Profits Before Patients: Structural Incentives and Their Impact on U.S. Healthcare Spending and Outcomes

Jocelyn Esmeralda Alvarez

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Introduction: The Cost of Commodification

The United States spends nearly twice as much per capita on healthcare as any other developed nation, yet consistently ranks near the bottom on critical health outcomes, from life expectancy to chronic disease burden. Americans pay more for hospital visits, physician services, and prescription drugs—not because care is more effective, but because the system is engineered to charge more. This contradiction is not incidental; it is systemic. The Iron Triangle of healthcare—cost, quality, and access—illustrates that optimizing one pillar often requires trade-offs with the others. Yet the U.S. manages to compromise all three. In pursuit of profit, it delivers a system that is simultaneously unaffordable, inaccessible, and often underperforming.

Unlike nations with universal or public healthcare systems designed to promote population health, the American model is fragmented, opaque, and driven by market logic. Insurance companies, pharmaceutical corporations, hospital networks, and medical device manufacturers all operate within a framework that rewards revenue generation over patient outcomes. This paper argues that the root cause of the nation's healthcare crisis is not inefficiency or lack of innovation—but a profit-centered architecture that treats health as a commodity. In such a system, administrative complexity is rewarded, pricing is unregulated, and the human need for care becomes subordinate to quarterly earnings. To build a just and sustainable healthcare future, we must confront a hard truth: profit and patient care do not—and cannot—share equal priority.

Administrative Waste Reflects a Market, Not a Mission

A staggering 25% to 31% of U.S. healthcare expenditures are absorbed not by patient care, but by administrative overhead—a rate nearly triple that of nations with single-payer or universal healthcare systems (Himmelstein and Woolhandler). This bloat is not accidental. It is a byproduct of a healthcare economy that values reimbursement more than recovery. Unlike streamlined models in Canada or Taiwan, where billing systems are unified and claims processing is centralized, the American system fractures its administrative labor across thousands of private insurers, each wielding its own rules, coding systems, and paperwork demands.

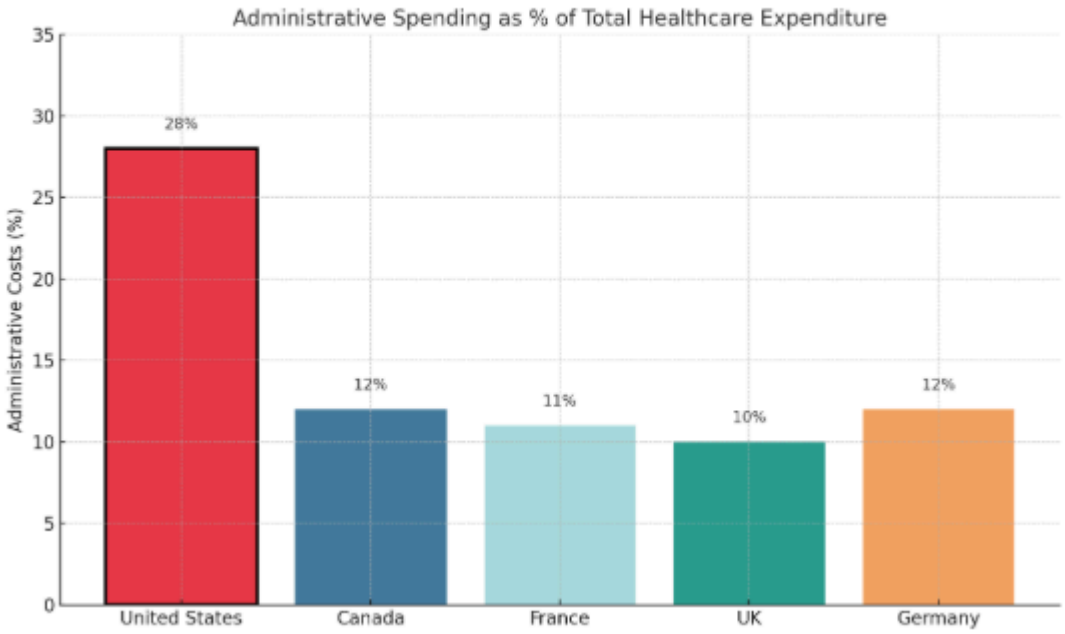


Figure 1. Administrative costs as a percentage of total healthcare expenditure. Data from Himmelstein & Woolhandler (2020); chart created by Jocelyn Esmeralda Alvarez. The U.S. far outpaces other developed nations, reflecting systemic inefficiency tied to profit-driven complexity.

Providers must navigate a labyrinth of preauthorizations, appeals, and reimbursement codes—not to deliver care, but to ensure they are paid for delivering it.

This inefficiency has clinical consequences. According to a 2011 study by Morra et al., American physicians spend nearly four times more hours on billing than Canadian counterparts—averaging $82,975 per physician annually in time and staffing costs just for insurance-related tasks. Such demands erode patient-facing time and fuel the burnout crisis now affecting over 60% of U.S. clinicians. As your 2025 health insurance lecture emphasized, patients are also ensnared in this maze—facing rising deductibles, opaque copays, and catastrophic out-of-pocket ceilings that defy comprehension. Meanwhile, small and rural practices—lacking economies of scale to manage the administrative deluge—are disproportionately likely to close or be absorbed by hospital systems, deepening healthcare deserts across the country.

Viewed through the Iron Triangle framework, this bureaucratic excess collapses two of its three pillars: it drives up costs while limiting access. Worse still, it signals a systemic inversion of healthcare's purpose. In a structure designed around throughput and transaction, healing becomes incidental. The complexity is not the cost of doing business—it is the business.

Insurance Structure and Patient Burden: Designed Confusion, Engineered Profit

For millions of Americans, health insurance functions less as a bridge to care than as a toll gate. The architecture of most U.S. insurance plans imposes steep and often opaque financial burdens through a tangle of deductibles, co-pays, co-insurance rates, and out-of-pocket maximums. As detailed in your lecture series, deductibles alone can exceed $3,500 annually, while out-of-pocket caps can soar above $8,000—costs that patients must absorb before receiving substantial coverage. Co-insurance policies, which obligate patients to pay a fixed percentage of treatment costs even after meeting their deductible, add yet another layer of uncertainty.

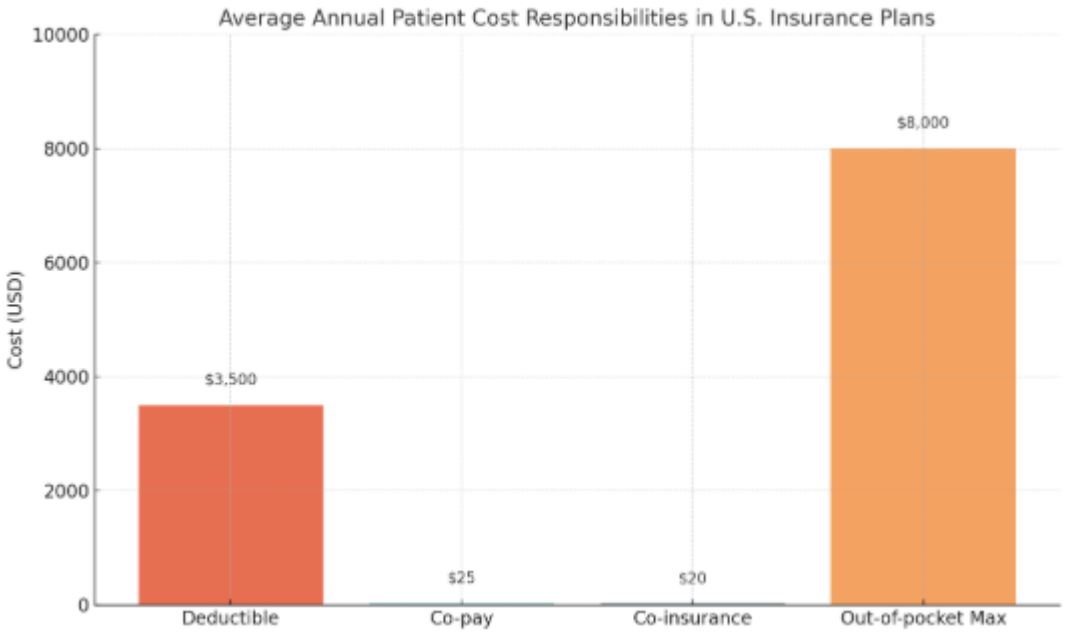


Figure 2. Average out-of-pocket costs for American insurance plans, showing deductibles and caps. Data from KFF and UTHS Lecture 2 (2025); chart created by Jocelyn Esmeralda Alvarez. These costs force patients to delay or avoid necessary care.

These mechanisms are often framed as promoting “personal responsibility,” but in reality, they function as cost-shifting tools—transferring financial risk from insurers onto the sickest and most vulnerable. As a result, individuals delay medical visits, decline preventive screenings, or abandon essential treatments entirely. These outcomes directly contradict the Triple Aim framework, which emphasizes improved patient experience, reduced costs, and better population health.

Even within insured populations, inequality persists. Health Maintenance Organizations (HMOs) restrict access through gatekeeping by primary care physicians, while Preferred Provider Organizations (PPOs) offer more flexibility—at a significantly higher premium. High-deductible health plans, once marketed to healthy young adults, have now become default offerings across employer markets. They lower monthly premiums but expose patients to catastrophic financial risk when illness inevitably strikes. Meanwhile, Health Savings Accounts (HSAs) reward only

those with disposable income, reinforcing a tiered system in which financial literacy and wealth—not need—determine access. As illustrated in Figure 2, these patient-borne costs are not incidental, but integral to a privatized structure that prioritizes market segmentation over equitable coverage. Unlike single-payer systems, where insurance is a conduit to care, the American model uses insurance as a barrier—ensuring that treatment flows not to those in greatest need, but to those most able to navigate its labyrinthine design.

Pharmaceutical Pricing: Legal Monopoly, Life-and-Death Consequences

Nowhere is the profit-first logic of American healthcare more visibly destructive than in the pricing of prescription drugs. Unlike in other developed countries, where medications are treated as essential goods and regulated accordingly, the U.S. pharmaceutical market operates under a system of legal monopolies—backed by patents, lobbying, and policy loopholes. According to Kesselheim et al. (2016), American patients pay two to ten times more for the same drugs than patients in peer nations. As illustrated in Figure 3, the price of insulin alone can exceed $300 per vial in the U.S., compared to just $35 in Canada and $20 in the UK. These differences are not grounded in production costs or drug efficacy. They are artifacts of a system that permits price gouging under the banner of innovation.

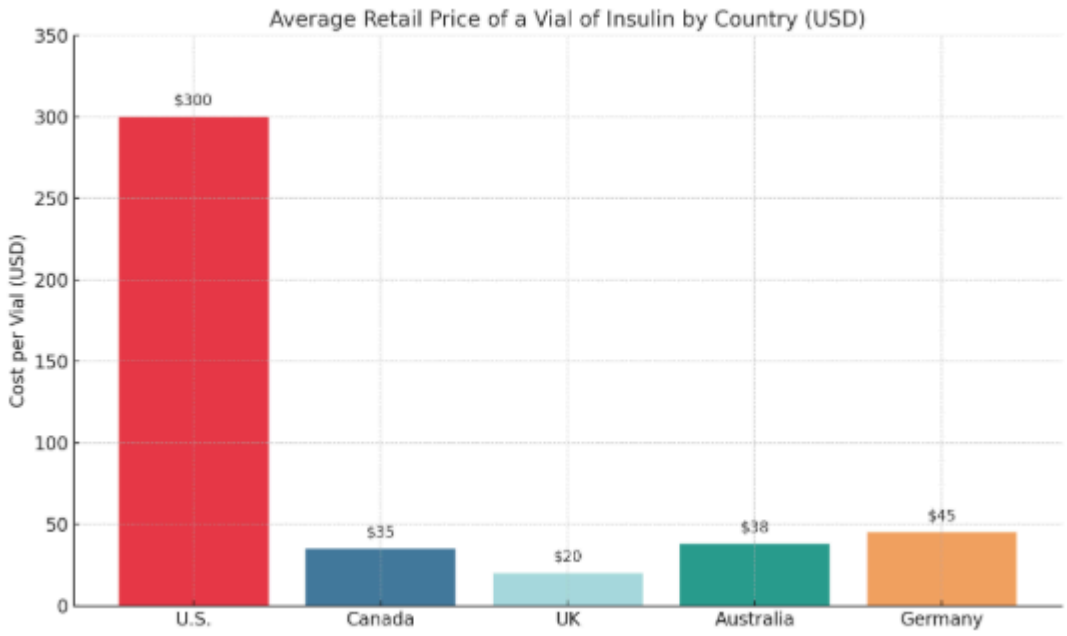


Figure 3. Average retail price of a vial of insulin in select high-income countries (in USD). Prices in the United States far exceed those in comparable nations, reflecting legal protections for monopoly pricing rather than differences in quality, innovation, or production cost. Data from Kesselheim et al. (2016); chart created by Jocelyn Esmeralda Alvarez.

Your class lectures confirm that pharmaceuticals account for a disproportionately large share of U.S. healthcare expenditures. While industry executives claim that high prices fund research

and development, many landmark treatments — from COVID-19 vaccines to breakthrough cancer drugs — were developed with public NIH funding. In other words, taxpayers often finance the science, only to be priced out of the cure. This has cascading consequences: a growing epidemic of cost-related nonadherence now forces millions of Americans to skip doses, split pills, or abandon therapies altogether. The result is not just worsened individual health, but measurable strain on population-wide chronic disease outcomes.

This pricing model fails all three elements of the Triple Aim: it restricts access, diminishes patient experience, and harms public health. In a truly patient-centered system, pricing would reflect therapeutic value and accessibility, not market exclusivity and quarterly profit margins. But in the United States, even a drug as old and essential as insulin becomes a commodity—weaponized against the very patients it was designed to heal. A prescription here is not a promise of care. It's a financial contract, dictated not by doctors, but by shareholders.

Billing Manipulation and Overcare: The Business of Doing More

In a healthcare model where revenue is tethered to procedure volume and coding complexity rather than actual patient outcomes, the incentives are not aligned with healing—they are aligned with billing. American hospitals, particularly those under corporate chains or private equity ownership, thrive on reimbursement models that reward doing more, not necessarily doing better. In *An American Sickness*, Elisabeth Rosenthal exposes how even basic items like a saline IV bag can carry markups exceeding 400%, while routine imaging procedures like CT scans or MRIs may be billed at 700–800% above cost (see Figure 4). These inflated prices are possible due to opaque pricing systems known as charge masters, which list hospital-set rates that are rarely disclosed to patients in advance.

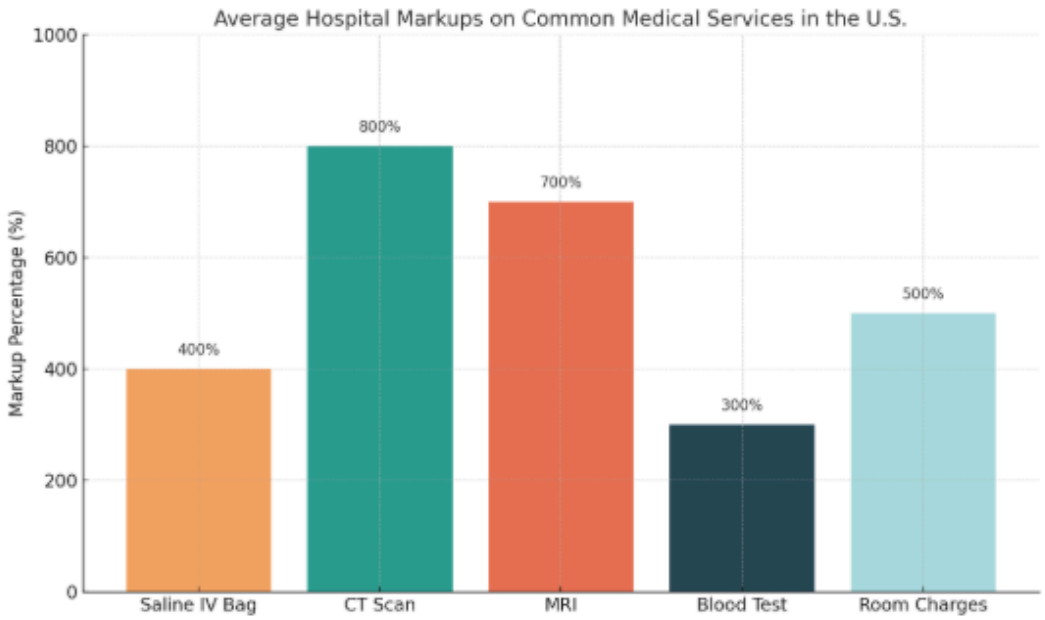


Figure 4. Average hospital markups on common medical services in the United States. Hospitals routinely inflate prices for basic services like IV fluids and imaging procedures, with markups reaching 800%, reflecting a system designed for revenue maximization rather than cost-effective care. Data from Rosenthal (2017); chart created by Jocelyn Esmeralda Alvarez.

Your lectures further illustrate how hospitals use HCPCS codes—standardized billing identifiers—to assign costs to procedures. While these codes were designed to streamline payment, they have become tools for upcoding (billing for more expensive services than were delivered) and unbundling (splitting services to charge separately for each step). These manipulations are not accidental; they are systemic. High-margin procedures like spinal injections or cardiac catheterizations are aggressively marketed, while underfunded areas like mental health, preventive care, and health education are sidelined due to lower financial yield.

This business-first approach skews both the process and outcomes dimensions of the quality-of-care triad taught in your course. Providers are nudged to prioritize profitable interventions over evidence-based, patient-centered care. The result? Burned-out physicians, overtreated patients, and a distorted healthcare economy where expertise in billing codes can prove more lucrative than clinical excellence. In this ecosystem, exploitation isn't a flaw—it's a feature.

Provider Consolidation and Private Equity: Profits Before Patients, Networks Before Needs

In recent decades, American healthcare has undergone a radical reconfiguration — not at the bedside, but in the boardroom. Mergers among hospitals, insurers, and private equity firms have birthed vertically integrated conglomerates that dominate regional markets and reroute care around profitability. While marketed as a strategy to "streamline delivery," consolidation has functioned more like monopolization in slow motion. According to your lectures, insurance companies use this leverage to form exclusive hospital networks — not to reduce patient costs, but to increase bargaining power and restrict patient mobility. Often, the insurer and hospital are now the same entity, turning external negotiations into internal accounting maneuvers that serve shareholders more than the sick.

The downstream effects are alarming. A landmark 2018 *Health Affairs* study found that in regions where hospitals merged, prices rose by over 12%, even as quality of care either stagnated or declined. At the same time, patient choice dropped by an estimated 25%, as people were funneled into closed networks that prioritized internal referrals over individualized needs (see Figure 5).

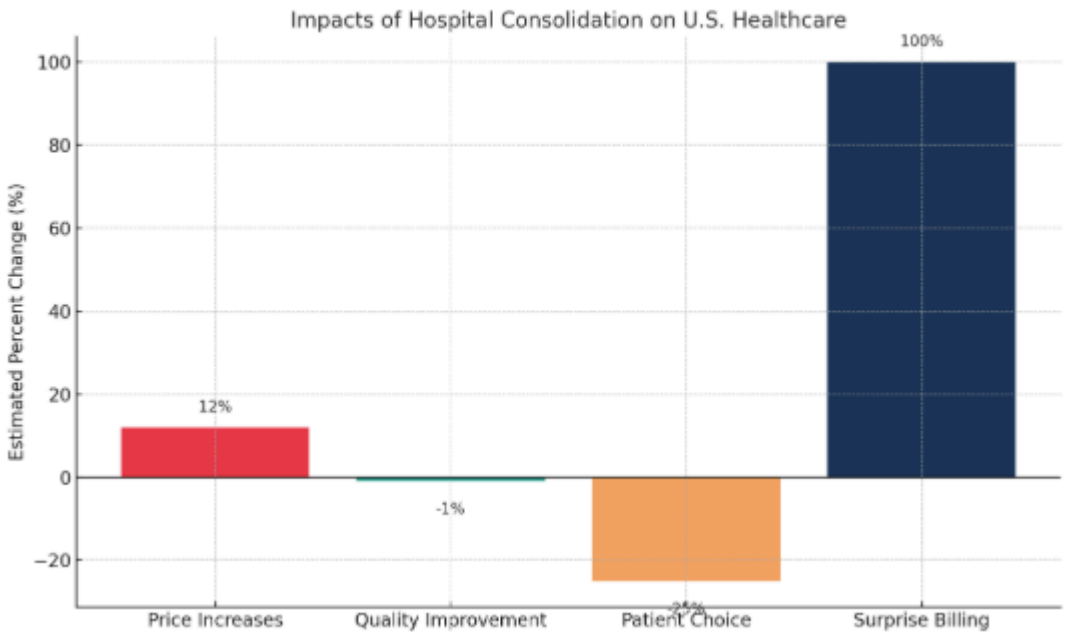


Figure 5. Impacts of hospital consolidation in the U.S. healthcare system. While marketed as efficiency improvements, consolidation often results in price hikes (12%+), reduced patient choice (25%↓), no quality gains, and a 100% increase in surprise billing — revealing the financial motivations behind provider mergers. Data from Zhang et al. (2018); chart created by Jocelyn Esmeralda Alvarez.

The results are not just theoretical. Investigations by *ProPublica* uncovered how private equity–backed ER staffing firms charged tens of thousands for out-of-network services — even at in-network hospitals — exploiting legal loopholes and patients' vulnerability in crisis.

Your lectures on integrated delivery networks (IDNs) further underscore this dynamic: while these networks offer potential for better coordination, they are increasingly deployed as revenue-containment ecosystems that keep both patients and profits in-house. This is not health planning — it's financial engineering. And when hospitals operate like asset pipelines, patients are no longer cared for as individuals, but processed as contractual obligations. In such a system, contracts—not clinicians—dictate the course of care.

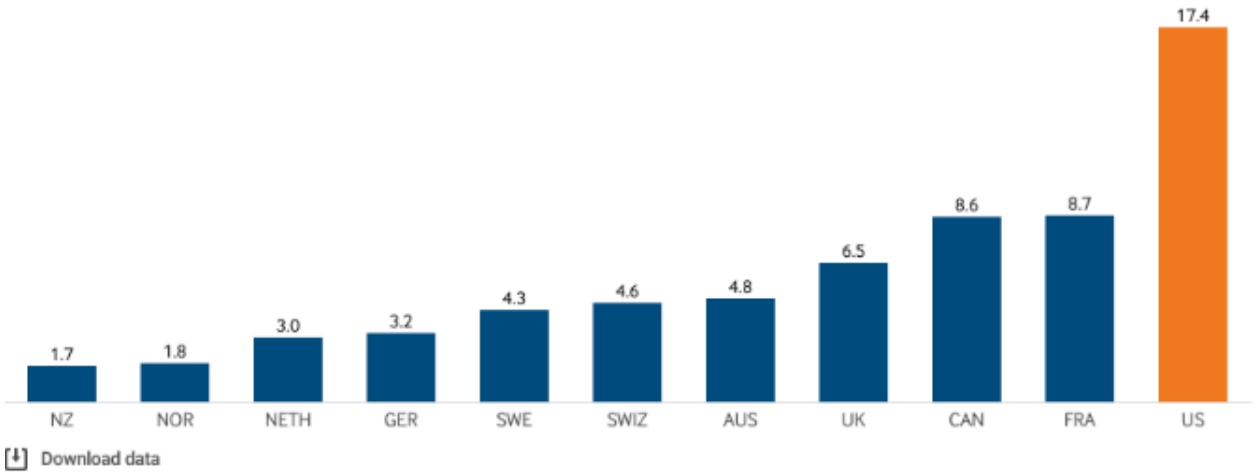
Systemic Outcomes and Social Inequities: A Crisis Beyond the Clinic

Beyond billing statements and hospital boardrooms lies a deeper moral fault line: America's healthcare system, built around profit, actively perpetuates inequality. Despite spending over $4.5 trillion annually, the United States ranks near the bottom among wealthy nations in critical health outcomes like maternal mortality, infant death, chronic disease management, and even preventable hospitalizations (see Figure 6). These aren't anomalies—they're engineered failures.

Exhibit 1

Maternal Mortality Ratios in Selected Countries, 2018 or Latest Year

Deaths per 100,000 live births



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Notes: The maternal mortality ratio is defined by the World Health Organization as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.

Data: OECD Health Data 2020, showing data for 2018 except 2017 for Switzerland and the UK; 2016 for New Zealand; 2012 for France.

Source: Roosa Tikkanen et al., *Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries* (Commonwealth Fund, Nov. 2020). https://doi.org/10.26099/411v-9255

Figure 6. *Maternal mortality rates per 100,000 live births in select high-income countries, highlighting the U.S. as the clear outlier.*

Your course lectures highlighted that rural hospital closures, driven by unsustainable financial models, have created medical “deserts” across the country. Communities most affected are disproportionately low-income, Medicaid-dependent, and people of color—groups that also experience higher rates of preventable disease and longer travel times to care. Then there’s cost-related nonadherence, where patients skip medications or avoid procedures due to price, deepening the chasm between wealth and health. This isn’t a failure of access or empathy—it’s a policy-designed outcome.

Moreover, quality metrics themselves can embed inequity. As your lectures noted, hospitals serving high-need patients often receive lower ratings, not due to poor care, but because they contend with systemic disadvantages—oscillating between underfunding and stigma. In a patient-centered system guided by the Triple Aim, efforts would aim to improve outcomes, enhance experience, and reduce disparities. Yet here, equity isn’t an objective—it’s collateral damage. When healthcare becomes a commodity, social justice is not the exception—it’s the omission.

Counterargument: Does Profit Drive Innovation?

Defenders argue that America's reliance on market forces isn't just functional—it's visionary, fueling rapid breakthroughs and safeguarding patient choice. It's true: the U.S. commands a leading global share of biomedical R&D and patents. But this success is intertwined with public investment long before private hands first intervene. According to NIH records, roughly 99% of drugs approved in the 2010s trace their origins to NIH funding. This reality reframes the narrative: innovation is not being born in profit-seeking labs, but in publicly funded research, assembled under private corporations later.

Even more revealing is which innovations thrive. The U.S. system funnels resources into high-margin areas like specialty drugs and advanced devices, while primary care, mental health, and affordable generics remain chronically underfunded. This disparity isn't a market failure—it's market design, one that sidelines population-level health needs.

Figure 7. Top 17 healthcare innovations of 2024, globally. While the U.S. leads in volume, much of this innovation is channeled through market-driven priorities, highlighting a mismatch between technological progress and equitable access.

In sharp contrast, countries like Sweden and Germany, with universal coverage systems, consistently rank high for both innovation and equity: Sweden recently led the world index in healthcare quality innovation . That success wasn't driven by profit, but by democratic investment and public stewardship.

Ultimately, innovation untethered from equity is ethically hollow. A healthcare system that produces breakthroughs it cannot deliver is a moral dead-end. True innovation, as the Triple

Aim emphasizes, is measured not by novelty, but by uplift in access, experience, and outcomes. The American model proposes that profit powers progress—but the evidence shows it powers exclusivity.

Policy Reform I: Administrative and Pricing Solutions

To meaningfully shift the American healthcare system away from profit-maximization and toward patient-centered care, reform must begin by targeting the structural inefficiencies that silently siphon billions: administrative bloat and opaque pricing. The U.S. spends over $1 trillion annually — roughly 25% of total healthcare expenditures — on administrative processes alone, not to deliver care, but to navigate convoluted billing systems, manage insurer-specific paperwork, and maintain sprawling bureaucracies (Himmelstein & Woolhandler, 2020). As emphasized in your course lectures, this burden is virtually nonexistent in systems like Taiwan's single-payer National Health Insurance, which uses a universal smart card for instant billing, or France's nationalized model that relies on standardized forms and consistent pricing.

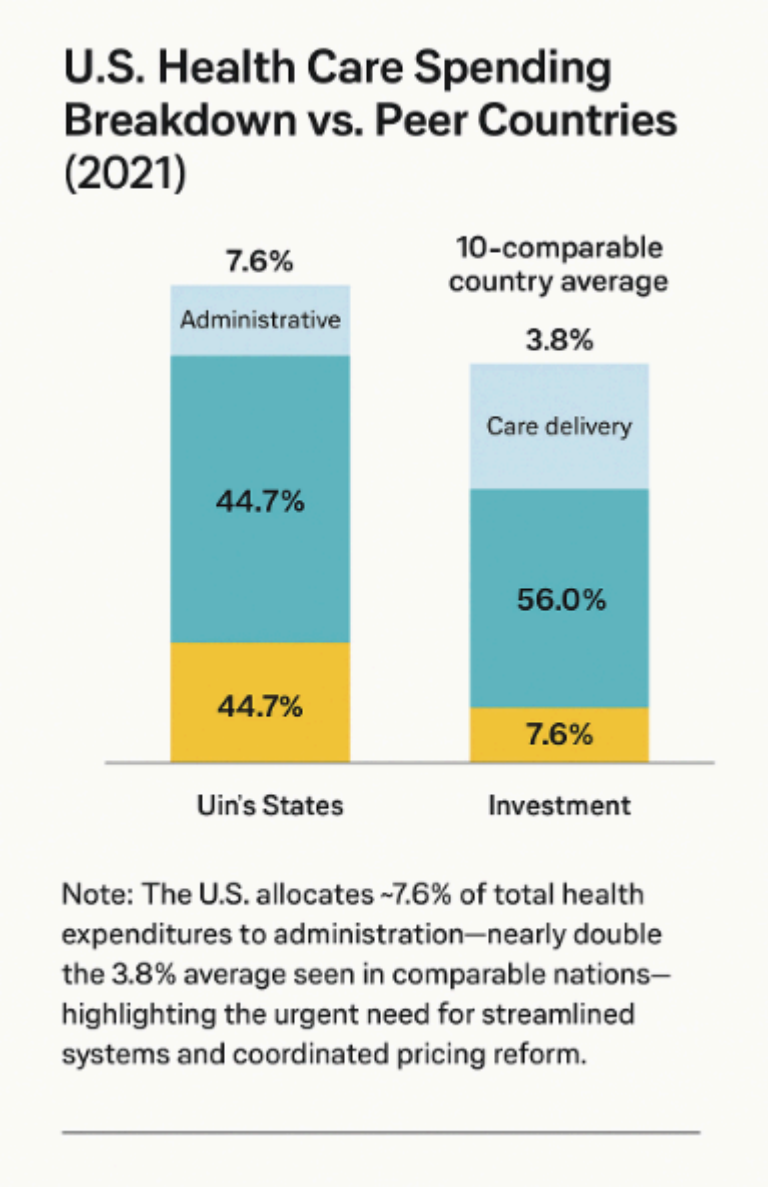

Figure 8. U.S. Healthcare Administrative Costs vs. Other Developed Nations — A quarter of all U.S. healthcare spending is consumed by administration alone, dwarfing the totals in single-payer and centralized systems such as Taiwan, Germany, and France.

These systems prove that streamlined administration doesn't just save money — it enhances care delivery and reduces clinician burnout.

One of the most effective policy tools to address American pricing chaos is all-payer rate setting, in which all insurers — public and private — reimburse providers at the same price for identical services. Already successful in Maryland, this approach eliminates wild price disparities, curtails the monopolistic power of hospital networks, and ensures predictable costs for patients. In a country where the cost of a CT scan ranges from $300 to over $3,000, implementing uniform pricing is not merely rational — it's urgent.

Equally critical is reforming the U.S. pharmaceutical pricing regime. Although the Inflation Reduction Act of 2022 granted Medicare limited negotiation rights for select drugs, the legislation remains a symbolic gesture without broader authority. A meaningful policy shift would grant Medicare full negotiating power across all drug categories, producing a ripple effect across the private market and resetting inflated price baselines. Alongside this, federally mandated price transparency laws should compel drug manufacturers and hospital systems to publicly disclose cost inputs, development subsidies, and pricing algorithms. This would expose price gouging disguised as innovation and restore public trust.

Collectively, these reforms — administrative simplification, all-payer pricing, and pharmaceutical transparency — represent more than fiscal corrections. They redefine the moral framework of American healthcare, restoring the view of medicine as a social covenant rather than a commercial enterprise. While the rest of the world has embraced this vision, the U.S. stands at a crossroads. The challenge now is not invention — it is implementation, and the political will to prioritize patients over profits.

Policy Reform II: Equity, Access, and System Redesign

Redefining American healthcare requires more than trimming inefficiencies; it demands a systemic transformation grounded in equity, justice, and public health stewardship. As emphasized in your course lectures, quality of care is not confined to clinical success but is inextricably linked to the infrastructure that supports it — physician availability, access to primary and preventive services, and the stability of local healthcare networks. A future-forward healthcare system must confront the geographic and racial disparities that have long dictated life expectancy and disease burden in the United States. This begins with targeted reinvestment: reopening rural hospitals shuttered by profit loss, expanding the footprint and funding of Federally Qualified Health Centers (FQHCs), and embedding preventive care services in the very communities most historically neglected. These reforms serve both moral and fiscal imperatives, as improving community access reduces emergency overutilization and avoids downstream spending — reinforcing the Iron Triangle's foundational access-cost relationship.

However, redesign must extend beyond location and logistics into financing and philosophy. Rather than embracing a rigid single-payer model, the U.S. could adopt a unified multi-payer framework akin to those in Germany or the Netherlands, where universal coverage coexists with consumer choice and competition is regulated for equity, not profit. Within this model, essential benefits would be standardized, mental and behavioral health care would be elevated to parity, and out-of-pocket costs would be capped to protect against medical bankruptcy — a uniquely American threat. Transitioning from fee-for-service to value-based payment, as your lectures detail, would further align provider incentives with measurable patient outcomes rather than procedure volume, transforming care from transactional to transformative. Additionally, expanding federal investment in the medical workforce — including tuition forgiveness for clinicians in underserved areas — would begin to close provider deserts and recalibrate access along lines of need, not market density. Ultimately, this second phase of reform demands a moral realignment: to treat healthcare not as a marketplace, but as a democratic promise— a

structural affirmation that wellbeing is not earned through employment or affluence, but guaranteed by citizenship itself.

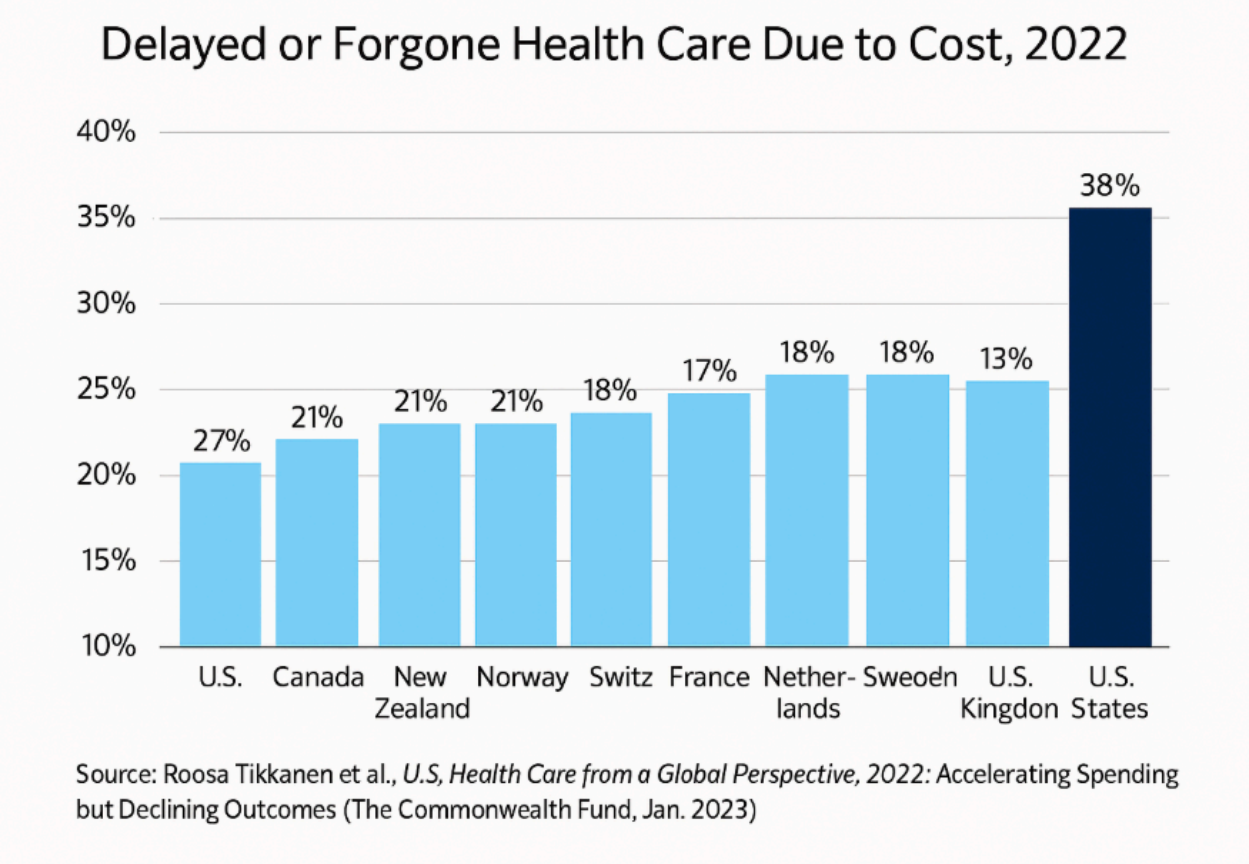

Figure 9. Percentage of U.S. adults who delayed or skipped care due to cost, 2023. Source: KFF (Kaiser Family Foundation), 2023.

Conclusion: Patients Before Profits

The American healthcare system, despite its technological sophistication and clinical innovations, continues to fail at its most essential mission: healing. This failure is not the result of poor intentions or insufficient resources, but of a deliberate architecture built to monetize illness rather than alleviate it. Every layer — from administrative bureaucracy and opaque billing practices to pharmaceutical profiteering and vertical consolidation — has been calibrated to prioritize financial return over patient wellbeing. The result is a system where access is rationed by affordability, quality is compromised by inefficiency, and the most vulnerable are consistently left behind.

Yet this reality is not immutable. As demonstrated by nations with more equitable models, it is entirely possible to decouple healthcare from hyper-capitalism without sacrificing excellence or innovation. The reforms explored in this paper — administrative streamlining, universal pricing frameworks, pharmaceutical regulation, and structural investment in underserved communities — represent not a utopian overhaul, but a practical recalibration. The Triple Aim and Iron

Triangle, far from abstract theory, provide a measurable blueprint for transformation rooted in population health, access equity, and cost containment.

Ultimately, the central question is not whether the U.S. can afford to reform its healthcare system — it is whether we can afford not to. Until profit is displaced as the system's governing logic, even the most groundbreaking cures will remain out of reach for those who need them most. A healthcare system built to serve should not treat compassion as a cost. It should place patients, not profit margins, at the heart of its purpose.

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