Involuntary Manslaughter: The Danger of Healthcare as a Privilege in American Domestic Policy

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Noah Benjamin Stern

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On my honor as a University Student, I have neither given nor received unauthorized aid on this assignment as defined by the Honor Guidelines for Thesis-Related Assignments

Advisor

Kathryn A. Neeley, Associate Professor of STS, Department of Engineering and Society

Involuntary Manslaughter: The unlawful killing of another human being without specific intent. – United States Department of Justice

Introduction – The United States is Falling Behind

According to the United States Centers for Medicare and Medicaid (2019), in the United States alone, healthcare is a multi-trillion-dollar industry. Within it is a massive network of insurance plans, hospitals, medical practices, and patients. On top of providing healthcare, billions more go in to investments for medical research(Viergever & Hendriks, 2016). In fact, data from UNESCO shows that the United States spends $100 billion dollars more than any other nation on medical research and the World Bank shows that United States has the highest healthcare expenditures per capita of any nation on Earth(UNESCO, 2019; World Bank, 2016). Despite leading the world in research and healthcare spending, the World Health Organization (WHO) reports, shown in Figure 1 below, that amongst developed nations the United States ranks 26th in life expectancy and overall health.

Figure 1: Despite leading the way in spending and research, the USA ranks

Across American politics, the solution to this growing discrepancy has been to double down and increase spending even more. Lost in this cycle, is the perspective of often marginalized lower-income areas. Research has shown that poorer communities do not receive care to the same extent as wealthier communities and this is a major contributor not only to lower life expectancy in the nation overall, but also to an increasing "healthcare gap" (Reitman, 2016, n.p.; Ross, 2018, n.p.). In the journal of American Medicine, Dr. Patricia Gabow writes that the "healthcare gap", or an inequality in healthcare provision, is the result of a host of socioeconomic, racial, and gender related factors that limit care to many Americans(Gabow, 2016, pp. 1337-1340). In essence, factors like socioeconomic status are a strong determinant of

overall health and data shows that those in worse socioeconomic conditions are disproportionately affected by life-threatening, yet preventable health concerns (Riley, 2012, pp 167-172; Shaw, 2016, n.p.). Despite ever-increasing spending and legislation targeted at eliminating the monetary burden surrounding healthcare, it does not appear that success has been achieved in closing the gap. After years of constant failure, these misguided efforts border on negligence and are costing countless lives. This suggests there is a much deeper issue surrounding how Americans view and provide healthcare. In this paper, I argue that this deeper issue is the widespread philosophy within the United States that healthcare is an exclusive privilege and that this view has led to catastrophic effects in the provision of healthcare across the United States. Further, I believe the best way to close the growing healthcare gap, and therefore help improve the overall health of the nation, is to recognize the effects this philosophy has on American society and to look externally to find remedies for this situation.

THE PROBLEMS IN AMERICAN HEALTHCARE GO DEEPER THAN MONEY

In America, where healthcare is mostly privatized, higher income is associated with better medical care. With the introduction of Medicare, Medicaid and the Affordable Care Act, the goal was to ensure more people could afford healthcare. Despite countless pieces of legislation surrounding healthcare spending within the United States, higher quality care is still disproportionately received by higher income people (Chernew et al., 2005, n.p.; Manchikanti et al., 2017, pp. 111-138; Schoen et al., 2013, n.p). This contributes to a growing disparity in overall health between low, middle, and high-income communities.

When listening to any campaign speech, political talk-show, or debate stage it is a guarantee that someone will say the key to healthcare in low-income areas is making it more affordable. However, if any attempt to actually include low-income community members in this

discussion were made and politicians recognized their focus on money only contributes to this growing disconnect, the issues would shift beyond just affordability and begin to include more important beliefs surrounding how care should be provided. Many of these issues can be broken down into three categories: *quality*, *accessibility*, and *trustworthiness*.

Low Quality Care for Low-Income Americans

Higher quality healthcare is the goal for everyone, yet economic feasibility has contributed to a gap in quality of care directly related to a person's socioeconomic status. The Affordable Care Act was introduced to ensure that everyone had a healthcare plan, yet more access has not equated with higher quality care for all. Per the United States Department of Health and Human Services, black and Hispanic Americans consistently receive lower quality care. Even more striking, is that 70% of members of low-income communities received worse medical care than high income community members (United States Department of Health and Human Services, 2016, n.p.). One potential explanation comes from a study that found that living in a low-income community was associated with "lower reliance on physician's offices" and a "greater reliance on community health centers"(Hussein et al., 2016, pp. 1041). Despite being able to receive higher quality care from a trained physician, members of low-income communities are more likely to seek out the more comfortable out-patient nature of a community clinic. Recent legislation has helped lessen the economic burden of quality medical care, yet to ensure quality healthcare is sought out it is equally important that members of the community see the advantage of higher quality care on top of it being both socially and culturally-friendly. Without making these provisions to ensure lower income people find their best options, the system is dooming these people to more life-threatening situations.

Low Accessibility for Low-Income Americans

Those who seek out healthcare receive lower quality care, yet some people do not have the opportunity to receive care at all because of factors limiting its accessibility. Members of low-income communities often work multiple jobs and can not take time off. As shown below in Figure 2, in the United States, medical care is much more accessible to wealthy people than poor people. Studies show that the inability to take time off and lacking the economic means to find childcare if necessary are major barriers to low-income patients (Birs et al., 2016, n.p.). An even larger contributing factor is that many people rely on public transportation (Syed et al., 2013, n.p.). People in these communities thus have very high rates of missed appointments and struggle to schedule them in the first place. Even if people want to receive care, they do not have the means to go get it. If they were to seek out care, they would risk losing their jobs, leaving their children alone, and taking long hours to get to their destination. In order for any progress to be made towards improving healthcare in the United States, members of low-income communities must be included in finding ways to ensure everyone can actually reach their care provider. If steps are not taken to include the needs of low-income community members, not only is the

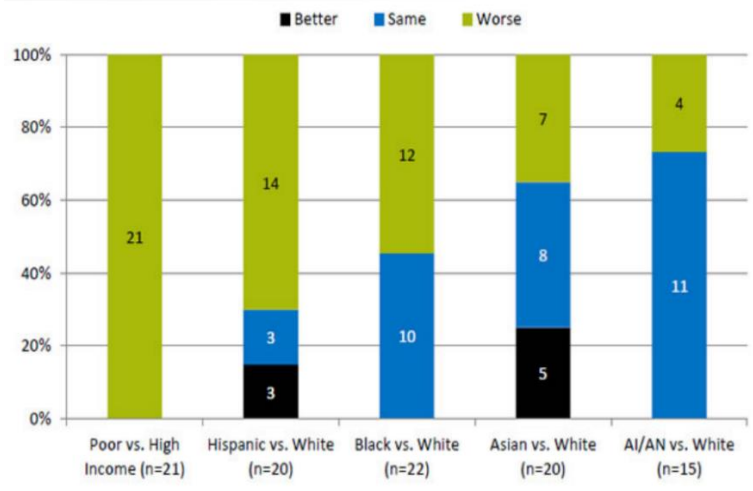


Figure 2: *Percentage of People who Experienced, Better, Same, Or Worse Access to Care.* In the United States, poor people have worse access to medical care than wealthier people. In general, white people had the best access to care, with hispanic and black people having the worst access. (United States Department of

ceaseless discussion of the economics a waste of time, but also is a sign that the government is passively remaining ignorant and neglecting its people.

Lack of Trust from Low-Income Patients

Even when patients have the means to seek out care, many still do not due to lack of trust in the medical community. In the United States, many members of low-income communities are immigrants who are both documented and undocumented. In recent years, as the Immigration and Customs Enforcement Agency (ICE) has grown bolder, many undocumented immigrants are afraid to seek out medical care because they fear deportation (Machado, 2014, n.p.). One woman said that her family is "afraid of maybe getting sick or getting into an accident, but the fear of [her] husband being deported is bigger" while another is about to "forgo chemotherapy because [she] had a child that was not here legally" (Kennedy, 2018, n.p.). On top of the fear of harassment or even deportation, there often exists a potentially dangerous language barrier, as English is not a primary language for many immigrants. Language barriers between healthcare providers and patients not only raise the chances for a misdiagnosis, but also contribute to a lack of respect and amicability (Meuter et al., 2015, n.p.). Fear or a language barrier should never outweigh the desire to seek medical care, yet that consistently occurs in the United States. Not only is the failure to include the needs of immigrants negligent and dangerous to their futures, but also the fact that the government supports and enforces the persecution of these immigrants is evidence of the American people's apathy to providing care for those in need.

This widespread failure in the provision of adequate medical care to the American people coupled with the fact that Americans pay more and invest more than anyone else in medical fields demonstrates that there is an institutional problem that is not being addressed. Despite stressing the values of equality, the actions of policymakers and the American people who turn a

blind eye suggest that they believe equality is not important in healthcare and should remain a privilege for the wealthy.

THERE ARE LESSONS TO LEARN BEYOND ECONOMICS IN SPAIN AND THE USA

In his, *American and Dutch Coastal Engineering: Differences in Risk Conception and Differences in Technological Culture*, Wiebe Bijker gives his thoughts on how American coastal engineers presided over a colossal failure of stormwater infrastructure in New Orleans during and in the aftermath of Hurricane Katrina in 2005(Bijker, 2007). Bijker opens by asking how the Americans could fail so drastically while "the Netherlands can exist below sea level" and has existed that way for years. To answer this question and to go beyond the superficial accounts of technical and organizational failure common in months and years after the disaster, Bijker uses two sources, one American and one Dutch, to compare the styles of the two nations' coastal engineers. Through his analysis, Bijker comes to the conclusion that the failure was not due to a discrepancy in "expertise and competence," but due to a cultural difference in how the nations viewed risk management.

In this paper, I intend to follow the same style as Bijker as I look into the institutional failure of the United States in providing adequate healthcare to its citizens. In my analysis, I will use two comprehensive reviews of healthcare, one of the United States (Rice et al., 2013) and one of Spain (Bernal-Delgado et al., 2018). These reviews, written by a coalition of leading public heath faculty are published by the World Health Organization every few years. It is essential to point out that both nations provide healthcare through two different economic systems, have wildly different histories, and have very different priorities and populaces. It is because of these reasons, that it is unfair to say one system would undoubtedly be better than the other, yet many of the discrepancies seen can be used to identify distinct cultural philosophies.

Like Bijker, I intend to argue that the discrepancy between these two nations is not solely the result of economics and historical decisions, but actually a widespread cultural difference in how the nations perceive the provision of healthcare.

Planning for the Future

From reading these two reports, it becomes immediately evident that the nations have a different philosophy on how to best improve and plan the future of healthcare within their respective nations. The coalition observing the United States notes that "compared to other countries, there is little coordinated system-level planning in the United States" and when it comes to looking to the future, "policy-makers associate planning with a comprehensive method, rather than the incremental one they prefer." This is far different than the Spanish approach, where "the locus for planning and regulation resides essentially in the Ministry of Health when it comes to nationwide laws and plans, and lays on the Departments of Health of the 17 ACs when it comes to the local implementation of national laws or plans, or the development of regional regulation and policies, within their legally bound attributions." Where the United States, avoids large-scale planning in favor of more incremental changes to care, the Spanish have detailed regulations regarding how large-scale changes are planned at a federal level and local municipalities are encouraged to adjust as they see fit. Throughout American politics, it is noted that "the conviction is widespread that incrementalism is the best way to proceed" as "planning also interferes with the give and take of behind-the-scenes negotiations that typically go into formulating policy in the United States." While across the Atlantic, Spain's "Ministry of Health in coordination with the 17 [local states], has been developing and implementing a number of "Health Strategies" aimed at increasing a more homogeneous response of the health system across the country." In the United States, philosophy has it such that healthcare is changed

incrementally and reactionarily, while in Spain, healthcare is planned years in advance and is implemented external to political decisions.

Treatment of Immigrants

Within the two nation's policies on the treatment of immigrants, it is clear that they have different ideas on who deserves healthcare. In the United States, sweeping legislation like Medicare, Medicaid, and the Affordable Care Act (ACA) have made important first steps in the push to improve healthcare coverage, but are still lacking in their provisions for its lowest-income residents and immigrants. Policies related to Medicaid "do not cover undocumented residents, nor are states required to cover legal residents during their first five years in the United States" and "most of the 30 million who remain uninsured after the ACA will be undocumented immigrants." Not only are undocumented immigrants not covered, but "they are [further] disadvantaged…[as] they are not permitted under the terms of the ACA to buy insurance on the exchanges and if their employers work with the exchanges to insure their employees, undocumented workers will be excluded."

Undocumented immigrants are treated differently in Spain. The excerpt below refers to healthcare entitlements and is taken from recent legislation passed in Spain in collaboration with the rest of the EU.

> "(a) people residing and working permanently in Spain received the same entitlement enjoyed by Spaniards; (b) EU citizens and people from countries with bilateral agreements, were entitled to receive the benefits although remained insured according to their national insurance schemes; and (c) only registered undocumented immigrants with annual incomes equal to or lower than the minimum interprofessional wage enjoyed full entitlement."

Built into Spanish law are provisions that ensure healthcare is received by the lowest income residents and immigrants permanently working. In fact, later it also states that in cases where people fall out of these coverage guidelines "emergency care, obstetric, and pediatric care [are]

still covered." Spain exists in a system where care is almost completely guaranteed no matter the status of the resident, while the United States exists in a system that "has wide variations in health-care spending by state" and where many low-income patients rely on "a variety of indigent and charity care programs." The Spanish view healthcare as an unalienable social good, while the United States sees it as an expensive commodity reserved for the few.

Policymaking Philosophy

As previously discussed, healthcare policy in the United States is the result of incremental change. The coalition examining the United States believes this is the result of "private sector stakeholders play[ing] a stronger role in the US health-care system than in other high-income countries" and the prevalence of private lobbying from healthcare providers. It is known that "lobbying and organized advocacy plays a large and growing role in United States politics, with spending at an estimated $3.5 billion in 2009." Pharmaceutical companies and insurance providers are some of the most notorious lobbyists in modern American politics. In Spain, where coverage is "virtually universal, mainly funded from taxes and predominantly provided within the public sector," there is little room for lobbyists to change how policy is implemented. Further removing themselves from central mandates, local governments purchase services from regional providers, integrate them into their plans and "negotiate global annual contracts with [their] integrated providers, primary care centers and hospitals and allocates lump-sum budgets." Local autonomy limits the amount of control large companies can exert on the provision of healthcare and makes policy less reactionary to political and economic stability. This means that in Spain, "despite the vast impact of the [recent] financial and economic crisis, and the austerity measures taken, it did not have any substantial short-term impact on health outcomes." Once again, within the United States, healthcare is not always available and can be

easily molded by large corporations, while in Spain, healthcare is guaranteed and not at the mercy of a multi-billion-dollar industry.

PHILOSOPHICAL CHANGE SHOWS A NEW PATH FOR HEALTHCARE POLICY

From this discussion, it should be clear to the reader that there is widespread inequality in the United States that pervades through society. The provision of healthcare is not excused from this rampant inequality, as the nation that leads the world in spending, research, and expertise consistently falls far behind. Some chalk it up to misallocation of funds, but what has become apparent is that the reason for this laughable gap in coverage is an institutionalized view in the United States that healthcare is a *privilege* for the few who have the means to seek it out and not a *right* for everyone who needs it.

Despite consistent legislation that has attempted to take the economic burden off of the American people, roadblocks are still present for the poorest Americans. Members of low-income communities may be able to pay for healthcare under Medicaid and the ACA, but the quality of care they receive will be worse than members of wealthy communities. Very few doctors seek to setup a practice in lower income areas and those that do are overworked, understaffed, and underequipped. No effort has been made to ensure that America's poorest communities have quality care, because policymakers believe it is sufficient to merely cover the cost and then let the people fend for themselves.

Beyond the lack of quality care, many of the lowest income people in the United States have no means of making it to their healthcare professionals even if they want to. These people rely on public transportation or have long working hours that prevent them from seeking out care. In many cases, health insurance is tied to their employment, yet they risk losing their jobs, and thus their healthcare, if they take time off of work to exercise their access to a doctor. This

absurd and paradoxical nature of healthcare access leaves low-income patients paralyzed and unable to actually seek care. Again, little has been done to help patients get to their appointments or take time off, that privilege is only enjoyed by people with their own vehicle, a higher quality job, or an employer that recognizes the humanity of their employees.

To many more, the problems of low quality and little accessibility have not even been encountered because they are much more worried about being able to safely leave their homes. American society exists in a state where undocumented immigrants are forgoing life-saving treatment like chemotherapy or are skipping out on emergency services because they fear being deported. This may be the most blatantly obvious example of healthcare as a privilege over a right, yet no one is talking about it, let alone discussing ways to address it. As noted previously, in Spain and many other developed nations, undocumented immigrants are ensured basic care no questions asked. While in the United States, undocumented immigrants are not even mentioned in healthcare legislation and are instead villainized by the legislators who represent the communities they live in.

These dangerous conditions and situations that low-income people are forced to live in are the result of this perspective that healthcare is a privilege. Politicians in the United States exist in a perpetual election cycle, and more often than not, the winners are determined by who has the larger monetary backing. In every aspect of American politics, those with money have the power to determine which policies are implemented. Through lobbyists, corporations and political groups can sway policymakers towards the views of their employers. In essence, the privileged few with power can and will maintain the status quo that allowed them to accrue power in the first place. They are responsible for the lack of comprehensive healthcare planning which are commonly seen in EU nations like Spain, as they are much more difficult to fund and

promote than the incremental and reactionary proposals that are more prevalent in American politics.

Where other nations have localized the provision of care to smaller regions within their nations, the reliance on lobbyists has kept the United States stagnant. As seen in Spain, the localization of care allows for individual regions to implement the best possible plans for themselves based on their own research and input from their communities. In the United States, there is a massive disconnect between low-income community members and their legislators. Before any progress can be made, this breakdown in communication must be remedied, and hopefully policymakers can begin to see their misplaced focus. This localization also means that lobbyists are much less prevalent and large companies have less power because each region gets to manage how their funding is allocated and each will have different goals. Allowing those with money to control how care is planned allows for the dangerous idea of healthcare as a privilege to diffuse throughout society, whereas nations like Spain, who allow the policymaking power to spread, can maintain healthcare as a right to all members of their nation.

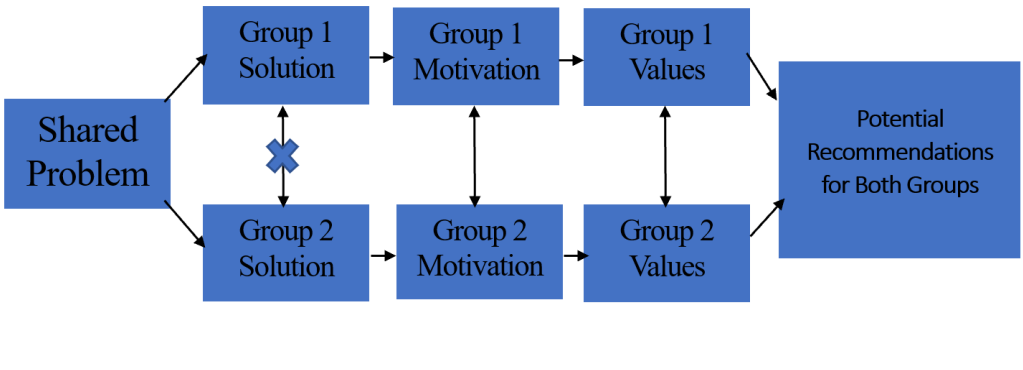


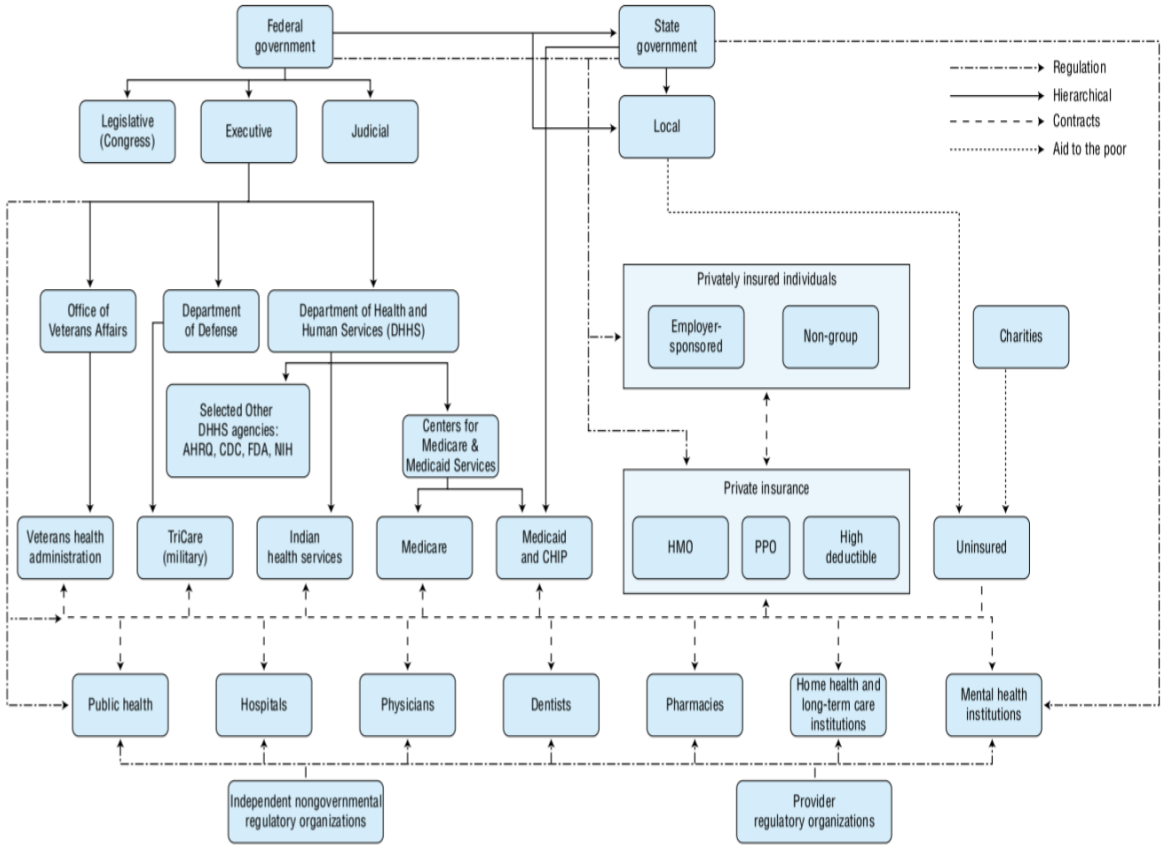
Figure 3: *Methodology.* When two groups with different backgrounds have a shared problem, it is not always viable to compare the two solutions. By first analyzing the motivations, history, and values behind the two group's decisions, it is possible to make more meaningful recommendations for the future.

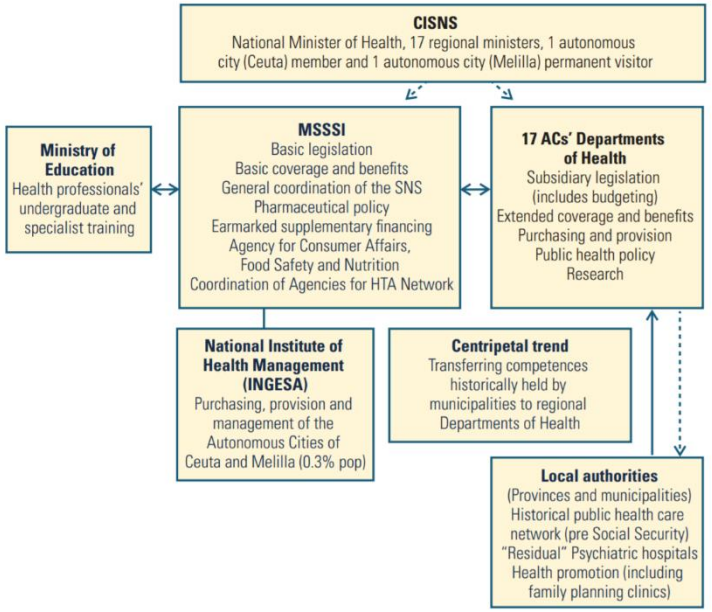
What may not be as clearly uncovered thus far, is the power of Bijker's approach in comparing two differing systems concerned with the same subject. Figure 3, above, shows the power of this approach. It is not always viable, or even appropriate, to compare the two solutions

directly. By first analyzing the motivations, history, and values behind the two group's decisions, it is possible to make more meaningful recommendations for the future. These recommendations will hold more weight and power when it comes to decision-making. Bijker's methodology, as shown in this discussion, can be used to understand deeper motivations behind different groups. Even when two groups or nations are very different his methodology can be used to find differences that go far beyond their superficial economic and structural characteristics. When discussion shifts to the concepts that Bijker's methodology can provide, more important comparisons can be made and in-depth analysis can be performed.

Many people who are unfamiliar with healthcare policy in the United States are quick to assume that the system in place is inferior to all other systems simply because of how it is funded, yet what has become evident from this research and discussion is the far more important and complex difference between the organizational structures of the United States and other nations. On the following page, Figure 4 shows an organizational flowchart of the United States' healthcare system on the left and a corresponding flowchart for Spain on the right. At first glance it should be obvious that the United States has more interconnected actors in its network than the Spanish. Each branch point adds more complexity with some regulating those above and below them, while others like the "Department of Defense" and "Mental Health Institutions" who seem unrelated are just one intermediary apart. With so many actors in this network, it's no wonder that change happens slowly or even not at all. Everything that is done will have an influence on several other actors and must fall in line with a host of sociopolitical factors. Under the Spanish system everything is far more defined roles with a simpler hierarchy. There are fewer actors, but they have more responsibilities. Within the United States' system connections go up and down with different meanings, whereas in the Spanish system power is delegated succinctly top to

Figure 4 – ***Dueling Organizational Structures in the United States and Spain***





bottom. The central government (CISNS) passes legislation that progressively pass down through smaller departments before reaching local communities. In the United States this organizational structure necessitates largescale and coordinated efforts to make even the smallest change, while in Spain a small focused effort can have a lasting effect on healthcare.

Conclusion

The United States Department of Justice defines involuntary manslaughter as "the unlawful killing of a human being" without specific intent (US DOJ, 2015). As discussed, the American healthcare allows, if not encourages, patients to use lower quality care, provides no aid in helping patients seek out their care, and in many cases persecutes people it does not see fit to deserve the privilege of healthcare. Politicians in the United States make no substantial attempts to plan for the future of their healthcare system, consistently take money and defend the views of those who give them most, and actively pass legislation that does not include the lowest income and marginalized members of society. To put it plainly, the United States government is dooming these marginalized members of society to death without proper care. The Constitution states the government is here to protect its people, yet it actively is not. People in the United States are unlawfully dying due to negligence from their own government. Whether or not this truly constitutes as criminal negligence and manslaughter is up to the reader, but from this analysis it should be obvious that a philosophical attitude contrary to American values is contributing to the maintenance of a status quo which keeps low-income people suffering.

If the data and argument presented does not persuade enough, simply look at the rhetoric and efforts from the United States government in response to the COVID-19 pandemic that at the time of writing grips the nation. To no surprise, the United States is lagging incredibly behind in preparedness and efforts to control the spread of the virus. Death tolls in the United States are

higher than other developed nations and politicians would happily risk the lives of their citizens if it would save the economy. It is definitely not a reach to call this negligence and with the death tolls rising it is undoubtedly fair to call this involuntary manslaughter.

If this argument is successfully interpreted by future scholars, there exists the potential for positive development of an otherwise stagnant American healthcare system. They may also expand on Bijker's methodology to further analyze other nations, such that a broader more appropriate system can be developed. Every nation is different, and it is unfair to say that one system will be the best system in every country, but without a doubt, it is useful to understand the philosophies behind policies so that the roots of success and failure can be identified. By first understanding a pervasive philosophy in American culture and recognizing the similarities and differences between the United States and other countries abroad, the American people can begin to come together and build a better healthcare system.

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