The Dismantling of American Health Care

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On July 4 President Donald Trump signed into law a piece of legislation that amounts to a declaration of war on the working-class and the sick. The “One Big Beautiful Bill Act” will slice more than $1 trillion from Medicaid over the next decade, stripping health coverage from more than 11 million lower-income Americans by 2034 and sending tens of thousands to an early grave—all in exchange for tax reductions for corporations and the wealthy. Despite Trump’s promises to the contrary, the law will also cut nearly $500 billion from Medicare over the same period by making the deficit surge past a point at which the Office of Management and Budget “is required to order a sequestration to eliminate the overage.”

This assault on the nation’s major public insurance programs is only the latest front in an ongoing right-wing campaign against health. On April 1 Trump’s hammer fell on the Department of Health and Human Services (HHS), the sprawling agency that encompasses the Centers for Disease Control and Prevention (CDC), the Centers for Medicaid and Medicaid Services (CMS), the National Institutes of Health (NIH), and the Food and Drug Administration (FDA), among other health-focused agencies. Having already forced out 10,000 HHS personnel earlier in his term, the Trump administration terminated 10,000 more on dubious legal grounds, devastating entire teams focused on major public health problems like tobacco control and occupational health. Altogether 25 percent of HHS’s workforce was dismissed. Since then a minority of the fired employees have been reinstated in the face of political pressure—but the depth and capriciousness of these chaotic cuts is without precedent. Disease surveillance, outbreak investigation, vaccine uptake, violence prevention, infection control, food safety, and opioid overdose prevention will likely suffer.

Meanwhile the nation’s biomedical research enterprise—in large part conducted by publicly financed scientists employed at universities—has been facing a sustained attack. NIH research grants that address important but now illicit health issues—like HIV/AIDS, racial health inequities, vaccine hesitancy, and LGBTQ health—have been wiped out in recent months. Not all of the cuts stem from specific bêtes noires: the administration has broadly decimated funding by canceling more than $1.8 billion in existing NIH grants in less than a month and a half (although some have been temporarily reinstated by court orders), reducing the issuance of new grant awards by 28 percent, and attempting to slash the “overhead” payments that cover universities’ costs for space and utilities via a now-stayed order that would have reduced grants from multiple federal agencies, including the NIH. This is on top of the funding blockades that the administration has imposed on many elite universities to bring them to heel—including all of the Ivies except Dartmouth and Yale.

The three fronts of this assault—on tax-funded medical coverage, public health, and medical research—have overlapping aims. The campaign to slash Medicaid—relied on by the poor since its establishment in 1965—follows a long neoliberal tradition of prescribing austerity for the working class and largesse for the rich. Trump and his allies seem to view public health, for its part, as waste that can be excised (DOGE-style) to fund tax cuts, as a source of regulatory excess that constrains profit-making, and as a locus of “woke” ideology and inconvenient facts. The assault on medical research is driven by similar concerns, with the added benefit of dominating rival centers of power like universities and the professions.

Yet such economic and ideological motivations do not explain the full measure of the administration’s agenda. It rests, too, on a Dark Ages disdain for science, part and parcel of Trump’s claim to be the arbiter of facts and truth. Robert F. Kennedy Jr.—the notorious antivaccine advocate appointed by Trump to lead HHS, who has previously engaged in AIDS denialism and spread conspiracy theories about chemtrails and 5G—touted cod liver oil to treat the measles epidemic that ripped through Texas and has since spread to other states. Casey Means, Trump’s most recent appointee for surgeon general, a position that requires “specialized training or significant experience in public health programs,” dropped out of her residency training to embrace a career in “functional medicine,” starting a business venture marketing supplements and other wellness products; recently she gave credence to a discredited link between vaccines and autism. And Trump’s choice to head the CMS, the former heart surgeon and television personality Mehmet Oz, was condemned in 2015 by his colleagues at Columbia University for expressing “disdain for science and for evidence-based medicine” on his TV program, where he also promoted the privatized Medicare plans he now regulates.

These shock troops of pseudoscience have already done harm. On June 9, in an extraordinary move, RFK Jr. cited flimsy conflict-of-interest charges (such as their prior participation in industry-funded research) to dismiss the entire panel of scientific experts who constitute the CDC’s Advisory Committee on Immunization Practices (ACIP), which helps establish vaccine schedules for both adults and children. Many of the replacement appointees seem distinguished mainly by their distrust of vaccines and their apparent willingness to further undermine vaccine uptake among the American public. The new committee members include Robert Malone, a scientist who rocketed to fame during the Covid-19 pandemic by circulating misinformation on right-wing media; James Pagano, an obscure emergency room doctor whose thin Internet footprint includes an Islamophobic tweet and a blog post in which he expresses skepticsm of climate change; and Vicky Pebsworth, a nurse with a public health policy Ph.D. who is also the volunteer director of research for an anti-vaccine organization.

It might be tempting to respond to this war on health by calling for nothing more than a return to the status quo ante. That would be a mistake. For one thing, propagandists for RFK Jr.’s “Make America Healthy Again” (MAHA) movement have drawn some of their strength by denouncing a shadowy health establishment, including powerful drug firms that are rightly criticized for abusive pricing practices. Sympathy for MAHA also stems from legitimate concerns about corporations’ malign effects on air, water, food, and drug safety—even if those concerns are voiced by bad-faith actors working to dismantle the very regulatory programs that protect us from such threats, like the Clean Water and Clean Air acts, which, if judged by deaths averted, are perhaps the most important pieces of public health legislation in US history.

More fundamentally, undue commercial influence, grave regulatory failings, and underfunding all afflicted the public health system long before Trump. Our medical research infrastructure likewise had preexisting flaws: it should not only be reestablished but also funded more sustainably and efficiently, and its products made available to all rather than monetized by industry. Similarly, Medicaid and other public health care programs must be fiercely protected; at the same time, they too need reform to address their many shortcomings, including inefficiencies born of privatization and fragmentation.

Admittedly, few if any of these reforms seem attainable in the near future, now that the federal government is busy dismantling what benefits the system did provide. But we still need a positive vision of how to improve the country’s health system, both to prepare for whenever the window for political change reopens and to help galvanize that shift now. We must resist Trump’s agenda today, even as we prepare to rebuild something better tomorrow.

2.

The first theater of Trump’s war on health—dismantling or hobbling federal public health agencies—is already inflicting harms that will accumulate over time as existing programs, environmental regulations, and agencies wither. Among the agencies decimated by the April 1 cuts at HHS was the CDC’s Division of Environmental Health Science and Practice, responsible for addressing lead poisoning, asthma control, radiation exposure, natural disasters, and other environmental hazards. In April, when Milwaukee requested the CDC’s help to investigate unsafe lead levels in its schools, it was rebuffed: there was literally no one to send.

That division was abruptly restored last month, when HHS reinstated nearly 20 percent of the employees fired on April 1, but other teams have been less fortunate. Some two thirds of the staff of the CDC’s Division of Reproductive Health were cut, including the team responsible for issuing national guidelines on contraceptives for women with serious medical conditions. The CDC’s Injury Center and its Division of Violence Prevention, which monitor and help prevent firearm violence and other injuries, were also greatly reduced in April. Most of the staff at the Office on Smoking and Health (OSH) were fired, notwithstanding tobacco’s unequaled contributions to chronic disease—ostensibly RFK Jr.’s chief concern. One of the OSH’s former heads described the attack as “the greatest gift to the tobacco industry in the last half century.”

Meanwhile the National Institute for Occupational Safety and Health (NIOSH)—a scientific agency established in 1970 during an era when Americans were regularly injured, poisoned, or killed on the job—was almost totally destroyed; 90 percent of its workforce was eliminated overnight. “Without warning, our research and ongoing studies were halted. We have not been allowed back to finish experiments, complete analyses, or collect data for publication,” a fired NIOSH worker recounted in Scientific American. The cut was so abrupt that some staffers were forced to euthanize their lab animals. A NIOSH program that investigates firefighter deaths was gutted. The destruction of another program has already put workers’ health at risk: in April the Mine Safety and Health Administration, citing the NIOSH “restructuring” and shortfalls in monitoring and protective equipment, delayed implementing a federal regulation meant to protect coal miners from deadly silica dust. In the face of a lawsuit and Congressional pressure, roughly a third of the fired NIOSH employees have been rehired, but the agency remains a shadow of its former self.

Health surveillance programs critical for assessing and addressing potential dangers are also under threat. Since 1971 the National Survey of Drug Use and Health has provided critical data on substance use; the team that runs it was eliminated in April. Workers responsible for the Pregnancy Risk Assessment Monitoring System (which collects data on pregnancy care and complications), the Web-based Injury Statistics Query and Reporting System (which tracks deaths and injuries), and AtlasPlus (a portal providing data on HIV, tuberculosis, and other infectious diseases) were also fired. The fates of these surveys are unclear. And the Agency for Health Research Quality, which conducts a survey that is the main source of data on Americans’ health care use and costs—data that we have used in many studies—is being dismantled.

Meanwhile “the FDA as we’ve known it is finished,” its former commissioner wrote in early April, after about a fifth of its workforce was laid off. Taking little heed of RFK Jr.’s anti-pharma rhetoric, the new commissioner, Marty Makary, has already vowed to speed up the approval of new drugs—which would, in practice, mean loosening the agency’s already lax approval standards. Such statements have, according to The Wall Street Journal, sent “a bullish signal to biotech.” The exception—for obvious reasons—is vaccines. They may, in contrast, face novel obstacles, including from RFK Jr.’s ACIP panel, which is now starting to re-review vaccines that have long been approved.

The administration is taking apart all this health infrastructure even as it embarks on an unprecedented assault on our environmental protections, as Jonathan Mingle has described in these pages. On March 12 the Environmental Protection Agency (EPA) announced what it called the “biggest deregulatory action in US history,” including thirty-one measures that will degrade air and water quality and endanger population health nationwide. For its part, the “Big, Beautiful Bill” will pull the rug out from under clean energy production, pushing the nation toward greater fossil fuel consumption and pollution emissions.

Much remains uncertain about what will survive the April bloodletting at HHS: just last week a federal court ruled the mass firings there illegal, with unclear immediate implications. Yet it already seems evident that public health agencies across the federal government—which may have saved more lives than all the country’s doctors and hospitals combined, and which were underfunded even before Trump took office—will never be the same. And even darker clouds are on the horizon: Trump’s budget proposal for the 2026 financial year calls for a $32 billion cut to HHS, about a quarter of its current budget, excluding the Medicare and Medicaid payments it administers. If the administration gets its way, the CDC’s budget will be slashed by more than half, the NIH’s by 40 percent, and the EPA’s, too, by more than half.

This funding squeeze is without historical parallel. Yet it also bears stressing that public health agencies have long been underfunded and neglected. Unlike medical care—which almost everyone periodically encounters when they go to a doctor or an emergency room—the equally essential work of public health is often invisible. Americans’ life expectancy soared by more than twenty years in the first half of the twentieth century, mainly owing to public health measures like safe drinking water, rather than to improvements in medical care. In more recent decades public health measures, like those that decreased air pollution and smoking, have been responsible for about half of life expectancy gains.

Despite these achievements, public health has long been the neglected stepchild of the US health system. It has received only a meager portion of the country’s total spending on health, including medical services and drugs. Public health activities accounted for only 3.1 percent of total health expenditures in 2024—$467 of the $15,264 spent per person on health care that year.

1 That figure reflects the short-term bump in public health spending precipitated by the Covid-19 pandemic; funding was set to recede even before the Trump blitzkrieg. By 2032 public health’s share of total health spending is projected to fall to 2.4 percent—the lowest proportion since the early 1980s.

A graph comparing total spending on public health initiatives to total health spending since 1929. Data on health spending from before 1960 comes from the Compendium of National Health Expenditures Data; from 1960 onward it derives from historical (1960–2023) or projected (2024–2033) National Health Expenditures Accounts. Per capita figures were calculated using population data from the US Census; dollar amounts are inflation-adjusted using the historical CPI-U from the Bureau of Labor Statistics or projections from the Congressional Budget Office.

In other words, today’s austerity is both unprecedented and an acceleration of a longer-term boom-and-bust cycle in public health funding. Interest and resources surge in response to crises and then fade, leaving us vulnerable to the next ones. Faltering federal public health spending along with the Reagan administration’s cuts to medical safety net programs in the early 1980s left the nation ill-prepared for the AIDS epidemic and resurgent tuberculosis. As we entered the Covid-19 pandemic, public health had been starved for years: over the course of the 2010s the CDC’s budget was reduced by 10 percent, adjusted for inflation, and in May 2018 the first Trump administration eliminated the White House’s pandemic preparedness office.

Similar dynamics have played out at state and local levels. Between 2008 and 2016 state and local public health agencies shed 50,000 staff positions. These agencies carry out much of the day-to-day work of public health, conducting disease surveillance and outbreak investigations in their communities, monitoring hazards like lead and fentanyl, educating the public about health risks, regulating and credentialing medical providers, inspecting restaurants, running state laboratories that provide tests unavailable in the commercial sector, procuring and managing supplies like vaccines, and more.

The problem is not just inadequate funding but tenuous, fragmented, and grant-dependent revenue streams. As the Institute of Medicine—today called the National Academy of Medicine—declared more than a decade ago, “the US public health financing structure is broken.” While doctors and hospitals bill for their efforts (and can reasonably trust that someone will pay), funding for most public health agencies is precarious. Today state and local health department agencies depend on CDC grants for about half their budgets. (The Trump administration has sought to withhold $11 billion in such federal support, although that move faces resistance in the courts.) This funding gets allocated largely through time-limited federal grants for which state and local health agency staff need to apply—a process that further strains their ever-expanding workloads. Many such grants, meanwhile, can only be spent on specific programs or diseases. And there is no guarantee that money goes to the communities that need it most.

Merely restoring public health funding as it existed before Trump, then, is not enough. When the Republican onslaught abates, grant-based funding for core public health activities should be replaced by bolstered, stable, and permanent funding streams, as public health experts have long advocated, to ensure that these agencies can deliver the full spectrum of public health services. Federal public health agencies, including the CDC and NIOSH, should not just be reestablished but expanded: addressing growing health threats like climate change and bird flu will require nothing less than ramping up the federal public health infrastructure. A companion agenda is necessary to both restore and advance biomedical research.

3.

“New impetus must be given to [scientific] research . . . [which] can come promptly only from the Government,” wrote Vannevar Bush, FDR’s director of the Office of Scientific Research and Development, in a landmark 1945 report that set the course for the postwar American scientific achievement. Bush called for a federal “National Research Foundation” that would generously fund scientific research projects at nonprofit institutes and universities and train the next generation of scientists through scholarships and fellowships.

Two research bodies realized that vision: the NIH—which predated the war—and a new institution called the National Science Foundation (NSF). Noncommercial health research soared in the postwar decades, rising from $67 million (in 2024 dollars) in 1940 to nearly $17 billion by the late 1960s. Growth slowed in the late 1960s and 1970s but rose sharply again thereafter until the mid-2000s.

A graph showing the increase in spending on health research since 1929. Data from before 1960 is from the Compendium of National Health Expenditures Data; from 1960 onward, it derives from the 2023 National Health Expenditures Accounts. Figures are inflation-adjusted using the historical CPI-U from the Bureau of Labor Statistics.

This investment had monumental effects. The US became a global leader in biomedical research, with the NIH funding the basic science that underlies much of the inestimable therapeutic advances of the postwar era. In recent decades NIH science helped drive the discovery of cures for hepatitis C, life-saving treatments for HIV, pivotal new cancer therapies, the basic science underlying GLP-1 agonists (such as Ozempic), and the Covid-19 vaccines, to name only a few examples. NIH funding contributed to every new drug that was approved in the country between 2010 and 2016.

With the Trump Administration hacking away at the NIH and NSF, it makes sense to emphasize such achievements. But they shouldn’t obscure the many defects in the system. Since the mid-2000s federal funding for research has become more erratic and unstable, driven by shifting political winds. Rapid expansions of research funding have been followed by sudden contractions—another boom-and-bust cycle that has sometimes left expensive laboratory space empty and highly trained individuals unable to find employment as scientists in the US.

Funding has also too often prioritized the development of expensive new therapeutic commodities, like drugs and devices, over more studies of potential social and public health interventions, such as reducing salt in the food supply to mitigate the hundreds of thousands of hypertension-related deaths annually, or implementing housing-first programs for homeless substance users. Moreover, new therapeutics that emerge from public research typically become the property of private companies: since the passage of the 1979 Bayh-Dole Act, which allowed companies to patent taxpayer-financed discoveries, the monetary rewards of publicly financed biomedical research accrue largely to drug firms. Those firms pay little or nothing for the “intellectual property” developed on the NIH’s dime, but charge plenty for the products they derive from it. (Moderna’s Covid-19 vaccine is a prime example of this profiteering.)

Alternative models could allow the public to retain ownership of the discoveries they help fund. The NIH itself could, if allowed, sponsor the final steps—most notably clinical trials—needed to turn basic research into products, rather than almost always ceding that task to drug firms, along with the profits those products generate. The resulting drugs could then be left unpatented, allowing low-cost generics to enter the market as soon as they gained FDA approval, as we and others have previously proposed. That would save patients billions. The government—which foots the bill for 59 percent of prescription drug purchases—would stand to save even more.

The FDA similarly needs reform. It has come to depend too heavily on drug firms for funding, and accommodates their interests too readily. Since 1992, when George H.W. Bush signed the Prescription Drug User Fee Act into law, drug firms have paid the FDA in exchange for faster reviews. Those payments now account for 75 percent of the agency’s drug division budget. RFK Jr. has criticized user fees—but Trump’s budget proposal, tellingly, would leave them undisturbed even while cutting the FDA’s public funding.

The result is that drug firms have partially captured the regulatory process, as evidenced by the approval of too many drugs with weak evidence of efficacy. (The FDA’s 2021 approval of Aduhelm, an ineffective and probably dangerous Alzheimer’s drug, was a particularly egregious example.) In recent decades “accelerated approval” pathways have also proliferated, allowing drugs to be approved on the basis of weaker standards of evidence.

Makary’s FDA looks set to accelerate this trend. “Companies aligned with US national priorities,” he has announced, will receive “National Priority Vouchers” that would shorten review times to a mere one or two months. Makary has already rolled out an AI platform across the FDA, telling employees (in an e-mail obtained by STAT) that they could use it to “expedite clinical protocol review and reduce the overall time to complete scientific review.” (Like other chatbots, STAT found, the tool produces output rife with errors.) The reality is that the FDA already has shorter review times than do comparable agencies in most other countries, and evidence suggests that rushed reviews lead to the approval of more unsafe drugs. Rebuilding the FDA should involve both making all its funding fully public and enforcing more robust safety and efficacy standards.

The fact that many scientists whose grants have been terminated find themselves in desperate straits points to another problem in the current method of research funding. Increasingly the salaries of university scientists have been funded by “soft money” support in the form of (mostly federal) grants, rather than being paid directly by universities. To continue working, they need to fundraise.

This status quo, as the economist Paula Stephan argued in a 2015 article, departs notably from Vannevar Bush’s vision.

2 Initially grants only covered faculty members’ summer salaries, when the academic year was not in session; trainees were supported through dedicated fellowships. In the following decades, however, universities pushed to use research grants to cover the salaries of scientists and trainees year-round. By 1960 the President’s Scientific Advisory Committee warned about the implications of this trend. In a passage Stephan quotes, it called for “avoiding situations in which a professor becomes partly or wholly responsible for raising his [or her] own salary,” noting that “if federal funds should fail, a most unsatisfactory sort of ‘second-class citizenry’ is created.”

And yet today many scientists find themselves in this position—responsible for raising their entire salaries and at risk of unemployment “if federal funds should fail.” The results have been both “an unsustainable hypercompetitive system” for federal grants, as one group of scholars put it, and a grant-writing enterprise that wastes countless dollars and hours of scientists’ time—a “form of brain drain” that detracts from “curiosity-driven research,” as the psychologist Gerd Gigerenzer and colleagues have noted.

3 This diversion of time and money means scientific roads not explored, missed opportunities for important advances, and ultimately fewer treatments for patients.

A more rational system would pay scientists salaries like other professionals. Grants would fund specialized equipment, reagents, or additional personnel needed for a particular study. Universities’ infrastructure for research might be funded by a dedicated funding stream, not by add-ons to each grant. And the fruits of scientific labor, paid for by the public, would be a public good available for the use and benefit of all.

4.

Having wreaked havoc on public health and scientific research, the Trump administration opened a third front of its assault on health: tax-funded health care coverage. The Medicaid program was passed into law during the Civil Rights era simultaneously with Medicare. Unlike Medicare—a federal program that covers virtually all elderly Americans—Medicaid was means-tested. Traditionally it also covered only certain categories of the poor—for instance, those eligible for cash welfare. It also borrowed the federalist structure of a slightly earlier program called Medical Assistance for the Aged, which—at the insistence of the conservative Southern Democrats behind it—had fallen largely under the control of state governments; under Medicaid states similarly had significant latitude in who they covered, and what they would pay for. (Many states have, for example, imposed limits on the number of prescription drugs Medicaid beneficiaries can receive.) Yet over time a series of expansions culminating in the Affordable Care Act (ACA) brought more than 70 million low-income Americans into the program; in states that implemented the ACA’s Medicaid Expansion, Medicaid is now available to all individuals with incomes below 138 percent of the poverty level.

Congressional Republicans took aim at the ACA Medicaid expansion early in Trump’s first term, but the attack faltered in the face both of divisions within the GOP ranks and of rage from the public, which contributed to Republican losses in the 2018 midterms. Now, eight years later, they have succeeded at pushing through catastrophic Medicaid cuts. Unlike in 2017, however, Republicans have not promoted their handiwork as a grand effort to “repeal Obamacare.” Instead, as the bill moved through Congress they cannily downplayed its impacts, perversely claiming that cutting some $1 trillion in Medicaid funding over a decade would somehow “protect” the program for deserving beneficiaries by shedding alleged freeloaders.

But in truth the size of the Medicaid cuts in the bill Trump signed into law are comparable in magnitude to those in the ACA repeal bill. These cuts, along with the law’s changes to Affordable Care Act marketplace plans, will result in an estimated 11.8 million Americans losing health coverage, with 5 million more becoming uninsured because Congress failed to extend Biden-era improvements to the ACA. As we recently reported in the Annals of Internal Medicine, the Medicaid cuts alone would cause more than 1.9 million Americans to lose access to their physicians, over 1.3 million to go without needed medications, almost 400,000 to forego needed mammograms, and more than 1.2 million to accrue medical debt. All this would result in more than 16,500 medically preventable deaths each year.

4 The cuts would also financially squeeze, and possibly shutter, many safety-net hospitals and clinics that rely on Medicaid revenues to stay afloat.

As with public health and medical research, these deadly cuts must be fiercely fought. But here too we must acknowledge the structural flaws that make Medicaid both vulnerable to attack and inadequate for its beneficiaries. Like much of the rest of US health care, there is indeed “waste, fraud, and abuse” in our public health insurance programs—but not the kind Republicans suggest. Over the decades both Medicare and Medicaid have been progressively privatized: today about three quarters of Medicaid beneficiaries and more than half of Medicare beneficiaries are covered by private managed-care insurers, whose overhead far exceeds those of the publicly administered programs. In a forthcoming analysis, we project that this Medicaid privatization will result in the waste of $500 billion over the coming decade. Similarly, each year taxpayers make enormous overpayments to private Medicare Advantage insurers like UnitedHealthcare, Humana, and CVS/Aetna—$84 billion this year alone, according to Congress’s official Medicare advisory commission. Those overpayments will, we estimate, add $1.4 trillion to Medicare’s costs over the next decade.

The Republicans’ cuts would do nothing about this wasteful privatization. Simply put, their bill would realize savings by throwing millions of people off Medicaid and the ACA. Indeed, in an analysis published on July 2, we estimated that it will cost nearly $5 billion for states to establish the new bureaucracy they’ll need to monitor whether nondisabled adults on Medicaid are meeting the bill’s new work requirement; much of that money will flow to corporate consultants.

Medicaid has other flaws beyond administrative inefficiency. Many doctors, and even some hospitals, refuse to accept it, shutting Medicaid patients out of care; many people who should remain eligible for coverage are disenrolled because they fail to fulfill red-tape eligibility requirements; others lose coverage because a small income bump boosts them over the eligibility threshold. The solution here is more ambitious. Single-tier national health insurance—also known as Medicare-for-All—would provide universal top-class coverage and end the medical segregation of the poor (and, inter alia, of people of color, who disproportionately depend on Medicaid). And from a political perspective, health care programs with users across the economic spectrum—like Medicare or universal systems in Europe and Canada—have proven more resilient to attacks than those relied upon only by the poorest. Perhaps the best way to rebuild Medicaid, in other words, would be to replace it with something better: a universal system.

It seems difficult at present to resist Trump’s regressive anti-health juggernaut, much less to envision something better for tomorrow. But the medical community, which still wields considerable power and influence, appears to be reaching a boiling point. Colleagues fear seeing their coworkers and patients deported; academic freedom is threatened; medical decision-making is constrained by political fiat and managed care restrictions; research funding has disappeared; public health protections have been eviscerated; access to vaccinations has been curtailed; and charlatanism is displacing science at the highest level. Health professionals, having watched Congress slash the public insurance programs on which their patients and institutions rely, are soon to witness the needless suffering and death that will predictably follow. All these assaults are also breeding disaffection among voters. As many polls indicate, health is perhaps Trump’s weakest suit with the general public; most Americans favor more funding for science and public health, as well as universal coverage.

We find ourselves living under a federal government unconcerned with the well-being of its people. The administration’s assault on health—coupled with Republicans’ planned surge in spending for the military and deportations—indicates that it cares far less about preserving the lives of Americans than about controlling, surveilling, and policing them. All of us ought to fight to minimize harm from these depredations. In the process, we should channel the dismay they inspire not just into restoring the nation’s health institutions as they were, but into reimagining them so that, at last, they truly serve the public good.

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