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Connecting Public Administration to Assist in Mitigating Health Care Costs

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Abstract

The United States has accomplished many advancements in the field of healthcare. However, despite this advancement, the cost of healthcare in the country remains one of the highest in the world. The rising health-related costs remain a significant policy issue in the U.S. Presently, the country spends the highest on healthcare compared to similar nations across the globe, with a per capita spending of about $14,570. The role of public administration in mitigating these costs varies from policy development, implementation, oversight, budgeting, and coordination between different parties tasked with roles aimed at cost mitigation. This review delves deeper into how public administration, the design, funding, and management of health programs rolled out by government agencies seek to reduce the burden of prohibitive costs. To achieve that, the review utilizes scholarly material and reports on the subject, focusing on policy formulation, regulation, budgeting, and coordination. As part of the investigation, the review investigates Medicare and Medicaid programs, the Affordable Care Act of 2010, and post-COVID-19 reforms in relation to medical cost mitigation. These eras have witnessed key policy reforms that have, over time, contributed positively to cost mitigation and improvement of care quality. Key findings point to the significant role played by administrative action in influencing costs through payment reforms, eligibility and enrollment policies, provider incentives, and cost-containment rules. All the efforts through public administration underscore the significant role it plays in mitigating the high medical costs in the U.S. This review identifies public administration as central to cost control in U.S. health policy, from rulemaking and budget decisions to program design and cross-agency collaboration.

Connecting Public Administration to Assist in Mitigating Health Care Costs

Chapter 1: Introduction and Aim of Study

Background of Study

Public administration and healthcare are intertwined and should be recognized as essential to enhancing service provision for the citizens. The present US setting highlights the need for administrative competence to deal with issues such as healthcare costs, underlying service disparities, and the government policies that can improve quality (Zia et al., 2024). Public administration is significant and driven by policy implementation, resource management, and government oversight in service delivery (Balio et al., 2023). Harnessing public administration into the healthcare sector should be the framework for a participative scope in overall improvements to care.

Statement of the Problem

The importance of public administration in healthcare emanates from the recognition of the government's role in promoting universal accessibility to services. In a setting where issues such as healthcare costs and health disparities plague the setting, it is prudent to examine the value of public administration (Zia et al., 2024). Prioritization of public administration has become viable in ensuring that measures are undertaken to mitigate healthcare problems. Central to the investigation area is the assessment of the healthcare costs as the basis to comprehend the role of public governance in the fiscal management and deployment of effective programs (Woolhandler et al., 2021). Public administration in the US is expansive, and insight into the influence on healthcare cost management should reveal efforts towards ascertaining equitable access and optimization of service delivery (Woolhandler et al., 2021). The generation of insight into the administration parameters, especially in policy formulation and implementation, can provide the

foundation for extensive studies (Balio et al., 2023). Aligning healthcare goals with administrative initiatives can be the basis for transformative research of the underlying challenges that shape service delivery.

Research Objective

Understanding the complementary role of public administration and healthcare is necessary for service development. In the US, public administration is integral in advancing changes to the healthcare sector (Zia et al., 2024). The effectiveness of healthcare efforts is driven by public administration (Balio et al., 2023). Hence, the main objectives of the study will be:

- Examine the need for communication between public administrators and healthcare stakeholders.
- Investigate public administration and its influence on healthcare cost management.
- Understand public resource requirements to advance healthcare.
- Comprehend measures to streamline public administration to foster adequate healthcare.

Specific Objective

- Examine the multiple roles of public administration in a healthcare setting.

Research Question: What is the role of public administration in the US health care setting in mitigating health care costs?

Significance of Study

The US society reveals its continued dependence on healthcare accessibility. With the recognition of expanding healthcare service requirements, the role of public administration remains an area of concern (Vargas et al., 2022). Governance and the diverse portfolios of involvement in healthcare access are essential inquiry that can inform decision-making (Balio et

al., 2023). Administration is a multilayered area within the US, from the federal to state and local (Vargassettings, 2022). Examining the influence of public administration across multiple areas of community healthcare service delivery should reveal the challenging areas and practical solutions. Effective comprehension of the opportunities that public administration generates for healthcare provision can advance policies and practices that improve the expectations of diverse communities (Vargas et al., 2022). For example, in promoting quality healthcare access, analysis of Medicaid and the role of public administration should reveal the aspects of policy implementation and regulation (Woolhandler et al., 2021). Advancing healthcare requires an evaluation of the practical, functional, and theoretical role of public administration.

Scope of the Study

The exploration of public administration as the basis for expanding healthcare accessibility and efficiency is the basis of the overall inquiry. Transitioning to a successful healthcare sector requires examining the essence of public administrators in the transformation of service delivery (Vargas et al., 2022). By diving into the facets of regulatory formulation and functional efforts, the comprehension of the measures to ensure equality and universal healthcare access is within the scope of evaluation (Balio et al., 2023). An expansive scope denotes the assessment of the stakeholders, such as the government, as the basis for comprehending healthcare and the role of public administration.

Organization of Study

Public administration remains prominent in the advancement of the US healthcare setting. Thus, the study will investigate the administrative position in advancing quality healthcare. Organizing the study will entail defining the scope and objectives while describing the research questions. Specification of the objectives should transition to the data collection methods and,

subsequently, the findings and recommendations.

Chapter 2: Literature Review

Policy-Making and Legislative Initiatives

One of the major roles played by public administrators is crafting and implementing policies that can potentially shape medical cost outcomes. Legislated programs set the framework for cost control, but agencies translate laws into detailed rules. For example, the ACA expanded coverage and introduced reforms intended to slow cost growth. Administrators in the U.S. Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS) developed regulations on premium rate review and insurer solvency. The ACA established requirements such as minimum medical loss ratios, ensuring that at least 80–85% of premiums fund care rather than overhead, and a rate-review process for large premium increases (French et al., 2016). These regulatory policies, implemented by federal agencies, aim to restrain insurer cost structures.

Public administration also influences policy design through demonstration and waiver programs. The ACA created CMS's Center for Medicare and Medicaid Innovation (CMMI) to develop new payment models, funded with $10 billion over 10 years. CMMI initiated mandatory Medicare pilots to penalize hospital readmissions and infections, and to bundle payments for joint replacements. Agencies oversee such programs, collecting data on savings and quality. A Commonwealth Fund review found that CMMI's first-decade innovations have reduced costs and improved quality in some models (Lewis et al., 2022). Public administration in public health and social services has also advanced coverage policies. For instance, ACA rules enforced expanded Medicaid eligibility, up to 133% of poverty in participating states, and subsidies for private insurance (French et al., 2016). These policy choices, made in legislation and turned into administrative rules, shape who is covered and how costs are shared. In short, the administrative enactment of major reforms, from Medicare's inception to ACA provisions, fundamentally

redefines spending trajectories.

Regulatory Framework and Oversight

Regulation is a core administrative tool for cost mitigation. Public agencies set standards and enforce rules on providers, insurers, and patients. Under Medicaid and Medicare, regulators establish payment rates and utilization rules. For example, Medicare's Diagnosis-Related Group (DRG) system, a 1980s innovation, was administratively expanded under the Balanced Budget Act of 1997 to set hospitals' DRG payments, shifting incentives toward efficiency. More recently, agencies have tried to enhance price transparency and competition. In 2021, CMS issued a Hospital Price Transparency Rule, requiring U.S. hospitals to publish standard charges for services. Studies of compliance found that only about one-third of hospitals were fully meeting the rule in early 2022. Patel et al. (2023) reports that compliance gaps remain huge and must be closed to realize the intended purpose of the creation of the rule. This example shows how a regulatory policy can theoretically constrain prices by empowering consumer choice, but its cost-containment effect depends on enforcement and compliance.

Other than regulation, overseeing insurer markets is another vital administrative tool in the quest for reducing healthcare costs. The ACA created state and federal insurance exchanges and imposed requirements on plans, all enforced by administrative bodies. These markets are monitored by agencies for affordability. For instance, ACA-established rate-review boards assess proposed premium hikes to protect consumers from unjustified cost inflation. Public insurers, on the other hand, also take an active part in the regulation. Medicare Advantage plans are designed in a way that they must meet certain benchmarks, currently receiving on average 104% of traditional Medicare costs (Cubanski & Neuman, 2023). Effective regulation of private plans and providers can potentially help curb the spike in medical costs. In general, regulation by public

agencies through rules on coverage, quality, and competition is a primary means by which the government controls health spending.

Budgeting and Financial Management

Through effective budgeting, the government can impose fiscal discipline on health programs. Public administrators set spending caps, negotiate budgets, and use financial levers to control costs. In federal budgeting, Medicare is financed by dedicated trust funds and annual appropriations for premium and cost-sharing subsidies. Federal administrators project Medicare's trajectory and recommend adjustments. For example, Medicare policy analysts regularly adjust payment formulas, geographic and relative value scales, to align spending with budget targets. When costs threaten deficits, Congress and the Office of Management and Budget (OMB) may act. Another instance is when the ACA included savings measures such as cuts in Medicare payments and new taxes on high-income earners and health plans. It imposed a 3.8% surtax on unearned income, a 2.3% excise tax on medical devices, and higher Medicare payroll taxes on high-income workers, all to offset expansions and restrain spending (French et al., 2016). Public agencies track these revenues and adjust spending programs accordingly.

At the state level, budgeting for Medicaid is a shared federal-state responsibility. Here, public administration in state governments is crucial. States submit Medicaid spending plans to CMS for approval and manage their share of costs. Remarkably, expanding Medicaid has often relieved state budgets. Commonwealth Fund analysis finds that, on balance, states that expanded Medicaid under the ACA saw net fiscal gains. State economists report that expansion yielded significant budget savings and revenue increases in many cases. In some states, the net state cost of expansion was far below the statutory 10% share, and even negative due to new taxes and savings from lower uncompensated care (Ward, 2020). Thus, state budget offices have sometimes used Medicaid

expansion as a cost-control strategy. However, efforts to trim Medicaid have raised concerns about raising costs elsewhere, particularly for uninsured care. Proposals like work requirements pushed for under Trump's administration would increase the uninsured rate and uncompensated care, ultimately costing states more eventually (Rosenthal, 2025).

Budgeting also guides and informs investments in medical innovation. Public administrators decide how much to fund alternative payment programs, technology, or preventive care. For instance, during the COVID-19 pandemic, the federal government temporarily increased the federal matching rate (FMAP) for Medicaid, reducing state outlays and thus alleviating pressures on state budgets. Similarly, pandemic relief laws, like the American Rescue Plan (ARP) of 2021, included health provisions and helped reduce costs to families and governments. The ARP extended ACA premium tax credits to higher-income enrollees and increased assistance for low-income individuals. Estimates suggest average marketplace enrollees saved about $70 per month on premiums under the ARP subsidies (Rae et al., 2021). By augmenting subsidies and federal funding, public budgeting decisions can immediately ease financial burdens on consumers and state programs.

In general, budgetary oversight and fiscal planning by public administrators frame the financial incentives of health care. By setting reimbursement levels, subsidies, and taxes, governments seek to balance coverage and quality against cost-containment goals. Evidence suggests that deliberate budgeting choices, such as funding innovative models or expanding coverage, can pay off in savings but require strict administration to realize those returns.

Program Implementation and Administrative Innovations

The effective execution of health programs is a key aspect in the quest for cost control. Public health agencies and program offices are vested with the responsibility of translating policies

into on-the-ground operations. Translation is done through different avenues, one of which is provider payment models. On that spectrum, CMS launched numerous value-based payment pilots with the aim of enhancing efficiency under the ACA. One of the administrative innovations that has had an impact on cost mitigation is Accountable Care Organizations (ACOs) introduced by Medicare through the Medicare Shared Savings Program. Essentially, ACOs are multi-provider networks that share financial risk for patient populations. Since 2012, CMS has continued to expand options under ACO. In 2022, it hinted at plans to scale ACO participation. According to research findings by Wilson et al. (2020), ACOs have been effective in saving costs for Medicare while preserving care quality (Wilson et al., 2020).

Another example of an administrative innovation is episode-based payment, in which the ACA's Bundled Payments for Care Improvement (BPCI) initiative assessed fixed payments for episodes like joint replacement and recovery. It was piloted in 2013, incentivizing hospitals to streamline care and participating in healthcare centers to work towards avoiding complications and patient readmissions. That way, they can cut on associated costs. Similarly, the ACA created the Medicare Value-Based Purchasing (VBP) program, paying hospitals partly on quality metrics and bonus payments for primary care physicians in shortage areas (French et al., 2016). These implementation initiatives reflect administrative strategies to align provider behavior with cost control.

Each model was implemented by public agencies (CMS and HHS) in coordination with providers. Evaluations of these models, especially ACOs and episode bundles, suggest that careful design affects their success. According to Horstman et al. (2022), benchmarks for ACOs can disincentivize savings if set improperly. Agencies respond by refining rules. CMS has adjusted ACO benchmarking methods and rolled out downside-risk tracks to better encourage cost-cutting

without eroding participation. This adaptive implementation, modifying programs based on feedback, is a hallmark of public administration.

Beyond payment, administrative programs address costs by improving access and reducing inefficiency. For example, many states have used federal Section 1115 waivers, administered by HHS, to assess cost-saving innovations in Medicaid, such as managed long-term care or work-and-skill requirements. Federal agencies also promoted continuous eligibility during COVID. CMS encouraged states to adopt 12-month continuous enrollment for Medicaid, reducing churning. Studies found that maintaining continuous coverage keeps people insured and reduces costs by avoiding gaps that lead to expensive emergency care. In practice, dozens of states extended renewals and accepted electronic income verification to streamline enrollment (Wikle et al., 2022). These programmatic changes, driven by administrative directives, cut paperwork and stabilize coverage, indirectly mitigating costs.

Finally, public health programs equally play a preventive role in cost containment. Different agencies run vaccination campaigns, chronic disease management, and health promotion. Though not always viewed as cost-cutting, such efforts, when implemented effectively, reduce future spending. Administrative coordination of public health illustrates how government interventions can avert costly conditions.

Interagency and Cross-Sector Coordination

Mitigating health costs effectively often requires coordination across government divisions and levels. For instance, state Medicaid agencies are advised to coordinate with other public benefit programs. By sharing eligibility data with the Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF), states can auto-enroll or renew patients in Medicaid (Wikle et al., 2022). This kind of inter-program data sharing reduces administrative

burden and prevents uninsured gaps, which in turn avoids costly delayed care. Federal guidance and funding have supported such cross-agency integration.

At the federal level, interagency task forces have tackled cost-related issues. For example, during the COVID-19 emergency, HHS, CDC, and FEMA collaborated on testing and vaccination strategies to control the pandemic, thereby limiting long-term healthcare costs. In Medicare drug pricing, CMS has solicited input from patient groups, industry, and insurers as required by law, demonstrating multi-stakeholder coordination in setting policy (Sullivan, 2023). Although the literature on interagency health policy is sparse, case studies suggest that when agencies align their actions, they can streamline enrollment and reduce errors.

Another vital aspect of effective cost control and reduction is intergovernmental coordination. Medicare and Medicaid programs must be managed jointly by federal and state agencies. For instance, the rules for administering Medicaid waivers or calculating state contributions require extensive negotiation between the federal and state health departments. Each state's public administrators must collaborate with federal officials to implement cost-saving provisions. Effective coordination, such as the federal government providing guidance and incentives, can amplify the impact of cost-control policies. According to Wilke et al. (2022), federal guidance and accountability are needed so that state administrators can reduce needless burdens on enrollees. In other words, collaboration across agencies and authorities enables the administrative machinery to operate efficiently, which is essential for any cost-mitigation effort.

Landmark Policies and Recent Reforms

In this section, the focus will be on highly significant policy eras and their respective administrative cost roles. They are Medicare and Medicaid of 1965 onward, the Affordable Care Act of 2010, and the COVID-19 era.

Medicare and Medicaid

From the beginning of the 20th century, medical insurance had attracted considerable attention in the U.S. as a vital aspect of healthcare. The years between 1915 and 1920 were characterized by the very first coordinated efforts at the State level to establish government health insurance. Unfortunately, the efforts yielded no fruit. In the 1930s, fresh interest developed at the Federal level and, still, there were remarkable results. Most of the population had a deep desire to have health insurance to shield them against unprecedented medical costs. At that time, the main issue was whether health insurance should be financed privately or publicly. Private insurance was more widespread. Numerous bills proposing national health insurance financed by taxes were introduced in the 1940s, but none were passed. In 1965, after lengthy debates and in the quest to improve healthcare, Congress passed legislation establishing Medicare and Medicaid. Medicare was aimed at meeting specific health care needs for the elderly, and Medicaid was meant to cap the inadequacy of welfare medical care under public assistance (Hoffman et al., 2000).

The creation of Medicare and Medicaid introduced large-scale public administration of health financing. Early on, administrative experiments like the DRG payment system and managed care were used to curb costs. Over time, agencies have continually adjusted program rules, for instance, tightening eligibility or cost-sharing when needed. Medicare's historical cost growth led Congress to pass successive reforms, each administered by government agencies. For example, as mentioned previously, in 1997, Medicare imposed inpatient prospective payment and outpatient payment reforms as part of the Balanced Budget Act (Jencks & Schieber, 1992). These measures were fully implemented by CMS staff with the aim of slowing spending.

Affordable Care Act 2010

The Patient Protection and Affordable Care Act, popularly known as the Affordable Care

Act (ACA), was formally signed into law by President Obama in 2010 (French et al., 2016). The law had three main goals when it was enacted. First, it sought to make health insurance affordable and accessible to more people in the U.S. by providing consumers with subsidies that reduced costs for individuals with incomes between 100% and 400% of the federal poverty level (FPL). Secondly, the law had the aim of expanding the already existing Medicaid program to cover all adults with an overall income below the 138% FPL mark. Lastly, the law was created to help support innovative medical care delivery means meant to reduce the overall healthcare costs. At the time of the ACA's enactment, approximately 50 million U.S. citizens did not have medical insurance, with the nonelderly population constituting a sizable portion of the statistics. Of all the uninsured individuals, about 91% had an income limit of 400% FPL and were therefore qualified for benefits under the new law. The new developments ACA introduced gave it the potential to enhance medical insurance access by the entire population regardless of their income levels (Kominski et al., 2017).

The ACA ushered in a wide range of administrative actions. Agencies implemented Medicaid expansion, set up insurance exchanges, and rolled out new payment models. Importantly, the ACA explicitly tasked HHS with tackling costs. It funded CMMI to develop, evaluate, and promote innovative payment and delivery models (Haeder & Yackee, 2020). According to Lewis et al. (2022), evaluations show mixed but modest success: many CMMI models reduced costs, though the magnitude of impact was modest overall. Nevertheless, some initiatives yielded savings and produced quality improvements. The ACA also expanded coverage, and coverage gains often correlate with lower uncompensated care costs for hospitals. Public administrators periodically adjusted ACA implementation, for instance, extending open enrollment and later temporarily funding cost-sharing reductions, to ensure program viability and control financial risk.

COVID-19 and Post-COVID Reforms

When the globe was hit by COVID-19, adverse implications were witnessed both from a global perspective and at individual national levels. The U.S. had the first reported case of COVID-19 in January 2020, and as of May 2022, there were more than eighty-one million reported cases. The total number of deaths due to the pandemic in the country is about 990,000. The pandemic attack constituted an emergency, which in turn caused a significant shift in healthcare expenditure as there was a need to adjust to help ensure the virus is contained. Other than impacting individuals directly, COVID-19 had an impact on the country's GDP, which was projected to be impacted by 15% to 23% (Rose, 2021). In research conducted by DeMartino et al. (2022), they found that COVID-19 placed a significant burden on the healthcare system of the U.S. In the study, they observed that there was a $3706 increased burden for patients benefiting from commercial insurance and $10595 for those using Medicaid in the first month of COVID-19 diagnosis, and the burden increased with time. Hospitalizations because of COVID-19 and related complications cost $21752 on average, with an average monthly cost of $1338 and $2214 for patients with COVID-19 and $456 and $736 for those with no COVID-19 (DeMartino et al., 2022).

The pandemic and its associated implications in the U.S. placed new demands on public administration and spurred fresh cost-containment measures. In 2020–2021, Congress passed relief laws that included health provisions administered by agencies. For example, the American Rescue Plan (2021) expanded ACA subsidies and offered a temporary 100% federal Medicaid match (FMAP) to support state budgets. Rae et al. (2021) report that the ARP made coverage more affordable for millions. It extended ACA tax credits to people above 400% of poverty and increased credits for lower incomes. The result was an increase in subsidy-eligible individuals of 20%. These administrative adjustments, setting new subsidy levels in regulations, directly reduced out-of-

pocket costs.

At the end of 2022, the Inflation Reduction Act (IRA) introduced Medicare drug price negotiation, a landmark shift that followed several years of debates on whether there was a need for the federal government to negotiate for drug prices with drug manufacturers. The law gives the Secretary of the HHS the power to produce processes that can be employed in the direct negotiation of prices with manufacturers on specific drugs under the Medicare program. This move is projected, by the Congressional Budget Office (CBO), to save up to $98.5 billion over a 10-year period. Effective capping of the inflation of drug prices and repeal of Trump's drug rebates administration policy could see an additional savings of $185 over the same period (Sullivan, 2023). Here, public administration is responsible for executing the first drug price negotiations: setting the list of drugs, hearing public comments, and finalizing prices. The effectiveness of this reform in lowering prices will depend on strong administrative implementation.

These examples are an illustration that administrative actions, from unfolding legislative mandates to adapting in crises, continuously shape health costs. The review shows that while implemented measures do not solve the problem entirely, cumulative administrative reforms can affect state and federal budgets.

CHAPTER 3: DATA AND METHODOLOGY

Introduction

This chapter covers the methodological framework that is employed to explore the linkage between public administration and healthcare costs. The section explains the research design, data collection stage, and methods of data analysis that will be used by this research based on a secondary data analysis approach. The methodology considers data released from 2010 to 2023. It also focuses on healthcare data from US and compares with data from other Organizational for Economic Co-operation and Development (OECD) and developing countries. The chapter finishes by explaining ethical issues and obstacles that were encountered when gathering data for this study.

Research Design

This research adopts a quantitative descriptive-comparative design. This research methodology is a non-experimental procedure that integrates descriptive and comparative research (Maiteh & Zoltan, 2023). Descriptive research is concerned with summarizing and analyzing the features of a population or phenomenon while comparative research will deal with systematic comparison of two or more groups, conditions, or variables to identify patterns and relationships between these factors (Maiteh & Zoltan, 2023). This design is quantitative because it will rely on numerical data and statistical analysis.

The descriptive aspect focuses on summarizing trends and expenditure features in selected countries, while the comparative element enables the research to examine cross-country differences in administrative spending, cost optimization, and healthcare provision outcomes (Lorenzoni & Dougherty, 2022). The methodology used by this research is suitable for policy-based research where variables cannot be manipulated experimentally (Siedlecki, 2020). It also fits in with this study because it will help to extract insights from large-scale data from numerous

countries. The methodology is objective and reproductive because it depends on standard indicators recommended by globally reputable organizations such as the World Health Organization (WHO) and OECD (Lorenzoni & Dougherty, 2022).

This study is longitudinal in nature (Siedlecki, 2020), allowing the researcher to monitor changes and trends in healthcare spending and administrative performance over a period of 13 years (2010-2023). The unit of analysis for this research is the national-level expenditure and public administration data across the US, other OECD and developing countries.

Data Sources

The study relies on publicly accessible secondary data that is obtained from well-established and credible institutions that are recognized for gathering and displaying comprehensive health and economics statistics. One of these institutions is the Centers for Medicare and Medicaid Services (CMS), a section of the US Department of Health and Human Services (HHS) that is tasked with administering country's major healthcare programs (CMS, 2025; Rhyan et al., 2020). CMS avails detailed datasets about healthcare expenditures and program administration that are linked to US healthcare industry. Another relevant database for cost analysis is the National Health Expenditure Accounts (NHEA) because it breaks down healthcare expenditure data by payer (government, private insurance, out-of-pocket) and by function (hospital care, physician services, administrative costs) (CMS, 2025; Rhyan et al., 2020).

In addition, US Census Bureau of Economic Analysis (BEA) enriches this study with socio-economic and demographic data that will be crucial in exploring the healthcare expenditure trends and calculating per capita figures and cost ratios (BEA, 2025; Rhyan et al., 2020). Moreover, Kaiser Family Foundation (KFF), a reputable non-profit organization, will deliver independent policy analysis, journalism, and data on US healthcare challenges (KFF, 2025). Its research will

be significant in understanding the degree of the affordability, insurance coverage, and administrative trends in the US healthcare sector.

Internationally, World Health Organization (WHO) global expenditure database will provide a standardized and comparable healthcare expenditure data across various countries (WHO, 2025; Jakovljevic et al., 2020). Countries selected for comparison include the United Kingdom (NHS model), Australia, and India. This data will enable the current research to evaluate how various countries distribute public and private resources in healthcare.

Data Collection and Management

Datasets will be downloaded in spreadsheet format and organized using Microsoft Excel. The data will also be cleaned to ensure that it is of high quality for generating accurate analysis (Alotaibi et al., 2024). Duplicate data rows and columns will be eliminated to prevent double counting of the same entries. Also, missing values will be filled using mean of the column entries where appropriate (Alotaibi et al., 2024). Also, the cleaning process will involve standardizing data units such as converting the financial data into US dollars for comparability purposes (Alotaibi et al., 2024).

Data cleaning is a fundamental step in data analysis because it transforms data to be of high quality for effective decision making (Alotaibi et al., 2024). In other words, this step helps to avoid costly errors that would make the results of this research to make poor policies in healthcare administration. Also, data cleaning will allow this study to comply with data protection regulations such as European Union's General Data Protection Regulation (GDPR) and by ensuring that if private data is accessed, it will be securely and ethically stored and used (Alotaibi et al., 2024). Also, data cleaning is a crucial stage for ensuring that the combined data is consistent and usable across all the countries and indicators included in the research (Alotaibi et al., 2024). This will

guarantee reliable cross-country comparisons and accurate analysis in longitudinal trends.

This study employs several crucial indicators that will be used to explore the healthcare expenditure of each country and the implications of this investment for the health outcomes of the citizens. These indicators are explained in the following table:

Indicator	*Definition*
Total Healthcare Expenditure per Capita	This is the average expenditure on healthcare per individual of a nation over one year (Folland et al., 2017).
Percent of GDP Spent on Healthcare	This indicator calculates the proportion of a country's Gross Domestic Product (GDP) that is spent on to service the healthcare sector (Folland et al., 2017). This indicator is important for comparison analysis because it will show the level of national investment each country allocates.
Private vs Government Health Expenditure	This indicator breaks down healthcare financing sources. Government spending is the expenditure of public authorities and private spending includes out-of-pocket payments, private insurance, and non-governmental organizations. Their balance shows the degree of public involvement in healthcare provision (Folland et al., 2017).
Out-of-Pocket Costs	These are upfront payments made by consumers at the time of accessing healthcare services, not including any payment reimbursements from insurance. High out-of-pocket expenses can reflect inadequate

	insurance coverage and can create financial obstacles to care access (Folland et al., 2017).
Public Sector Administrative Expenditure	This is the amount of healthcare spending that goes toward non-clinical functions like billing, insurance processing, data management, and regulatory compliance. Elevated administrative expenditures can be a sign of inefficiency or a complicated healthcare system (Folland et al., 2017).
Chronic Disease Prevention and Treatment Cost	This encompasses all the spending related to treating long-term conditions like diabetes, heart disease, or cancer. It includes both cost of disease prevention and treatment (Folland et al., 2017).
Health Outcomes	These metrics gauge how well a healthcare system is performing in enhancing population health. Life expectancy is the number of years, on average, that a person is expected to live based on current mortality rates (Folland et al., 2017). Mortality rate is the number of deaths recorded in a certain population within a defined period (Folland et al., 2017).

Data Analysis Techniques

Descriptive Statistics is one of data analysis techniques that will be used to summarize key features of the datasets for each country. Trend Analysis will be applied to track changes in healthcare spending and administrative costs over the 13-year period from 2010 to 2023. Time-series visualizations, including line graphs and bar charts, will be used to illustrate how per capita expenditures, funding sources (public vs. private), and administrative overhead have evolved (OECD, 2022; Rhyan et al., 2020).

Comparative Analysis will contrast the structure and scale of healthcare costs in the U.S. with those in other OECD member states (OECD, 2022; Rhyan et al., 2020). Key indicators that were mentioned earlier will be used to assess differences and similarities. Where applicable, standardized metrics such as administrative costs as a percentage of total healthcare expenditure will be calculated to enable fair cross-country comparisons.

All data analysis will be conducted using Microsoft Excel. Graphs and visual presentations will be created using Excel to ensure clear and professional data visualization.

Validity and Reliability

This study ensures validity as it uses data from internationally recognized and credible sources. These organizations apply standard definitions and uniform indicators that make exact country-to-country comparisons possible (Rhyan et al., 2020).

Construct validity is attained through the choice of definite and measurable indicators that were mentioned earlier. These indicators are standard in health economics and represent main elements of the research question (Folland et al., 2017).

To support reliability, publicly available datasets and a clearly defined data management process are used in the research. All processes, from downloading the data to cleaning the data and analysis, are documented to facilitate replication. Excel is used in statistical analysis to reduce errors in calculations along with uniform results.

The study covers data recorded within 10 years, a move that improves reliability by reducing the impact of short-term change or outliers. As a result, this ensures that the results are consistent and suitable for application shaping public policy in healthcare sector.

Ethical Considerations

This study uses secondary data only, which means there is no involvement with human subjects or confidential information. As a result, the ethical risks are minimal. Still, strong ethical standards guide every stage of the research process.

All data is sourced from publicly available and reputable databases. These sources are properly cited to ensure intellectual property rights are respected (Vyas et al., 2018). When preparing the data for analysis, the study follows clear and honest procedures. The goal is to present findings that are both transparent and accurate.

The research does not involve fabrication, data omission, or selective reporting (Vyas et al., 2018). Particular attention is given to avoid drawing misleading or harmful conclusions, especially when comparing countries with diverse levels of economic development. Data is interpreted within context to reduce the risk of bias.

The study follows academic integrity policies in full. All sources, statistics, and frameworks are cited using APA guidelines. If third-party visuals or charts are included, permission will be obtained where necessary, and credit will be clearly stated.

Limitations

This study maintains a clear research focus, but several limitations must be acknowledged. The most significant constraint arises from relying entirely on secondary data. The quality and completeness of the analysis depend on how thoroughly source organizations, such as WHO, and national health agencies, have collected and reported their data. Informal expenditures, administrative inefficiencies, or off-the-record transactions are typically excluded from official datasets, which narrow the scope of insight.

Another limitation involves the challenge of comparing countries with differing healthcare systems, accounting standards, and definitions of administrative costs. Even with standardized

indicators, variations in how data is interpreted or classified across nations can affect the reliability of direct comparisons.

The selected time limit, 2010 to 2023, supports meaningful trend analysis but leaves out historical developments that may have shaped current spending patterns. It also excludes the potential impact of policy shifts or reforms that occur beyond 2024.

Additionally, focusing on national averages overlooks important sub-national differences. Variations at the provincial or regional level, especially in large countries like the UK, Australia, or India, are not captured in this analysis.

Finally, since this is an observational study, it cannot confirm causality. While relationships and trends will be highlighted, the findings cannot establish direct cause-and-effect conclusions. Even with these limitations, the study offers a grounded and comparative perspective on healthcare spending and administrative efficiency across diverse national contexts.

Summary

This chapter presented the research design adopted in investigating the role of public administration on healthcare expenditure. A quantitative, descriptive-comparative design was adopted to detect trends in spending and compare the health systems between countries in a systematic and quantifiable manner. The study is based on secondary data for the years 2010-2023. The sources of data are reputable national and international agencies. These datasets offer key indicators such as administrative spending, public and private sector financing shares, and disease-wise spending amounts. All the data will be cleaned, screened, and standardized using Microsoft Excel before analysis. Statistical analysis will be conducted using Excel to facilitate consistent trend analysis and cross-national comparisons.

Ethical criteria are maintained by utilizing only public data, referencing all sources

appropriately, and being transparent in data management. Validity is enhanced by employing internationally accepted indicators, and reliability is ensured through stable methods and a well-documented process. Identified limitations, such as variations in worldwide data collection and the constraints of secondary data, do not meaningfully subtract from the study's findings. Overall, the methodology provides a solid foundation for identifying trends in healthcare expenditure and determining the effectiveness of public administration on cost results.

CHAPTER 4: RESULTS AND ANALYSIS

Introduction

This chapter presents the findings from the data that was collected and organized in the previous chapter. The main aim is to see how healthcare costs in the United States have changed from 2010 to 2023 and what those shifts reveal about the wider system. Instead of only looking at spending in isolation, the analysis connects those figures to factors such as GDP growth, per capita amounts, administrative costs, and equity issues. Trends that were observed during the COVID-19 pandemic are also highlighted. This is because Covid-19 pandemic disrupted normal patterns of healthcare spending and policies in a dramatic way. Finally, the chapter compares the U.S. with other countries to judge whether the American healthcare approach is effective.

Total Health Expenditure vs. % of GDP (2010–2023)

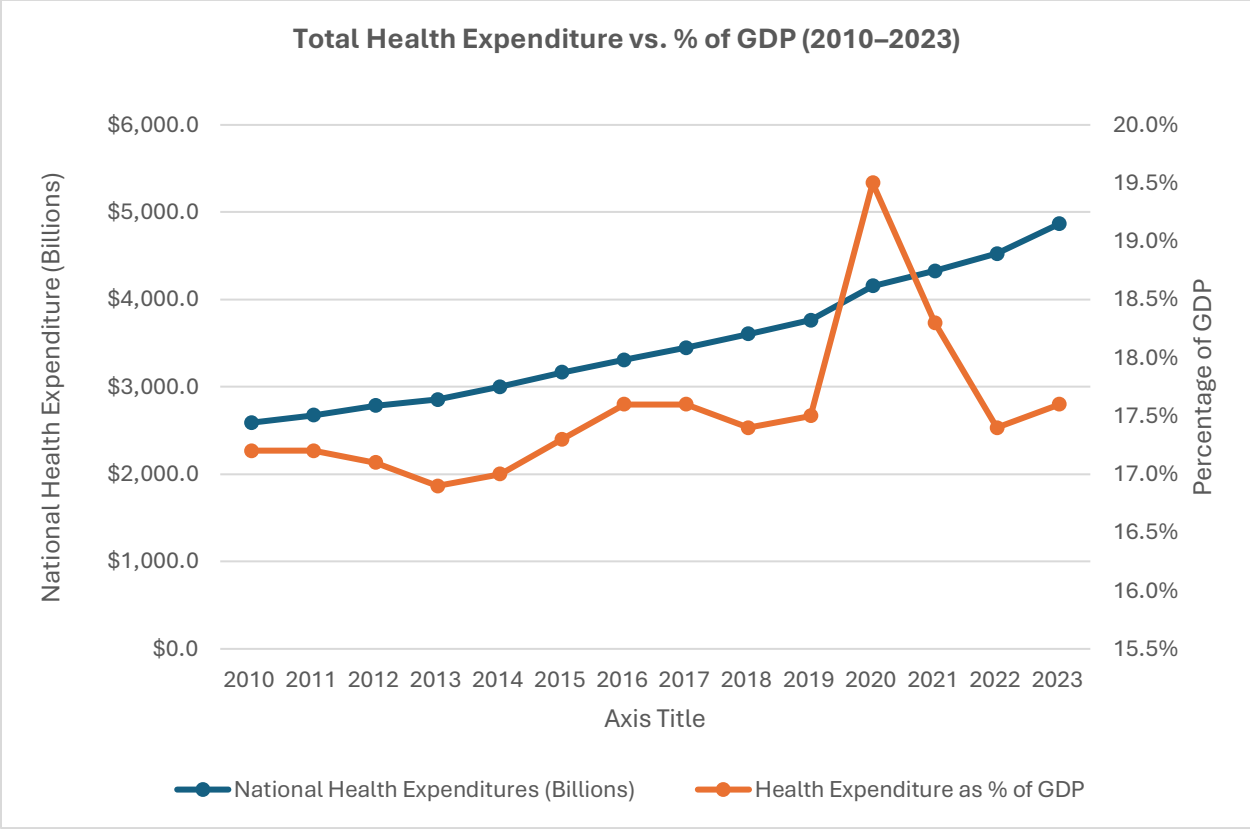


Figure 1: US Total Healthcare Expenditure vs. % of GDP (2010–2023)

US healthcare expenditure has been rising steadily in the past decade, regardless of the GDP. In figure 1 above, the orange line also tracks the percentage of country's GDP that is being spent on healthcare. From 2010 to 2013, this percentage decreased steadily but started to regain from 2014 to 2019. In 2020, this percentage increased sharply because Covid-19 pandemic led to hefty healthcare costs and decline of GDP (Hartman et al., 2022). Healthcare costs spiked because of the emergency. Hospitals were overwhelmed, testing and treatment expenses exploded, and governments poured money into vaccines and public health responses (Hartman et al., 2022). On the other hand, GDP itself shrank because businesses closed, unemployment rose, and economic activity slowed (Hartman et al., 2022). Putting these together gives the sharp jump in healthcare as a percentage of GDP that shows up in the data. The percentage went down to its normal levels in 2022 when economy started to expand.

By 2023, the share of GDP spent on healthcare was closer to its pre-pandemic levels, even though the absolute dollar amount continued to climb. This points to a constant tug-of-war: healthcare costs rise year after year. However, whether they look overwhelming compared to the entire economy depends a lot on how fast GDP is growing at the same time.

Another way to think about this is in terms of sustainability. If healthcare costs keep growing faster than GDP eventually, then more of the nation's resources will have to be devoted to healthcare (Hartman et al., 2022). This potentially squeezes out other priorities like education or infrastructure. For now, the U.S. seems able to carry the load, but the sharp rise during COVID was a reminder of how fragile the balance can be when an unexpected crisis hits (Hartman et al., 2022).

As evidenced in the figure 1 above, healthcare expenditure, denoted by the blue line, has expanded from $2.58 trillion in 2010 to $4.86 trillion in 2023. As seen, the smooth increase in

healthcare expenditure confirms that the United States is committed to strengthen the health wellness of its citizens. This is further shown in the figure 2 below which highlights that the national health expenditure has been increasing at a higher rate despite the population of the country expanding slowly. So, the rising expenditure is not just because there are more people to cover; it is also because the cost of care per person is going up. Whether that increase is leading to better health outcomes is another debate entirely. However, from a financial perspective, the data shows an upward climb that does not seem to be slowing down.

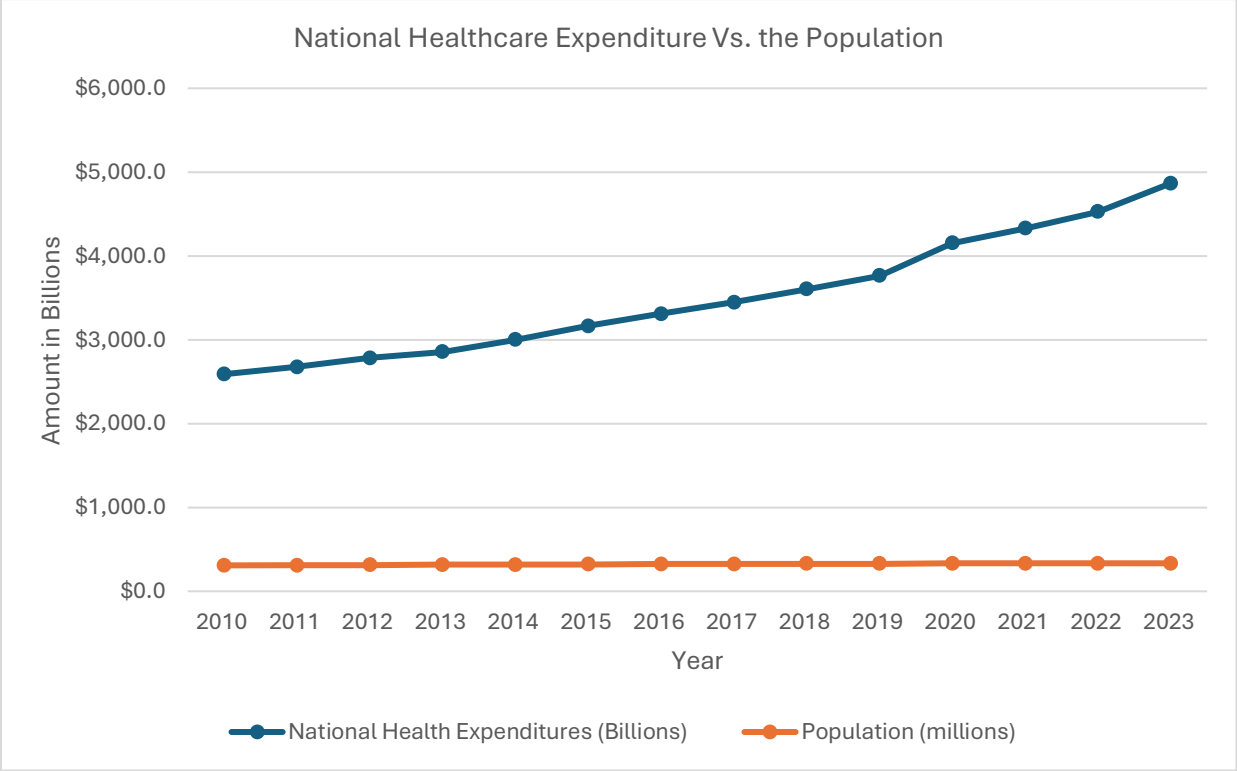


Figure 2: National Healthcare Expenditure alongside the Population

Composition of National Health Spending (2010–2023)

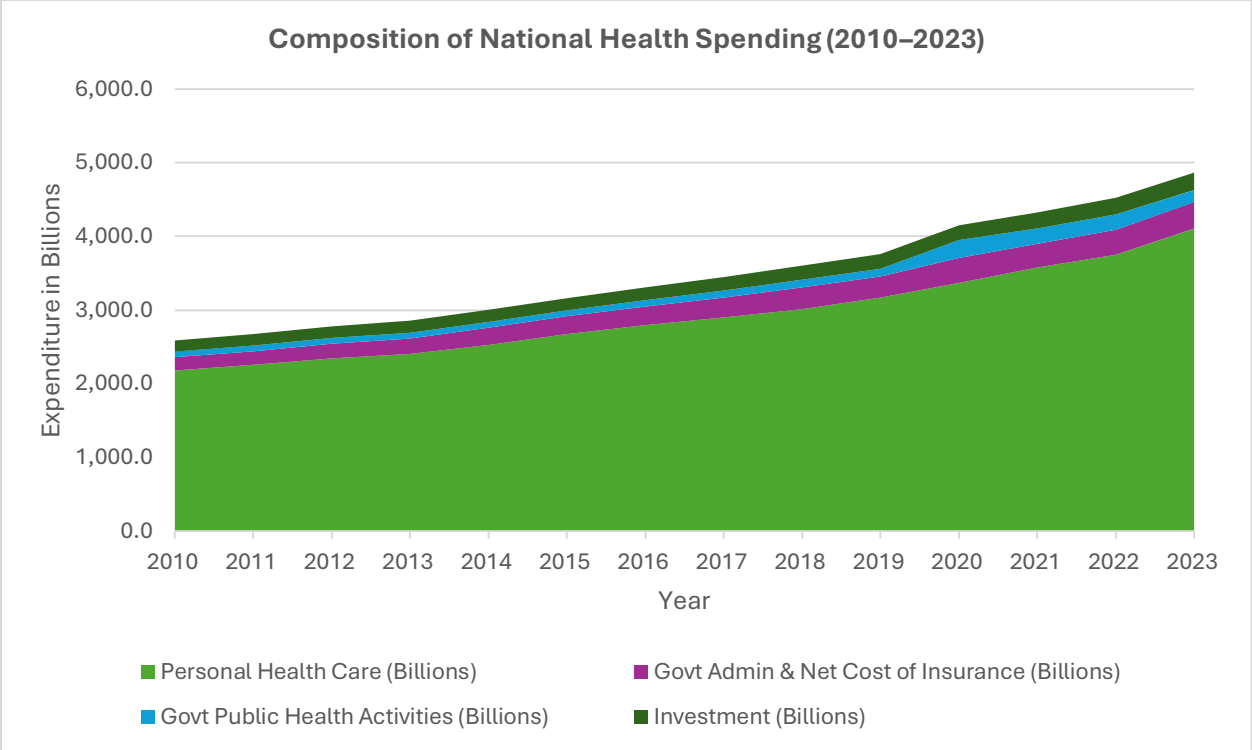


Figure 3: Composition of National Health Spending (2010–2023)

As shown in the figure 3 above, from 2010 to 2013, the personal health care expenditure consumes majority of the national healthcare expenditure. Personal health care covers the amount of funds spent on hospital care, professional services (like paying physicians and dental services, home health care, nursing care facilities, and retail outlet sales of medical products (like prescription drugs) (Centers for Medicare & Medicaid Services, 2023). The other composition of national health spending from 2010 to 2023 is government administration and net cost of insurance. This section encompasses administrative costs of sustaining health schemes such as Medicare and Medicaid and private insurance overheads (Centers for Medicare & Medicaid Services, 2023). The other category of national health spending is the government public health activities. This section entails the amount spent on public health programs such as disease prevention. The last composition of national health spending is investment. The United States

healthcare ministry allocates money and resources to cater for research, construction of health facilities, and acquisition of medical equipment (Centers for Medicare & Medicaid Services, 2023). Investment spending is crucial because it lays the foundation for future healthcare capacity. In future, this helps in building new hospitals, upgrading medical technology, or funding biomedical research (Centers for Medicare & Medicaid Services, 2023). As seen in figure 3 above, while this category grows steadily, it remains a small proportion compared to personal healthcare spending. Yet without it, the system risks falling behind in innovation and infrastructure.

In general, each composition of national health spending has been increasing since 2010 because US healthcare sector allocates each category proportionally to ensure that none of the area is struggling to deliver quality healthcare services to the patients (Centers for Medicare & Medicaid Services, 2023). The bulk of resources go to direct care and services, while less is channeled into prevention, public health, and long-term infrastructure. That helps explain why costs keep rising: treating disease after it develops is usually more expensive than preventing it in the first place.

Per Capita Trends in National Health Spending

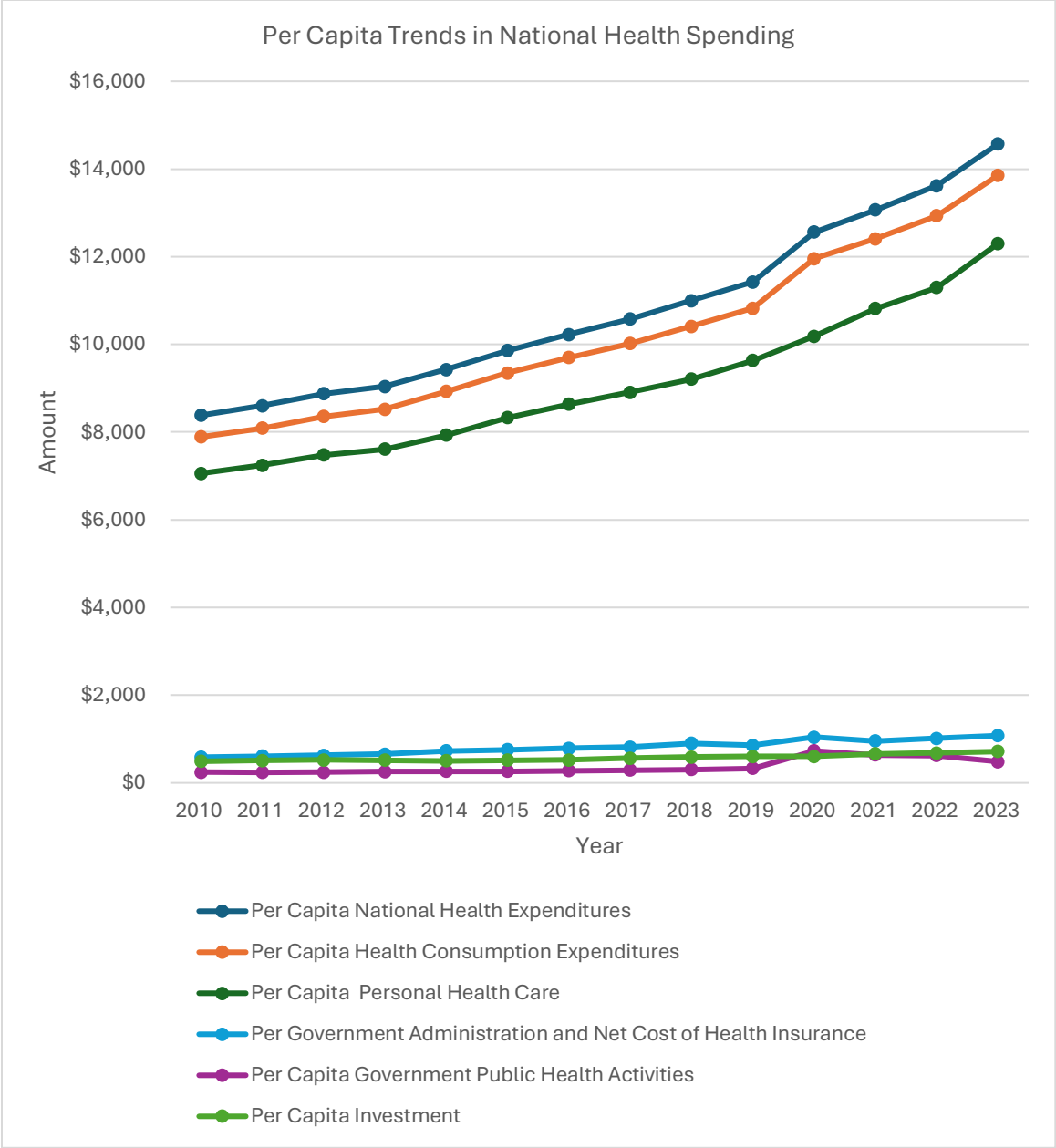


Figure 4: Per Capita Trends in National Health Spending

As shown in the figure 4 above, the per capita trends in the national healthcare expenditure, health consumption expenditure, and personal health care have been increasing since 2010. This confirms that each individual citizen continues to get more funds and resources from government to access quality healthcare.

This rise reflects not just inflation, but also the growing intensity of healthcare services. People are living longer with chronic diseases, and many treatments involve expensive technologies and drugs. As a result, even if someone does not feel like they are personally using more care, the average cost per person is still climbing (Centers for Medicare & Medicaid Services, 2023). For example, one new cancer therapy can cost hundreds of thousands of dollars per patient. When such treatments become standard, they push up average spending even if only a small share of patients receive them.

On the other side, looking at per capita spending on categories like government administration, public health activities, and investment, the numbers are far smaller. In other words, while every individual "accounts" for several thousand dollars of personal health care each year, only a tiny fraction of that is linked to preventive programs or health infrastructure investment. The data shows that even as total per person spending keeps rising, the emphasis remains tilted toward immediate care rather than long-term system strengthening.

An interesting detail comes from comparing per capita expenditure with per capita investment (Figure 5 below). The gap between the two is stark: while national health expenditure per person soars, per capita investment remains flat. That means the system is spending more each year to keep people healthy in the present. However, it is not proportionally expanding its capacity for the future. In practice, which could translate to shortages of healthcare workers, outdated equipment, or underfunded research down the line.

Another implication of rising per capita spending is affordability. For patients, higher average spending does not always mean better access. In fact, many Americans still struggle with high out-of-pocket costs and insurance premiums (Hartman et al., 2022). Therefore, while the numbers suggest that more money is being spent "on" each person, it does not necessarily feel that

way for individuals facing surprise medical bills or denied insurance claims. This mismatch between system-level spending and patient-level experience is one of the central paradoxes of U.S. healthcare.

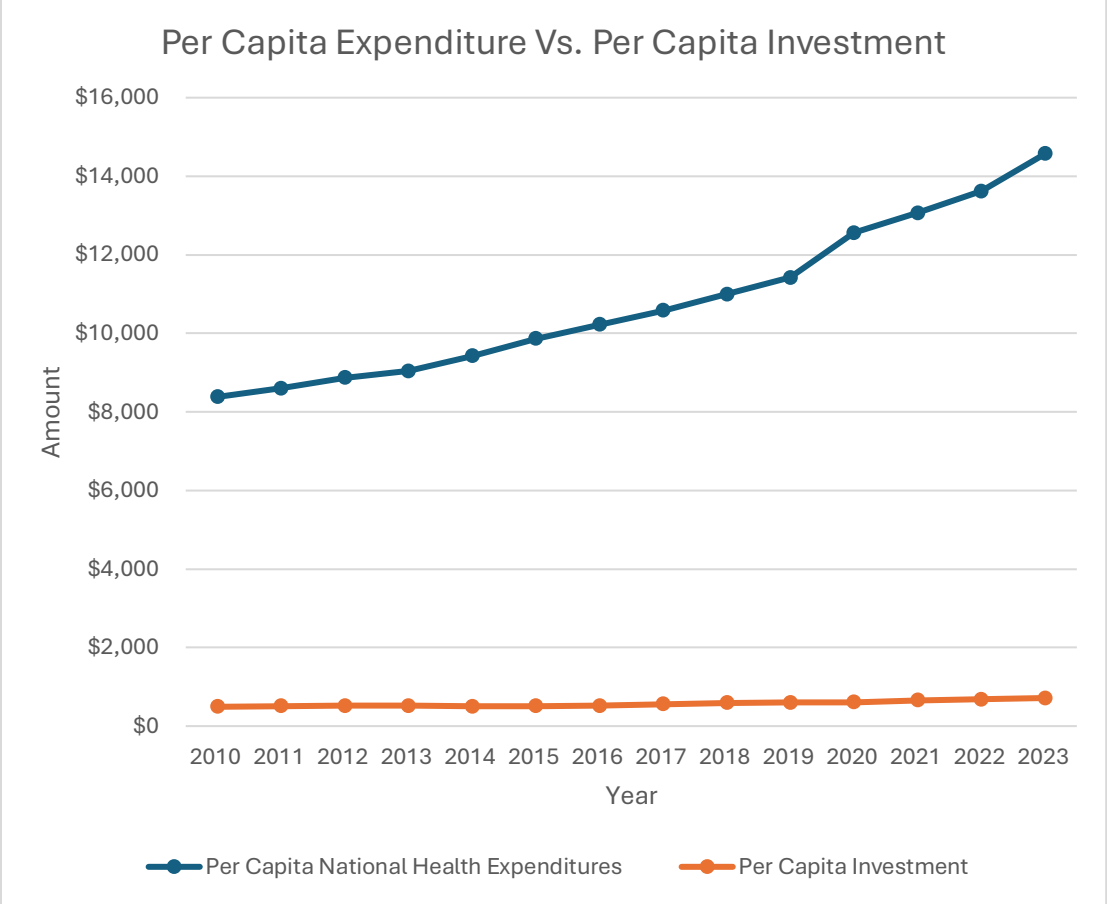
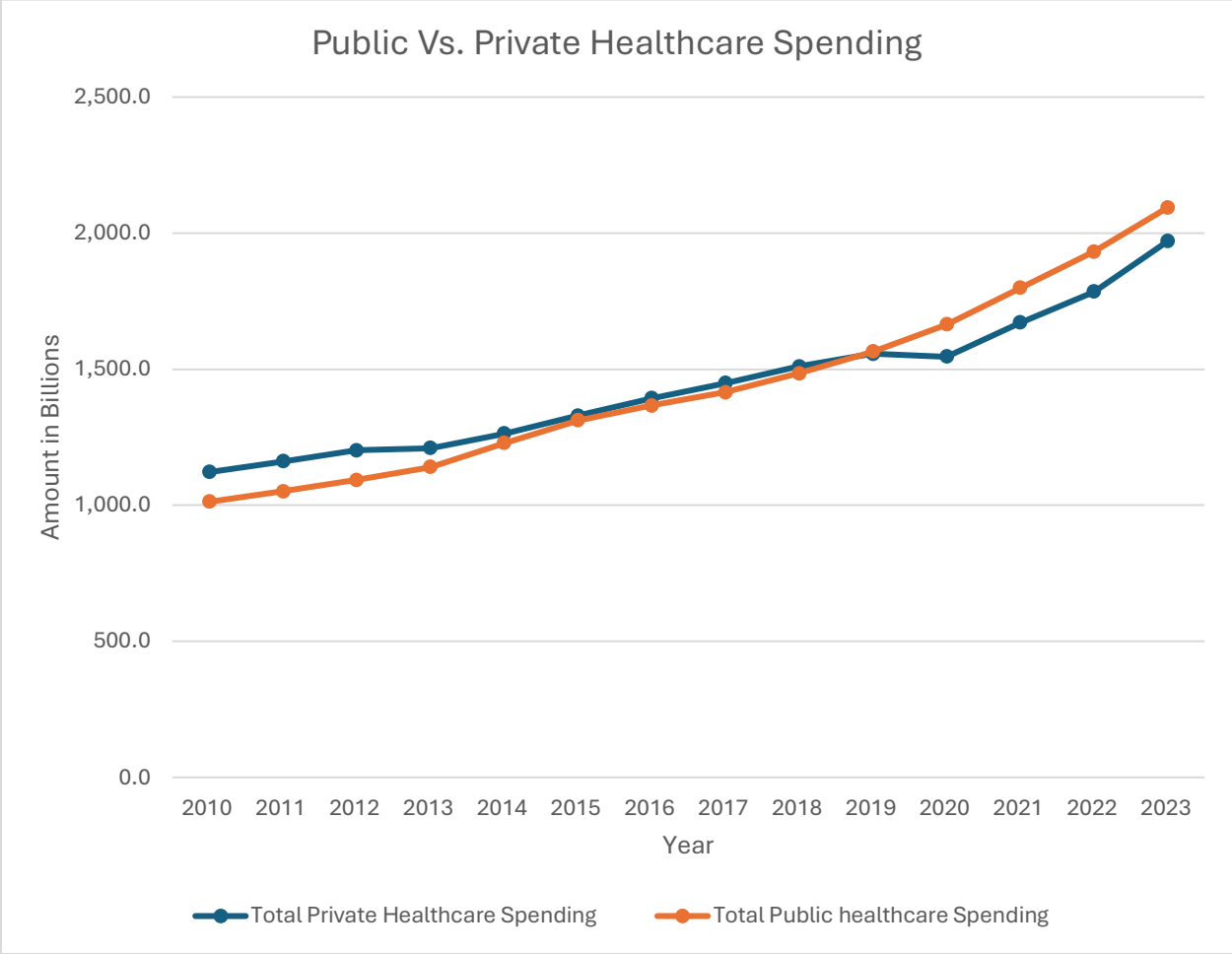


Figure 5: Per Capita Expenditure vs. Per Capita Investment

Public versus Private Healthcare Spending



Graph 6: Public vs. private healthcare spending

According to graph six above, from 2010 to 2023, the total private healthcare spending has been closely equivalent to the total public healthcare cost. As reflected in the graph, prior to 2019, public healthcare cost has been gradually lower than the private healthcare expenditure. This makes sense given the U.S. system relies heavily on private insurers (Centers for Medicare & Medicaid Services, 2023). People often get health coverage through their jobs. Hence, a huge share of health dollars flows through those private channels.

However, in 2020, COVID-19 forced the government to step in at an unprecedented level.

Public healthcare spending shot past private spending (Hartman et al., 2022). Massive federal funds went into Medicare, Medicaid, and direct public health initiatives. Direct public health initiatives included activities like emergency hospital support, vaccine development and distribution, and even free COVID testing for the population (Hartman et al., 2022). At the same time, private spending dropped because many elective procedures and routine visits were delayed, while people avoided hospitals unless necessary (Hartman et al., 2022). The public sector ended up carrying much of the cost burden during those years.

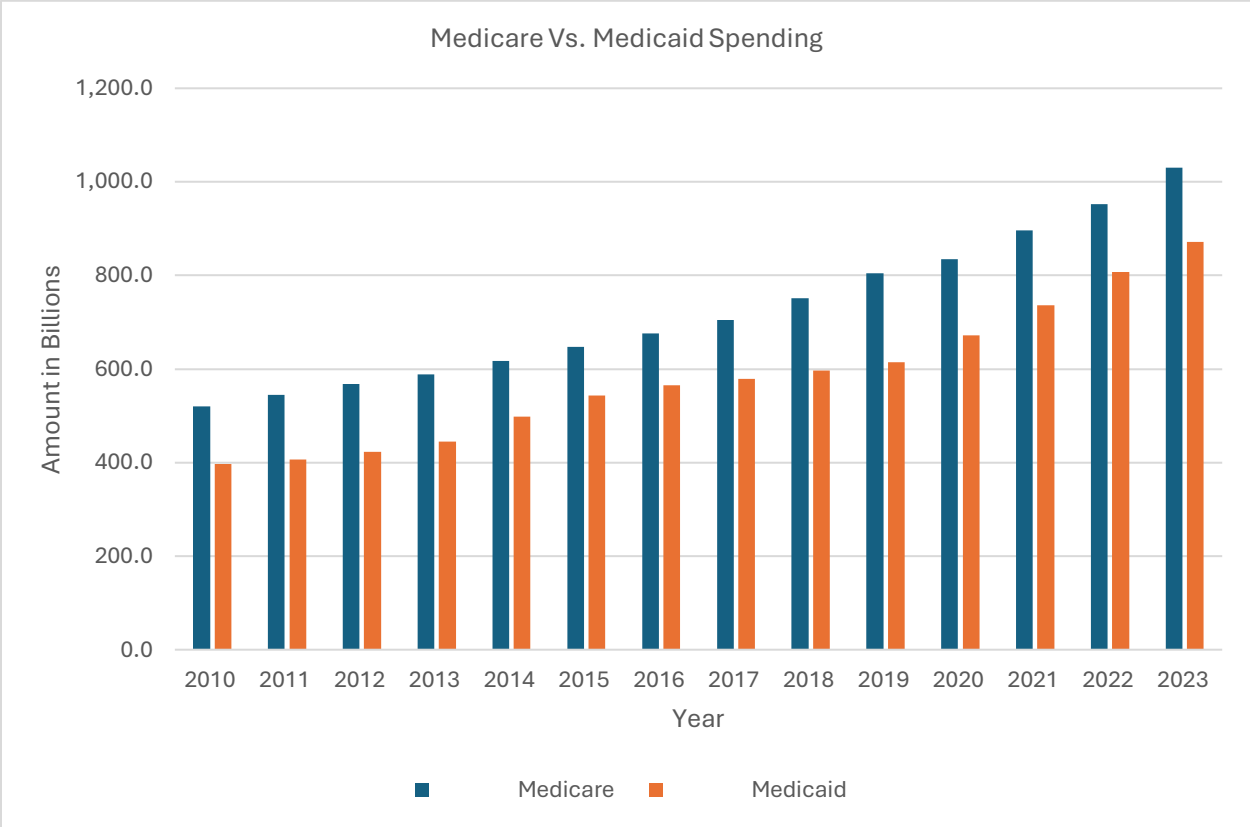
By 2022 and 2023, as the economy reopened, private spending rebounded, but public spending remained relatively high. It shows how much of a stabilizing role government funding can play in healthcare. When the private system fails to adequately cover healthcare costs, public spending fills the gap.

Another crucial point is how this mix impacts accessibility. Private spending often reflects the costs paid by individuals and employers (Centers for Medicare & Medicaid Services, 2023). That means people who do not have good insurance or stable employment are at a disadvantage. Public spending, on the other hand, is tied to programs like Medicare, Medicaid, and public health efforts that target vulnerable populations (Centers for Medicare & Medicaid Services, 2023). Moreso, when the share of public spending rises, it often signals more direct support for groups that the private market does not serve well.

The tension between public and private spending has been a long-running debate in U.S. healthcare. Critics argue that too much reliance on private spending keeps costs high, since insurance companies add administrative layers and profit margins (Himmelstein et al., 2020). On the other hand, defenders of private spending say it fosters choice and competition. What the last decade really shows, though, is that the system works like a partnership. Neither side could

realistically replace the other entirely. Instead, both grow side by side. However, in times of crisis, it is public spending that expands most sharply to cushion the blow.

Medicare vs. Medicaid Spending



Graph 7: Medicare vs. Medicaid Spending

Looking at Medicare and Medicaid between 2010 and 2023, one clear pattern jumps out: Medicare spending is consistently higher than Medicaid spending, year after year. This is not surprising when you think about who each program serves and how the costs are structured.

Medicare covers people over sixty-five and younger people with certain disabilities. Older adults tend to need more healthcare that often involve chronic disease management, hospital stays, and expensive prescription drugs (Centers for Medicare & Medicaid Services, 2023). More Americans are living into their late 70s, 80s, and beyond. This naturally raises Medicare's price

tag. On top of that, medical technology for operations like advanced surgeries, cancer treatments, or life-prolonging therapies are costly (Centers for Medicare & Medicaid Services, 2023). Medicare shoulders much of that bill. So, Medicare's spending curve reflects both the growing elderly population and the rising costs of caring for them.

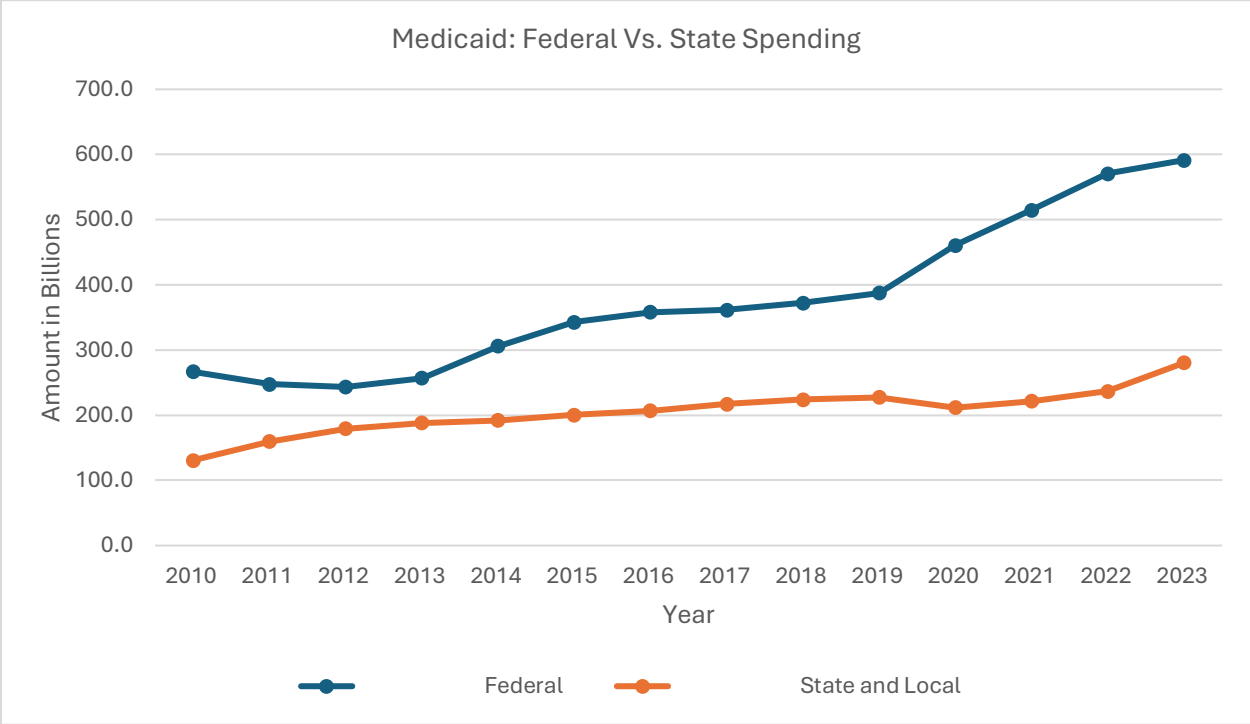
Medicaid, by contrast, is targeted at low-income individuals and families, including children, pregnant women, and some disabled adults (Centers for Medicare & Medicaid Services, 2023). While it covers millions of Americans, the per-person spending tends to be lower because the population is younger on average. Kids and younger adults, statistically, require less costly care than seniors. Medicaid also has stricter rules and state-level variations in coverage (Centers for Medicare & Medicaid Services, 2023). As a result, this keeps its growth a bit more contained compared to Medicare.

However, Medicaid has also been increasing. One key to that growth was the Affordable Care Act (ACA) because it increased the eligibility of most states to Medicaid beginning in 2014. Millions of new sign-ups, mostly the low-income adults, were insured in this coverage. Then, during the Covid-19 pandemic, Medicaid sign-ups again grew even higher as people lost their jobs and employer-based insurances (Hartman et al., 2022). Federal rules also temporarily prevented states from cancellations (Waitzberg et el., 2021). Thus, this kept Medicaid rolls at record highs as of 2022.

So, while Medicare spending is larger overall, Medicaid's growth highlights how the program acts as a safety net. Medicare spending tells the story of an aging population and rising medical technology costs. Medicaid spending tells the story of economic vulnerabilities and government efforts to ensure basic coverage for low-income groups. Together, they reflect two different but equally important challenges: caring for the elderly on one side and making sure the

poor and disadvantaged are not left out on the other side.

Medicaid Analysis: Federal Funding versus State Funding



Graph 8: Medicaid Analysis: Federal vs. State Spending

By exploring Medicaid funding, the split between federal and state dollars is key. Medicaid is unusual compared to Medicare because it is not purely federal. Both the federal government and the states chip in funding Medicare, but not equally (Centers for Medicare & Medicaid Services, 2023). Looking at the data from 2010 to 2023, the federal government consistently puts in more than the states. As shown by graph eight above, this gap has grown larger over time.

This structure is intentional. The federal government matches state spending at varying rates (called the FMAP, or Federal Medical Assistance Percentage) (Centers for Medicare & Medicaid Services, 2023). Poorer states get a higher federal match, while wealthier states get a lower one. The idea is to even reduce disparities to ensure that states with smaller tax bases can

still support Medicaid programs (Centers for Medicare & Medicaid Services, 2023). As a result, federal contributions make up the bulk of Medicaid spending nationally.

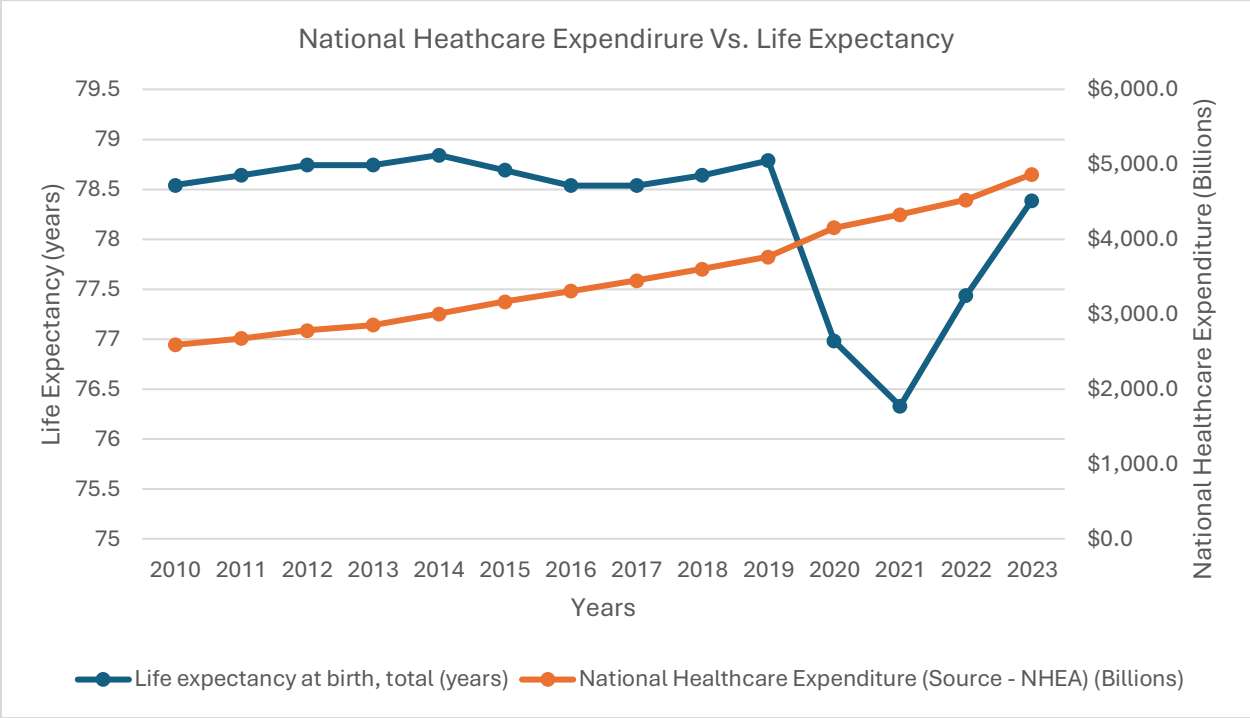
The pandemic again stands out here. In 2020, the federal government temporarily increased its share of Medicaid funding to help states deal with the surge in enrollment and the strain on their budgets (Hartman et al., 2022). Many states were struggling with revenue shortfalls because of shutdowns. Without extra federal dollars, they might have had to cut Medicaid benefits or provider payments. Instead, federal aid allowed states to maintain and even expand services during the crisis.

That said, state governments still play a significant role. They determine eligibility rules (within federal guidelines), decide what optional benefits to cover, and manage the actual operation of Medicaid programs (Centers for Medicare & Medicaid Services, 2023). This flexibility is why Medicaid looks vastly different across the country. For instance, some states cover dental and vision care while others do not. Some states pay providers more generously, while others keep rates low, which affects access to healthcare. But no matter how a state designs its program, the federal government's larger financial contribution gives it noteworthy influence over the system (Centers for Medicare & Medicaid Services, 2023).

The balance between federal and state funding has broader policy implications too. When the federal share rises, states have more room to expand coverage or improve services (Centers for Medicare & Medicaid Services, 2023). When states are expected to carry more of the cost, they often tighten eligibility or cut optional benefits to save money. The long-term trend of rising federal contributions suggests Washington is increasingly central to keeping Medicaid sustainable. This is especially crucial during economic downturns or national health emergencies.

National Health Expenditure, Life Expectancy, and Death Rates

a) *National Health Expenditure vs. Life Expectancy*



Graph 9: National Health Expenditure vs. Life Expectancy

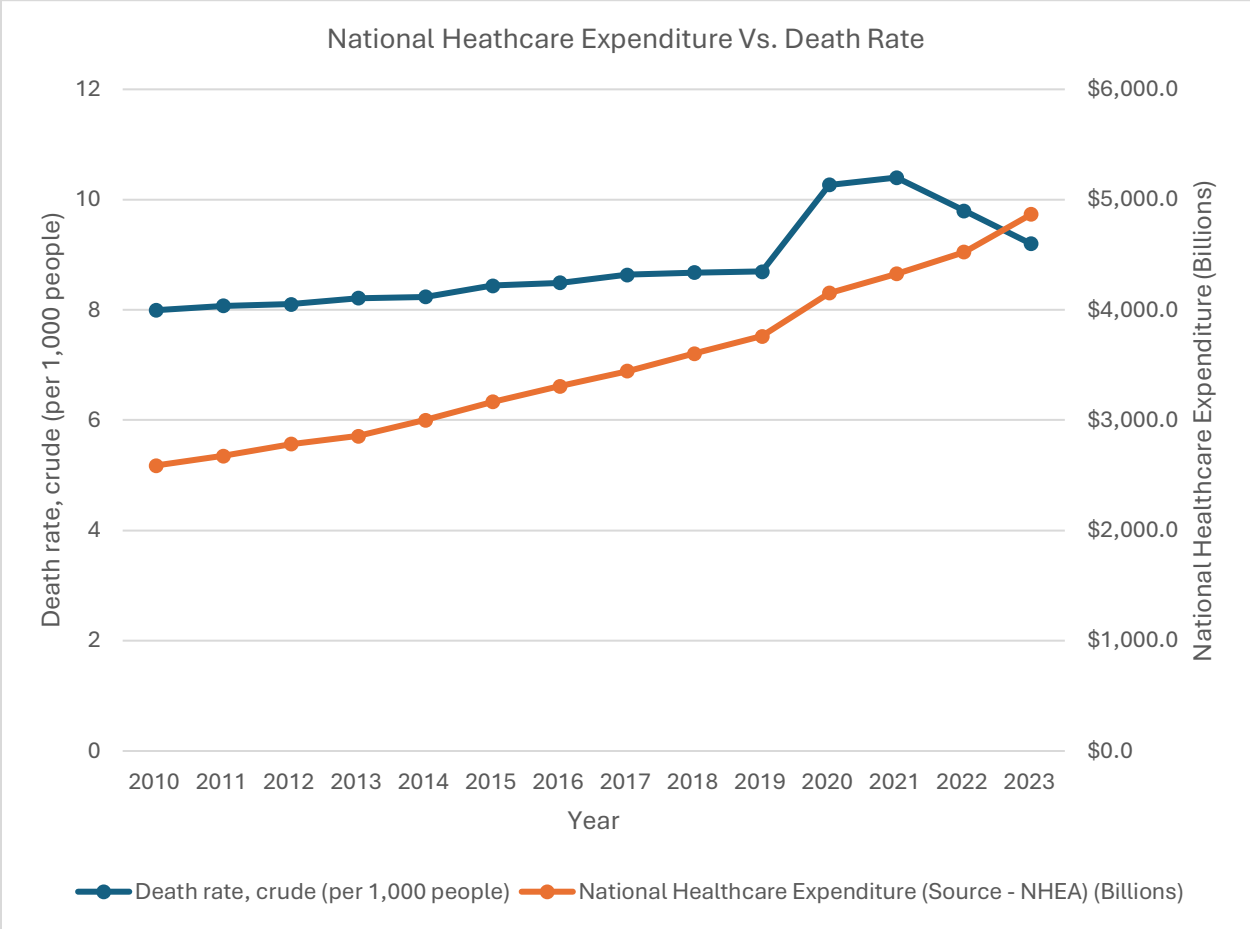
When national health expenditure is put side by side with life expectancy, the picture that emerges is a bit puzzling. As seen in graph nine, from 2010 to 2019, life expectancy barely makes substantial changes. Instead, it hovers around 78.5 to 79 years. On one hand, the U.S. has been pouring more money into healthcare almost every single year from 2010 to 2019. In 2010, the total health expenditure was about $2.6 trillion. By 2019, that number was exceeding close to $3.7 trillion. What this tells us is that despite billions of dollars being added to the system every year, the return in terms of years of life gained was practically stagnant.

In 2020, the pandemic hit and made everything change in a flash. As noted in graph nine, life expectancy fell sharply in 2020. By 2021, it had dropped to around 76.3 years. This erased the prior tendency of life expectancy to remain relatively constant. It is rare to see life expectancy drop

so suddenly in a developed nation. This speaks to how Covid-19 left devastating impacts on both mortality and the ability of the healthcare fraternity to protect the Americans (Hartman et al., 2022). Governments, hospitals, and insurers spent heavily on emergency response, testing, treatments, and vaccines.

As seen in graph nine, the national health expenditure line rises smoothly annually. There are no dips, not even in 2020 when the economy slowed and life seemed difficult for government and citizens (Hartman et al., 2022). That kind of mismatch is striking because it shows how money alone cannot shield a population from an acute crisis (Venkataramani et al., 2021). The high and rising spending with uneven gains in life expectancy has often been described as the “U.S. paradox” (Adebayo et al., 2024). As seen in graph nine, by 2022 and 2023, life expectancy began to recover. However, it does not fully recover because it remained below pre-pandemic levels.

b) National Health Expenditure vs. Death Rate



Graph 10: National Health Expenditure vs. Death Rate

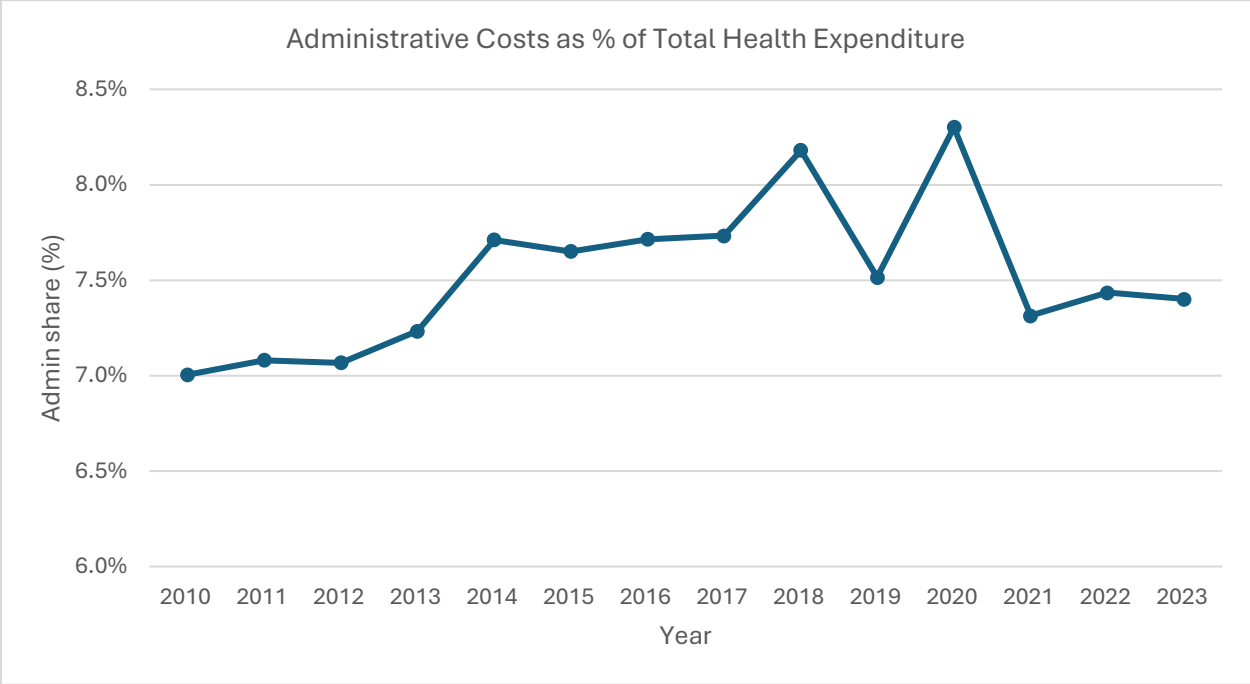
Graph ten paints a closely related picture to graph nine, but from a different angle. Here, instead of looking at life expectancy, it looks at the death rate. The spending side shows that expenditure is steadily rising from $2.6 trillion in 2010 to nearly $5 trillion in 2023. But the death rate tells a story that feels almost like a mirror image of life expectancy.

As seen in graph ten, between 2010 and 2019, the U.S. death rate was stable, about eight deaths per 1,000 people. There were small fluctuations, but nothing dramatic. Then in 2020, the death rate jumped sharply, peaking above 10 deaths per 1,000 in 2021. This spike coincides

perfectly with the COVID-19 pandemic. The disease itself claimed hundreds of thousands of lives. What is interesting is that during these Covid years, healthcare expenditure was at its highest (Hartman et al., 2022). Billions were poured into ventilators, emergency staffing, vaccine development, and public health campaigns. Yet, the death rate rose. This contrast underlines a core reality: expenditure can rise in response to crisis, but that does not mean outcomes improve immediately. Sometimes, spending is simply a reaction to worsening conditions rather than a driver of better ones. By 2022 and 2023, the death rate declined but these levels are still below the pre-pandemic records. In other words, the U.S. is still losing more people per capita each year than it did in the previous decade. This could reflect ongoing COVID deaths, indirect effects like weakened immune systems, and a worsening opioid crisis (Adebayo et al., 2024).

The broader lesson here is that healthcare spending and mortality do not always move coordinated. According to Adebayo et al. (2024), healthcare spending is often reactive, while mortality reflects a mix of long-term health patterns, socioeconomic conditions, and unexpected shocks like pandemics. Even with $5 trillion in annual expenditure, the U.S. cannot immediately reverse a mortality spike.

Administrative Costs as % of Total Health Expenditure



Graph 11: Administrative Costs as % of Total Health Expenditure

Looking at graph eleven, administrative costs make up a relatively small slice of total U.S. healthcare spending. On average, these costs hover around 7–8% of the national health expenditure. That might not sound like a lot at first glance, but when the scale of U.S. healthcare spending is put into consideration, this percentage represents hundreds of billions of dollars each year. In other words, even a seemingly "small" fraction translates into a huge sum of money.

By digging a little deeper into the trends, some interesting patterns can be uncovered. Administrative costs ticked up notably in 2018, reaching around 8.2%, and again increasing to 8.3% in 2020. The spike in 2020 is not surprising because it coincides with the COVID-19 pandemic. Managing healthcare during a global crisis requires extra administrative effort. This entailed processing emergency claims, coordinating federal and state responses, overseeing the

massive influx of new Medicaid and Medicare enrollees, and ensuring hospitals could keep operating under new safety protocols (Chernew & Mintz, 2021). This highlights that administrative costs are not just about office work, they are also about coordination, coordination, and system management.

After 2020, the share of administrative costs started to decline slightly and stabilized at 7.4%. This shows that while the system adjusted to the crisis, a baseline level of overhead is always necessary. Even in "normal" years, administrative expenses exist because of the complexity of the U.S. healthcare system (Chernew & Mintz, 2021). Between private insurance companies and government programs, there is no effective strategy of eliminating these costs entirely.

However, there is an ongoing debate about efficiency. Critics argue that spending over 7% of total healthcare dollars on administration is too high. This causes diversion of hefty money away from direct care. Proponents assert that a certain level of administrative cost is unavoidable in the current mixed public-private system. They also argue that these costs help in maintaining accountability, preventing fraud, and managing resources effectively. Essentially, streamlining administration could, therefore, not only save money but also make healthcare more accessible and less frustrating for patients.

Healthcare Access and Equity

To further understand how the US healthcare system functions, it is important to understand who benefits most from spending, and who is left behind? That is where questions of access and equity come in. At its core, healthcare equity means that all diverse groups should have a fair chance of living healthy lives and accessing care when they need it. The data shows persistent gaps. For example, Black and American Indian or Alaska Native (AIAN) communities consistently experience worse outcomes across a wide range of indicators. Infant mortality is one striking case

worth noting. In 2022, Black infants died at more than twice the rate of White infants (Ndugga et al., 2024). AIAN and Native Hawaiian or Pacific Islander (NHPI) infants also had much higher mortality rates than White infants (Ndugga et al., 2024). These are not minor differences; they represent lives cut short in communities that already face systemic barriers.

The same pattern shows up in maternal health. Between 2017 and 2019, NHPI, Black, and AIAN women had the highest pregnancy-related mortality rates in the country (Ndugga et al., 2024). This is particularly concerning because maternal mortality is often considered as an indicator of how well a healthcare system serves women. Despite the U.S. spending far more on maternity care than most countries, outcomes are worse, and the disparities are glaring (Dwyer-Lindgren et al., 2024). The issue is not lack of spending but rather where resources flow and whether vulnerable populations can access timely and quality care.

Chronic disease outcomes paint another clear picture of inequity. The age-adjusted mortality rates for diabetes in 2022 were about twice as high for NHPI, AIAN, and Black people compared to White people (Ndugga et al., 2024). Hispanic communities also had higher death rates from diabetes. These statistics matter because diabetes is largely manageable with the right combination of preventive care, affordable medication, and ongoing support (Ndugga et al., 2024). The fact that some groups are dying at double the rate of others is perpetuated by factors such as fewer clinics in rural areas, higher costs, or a lack of culturally appropriate care. Rural communities, for instance, face shortages of providers, hospitals closing due to financial strain, and longer travel distances to reach specialty care (Ndugga et al., 2024). Dwyer-Lindgren et al. (2024) add that many of these areas are also home to a large share of AIAN and low-income populations.

Life expectancy data ties all these disparities together. In 2022, Black Americans had a life

expectancy of 72.8 years (Ndugga et al., 2024). This is nearly five years shorter than that of White Americans that stands at 77.5 years. For AIAN communities, the gap was even wider (Ndugga et al., 2024). What is especially troubling is that these gaps widened during the COVID-19 pandemic. The virus did not create health disparities, but it magnified them. Communities with higher poverty rates, frontline workers, and crowded living conditions were hit hardest. Meanwhile, preexisting barriers to care such as being uninsured or underinsured made it even more difficult for many people of color to get treatment quickly (Ndugga et al., 2024).

Access to health insurance is another major piece of the equity puzzle. Despite the Affordable Care Act expanding coverage, racial disparities in insurance remain. As of 2022, nonelderly AIAN, Black, Hispanic, and NHPI individuals were still more likely to be uninsured than White people (Ndugga et al., 2024). Lack of insurance is a direct barrier to access. However, even those with coverage may face challenges such as high out-of-pocket costs, limited provider networks, or bureaucratic hurdles that delay care.

Addressing these inequities is not just a moral issue but an economic one. Disparities in health outcomes lead to billions of dollars in excess medical costs, lost productivity, and premature deaths. The KFF brief points out that these inequities also undermine overall national health. If large segments of the population experience higher disease rates and shorter lifespans, the nation pays the price.

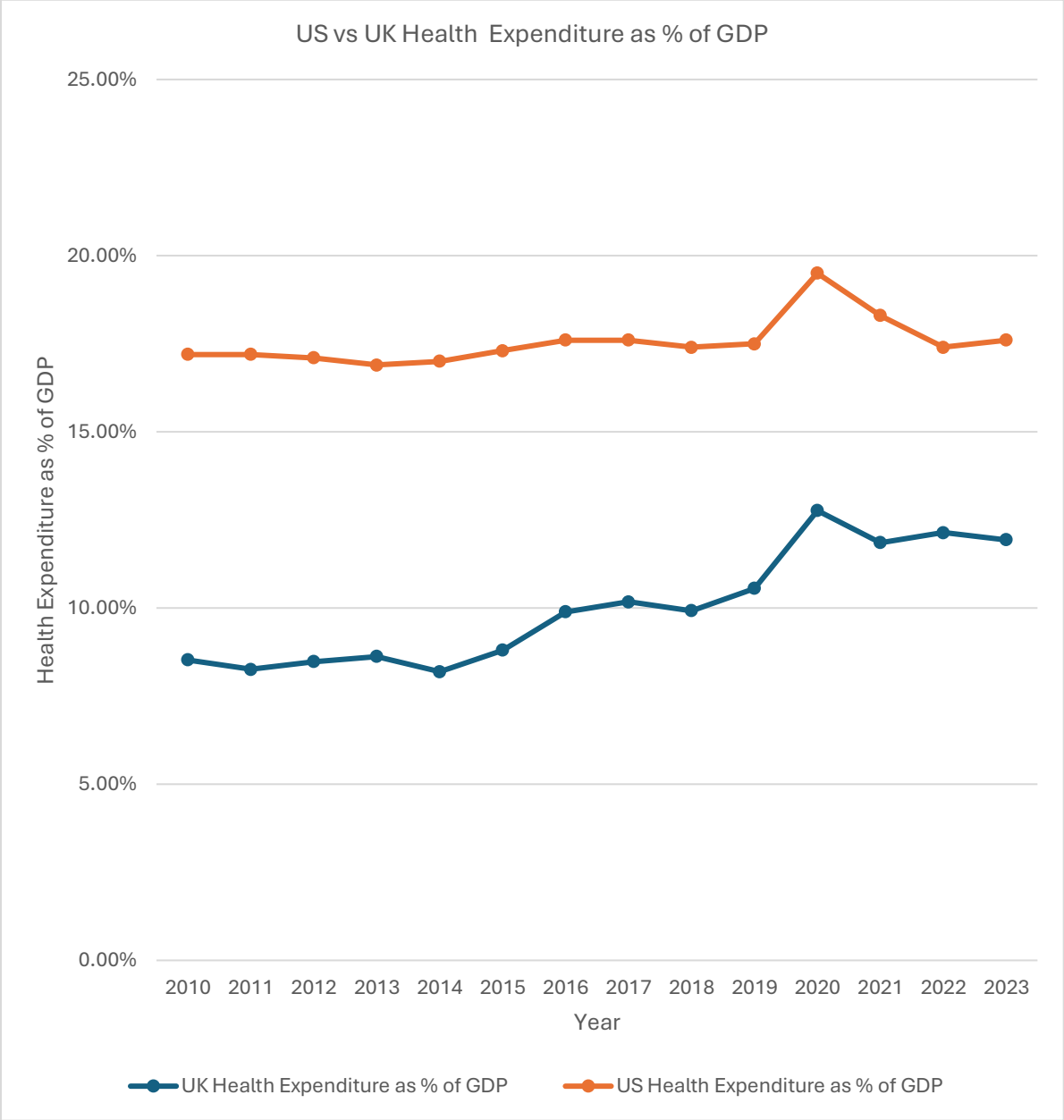
There have been recent federal actions to try to close these gaps. For example, the Biden administration directed federal agencies to develop Equity Action Plans and updated the CMS health equity framework (Ndugga et al., 2024). Efforts to stabilize Medicaid during the pandemic helped millions of people maintain coverage when they otherwise might have lost it. However, once those protections expired in 2023, millions were disenrolled (Ndugga et al., 2024). This

implies that disparities are at risk of widening again. Similarly, temporary expansions of the Child Tax Credit in 2021 lifted millions of children, especially Black and Hispanic children, out of poverty (Ndugga et al., 2024). But when the expansion expired, poverty rates rebounded. This depicts how fragile progress can be when policies are short-lived.

Looking ahead, several challenges remain. Mental health disparities are widening, with people of color facing disproportionate barriers to accessing mental health care even as needs rise. Drug overdose death rates have climbed sharply for AIAN, Black, and Hispanic populations (Ndugga et al., 2024). Climate-related health risks, such as extreme heat and air pollution, are also expected to hit marginalized communities hardest. This adds a new layer to equity concerns. Also, the evolving state policies on reproductive health following the Dobbs decision are likely to worsen existing maternal health disparities (Ndugga et al., 2024).

International Comparative Analysis

a) US versus United Kingdom Health Cost and Policy Comparison



Graph 12: US vs. UK Health Expenditure as % of GDP

When the U.S. and the U.K. health expenditure curves are placed side by side by graph

twelve, the first thing that jumps out is the spending gap. The United States puts around 16–17% of its GDP into healthcare, while the U.K. spends closer to 10–11%. That means the U.S. devotes about one and a half times more of its economic output to healthcare than Britain does.

The U.K.'s system is organized around the National Health Service (NHS), which is publicly funded and provides care that is free at the point of use (Cazzaniga, 2022). This system is funded by taxes and the government acts as the main payer and planner. In practice, which means administrative costs are incredibly low compared to the US because there is only one major payer rather than hundreds of insurance companies (Cazzaniga, 2022). Patients do not get hit with surprise bills for things like hospital stays or emergency care.

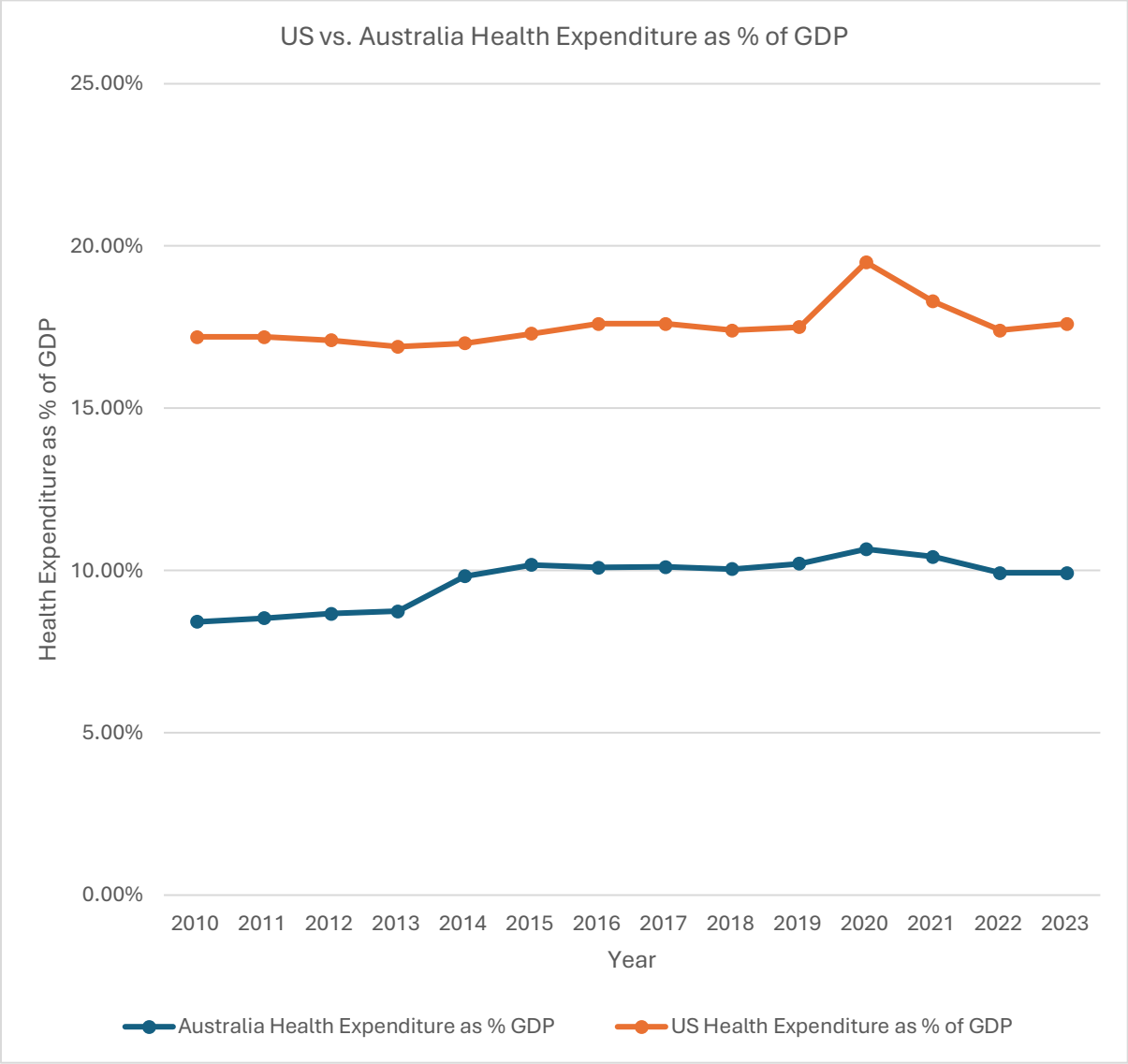
The US health system is far more dispersed than in UK. There are different rules for private insurance companies, employer-sponsored plans, Medicare, and Medicaid (Cazzaniga, 2022). This complexity exists due to the variety of rules. For example, patients typically face issues of copayments, deductibles, and narrow networks in this system. While the US has greater healthcare delivery expenditure, a sizable portion of it goes to pay for administration expenses rather than directly for the delivery of services.

When equity is involved, it shines even brighter. Yes, inequality persists in the UK, but everyone is at least guaranteed access to basic healthcare (Cazzaniga, 2022). In America, however, coverage is not universal. That is why millions of people still stay underinsured or uninsured. Access to healthcare largely determined by the personal income, being employed, and the state's laws (Cazzaniga, 2022). This disparity is what accounts for maternal and infant mortality rates being considerably higher in the US than in the U.K.

Policy choices also determine the difference in healthcare management between both countries. The UK has chosen to keep costs relatively low through negotiation with stakeholders

and keeping the budget at the national level for health services and drugs (McKeown, 2024). The US instead leaves market forces to dictate the price of healthcare services and products (McKeown, 2024). While this approach sustains healthcare innovation, it pushes prices to alarming rates.

b) US versus Australia Health Cost and Policy Comparison



Graph 13: US vs. Australia Health Expenditure as % of GDP

Despite both US and Australia being ranked as developed nations, the above graph demonstrates that healthcare spending patterns in these countries are substantially apart. As

highlighted by graph thirteen, the U.S. devotes roughly 16–17% of GDP to healthcare, while Australia stays near 9–10%. That means America spends almost double in relative terms. Yet Australia manages to deliver coverage to all its citizens at a fraction of the cost.

Australia's system is built around Medicare (not to be confused with US Medicare)**,** a publicly funded universal healthcare program that covers costs in areas like hospital care, basic doctor visits, and essential services (Angeles et al., 2023). This healthcare system is primarily funded through taxes. Every Australian is entitled to access to the services offered by this system (Angeles et al., 2023). At the same time, private insurance plays a supplementary role (Angeles et al., 2023). For instance, people can buy private coverage to get faster access to elective surgeries or private hospitals. This creates a blend of public security and private choice.

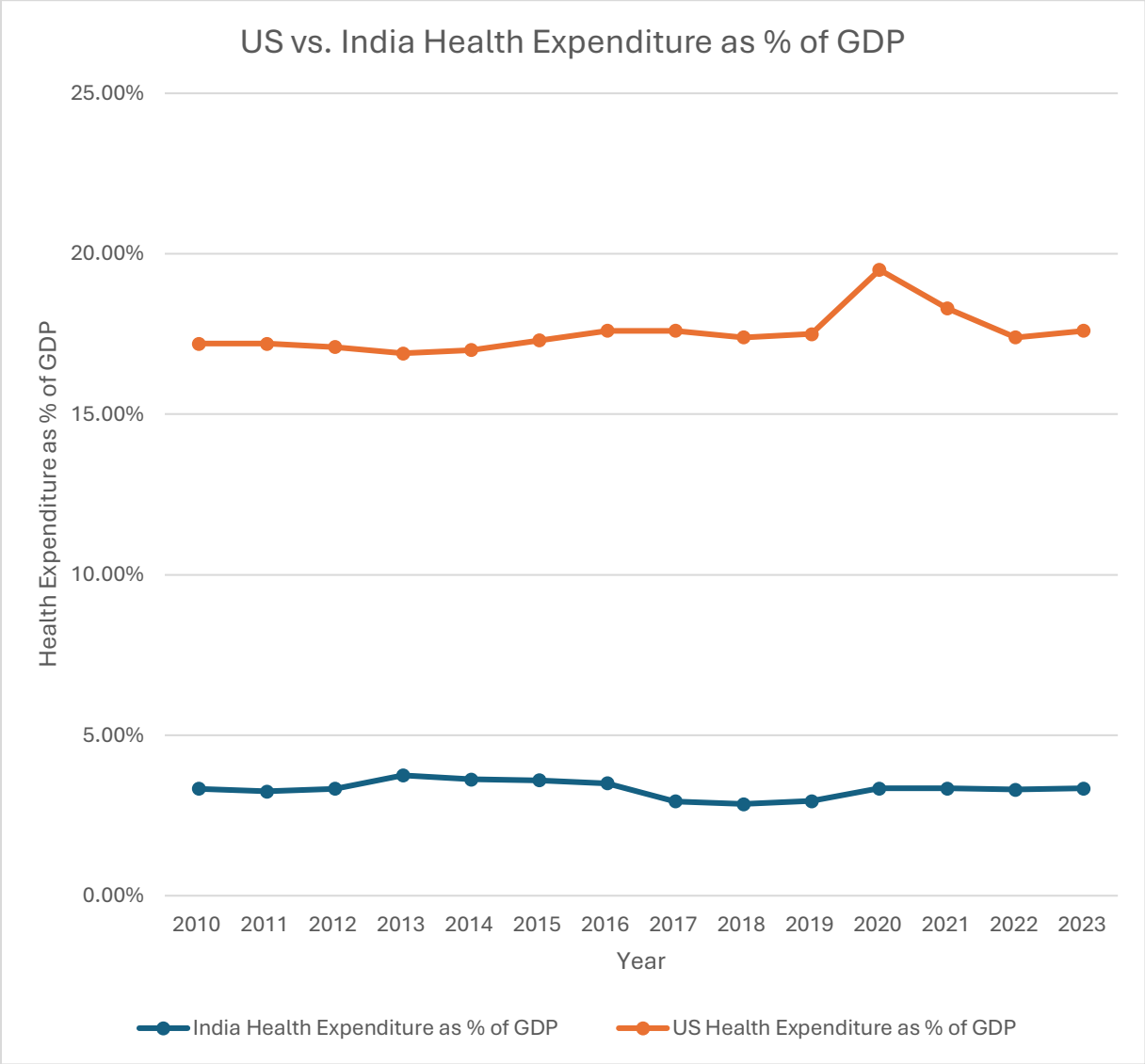
As earlier discussed, in the U.S., there is no such universal backbone. Coverage depends on employment, state of residence, or eligibility for government programs like Medicare and Medicaid. As earlier noted, the lack of a guaranteed system translates to large administrative costs, uneven access, and higher prices across the board. For instance, a US hospital bill for something as straightforward as childbirth or a broken arm can run into tens of thousands of dollars. In Australia, the public system absorbs much of that cost.

Equity in healthcare provision also varies in the two countries. In Australia, even as there are inequalities in access for Indigenous and rural people, the universality of the system implies that no one is entirely uninsured (Khatri & Assefa, 2022). This is different to the US because there are millions of people who are entirely uninsured. Many more patients delay care because of heightened medical bills. That difference is more apparent in population-based outcomes because the Australians are found to have a better average life expectancy and lower rates of preventable hospitalization compared to Americans.

Pharmaceuticals is another area that shows differing trends in healthcare dimensions of the two nations. Australian drugs are less expensive as it negotiates drug prices under the Pharmaceutical Benefits Scheme (PBS) (Grudnoff, 2025). America has no such rigid price negotiation structures. That is why Americans end up paying significantly more for the same drugs than Australians.

Both countries had their systems stress-tested by COVID. Australia depended more upon its public system to coordinate testing, quarantines, and vaccinations (Unruh et al., 2022). This country performed better early during the pandemic. The American response was to invest more money, but they were filtered through private insurers, state programs, and federal agencies (Unruh et al., 2022). Once again, the higher spending did not directly translate to better health outcomes in America.

C) US versus India Health Cost and Policy Comparison



Graph 14: US vs. India Health Expenditure as % of GDP

Graph fourteen immediately indicates a vast gulf between the United States and India in expenditure on health care as a percentage of GDP. Whereas the US spends approximately 16–17% of economic output on health care, India struggles to manage 3–4% of GDP that it pumps to healthcare system. This gap indicates largely different strategies towards financing, organization,

and delivery of health care. The United States has a highly fragmented system. Private insurance firms, employer-sponsored plans, Medicare, Medicaid, and state programs all regulate independently. Administrative fees are high with so many layers of bureaucracy and a great deal of the funds being used to administer the insurance rather than paying for medical treatment. Copayments, deductibles, and surprise bills, especially for a hospitalization or ER visit, are experienced by patients. Access to healthcare is strongly associated with income, employment, and state policy. Millions of Americans are either uninsured or underinsured. This directly impacts on health outcomes like maternal and infant mortality, chronic disease control, and life expectancy.

India's health system has a leaner budget but is not without challenges. Public health is primarily financed through general taxation, with some state-level schemes focusing on vulnerable groups (Rudrappa et al., 2018). Out-of-pocket expenditure is a striking feature of the Indian system and forms a significant percentage of total spending on health (Rudrappa et al., 2018). In most families, out-of-pocket payments for visits, medicines, or hospitalization are made. This potentially pushes families into financial difficulties. Infrastructure in India is still low, with greater towns having better facilities and rural areas normally having minimal basic services (Rudrappa et al., 2018). Despite low expenditure, the government has attempted to expand access through programs like Ayushman Bharat, trying to provide insurance coverage to poorer households (Mehta et al., 2023). Yet, coverage gaps persist, and health outcomes are highly unequal by area, socioeconomic status, and education.

Pitting healthcare delivery against each other, the differences are striking. In America, hospitals and clinics have the latest equipment, specialists, and high availability of services at an excessive cost. Indian government facilities are inadequately staffed and funded, yet it is still able to reach much larger populations with much lower budgets (Roy et al., 2023). Primary health care

and preventive care are given priority in India, but capacity and quality vary. Private hospitals in India treat patients who are willing and able to pay more (Rudrappa et al., 2018; Roy et al., 2023). This establishes a two-tier system similar in some ways to the U.S., but on a lower costly scale.

Equity and access point to healthcare is another notable difference between US and India. The US boasts of superior infrastructure and medical technology. However, the unequal coverage limits population-wide benefits to all people. The choice of policy also impacts healthcare management and outcomes. The U.S. relies heavily on market mechanisms to determine price of healthcare services and products. On the other hand, India uses bodies such as National Pharmaceutical Pricing Authority (NPPA) to regulate the prices of essential medicines and certain medical devices (like stents and knee implants) to keep them affordable to the masses. Also, India employs a combination of public provision and targeted insurance schemes to reach more people with limited resources. This not only maintains overall healthcare spending low but also restricts advanced care to people who can afford it. This failed approach explains why tribal communities, who often reside in remote areas of India, have limited access to healthcare facilities and practitioners (Roy et al., 2023). Also, like United States case, the wide socioeconomic disparity in Indian society makes it hard for poor people and illiterate people to access quality healthcare (Roy et al., 2023).

Recommendations for US Health Expenditure and Public Administration

Controlling Rising Healthcare Costs

As noted in the above discussion, one of the biggest challenges facing the U.S. healthcare system is the steady rise in costs year after year. Spending has gone up not just because more people need care, but because the price of almost everything related to healthcare keeps climbing. This constant rise places pressure on families, employers, and the government alike. It raises the question: how can the system deliver care people need without draining resources at such an unsustainable pace? The traditional fee-for-service model rewards volume of medical tests and procedures rather than health outcomes. Starting to pay healthcare providers based on patient health improvements can help to cut down on unnecessary services (Shi & Singh, 2022). It encourages efficiency and shifts the mindset from doing more to doing better health-wise. However, this requires careful design to avoid under-treatment that can compromise the quality of healthcare services (Shi & Singh, 2022).

Also, transparency could make a real difference. Patients often do not know the cost of a procedure or drug until after they receive the bill. Publishing clearer price information and creating tools that allow patients to compare costs can foster competition and hold providers accountable (Shi & Singh, 2022). While transparency alone will not solve the problem, it can guide the system toward more reasonable pricing.

Strengthening Public Administration in Healthcare

As noted in the above discussion, one of the most persistent challenges in the U.S. healthcare system is the way it is managed. A good starting point is cutting back on unnecessary complexity. For instance, when it comes to billing, hospitals can standardize their billing systems and reduce the number of forms to be filled by clients. This would allow healthcare professionals

to spend more time with patients instead of wrestling with paperwork (Folland et al., 2017).

Secondly, transparency is another key area that needs to be addressed. Right now, patients often feel left in dark about what procedures will cost or why insurance covers some treatments while avoiding others. If public agencies required clearer and more consistent communication of costs and coverage, it would reduce frustration and build trust (Shi & Singh, 2022). Patients should not need a law degree or hours on the phone to understand what their insurance covers (Shi & Singh, 2022). Making information easy to access and written in plain language would make an enormous difference.

Thirdly, if US healthcare system wants to be effective, it must upgrade its technology. Many agencies and hospitals still rely on outdated systems that do not talk to each other. This means information about a patient may be scattered across multiple databases. As a result, this slows down care and leads to errors. By investing in modern healthcare systems, public administration could streamline communication and reduce duplication (Shi & Singh, 2022). For example, if Medicare, Medicaid, and private insurers used more compatible platforms, doctors would not have to repeatedly chase down patient records.

Fourth, public administration in healthcare should strengthen its accountability when serving citizens. Public programs like Medicare and Medicaid represent enormous amounts of taxpayer money. If oversight is weak, funds can be lost to fraud or mismanagement. Improving auditing systems, tightening rules on provider payments, and making data on spending publicly available are ways to show that money is being used responsibly (Shi & Singh, 2022). This not only saves resources but also helps rebuild confidence in public programs.

Lastly, public administration must focus on coordination. During COVID-19, one of the biggest problems was the lack of clear communication between federal, state, and local health

agencies. Some areas moved faster on testing and vaccination than others, while others struggled with organization. A stronger administrative backbone would mean better preparedness when the next crisis arrives.

Expanding Access and Equity

Expanding access and equity in the U.S. healthcare system starts with confronting long-standing disparities that prevent certain groups from receiving timely and effective care. Unless they are addressed directly, the benefits of rising healthcare spending will continue to reach some Americans far more than others.

The priority is to reduce racial and ethnic health disparities. As earlier noted, Black, American Indian/Alaska Native, and Pacific Islander communities face higher maternal and infant mortality rates and experience more deaths from chronic conditions like diabetes. Insurance coverage alone does not solve this problem, since many still struggle with fewer nearby providers while some face bias in how care is delivered. Expanding community health centers in underserved neighborhoods, training more providers from within minority groups, and requiring cultural competency in medical training would help close these gaps (Shi & Singh, 2022). This is not only about funding programs but also about reshaping the way care is offered so that trust and accessibility improve. Undeniably, telehealth is one of the promising solutions for strengthening healthcare access in remote regions. The COVID-19 pandemic showed that remote consultations can keep patients connected to doctors when distance or cost is a challenge (Ndugga et al., 2024). Making telehealth a permanent part of insurance coverage and expanding broadband access in rural regions would give these communities more reliable access to care. This is a cost-effective way to extend services without needing to build new facilities in every small town.

Insurance coverage also remains central to equity. Millions of Americans are still uninsured

or underinsured, especially in states that have not expanded Medicaid. Policy changes that expand Medicaid eligibility and simplify the application process would help more families maintain consistent coverage (Ndugga et al., 2024). At the same time, coverage must translate into actual care. For instance, there is need to reduce the high deductibles and copayments that still discourage patients from seeking preventive services. Lowering these costs, particularly for routine and preventive care, would ensure that insurance provides rather than theoretical protection (Ndugga et al., 2024).

Mental health and reproductive health highlight two more urgent areas. Many people of color face unmet mental health needs. Integrating counseling into schools and primary care could reduce these gaps (Ndugga et al., 2024). Reproductive health access has also become uneven across states. These restrictions are leaving many women in certain locations to be excluded from reproductive wellness (Ndugga et al., 2024). Federal and state healthcare providers should keep these services more equitable.

Finally, delivering equity in healthcare also means preventing future risks. Climate change is already creating health burdens that range from extreme heat to worsening air quality. These harms fall hardest on poorer communities that lack protective resources like air conditioning (Ndugga et al., 2024). Healthcare stakeholders should be at forefront in fighting against climate change to protect disadvantaged communities from bearing these climate challenges (Ndugga et al., 2024). Preparing for these shifts means treating equity not as a side issue but as central to public health planning.

Improving Crisis Preparedness and Resilience

The COVID-19 pandemic and other recent health emergencies exposed weaknesses to the US healthcare systems. This highlights the need for better crisis preparedness and resilience. One

critical step towards achieving this is developing comprehensive emergency response plans at national, state, and local levels (Shi & Singh, 2022). These plans should clearly define roles and responsibilities of each stakeholder. They should also state the communication channels to be used when disaster hits and decision-making frameworks to be followed. Stakeholders should be conducting simulated exercises and regular drills to help identify gaps in disaster preparedness and ensure readiness (Shi & Singh, 2022). A resilient healthcare system relies on well-trained personnel who can adapt to high-pressure situations. Healthcare workers should be cross trained to expand the telehealth capabilities. Also, maintaining a reserve of trained volunteers or retired professionals can boost the availability of healthcare practitioners needed during crises. In addition, the frontline workers should be protected using appropriate safety protocols and mental health support to strengthen the system resilience.

Another promising step is for healthcare organizations to improve their investment in public health infrastructure. When public laboratories, surveillance systems, and rapid diagnostic channels are operationally ready, they can help in detecting and containing diseases early before the outbreak (Shi & Singh, 2022). Expanding data-sharing networks and integrating electronic health records can also improve tracking of disease patterns in real time. This can drive faster and more informed decisions. Government should strengthen supply chains for critical medical equipment, such as ventilators, personal protective equipment, and vaccines, to ensure that shortages do not hinder response efforts during emergencies (Shi & Singh, 2022).

There should also be improved coordination between public and private sectors to amplify the effectiveness of preparedness efforts (Folland et al., 2017). For instance, when hospitals, pharmacies, and private laboratories are collaborating this can streamline sharing of resources and rapid deployment of interventions.

Finally, continuous evaluation and adaptation are essential during and after the health crisis. After each crisis, thorough reviews should identify successes and failures. They should inform about the updates to policies, protocols, and infrastructure investments (Shi & Singh, 2022). US healthcare decision-makers should learn from both domestic experiences and international best practices to ensure that health systems evolve to meet emerging threats effectively.

Policy and Governance Reforms

All the above recommendations depend on policy and governance reforms that set the rules of the game. Without structural change, individual fixes will remain patchwork solutions (Shi & Singh, 2022). What is needed is a governance framework that reduces fragmentation, ensures accountability, and builds flexibility into the system.

First, federal and state coordination must be improved. The U.S. system is famously fragmented, with overlapping responsibilities across agencies and states (Shi & Singh, 2022). During COVID-19, this fragmentation made responses uneven and confusing. One way forward is to create clearer federal standards for crisis management, insurance coverage, and equity targets, while still giving states flexibility in how to implement them. The federal government should set the floor, not just the guidelines, to ensure that no state falls far behind in providing basic access.

Second, stronger regulations on costs are unavoidable. Drug pricing is one example where governance reform could have an immediate impact. Allowing Medicare to negotiate directly with pharmaceutical companies, and extending that power to more drugs, could bring the U.S. closer to peer countries where governments leverage their purchasing power (Grudnoff, 2025). Similarly, setting limits on surprise billing and enforcing transparency in hospital pricing would reduce the burden on patients. These steps are political, but without them, technical reforms in other areas will continue to be undermined by runaway costs (Grudnoff, 2025).

Third, governance reforms must address accountability and oversight. Public programs like Medicare and Medicaid manage huge sums of taxpayer money. Strengthening auditing systems, publishing detailed spending data, and increasing penalties for fraud could save billions each year (Shi & Singh, 2022). Patients and providers alike also need systems that explain rules and costs of healthcare. A governance model that reinforces clarity can rebuild trust in a healthcare system that many see as opaque.

Finally, healthcare governance must be ready to adapt to the evolving changes. The legal framework should allow for rapid adjustments in funding, data sharing, and workforce deployment (Shi & Singh, 2022). Establishing permanent task forces with clear authority could help avoid the "scramble and improvise" approach that was seen in the recent crises.

Summary of Key Findings and Conclusion

One of the clearest findings of this research is that there is a relentless upward climb in total and per capita health spending in the US. Modern medicine keeps discovering new ways to treat and prolong life, and those innovations are costly. But the gap between the amount spent and the improvement in outcomes feels too wide to ignore. Spending rises sharply, while life expectancy moves almost flat and dip during Covid-19 crises. That mismatch demonstrates the height of the America's healthcare paradox.

Looking at how money is divided, the above analysis reveals another imbalance. Most dollars go toward personal healthcare while far smaller shares go to disease prevention, public health programs, or long-term investments. This is not just a financial unusualness. It reflects the U.S. system mindset that is built to treat problems once they appear rather than preventing them early. The steady rise in chronic conditions like diabetes and heart disease demonstrates the cost of this approach. If the U.S. healthcare system wants to rein in costs over the long run, it must shift

more resources toward public health.

The balance between public and private spending tells another important story. Historically, the private side, which is driven by employer-based insurance and private insurers, has dominated the public side. But in 2020, when COVID-19 hit, public spending surged past private expenditure for the first time in years. The government had to step in because the private system alone could not carry the load of healthcare challenges brought by the pandemic. This episode highlighted the stabilizing role of public administration. In times of crisis, it is public funds and programs that keep the system from collapsing. Even outside of emergencies, programs like Medicare and Medicaid cover tens of millions of Americans who would otherwise be left behind. Yet, the partnership between public and private remains uneasy. While private spending adds choice of treatment channels and innovation, it also adds layers of bureaucracy and cost. Public spending provides stability and equity in healthcare. However, it can struggle with political battles and budget constraints. Together, public, and private spending form a system that is neither fully market-driven nor fully public.

The differences between Medicare and Medicaid add another layer of complexity. Medicare spending consistently outpaces Medicaid, largely because it serves the elderly, who need more care and more expensive treatments. Medicaid, though smaller, acts as the safety net. It expands when the economy declines or when reforms like the Affordable Care Act are adjusted to broaden eligibility of the residents. During COVID, Medicaid enrollment reached record highs, underscoring its role as the fallback for millions of families.

Equity is where the picture turns most troubling. The data shows that not all groups benefit equally from the massive U.S. healthcare budget. Racial and ethnic disparities remain to be a challenge. Black and American Indian/Alaska Native communities face higher infant mortality,

higher maternal mortality, and lower life expectancy compared to White Americans. Chronic diseases hit minority groups harder, not because of biology, but because of barriers like limited access to clinics, excessive costs, and systemic inequities. Even as per capita spending rises overall, many individuals still struggle to see the benefits. This is one of the harshest contradictions: America spends more on healthcare than any other country in the world, yet some of its communities' experience health outcomes that look more like those in developing nations.

When we step outside U.S. borders, the comparisons drive the point home. The U.K. and Australia both spend far less of their GDP on healthcare but deliver more equitable coverage and, in some cases, better population-wide outcomes. Their systems lean more heavily on universal coverage and government negotiation of prices, keeping costs under control. India, on the other hand, spends only a fraction of what the U.S. does, but it faces different challenges: limited infrastructure, high out-of-pocket costs, and stark urban-rural divides. The comparisons make clear that the U.S. system is not inherently doomed by its size or diversity. Rather, it is shaped by policy choices. Other countries show that universal access at lower cost is possible, though each approach comes with trade-offs.

Administrative costs add yet another piece to the puzzle. While 7–8% may sound like a small slice, in dollar terms it means hundreds of billions going to paperwork, billing systems, and insurance processing. Some of this is unavoidable in a system as complex as the U.S. But the spikes during COVID, and the ongoing inefficiencies in billing and record-keeping, show there is room to cut waste. Every percentage point shaved off administration could mean billions redirected to direct care or prevention.

So where does this leave us? The recommendations outlined earlier point to several paths forward: controlling costs through new payment models and transparency, modernizing

administration with better technology, expanding equity through insurance coverage and community-based care, and strengthening resilience for the next crisis. None of these fixes are easy, but together they sketch a roadmap. At the heart of it all is governance. Without stronger, more coordinated public administration, reforms risk being ignored. Healthcare needs clear rules, accountability, and the ability to adapt quickly when emergencies arise.

The U.S. system is failing, but that it is strained. It is capable of remarkable achievements such as life-saving technologies, rapid vaccine development, world-class research. However, it is also weighed down by inefficiency, inequity, and costs that outpace healthcare outcomes.

CHAPTER 5: DISCUSSION

Public health refers to the science and practice of disease prevention, disease-induced lengthening of life and promoting health to society in an organized manner. It deals with the area of both surveillance, policy formulation, health education, and population-wide interventions that are aimed at enhancing well-being and lessen health disparities (Jit Khong Goh, 2025). Public health is focused on collective responsibility and systematic solutions to extensive health issues contrary to individual clinical care. Due to various changes in health threats around the world, including pandemics, chronic diseases, and climate risks, the role expectations put on the public health system also continue to rise (Ugwu et al., 2025). To eliminate these complex issues, intersectoral collaboration, novelty, and inclusive governance are necessary to make sure that population-wide approaches are beneficial and fair (World Health Organization, 2023). In this way, the concept of public health is becoming more than merely a study of medicine but a source of sustainable development, social and national stability.

Health administration is the steering wheel by which the public health objectives are translated into policies and services that can be rendered. Administrators take pivotal decisions regarding the way funds are distributed, the design of programs, the way the workforce is used, and the accountability of the institution as well as all of them affect the outcome of health interventions (Valiotis et al., 2025). This is because their leadership directly influences the responsiveness of the health systems, their resilience, and their efficiency. Even the most excellent public health programs may be spoiled due to administrative fails (poor planning, fragmented service delivery, or data integration not done). Conversely, properly guided systems that read between, transparent, workforce efficient, and interaction coordinated are the more likely ones to

make high-impact results (Oye & Owen, 2024). As the pressure on the health systems grows, the administrative ability to plan and to adapt emerges as a determinant of health equity and quality outcomes, particularly in low-resource countries.

The fast pace of growth of global and national health expenditure has raised cost management to the health system agenda. It has become a challenge to most countries to provide quality care and restrain spending in the face of escalating pharmaceutical prices, technological spending, and an aging population (Cashin et al., 2017). Poor or uneconomical management also increases the cost pressures and services are frequently duplicated, delayed and resources are often underutilized (Adjagba et al., 2025). Consequently, governments and institutions are being put on strain to achieve more with less- requiring innovations in budgeting, monitoring systems, and performance management. Nevertheless, short-term cost-reduction may adversely affect preventive care and increase health inequities (Liaropoulos and Goranitis, 2015). In order to prevent this, there is a need to put the emphasis on active investment in the system of public health as well as administration aiming to provide efficiency and sustainability.

A confluence of the health-related objectives of the populations, the administrative abilities, and the financial limitations has posed a lasting strain on the system of contemporary health. Professionals in the field of public health strive to enhance the results and decrease the disparity, and the administrators have to manage scarce resources and more sophisticated models of delivery (Singh & Jermsittiparsert, 2024). In the meantime, policymakers are financially responsible and are therefore prone to political influences that inhibit long-term investment in prevention (Hamdounia et al., 2012). This battle may result in piecemeal attempts, distorted motivation, and ill health results. This gap needs an evidence-driven systemic reform that is built

on equity and collaboration. A comprehensive strategy, which includes person-brushing up with administrative effectiveness and cost imposition, is crucial to the continuity of system functionality (Ayer et al., 2014). The interplay between these three spheres will be crucial in promoting policy models that are able to adjust to the future health risks as accountable and affordable.

This paper is based on the fact that the sustainable health systems should have an equilibrium between the public health priorities and cost discipline and administrative effectiveness. Sustainable growth and success of the most promising strategies in public health cannot exist without the effective health governance (Asamani et al., 2021). Moreover, absence of synergies between health financing, health management practices, and health results of the population remains to impede the process in developed and developing countries (Cerovic et al., 2017). Good administration goes beyond cost control; it is the ability to flex strategic leadership and make the most of it, increase efficiency, and foster trust among the population (Jensen et al., 2022). Through the investigation of the interconnections between these forces, this research will bring an enlightenment on how systems can be redesigned to become resilient, equitable, and valuable in the long term to both the populations and the providers.

The issue of the modern healthcare system remains the same and complicated, as there is a necessity to work simultaneously on the health outcomes of the population, administrative efficiency, and the cost increase. These usually aims conflict with each other and not complement. Long term costs could be decreased by investments in public health interventions like chronic disease prevention, vaccination, and health education but demand large initial investment and administrative restructuring (Cerovic et al., 2017). Nonetheless, a tight budget and political situation often compel administrators to put short-term monetary objectives at the forefront of

long-term health improvements (Asamani et al., 2021). This short-termism services sustainability and puts pressure on already strained systems. Meanwhile, the demand of the people towards high quality and accessible care is also increasing, and the process of resources allocation is getting even harder (Hamdounia et al., 2012). The tension that results bring about inefficiencies, inequities in service delivery and missed chances in striking health reform.

To balance these three pillars' outcomes, efficiency, and cost, leadership structures and policies are necessary to balance conflicting interests without compromising quality or access of care. However, fragmentation between health sectors, the absence of sufficient investment in digital infrastructures, and clear performance measurement have kept this integration at bay in numerous environments (Jensen et al., 2022). Administrative wastefulness may contribute to repetitive work, allocation of resources, and burnout in staff, all of which negatively affect the performance of the systems (Valiotis et al., 2025). In addition, the attempt to lower expenses through constraining services or reducing labor-force expenditures can unintentionally aggravate the population health outcomes in the underserved communities (Saadati, 2025). Health systems are at risk to continue the cycles of inefficiency and inequalities without deliberate plans to combine the populace health objectives with the realities of the administration and financial restraint. Reform needs to take this three-way tension by storm, address it based on the evidence, allocating resources ethically, and continuing investing in prevention-oriented models (Alami et This research is aimed at looking at the effectiveness of health administration as a driver of streamlining of the results of the public health with an economic constraint in mind. Efficient administration leadership lies at the core of harmonising the social health goals with the capability of operations and financial constraints (Valiotis et al., 2025). Effective administration enhances the coordination of programs, timeliness, and efficiency of service provision, as well as utilizing

resources available (Alsubaie et al., 2024). Furthermore, by taking a strategic perspective on prevention and population health, administrators establish a situation in which long-term health benefits can be obtained without necessarily increasing expenditures (Cashin et al., 2017). Through the analysis of this relationship, this study will identify the potential administrative functions as not only a support system, but also as a central contributor to health system performance.

The other goal is to assess the extent to which a variety of administrative models affect health outcomes and cost effectiveness. As an example, decentralized governance options might be able to provide some flexibility in responding to local health demands, whereas centralized systems can be more consistent and control resource use (Asamani et al., 2021). It is critical to appreciate these processes when developing systems with demonstrable positive public health outcomes at the cost of financial sustainability (Cerovic et al., 2017). Further, digital transformation and value-based management are recognized as more administrative strategies that can be used to cut on unnecessary resources and enhance accountability (Jensen et al., 2022). The paper explores the potential of such innovations to minimize inefficiencies and drive outcome-based healthcare systems in a manner done effectively.

Lastly, the research will aim at giving evidence-based information that will guide future policy and reform. A considerable number of health systems have difficulties embracing administrative solutions (scales) that can support access, quality, and cost (Adjagba et al., 2025). Through case study analysis and the identification of key success factors, the study will put emphasis on practices that can be replicated to formulate general reforms in the health sector (Saadati, 2025). By so doing, the study will aid in the current health equity, sustainability, and system resilience debates, especially in the view of increasing global health risks and fiscal

demands (Alami et al., 2023). The eventual aim is to empower decision-makers in designing administrative approaches to promote health and financial outcomes among different al., 2023).

The research is of paramount importance to policymakers because the study can provide information based on facts regarding the utilization of administrative strategies to enhance the overall health of the population without blowing the cost-out. When attempting to create health coverage and fulfill the needs of the population, it becomes crucial to learn what administrative practices have the greatest value (Oye & Owen, 2024). Policymakers need to be advised on the distribution of resources that comply with factors that reflect fiscal limitations and equity in service coverage, especially in the underserved areas (World Health Organization, 2023). Through the analysis of the overlap between health results, management, and spending, the study can be applied to creating consistent policies, which can be both realistic and applicable to all health systems (Ayer et al., 2014). Administrative evidence can progress more responsive reforms which can assist countries to avoid spending money inefficiently and also inequalities in care delivery.

To health administrators, the study provides a model to link leadership, workforce planning and operational choices to quantifiable population health improvements. The fragmented systems and the absence of coordination often cause administrative inefficiencies, duplication of services, increased wait times, and poor care quality (Dhaliwal, 2019). This study will enable administrators to go beyond reactive models and adopt more initiative-taking, integrated approaches by discovering the best practices (Singh & Jermsittiparsert, 2024). Innovation in day-to-day activities can be supported by a special emphasis on administration in the area of preventive treatment, data collection, and intersectoral partnership (Alsubaie et al., 2024). Knowledge facilitates the

development of leadership that is desperately needed to make change in the increasingly complex and strained health systems.

This study will also be useful to the professionals in the field of public health as they will know the importance of effective administration to offer preventive and promotive health services. More frequently, great programs do not really work because of poorly implemented programs and administrative choke points, rather than poor public health approaches (Saadati, 2025). The findings of this study may help shape more collaborative planning activities where an administration and frontline personnel co-design and develop community driven and economically viable interventions (Alami et al., 2023). Additionally, this work can also be added to a more comprehensive concept of sustainability alongside administrative efficiency, not just financial, but also in the resilience of population in the long term and the ability of the system to endure various changes (Jit Khong Goh, 2025). It is essential to reinforce the administrative base of the public health work so that it would reach the population, which most needs it, and survive during political and economic changes.

There are three pillars in the field of public health prevention, protection, and promotion of the health of the people. Shi and Singh (2021) describe these functions as acting as a collective way to enhance life expectancy and decrease disease burden by aiding social, environmental, and behavioral health determinants. Starfield (1998) states that a professionally designed public health system makes sure that preventive health and promotion are not pushed out by the more glaring needs of curative medicine. Vaccinations, sanitation, and health education initiatives have become invaluable in terms of lowering mortality and building resilience within communities (Egharevba,

2024). Prevention seeks to prevent disease, protection safeguard against health risks and promotes healthier behaviors-- all three form the foundation of the population health.

The history of public health has brought a transition period of treating infectious diseases to the long-term conditions. Ferlie and Shortell (2001) indicate that contemporary public health is characterized by complex burdens like chronic disease, aging, and mental health crisis. Malakoane et al. (2020) assert that poor infrastructures and reduced human resources have a tendency to render the public health systems adjust poorly to these new demands. Also, there exist global challenges that reveal the vulnerabilities within the system and the resource gaps between the health systems, such as pandemics (Bartolo-Cariaga et al., 2025). These changes necessitate a redefinition of the models of public health focusing on not just clinical intervention but also administrative creativity, community integration, and resiliency planning.

Byskov et al. (2019) believe that the increased complexity of the public health challenges necessitates a system-thinking approach to the realization (and acknowledgment) of the interdependence between such spheres as education, urban planning, and economics. Okuonzi, Karamagi, and Mwanje (2025) tend to suggest that it is impossible to attain sustainability in the public health sector without the involvement of long-term innovation into the national health governance. This strategy focuses on mission-oriented health investments, which goes beyond episodic allocation or political reactions. The resilience of health systems as a whole has to be designed, which will mean cross-sector collaboration and less reactive management of crises (Ticona Machaca et al., 2025). These changes are necessary to deal with non-communicable diseases and environmental health hazards as well as global pandemics that arise in a more fair and effective manner.

There is another aspect of public health, which is a global environment where resource inequalities between high-income and low- and middle-income countries have an impact. Butt et al. (2024) point out that prevailing workforce deficit and remuneration challenges tend to drag on the developing nations, deteriorating their public health system. To create health equity, Ticona Machaca et al. (2025) suggest that a policy based on human capital development, especially among those marginalized, is necessary. Moreover, Subramani et al. note the importance of the data-driven systems in detecting and eliminating gaps in the delivery of the public services. Influencing health in such environments does not only rely on campaigns but also on making sure the system as a whole is able to access clean water, healthy foods, and basic healthcare (Lakshminarayan et al., 2023). By filling in these structural gaps, it is possible to develop sustainable and inclusive global health systems.

Technology and data intelligence are nowadays viewed as a means of promoting and preventing the functions of the prevention and promotion of public health. Lakshminarayanan et al. (2023) also state that new methods of accessing the populations with low healthcare access are available through the means of such tools as augmented reality and edge computing. According to Kukreti et al. (2024), digital infrastructure can assist in observing disease patterns, intervening, and encouraging behavioral change on a mass scale. Nevertheless, these inventions should be backed by just policies to prevent enlarging the existing gaps (Borgonovi et al., 2018). Technology is not something that needs to take over but rather something that needs to enhance community based public health programs. The merger of smart health systems with policy reform can open a door to more responsive, data-driven, and fair public health solutions that can address 21st Century health challenges.

Health administration is at the center of the functioning and the development of health systems. Shi and Singh (2021) note that health administrators have the responsibility of leadership, strategic planning, distribution of resources, and policy implementation as part of the core tasks. These functions are important to identify the institutional objectives in line with the overall public health goals. According to Ferlie and Shortell (2001), health policies that are well conceived do not necessarily get any tangible results unless the leadership is competent. Good leaders lead teams, organize stakeholders, and produce evidence-based decisions to make the most out of scarce resources. Planning entails making projections of future requirements, strategic planning in operations as well as adjusting to new threats to health. In the meantime, resource allocation will secure those budgets, workforce, and technology are shared fairly and efficiently. All these roles are all related to policy implementation and actualizing ideas into practice and quantifiable outcomes. Not only does the administrator have to know policies but also has to overcome political, logistical, and institutional obstacles to achieve this (Ticona Machaca et al., 2025).

Governance structures are also very much related to the effectiveness of health administration particularly between the systems of the public and private. Egharevba (2024) notes that such centralization tends to produce more bureaucratic but universal coverage of governments and the governance of public health activities in general. Conversely, Butt et al. (2024) maintain that private health systems are more focused on competition, performance and financial sustainability which allows them to make decisions faster, but at the expense of inclusivity. Public systems that are governed often include several levels of control, regulation and accountability that may slow policy making and innovation. The private systems are leaner but might not focus on the results of the population as a whole. This dichotomy guides the decision-making of administrators working in any sector; the former might have to decide what is better as a political

requirement or a goal of the population health, whereas the latter might find it necessary to think about cost-effectiveness and market orientation (Bartolo-Cariaga et al., 2025). These governance dynamics are important in the development of effective administrative strategies that can be designed according to the circumstances.

The efficiency of the administration procedure is an essential element in the extent of efficiency in functioning health systems, especially where financial or human resource limitations are present. Inefficiencies within the management of service delivery, which may include duplicate delivery of services, disjointed supply chains, or slow procurement, have the potential to severely damage service delivery (Okuonzi et al., 2025). According to Malakoane et al. (2020) clinical constraints are most frequently harmful to the outcomes in practicing environments with fewer resources compared to administrative bottlenecks. With good administration, it becomes easy to conduct timely interventions and even to ensure that resources are used optimally and that there is good coordination of departments and sectors. It also facilitates productivity of the workforce as well as minimizing waste expenditure. Notably, administrative efficiency promotes accountability and transparency in service delivery in the public service, which are the characteristics that ensure the maintenance of the public trust and long-term policy success (Subramani et al.). Even the most progressive health systems may be brought to holes when administrative operations are feeble, responsive, and biased (Lakshminarayan et al., 2023).

Other emerging issues that health administration leadership should oversee include global pandemics, population changes, and fast-changing technology. As noted by Byskov et al. (2019), adaptive leadership has become unnecessary when it comes to system resilience, especially during the period of crisis. The administrators should not be able to think in future, but real-time response

to changing health requirements and systemic shocks should also be provided. Kukreti et al. (2024) likewise state that effective administrators combine intelligent technologies and data analytics to foresee trends and make decisions. The tools enable leaders to stop being reactive in case of crises and become initiative-taking in upholding systems. The technological solutions, however, have to be supported by effective governance, ethical management, and involvement of the stakeholders. Other qualities of good leadership are a good workforce, teamwork amongst departments and clear communication between the policymakers and the citizens (Borgonovi et al., 2018). In the absence of this capacity, health systems will be prone to disruptions and cannot institute initiative-taking and equity-based reforms.

Policy implementation is the intersection point of the health reform vision and reality. According to Ticona Machaca et al. (2025), policy failure can be more associated with failure to execute instead of poor design. Administrators will see that policies are put into a service format especially so that marginalized or at-risk populations can avail themselves. As proposed by Alsubaie et al. (2024), this is a process that entails planning, coordination, monitoring, and adaptation. Superior performance is reliant on organizational preparedness, investment by the stakeholders, and the performance analysis in real-time. Administrators should also close the divide between the technical guidelines and the realities on the grounds, the workforce constraints, cultural norms, infrastructure limitations etc. Implementation is not a single event but a continuous process that transforms with changing policy trends and needs of the community (World Health Organization, 2000). It can bring drastic change when well undertaken; when without proper attention, it reduces policy into paperwork without substance.

The world is increasingly spending a lot on healthcare, and this is a huge burden on the state budgets and home incomes. Shi and Singh (2021) state that healthcare spending is rising at a tremendous rate in both high-and low-income nations and in many cases, it is growing at faster rates than the economy. Byskov et al. (2019) note that a higher expenditure can indicate increased access and innovation, but it also creates the issue of sustainability, especially when these funds are misdirected. Out-of-pocket expenditure can force families to be impoverished by lack of universal coverage in most of the low- and middle-income countries. Costs are increasing at a higher rate than inflation even in well-resourced systems thanks to the structural inefficiencies and the increase in the demand (Egharevba, 2024). Such trends require improved resource planning, enhanced regulation, and a model of value-based planning to characterize the spending on basis of results instead of volumes.

The key factors contributing to the increase of healthcare costs are medical technology, pharmaceuticals, aging populations, and administrative inefficiencies. As Bartolo-Cariaga et al. (2025) remark, although innovation enhances the quality of care, the models frequently bring high-priced processes and devices that small scales cannot afford. Borgonovi et al. (2018) posits that the demographics (especially the increasing number of older demographics) are putting pressure on the spending budgets on long-term care and the management of chronic diseases. Operation expenses are also worsened by the administrative inefficiencies that include bloated bureaucracies and divided service delivery. Even health systems with substantial budgets have difficulties with waste unless they are coordinated, have digital structures, and effective processes (Lakshminarayan et al., 2023). Due to the increasing number of cost drivers, governments and administrators should embrace even cleverer means of budgeting and delivery so as to save not only the fiscal but also the lives of the populace.

Preventable diseases have been one of the largest yet least taken care of healthcare expenditures. The study by Okuonzi, Karamagi, and Mwanje (2025) suggested that the proportion of non-communicable illnesses such as diabetes, high blood pressure, and heart disease in healthcare budgets all over the world is increasing, even though all of them can be prevented by early intervention and public health. Ticona Machaca et al. (2025) postulate that the cost of prevention in the downstream is increased because of inadequate investment by individuals in preventing misfortune caused by hospitalizations, long-term treatment, and loss of productivity. There is a tendency of diseases being extremely expensive in systems that have poor primary care and health literacy since early symptoms are not addressed. Prevention services, community education, and screening can help a great deal in decreasing the economic cost of health systems.

The reaction of individual nations towards the expenditure on healthcare differs, yet the economic impacts of the lack of interventions are universal and harmful. Malakoane et al. (2020) claim that the growing expenses in most developing countries push out other important investments such as education and infrastructure. At the same time, according to Butt et al. (2024), increased health costs in advanced countries lead to increased inequality, with the insurance services of the private system being made less affordable. The sculpture to contain funds, with quality care is of global interest in universal health coverage, outcome-based financing, and public and corporate collaborations. Still, without reducing the systemic causes of inefficiency and preventable disease, such reforms might not be sufficient (Kukreti et al., 2024). In order to prevent economic turmoil and decreased health among the population, a sustainable health system ought to be financially sound, result oriented, and well enshrined in prevention.

Administrative ruling is vital in influencing the manner in which healthcare budget is allocated particularly in regard to preventive medication. Saadati (2025) says that lots of the systems focus on the acute and curative services rather than the long-term preventive investments as it is caused by political and fiscal pressure in many cases. According to Alami et al. (2023), strategic administrative planning should include sustainability and equity to rebuke expenditure on the public health interventions including vaccination, early screening, and health promotion. Such preventative measures cut the costs in the long-run and enhance the health of the population given that they demand continuous administrative dedication and allocation of funds (Ticona Machaca et al., 2025). With increased investments made on prevention, administrators can transform systems which are reactive to initiative-taking and decrease the economic and social burden of disease.

Low levels of efficiency and prohibitive costs in the system, ineffective administrative management are among the major causes. Hamdounia et al. (2012) suggest that disjointed leadership, ineffective processes, and poor accountability systems cause service redundancy, time and resource wastage, and inefficient resource distribution. Jensen et al. (2022) argue that poor governance compromises the responsiveness of health systems and frequently results in poor patient outcomes and increased financial waste. Such failures particularly hurt on a small scale, low-resource settings, where every dollar does matter (Subramani et al.). The investment in competent leadership, single-stop data system, simplified workflow will significantly enhance the performance of operations, cut down on unwarranted spending, and create a sense of trust among the people.

The paradigm of value-based care is one of the biggest opportunities to reconcile the intentions of public health with financial sustainability. According to Oye and Owen (2024), this model motivates healthcare professionals to make efforts to protect quality and preventive measures to boost outputs by prioritizing quality instead of quantity of services. Cashin et al. (2017) states that value-based care puts administrators to task over the measurement-based patient outcomes, which brings about transparency and better funds. Alsubaie et al. (2024) accentuate that the ability of the administration to track data, control performance, and adjust organizational systems is crucial to successful implementation.

Dynamism in outcomes-based systems of management promote wiser expenditures and fairer provision of care. According to Adjagba et al. (2025), administrative decisions based on the use of performance data are useful in eliminating waste and scaling effective programs. Ayer et al. (2014) observed that data-driven strategies give administrators the capacity to realize low-value practices and redirect resources to interventions with known advantages. Dhaliwal (2019) emphasizes that such systems also need an administrative culture that accepts evaluation, feedback, and continual improvement. The centralization of public health administration within the framework of outcome-oriented measures helps not only to ensure financial sustainability but to facilitate the improvement in quality, access, and population-level health outcomes, as well.

This study employs a qualitative research design to examine how effective health administration impacts population health outcomes and healthcare cost management. Qualitative methods are best suited to exploring the complex and context-dependent dynamics of health systems, where policy implementation, leadership behavior, and organizational culture deeply influence outcomes. Rather than relying on numerical patterns, this approach draws from

document analysis, policy reviews, and administrative case studies to uncover the decision-making processes behind resource allocation, governance structures, and service delivery. For example, policy texts may reveal motivations behind budgetary reforms, while administrative reports provide insight into how frontline managers interpret and execute those reforms (Phua, 2017). This design also supports triangulation, using multiple sources to validate findings and offer a holistic understanding of how administration interacts with cost and public health goals (Matheny et al., 2025).

Thus explains findings of the study as compared to literature, with regard to how effective health administration can improve health outcomes of the population, as a cost-controlling approach to healthcare. It looks at the applications of administrative leadership, budgetary allocations, and governance models in attaining efficiency and equity in the system. Developing the principal areas of focus like investment in preventive care, the efficiency of administration system, and value-based care, this section will bridge the gap between data and the real-world issues by helping to tie together data with the problems that the world faces. It also deals with unending impediments such as mismanagement of resources and political limitation. Finally, the discussion is also meant to offer practical information to policymakers, administrators, and prevention health professionals in a bid to have sustainable health systems.

The Role of Public Health in Cost Reduction

Among the most effective measures of reducing long term healthcare costs are public health interventions that focus on prevention as opposed to treatment. Preventive services include vaccinations, health screenings, health education, and nutrition which allows the identification of diseases at an early stage or even prevent diseases altogether, leading to a significant reduction in

treatment costs. The global community estimated that per dollar spent on prevention can give an equivalent of up to 14 in health and productivity savings (World Health Organization, 2000). Digitally, as a case in point, hypertension and diabetes screening initiatives not only decrease the hospital admission burden but health systems impose less financial pressure on the societal financial systems by enhancing quality-adjusted life years (QALYs) (Martin et al., 2018). In developed nations such as Canada, strategic investment has been made in children health which has resulted in expenditure on health per capita being lower in comparison to other nations with the same disease burden but poor prevention efforts (Matheny et al., 2025). The workforce is also affected by the broader economic effects of preventive care, with issues such as absenteeism and disability being low and the productivity of the workforce being better (Phua, 2017).

Health equity is also provided by the preventive systems of health and especially when targeted at the underserved. As an example, prevention-based outreach activities in rural societies in South Africa have reduced the rate of maternal and infant deaths, which would otherwise create significant long-term costs in care (Malakoane et al., 2020). These instances explain why a strong infrastructural situation in public health might develop not only economical gains but also social virtues. Notably, preventive services are cheaper to upscale especially when they are incorporated into the primary care systems-aiding financial stability in addition to logistical sustainability (Starfield, 1998). The economic case in favor of prevention has been enhanced as long-term economic terms due to the quest of governments to decrease medical spending but maintain access and quality of care (He & Lin, 2025).

Vaccination is one of the most affordable interventions in terms of public health in the world. The WHO reveals that a yearly death toll of 4-5 million is prevented due to vaccines and

the expensive treatment or hospitalization is avoided (World Health Organization, 2000). As an illustration, vaccination against measles is about one dollar per shot, but in comparison, it prevents the most expensive illness in terms of complications and therapy, such as pneumonia or encephalitis, which cause prolonged and intensive treatment (Martin et al., 2018). The CDC estimates that childhood immunization program in the United States has cost the society more than 1.38 trillion saved since 1994 (Matheny et al., 2025). Such savings do not only result in lower treatment expenses but also in savings relating to lost productivity because of disability or having to take care of the sick person or a loved one.

Vaccination programs also play a crucial role in taking off economic burden in developing countries since it helps to avoid outbreaks that otherwise might be overwhelming to already minimal healthcare infrastructure. Cervical cancer is a disease usually diagnosed late and treated at great expense, and in South Africa, HPV vaccination has been implemented in schools with students to prevent it (Malakoane et al., 2020). Besides, immunization reaches in times of the COVID-19 pandemic the powerful countries recuperated faster at both economic and social levels, proving the impact of vaccines to be less substantial not only in morbidity but also in macroeconomic breakage (He & Lin, 2025). Scale-up of vaccine access has also been largely enabled by public-private partnerships particularly in the remote or resource-poor areas (Phua, 2017). This illustrates that a healthy investment in vaccination is not just a health policy but a strong form of cost-containment in terms of expenditure also.

Among the major drivers of healthcare costs in the world are chronic diseases ranging between diabetes, cardiovascular diseases, and respiratory diseases. Nonetheless, initiative-taking measures in the treatment of such disorders have proved to save a lot of money. As an example,

one of the studies in the United States, the Diabetes Prevention Program (DPP) demonstrated that lifestyle modification programs at approximately 1,400 dollars could decrease type 2 diabetes by 58 percent in three years (Matheny et al., 2025). This would translate into long-term care, dialysis or hospitalization thousands of dollars saved per patient. The same cost-saving trends have registered in Canada whereby proactive chronic disease management has enabled to prevent avoidable emergency room visits and inpatient care (Martin et al., 2018).

In places such as China, where health initiatives feature lifestyle coaching, electronic health app monitoring and screenings in preliminary stages have lowered the treatment expenses of cardiovascular disease and hypertension (He & Lin, 2025). Such efforts focus on the modification of the risk factors that are both modifiable e.g., smoking, poor diet, and sedentary behavior, and which contribute a significant percentage of the disease burden across the globe. Such interventions put in place at a community level are usually much cheaper to implement, compared to treatment of the end-stage disease. The economic reason is even greater in the aging populations, whose prevalence of chronic diseases is greater, and the cost of long-term care may be staggering (Starfield, 1998). The preventive interventions towards chronic diseases not only add up to the lifespan but also maintain economic stability by saving costs.

The economic importance of preventive public health measures helps in underlining the necessity of policy change that focuses on long term investment as opposed to short term cost control. Historically, a sizable number of governments had prevented specific services as a primary priority, taking curative care, although the existing evidence has been overwhelming concerning cost-benefits (Phua, 2017). However, a shift is occurring. In Canada, as an example, the federal health agencies started devoting increasing resources to community-based prevention, and it is

estimated that, in long term, the chronic disease-related expenditures would be decreased to 4 billion a year (Martin et al., 2018). Likewise, other new economies like South Africa are increasing health education in schools, and mobile health clinics, to target the population at an early age, so they only incur less in terms of treatment expenses in the future (Malakoane et al., 2020).

The problem is one in proving short-term payback on prevention since the fiscal rewards may not be seen till years later. This complicates securing political support in environments where the political cycles and election cycles take center stage in making decisions about health policy. However, global organizations and health economists are demanding cost-benefit models that should be able to sum up both the physical savings and indirect benefits on society, including increased productivity and decreased caregiver load (He and Lin, 2025). Setting priorities on public health funding can reduce the growing cash outlays in healthcare and enhance the population health effects- a necessary twofold success in the creation of sustainable health systems (World Health Organization, 2000).

Administrative Performance and Health Outcomes

The efficiency of administration is the key to quality, accessibility, and sustainability of healthcare services. The structure of governance which determines the planning, management, and delivery of services can be considered one of the most powerful. This feature, i.e., standardization of policies and coordinate at the national level, encourages equity and cost-controllability in centralized systems such as Canada's one, but can be less responsive locally (Martin et al., 2018). Decentralized systems, like those in South Africa, in contrast, can be more adapted locally but may have issues regarding oversight and equality in service delivery (Malakoane et al., 2020). Studies indicate that a disjointed governance system translates into inefficiencies, duplication of services

and the lack of accountability (World Health Organization, 2000). Balanced governance will eliminate autonomy and control so that priorities of the public health are achieved without making them go through red tape in bureaucracies or excessive resource dislocation. Those countries that manage to achieve this balance usually perform more appropriately on immunization coverage, maternal mortality, and chronic diseases management indicators (Phua, 2017).

Leadership, workforce planning and using digital technology are also critical to administrative efficiency. Having good leadership can guarantee to have a strategic vision, good coordination, as well as accountability culture. As an illustration, the high-performing OECD nations such as the UK, Canada, and China incorporate workforce planning into their national workforce management that ensures the appropriate balance of professionals in the healthcare sector is availed to every region (Butt et al., 2024). Conversely, improper management of workforce results in staff shortage, overworking, and burnout; problems which have direct impact on patient outcome. Furthermore, digital transformation has become one of the significant levers of enhancing the efficiency of administration. The report provides an example of a similar system in the Zhejiang Province of China that facilitated regional coordination of health services in digital dashboards, ensuring that care redundancy was minimized (He & Lin, 2025). Similarly, the U.S and the U.K have shown that the electronic health records, AI-enhanced diagnostics, and data analytics have the potential to streamline the operations and decrease the error rates (Matheny et al., 2025). These systems, however, need to be invested in and leadership with the strong will to implement them. The following table summarizes how governance structure and digital tools correlate with selected health outcomes across a few real-world systems:

Country	Governance Type	Digital Integration	Health Outcome (Example)
Canada	Centralized	Moderate (EHR, AI pilots)	Low avoidable mortality rate (185/100,000)
South Africa	Decentralized	Limited	High maternal mortality (119/100,000)
China	Regional hybrid	High (dashboards, AI)	Improved hypertension control (42% compliance)
United Kingdom	Centralized	High (NHS digital)	Reduced prescribing errors by 50% post-EHR

(Data: Martin et al., 2018; He & Lin, 2025; Malakoane et al., 2020)

In conclusion, administrative efficiency is not just an operational concern—it directly shapes health outcomes. Effective governance enables better resource alignment, while strong leadership and digital innovation enhance system responsiveness and patient care. As global health systems face increasing cost and capacity pressures, administrative reform should be prioritized alongside clinical care to ensure sustainable, high-performing health delivery.

Cost Management and Financial Sustainability

The healthcare system of the world is strained due to increased prices combined with aging, chronic diseases, medical technologies development, and administration ineffectiveness. Evidence-based approaches to control health government spending and not affect access or outcomes are being explored by governments and health administrators. One of the most popular methods is the global budgeting, which is applied in such countries as Canada and Germany. In Canada, provinces like Ontario and British Columbia put restrictions on the amount of money

hospitals can spend by a set number each year and this brings the administrators to maximize the services that should be offered within the stipulated budget. The strategy has aided to keep the spending on health in Canada at approximately 10.8 percent of GDP and has also provided access to almost all the services (Martin et al., 2018). In Germany, a similar model is used with negotiated expenditure limits among the sizable slickness reserves (public insurers) and the healthcare establishments, which contribute to efficiency and avoid inflation of costs (World Health Organization, 2000). In China, especially Zhejiang Province, procurement and utilization patterns in hospitals are monitored digitally to have a better prediction of costs and reduce frauds, which have enhanced efficiency in the system (He & Lin, 2025). Such strategies involve discipline of budgeting and digital controls to enhance control and responsibility.

Global nations have put in place some form of regulation in terms of unwarranted expenditure. Singapore has a highly controlled structure where service charges are standardized, and subsidies are kept to minimum so that it is not abused. The population must also make payments to a mandatory health-related savings fund called Medisave, which helps prevent moral hazard and perpetrates personal fiscal responsibility (Phua, 2017). Although Singapore has been incurring only 4.1% of GDP on health, the country has been amongst the highest achievers in terms of life expectancy and disease burden alleviation. On the same note, hospital costs in Norway and Finland have been minimized by centralized buying of drugs and machines to exploit the economies of scale to secure low costs (World Health Organization, 2000). Normal clinical pathways and resource planning tools are also used in the United Kingdom as a means of physicians to pursue cost-effective treatment to reduce variability in service delivery and reduce costs without altering outcomes (Matheny et al., 2025). These control and planning mechanisms can guarantee that the healthcare systems do not spend their money in a generous way.

Nevertheless, it is a hard job to strike the right balance between cost control and quality of the services. Unreasonably active cost-reduction may lead to understaffing of the facilities, prolonged waiting, and delayed care. South Africa is a good example of this tension. Decentralized financing model allows provincial authorities to spend money independently, which is commonly inefficient and disjointed services and uneven distribution of resources, especially in rural contexts (Malakoane et al., 2020). Sweden, on the contrary, shows the example of combining cost control with high service quality. Sweden uses value-based reimbursement and health technology assessments in its implementation through the county councils to make sure that the services that are publicly funded are effective ones. Sweden allocates approximately 10.9 percent of GDP towards health, and it scores high in OECD outcome indicators (He and Lin, 2025). Similarly, the Singaporean dual focus on cost-sharing and outcome measurement makes quality not be compromised on the cost factor. Digital systems, workforce planning, and closely tracked performance indicators enable this balance, which proves that efficiency does not necessarily have to compromise the effectiveness (Phua, 2017).

The digital transformation has become a force enhancing economic care provision. Electronic health records (EHRs) have been used throughout Finland, which has led to enhanced care coordination and decreased duplicating programs and tests, resulting in cost-saving of an estimated amount of three hundred and fifty million euro (World Health Organization, 2000). On the same note, a national health system that uses blockchain technologies in Estonia enables hospitals and insurers to share patient data in a secure and cost-effective manner. AI-based systems in the United States such as IBM Watson Health and predictive analytics systems are assisting hospital systems in the detection of high-risk patients and cutting emergency readmissions, with some having reduced care episode costs by 10-15 percent (Matheny et al., 2025). These IT tools

make the work of administrators more effective, permit tracking costs in real-time, and enable making better clinical decisions. Nevertheless, digital transformation involves massive up-front expenditure and competent management to make sure the process is brought on board successfully. Unless it is governed, then the benefits might not be distributed around even or achieved.

Health Technology Assessment (HTA) is one of the best structural instruments in ensuring financial sustainability. HTA assesses clinical performance and the economical merits of new treatment, prior to its implementation. The CADTH (Canadian Agency for Drugs and Technologies in Health) does the evaluation and advises on drug reimbursement and government funding in Canada to avoid paying prohibitive costs on slightly effective innovations (Martin et al., 2018). Sweden uses HTA by the Dental and Pharmaceutical Benefits Agency (TLV) which evaluates pharmaceuticals to meet the qualification to be included in the national scheme of benefits. In Germany, IQWiG (Institute of Quality and Efficiency in Health Care) conducts such assessments to ensure that new treatments bring value as compared to existing provisions. External reference pricing is applied in France and Italy, under which drugs are identified by the average of the chosen European nations to ensure pharmaceutical spending is under control (He & Lin, 2025). Such systems avoid cost inflation and health spending is targeted with high impacts and evidence-based interventions.

Integration of Public Health and Administrative Policy

The success of public health system depends not just on effective health objectives but also put in place administrative power to execute them. Even the best-planned policies become doomed even in cases where a disconnect occurs between the administrative resources and the public health ambitions. Administrative alignment entails having adequate workforce, infrastructure, funding

mechanisms, and digital systems in place to facilitate the work of the public health interventions. Indicatively, Canada has experienced a continuous delay to institute a national mental health and Indigenous health program because of disproportional administrative capacity across provinces despite the presence of cohesive national administration policy (Martin et al., 2018). The lack of provincial departments to plan and utilize resources well has impeded maternal health efforts in South Africa, showing a gap in the coordination of goals of the national health care with local administrative units (Malakoane et al., 2020). Such disjuncture is not solitary as in nations, World Health Organization (2000) has reported instances where failures in states to perform in public health have to do with lack of proper management frameworks rather than policy failures. There are many goals of the government in health care, and aligning governmental needs with the realities of the administration is a way to make sure that money gets to where it is needed, schedules are possible, and results will be attained.

Among the key aspects of this alignment is the connection between the planning of public health and wider administrative systems, notably using digital infrastructure. The Zhejiang Province in China, the regional health system connects real-time administrative data, health indicators, and the public expenditure. This will enable provincial leaders to change resource distributions depending on the performance in health, leading to a rise in equity in services and quick reaction to the health demands (He and Lin, 2025). However, most decentralized systems including those found in South African regions fail to integrate the administrative roles with health objectives and frequently work on old and disjointed data systems (Malakoane et al., 2020). The budgeting and policy implementation are compromised in systems where the administrators cannot access the correct or timely information. This is why Matheny et al. (2025) focus on the importance of artificial intelligence (AI) and digital dashboards in the contemporary operational system of the

public health, as these could facilitate improved service delivery, minimize redundancy, and facilitate better decision-making. Administrative capacity does not only refer to staffing and finance, but the readiness in terms of technology and the ability of systems to interoperate is also added to it.

Intersectoral collaboration is also an equally vital component of health system integration. The outcome of health cannot be reduced to only the result of medical interventions- housing, education, transportation, and labor. Singapore has provided a model of intersectoral cooperation which is quite well-structured based on its vision of urban planning, school curricula, and policy of physical housing and the combination of these with the aim of enhancing health such as slowly reducing diabetes and more effective physical activities (Phua, 2017). Equally, Health in All Policies (HiAP) approach in Sweden demands that all government departments evaluate health outcomes of their decisions resulting in quantifiable improvements in regional health disparities (World Health Organization, 2000). The models understand that health is a ministry wise responsibility and not necessarily the preservation of health departments. On Zhejiang, China, the urban-rural health difference has been decreased through the coordinated policies in economic and health policy by aligning the goals of urban development with the objectives of population health (He & Lin, 2025). These systems do not keep administrative integration local in health ministries but are pervasive throughout government. The following table offers a comparison between the strategies and results of incorporation of the specific countries in the health system into the administrative system and into the intersectoral system:

Country	Integration Strategy	Administrative Feature	Intersectoral Partnership Example	Resulting Impact
Canada	Provincial implementation of national health goals	Health authorities manage regional planning	Integration with Indigenous Affairs for rural health	Uneven rollout, gaps in access between provinces
South Africa	Decentralized district health systems	Weak provincial budgeting, poor HR management	Pilot programs link local government with clinics	High disparity in service quality and efficiency
Sweden	Health in All Policies (HiAP)	Centralized health governance	All ministries must assess health impact of decisions	Improved regional equity and cross-sector collaboration
Singapore	Healthy Living Master Plan	Digitally supported policy tracking	Housing and education ministries support health promotion	High life expectancy and low health costs (4.1% of GDP)
China (Zhejiang)	Digital dashboard-based regional coordination	Integrated administrative data systems	Public health linked to regional economic planning	Reduced rural-urban health inequities

To be successful, intersectoral collaboration should be institutionalized in the form of formal governance systems, i.e., joint lines of budget, joint chairing of committees, or inter-ministerial working groups. Hospital, public health, and community care decisions and resources are more coordinated in Canada, as integrated health authorities in such provinces as British Columbia bring hospital, public health, and community care together under the same

administrative body (Martin et al., 2018). In South Africa, pilot models within the District Health System framework seek to identify a relationship between delivering public health and local governance and social services, but full execution is yet to be realized because of financial constraints and human resources (Malakoane et al., 2020). The other area that is on the ascending trend is digital integration. Zhejiang is where the real-time data systems can give administrators a view of the impact of change in the housing or education policy on the indicators of health, through giving the system dynamic policy feedback loops (He & Lin, 2025). Such mechanisms transform such collaboration into more than a dream, they turn it into an operationality.

To conclude, to achieve high-performing and equitable health outcomes, the integration between administrative systems and the policy of the public health should be effective. It demands not only goal correspondence, but coordination of budgets, management frameworks, and computer systems. The examples of countries such as Sweden, Singapore, and Zhejiang (China) are useful demonstrations of the ways in which such integration can be attained by designing cross-sector policies, basing the plan on data, and holding all parties accountable. At the other end, systems that are fragmented and under-resourced administrations, such as some in South Africa, bring into view the dangers of not connecting what the policy of the health system tries to achieve and what the system is able to perform. Public health should be incorporated within all levels of administration in the quest to gain sustainability and equity and be spread to all areas of relevance.

Challenges and Barriers

Resistance to change is one of the most intractable problems faced in the way to better the public health systems; it may be based on political, fiscal, or organizational resistance. Policymakers might not wish to invest in long-term reforms that do not give them instant benefits

particularly during election years which require speedy deliverables. An example of this is that although there is a solid case in favor of preventive care, the governments often give priority to acute care as it is more observable and politically extremely attractive (World Health Organization, 2000). There is a tendency to find financial opposition due to institutional budget setups that do not encourage cross-sector expenditure or redistribution. South Africa has been hindered in reallocating resources to primary and community-based care due to inflexible provincial budgets and lack of autonomy within administrations (Malakoane et al., 2020). Organizational resistance is also an influential factor since health professionals and bureaucrats can voice their opposition to structural changes that modify the existing hierarchies or performance standards. The inter-ministerial inefficiency in Indigenous health initiatives in Canada explains how administrative silos that are deeply rooted in an organization system can delay the process of reform, even in high-capacity systems (Martin et al., 2018).

Data fragmentation and lack of accountability in most health systems is another barrier that is critical. In low- and middle-income nations, the data can be incomplete, out-of-date, or fragmented across the agencies, which narrows the scope of its use in informing decision-making. As the case of South Africa district health system, which faces inadequate integration standards between clinical records, budgeting records, and the public health surveillance, illustrates, it becomes hard to monitor performance or distribute resources properly (Malakoane et al., 2020). In modern systems, the sharing of valuable information may not be done in cases where ownership and privacy issues are the focus. This impairs monitoring of performance and coordination in the provision of care. However, in China, Zhejiang Province has advanced a step further in integrating both administrative and clinical information using digital dashboards, which can be used to monitor performance in real time and dynamically budget (He & Lin, 2025). In the absence of

clear and interoperative data systems, it would be hard to hold the administrators to accountability on basis of result. As Matheny et al. (2025) claim, efficient governance can only be achieved with the help of real-time data systems, which must be regarded as an essential infrastructure investment and not an upgrade.

Implications for Policy and Practice

The reform agenda that is necessary to establish equitable and efficient health systems is decentralization with checks and balances, making decisions that are informed by data, and multisectoral collaboration. Indicatively, the centralized policy design of Sweden is localized on counties councils that give local flexibility on national structures. This helps with accountability as well as responsiveness (World Health Organization, 2000). On Zhejiang, the resolved digitization of planning tools has enabled mid-level administrators to make decisions concerning the budgeting process, founded on actual-time requirements, instead of the state directives (He and Lin, 2025). By contrast, the South African experience revealed that unsupported and untrained decentralization would result in fragmented services and low performance (Malakoane et al., 2020). Like reforming policy, then it must be not only a structural redesign but also a capacity building regarding the district and regional levels where it occurs during implementation.

Regarding the idea of sustainable financing, the policy should encourage prevention, equity, and efficiency in the same equation. Performance-based budgeting is one of these strategies according to which money is distributed on the measure of improvements in health indicators. It has been assessed in several Canadian provinces, in which community funding on health is pegged on community-based outcomes such as the vaccination rates and prevention of chronic diseases (Martin et al., 2018). In such countries as France and Italy, pharmaceuticals are priced externally,

which assists in preventing the excessive expenditure toward expensive medications without restricting access (He & Lin, 2025). A decrease in the degree of reliance on reactive care is also important concerning long-term sustainability. On the part of example, WHO estimates show that investing in tobacco control, vaccination, and diabetes prevention can provide returns of up to $14 per $1 spent (World Health Organization, 2000). Funding paradigm shifts that values prevention rather than treatment is necessary to curve the cost curve and improve equity in the system.

CHAPTER 6: CONCLUSIONS

Summary of Key Findings

An administrative organization and strategies related to finances are closely related to the result in terms of public health. The results of this paper reveal that the achievement of the goals of public health like prevention of diseases, health promotion and protection of the community is not possible in the full spectrum without the achievement of competent administration to facilitate achievement of these goals. Such health systems are better placed to implement high impact public health interventions based on having invested in strong leadership, strategic planning, and useful resource allocation. To illustrate the point, fragmented service delivery and poor resource management are common in decentralized health systems with a weak administrative capacity, which disrupts the initiatives in the field of preventive care and population health management (Malakoane et al., 2020). On the other hand, however, there is integrated administrative systems, such as those in Sweden or Zhejiang Province, which show that when governance and priorities around public health are aligned the result will be more effective and equitable (He & Lin, 2025). Simply put, it becomes clear that it is not only the medical infrastructure of a system or vision of policies of a system but also the appropriateness of policies to operationalization through coherent and capable administrative action that gives a system its capability to provide benefits in terms of public health (World Health Organization, 2000).

The study also concludes that it is not the trends of the population structure or technological development that drives the costs of the health systems, but the structural inefficiency and the unbalanced incentives. The consequences of administrative decisions, the allocation of funds, staff management, and allocating care priorities directly affect the spending and the sustainability of the

system in the long-term. This is because systems that either favor reactive care or curative assistance rather than preventive care tend to experience a considerable rise in expenditures relative to population health. Conversely, countries that adopt value-based care models, electronic planning applications, and performance-based budgeting have a greater control over any expenditures and shows better health outcomes (Martin et al., 2018). Also, the causes of waste in the form of administrative inefficiencies include data silos, ineffective procurement procedures, and legacy governance frameworks. This increases the necessity of systems being developed out of fragmented, reactive models, to preventive, efficient, and data-driven administration (Phua, 2017). The analysis reveals that cost control could not be detached by issues of leadership, accountability, and administrative design (World Health Organization, 2000).

One of the main conclusions of this research is that integration is central: sustainable and fair health systems will be formed in case of the strategic alignment of the public health objectives, administrative, and financial mechanisms. When countries coordinate these elements, that is, intersectoral coordination, shared accountability schemes, and integrated service delivery, they can achieve desirable results with fewer expenditures. Integrated governance can be seen to enable coordination in ministries, enhance budgetary efficiency, and make sure the health policies are responsive to the needs of the population. As an example, the Healthy Living Master Plan of Singapore and remote Health in All Policies of Sweden represent the ways administrative integration generates prevention and equity with the help of collaboration between multiple sectors (Phua, 2017; World Health Organization, 2000). Furthermore, the role of technology within the connection of these areas, including with the use of digital dashboards or AI-intensive policy planning, only reinforces the significance of modernization to reach the objective of the health system (Matheny et al., 2025). Overall, this paper contends that efficiency, equity, and

effectiveness in health systems are reinforcing in case of the integration of public health, administration, and cost frameworks to operate jointly.

Recommendations

Health systems are required to embrace administrative and policy changes to promote efficiency, accountability, and prevention to maximize health results with constrained budgets. One of the underlying suggestions includes the reorganization of governance systems, which enhance communication among services. The success of countries such as Sweden has led to regionalized governance systems whereby the united governance systems accommodate primary care, hospital, and public health services under one administrative system and thus make one-time decisions and have their budgetary allocations aligned (World Health Organization, 2000). Equally, Canadian provinces with Regional Health Authorities have been more responsive by connecting resource allocation and localized health priorities (Martin et al., 2018). Training in administration and leadership should also be emphasized since poor administration means wastage and procrastination. Moreover, the models of value-based care, according to which the providers' reimbursement is determined not according to the number of services provided but according to the health outcomes, need to be magnified. These models promote more productive and preventive actions and deter redundant surgical operations, which control cost but enhance health outcomes in populations (Phua, 2017). Investments in the direction of workforce planning and intersectoral cooperation should also be considered strategic so that the policies could be implemented without delays and inefficiencies. Such administrative enhancements should be intricately connected with broad objectives of public health.

The system-wide focus on prevention, transparency, and data-driven decision-making is also important. A higher proportion of healthcare spending should be redistributed by the governments through preventive measures like vaccines, screening of chronic diseases, and community-based measures. Even though these interventions are not as visible as hospitals or emergency services, they bring great returns in the long run. As an illustration, preventive care has the potential to decrease instances of noncommunicable diseases and hospitalization that are expensive thus enabling stabilize national health spending (World Health Organization, 2000). Outcome-based budgets need to be made transparent, and it should be a norm such that the financials put in are connected to quantifiable health outcomes. Administrative visibility can be boosted by using digital tools, including real-time dashboards and AI-based planning software, which will contribute to the ability to reallocate resources dynamically (Matheny et al., 2025). There is also a possibility to monitor performance more accurately with the help of these tools, which facilitate evidenced-based policy changes, as well as encourage accountability among administrators. Digital transformation models should be used based on systems such as those available in Zhejiang Province, China, where an integrated data platform is used to manage the health of the population in real-time (He & Lin, 2025). Finally, a transparent and information-centered administrative culture will make sure that the process of healthcare becomes not only cost-effective but also fair, robust, and able to adjust to new health needs.

Future Research

Several essential issues would be of interest to explore to enhance the evidence base and improve the design of the policy and administration. To begin with, the concept of digital administration should be further expanded: how artificial intelligence, big data analytics, and

integrated information systems can enhance efficiency, cost containment, and population outcomes in administration (Matheny et al., 2025). Second, comprehensive cost benefit evaluations of preventive interventions are scarce: longitudinal and cross-national studies would provide more parameters on returns on investment in prevention, especially in low- and middle-income settings. Third, the equity-based financing models should be considered: how can health systems integrate equity strategies, including risk adjusted funding, subsidized systems, and cross subsidies, to assure universal access and keep their fiscal sustainability (Phua, 2017). Fourth, governance innovations need research: comparative research on centralized and decentralized administrative design, quality control of costs and healthcare provision, and equity, etc. (Martin et al., 2018). Lastly, improvements in administrative reform research, including what causes successful policy implementation, how to prepare the workforce and provide administrative culture change could be the answer to addressing the gap between what policy is supposed to accomplish and what the systems achieve.

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