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USA

# Lean & Mean Health Care

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**Writers in Alternative Left media – e.g. Socialist Worker, Labor Notes, Jacobin and Truth Dig – have reported on what the Affordable Care Act (ACA) will mean for health care consumers (the individual family or individual shopfloor) when they sign up for health insurance.**

Their reporting is thorough, but limited to how the law looks from the perspective of consumers. From this angle, the ACA appears as yet one more way for monopolies to charge their customers more, with inflated costs and inferior quality.

I hope to offer a more synoptic view of three parts of the healthcare system – healthcare production, healthcare “commerce” and healthcare finance – to situate the Affordable Care Act within the context of recent and potential changes in the industry as a whole.

Looking first at reforms aimed at “providers” – the collective name for hospitals, clinics and independent practices – we can see a longer-term trend of state regulation, standardization and consolidation of the production of U.S. health care.

Providers are developing new forms of metropolitan networks and responsive information technology to coordinate health care delivery in a way that resembles just-in-time, lean production in the manufacturing industries. But these new initiatives – and health production as a whole – will stop dead if the cash flow for the industry isn’t standardized and consolidated, too.

For this reason, ACA attempts to reform some of the industry’s largest “payers” (private insurance companies and Medicaid). Like leveling the grade in order to lay down train tracks, the Affordable Care Act grades patients and their contracts in order to smooth out the distribution of health care throughout the just-in-time healthcare system. Even though this is done to avert a potential blockage in the healthcare industry’s cash flow, it could lead to even larger financial instabilities down the road.

## “Reforming” Healthcare Production

In a puff piece for The New York Times Magazine (November 3, 2013), Adam Davidson (from NPR’s Planet Money) reports on the capitalist entrepreneurship at the heart of the ACA, with the critical depth of a cotton swab – but for all its blindspots, his piece is looking in the right direction.

One source, Elizabeth Fowler, who helped design the ACA as a cost-saving and competition-increasing policy while working in Senator Max Baucus’ office, says, “Everybody is focused on the coverage angle, but the changes in the law designed to address cost could be a bigger and longer-lasting change.” (Davidson neglects to report that Fowler is also, according to Truth Out, “an insurance company executive from Wellpoint ... hired by Obama’s HHS [Department of Health and Human Services] to implement the law and now works for a pharmaceutical giant.”)

One such federal initiative is the Patient-Centered Medical Home (PCMH), a cozy euphemism for the large-scale vertical integration of the health care industry. The Agency for Healthcare Research and Quality is pushing it as a

method for “transforming how primary care is organized and delivered.” The initiative intends that the disparate medical offices through which a patient receives care become “centered” around the patient, requiring the cooperation and collusion of these formerly separate providers on a metropolitan level.

The federal government will even directly fund health care companies if they join together under regulated cartels called Accountable Care Organizations. Many large corporations, moved by the state-backed spirit of cooperation, have been inspired into what Forbes calls a “mergers and acquisitions frenzy” in the wake of ACA’s passage.

## “Coordinated Care”

Initiatives like this, often called “coordinated care,” aim to redefine the flow of patients through the healthcare delivery system in much the same way that lean, just-in-time production has redefined the flow of commodities through the global supply chain. In Charlie Post and Jane Slaughter’s words, manufacturers speed up work and cut down inventories by making sure “each phase of the production process is tightly synchronized with the next.”

Healthcare CEOs are exhorting each other to apply manufacturers’ lean methods to streamline use of medical equipment and supplies. The lean lessons of the Toyota Production System have been carefully studied by health informatics researchers and the National Institutes of Health, and applied in hospitals around the country.

Like lean production, coordinated care moves the patient through the health care system with much higher efficiencies. Patients may notice this more efficient care, but what appears as coordination or integration from the perspective of capital looks more like a disintegration from the perspective of patients and workers.

Industrial healthcare delivery requires a series of workers who can provide direct care for the patient or regulate the flow of patients through the clinic or hospital. PCMH will multiply this division of labor, creating new steps in the patient flow.

For example, after a doctor tells a Medicaid patient that they need an X-ray, a referral coordinator might be on hand to coordinate between the workers at the Medicaid office and the workers at the radiology department.

Under this multiplied division of labor, the patients may know nothing about this work happening behind the scenes, and the workers themselves may only know their own particular part in the chain. Nobody except the referral coordinator can determine which hospital the patient will be referred to, and the referral coordinator may know little else about the patient’s care.

This de-skilling of healthcare work — another component of lean production — may happen at every point in the patient flow, from the front desk to the operating room. The just-in-time vertical integration of healthcare requires a disintegration of the patient experience too. As care becomes more coordinated, the workers might move the patient along virtually, their chart and paperwork sent between workers at, say, the clinic, Medicaid office, and hospital. The patient herself also has less of an active role in her own health, and even less understanding of the whole process.

The patient and her virtual health can move independently of each other, the latter spirited away while the former follows in its wake. Along the way, glimpses of the patient’s health will appear to her through the intermediary and inscrutable products that her chart leaves behind: a Medicaid card, a referral, a diagnosis, a prescription, a drug. If she asks the workers to help decipher these hieroglyphs, the workers might be just as clueless about the process beyond the limited horizon of their position.

This suggests a limit to how lean production can be applied to the healthcare system. If lean healthcare hinges its profit margins on the ability to coordinate patients, what happens when patients want a say in that coordination, or make their own decisions? When patients decide to skip appointments or not to be “compliant,” it can threaten the provider’s bottom line.

Lean production relies upon directing passive goods at the speed of information, while healthcare struggles with patient self-management and “compliance,” pulling a lean healthcare system in two, contradictory directions. As I’ll argue below, the Affordable Care Act attempts to resolve this contradiction in capital’s favor.

## Clinics as Pit Crews

Despite all the above, tangible material benefits do result from a health care industry developed by capital. Even if patients are only presented with their health as a final product, they may still notice that the product is more efficiently produced and of higher quality than they would have received in a less developed system. As an ideal, the patient’s medical chart would move seamlessly from doctor’s office to doctor’s office, and mistakes would decrease.

Healthcare reformers are quick to emphasize that more than just lives will be saved, money and time will be saved too. (Neo)liberal darling Atul Gawande, when receiving an award from the main PCMH-accreditation body, the National Committee for Quality Assurance, compared it and similar NCQA approaches to turning clinics into pit crews. Writing for the New Yorker, he turns a pleasant family trip to the Cheesecake Factory into an epiphany for “large-scale, production-line medicine.”

Here we can see the danger of a half-critical, consumer-side approach to the ACA. The liberal demands for an efficient healthcare system and for controlling costs “if they do not include demands for increased worker and patient control over the system” could become the justification for treating patient flow as an assembly line, turning health workers into mechanics, and patients into lug nuts.

Meanwhile, efficiency as a whole may increase, but even a healthcare system that efficiently adapts to its own anarchic, market forces will be less efficient than one where patients and workers are developed to be conscious participants.

In a video explaining the role of NCQA, Gawande said, “We need to be able to have ways that you can see whether your local system is succeeding or failing.” Of course, we’d all like a transparent system, but transparent for whom?

Gawande would limit this need to transparency for technocrats and investors who can correctly allocate resources, even if this transparency leads to further opacity for workers and patients themselves.

Meanwhile those teachers, students and parents fighting for public education will recognize the coded language of “school failure” determined by outside, privatized accreditation bodies. And healthcare workers and patients in the coming fight against “healthcare reform” will have a lot to learn from the students and teachers fighting against “education reform.”

To achieve its goals for coordinated care, the healthcare system requires seamless coordination of formerly disconnected information systems. If standardized testing is the bureaucratic linchpin of education reform, the linchpin for healthcare reform will be electronic health records.

AHRQ argues, "Health IT can support the PCMH model by collecting, storing, and managing personal health information, as well as aggregate data that can be used to improve processes and outcomes. Health IT can also support communication, clinical decisionmaking, and patient self-management."

To encourage the expansion of EHR, the Centers for Medicare and Medicaid Services (CMS) introduced Meaningful Use, a method to track the clinical experience. Aside from being a source of frustration to clinical workers when the record system crashes with a packed waiting room, Meaningful Use has far more exploitative effects on healthcare delivery and coordination.

Patient care is reduced to ticking off checklists, helping to replace all healthcare workers with less skilled, less expensive staff. In addition, electric health records provide a full range of surveillance tools for Taylorizing the clinic floor. Post and Slaughter note the role that technology and computerization plays in creating a "lean workplace," replacing expert workers with "expert programs." Add some employer subsidies and incentives for rolling out these programs, and the meaning of Meaningful Use is clear: profit.

## Potential and Reality

To be sure, PCMH and Meaningful Use can be real advancements. We all want to be healthy as quickly and completely as possible, and quality health care would seem to be the best way to achieve that, for as many people as possible. The automation of public health through electric records can be the basis for developing radical advancements in social health. The potential of the coordination and information technology mentioned above would be immense, if it were under the control of patients and workers.

The public health practitioners who are implementing these systems, however, regardless of their personal politics or ideals, are largely employed by private companies most concerned with maximizing profits, or governments most concerned with cutting costs. As long as capital hires the workers, owns their tools and regulates their usage, the public health outcomes will always be secondary to capital accumulation.

In our current system, what "healthy" means is determined by what clinics, hospitals and insurance companies agree is normal for you and your body. This has the potential to undercut, for example, the struggles of feminists and trans activists for control of their own bodies, in favor of distant and technocratic financial considerations. Monthly insurance premiums only promise you the right to live at a certain level of health, and to live in your body in a certain way, on a month-to-month basis. These levels and ways of living are determined by deductibles, not democracy.

PCMH may put patients at the center, if only because those patients bear a peculiarly profitable commodity, health, in their bodies. Writing about similar industrialization processes in the Socialist Register (2010) volume "Morbid Symptoms," Rodney Loepky explains how the health industry is unique in the sort of basis it hopes to provide for a "new economy" and national wealth:

"Health represents a domain in which the maximization of returns appears limitless. There is neither a ceiling for how healthy societies should be, nor a shortage of medical conditions — real or contrived — that require diagnosis and (preferably prolonged) treatment... The various components of the health industry enjoy the luxury of self-identifying as social actors who are first and foremost in the business of meeting human needs, obscuring the reality of their enormous returns on investment and being able to represent these, when they are noticed, as being of secondary importance. Who, after all, can be against the pursuit of health?"

Often quality health care is seen as the solution to social problems. Unfortunately, the focus on quality healthcare can give a pass to what that healthcare is healing: often the slow violence of overwork or unemployment, or of living in the runoff stream of a capitalist ecological system. An injury to all cannot be solved by bandaids for each. Even the focus on prevention built into the PCMH model will never take the political step of actually preventing the real, economic causes of the majority of the world's sickness and injury.

# Reforming Healthcare Commerce

Instead of taking us a political step forward, the Affordable Care Act will take a deeper step into just-in-time healthcare by standardizing and consolidating its cash flow.

For the work that happens in hospitals or clinics to continue, those services need to be bought and paid for. In America's multiple-payer system, private insurance companies and the federal Centers for Medicare & Medicaid Services form the multi-chambered heart of the healthcare industry, pumping a steady flow of payments through the entire social organism.

Payers oversee the commercial exchange of cash and claims, paying for the healthcare services and regulating their distribution, functionally analogous to the wholesalers and retailers that handle commerce and distribution of consumer goods.

But sometimes the money flow between the payers' commercial exchange and the providers' production gets out of whack. Obstructions to a steady flow can cause a crisis, and sometimes become too big for any one payer to handle. As one example, Adam Davidson parrots Republicans who have blamed the government for its Medicare fee-for-service model. The ACA will attempt to address fee-for-service as one of the market forces that has allowed exchange value to go too far astray from what is socially necessary in the healthcare system.

While designing the ACA, Obama sat down with other payers and healthcare providers to figure out how to handle another of the big obstructions to the industry's capital flow: uninsured patients.

From the perspective of a commodified health system, uninsured who can't pay for the healthcare they receive are seen as an economic blockage. They're talked about as clogs that jam up the ER waiting rooms, even though they result from the same anarchic, market forces that produced those ER departments and fills them with medical emergencies.

They're described as unable to get preventive services, which creates problems that "pile up" and become more expensive. What starts as sediment from the healthy capital flow of the health industry calcifies into a foreign mass that needs to be amputated or integrated for the organism to survive. From the perspective of capital flows, the uninsured are kidney stones, blood clots.

ObamaCare will address the issue of uninsured people but what sort of issue is this, a medical or a social one?

Some show sympathy for the uninsured by describing them as simply unfortunate, like the victims of a rare degenerative disease, when they are in fact the direct result of the capitalist insurance system. They result from socially produced inequalities, not random afflictions. A post-capitalist healthcare system will need to address the latter and their higher medical costs, but until then we should try our best to differentiate the pathologies of our social structure from those of our biology.

The Center for Medicare and Medical Services' own estimates show that 48% of uninsured adults are healthy and young, and 54% of those individuals say that premium costs are a main reason that they don't buy health insurance. (Of those healthy and young uninsured, 9.3% have now been officially identified by federal agencies as "Hipsters," a much-blogged about target for ACA.) In fact, other segments of the uninsured are even more emphatic that the cost of health insurance is what keeps them from enrolling.

Regardless of these facts, CMS provides official marketing resources that suggest the uninsured are simply unwilling to buy insurance, needing either to be convinced or, for those who won't listen to reason, penalized come tax time. To make them listen, the ACA has provided federal and state grants to providers and other nonprofits to hire navigators and steer people towards private insurance contracts offered on the Marketplace website.

Navigators, though they are essentially insurance brokers, don't receive a commission; their bosses are compensated for meeting the enrollment quotas in their grant requirements. The navigator's role, however, is limited and transitional; at bottom, they are training patients on managing their own user account on the Health Insurance Marketplace, how to buy their own contracts, how to manage their own health information. They are even asked to train mothers to broker insurance to their uninsured adult children.

## Patient, Manage Thyself

Lean production often includes workers in the "speeding up of their own jobs, through task forces and teams," write Post and Slaughter. That is definitely true in healthcare, as seen in PCMH and the related ideal of "team-based care." In addition, however, patients are included as part of the team, joining the team and managing their own health.

Ultimately, that's how the ACA plans to integrate those stubborn uninsured patients. When insurance companies underwrite a contract, they collect personal information about the uninsured, calculate the risks and then set their costs accordingly. With the Marketplace, the underwriting of health insurance is internalized into a website and calculated according to pre-set costs in real time "if you log on during off-peak hours like one in the morning.

This automated underwriting prevents discrimination through internalized regulations, and standardizes output through different tiers of contracts: Catastrophic, Bronze, Silver, Gold or Platinum. Aside from possibly a navigator who may help the uninsured patient complete and submit their application, no humans intervene between the patient and the insurance company "or in the case of the ACA's Medicaid expansion, the government.

By replacing the insurance brokers and public aid office workers "many of whom may be unionized women of color" with websites, the ACA also removes the element of human discretion, cutting out any supplicating power that the applicant may have. Inhospitable Medicaid enrollment websites prevent any sort of Cloward-Piven strategy of demanding public aid office workers to enroll mothers and address their needs. Instead, patients must be their own advocates as they face massive corporations and anonymous government departments, given only the options to apply for or appeal their eligibility. In checkboxes, no one can hear you scream.

What's more, by discounting insurance patients who manage their own health, ACA is also encouraging patients to become their own health workers. In essence, patients in wellness programs and facing penalties for tobacco use are being paid to manage their own health. This resolves somewhat the contradiction between a just-in-time healthcare system that must coordinate the mobility of patients as passive containers while subject to the automobility of the autonomous patient "but it resolves the contradiction by internalizing it in the patient.

Making patients look after their own health as a commodity puts them in an alienated relationship to this expensive thing contained within their body. Further disintegrating the patient's experience, insurance capital opens up a rift between me-as-health manager and me-as-body, and inserts a contract in the middle of the two. In *Limits to Capital*, David Harvey describes financial capital as the central nervous system of capitalist society, but what does it mean when financial capital fuses with the central nervous system of my body?

I will then be examining every part of myself that needs care – my teeth, my feet, my mental state – through the eyes of the insurance company, what I think they would deem medically necessary, and what the contract has decided I should pay for that body part. I relate to each part of my body not as a metaphysical relation to myself, but as a financial relation between my bank account and my organs, as a relation between money and commodities, a relation between things and things, reified innards vertically integrated into reified healthcare bureaucracies.

The ACA, together with online wellness programs and Meaningful Use, creates the framework for a lean, just-in-time healthcare bureaucracy – responsive not only to patients' vitals but also to the sudden crises and fissures that regularly appear between exchange and production. De-skilled office workers, who previously mitigated those fissures and moved the cash flow along, are replaced with patients processing their own paperwork.

It may seem like this grants patients more autonomy over their own health. But the information I provide is placed into computer systems – such as Healthcare.gov and new Medicaid electronic eligibility systems – for centralized decisions, and the health professionals who could once advocate for me are weakened and deprofessionalized. Insurance companies can depend on us self-help patients to mitigate crises and ruptures because our health is entwined with the health of the industry as a whole.

## How “Efficient” Is It?

Adam Davidson lauds the ACA as the culmination of fifty years of healthcare policy intended “to make health care mimic other efficient markets.” Letting slide the dubious fiction of “efficient” markets, what will be the likely outcome of this financialization of healthcare?

Fifty years ago, government policies also stepped in to make the mortgage market efficient enough for expansion, creating Fannie Mae and Freddie Mac, standardizing, rating and consolidating mortgage contracts, all of which led to the pooling, securitization and over-extension of these contracts.

After 50 years of accelerating credit flow, that market suddenly froze and contorted in a financial crisis. Is it too much of a leap to imagine that the standardized contracts that we're buying on the Marketplace today – tranches into “metal” classes like the rating system that buttressed the secondary mortgage market – will be bundled and sold, and then cut and re-bundled and re-sold?

Risk-taking investors may even squeeze every drop of profit out of subprime catastrophic plans, the way investors bought shares of weird derivatives (CDOs and MBS's) in the subprime mortgage market. Insurance premiums, like payments on housing debt and other “fictitious” capital, are an income stream that doesn't actually grow the GDP or add to the fundamentals of the economy, very easily lending itself to speculation and over-leveraging.

Securitization hasn't hit the health insurance industry yet, but there's been peer pressure from industries on both the “health” and the “insurance” flanks. On the health care side, providers are securitizing their receivables, bundling claims on money that they get for their services. Finance lawyer and Duke University professor Steven Schwarcz



wrote during the housing securitization boom of the 1990s that hospitals are among “the most promising candidates for securitization.”

On the insurance side, there has been an uptick in the securitization of life, catastrophe and property-casualty insurance since 2008, prompting handwringing from the mainstream media still unable to understand why the last financial crisis happened.

Even more worrying, the descriptions of legal and economic obstacles to these trends reads like a description of recent health reforms written in reverse.

Schwarcz notes that originators of securities need to be adequately rated before investors will get in on bundling up those “most promising” promises to pay. Other lawyers writing for “Securitization Conduit” in 2000 estimated that “as health care providers consolidate and fully integrate their management information systems (including on-line, real time, accounts receivables systems) and more health care payments are made based on preset and nationally standardized reimbursement rates, more providers are likely to consider securitizing their health care receivables.”

Federal laws prevent securitizing MediCare and Medicaid payments to health care providers, or laws like HIPAA (Health Insurance Portability and Accountability Act) aim to prevent the sharing of private health information, but law firms are researching how to accommodate both the letter of the law and the wallet of the investor.

More recently, a Goldman Sachs investment analyst, who views insurance securitization “as an accelerating convergence of finance and insurance,” wrote up a wish list so that insurance securitization can “flourish to the extent that the [recently crashed] asset-backed markets have,” in particular “increased transparency, better standardization of modeling techniques, and an improved secondary market.”

These wishes for increased rating, integration and standardization have been acted on in recent years, perhaps in order to satisfy finance capital’s prerequisites. With the standardized, bronze-to-platinum contract rating system built into the ACA so closely resembling Freddie and Fannie’s ratings of home loans, it is easy to imagine the securitization of health insurance contracts, moving from the health production to the commercial exchange part of the industry.

Eventually this capital accumulation could throw exchange and production out of whack once more. What happens when all of a sudden, people realize they can’t pay their premiums or out-of-pocket costs anymore, and break their contracts? Or what happens to all that capital investment when the Baby Boom generation passes away, and that surge in patient flow peters out?

If financial analysts couldn’t manage the systemic risk generated by algorithms and computer models anchored in the housing market, a human-made and human-unmade phenomenon, could we expect those models to do any better predicting a market where the underlying fundamentals “the stochastic (probabilistic ed.) biochemical and epidemiological processes that shape public health” are riddled with innumerable mysteries, unexplainable by human knowledge?

Given that some financial corporations, such as Blackstone Group, have profited from both the ACA mergers and acquisition frenzy and post-crisis land grabs, it is likely that health insurance securitization would be built upon the same base of information technologies and institutions as the last crisis, with equally unforeseen consequences.

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