PUBLISHED IN **Visionary Vogues** · Magazine column · web
PUBLISHED 18 November 2026
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SOURCE https://visionaryvogues.com/boardroom-reflections-the-merchants-of-health-ravi-iyer
RECORDED 23 November 2026 · record AR-2026-11-006

THE HEALTHCARE RECKONING · PART 2 OF 4

# The Merchants of Health

*Who controls the price when someone else pays the bill?*

By **Ravi R. Iyer, MD**




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The hidden economics of pharmaceutical pricing, insurance intermediaries, value-based purchasing, and the shared-savings illusion. By Ravi R. Iyer, MD November 18, 2026

## THE BUSINESS OF MAKING FEAR GO AWAY

Imagine a marketplace in which the buyer does not know the price, the seller does not necessarily receive what the buyer pays, the intermediary may profit from the difference, and the person making the purchasing decision may have no meaningful ability to refuse.

- Now imagine that the commodity being traded is not an

- automobile, a computer, or a piece of real estate.

> It is the possibility of staying alive.
> Welcome to American healthcare.

In Part 1 of The Healthcare Reckoning, I examined the Great American Healthcare Illusion: the extraordinary contradiction of a nation possessing some of the world's most advanced medical capabilities while its principal healthcare purchasers remain remarkably disconnected from the economics of what they buy.

> But there is a deeper question.
> Who benefits from this disconnection?

Who controls the price of a pharmaceutical when the patient needs the medicine, the physician prescribes it, the employer finances the benefit, and an intermediary negotiates the transaction?

Who benefits when a hospital's published charge bears little relationship to what different purchasers actually pay?

- Who benefits when a physician is rewarded for reducing
- expenditure, only to discover that yesterday's savings have
- become tomorrow's lower benchmark?

And what happens when the financial architecture of healthcare becomes dependent on the continuous circulation of premiums, claims, rebates, incentives, and new enrollments?

To understand American healthcare, we must follow the money.

Not merely to discover who receives it.

But to understand who controls the rules by which everyone else must earn it.

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## I. THE MERCHANTS OF FEAR

I have spent more than four decades practicing medicine.

And there is one reality that becomes impossible to ignore after sitting across from thousands of patients confronting illness, disability, and mortality.

- The patient is not purchasing a commodity.
- The patient is seeking relief from uncertainty.
- Will I survive?
- Will I recover?
- Will I lose my independence?
- Will my family suffer?
- Can this be prevented?
- What happens next?

Fear transforms the economics of the transaction.

- When the alternative is pain, disability, or death, ordinary
- bargaining power can disappear.

> The physician possesses specialized knowledge.

> The hospital controls access to facilities and services.

The pharmaceutical manufacturer may control the only available patented treatment.

The insurer controls the terms of coverage.

- The intermediary may control access, reimbursement, or
- distribution.
- And the patient stands at the center of this commercial
- architecture, frequently unable to distinguish the actual cost of
- care from the price demanded for access to it.

This does not make every participant a profiteer.

Physicians, hospitals, insurers, pharmaceutical companies, and benefit administrators perform essential functions.

- Medical innovation requires capital. Hospitals require
- infrastructure. Insurance requires risk management.
- Pharmaceutical distribution requires logistics and safety
- controls.

The issue is not whether these services deserve compensation.

- The issue is whether compensation is determined by the value
- created, or by the power to control access to something the
- purchaser cannot safely refuse.
- That distinction separates legitimate enterprise from the
- exploitation of vulnerability.

And it is the starting point for understanding the merchants of health.

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## II. THE PHARMACEUTICAL PARADOX: WHO ACTUALLY KNOWS THE PRICE?

> Consider the journey of a prescription medication.
> A pharmaceutical manufacturer develops and markets a drug.

- A pharmacy benefit manager, or PBM, may negotiate rebates,
- formulary placement, pharmacy reimbursement, and
- administrative arrangements.

An insurer or employer-sponsored plan finances the pharmacy benefit.

> A pharmacy dispenses the medication.
> The patient pays whatever cost-sharing the plan requires.

At first glance, this appears to be a conventional supply chain.

> But the economics are considerably more complicated.
> There may be a manufacturer list price.

- A negotiated rebate.

- Additional administrative or service fees.
- A pharmacy acquisition cost.
- A PBM reimbursement rate.
- A patient copayment or coinsurance obligation.
- And a final net cost to the employer.

These figures may be substantially different.

The list price is not necessarily the manufacturer's net revenue.

The amount reimbursed to the pharmacy is not necessarily what the PBM charges the employer.

The patient's out-of-pocket payment may be calculated using yet another contractual formula.

- Some PBMs pass through rebates and charge transparent
- administrative fees. Others have historically operated under
- arrangements involving retained rebates, spread pricing, or
- other compensation mechanisms.

> The arrangements vary.
> But the underlying governance problem remains.

- How can the employer determine whether a pharmaceutical is
- competitively priced when the complete economics of the
- transaction are not visible?

- Imagine a corporation purchasing $20 million annually in
- industrial supplies.

Its purchasing department discovers that the purchasing agent negotiates undisclosed supplier payments, controls which products may be purchased, and determines the price reported to the corporation.

- Would the CFO accept that arrangement without an
- independent audit?

- Yet comparable questions have persisted for years in
- pharmaceutical benefit contracting.

The problem is not simply the existence of intermediaries.

It is the potential conflict between the interests of the purchaser and the financial incentives of the agent.

And the solution begins with a simple principle.

- The person paying the bill must be able to see the true net
- price.

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## III. THE HOSPITAL PRICING MAZE

> Pharmaceuticals are only one part of the problem.
> Consider hospital services.

A single procedure may have multiple prices depending on the insurer, contract, site of service, and patient's coverage.

> The hospital may publish a gross charge.
> Medicare may reimburse a different amount.

- A commercial insurer may negotiate another rate.
- A self-pay patient may be offered a cash price.
- A patient with a high deductible may face substantial financial
- responsibility despite being insured.

Some of these differences are economically explainable.

Different contracts involve different patient volumes, service obligations, risk arrangements, and reimbursement structures.

But the resulting system is extraordinarily difficult for employers and patients to navigate.

- Federal hospital price-transparency requirements have
- increased the availability of negotiated-rate information.
- Yet publishing data is not the same as making it
- understandable, comparable, or actionable.

A machine-readable file containing thousands of billing codes is not necessarily purchasing intelligence.

The employer needs answers.

- What is the complete episode-of-care price?
- What is included?
- What is excluded?
- How do complications affect the total?
- What are the outcomes?
- How does the price compare with clinically equivalent
- alternatives?
- And what does the patient actually pay?
- Without those answers, price transparency risks becoming
- another administrative exercise.

Transparency without comparability is information. Transparency with comparability becomes negotiating power.

That distinction will become central to Part 3 of this series.

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## IV. THE INTERMEDIARY ECONOMY: WHEN COMPLEXITY BECOMES A BUSINESS MODEL

- American healthcare has developed an enormous infrastructure
- of organizations that sit between the purchaser and the
- provider.

- Insurers.
- Third-party administrators.
- Pharmacy benefit managers.
- Claims processors.
- Utilization management companies.
- Specialty pharmacy networks.
- Provider contracting organizations.
- Revenue-cycle management companies.
- Benefits consultants.
- Data analytics vendors.
- Each may perform useful functions.

But each additional layer introduces another set of contractual relationships, administrative costs, and potentially conflicting incentives.

Some intermediaries reduce costs through scale, coordination, fraud prevention, negotiated discounts, or improved clinical management.

Others may add complexity without delivering commensurate value.

> The challenge is to distinguish between them.
> Consider a hypothetical transaction.

- A medical service costs $1,000 to deliver.
- The provider receives $1,200.

The employer ultimately pays $1,500 after administrative and contractual expenses.

The $300 difference is not automatically waste. It may finance legitimate services.

- But what services?
- Who provided them?
- Were they necessary?
- Could they have been purchased more efficiently?
- And did they improve the patient's outcome?

These are the questions that should determine compensation.

Instead, healthcare contracts can make the answers difficult to obtain.

This creates an uncomfortable possibility.

The complexity of the system can become economically valuable to those who understand it, and economically costly to those who do not.

The more difficult it becomes to understand a transaction, the harder it becomes to challenge its price.

And the harder it becomes to challenge the price, the weaker the pressure to demonstrate value.

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## V. THE GREAT MYTH OF VALUE- BASED PURCHASING

Now we arrive at what may be the most consequential illusion of all.

- Value-Based Purchasing.
- Value-Based Care.
- Pay-for-Performance.
- Shared Savings.
- Accountable Care.

These terms have dominated healthcare reform discussions for years.

The premise sounds entirely reasonable.

- Rather than paying physicians and hospitals simply for the
- volume of services delivered, reward them for better outcomes
- and more efficient care.

Who could object?

I certainly do not object to rewarding genuine clinical value.

But there is a profound difference between paying for value and transferring financial risk under the banner of value.

> And that difference deserves much closer examination.
> Consider the conventional shared-savings proposition.

The payer establishes an expected expenditure benchmark for a population of patients.

The provider is encouraged to reduce unnecessary utilization, improve chronic disease management, prevent complications, and coordinate care more effectively.

- If expenditure falls below the benchmark, the provider may
- receive a portion of the savings.

In some arrangements, the provider also assumes downside financial risk if spending exceeds the target.

The promise is seductive.

- Improve care.
- Reduce costs.
- Share the savings.
- Everybody wins.

But examine the transaction more closely.

- The physician must often invest in care coordinators, technology,
- clinical protocols, analytics, outreach, and administrative
- infrastructure.

The physician may be held accountable for expenditures influenced by hospital pricing, pharmaceutical costs, patient behavior, and other factors outside the physician's direct control.

The payer, meanwhile, may retain substantial authority over reimbursement arrangements, covered benefits, and contract design.

The provider is asked to assume responsibility for the financial outcome of a system the provider does not fully control.

This is not necessarily value-based purchasing. It can become risk transfer disguised as partnership.

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## VI. THE SHARED-SAVINGS RATCHET: WHEN SUCCESS BECOMES TOMORROW'S PENALTY

Consider a hypothetical healthcare organization responsible for managing a population with an annual spending benchmark of $100 million.

- Through improved care coordination, more appropriate
- utilization, and effective chronic disease management, the
- organization reduces expenditure to $90 million.

It generates $10 million in savings.

Under a 50% shared-savings arrangement, it receives $5 million.

> A success.
> The provider celebrates.

- The payer celebrates.
- The consultants celebrate.

But what happens next year?

Suppose the benchmark is reset to $90 million, reflecting the previous year's actual expenditure.

The provider must now reduce expenditure below $90 million to generate additional savings.

If it produces another 10% reduction, expenditure falls to $81 million.

> The new savings are $9 million.
> The provider's share becomes $4.5 million.
> In the third year, the benchmark may fall again.

- And again.
- And again.

> THE HYPOTHETICAL SHARED-SAVINGS RATCHET
> Spending benchmark Provider reward
> $0$30M$60M$90M$120MYear 1Year 2Year 3Year 4Year 5

Illustrative model: 10% annual spending reduction, benchmark resetting to prior-year actual expenditure, and 50% provider share. Real contracts may include inflation trends, regional comparisons, risk adjustments, rebasing safeguards, and other provisions.

- The provider continues producing the same percentage
- improvement.

Yet the absolute reward declines.

- Meanwhile, staffing expenses may rise.
- Technology expenses may rise.
- Clinical complexity may rise.
- Regulatory compliance costs may rise.

The provider must continually find additional efficiencies simply to maintain a shrinking stream of incentive income.

- At some point, the easiest opportunities for reducing
- unnecessary expenditure have already been captured.

> The remaining reductions become progressively harder.
> And potentially more dangerous.

Because when waste has been removed, further reductions may begin to affect necessary services.

This is the economic ratchet.

Yesterday's exceptional performance becomes today's minimum expectation.

- And the provider discovers that success can become the
- mechanism by which future compensation is compressed.

Not every value-based contract uses this structure. Some benchmarks are adjusted for inflation, population risk, regional spending, or other factors, and some models protect providers from excessive rebasing.

But wherever a provider's prior savings are incorporated into future targets without an appropriate long-term reward for the investment that produced them, the underlying conflict remains.

- Who owns the economic value of better care once the
- improvement becomes permanent?

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## VII. ARE PROVIDERS BORROWING THEIR FUTURE EARNINGS INTO THE PRESENT?

There is a deeper financial implication.

Suppose a physician group invests $2 million in infrastructure that reduces avoidable hospitalizations.

The group receives a shared-savings payment.

But the following year's benchmark incorporates some of those savings.

The payer or purchaser continues benefiting from the reduced expenditure.

The physician group continues paying for the infrastructure.

Yet the incremental financial reward may decline.

In effect, the provider has monetized part of the future value of its improvement in the present.

This is not a loan in the conventional accounting sense.

But economically, it can resemble the acceleration of future earning potential into an immediate incentive payment.

The provider receives a reward today while the future baseline becomes more demanding.

And if the underlying improvement is sustainable, much of its continuing financial benefit may accrue elsewhere.

The paradox is striking.

The party that creates the efficiency may not retain the long-term economic benefit of the efficiency.

This raises a fundamental question of fairness.

- Why should physicians be encouraged to make investments that
- permanently improve care if the financial reward for those
- investments is progressively extinguished?

A sustainable value-based system must reward not merely the initial discovery of efficiency, but the continuing maintenance of genuine clinical value.

Otherwise, the provider is being asked to finance the payer's future savings.

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## VIII. THE PONZI QUESTION: DOES THE SYSTEM DEPEND ON AN ENDLESS SUPPLY OF NEW INSURABLE LIVES?

> Now consider the larger financial architecture.
> Insurance operates through risk pooling.
> Premiums are collected from a population.

Those funds, together with reserves and investment income where applicable, finance covered medical expenditures and administrative obligations.

This is a legitimate and essential financial mechanism.

But it introduces a question that deserves much greater scrutiny when combined with the shared-savings ratchet.

What happens when the system's promises of continuing value become dependent on a continuing influx of premium-paying lives?

- Existing members renew.
- New members enroll.
- Premium revenue enters the system.
- Current medical obligations are financed.
- Providers assume expenditure risk.
- Shared-savings incentives are calculated.
- Benchmarks are revised.
- And the process repeats.

There is nothing inherently fraudulent about this circulation of money.

- Insurance pools routinely use current premiums to finance
- current claims. A financially sound insurer does not require
- perpetual enrollment growth to remain solvent.

But consider a different situation.

- Suppose the financial obligations of a particular arrangement
- cannot be sustained through its existing premium base,

- reserves, and genuine recurring savings.

Suppose the provider's capacity to generate further savings has diminished.

Suppose the payer continues promising economic rewards that cannot be supported by the underlying value created.

And suppose the shortfall is increasingly concealed by the inflow of revenue from expanding enrollment.

At that point, we confront the Ponzi question.

A Ponzi scheme is a specific fraudulent structure in which promised returns are financed through money obtained from newer participants rather than genuine underlying earnings.

Value-based care is not inherently such a scheme.

But the economic analogy becomes relevant if an arrangement requires continuous growth in new paying participants to fulfill commitments that its underlying economics cannot sustain.

This is not an accusation that every insurer or value-based care organization operates fraudulently.

It is a demand for financial accountability.

If value-based healthcare truly creates sustainable economic value, it should be capable of demonstrating that value without depending on perpetual enrollment growth.

The test is simple: Can the arrangement survive when the supply of new insurable lives stops expanding? Can the payer remain solvent? Can the provider remain financially viable? Can patient outcomes remain protected? Can incentives continue to reward genuine improvements? Can the system sustain itself without continually lowering provider benchmarks or increasing the burden on patients?

If the answer is yes, the model may be sound.

If the answer is no, and new premium inflows are essential to sustaining otherwise unfunded promises, then the system's financial logic deserves serious scrutiny.

- The relevant evidence would include contract-level cash flows,
- risk-adjusted medical spending, provider compensation,
- enrollment trends, reserves, and the financing of future
- obligations.

Without those data, the Ponzi comparison remains a hypothesis, not an established description of the industry.

- But it is a hypothesis that the architects of value-based
- purchasing should be willing to confront.

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## IX. THE QUESTION NOBODY WANTS TO ASK: WHAT HAPPENS WHEN THERE ARE NO MORE SAVINGS?

- Every efficiency initiative eventually confronts diminishing
- returns.

> The first opportunities may be relatively straightforward.
> Eliminate duplicate testing.
> Reduce avoidable hospitalizations.
> Improve medication reconciliation.
> Prevent unnecessary emergency department visits.
> Coordinate care more effectively.

- These interventions can produce real clinical and economic
- benefits.

But the opportunity to reduce waste is not infinite.

- At some point, the remaining expenditure increasingly reflects
- necessary care, legitimate medical complexity, and the
- unavoidable costs of aging and disease.

What happens when the contractual expectation of additional savings continues after the clinically appropriate opportunities have been exhausted?

- The incentives may become distorted.
- Necessary services may be delayed.
- Access may become more restrictive.
- Clinicians may face pressure to avoid high-risk patients.
- Complex patients may become financially unattractive.

The system may begin rewarding reduced expenditure without adequately distinguishing between the elimination of waste and the withholding of beneficial care.

- These outcomes are not inevitable. Proper risk adjustment,
- quality measurement, patient protections, and independent
- oversight can mitigate them.

But the risk is real.

There is a profound difference between reducing the cost of unnecessary care and reducing care because the financial target demands it.

> One creates value.
> The other may destroy it.

- And a healthcare system that cannot reliably distinguish
- between them has no business calling itself value-based.

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## X. THE FUNDAMENTAL MISALIGNMENT: WHO PROFITS FROM BETTER HEALTH?

Consider the physician who prevents a myocardial infarction.

- The patient benefits.
- The family benefits.

The employer may benefit through reduced absenteeism and improved productivity.

The insurer or purchaser may benefit through avoided medical expenditure.

Society benefits.

But how much of that value returns to the physician or care team responsible for the intervention?

Often, the answer is difficult to quantify.

- And if the improvement lowers future expenditure benchmarks,
- the provider may find that the reward for maintaining the
- improvement diminishes over time.

> Now consider the opposite scenario.
> A patient develops a preventable complication.

- Hospitalization occurs.
- Procedures are performed.
- Claims are submitted.
- Reimbursement flows through the system.
- Multiple organizations receive payment for their roles in
- managing the event.

The patient may recover.

But the event has generated an extensive sequence of financial transactions.

This does not mean the participants wanted the complication to occur.

- It means the financial architecture is often better organized to
- pay for recognized medical events than to reward their
- successful prevention.

The system can precisely price the treatment of catastrophe while struggling to reward the prevention of catastrophe.

That is not merely an accounting problem.

It is a fundamental misalignment between economic incentives and biological value.

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## XI. THE MERCHANTS OF HEALTH AND THE MORAL QUESTION

> Commerce is not inherently immoral.
> Profit is not inherently exploitation.

Pharmaceutical companies should be rewarded for genuine innovation.

> Hospitals must be financially sustainable.
> Insurers perform legitimate risk-management functions.
> Physicians deserve fair compensation.

Intermediaries that improve efficiency should be paid for the value they create.

But healthcare is not an ordinary commercial enterprise.

- Its ultimate customer is a vulnerable human being whose
- capacity to bargain may be constrained by illness, fear, or
- medical necessity.

That reality creates a special obligation.

The price of care should not be determined solely by the ability to exploit informational asymmetry.

- The reward for managing healthcare should not depend on
- concealing its true economics.

The compensation of physicians should not be progressively undermined by the very improvements they are encouraged to produce.

And the financing of future healthcare obligations should not depend on an unsustainable expectation of endless enrollment growth.

- The legitimacy of healthcare commerce rests on its ability to
- demonstrate that financial rewards correspond to genuine
- human value.

Without that connection, we risk transforming the suffering of patients into an endlessly renewable commercial opportunity.

- And that is the moral contradiction at the heart of the
- merchants of health.

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## XII. THE BOARDROOM REVOLUTION: WHAT IF THE PURCHASERS REFUSED TO REMAIN BLIND?

Now imagine a different arrangement.

An employer knows the true net cost of every pharmaceutical purchased through its health plan.

It knows the actual prices paid for comparable hospital services.

- It can identify administrative compensation retained by
- intermediaries.
- It can compare clinical outcomes across providers.
- It can distinguish avoidable expenditure from medically
- necessary care.
- It can negotiate transparent contracts.

And it can measure whether its healthcare spending produces meaningful improvements in employee health.

- Now imagine 100 employers sharing this purchasing
- intelligence.
- Or 1,000.
- Imagine those employers aggregating their purchasing
- requirements.
- Negotiating directly with pharmaceutical manufacturers.
- Contracting with laboratories and imaging centers.
- Establishing transparent arrangements with high-quality

- physician networks.
- Paying administrative vendors fixed, auditable fees.
- Rewarding clinical outcomes without imposing an endless
- downward ratchet on provider compensation.

What would happen to the negotiating power of intermediaries whose principal advantage depends on controlling information? What would happen to pricing structures that cannot withstand direct comparison? What would happen if the employer purchasing community became capable of seeing the entire healthcare transaction?

> The opportunity is not simply to remove middlemen.
> Some intermediaries perform indispensable functions.

The opportunity is to eliminate unnecessary intermediation, expose hidden compensation, and ensure that every participant is paid for demonstrable value.

- And for the first time, artificial intelligence may make the
- necessary scale of analysis and coordination practical.

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## XIII. THE NEXT REVOLUTION WILL BE A REVOLUTION IN PURCHASING

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## INTELLIGENCE

Artificial intelligence cannot abolish medical risk.

- It cannot eliminate the cost of innovation.
- It cannot replace the judgment of physicians.
- It cannot transform every healthcare service into a perfectly
- competitive commodity.
- But it can potentially make fragmented pricing information
- intelligible.
- It can compare complex contracts.
- It can identify unwarranted variation.
- It can support pharmaceutical price negotiations.
- It can help employers organize purchasing consortiums.
- It can monitor whether negotiated savings actually reach the
- purchaser.
- And it can help evaluate healthcare expenditure against
- clinically meaningful outcomes.

That is a very different use of AI from simply automating prior authorizations or accelerating claims processing.

It is the application of intelligence to the economic architecture of healthcare itself.

- The central question becomes:
- What happens when the people paying for healthcare finally

- possess the intelligence to negotiate what they purchase?

For decades, healthcare's intermediaries have benefited from advantages in information, scale, and contracting expertise.

AI may allow employers to narrow that gap.

- Not by replacing physicians.
- Not by denying necessary care.
- Not by transferring ever more financial risk downstream.
- But by making the economic transaction transparent,
- measurable, and accountable.

That is the transformation awaiting us.

And it brings us to the most consequential proposition in this series.

What if America's employers stopped purchasing healthcare individually, and began purchasing it intelligently, collectively, and directly?

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## NEXT IN THE SERIES | PART 3 FROM BLINDNESS TO VISIONARY

- Can AI Turn America's Employers into the Most Powerful
- Healthcare Purchasing Consortium in History?
- November 23, 2026 | 4:00 PM Eastern

In Part 3, we move from exposure to transformation.

We examine how AI-enabled purchasing consortiums could aggregate employer demand, reveal net pharmaceutical prices, compare hospital and diagnostic costs, negotiate transparent contracts, and establish a new relationship between purchasers, physicians, manufacturers, and patients.

The objective is not merely cheaper healthcare.

- It is a system in which purchasing intelligence, clinical
- accountability, and measurable human value finally become
- aligned.

The future of American healthcare may not begin with another insurance reform.

It may begin when America's employers discover the power of purchasing together.

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**ABOUT THE AUTHOR**

Ravi R. Iyer, MD , is a physician-scientist, entrepreneur, author, and 5x TEDx speaker who has spent four decades exploring a deceptively simple question: What makes human beings, and the organizations they create, perform at their best? A Harvard-trained physician, corporate strategist, and the founder of multiple healthcare and performance ventures, he is the creator of Neuroalignment, a framework for building high-performance organizations around the realities of human cognitive diversity. His work sits at the intersection of biology, leadership, technology, and human behavior. Boardroom Reflections is where those worlds meet.

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