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Profit Over Patients: How Financial Corporations Prioritize Earnings at the Expense of Patient Care

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ABSTRACT

The U.S. healthcare system, despite its advanced technologies, faces critical issues with affordability, accessibility, and care quality. This study investigates the financial motivations behind these challenges, revealing how key players—nonprofit and for-profit hospitals, insurance companies, and lobbyists—often prioritize profits over patient well-being. Through an analysis of restrictive insurance policies, the influence of lobbying in legislative decisions, and the Purdue Pharma case's impact on the opioid crisis, the research highlights the ways corporate profit strategies compromise patient access and safety. Findings underscore that lobbying efforts and insurance barriers significantly raise healthcare costs, reduce transparency, and limit patient access to essential care. The study calls for policy reforms focused on protecting patient welfare over corporate interests, exploring alternatives like universal healthcare or price control measures to curb exploitative practices. This paper emphasizes the need for a balanced healthcare model, prioritizing affordability, transparency, and patient-centered care over profit maximization.

Introduction

The U.S. healthcare system is a paradox—while boasting some of the world's most advanced medical technologies, struggles with issues of accessibility, affordability, and quality of care. A significant reason for these systemic problems lies in the healthcare system's entrenched prioritization of profits over patients, primarily through hospitals, insurance companies, pharmaceutical firms, and lobbying efforts. These entities, working under a capitalist framework, are incentivized to maximize earnings, even at the expense of patient well-being. This financial focus distorts the mission of healthcare, leading to significant disparities in health outcomes and unequal care delivery [1]. The following discussion delves into how financial corruption within nonprofit and for-profit hospitals, the pervasive influence of insurance companies, the overwhelming role of lobbying in healthcare legislation, and the devastating outcomes of the opioid crisis not only skew healthcare delivery but also exacerbate inequities, creating a system that serves corporate entities better than it serves patients.

Nonprofit vs. For-Profit Hospitals: A False Dichotomy

Nonprofit hospitals were initially created to provide equitable care, viewing healthcare as a public service. These institutions are to emphasize community health over profit [2]. However, the healthcare landscape changed dramatically with the rise of for-profit hospitals in the 1960s, led by the Hospital Corporation of America (HCA). HCA applied a business model to hospital management, marking a shift toward investor-driven healthcare. This model introduced profit as a primary goal, leading hospitals to operate more like businesses focused on maximizing earnings for investors and shareholders [8].

On the other hand, nonprofit hospitals operate under charitable models and are exempt from taxes. They focus on community health and typically rely on government funding, grants, and donations, allowing them to offer financial assistance programs and meet specific community health standards. Unlike for-profit hospitals, they aren't

obligated to return profits to shareholders and instead reinvest surplus funds into improving services, equipment, and patient care programs. Their tax-exempt status and public funding come with obligations to assess and meet local health needs.

Although nonprofit hospitals are initially established to serve community needs, their tax-exempt status, funding sources, and lack of shareholder accountability create incentives for revenue-driven practices. For example, nonprofit hospitals might prioritize high-revenue services like elective surgeries or advanced imaging, which attract well-insured patients, over essential care for underserved populations [14]. Additionally, many profits engage in aggressive billing or limit the availability of financial aid to increase income from patients [21]. These practices can lead to criticisms that some nonprofits operate similarly to for-profit entities while still receiving tax benefits. In fact, a 2022 study conducted by the Lown Institute found that 82 percent of nonprofit hospital systems spent less on charity care and community investment than the value of their tax exemptions, capturing an estimated $18.4 billion that should have supported the communities they serve. This aligns with the idea that nonprofit hospitals often act more like profit-maximizing entities than community-focused providers [11].

Government policies further accelerated this shift. Programs like Medicare and Medicaid, established in 1965, provided hospitals with steady funding but also incentivized practices focused on profitability. For instance, the Affordable Care Act (ACA) of 2010 promoted mergers among hospitals to streamline care and reduce costs. This led many nonprofit and for-profit hospitals to consolidate into larger systems, often prioritizing market expansion over individualized community care [22]. Government tax policies play a significant role in shaping hospital operations, particularly for nonprofits. These hospitals maintain tax-exempt status if they meet charity care requirements, designed to benefit underserved communities. Many nonprofit hospitals accumulate substantial surpluses classified as "operating income" that are often directed toward executive salaries, new facilities, or investments instead of patient care [8]. For example, Kaiser Permanente, one of the largest nonprofit healthcare systems, generated over $84 billion in revenue yet allocated less than 3% to charity care, highlighting a trend where financial goals often overshadow community-focused missions [14].

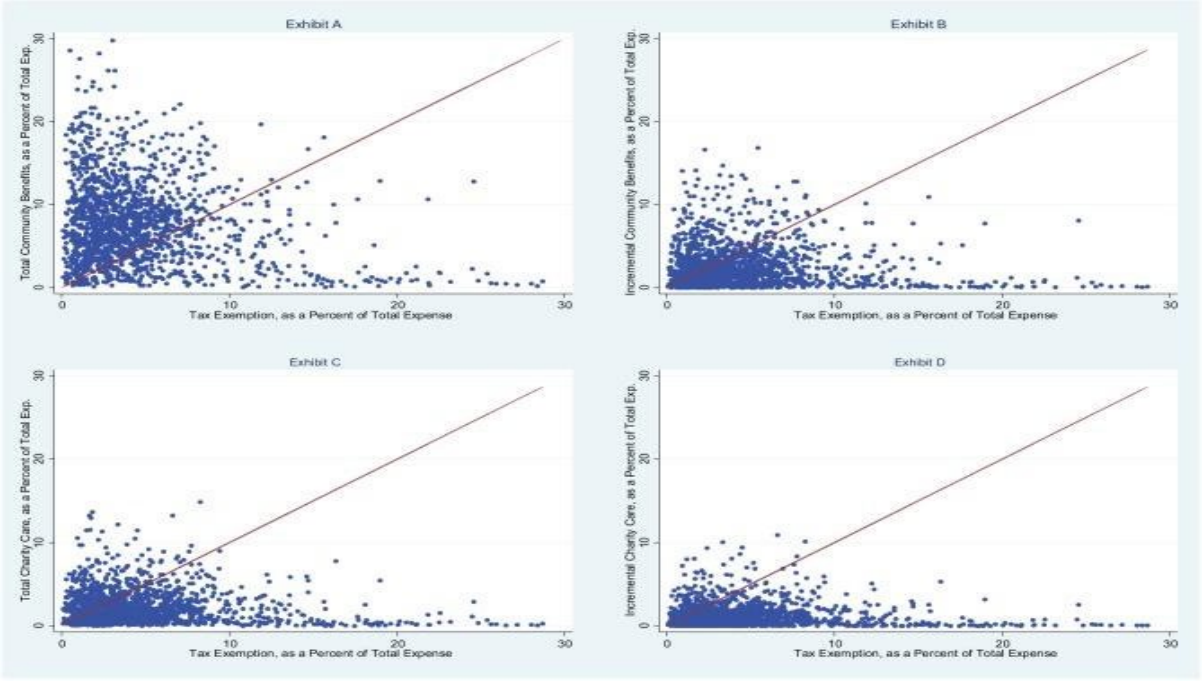

Figure 1. Distribution of Community Benefits Relative to Tax Exemption for Nonprofit Hospitals in 2012 [28]

Figure A's y-axis represents Total Community Benefits, Figure B's shows Incremental Community Benefits, Figure C's displays Total Charity Care, and Figure D's depicts Incremental Charity Care. In each figure, the x-axis represents Tax Expenditures. Data includes 1,648 nonprofit hospitals from 2012, derived from IRS 990 Schedule H, Centers for Medicare and Medicaid Services Hospital Cost Reports, and the American Hospital Annual Survey.

For-profit hospitals explicitly prioritize revenue, often focusing on high-revenue procedures. Needleman's research shows that for-profits are more likely to offer services like orthopedic and cardiovascular surgeries, which generate high profits, while cutting back on essential services like trauma care. This selective service offering creates significant disparities in access, especially for low-income patients who rely on affordable care for chronic or emergency needs [9]. Financial incentives also drive hospitals to specialize in high-revenue fields, such as orthopedics and cardiology. This trend has led many facilities to direct resources toward specialized treatments that bring in more profit while often neglecting general healthcare services. The preference for profitable treatments limits access to essential but less lucrative care, impacting patients who may need more comprehensive health services. The focus on specialties underscores how financial priorities shape healthcare, as hospitals concentrate resources where earnings are highest [16].

The emphasis on profit, seen in both nonprofit and for-profit hospitals, affects patient outcomes significantly. For-profit hospitals implement cost-cutting measures that lead to understaffing and compromise patient care. There is a 2% higher mortality rate in for-profits due to these cost-cutting practices [14]. Additionally, government reimbursement policies encourage hospitals to invest in specialized, high-margin services, like cardiology and orthopedics, which divert resources away from general care. This results in longer wait times, limited access, and disparities in quality, particularly affecting patients who need more routine but critical care.

The Role of Insurance in Limiting Care

In the landscape of American healthcare, insurance companies play a central role in determining access to medical services. Some examples of major insurers include UnitedHealth Group, Anthem, and Aetna. These companies work by setting terms and conditions for coverage, which directly affects patients' access to medical treatments. The relationship between a patient's hospital and the insurance company often involves negotiations on reimbursements and the approval of treatments. Major insurers such as UnitedHealth Group, Anthem, and Aetna implement various financial strategies that often limit patient access to necessary care [36]. These companies prioritize profitability over patient well-being, with their policies frequently disadvantage ring lower-income individuals and families. Research indicates that insurance practices such as prior authorization, formulary restrictions, and narrow networks serve primarily to manage costs and maximize profits, rather than to meet the healthcare needs of all patients [44].

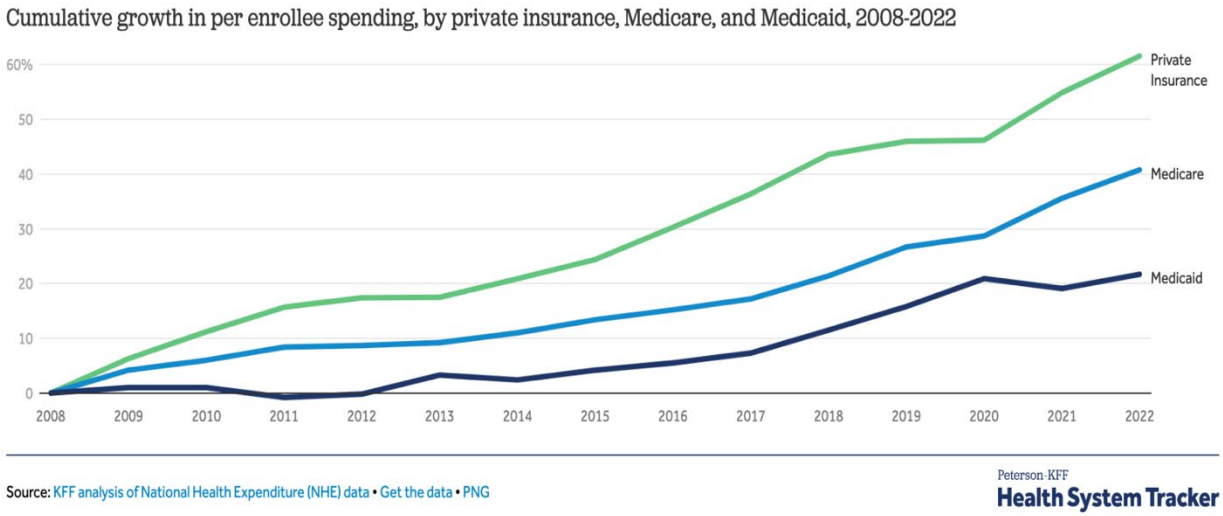

Figure 2. Comparing Health Insurance [34]

The growing prominence of private insurance over public programs like Medicare and Medicaid reflects a significant shift in healthcare access and affordability. This trend suggests that fewer individuals are enrolling in these public options, which may indicate barriers such as eligibility restrictions or inadequate awareness. As private insurers often prioritize profitability, this shift can exacerbate disparities in care, leaving vulnerable populations without sufficient support. The reliance on private insurance may lead to increased out-of-pocket expenses, ultimately compromising access to essential medical services for those who need it most. Individuals who cannot afford private insurance and remain uninsured often face dire consequences for their health and financial stability [36]. Without access to regular medical care, they may postpone necessary treatments, leading to worsening health conditions that could have been managed with timely intervention. Many are forced to rely on emergency services for acute care, resulting in significant medical debt and potential bankruptcy. Additionally, the lack of preventive care can lead to higher rates of chronic diseases, further straining both personal resources and the healthcare system as a whole.

Insurance companies operate by providing policies that cover medical expenses for individuals in exchange for regular premium payments. When a patient seeks care at a hospital, the hospital and the insurance company have a contractual relationship defined by the terms of the insurance policy. The hospital agrees to provide services, and in return, the insurance company agrees to reimburse the hospital for covered services according to their negotiated rates [5]. This arrangement influences the types of treatments covered, the approval processes for care, and the overall cost burden on patients. These companies are primarily incentivized by profit maximization. To achieve this, they design policies that limit coverage for certain treatments or medications, implement cost-sharing mechanisms such as copays and deductibles, and establish narrow provider networks. The U.S. spends more on healthcare per capita than any other nation, totaling approximately $4.3 trillion, which averages about $12,900 per person. Additionally, medical issues account for 66% of all bankruptcies in the U.S., illustrating the financial burden placed on individuals and families. These strategies help control expenditures and increase revenue. Additionally, by lobbying against regulations that could reduce their profits, such as allowing Medicare to negotiate drug prices, insurers maintain a system that prioritizes their financial interests over patient care. This results in the U.S. paying some of the highest prices for prescription drugs, at about 2.5 times higher than other countries [45].These strategies help control expenditures and increase revenue. This profit-driven approach can create barriers to access, particularly for vulnerable populations. For example, Cigna, a leading health insurance company, made $6.7 billion in profit in 2022, indicating the scale of these companies' financial incentives [37].

Prior authorization requires patients to obtain approval from their insurance provider before receiving certain medical treatments or medications [5]. This process can delay critical care, particularly for low-income patients who may not have the resources to navigate complex insurance requirements. Additionally, formulary restrictions limit the medications covered by insurance plans, often forcing patients to opt for less effective or more costly alternatives. These practices disproportionately affect those already facing economic hardships, effectively prioritizing the healthcare needs of wealthier patients who can afford higher out-of-pocket costs [3]. The increasing prevalence of high-deductible health plans (HDHPs) exacerbates the financial strain on patients, transferring a greater share of healthcare costs onto individuals. Currently, HDHPs account for approximately 31% of employer-sponsored insurance plans, a stark rise from previous years [3]. These plans require patients to pay significant deductibles before coverage begins, leading many to delay necessary treatments or forgo care entirely due to cost concerns. This trend highlights a growing divide in healthcare access, where wealthier patients can afford comprehensive care while those with lower incomes are often left to navigate a system that prioritizes profit over patient needs.

Moreover, narrow provider networks, which restrict the range of doctors and hospitals available to patients, limit access to high-quality care. Insurers create these networks to negotiate lower rates, but the resulting lack of choice often leaves patients without access to specialized services necessary for managing complex health conditions. For instance, patients requiring advanced treatments may find that their insurance plan excludes leading medical centers known for their expertise, thus compelling them to seek care in less equipped facilities [5]. The influence of the insurance lobby in shaping healthcare policy cannot be overstated. During the legislative debates surrounding the Affordable Care Act (ACA), insurance companies invested over $120 million to advocate for the preservation of their role in the healthcare system [11]. These lobbying efforts ensured that private insurers continued to play a prominent role, allowing them to profit from the expansion of coverage while maintaining policies that often favor wealthier individuals. Insurance companies have consistently resisted proposals aimed at controlling healthcare costs, including allowing Medicare to negotiate drug prices or creating public insurance options. By opposing such reforms, insurers safeguard their financial interests, often at the expense of those who cannot afford adequate care. This dynamic reinforces existing disparities within the healthcare system, as individuals with lower incomes face increasing barriers to accessing necessary treatments and medications.

Medicaid is a public health insurance program designed for low-income individuals and families, jointly funded by the federal government and states. It provides coverage for a wide array of services, including hospital visits and preventive care. The ACA expanded Medicaid eligibility in participating states, thereby increasing access to healthcare for millions of low-income Americans [36]. In contrast, Medicare primarily serves individuals aged 65 and older, as well as some younger individuals with disabilities. This federal program encompasses various parts: Part A (hospital insurance), Part B (medical insurance), Part C (Medicare Advantage), and Part D (prescription drug coverage). As of now, Medicare provides coverage for approximately 65 million Americans, reflecting its significance in the healthcare landscape [10]. The Affordable Care Act was enacted in 2010 to expand health insurance coverage, improve healthcare quality, and reduce costs. The ACA introduced health insurance marketplaces where individuals can compare and purchase plans and mandated Medicaid expansion for states [34]. Despite facing political challenges, the ACA remains vital in providing coverage for millions who might otherwise lack access to healthcare.

Lobbying and Legislative Influence: The Power of Money

Lobbying in healthcare refers to the activities where corporations, such as insurance and pharmaceutical companies, actively seek to influence lawmakers and government officials to create favorable policies. Lobbyists advocate for regulations that benefit their organizations, such as opposing price controls or negotiating power for Medicare, which ultimately prioritizes profit over patient care. By shaping legislation that safeguards their financial interests, these corporations contribute to a healthcare system that leaves many patients struggling to access affordable and quality services [7]. Lobbying by the healthcare industry has significantly shaped U.S. healthcare policy, often prioritizing corporate profits over patient welfare. In 2023 alone, healthcare-related lobbying expenditures exceeded $700 million,

the highest among all industries [28]. Leading players include major insurance providers like UnitedHealth Group, pharmaceutical companies like Pfizer and Johnson & Johnson, and hospital networks [8]. These corporations lobby for policies that maximize their profitability, often at the expense of affordable and accessible care for patients.

One clear example is the American Hospital Association (AHA), which represents nonprofit and for-profit hospitals alike and spends millions lobbying against transparency regulations and reimbursement cuts. The AHA and similar groups argue that such policies would harm the healthcare system, but critics contend that these efforts primarily protect hospital revenue streams rather than patient outcomes [25]. These lobbying efforts often succeed due to close relationships between industry lobbyists and lawmakers, influencing policies that limit competition and maintain high prices for medical services and drugs.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, which established Medicare Part D, serves as a powerful example of corporate influence on healthcare legislation. Pharmaceutical companies, including giants like Merck and Pfizer, invested heavily in lobbying efforts to include a provision in the bill that prohibits Medicare from negotiating drug prices [40]. This legislative decision has allowed pharmaceutical companies to set drug prices independently, often leading to exorbitant costs for essential medications [5]. For example, brand-name drugs like Advair, a common asthma medication, are priced up to five times higher in the U.S. than in other high-income countries. The inability of Medicare to negotiate prices enables companies to maintain monopolistic pricing strategies, ensuring high profits. This not only affects taxpayers, who fund Medicare, but also restricts access for patients who cannot afford high-cost drugs [29]. The pharmaceutical lobby is one of the most powerful forces in American politics, with companies like Eli Lilly, Pfizer, and Johnson & Johnson consistently among the top spenders on lobbying. These companies employ multiple tactics to prevent price controls and generic competition, which include aggressive patent strategies. For instance, companies file multiple patents on a single drug, often called “patent thickets”, to extend their monopoly beyond the initial patent period [16]. Drugs like Humira, a treatment for autoimmune diseases, are covered by over 100 patents, delaying generic alternatives and allowing manufacturers to maintain high prices for years after the original patent expires [18].

Additionally, by lobbying against regulations that could reduce their profits, such as allowing Medicare to negotiate prices, insurers maintain a system that prioritizes their financial interests over patient care. Elevance Health and CVS Health also exemplify this trend, as they maintained significant profits—$6 billion and $4.2 billion, respectively—while limiting care options for patients. This profit-driven approach can create barriers to access, particularly for vulnerable populations. The practice known as “pay-for-delay” involves brand-name drug companies paying generic manufacturers to delay the release of cheaper generic alternatives. This practice is estimated to cost U.S. consumers billions annually by keeping drug prices high. In recent years, federal regulators have attempted to curb pay-for-delay agreements, but the pharmaceutical industry’s lobbying efforts have stymied many of these initiatives [28]. For instance, the cost of insulin—a life-saving drug for millions—remains disproportionately high in the U.S., partially due to these anti-competitive tactics.

Nonprofit hospitals, which are exempt from federal income taxes due to their charitable status, have increasingly acted in ways that prioritize revenue over patient care. Originally founded with the mission of providing care to low-income populations, many nonprofit hospitals now operate similarly to for-profit entities [37]. The American Hospital Association and other lobbying organizations represent these hospitals, pushing for policies that protect their tax-exempt status while allowing them to engage in revenue-driven practices. In contrast, for-profit hospitals like those managed by HCA Healthcare are explicitly profit-driven, but they often receive the same policy protections as nonprofits due to successful lobbying efforts. Both nonprofit and for-profit hospitals have lobbied to limit requirements for community benefits, which originally justified nonprofit hospitals’ tax exemptions. Critics argue that, in many cases, these hospitals charge high fees to uninsured patients and fail to meet their charitable obligations, raising questions about the genuine benefit these institutions provide to their communities.

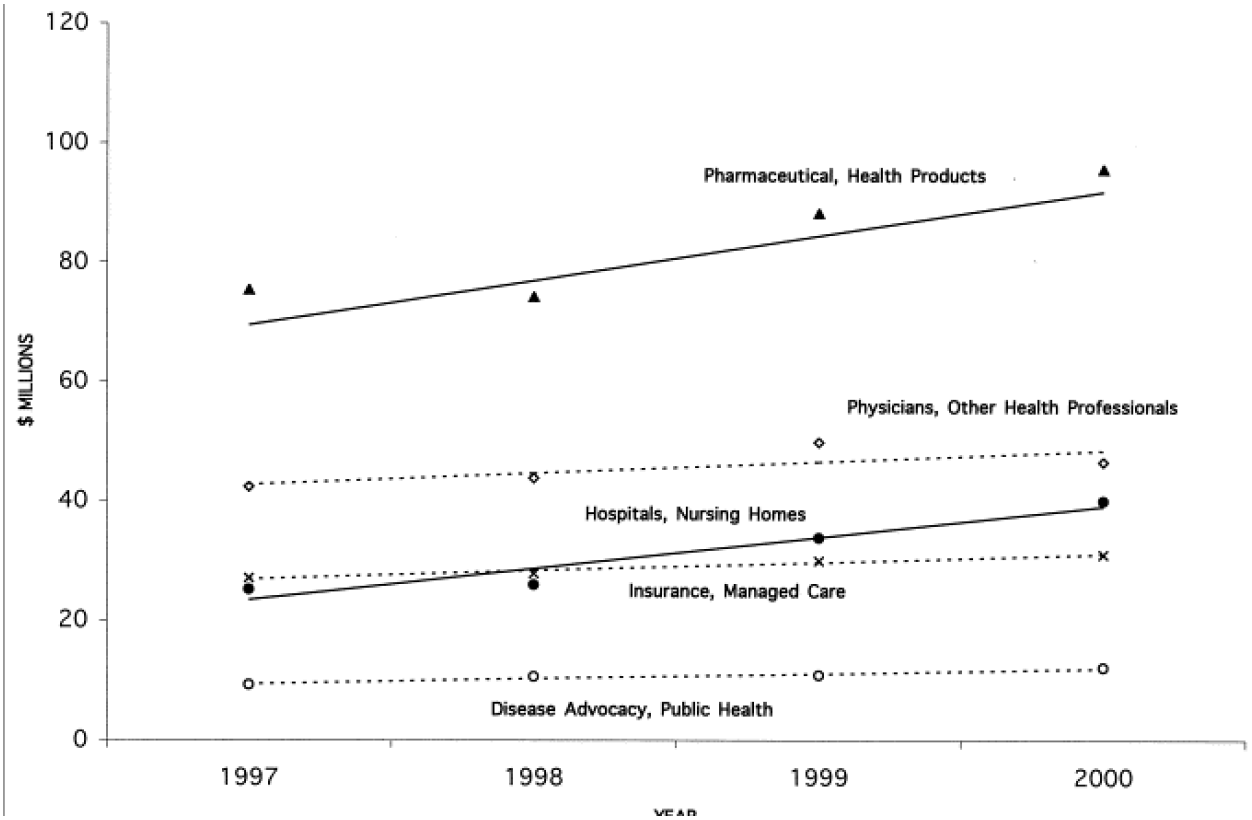

Figure 3. Trends in health lobbying expenditures by different types of groups 1997-2000 [21]. The rate of increase in expenditures was significantly greater ($P < 0.05$) among pharmaceutical/health product companies and hospitals/nursing homes (solid lines) compared with other organizations (dotted lines).

The graph illustrates the disparity in lobbying expenditures across various sectors within the American healthcare system from 1997 to 2000, underscoring the pharmaceutical industry's dominance in policy influence. Pharmaceutical and health product companies consistently spent the most on lobbying, with their expenses increasing each year and peaking around $80 million in 2000. This trend aligns with the argument that pharmaceutical companies wield significant power to influence healthcare policy, often to protect their profits, as shown in your examples of lobbying against Medicare price negotiations [27]. Hospitals and nursing homes show moderate lobbying expenditures, with a slight upward trend, generally spending between $20 and $40 million, reflecting their interest in policy but at a much lower scale compared to pharmaceuticals. Insurance and managed care companies also exhibit steady but moderate spending, staying around $20 million, which likely represents their stake in regulations impacting managed care. Physicians and other health professionals maintain consistent lobbying efforts around $30 million, suggesting their involvement in healthcare policy, though without the same impact as pharmaceuticals. Meanwhile, disease advocacy and public health organizations have the lowest expenditures, spending under $10 million without significant growth, highlighting their limited influence compared to profit-driven sectors. This disparity emphasizes how sectors focused on patient welfare, like public health advocacy, are overshadowed by the financial power of pharmaceutical companies, which use their substantial lobbying budgets to block reforms that could threaten their profits and reduce drug prices for patients.

Pharmaceutical companies leverage lobbying to maintain high drug prices across the board. In addition to manipulating Medicare Part D policies, drug companies fight legislative efforts aimed at pricing transparency. For example, the industry lobbied extensively against recent federal efforts to allow Medicare to negotiate prices for a list of 10 high-cost drugs, including popular medications like Advil, Lipitor, and Eliquis. These lobbying efforts are

backed by powerful organizations like PhRMA (Pharmaceutical Research and Manufacturers of America), which spent nearly $30 million in 2022 alone on campaigns aimed at blocking price control legislation [16]. PhRMA, representing companies like Johnson & Johnson and Pfizer, argues that price controls would hinder innovation by reducing the funds available for research and development. However, critics counter that high drug prices in the U.S. are largely a result of monopolistic practices and a lack of competition, rather than genuine innovation costs. Americans pay almost four times as much for prescription drugs as citizens in other developed nations, an outcome directly linked to lobbying efforts that prevent market competition and price negotiations [5].

The extensive influence of corporate lobbying on U.S. healthcare policy highlights a system where profit motives often overshadow patient needs. From Medicare Part D's ban on price negotiation to patent abuses and pay-for-delay agreements, the tactics used by pharmaceutical companies and hospital networks reinforce high costs and restrict access to affordable care. As a result, patients—particularly those from lower-income backgrounds—face limited access to essential medications and services, illustrating how financial interests continue to dictate the priorities of the healthcare industry. Addressing these inequities will require confronting the entrenched power of the healthcare lobby and enacting reforms that prioritize patients over profit.

Purdue Pharma and the Opioid Crisis Case Study

The opioid crisis in the United States starkly illustrates how the prioritization of profit over patient well-being can lead to devastating public health outcomes. At the center of this crisis is Purdue Pharma, the manufacturer of OxyContin, which has faced scrutiny for its aggressive marketing strategies and misleading claims regarding the drug's safety and addictive potential. Introduced in the late 1990s, OxyContin was marketed as a revolutionary solution for pain management. Purdue promoted the notion that it was less addictive than other opioids due to its time-release formulation. Purdue's marketing minimized the risks associated with long-term opioid use, misleading healthcare providers and patients alike into believing that OxyContin was a safe option for treating chronic pain.

Purdue Pharma's business model was predicated on maximizing profits, often at the expense of patient health. The company employed various tactics to boost OxyContin prescriptions, including direct marketing to physicians, offering lucrative incentives for high prescribers, and funding pain management programs that promoted opioid use. These marketing campaigns framed opioids as essential for alleviating pain, effectively reshaping medical practice to align with corporate interests. The aggressive promotion of OxyContin led to a staggering increase in opioid prescriptions; by the early 2000s, it became one of the most prescribed medications in the U.S., contributing to a spike in addiction and overdose rates. The financial motivations behind Purdue's actions become even more evident when examining the company's responses to the escalating addiction crisis. Despite mounting evidence of addiction and overdose deaths, Purdue continued to push for higher sales of OxyContin, demonstrating a blatant disregard for patient safety. In 2007, Purdue paid $634 million in a settlement for misleading marketing practices, but this penalty was merely a fraction of the profits generated during the peak of OxyContin's sales. Critics have argued that such settlements do little to deter corporate misconduct; they are often viewed as the cost of doing business rather than genuine accountability [26]. This lack of accountability raises critical questions about the effectiveness of the legal system in addressing corporate malfeasance, particularly when financial penalties do not equate to the harm inflicted on communities across the nation.

The human cost of Purdue Pharma's actions is staggering. Reports from the National Institute on Drug Abuse indicate that opioids were involved in over 70% of all drug overdose deaths in the U.S. in 2020 [35]. This crisis has disproportionately affected marginalized communities, exacerbated existing health disparities and highlighting how a profit-driven healthcare model can harm vulnerable populations. Patients seeking relief from pain were often left without adequate support or alternative treatments, as the focus shifted to maximizing sales rather than addressing the root causes of their suffering. Purdue's marketing strategies contributed to a culture of over-prescription, where medical professionals felt pressured to prescribe opioids for pain management, despite the significant risks of addiction. Purdue Pharma's bankruptcy filing in 2019 exemplifies the ongoing challenge of holding corporations accountable

for their role in the crisis. The proposed settlement aimed to limit the company's liability, which drew criticism from lawmakers and advocacy groups who expressed concern that it was insufficient to address the extensive harm caused by Purdue's actions [32]. This situation further illustrates the tension between corporate interests and public health, revealing systemic issues that allow profit motives to overshadow patient care. The Supreme Court has historically ruled in favor of corporate interests, often prioritizing economic considerations over the welfare of citizens. This pattern reflects a broader issue within the American legal system, where corporations can escape full accountability for their actions, leaving victims and communities to bear the burden of corporate greed.

The opioid crisis ultimately highlights the dire consequences of allowing corporate profits to dictate healthcare practices. Strengthening regulatory oversight and implementing stricter marketing guidelines for pharmaceutical companies are crucial steps toward preventing similar situations in the future. Ensuring that patient welfare takes precedence over financial gain is essential to restoring trust in the healthcare system and safeguarding public health. As the U.S. continues to grapple with the repercussions of the opioid epidemic, the lessons learned from Purdue Pharma's actions should inform policy decisions aimed at prioritizing patient care and fostering a healthcare environment that values transparency and accountability over profit. This is not to say that it also catalyzed a public health disaster. Many patients became addicted to the drug, transitioning from prescription opioids to cheaper alternatives such as heroin and fentanyl when prescriptions were no longer available. As overdose rates soared, it became evident that Purdue Pharma's profit-driven practices had significantly contributed to the opioid epidemic [35].

Purdue Pharma's marketing materials downplayed the risks of addiction, while internal documents later revealed that executives were aware of the drug's potential for abuse. The company also promoted higher dosages, which increased both the potency of addiction and corporate earnings. By encouraging physicians to escalate dosages for chronic pain patients, Purdue ensured that demand remained high, fostering long-term dependency among users.

The fallout from these practices led to numerous lawsuits, with states, cities, and individuals suing Purdue for its role in the opioid crisis. In 2020, Purdue declared bankruptcy, agreeing to a $4.5 billion settlement as part of a larger resolution to compensate victims and fund addiction treatment programs [26]. However, critics argue that the settlement is insufficient, given the scale of the epidemic, which has claimed over 500,000 lives since the late 1990s [26]. The Purdue case illustrates how financial incentives in healthcare can prioritize corporate profits at the expense of public health, underscoring the dangers of unchecked capitalism in medical industries. The opioid epidemic, insurance practices, and hospital consolidation trends provide clear evidence that financial incentives have distorted the U.S. healthcare system. When hospitals prioritize revenue over care, insurers limit access to affordable treatment, and pharmaceutical companies promote harmful drugs for profit, patient outcomes inevitably suffer. These dynamics reveal a critical flaw in the U.S. healthcare system: it often serves corporate interests better than it serves patients.

Conclusion

While this paper addresses the role of profit in healthcare, it is limited by its primary focus on financial impacts without a deep exploration of potential regulatory solutions or specific patient outcomes. Future research could examine alternative healthcare models that prioritize patient care, such as universal healthcare or stronger regulations on pharmaceutical marketing and hospital pricing. Additionally, further analysis of the outcomes of recent legislative attempts to curb excessive profits in healthcare could provide insights into creating a more balanced, patient-centered system.

In summary, this paper has explored how profit motives in the American healthcare system often take priority over patient care. For-profit hospitals, unlike non-profit ones, focus on maximizing revenue, while nonprofits typically reinvest in community health, showing a concerning shift toward financial gains over patient welfare. Insurance companies add to this issue, as high premiums and restrictive policies reveal a system focused more on profit than on providing affordable access to care. Lobbying by pharmaceutical companies further worsens this imbalance by shaping policies that protect their profits, blocking transparency and preventing Medicare from negotiating drug prices—leaving patients to face steep costs. The Purdue Pharma case, with its role in fueling the opioid crisis, demonstrates the harmful impact of profit-driven practices on public health, underscoring the need for urgent reform in how

healthcare operates in America. The ultimate goal is a balanced healthcare system where access, affordability, and patient care take precedence over financial interests.

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