The American Wealthcare System

Injustice in Healthcare Through the Lens of COVID-19

Critical Corporate Theory Collection

Author

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About the Critical Corporate Theory Collection

The Critical Corporate Theory Collection is part of the *Systemic Justice Journal*, published by the Systemic Justice Project at Harvard Law School. The Collection is comprised of papers that analyze the role of corporate law in systemic injustices. The authors are Harvard Law students who were enrolled in Professor Jon Hanson's Corporations course in the spring of 2021.

The Collection addresses the premise that corporate law is a core underlying cause of most systemic injustices and social problems we face today. Each article explores how corporate law facilitates the creation and maintenance of institutions with tremendous wealth and power and provides those institutions a shared, single interest in capturing institutions, policies, lawmakers, and norms, which in turn further enhance that power and legitimates its unjust effects in producing systems of oppression and exploitation.

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ABSTRACT

Healthcare in America does not work. The systems and subsystems that comprise American healthcare are run by corporate actors who value money over all else, and as a result maintain oppressive cycles of injustice. These cycles manifest appallingly in lower life expectancies, widespread mental health crises, and perpetual financial subjugation of the indigent, among other things. These effects can be identified and analyzed in fields including but not limited to pharmaceuticals, insurance, physician care, hospital care, and personal protective measures.

The COVID-19 pandemic provides a revealing lens through which the effects of corporate injustice in the realm of healthcare become abundantly, shockingly, clear. Touted originally as a 'great equalizer,' the novel conronavirus instead has demonstrated the cruel machinations of private actors who seek to inflate their pockets at the expense of human, far too often black and brown, life. As humanity emerges from the pandemic, the inequality it so starkly laid bare must not be forgotten, but instead used as a tool by which to influence and inform a progressive path forward.

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INTRODUCTION – STORIES AND STATISTICS

On March 11th, 2020, the World Health Organization declared the novel coronavirus a global pandemic. On March 22nd, Madonna (net worth $550 Million[1]) declared the virus "the great equalizer" while livestreaming from her bathtub, claiming that the virus didn't care "how rich" you are or "where you live."[2] Some perspective: Madonna has spent most of the pandemic in her £6 Million, 16,146 sq. ft. Lisbon Mansion.[3] If, somehow, she still managed to contract the virus, emergency healthcare in Portugal is free for visitors. In fact, the only cost that a nonresident can expect while utilizing the Portuguese healthcare system is a small surcharge for tests and consultations.[4]

Back stateside, Gabby Sutton shared a four-bedroom homeless shelter with six others in Washington. Mark Stokes slept on a friend's floor with ten others after dorm closures in Pennsylvania. Cathy Connor lived with three others in a one-room trailer without running water in Oklahoma.[5] In such crowded conditions, likelihood of coronavirus infection increases dramatically; in the unfortunate event of a COVID-related hospital stay, struggling uninsured Americans don't share the same luck as an American holing up in Portugal - the average hospital bill for a coronavirus related stay in the United States is $73,300.[6] In the case of Andrea Ceresa of Branchburg, New Jersey, the financial ramifications were even worse. In her words:

> *April 17 was the first day I woke up feeling really ill… At the beginning of May, my*

> *employer gave me an option: Stay on my insurance and pay the full premium myself, or go off insurance. I decided to stay on and pay the full premium out of pocket … In November, I had to be hospitalized for nine days at Mount Sinai. The hospital bill I received for my stay was over $133,000 — and that's not including the cost for individual doctors who came to see me each day.*[7]

Unlike Madonna, indigent Americans, especially impoverished Americans of color, lost their jobs (with losses concentrated in low-paying industries), faced more difficulty putting food on the table, and experienced increased housing instability paired with an inability to isolate in COVID-safe environments.[8] At the same time, large corporations that have paid over $13 billion for regulatory violations received nearly $150 billion in federal aid.[9] While the myth of COVID-19 as an equalizer has been thoroughly debunked, the effects of wealth inequality and corporate power as related to COVID are being felt stronger than ever as the page is turned to a second year of Pandemic Earth.

In New York City, neighborhoods in the bottom quarter for virus-related deaths have double the income of those in the top quarter.[10] Of the ten hardest hit zip codes, all but two have predominantly Black and Latinx populations.[11] Since the beginning of the pandemic, 14% of Black and 23% of Latinx New Yorkers lost health insurance, compared to only 6% of Whites.[12] As a result, significantly more communities of color already at an economic disadvantage find themselves in medical debt.[13]

Mortality rates in the city vary tremendously based on which hospital patients are admitted to, which is nearly entirely dependent on wealth and insurance coverage. At private medical centers in Manhattan (New York-Presbyterian, NYU Langone, the Mount Sinai Health System, Northwell Health, and Montefiore Medical Center, which spend $150 million in advertising and pay executives $30 million per year), two thirds of patients have insurance, and most have access to advanced treatments, medications, and procedures.[14]

At public and independent hospitals, where only 10% of patients have insurance, the sick are lucky to receive a hospital bed and basic treatment like continuous dialysis.[15] In July of 2020, there were 5

hospital beds for every resident of Manhattan, where cases were 16 per 1,000 residents and median income is $82,000. The Bronx had fewer than half the available beds, despite having more than double the cases. Median income in the Bronx? $38,000.[16] If these underfunded and overcrowded hospitals had some more help, Dr. Alexander Andreev of Brookdale University Hospital thinks that three of every ten deaths could have been prevented.

COVID-19 provides a useful lens through which to analyze the effects of powerful corporate injustice on American healthcare, but it is just the tip of the iceberg. The American healthcare system is fundamentally broken, and treats sickness as an opportunity to profit without a thought for the person behind the diagnosis. In America, wealth equals health. It doesn't take much extrapolation to draw the direct causal link between the two - in Chicago's wealthy Streeterville neighborhood (ZIP 60610, 72.3% White[17]), residents are expected to live until 90 years old.[18] In Englewood (ZIP 60621, 95% Black[19]), just 9 miles south, that expectancy drops to 60 years. Streeterville's average household income? $148,946.[20] Englewood's? $34,586.[21]

Why are these numbers so vastly different? Indigent communities are beset on all sides by health risks. Washington D.C.'s 7th and 8th Wards, 90% Black low-income neighborhoods, have both the city's highest concentration of coronavirus death and homicides.[22] According to Sanchita Sharma, a psychologist at a local children's hospital, shootings occur so often "that many families living in ground-floor apartments strategically arrange their furniture to minimize the risk of being struck by bullets that might come through their windows."[23] As a result, children suffer from lifelong acute mental illness like PTSD, the consequences of which are devastating and far reaching.[24] Tiffany Porter, single mother of five and Ward 8 resident whose husband was gunned down in 2019, was left with $23 after having to pay for surgery for one of her sons. She hasn't been able to find employment during the pandemic and has been relying on disability payments to get by.[25] For those who can find work, occupational hazards compound these risks. According to the National Institute for Occupational Safety and Health, "there are disparities in the burden of disease, disability, and death experienced by certain population groups, including low-income workers and racial/ethnic minorities."[26]

Income and wealth inequality had been growing rapidly prior to the pandemic, marked by a decline in intergenerational economic mobility, wage stagnation, and a growing divide in health. According to the Brookings Institution, COVID has exacerbated the problem by

intensifying "the shift toward more oligopolistic, less competitive markets," paired with labor markets being tilted "against low-skilled, low-wage workers."[27] One of the most indicative of these oligopolistic mrkets is healthcare, marked by giant conglomerates capitalizing on illness and poverty to rake in billions. Examples include CVS's $69 billion purchase of Aetna in 2019, regional healthcare consolidations, and massive insurers like UnitedHealth sweeping hundreds of physicians' practices into their portfolios.[28]

As corporate influence over all aspects of healthcare grows larger and more centralized, indigent consumers lose any option of seeking affordable aid. Looming over this discussion but not yet explored is the phenomenon of exorbitantly high drug prices controlled by a select few pharmaceutical giants. Perhaps no example is more well-known than Daraprim, the $1-to-produce AIDS drug Martin Shkreli increased in price from $13.50 to $750 *per pill* in 2015.[29] Similar price gouging is not limited to such specialized or narrowly used drugs; Insulin increased from $344 per prescription in 2012 to $666 in 2016.[30] EpiPens, acquired and monopolized by Mylan Pharmaceuticals, went from ~$100 at the time of acquisition to over $500 in 2016. They cost the company $34.50 each.[31]

Society's affirmation and legitimation of these phenomena perfect a vicious cycle of exploitation, a cycle which far too often ends in the premature deaths of those marginalized. The harrowing reality of the situation is that corporate influence over healthcare in America is broad and deadly, a fact only made worse by the COVID-19 pandemic. As healthcare is an incredibly broad field, the effects of this truth extend to insurance, pharmaceuticals, and physician/hospital treatments, and beyond. Greed has infected American healthcare and manifested itself in corporations exerting power, protected by corporate law, to fuel injustice. By restructuring corporate law to focus on welfare rather than wealthcare, America's health infrastructure can be adapted to advance equity and help people in need.

THE DOMINANT NARRATIVE

Bernie Sanders' official Twitter account asked followers in January of 2020 if they had ever avoided taking an ambulance to the hospital because the cost was too high; amidst many disturbing stories ("A guy in my town passed out while trying to drive himself to the hospital and

killed a pedestrian when he went off the road") was a now-deleted tweet – "The ambulance is not your taxi to the hospital."[32] On the one hand, the thread is a cry for help from vulnerable members of society. On the other, it is representative of the attributional divide at the center of the debate over the future of American healthcare; is healthcare a right or a privilege?

Wesley Hohfeld's seminal 1913 law review article "Some Fundamental Legal Conceptions as Applied in Judicial Reasoning" provides a useful jumping-off point in analyzing this question from a legal perspective. According to Hohfeld, a right is best understood by its correlative – duty. If X has a right to healthcare, then healthcare providers have a duty to treat X. Similarly, privilege (or liberty, which Hohfeld determines to be a legal synonym) is best understood by its correlative "no-right," or the restriction of third-parties to interfere with privilege. If X has the privilege to contract with a healthcare provider for aid, then it is third parties' (like regulatory agencies) "no-right" to interfere in such a negotiation. Of course, as pointed out in the article, the degree of non-interference is not absolute but rather a question of policy and justice. These empirical definitions, however, are indicative of a fundamental premise on which our healthcare system is based – the availability of choice.

Absent universal affordable healthcare, the degree of coverage for individuals becomes a question of privilege, or Hohfeldian liberty. As indicated above, inherent in this privilege are certain restrictions (or no-rights) of third parties to interfere. In this system, what healthcare an individual receives is thus, at least to some essential degree, a product of contracting; the freedom to contract, to *choose*, evolved quickly and forcefully in the 1970's and 1980's into the powerful Law and Economics movement, among other things. According to legal economists led by the likes of Milton Friedman and Richard Posner, contracting for healthcare (just as contracting for anything else) is a consensual representation of values and desires resulting in an economically efficient allocation of privileges and resources. Friedman, in his 1980 book *Free to Choose*, sets forth the core tenets of this "choice frame," or dominant, legitimating schema:

> *A society that puts equality—in the sense of equality of outcome—ahead of freedom will end up with neither equality nor freedom. The use of force to achieve equality will destroy freedom, and the force, introduced for good*

> *purposes, will end up in the hands of people who use it to promote their own interests… [Freedom] preserves the opportunity for today's disadvantaged to become tomorrow's privileged and, in the process, enables almost everyone, from top to bottom, to enjoy a fuller and richer life.*[33]

By making value judgments as to where money is best spent, the market (supposedly) will quickly and naturally adjust prices to reflect that. Healthcare providers, therefore, will be able to efficiently allocate different levels of care to those who weigh healthcare differently as opposed to other costs; this system promotes liberty and combats paternalism, as the man would have us believe. When asked in 2006 if there was any particular sector that he believed had fallen to the wayside of freedom, Friedman singled out healthcare. In his view, "we have a socialist-communist system of distributing medical care. Instead of letting people hire their own physicians and pay them, no one pays his or her own medical bills. Instead, there's a third-party payment system. It is a communist system and it has a communist result."[34] The solution? In an article written for the Hoover Institution in 2001, Friedman suggested the following four steps:

1. Repeal the tax exemption of employer-provided medical care
2. Terminate Medicare and Medicaid
3. Deregulate insurance
4. Restrict the role of government to state/local financing for hard cases[35]

"Socialized medicine" (as the dispositional economist is likely to dub a system in which healthcare is a right as opposed to a privilege) is wont to gum up the healthcare system with long lines, poor care, and overall inefficient confusion. By implementing the above steps, power will be returned to the people to make their own decisions and figure out which provider and plan work best for them. Government regulation, per the dominant narrative, can't know what is best for people – only the individual can make that judgment for themselves.

In this fantastical scenario, consumers are dubbed dispositional actors at liberty to peruse various options and see which glove fits just right.

Insurance companies and healthcare providers are thus situational actors, changing their prices depending on market influences and hoping to be chosen. Because nobody can know exactly the contents and considerations of an individual or family's budget, they should retain the entire privilege to contract for care. The free market system, as maintained by this schema, will provide all necessary safeguards to ensure good faith and fair dealing. Because contracting costs are low and information largely transparent, consumers are able to sift through the scammers and pan for their golden plan. Providers will therefore try to make their plans and payment structures as appealing as possible to beat out the competition, resulting in competitive plans for reasonable prices. Government interference or regulation would only impose unnecessary restrictions on this process, inefficiently interfering with the natural progression of negotiation or contract. This greatly idealized marketplace scenario views consumers entirely as dispositional actors with infinite degrees of freedom. The idea of consumers of healthcare as dispositionist (as opposed to situationally influenced) actors is especially useful when analyzing the dominant narratives swirling around COVID-19.

The COVID-19 pandemic is an especially interesting addition to the dominant legitimating script, as it fits comfortably within the dominant narrative while adding layers to the illusion of choice it perpetuates. Taking the free market description above, the pandemic essentially adds another dimension by imposing relationships between consumers in the marketplace as opposed to considering strictly consumer/company transactions. Individuals are still contracting with healthcare providers and insurance companies, only now they're also implicitly contracting with other individuals using perceived safety as currency. It is constructive to view these relationships through a situational/dispositional dichotomy, as it can help to explain many of the responses and philosophies of companies, governments, and individuals to the pandemic.

Consider the following corporate public relations campaigns:

- Nike: Play Inside, Play for the World
- Coca Cola: Together We Can
- Anheuser Busch: It's All in Our Hands to Make a Difference

What do all three have in common? They all distribute responsibility and accountability to the consumer. In contrast, corporations claim to

do no wrong by simply trying to make margins and offset costs. In the realm of drug prices, skeptics are generally pointed in the direction of high research and development costs. As Johnson and Johnson stated in its 2017 transparency report, "We have an obligation to ensure that the sale of our medicines provides us with the resources necessary to invest in future research and development."[36] Put slightly differently, high prices are a result of uncontrollable situational forces to which the company has no choice but to respond. These corporate messages, echoed by all levels of government, reflect the dominant attributional narrative created by large corporations and supporters of free market capitalism, namely that individuals are dispositional actors making choices solely based on consensually developed preferences while companies exist to respond.

In the same way that consumers rely on preferences and information to inform marketplace transactions for goods and services, so too must they rely on the same to inform their pandemic behavior – or so the dominant attributional schema says. By this logic, responsibility lies entirely in the hands of the individual. When thinking about what COVID irresponsibility looks like, the person walking around with no mask is going to come to mind far more often than the corporate executive declining to transition manufacturing to PPE. While this mentality may not be entirely true globally, research indicates that this attributional schema rules in the United States. A Stanford University Graduate School of Business research paper found that "whereas, American culture primarily conceptualizes agency as a property of individual persons, other cultures conceptualize agency primarily in terms of collectives such as groups or non-human actors."[37] The research conducted to come to that conclusion involved testing implicit theories of agency, which define individuals' conceptions and attributions towards other entities. The American implicit theory of agency, rooted in Judeo-Christian fables and works like Ralph Waldo Emerson's *Self-Reliance*, ascribes the bulk of agency and responsibility to persons and, as a result, shields corporate entities. Returning to healthcare, an individual's coverage and care is thus strictly a result of decisions they've made in the mind of the average American. To accredit someone's healthcare situation to corporate decision making and power is firmly in opposition to this overriding theory of agency.

Corporations, on the other hand, sit on this other end of the attributional spectrum. Simultaneously with calling on consumers to change their behaviors and take responsibility for slowing the spread, large companies cry wolf. The Republican-sponsored CARES Act, signed in

March of 2020, sent $1,200 checks to individuals, sure, but it sent far more per capita (nearly $89 **BILLION**) to corporations.[38] At the time the act was signed, people with money lamenting the state of stocks and quarterly reports were just as present across media platforms as those dealing with financial instability and greiving lost loved ones. Naturally, the folks concerned with the state of their investment portfolios were too preoccupied following corporate America's directive to take the reins of pandemic responsibility to see the suffering around them; woe are corporations losing money!

CORPORATE POWER IN HEALTHCARE

Choice-based dispositionism manifests itself as a toxic veil draped over the eyes of the everyman, an illusion of freedom buttressing and legitimating those systems of (corporate) power dominating the lower castes they've quietly created. As described by Jon and Kathleen Hanson, "because choicism can be applied 'equally' to all people," in a facially neutral manner, it allows those in power to separate themselves from the injustices they've produced.[39] Corporate practices in the realm of healthcare have capitalized on this narrative incredibly successfully, thrusting the following vicious and insidious cycle onto indigent and marginalized communities:

- **Stage One** - General Healthcare Inequity
    - The first stage of the cycle reflects the vastly disproportionate health risks that indigent and minority communities endure on a daily basis. Poverty often results in acute mental illness, low wage jobs impose dangerous occupational hazards, and poor, segregated neighborhoods increase risk of homicide.
    - During the pandemic, this manifests as lower income communities having to work frontline jobs, greatly increasing the risk of infection. Poor individuals often live in densely concentrated buildings/areas and rely on public transportation and facilities, making this problem even worse.
- **Stage Two** - Pre-Sickness
    - Indigent individuals and families are generally unable to see specialists and pay for preventative care. From multivitamins to corrective heart surgery, those with

money can spot issues early and deal with them accordingly. For people who often have to decide between paying rent or paying for food, such luxuries are off the table.

- The COVID-19 pandemic reflects an interesting phenomenon in which all, regardless of status, are aware of a pressing health concern. As a result, important anticipatory measures become hot commodities leading to a shortage and price increase for some time. Just as budgeting can preclude families from seeking out preventative treatment, it can also make hand sanitizer, surgical masks, and disinfecting wipes unaffordable.

- **Stage Three** - Sickness

  - When an individual does become sick, choosing between seeking help or continuing to work to conserve funds has long-lasting consequences. Oftentimes, those without job security are at risk of being let go if they're forced to take time off for sickness; the threat of losing income beats out seeking medical attention. The same mentality applies during the COVID-19 pandemic, only with the added caveat that not seeking aid can contribute to the spread of the virus within densely populated low-income areas.

  - When someone does choose to seek aid, the quality of care received and treatments available are highly dependent on ability to pay.

Considered bluntly, this dismal rotation begs the questions: Where is corporate law in all of this? What role does the law play in influencing who gets what care? What role *should* the law play? The answer to the first question is as deceptively simple as it is concerning; American corporate law *is* the absence of meaningful regulation. The current controlling script imposes a singular, unilateral, duty upon corporate managers - to produce profit for shareholders.

Ronald Chen and Jon Hanson analyze the illusion of corporate law by breaking it up into levels, namely the "meta" level (free markets beat out regulations) and "macro" level (profit maximization beats out social responsibility), which are then codified in the "micro" level of actual statute and doctrine.[40] At the meta level, free markets supposedly do a better job efficiently allocating healthcare and insurance to those who

desire it whereas regulators are disconnected and at risk to be captured by special interests. Our macro level corporate law revolves around the ideas that investors need more protection than consumers (who are protected by contract law), and the single maximand of profit enhances accountability and decision-making. When combined, these scripts contribute to the deep capture of corporate law, or the phenomenon of society's institutions *and individuals* implicitly justifying the perpetuation of unequal power structures. The result of this? The effect of corporate law and corporations on injustice and inequality can be ignored. These scripts serve to allow corporations to beat individuals into dispositionist submission, manipulating situations to enforce existing power structures. As has become a more and more common refrain in modern politics, the rich get richer (and healthier) while the poor get poorer (and sicker).

A prime example of these schemas in action is the phenomenon of exorbitantly high pharmaceutical prices. While drug manufacturers claim that high research costs paired with extended FDA approval processes drive prices up, the truth is that they're deflecting from price gouging by crying situational wolf. In the words of ex-Pfizer CEO Hank McKinnell: "How do we decide what to charge? It's basically the same as pricing a car … A number of factors go into the mix. These factors consider cost of business, competition, patent status, anticipated volume, and, most important, our estimate of the income generated by sales of the product."[41] Note that any reference to patient wellbeing is omitted from these considerations; not only does societal wellbeing through drug affordability not drive pharmaceutical development, but it also doesn't even make it into the pricing calculus!

What are the effects of this injustice? A 2019 piece in *The Atlantic* finds them to be twofold:

1. Patients do not take their medicine due to price gouging. Using oral cancer drugs as an example, a December 2017 paper in the *Journal of Clinical Oncology* found that 13 percent of cancer patients did not buy approved chemotherapy drugs if they had a co-payment of $10 a month, while 67 percent did not when they had to pay $2,000 or more.

2. Pharmaceutical research prioritizes financial gains as opposed to health gains. "[M]any of the drugs that companies are pursuing have low promise, where the health gains are small—weeks of added life, not big cures. While even this short extra time can be valuable to individual families, too much investment in oncology

> means not enough in drugs for…illnesses whose treatments cannot be so highly priced."[42]

Corporate patent protections and FDA marketing exclusivity provisions serve to create monopolies on brand named drugs for big pharma. Absent competition, the corporate powers that be can raise prices all they want without excessive fear of consumer rejection or reproach; alongside physicians relentlessly pushing unnecessary drugs for bonuses, these practices provide the perfect ingredients for incredible inequality incited by corporate greed and protected by corporate law.

CONCLUSION: WHERE DO WE GO FROM HERE?

All hope is not lost. Quite the opposite, in fact. By identifying these injustices and thinking about them deliberately – by approaching the reality of corporate injustice in healthcare with *purpose* – we can begin to build a better system. Inherent in this approach is a dichotomy vital for any proposed package of solutions to succeed: meaningful legislative or doctrinal solutions must be paired with equally (if not more) meaningful recognition and intent. Deep capture of corporate law, of course, thrives by existing insidiously at the crux of individual subconsciousness and the societal hive mind; correcting the injustice it has caused is thus predicated upon laying the rot bare for all to see.

While the movement to oppose and replace insidious corporate and legislative practices within the field of healthcare has swelled in recent years, a strong grasp of the attributional narrative which caused the problem in the first place is still required to thoroughly address it. As such, progress is predicated on continuing conversations between consumers, policymakers, corporate leadership, and scientists which frankly address their respective roles in healthcare. While a complex and multidimensional symbiosis between proposals and reforms is necessary to cure America of its wealthcare disease, there are treatments available to address some of the symptoms.

To combat the monopolistic vice-grip that private healthcare actors (pharmaceutical companies, hospitals, specialists, insurance providers, etc.) have on the industry, for example, antimonopoly measures have great potential. Exclusivities for pharmaceutical companies should be limited (if not abolished), and both exclusivity and patent protection should hinge upon compliance with fair price standards promulgated by government agencies. According to Public Citizen, aggressive price

negotiation with pharmaceutical corporations during periods of market exclusivity is instrumental in preventing excessive pricing: "Congress should, at the very least, authorize DHHS to negotiate drug prices for Medicare Part D plans, as it does for nearly all other services. Doing so could save Medicare Part D up to $16 billion a year."[43]

Abolishing the convoluted tangle of insurance actors in favor of a single payer system would further address many healthcare related problems in one fell swoop. According to Harvard Medical School, a single payer healthcare regime would not only "be a major step towards equality, especially for uninsured and underinsured Americans," but also better control wasteful spending through reduced administrative costs.[44] This regime, which has been gaining popularity quite quickly in recent years, would also provide greater incentives to use funding to target public health initiatives and preventative care instead of concentrating resources in high-cost, low-return, end-of-life care.

Although targeted medicines can provide some much-needed symptomatic relief, the search for a true cure requires a significant expansion in scope. America's healthcare system is an incredibly complex web of subsystems, and yet it is but one organ afflicted by the corporate disease infecting the national corpus. Not too dissimilar from the novel coronavirus, corporate law has proven to be as pervasive as it is deadly. Systemic change in American corporate governance is necessary, nay, obligatory for justice, not just in healthcare but in all aspects of life.

On April 3rd, 2020, exactly a year prior to this paragraph being written, New York City nurse Derrick Smit told a dying coronavirus patient he needed to be intubated. The patient's labored words before speaking to his wife for the final time?

"Who's going to pay for it?"[45]

FURTHER READING

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