Whose Strategy Is Healthcare?

Idea In Short

Stop asking for the one strategy that fixes American healthcare. The system is a wartime accident grown into a fifth of the economy, failing the triple aim while every participant rationally optimizes its own piece. Analyze it by asking whose strategy, seat by seat, and consider collaboration over competition.

Broken in Many Places

United States healthcare holds enormous potential and remains super-fragmented, inefficient and often unjust, broken in many places at once. The industry commands a fifth of the economy, and by some estimates a third of that spending is waste, a combination puzzling enough to anchor an entire graduate strategy course. Understanding the system starts with its strange origin story rather than its current org charts, because the design was never designed.

An Accident of Wartime Wage Caps

The current system originated during World War II, when government wage caps pushed companies toward employer-sponsored insurance as a way to attract workers without raising forbidden wages. Because the government does not tax such benefits, the arrangement became an incredibly tax-efficient way to transfer value to employees, and from that ostensibly logical beginning it grew until more than 55 percent of Americans received healthcare coverage through their employers.1 Among developed economies, only Japan runs a notably similar design. Reform has arrived continuously since: the 1965 Social Security amendments created Medicare for the elderly and Medicaid for the poor, the 1990s added the children's health program, the 2000s brought prescription drug coverage and state-level experiments such as Massachusetts, each layer adding capability and complexity in equal measure.2

Failing the Triple Aim

Evaluated through the reductionist lens of the triple aim, quality, access and cost, national performance has been poor. Quality shows extremes: some of the world's most advanced technologies, therapies and practitioners coexist with life expectancy at birth below the average of developed countries, and outcomes diverge sharply by insurance status, race, income and location.3 Access shows gaps: roughly one in twelve Americans is uninsured, often forgoing preventive care in favor of the safety net of last resort, and more alarmingly, over a quarter of all Americans report difficulty accessing the system at all. Cost shows excess: about 17 percent of gross domestic product, some 9,000 dollars per person, growing faster than nearly anything else in the economy, with an estimated quarter of it wasted. Any private enterprise with that scorecard would have been restructured decades ago.

Not a Free Market

Standard market intuitions mislead here, because the ecosystem is not a free market in any traditional sense. Federal and state governments actively legislate and regulate, non-governmental organizations lobby for favorable rules and two-thirds of hospitals are public or not-for-profit, a single statistic that reframes the whole industry. Business-school precepts still apply, supply and demand, willingness to pay, competition, value chains and strategy, and they require nuanced application rather than direct import. The analyst who treats healthcare like retail will misprice every incentive in the building.

The Numbers Behind the Waste

The waste estimate deserves decomposition rather than a shrug, because a quarter of 17 percent of the economy is real money measured in hundreds of billions annually. The recognized categories include administrative complexity from thousands of payer-provider combinations each with distinct billing rules, pricing failures where identical procedures vary severalfold across a single city, low-value care delivered because fee-for-service pays for volume, and coordination failures that readmit patients whose handoffs failed. Each category maps to an incentive rather than an incompetence, which is why exhortation never fixes it. The analyst's discipline is tracing every waste stream back to whoever profits from its existence, because that trace explains both why the waste persists and who will fight its removal.

Sub-Optimization and the Guiding Question

The most useful diagnosis is classic sub-optimization: groups of independent participants, hospitals, physicians, device makers and insurers, each responding to incentives and optimizing their own piece of the puzzle while the whole underperforms. Complex problems of this shape admit no simple answer and no single strategy, which converts the naive question into the productive one asked throughout any serious study: whose strategy? The seats multiply quickly. The delivery system spans hospitals, skilled nursing facilities, ambulatory surgery centers, managed care organizations and the physicians, nurses and practitioners inside them. Payers split public and private, from Medicare, Medicaid and military coverage to the large commercial insurers. Research, drugs and devices add medical technology firms, pharmaceutical and biotechnology companies, distributors and pharmacy benefit managers. Each seat holds a defensible strategy, and the strategies collide.

Working the Question in Practice

The whose-strategy discipline converts directly into analytical method. For any healthcare question, first name the seat you are answering from, because a hospital system's optimal move on price transparency differs from an insurer's and inverts a device maker's. Second, map the incentive chain around your seat: who pays, who prescribes, who profits and who bears the risk when those diverge. Third, stress-test every recommendation against the other seats' rational responses, since sub-optimized systems punish strategies that assume everyone else stands still. Fourth, locate the policy exposure, because in a market this regulated, a single rule change can reprice an entire strategy overnight. Analysts trained on ordinary industries skip these steps and produce elegant answers to the wrong seat's question, which is the most common failure mode in healthcare strategy work.

Strategy, Applied to Healthcare

Framed as a strategy discipline, the analysis takes the general manager's perspective: seeking sustainable competitive advantage through deliberate choices of cost leadership or differentiation, applying the fundamental tools and frameworks entirely within healthcare's constraints. The exercise rewards anyone in the industry, from executives and investors to clinicians moving into management, because position-specific strategy is exactly what the fragmented system rewards. And the closing provocation deserves its classroom pairing-and-discussion treatment far beyond the classroom: given the waste generated by everyone optimizing separately, perhaps the system needs more collaboration, not competition. The

question is not rhetorical. It is the industry's trillion-dollar homework.

- 1Health insurance in the United States
- 2Medicare
- 3OECD

Summary

American healthcare began as a wage-cap workaround and grew into a fragmented fifth of the economy failing on quality, access and cost. It is not a free market, and no single strategy exists, only strategies per participant. The provocation stands: more collaboration, not competition.