market with a nearly 90% market share nationally.[148] The insurance market monopoly is grounded in the McCarran-Ferguson Act of 1945. The Act exempts the insurance business from most federal regulation and in particular from crucial antitrust laws. It allows states to create local monopolies by making selling insurance across state lines illegal. As a result, insurance companies completely dominate their own states. The median

market share in a given state of the leading health insurer is 54%. In 17 states, a single insurer covers more than 65% of the consumers, and there are 24 states where the market leader has more than 55%.[149] In some states, such as Alabama, a single insurance company has near total monopoly. In half of all metro areas, just two health insurers divide two-thirds of the market.[150]

A study published in the American Economics Review in 2012 found that the share of US communities in which the health insurance market had become highly concentrated went up from 68% in 1998 to 99% in 2006.[151]

The Affordable Care Act (Obamacare) has had a devastating effect on the health insurance market monopolization. The Kaiser Family Foundation estimated that by the end of 2017, 22% of the American consumers would in their states not have any option but to purchase the health insurance from one monopoly provider. Another 21% would be given only two insurance companies to choose from.[152]

Health insurance is a relatively recent phenomenon, in the early 1940s, only 9% of the population was insured in some form. However, just a few decades later, by the end of 1970s, the private health insurance industry had grown and consolidated enormously. But this was already the time when anti-trust enforcement had been killed by the snake oil ideology.[153]

US Hospitals – The Real Health Scare

The European reader would not generally know, but contrary to popular belief, Obamacare – President Obama's healthcare reforms – brought a lot of adverse developments to the already beleaguered US healthcare system. Among other things, Obamacare unleashed a merger frenzy in the hospital industry.[154] The increasing monopolization of hospital and other patient service facilities markets is a relative newcomer to the monopolization craze, but as these account for the majority of US health care spending it has now become a leading cause of the skyrocketing medical expenses.[155] Nearly one half of the country's hospital markets are now highly concentrated. Since the passage of the Obamacare Act, hospital consolidation has more than doubled with a record number of mergers in 2017.[156]

The M&A frenzy has pushed formerly independent hospitals and all the healthcare infrastructure to form giant *health systems*. Expanding vertically, hospitals increasingly own physician practices and health care entities that provide post-acute care. These health systems now combine one or more academic central hub hospitals, other acute care hospitals, clinics, physicians' practices, rehabilitation facilities, outpatient home care services and other health care practitioners and organizations.[157]

As both horizontal and vertical consolidation has increased, 60% of hospitals are now part of health systems. From 2007 to 2012, 432 hospital merger and acquisition deals were concluded, involving 835 hospitals. From 2004 to 2011, hospital ownership of physician practices increased

from 24% of practices to 49%.[158]). In 2016, for the first time ever, a majority of physicians did not own the place where they practiced, a decrease of roughly 30 percent compared to 1983.[159]

It has been established that the hospital markets in 90% of Metropolitan Statistical Areas are now officially highly concentrated. The immediate effect on prices of a hospital acquisition was estimated as a 20% hike.[160]

Predictably, there is one group of people that among this monopolization mayhem have seen their lot improve – and improve a lot – the executive class. Compensation for hospital CEOs and executives has been soaring, from 2005 to 2015, the average major "nonprofit" medical center CEO compensation rose by 93%. In the same period the average health care worker wage rose 8%. [161]

The non-profit scam

Hospitals enjoy a special kind of quirky anti-trust protection inasmuch as the FTC is not permitted to prosecute anticompetitive practices by nonprofit organizations. The real twist to this story is that nearly half of the US hospitals have disguised themselves as such.[162] Health Affairs reported, that approximately 60% of US hospitals are organized as so-called non-profit organizations[163] but that does not make any difference whatsoever in their actual business model compared with the openly for-profit hospitals. The non-profit hospitals are similarly driven by crony capitalist greed and apply the absolutely same price gouging markups as American hospitals in general. In fact, McKinsey found that a survey including 2,900 major nonprofit hospitals (2,900 out of a total of 3,900), actually showed that the non-profits had on average higher operating profit margins than the 1,000 biggest for-profit hospitals after accounting for their tax obligations. Findings are corroborated by an article in Health Affairs which found that 7 of America's 10 most profitable hospitals were working under the non-profit umbrella.[164]

According to US tax laws, nonprofits are exempt from US federal income tax and property taxes but they are not prohibited from making a profit (to whatever extent), they just are not allowed to distribute that profit to shareholders, because *formally* they don't have any shareholders. What they instead do is to plow the profit back to stakeholders[165] in various (often corrupt) forms such as: spending on equipment, reconstruction and expansion of facilities and other real estate investments (with corresponding lucrative contracts); horizontal and vertical acquisitions (increasing the rate of monopolization of the healthcare market); and predatory marketing (helping to further raise the prices). Obviously, these non-profits (aka charities) are also heavily invested in the financial markets expanding beyond stocks and bonds into hedge funds, private equity, and other forms of vulture capital.[166] Make no mistake, there are always some very real beneficiaries of such investments and lavish spending. And to keep the money rolling non-profit organization spend heavily on lobbying, political campaign contributions and other political activism. The charitable status is frequently abused to form vehicles of political manipulation for meddling in the US electoral system.

In order to masquerade as charitable organizations these price gouging callous hospitals put on a veneer of a charity organization by organizing charity dinners and other such marketing stunts. For example Stamford Hospital raised just over 1% of its total revenue of $495 from charitable contributions last year. At the same time as it collected these $5 million of charitable contributions, Stamford made a profit of $63 million in the same year.[167], [168]

Executive pay at non-profit hospitals out-of-control

The most direct form in which hospitals and other non-profit organizations reward their stakeholders is by way of paying enormous compensations to their executives. The trend of paying huge salaries for leading executives at colleges, hospitals, and charities, has been growing for years. Compensation for hospital CEOs and executives has been soaring, from 2005 to 2015, the average major "nonprofit" medical center CEO compensation rose by 93%. In the same period the average health care worker wage rose 8 percent.[169]

The Wall Street Journal found in 2017 that 2,700 executives at U.S. nonprofits were paid more than $1 million in 2014.[170]

For example, Steven Safyer, chief executive of Montefiore Medical Center, a large nonprofit hospital system in the Bronx, had a salary of $4,065,000. The chief financial officer for the same hospital received $3,243,000, the executive vice president $2,220,000, and the head of the dental department ($1,798,000). [171]

Executives at the health insurance companies have seen their lot improve equally fortuitously. A study found that the CEOs of the eight largest publicly traded health insurers were also among the most highly compensated executives in the world, taking home a combined $171.8 million in total compensation in 2016.[172]

Ronald DePinho, the president of MD Anderson Cancer Center in Houston – another non-profit scam – was paid $1,845,000 in 2012.[173] In that year, this ostensibly non-profit hospital made a profit of $531 million, a profit of 26% on a revenue of $2.05 billion.

One of the faux charitable hospitals is Mercy Hospital – with an expanding chain of 31 hospitals and 300 clinics – which is owned by an organization under the umbrella of the Catholic Church called Sisters of Mercy. And although it has a track record of hellishly overcharging its patients and ruining their life with bills they cannot pay. Mercy Hospital defines its mission as "to carry out the healing ministry of Jesus by promoting health and wellness."[174] In 2011, the president and CEP of the Mercy Health chain Lynn Britton made $1,930,000, and an executive vice president, Myra Aubuchon, was paid $3.7 million. In all, seven Mercy Health executives were paid more than $1 million each. The chain Mercy Health had $4.28 billion in revenue for that fiscal year, but its actual charity activities were valued at only $13 million.[175]

Time to abolish the non-profit scam altogether

President Trump's tax reform bill effective January 1, 2018 tried to address some of the excesses in the non-profit system by imposing a new tax on executive pay. A 21% excise tax was slapped on nonprofits that pay compensation of $1 million or more to any of their five highest-paid employees. [176]

The restrictions on executive pay are largely symbolic though, while a permanent solution conforming to the principles of market economy would be to abolish the non-profit exemptions from all organizations that in actual fact are engaged in making a profit, whatever they want to call it. By and large the oversized non-profit sector is part and parcel of the American crony capitalist scam. The non-profit sector contributed in 2012 5.4% of the US GDP while the sector's revenue equaled a 10% share of the GDP.[177] The nonprofits account for 12.3 million jobs or10.2% of private sector employment (2016).[178]

Author Mike Lofgren has rightfully questioned whether these tax-exempt nonprofit organizations actually support legitimate charitable, educational and social welfare purposes.[179] He casts as examples the National Football league's tax-exempt status, while all the owners of the teams that make up the league are billionaires. Also, many of the educational foundations are nothing but political advocacy organizations for wealthy donors like the Koch brothers and George Soros, Lofgren reports. The abuse of non-profit status for political activities is overwhelming in the United States, where any political propaganda group can organize as a tax-exempt political foundation, among them all the so-called think tanks. A particularly ugly example of the non-profit scam is provided by the various fraudulent businessmen masquerading as pastors who have carved out multi-million fortunes for themselves by preaching questionable religions.[180], [181]

US universities are also mainly organized as non-profit organizations.

Traditional charities such as the Red Cross – the type of organizations for which the law was originally intended – are also known to plow down a large chunk of their donations on executive compensation and other overhead costs[182] lavishly rewarding their operatives at the same time when there are grave concerns on how they actually spend the money. For example, in an article titled "The Red Cross CEO Has Been Serially Misleading About Where Donors' Dollars Are Going" authors Jesse Eisinger and Justin Elliott have brought up such concerns.[183] A case in point is the mystery on how the American Red Cross spent the half a billion dollars it raised for the alleged purpose of aiding Haiti after the 2010 earthquake. An investigative report by NPR and ProPublica shows that it is altogether impossible to account for that money but what is clear is that almost $125 million were spent on the internal expenses of the Red Cross and at the end of the analysis only six permanent homes were built by this charity. In addition the charity has distributed tents and repaired "4000 homes," amounting to an admission that not much was done.[184]

There are also legitimate concerns about the Clinton foundation having participated in the plunder of Haiti in a similar fashion.[185], [186]

Astronomical hospital markups

On the already astronomical markups of drug makers, hospitals add their own yet much more insane margins. A study found, that the hospital average markup for drugs was 480% in 2016, ut often the markup is 7 to 10 times on the original purchase price, but could be even more.[187] In fact, hospitals are not bound by any legal, business or ethical constraints and mark up their prices as much as they think they can get away with. A 2013 article by Steven Brill in Time Magazine – aptly called: Bitter Pill: Why Medical Bills Are Killing Us – contains a welter of cases studies in how hospitals overcharge.[188] I will proceed by quoting from there. (Further references to said article indicated by author Steven Brill's name).

One patient, Sean Recchi, was charged $13,702 for one injection of 660 mg of a cancer drug called Rituxan. According to Steven Brill, the average price paid by all hospitals for this dose is about $4,000, but the hospital in question, MD Anderson Cancer Center in Houston, probably gets a volume discount that would make its cost $3,000 to $3,500. That means the nonprofit cancer center's markup on Recchi's lifesaving shot would be about 400%. The total cost, in advance, for Sean to get his treatment plan and initial doses of chemotherapy was $83,900. Recchi had purchased a health insurance, but the plan would compensate only $2,000 a day and was therefore refused by the cancer clinic.

In another of the cases examined by Steven Brill, a patient called Steve H. was charged at Mercy Hospital $49,237 for a Medtronic neurostimulator which was to be surgically implanted in his back. Brill's investigation showed that the wholesale list price of the Medtronic stimulator is about $19,000, in addition to which Mercy should be eligible for discounts as a major hospital chain. Thus Mercy made a margin of at least $30,000 just for that device, a profit margin of more than 150%. Steve H. was at Mercy as an outpatient, spending only the one day of the surgery there. Anyhow his total bill was $86,951. After his insurance paid that first $45,000, he still owed more than $40,000 for only the device and the procedures, not counting doctors' bills.

Scott S. was in the hospital for 32 days for pneumonia. Steven Brill reports that at the end of the ordeal his medical bill was $474,064. Out of that Scott was charged $132,000, or more than $4,000 a day, for routine blood, urine and other laboratory tests. That was on top of being charged $2,293 a day just for the room-and-board, in total $73,376. Notwithstanding the already exorbitant room charge, Scott was charged colossal amounts for care which would normally be included in the hospital room charge. The "specialized and personalized" care is exactly what hospitals motivate their huge room charges with. For example, he was charged $94,799 for "RESP SERVICES," which means supplying the patient with oxygen and testing the breathing, included were multiple charges of $134 per day for supervising oxygen inhalation. There was also $108,663 for "SPECIAL DRUGS," among them sodium chloride, a standard saline solution used intravenously to maintain a patient's

water and salt levels. That saline solution can be bought online for $5.16, while Scott was charged $134 for dozens of these saline solutions.

Another hospital bill reviewed by Steven Brill contained multiple charges of $7 each for square cotton pads used to sterilize the skin with alcohol prior to an injection. A box of 200 pads can be bought online for $1.91.

Pat Palmer, an expert interviewed by Steven Brill convincingly argues that the hospital in Scott's case – like so many other hospitals – was triple-billing. "First they charge more than $2,000 a day for the intensive care unit…Then they charge $1,000 for some kit used in the IC… And then they charge $50 or $100 for each tool or bandage or whatever that there is in the kit." In another case examined by Pat Palmer she detected that the hospital had charged separately for items such as a surgical gown, a blanket warmer and a marking pen, and even the shade attached to an examining lamp.

The practices of charging and hellishly overcharging for such standard items is the rule in American hospitals. The examples could go on and on. Let's round up that with one more example from Steven Brill's report, where he found that one bill included a charge for basic instruments and bandages and even the tubing for an IV setup.

As for drugs, hospitals also apply outrageous markups to all their other purchases, as well as to their work. For example, it was found that Stamford Hospital charged $293.2 million for all its laboratory work in 2010, although they had cost it only $27.5 million to produce. That meant a surcharge of 11 times its cost.[189]

All the egregious markups cumulate into outrageous total bills. A single trip to the emergency room can easily cost you $100,000, and if you happen to get cancer you could end up with medical bills in excess of a million dollars.[190], [191]Because of the limits on health care coverage, a single major illness is often enough to push most American families into bankruptcy.

There are examples galore. Steven D. died at his home in Northern California after an 11 month battle against cancer. In that time his wife Alice had collected bills for Steven's treatment totaling $902,452.[192]

Sovereign Valentine, 50, a personal trainer in Plains, Montana was billed $540,841. for 14 weeks of dialysis care at a Fresenius clinic. Valentine's insurer paid $16,241 out of that, but the clinic billed Valentine for the unpaid balance of $524,600.[193]

Emilia Gilbert, a school-bus driver, slipped and fell on her face one summer evening in June 2008 in the yard behind her house in Fairfield, Connecticut. (Reported by Steve Brill). Because her nose was bleeding heavily, she was taken to the emergency room at Bridgeport Hospital. She was in there for 6 hours, saw a doctor for 15 minutes, got blood tests, and had three CT scans — of her head, her chest and her face. The total bill was $9,400.

Sherry Young, a retired librarian who underwent two relatively minor surgeries in one day, one for a shoulder injury and one for a bone spur in her foot. For her treatment and three days in hospital she was billed over $115,000.[194] Her bill contained a charge of $15,076 for four tiny screws made by a company called Arthrex that were placed in her foot. According to an industry expert, the likely manufacturing cost for those screws was $30.

On October 19, 2016, Jessica Pell fainted and hit her head on a nearby table, cutting her ear. She went to the emergency room at Hoboken University Medical Center, New Jersey. On arrival, she received an ice pack, and that was the only treatment she received. Before the hospital would diagnose her, Pell discovered that the plastic surgeon who would see her was not covered by her health insurance plan, so she declined further service and walked out.[195] Turned out that refusing service was not enough to avoid a bill, which eventually arrived for $5,751. Pell's health insurance agreed to pay the hospital, but only $862, what it deemed "reasonable and appropriate" for the service rendered. Nevertheless, the hospital claimed Pell for the remaining $4,989.

The steep charge was due to something called **triage or facility fee**, which is a fee that hospitals apply in an arbitrary manner for something which essentially is a reception fee. These facility fees have become ever more popular items in the American hospital racket, a study published in 2017 showing that the prices for them rose 89% between 2009 and 2015, twice as fast as overall health care prices.[196]

An 8-month old son of a Korean couple vacationing in San Francisco in 2016 fell off the bed in the family's hotel room and hit his head. The worried parents decided to call an ambulance, which took them to Zuckerberg San Francisco General Hospital. At the hospital, the doctors quickly determined that the baby was fine with just a little bruising on his nose and forehead. He took a short nap in his mother's arms, drank some infant formula and was discharged a few hours later with a clean bill of health. The family continued their vacation, and the incident was quickly forgotten until the bill arrived at their home in South Korea. The total was $18,836 for that visit lasting three hours and 22 minutes. The bulk of the bill, $15,666, was something labeled "trauma activation".[197]

Trauma activation (aka trauma response fee) is akin to the facility fee but with a bit more of drama around it – with corresponding additional egregious surcharges – as it is charged for supposedly putting the emergency room on special alert for receiving a new patient. According to a report in CNN, charges ranged from $1,112 at a hospital in Missouri to $50,659 at a hospital in California. Data from the Health Care Cost Institute showed that the average price that health insurers paid hospitals for trauma response was $3,968 in 2016. Hospitals in the lowest 10% of price levels received an average of $725, while hospitals among the most expensive 10% were paid $13,525. It was shown that Medicare on average pays just $957.50 for the facility fee.[198] As it is with so many billing items in the Wild West of American health care, these charge rates are like a starting of a bargain. Health Insurers press down the fees, which are egregiously high in order to

accommodate the discount. But this means that the poorer people pay more, because they either have no insurance or a second rate one, which does not cover the whole charge.

According to the above referenced CNN report, Alexa Sulvetta, a 30-year-old nurse, broke her ankle while rock climbing at a San Francisco gym in January. She was charged $113,338 for surgery and her overnight stay in the hospital. The bill included $15,666 for trauma activation. Her insurer renegotiated the bill with the hospital paying only what it deemed reasonable, but the hospital then went after Sulvetta for a remaining $31,250.

Sam Hausen, 28, was charged $26,998 for a short visit at a hospital in Napa, California. (Cited in above referenced CNN report). He was at the hospital for only about half an hour for a minor cut on his head, which did not even require X-rays, CAT scans or a blood test. The “trauma response fee” on the bill amounted to a staggering $22,550.

Contrast the US hospital prices with what Americans pay in Russia

In gathering material for this study, Stan J. an American living in St. Petersburg, Russia, told about his experience of US healthcare versus that of Russia. In 2008, Stan signed in for a hip replacement operation in a hospital in California. But his private insurer, whom Stan contacted in advance of the operation, denied coverage. Stan was befuddled, “the insanity was that I had been paying 12 years up to that point $824 a month” and now they denied the coverage “the very first time I attempted to use it.” The claims approval department had ruled – apparently out of thin air – that the deteriorating hip joint was a prior condition from 13 years before. Never mind that Stan had undergone a full enrollment exam when first getting that insurance.

Upon complaining about the denial, the insurer resorted to another excuse, this time motivating the denial with the fact that Stan had been working and living abroad all during those years. In total, Stan had paid in $118,656 on insurance premiums during the 12 years.

After being turned down by the insurance company, Stan checked with the community hospital in the town across the Golden Gate Bridge from San Francisco where his house was. At the time in 2008, the hip replacement there would have cost without insurance no less than $160,000: $90,000 for 2 days in a 6-bed ward, plus surgeon fees of $30,000, therapy, up to $30,000, the joint $12,500, and miscellaneous… “Will that be cash or credit card?” – forestalling that question, Stan rejected the offer out of hand.

Having made up his mind, Stan returned to Russia after his unsuccessful attempt to get the medical care in the United States which he had duly paid for in 12 years. Upon returning to St. Petersburg, Stan asked friends to recommend the best local orthopedic surgeon. An appointment was arranged immediately. “That was the beginning of a really great medical journey,” Stan recalls. A date for surgery was set within a few more days and soon Stan was operated on by a surgeon who was the head of orthopedics at the largest hospital in St. Petersburg, a professor at the

prestigious Military Medical Academy. After the successful operation, Stan was lying for 10 days with a new hip joint in a private VIP room – an apartment on its own – with a living room for receiving guests, and a kitchen. It even had a gigantic private SPA section, with a Finnish sauna and a bathroom with a whirlpool bath, massage table and large glassed in shower.

The bill for the surgeon was $500 and $300 for the anesthesiologist – and that's for an uninsured person. In addition to that Stan paid a couple of thousand for the stay in the VIP room.

In 2019 Stan had another experience with the Russian medical system. Stan had tripped while moving a heavy amplifier and flown headfirst into a large mixing console on the floor. He ended up laying there unable to move his legs in a fast flowing gushing of blood that filled the floor. What he managed to do was to reach for a towel and some t-shirts which he pressed on the five holes in the head. Fortunately his partner happened to come home just then and she called an ambulance. It arrived within minutes with a doctor and a medic fast giving first aid. And soon Stan was on his way to the city hospital specialized in head trauma. Within six hours, his wounds had been fully treated.

At that point, Stan started to worry about the bill. After half a day of monitoring, he was released from the hospital, and checking out he was prepared for the worst. "So, please, let me settle the bill," Stan told the clerk. "There is no bill, Sir," was the reply. "It was an emergency and according to the Russian law no patient is billed for emergency care. Thank you, Sir and wish you quick recovery."

Another American living in St Petersburg for 15 years needed dialysis three times a week. He initially put it off because he lacked health insurance, but after a crisis forced him to seek medical attention, he learned that residents are covered by the national health system and his treatment was provided 100% free of charge. He relayed that all medical care he received and the professionalism which it was provided were exceptional. In 2018, after becoming a full-fledged citizen, he was placed on the transplant waiting list. He knew that in the US the queues could extend for years and that all the costs would not be covered. He was shocked to get a phone call just two weeks later, informing him he needed to get to the hospital right away as there was a kidney waiting for him. That very day he was prepped for the transplant and next morning he woke up with a new kidney. And what was the cost for this kidney transplant? – Zero. It was all covered by his Russian social health insurance. They even pay for his anti-rejection drugs and his regular follow up tests and any necessary treatment.

The chargemaster, start of the bargain for some, death sentence for others

The exorbitant prices are pulled out of the hospital chargemaster, a computerized catalogue which lists every single item that the hospital would charge for complete with the insane markups. Some hospital managers defend the gross markups in the chargemaster by arguing that those prices only reflect the start of the bargain. Because, Medicare and strong private insurers are prone to

demand so steep discounts, the hospitals have jacked up the prices in advance to accommodate the bargain. Steven Brill reported that after applying the discounts to Medicare and private insurers, for example, Stamford hospital ends up receiving about 35% of what it bills, which is the yield for most hospitals. Top brand hospitals like Sloan-Kettering and MD Anderson, would get about 50%. [199]

That might work in the US healthcare bazaar between the big players as they haggle over prices but the poor and the ever more struggling middle class will be left with the joker and pay the full price. According to one report, it is not uncommon for insurance companies to get hospitals to knock their bills down by up to 95%, but if you are uninsured or you don't know how the system works then you are in trouble.[200]

Those who don't possess the bargaining power, people who do not qualify for Medicaid or Medicare and don't have insurance, or sufficient insurance – which is increasingly the issue – are the ones ending up paying the maniacal chargemaster prices. Hospital executives come up with all kinds of excuses for their immoral billing practices, like John Gunn, chief operating officer of Sloan-Kettering, who callously claims they charge those rates so that when we get paid by a [wealthy] uninsured person from overseas, it allows us to serve the poor."[201] In fact, there are preciously few American hospitals which in actual fact would run the business model of serving the superrich foreigners like your proverbial Saudi sheik, and none who would do it in order to subsidies medical care for the poor.

Medicare's Restraining Influence on Hospital Price Gouging

Perhaps a bit counterintuitively, the one part of the US healthcare system that seems to be working is the government run Medicare and Medicaid systems.

Their legal mandates and bargaining power have put these public health insurers in the position to dramatically cut hospital bills. The literature I have reviewed and referenced here, shows that Medicare routinely cuts billing items by a magnitude of 8 to 12 times.

Medicare's reimbursement formulas are to a large extent regulated by Congress and aimed at reimbursing hospitals according to the true cost and a fair margin. To determine the true cost, Medicare collects troves of data on what every type of treatment, test and other service costs hospitals to deliver. Under the law, Medicare is supposed to reimburse hospitals for any given service, factoring in not only direct costs but also allocated expenses such as overhead, capital expenses, executive salaries, insurance, differences in regional costs of living and even the education of medical students.[202]

A study by Ge Bai of Washington Lee University and Gerard Anderson of the Johns Hopkins Bloomberg School of Public Health found that the 50 hospitals that mark up their prices the most

had an average markup of 1013% over what Medicare pays them. The average markup (over Medicare reimbursements) for the other 4,333 hospitals surveyed was still 340%.[203]

Steven Brill shares a welter of cases where Medicare has reduced hospital charge rates by 80% or more. In one of Brill's examples, the cancer center Sloan-Kettering gets paid $302 by Medicare for about $2,400 worth of its chargemaster charges, and the patient ends up paying $6. (The patient had a supplemental private insurance which pays 90% of the 20% of costs for doctors and outpatient care that Medicare does not cover).

In the case of Scott (cited above), he was charged $134 per day for supervising oxygen inhalation, for this Medicare would have paid $17.94. He was also charged $132,303 charge for laboratory, which included hundreds of blood and urine tests ranging from $30 to $333 each, for these Medicare either pays nothing because it is part of the room fee or pays $7 to $30.

Stamford charged one patient $199.50 per troponin test (measuring protein levels in the blood), but the Medicare reimbursement – based on the actual cost – would have been only $13.94 for each troponin test. The same patient was charged $157.61 for a CBC blood count, Medicare would pay $11.02 for a CBC in the same area. Another example concerning the same patient shows she was charged $7,997 for a stress test using a radioactive dye that is tracked by an X-ray computed tomography, or CT, scan. Medicare would have paid Stamford $554 for that test.

Kaiser Health News reported that Fresenius Kidney Care clinic in Missoula, Montana, billed the its patient Sovereign Valentine $540,841 for 14 weeks of urgent dialysis treatment of his kidney. The charge per dialysis session was $13,867. That was 59 times the $235 Medicare pays for a dialysis session.[204]

Interestingly, hospital executives tend to argue that they lose as much as 10% on an average Medicare patient.[205] Contrary to their intentions that argument makes a huge hole in their entire pricing policy, because even if Medicare would add that additional 10% to what it price, the hospital charge rates would still be some 80% further off the mark. The fact is that even these steeply discounted Medicare payment rates are profitable for hospitals, because otherwise so many would not have their business model organized to serve Medicare patients.[206]

Medicare discounts also set the tone for discounts applied to private health insurance as the insurance companies insist on applying the pricing and compensation policies followed by Medicare. The insurance companies do not receive as steep discounts as Medicare but are able to significantly reduce the bills.[207]

Group Purchasing Organizations and Pharma Benefit Managers

A very special kind of stupid in the US health care system are **GPOs or Group Purchasing Organizations**. GPOs were originally set up as organizations that pooled the buying power of hospitals in relation to pharmaceutical vendors. As Jonathan Tepper writes, they might have

initially helped to lower prices, but over time their effect came to be the opposite as they have raised prices and become leeches on the medical system.[208] By today four GPOs – Vizient, Premier, HealthTrust, and Intaler – have monopolized the market, controlling $300 billion of annual purchases of drugs, devices and supplies for 5,000 hospitals and other health systems and thousands of clinics and care facilities. (The combined market share of the three first mentioned was 75% according to a 2018 article[209]). Rather than collect dues from the member hospitals and clinics, GPOs collect fees from the supplies as a percentage of sales. Essentially, these are kick-backs designed to keep the prices high, totally in contradiction to the initial aim. These are not just any kick-backs, but institutionalized kickbacks made legal by a 1986 Congressional bill explicitly exempting GPOs from anti-kickback laws.

So-called **pharmacy benefit managers (PBMs)** constitute a similar scam as the GPOs, but these are placed as middlemen between 250 million health insured Americans and pharmacies. PBMs were formed in the late 1960s to supposedly reduce prices by helping process the paperwork and aggregate orders. But predictably – and fully in keeping with the American healthcare rip-off – the opposite has happened. Just like the GPOs, the benefit managers have been getting kick-back from the drug companies.[210]

Today, just three companies control 75 to 80% of the PBM market: Express Script, CVS Caremark and OptumRx (a division of UnitedHealth Group).

US Pharma and Healthcare – A Giant Monopoly System

This report has shown how each product segment in the pharmaceutical and healthcare markets suffer from monopoly price gouging. The entire US healthcare system is distorted and rotten to the core and all the way up to what is supposed to be government control and regulation for public benefit. Each segment is controlled by an oligopoly of just a few vendors. But it gets worse yet, when we realize that the companies forming the oligopoly are themselves owned by the same set of a few oligarchic investors. This is a condition called **horizontal shareholding**, oligopolies owning oligopolies, defined as a common set of investors owning significant shares (de facto controlling interests) in corporations that are (formally) horizontal competitors in a given product market. The work of Einer Elhauge and José Azar and others have demonstrated – which shouldn't come as a surprise to anybody – the pernicious anti-competitive effects and great social costs of such ownership concentration.[211], [212]

The present report follows on my earlier report on the extreme concentration of ownership in the United States.[213] That report demonstrated how the ownership of all major corporations in the United States – in general, and not only concerning those of the healthcare and pharma sector – has been concentrated in incredibly few hands. Most of America's industries are now oligopolies and the cancerous condition of horizontal shareholding has spread across the entire US economy with the same handful of investors owning controlling stakes in the overwhelming majority of the

largest US corporations. It was established that, institutional investors like BlackRock, Vanguard, State Street, Fidelity, and JP Morgan, now (2016) own 80% of all stock in S&P 500 listed companies. The Big Three investors – BlackRock, Vanguard and State Street – alone constitute the largest shareholder in 88% of S&P 500 firms, which roughly correspond to America's 500 largest corporations. Both BlackRock and Vanguard are among the top five shareholders of almost 70% of America's largest 2,000 publicly traded corporations.

Blackrock had as of 2016 $6.2 trillion worth of assets under management, Vanguard $5.1 trillion, whereas State Street has dropped to a distant third with only $1 trillion in assets. This compares with a total market capitalization of US stocks according to Russell 3000 of $30 trillion at end of 2017 (From 2016 to 2017, the Big Three has of course also put on assets). Blackrock and Vanguard would then alone own more than one-third of all US publicly listed shares.

From an expanded sample that includes the 3,000 largest publicly listed corporations (Russell 3000 index), the same few institutions owned (2016) about 78% of the equity.

Pharmaceutical corporations

Judging by market shares, the US pharmaceutical manufacturing companies would not seem especially monopolized. The top 10 companies each have a market share ranging from 6 to 4%. However, in branded drugs (non-generics) the market shares of the leading corporations reach 9 to 11%.[214]

But the figures on total market share mask the fact that there is preciously little competition between the companies in specific drugs or classes of drugs. Already by 2006, there were 52 blockbuster drugs generating annual sales of at least $1 billion for one company.[215] The lack of competition between the established Big Pharma companies and potential newcomers has been cemented by government granted patent monopolies and other regulatory barriers, which have already been discussed in this report. Besides, the relatively small individual market shares could soon also be a thing of the past as the pharma industry is presently rapidly consolidating through mergers and acquisitions.[216]

Concentration of ownership of pharmaceutical corporations and the entire healthcare sector

Below follows charts on the largest companies according to market share in pharma and the main healthcare sectors. Next to the market share we list the owners of the companies. Hospitals – or health systems, as the conglomerates of hospitals are called – are mostly organized as local monopolies, as reported above, and are therefore not included in below charts of concentration of ownership, but some of the big hospitals are already owned by these same oligarch institutions. For example, the biggest health system, HCA Healthcare with 185 hospitals is owned by Vanguard, BlackRock and the other oligarch institutions, which we will see are the reoccurring owners time

after time in all the leading pharma and other healthcare companies. A similar pattern is found in the fourth biggest hospital company, Community Health Systems (105 hospitals) and seventh, Tenet Healthcare (65 hospitals).[217] [218] [219], [220]

Pharma manufacturers

Pharma Manufacturers
US market share (2015) and biggest owners

	Market share	Owner 1	Owner 2	Owner 3	Also among top 10 owners				
Gilead Sciences	7%	Vanguard	BlackRock	Capital	State Street	Geode	Dodge & Cox	Northern T.	
Johnson & Johnson	5,9%	Vanguard	BlackRock	State Street	Geode	Bank of Am.	Capital	Northern T.	
Roche	6%	Vanguard	BlackRock	State Street					
Merck & Co	5,7%	Vanguard	BlackRock	State Street	Capital	Wellington	Geode		
Amgen	5%	Vanguard	BlackRock	Capital	State Street	Bank of Am.	Geode	Northern T.	
Pfizer	4,7%	Vanguard	BlackRock	State Street	Capital	Bank of Am.	Northern T.	Wellingto	Geode
Fresenius Kabi	5%	Morgan S.	Thornburg	Bank of Am.	Goldman Sachs	Northern T.			
AbbVie	4,4%	Capital	Vanguard	BlackRock	State Street	Northern T.	Geode	Bank of Am.	
Sanofi	4%	Dodge & Cox							
Novartis	3,3%	Dodge & Cox							
Total	50,8%								

Note for Roche, the shareholding chain is derived via the primary owner Parametic Portfolio Ass. And further its owner, Eaton Vance.
Capital stands for Capital Group or any of its affiliates
Morgan S. is Morgan Stanley
Northern T. stands for Northern Trust Corp.
Bank of Am. Is Bank of America

Source: For market share, USC Schaffer; for ownership, mainly www.stockzoa.com

Pharmacies

Pharmacies
US market share (prescription revenue, 2017), and biggest owners

	Market share	Owner 1	Owner 2	Owner 3	Also among top 10 owners				
CVS Health	24%	Vanguard	BlackRock	State Street	Wellington	Capital	Northern T.	Geode	Dodge&Cox
Walgreens Boots Alliance	15,6%	S. Pessina	Vanguard	SSgA Funds	BlackRock	Capital	Northern T.	Wellington	
Express Scripts (Cigna)	11%	Ascend Cap.	CIBC	Gulf Int.					
UnitedHealth Group	5%	Vanguard	BlackRock	State Street	Capital	Wellington	Northern T.		
Walmart	5%	Vanguard	BlackRock	State Street	Bank of Am.	Geode	Wellington	Northern T.	
Rite Aid	3,8%	Vanguard	Oppenheimer	State Street	Geode				
Kroger	3%	Vanguard	BlackRock	State Street	Geode				
Humana Pharmacies	1,5%	BlackRock	Vanguard	Capital	State Street	Wellington	Bank of Am.		
Total	68,8%								

Source: for market share, Drug Channels Institute; for ownership mainly www.stockzoa.com
https://www.drugchannels.net/2018/02/the-top-15-us-pharmacies-of-2017-market.html

Drug wholesalers

Drug wholesalers - US market share 2015
US market share (2015) and biggest owners

	Market share	Owner 1	Owner 2	Owner 3	Also among top 10 owners	
McKesson	32,7%	Vanguard	BlackRock	State Street	Wellington	
AmerisourceBergen	31,6%	Vanguard	BlackRock	State Street	Bank of Am.	Northern Trust
Cardinal Health	20,7%	Vanguard	BlackRock	State Street		
Total	**85,0%**					

Source: for market share, USC Schaffe; for ownership mainly www.stockzoa.com

A further layer of monopolization of the American drug market is formed by the three companies that handle more than 90% of the drug wholesale market. AmerisourceBergen, McKesson, and Central Health.[221] The total revenue of these the drug distribution divisions of these three giant was estimate as $425.1 billion (2017).[222] Note, that the same major oligarch investors who own the drug makers and the pharmacies also own these wholesale distributors.

Health insurers

Health Insurers
US market share (2015) and biggest owners

	Market share	Owner 1	Owner 2	Owner 3	Also among top 10 owners		
UnitedHealth Group	11%	Vanguard	BlackRock	State Street	Capital	Wellington	Northern T.
Anthem	9%	BlackRock	Vanguard	T. Rowe Price	State Street	Wellington	Geode
Humana	9%	BlackRock	Vanguard	Capital	State Street	Wellington	Bank of Am.
Aetna (CVS Health)	5%	Vanguard	BlackRock	State Street	Wellington	Capital	Northern T.
Aetna cont.						Geode	Dodge&Cox
Cigna	5%	Ascend Cap.	CIBC	Gulf Int.			
Centene	3%	BlackRock	Vanguard	T. Rowe Price	Capital	State Street	Geode
HealthNet (Centene)	3%	BlackRock	Vanguard	T. Rowe Price	Capital	State Street	Geode
WellCare	2%	T. Rowe Price	Vanguard	BlackRock	Wellington	State Street	Capital
Molina	2%	BlackRock	Vanguard	T. Rowe Price	Wellington	State Street	Capital
Magellan	1%	BlackRock	Vanguard	Startboard V.	State Street	Northern T.	
Total	49%						

Source: For market share, USC Schaffer; for ownership, mainly www.stockzoa.com

Pharma Benefit Managers

Pharma Benefit Managers - US market share 2015

Express Scripts (Cigna)	29%
CVS Health	24%
Optum Rx (United Health Group)	13%
Total	**66%**

Source: USC Schaffer

CONCLUDING REMARKS

The definitive takeaway from all this is that the myth of the superiority of private over public ownership is wrong. It would absolutely not make any sense to privatize healthcare and public utilities according to the tenets of the free-market religion. It is perfectly well and beneficial to leave the backbones of the economy in public ownership as long as there is a mixed economy with private competition challenging government ownership and as long as the government does not mess with areas of the economy which are not crucial for the national well-being.

The most important lesson for the rest of the world from this case study of the US healthcare sector is that the US ideology of neoliberalism and the crony capitalism that it breeds does not bring real life value for an economy, on the contrary, we have seen that privatization is detrimental over state ownership and public services in the healthcare sector, and therefore it must be the case in many other core sectors of the economy as well.

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[1] The actual contribution of health care and social assistance to US economic value-added (GDP) in 2018 was 7.4% or $1.526 trillion out of a total GDP of $20.5 trillion. Source: Table 5. in Gross Domestic Product by Industry: First Quarter 2019. Do note, that something measured "as a share of GDP" is different from its "contribution to the economic value-added of GDP." // Back in 1960, the US health care costs was $27.2 billion equaling just 5% of GDP, See: The Rising Cost of Health Care by Year and Its Causes

[2] Hospitals & Monopoly

[3] US life expectancy has been declining. Here's why

[4] The US was once a leader for healthcare and education — now it ranks 27th in the world

[5] US life expectancy has been declining. Here's why

[6] China Is Striving for the World's Best, Cheapest Healthcare

[7] Zerohedge

[8] The State of US Health, 1990-2016

[9] The Racial Life Expectancy Gap in the U.S.

[10] En España la salud es cada vez más privada

[11] The Putin Effect: Russian Life Expectancy Surges to 74 Years

[12] The Putin Effect: Russian Life Expectancy Surges to 74 Years

[13] US drug prices higher than in the rest of the world, here's why

[14] How the U.S. Pays 3 Times More for Drugs

[15] Health Care Spending in the United States and Other High-Income Countries

[16] Why pharmaceuticals are cheaper abroad

[17] U.S. Drug Prices vs The World

[18] Brand-Name Drugs Increasing at 10X Cost of Inflation, McCaskill Report Finds

[19] Big Pharma Hikes Drug Price 879% And That's Just One Of 3,400 So Far This Year

[20] The Rising Cost of Health Care by Year and Its Causes

[21] U.S. Inflation Rate, $100 in 1997 to 2007

[22] No Justification for High Drug Prices

[23] How 4 drug companies rapidly raised prices on life-saving drugs

[24] No Justification for High Drug Prices

[25] No Justification for High Drug Prices

[26] High Drug Prices & Monopoly

[27] Politicians demand action on prescription drug scandal

[28] The same pill that costs $1,000 in the U.S. sells for $4 in India

[29] Brazil court strips Gilead of hepatitis C drug patent

[30] Drug companies are reeling after the Martin Shkreli incident — and it could shake up the entire industry

[31] See, also: Sudden Price Spikes in Off-Patent Prescription Drugs: The Monopoly Business Model that Harms Patients, Taxpayers, and the U.S. Health Care System.

[32] The Insulin Racket

[33] Drug prices in 2019 are surging, with hikes at 5 times inflation

[34] The Insulin Racket

[35] U.S. Drug Prices vs The World

[36] Why the price of prescription drugs in the US is out of control

[37] Big Pharma: Investing Boldly in Advertising and Profits, not R&D

[38] Average Research & Development Costs for Pharmaceutical Companies

[39] The top 10 pharma R&D budgets in 2016

[40] Changing R&D models in research-based pharmaceutical companies

[41] PHARMACEUTICAL R&D. What do we get for all that money?

[42] Clinical Trial Evidence Supporting FDA Approval of Novel Therapeutic Agents, 2005-2012

[43] How drug companies exaggerate research costs to justify absurd profits

[44] Big Pharma shells out $20B each year to schmooze docs, $6B on drug ads

[45] Drug Companies Have Big R&D Expenses and Still Make Large Profits

[46] US drug 2016 sales, at $450 billion, moderate to single-digit growth

[47] Pharmaceutical Companies Spent 19 Times More On Self-Promotion Than Basic Research: Report

[48] PHARMACEUTICAL R&D. What do we get for all that money?

[49] High Drug Prices & Monopoly

[50] David Stockman, The Great Deformation, page. 472

[51] Allocating Purchase Price for a Pharma Transaction – Pfizer Acquires Medivation (Part 2)

[52] Big Pharma's Role in Clinical Trials

[53] Big Pharma Pays Universities for Most Medical Research in U.S. Today

[54] Big Pharma's Role in Clinical Trials

[55] Industry Funding of Clinical Trials: Benefit or Bias?

[56] Publication bias: What are the challenges and can they be overcome?

[57] Western Medicine Untrustable & Fraudulent, Say Insiders and Experts

[58] "Peer Reviewed:" Science Losing Credibility As Large Amounts Of Research Shown To Be False

[59] The Statin Mafia Censors Pharmaceutical Harm

[60] Americans Spent Nearly $150 Billion On Illegal Drugs Last Year

[61] Opioid Overdose Crisis

[62] Americans Spent Nearly $150 Billion On Illegal Drugs In 2016

[63] Who Are the Players in the Pharmaceutical Industry (Big Pharma)?

[64] Sackler family could pay billions in personal wealth to settle opioid lawsuits

[65] Addicted America: The Big Pharma Cartel

[66] Who Are the Players in the Pharmaceutical Industry (Big Pharma)?

[67] Sackler family could pay billions in personal wealth to settle opioid lawsuits

[68] Who Are the Players in the Pharmaceutical Industry (Big Pharma)?

[69] Who Are the Players in the Pharmaceutical Industry (Big Pharma)?

[70] Tepper, Jonathan. The Myth of Capitalism: Monopolies and the Death of Competition (2018). p. 173

[71] Tepper, Jonathan. The Myth of Capitalism: Monopolies and the Death of Competition (2018). p. 175.

[72] Tepper, Jonathan. The Myth of Capitalism: Monopolies and the Death of Competition (2018). p. 175.

[73] Tepper, Jonathan. The Myth of Capitalism: Monopolies and the Death of Competition (2018). P. 178.

[74] Tepper, Jonathan. The Myth of Capitalism: Monopolies and the Death of Competition (2018). p. 175.

[75] Harvard Study Finally Admits Drug Prices are High Because Govt Grants Big Pharma a Monopoly

[76] A Look At How The Revolving Door Spins From FDA To Industry

[77] The Revolving Door: FDA and the Monsanto Company

[78] The Revolving Door: FDA and the Monsanto Company

[79] The Revolving Door: FDA and the Monsanto Company

[80] Revolving Door Continues to Turn as Former FDA Head Joins Pfizer

[81] Harvard Study Finally Admits Drug Prices are High Because Govt Grants Big Pharma a Monopoly

[82] Former Monsanto Employee to Utilize Trump's Revolving Door to Join US Secretary of the Interior David Bernhardt

[83] Are Enormous Speaking Fees and Huge Donations Really Camouflaged Bribes?

[84] After Failing to Prosecute Bankers, Obama Cashes In With Wall Street Speeches

[85] Obama paid $600,000 for a single speech

[86] How big pharma's money – and its politicians – feed the US opioid crisis

[87] How Big Pharma Was Captured by the One Percent

[88] How Big Pharma Was Captured by the One Percent

[89] How Big Pharma Was Captured by the One Percent

[90] High Drug Prices & Monopoly

[91] High Drug Prices & Monopoly

[92] High Drug Prices & Monopoly

[93] High Drug Prices & Monopoly

[94] High Drug Prices & Monopoly

[95] The Insulin Racket

[96] How Big Pharma Was Captured by the One Percent

[97] How Big Pharma Was Captured by the One Percent

[98] Patents, Profits, and the American People — The Bayh–Dole Act of 1980

[99] How Big Pharma Was Captured by the One Percent

[100] How Big Pharma Was Captured by the One Percent

[101] How Big Pharma Was Captured by the One Percent

[102] How Big Pharma Was Captured by the One Percent

[103] How Big Pharma Was Captured by the One Percent

[104] How Big Pharma Was Captured by the One Percent

[105] How Big Pharma Was Captured by the One Percent

[106] How Big Pharma Was Captured by the One Percent

[107] How Big Pharma Was Captured by the One Percent

[108] How Big Pharma Was Captured by the One Percent

[109] U.S. Drug Prices vs The World

[110] How Pharma keeps generics off the market

[111] The FDA process, patents and market exclusivity

[112] U.S. Drug Prices vs The World

[113] Big Pharma Companies Accused Of Conspiring To Inflate Prices Of Over 100 Generic Drugs By Up To 1000%

[114] FDA Bans Generic Drug Imports From Ranbaxy Laboratories in India

[115] FDA bans imports from Sun Pharma plant in India crackdown

[116] Medical malpractice litigation raises health-care cost, reduces access, and lowers quality of care

[117] The Shocking Truth about Medical Malpractice

[118] 50 Signs That The U.S. Health Care System Is A Gigantic Money Making Scam

[119] Tammy Baldwin: Federal government prohibited ‘from negotiating lower prescription drug prices’

[120] The Medicare Drug Price Negotiation Act Would Lower Costs and Preserve Care

[121] This Is Why Your Drug Prescriptions Cost So Damn Much

[122] Medicare’s Prescription Drug Coverage Became Law Under George W. Bush On This Date

[123] The Politics of Medicare and Drug-Price Negotiation

[124] After Obamacare

[125] The Insulin Racket

[126] Bitter Pill: Why Medical Bills Are Killing Us

[127] Bitter Pill: Why Medical Bills Are Killing Us

[128] Examining the Impact of Health Care Consolidation

[129] United States Health and Medical Insurance Market

[130] Long-Term Trends in Employer-Based Coverage

[131] United States Health and Medical Insurance Market

[132] Health Care Spending in the United States and Other High-Income Countries

[133] Health Insurance Coverage Eight Years After the ACA

[134] More Adults Foregoing Medical Care, Health Insurance Due to Cost

[135] Wealth and Generations

[136] Wage Stagnation in Nine Charts

[137] 53 Million Americans Drowning In Cycle Of Low-Wage Work

[138] Wealth and Generations

[139] Wealth and Generations

[140] Two-thirds of Americans can't afford a $500 emergency

[141] The Surge In "Surprise" Medical Bills Bankrupting Americans Can Be Blamed On Private Equity

[142] Prevalence and Correlates of Medical Financial Hardship in the USA

[143] Americans Had To Borrow 88 BILLION Dollars To Cover Their Medical Bills Last Year

[144] A New Study Discovers Two-Thirds Of All Bankruptcies In The United States Are Primarily Caused By Medical Bills

[145] Medical Debt Is Crushing Many Americans. Is The Health Care System On The Verge Of Collapse?

[146] Doctors' Bills Play Role In Majority Of Personal Bankruptcies

[147] Americans Are Putting Off Medical Treatments Because They Can't Pay

[148] Tepper, Jonathan. The Myth of Capitalism: Monopolies and the Death of Competition (2018). p. 30

[149] Tepper, Jonathan. The Myth of Capitalism: Monopolies and the Death of Competition (2018). p. 31

[150] Health Insurance & Monopoly

[151] Health Insurance & Monopoly

[152] Health Insurance & Monopoly

[153] Health Insurance & Monopoly

[154] Tepper, Jonathan. The Myth of Capitalism: Monopolies and the Death of Competition (2018). p. 173. 129.

[155] Hospitals & Monopoly

[156] Hospitals & Monopoly

[157] Hospitals, Market Share, and Consolidation

[158] Hospitals, Market Share, and Consolidation

[159] Hospitals & Monopoly

[160] Hospitals & Monopoly

[161] Hospitals & Monopoly

[162] Hospitals & Monopoly

[163] The Fairy Tale of a Non-Profit Hospital

[164] The Fairy Tale of a Non-Profit Hospital

[165] Bitter Pill: Why Medical Bills Are Killing Us

[166] How Should Nonprofits Invest?

[167] Bitter Pill: Why Medical Bills Are Killing Us

[168] America Is Self-Destructing: Wealth, Greed, and Ideology Trump Common Cause and Social Justice. Thomas P. Wallace 2013. PAGE 63 As nonprofits, such hospitals solicit contributions, and their annual charity dinner, a showcase for their good works, is typically a major civic event.

[169] Hospitals & Monopoly

[170] How tax reform will end the nonprofit executive pay scam

[171] Bitter Pill: Why Medical Bills Are Killing Us

[172] Health Insurance & Monopoly

[173] Bitter Pill: Why Medical Bills Are Killing Us

[174] Bitter Pill: Why Medical Bills Are Killing Us

[175] Bitter Pill: Why Medical Bills Are Killing Us

[176] Tax Reform Hits Compensation of Nonprofit Executives in 2018

[177] The Nonprofit Sector in Brief 2014

[178] Nonprofits account for 12.3 million jobs, 10.2 percent of private sector employment, in 2016

[179] Lofgren, Mike. The Deep State: The Fall of the Constitution and the Rise of a Shadow Government (2016), p. 224.

[180] The Shocking Net Worth of These 10 Richest Pastors Will Blow Your Mind

[181] Fraud Thriving In U.S. Churches, But You Wouldn't Know It

[182] You Won't Believe the Overhead Costs at These 25 Nonprofits

[183] The Red Cross CEO Has Been Serially Misleading About Where Donors' Dollars Are Going

[184] In Search Of The Red Cross' $500 Million In Haiti Relief

[185] US election 2016: What really happened with the Clintons in Haiti?

[186] Haiti Needs $2 Billion the Clinton Foundation Stole From Its Relief Funds

[187] When Hospitals Mark Up Drug Prices

[188] When Hospitals Mark Up Drug Prices

[189] Bitter Pill: Why Medical Bills Are Killing Us

[190] 50 Signs That The U.S. Health Care System Is A Gigantic Money Making Scam

[191] She didn't get treated at the ER. But she got a $5,751 bill anyway.

[192] Bitter Pill: Why Medical Bills Are Killing Us

[193] First Kidney Failure, Then A $540,842 Bill For Dialysis

[194] Outrageous Medical Bills? Get Them Itemized First

[195] She didn't get treated at the ER. But she got a $5,751 bill anyway.

[196] She didn't get treated at the ER. But she got a $5,751 bill anyway.

[197] A Baby Was Treated With A Nap And A Bottle Of Formula. The Bill Was $18,000

[198] A Baby Was Treated With A Nap And A Bottle Of Formula. The Bill Was $18,000

[199] Bitter Pill: Why Medical Bills Are Killing Us

[200] 50 Signs That The U.S. Health Care System Is A Gigantic Money Making Scam

[201] Bitter Pill: Why Medical Bills Are Killing Us

[202] Bitter Pill: Why Medical Bills Are Killing Us

[203] WHY HOSPITALS MARK UP PRICES BY 1,000 PERCENT

[204] First Kidney Failure, Then A $540,842 Bill For Dialysis

[205] Bitter Pill: Why Medical Bills Are Killing Us

[206] Bitter Pill: Why Medical Bills Are Killing Us

[207] Bitter Pill: Why Medical Bills Are Killing Us

[208] Tepper, Jonathan. The Myth of Capitalism: Monopolies and the Death of Competition (2018). p.129

[209] Premier: Healthcare GPO Provider Summary — Introduction, Summary Analysis, SWOT and Customer Engagement Tips

[210] Tepper, Jonathan. The Myth of Capitalism: Monopolies and the Death of Competition (2018), p. 130.

[211] Azar, José and Schmalz, Martin C. and Tecu, Isabel, Anticompetitive Effects of Common Ownership (May 10, 2018). Journal of Finance, 73(4), 2018. Available at SSRN or dx.doi.org

[212] Azar, José and Schmalz, Martin C. and Tecu, Isabel, Anticompetitive Effects of Common Ownership (May 10, 2018). Journal of Finance, 73(4), 2018. Available at SSRN or dx.doi.org

[213] Extreme concentration of ownership in the United States

[214] The Flow of Money Through the Pharmaceutical Distribution System

[215] Prescription Drug Spending Trends In The United States: Looking Beyond The Turning Point

[216] In pharma M&A, 2015 trumps red-hot 2014 so far, report says

[217] 100 of the largest hospitals and health systems in America | 2019

[218] Who owns HCA HOLDINGS Inc?

[219] Who owns Community Health Systems?

[220] Who owns Tenet Healthcare Corporation stock?

[221] Tepper, Jonathan. The Myth of Capitalism: Monopolies and the Death of Competition (2018). p.130

[222] 2018 MDM Market Leaders | Top Pharmaceutical Distributors