ISSN: 2754-5008

Journal of Pharmaceutical Research and Reports

SCIENTIFIC Research and Community

Research Article

Open Access

Healthcare Without Profit: An Embodied Theological Vision

Julian Ungar-Sargon

Borra College of Health Sciences Dominican University River Forest IL, USA

ABSTRACT

Healthcare systems worldwide face a fundamental tension between profit maximization and healing. In the United States, market-driven healthcare has created systemic inequities, operational inefficiencies, and what recent scholarship identifies as physician moral injury-the psychological distress experienced when economic pressures compromise ethical medical practice.

This article examines what healthcare might look like without profit motivation and explores how such transformation aligns with embodied theological understandings of healing as covenant, justice, and divine presence.

We conducted comparative analysis of international healthcare models, integrated findings from health economics literature, and synthesized theological scholarship from Jewish mystical and ethical traditions. The analysis draws extensively from contemporary work on physician moral injury, pharmaceutical industry practices, and institutional coercion in medical settings.

Global healthcare systems treating health as a public good consistently deliver superior outcomes at lower costs compared to profit-driven models. Single-payer systems achieve 10-20% administrative cost savings while ensuring universal access. Research demonstrates that for-profit healthcare organizations prioritize shareholder returns over patient care, particularly during crises, while nonprofit institutions maintain community focus and quality measures. Theological analysis reveals that profit-driven medicine violates covenantal principles by reducing sacred healing encounters to financial transactions.

Healthcare without profit represents both economically viable policy direction and theologically compelling vision. Removing profit as the organizing principle enables medicine to recover its deepest vocation: honoring human vulnerability, enacting justice, and witnessing divine presence through compassionate care. Implementation requires systematic transformation of financing mechanisms, medical education, and institutional cultures to support covenantal rather than contractual relationships between healers and patients.

***Corresponding author**

Borra College of Health Sciences Dominican University River Forest IL, USA.

Received: September 23, 2025; **Accepted:** September 26, 2025; **Published:** October 07, 2025

Keywords: Healthcare Economics, Profit Motive, Physician Moral Injury, Embodied Theology, Healthcare Justice, Single-Payer Systems, Theological Ethics, Covenantal Medicine, Healthcare Reform, Divine Presence

Introduction

Healthcare systems across the globe confront a fundamental paradox: as medical technology advances exponentially, the human dimension of healing appears increasingly endangered. In the United States, the profit motive has achieved unprecedented dominance over healthcare delivery, permeating every aspect from insurance architecture and pharmaceutical pricing to hospital governance and clinical decision-making. This market-driven paradigm has undeniably catalyzed remarkable technological breakthroughs and pharmaceutical innovations, yet simultaneously fostered systemic inequities, operational inefficiencies, and what can only be described as the spiritual impoverishment of therapeutic encounters [1,2].

The contemporary American healthcare landscape presents a striking contradiction: the world's most expensive healthcare system consistently underperforms when measured against peer nations in virtually every metric of population health [3,4]. This paradox demands not merely technical reform but fundamental reimagining of healthcare's organizing principles. This article interrogates a critical question that extends beyond policy analysis into theological territory: what would healthcare look like if the profit motive were systematically eliminated? Furthermore, how might such a transformation resonate with an embodied theology of healing that understands medicine as covenant, justice, and divine presence rather than commodity exchange?

Drawing from health economics, comparative global health policy, and theological scholarship-particularly Jewish mystical and ethical traditions-this essay proposes that healthcare without profit represents both an economically viable policy direction and a theologically coherent vision of human flourishing. Through comparative analysis of international healthcare models, integration of theological frameworks, and examination of contemporary challenges including physician moral injury, this work argues for a fundamental reorientation of healthcare delivery toward covenantal rather than contractual relationships.

The stakes of this investigation extend far beyond academic discourse since market imperatives systematically compromise

the therapeutic relationship, creating what he terms "compromised healers" caught between economic demands and ethical obligations [5,6]. This moral distress reflects deeper theological questions about the nature of healing itself: whether medicine serves human flourishing or market efficiency, whether physicians function as agents of wholeness or instruments of profit maximization.

Economic Inefficiencies and Moral Distortions

The United States healthcare system consumes approximately 20% of GDP while delivering outcomes consistently inferior to peer nations that spend significantly less [1,4]. This inefficiency stems not from technological inadequacy but from systemic distortions introduced by profit maximization as the organizing principle. Relman's prescient analysis of the "medical-industrial complex" identified how corporate actors increasingly shape healthcare priorities, often in direct conflict with patient welfare [2].

The entrenchment of for-profit hospitals, insurance conglomerates, and pharmaceutical companies has created what Arrow recognized as a fundamental category error: treating healthcare as a standard commodity despite its inherent characteristics of uncertainty, information asymmetries, and profound ethical significance [3]. This commodification generates what economists' term "Market Failures" but what theologians might recognize as spiritual crisis: the reduction of sacred encounters to financial transactions.

Administrative costs alone consume nearly 30% of healthcare spending in the United States, compared to less than 10% in single-payer systems. Yet these figures, while staggering, represent only the visible portion of profit's corrosive effects. More profound damage occurs in what Ungar-Sargon identifies as the systematic erosion of physician moral agency through economic coercion.

The Phenomenon of Physician Moral Injury

Physician moral injury reveals how profit imperatives create systematic conflicts between medical ethics and economic demands [6-11]. Healthcare providers increasingly find themselves trapped between corporate mandates for productivity and professional obligations to patient welfare. This conflict generates what he terms "Moral Ambiguity" in the physician's role-a state where healing professionals become complicit in systems that prioritize financial returns over human flourishing [6].

The psychological toll of this moral injury extends beyond individual practitioners to the entire healthcare ecosystem. When physicians cannot practice according to ethical principles due to economic constraints, the therapeutic relationship itself becomes compromised. Patients sense this compromise, leading to decreased trust, poorer outcomes, and further system deterioration. This cycle creates "Compromised Healers" who experience existential crisis as they witness their vocation's transformation from sacred calling to market function [11].

This moral injury phenomenon illuminates the theological dimensions of healthcare reform. The profit motive doesn't merely create economic inefficiency; it violates the fundamental covenant between healer and patient, corrupting what should be encounters of presence and care into calculations of reimbursement and liability.

Pharmaceutical Industry and the Commodification of Healing

A critical analysis of pharmaceutical industry practices reveals how profit maximization systematically distorts medical research, clinical practice, and therapeutic relationships [10]. The industry's focus on profitable chronic conditions rather than curable diseases, its manipulation of clinical trial data, and its aggressive marketing to both physicians and patients represent what he terms "The Profit Paradox": the more profitable medicine becomes, the less healing it provides [10].

The pharmaceutical sector's influence extends beyond drug pricing into the fundamental epistemology of medical practice. When profit-driven research determines which questions get investigated, which populations receive attention, and which therapeutic modalities receive validation, the entire knowledge base of medicine becomes skewed toward market rather than healing imperatives [12].

This distortion creates "Evidence-Based" medicine that paradoxically undermines evidence by excluding non-profitable interventions from consideration. Alternative healing modalities, lifestyle interventions, and community-based approaches often demonstrate superior outcomes but receive minimal research attention due to their limited profit potential [13].

Lessons from International Systems

Comparative analysis of global healthcare systems demonstrates that treating health as a public good rather than market commodity consistently produces superior outcomes at lower costs. Canada's single-payer system achieves universal coverage through public financing while maintaining effective cost control and high patient satisfaction [14]. The system's administrative efficiency allows resources to flow toward patient care rather than insurance bureaucracy.

The United Kingdom's National Health Service exemplifies healthcare organized around need rather than ability to pay. Despite periodic funding challenges, the NHS delivers comprehensive care through general taxation, demonstrating that healthcare can function effectively when removed from profit imperatives [15]. Importantly, the NHS model preserves clinical autonomy while eliminating the moral injury that accompanies fee-for-service medicine.

Nordic welfare states integrate healthcare within comprehensive social policy frameworks that address health's social determinants rather than merely treating disease [16]. These systems recognize that health emerges from social conditions-housing, education, employment, community-rather than primarily from medical interventions. This holistic approach aligns with theological understandings of healing as encompassing physical, social, and spiritual dimensions.

Comparative Performance

Research consistently demonstrates that nonprofit healthcare organizations reinvest operational surpluses into community services, quality improvements, and staff development, while for-profit institutions prioritize shareholder returns [17]. This difference manifests not merely in financial flows but in organizational culture, staff morale, and patient experience.

Horwitz's analysis reveals that nonprofit hospitals maintain higher nurse-to-patient ratios, invest more heavily in unprofitable services like emergency departments and mental health programs, and demonstrate greater resilience during economic downturns [17]. These findings suggest that organizational motivation-profit versus mission-fundamentally shapes healthcare delivery quality.

Economic modeling by Himmelstein and Wool handler indicates that transitioning to a single-payer system in the United States could generate hundreds of billions in annual savings through

administrative efficiency alone [18-19]. These savings could fund universal coverage while improving quality-a remarkable demonstration that moral imperatives and economic efficiency align when profit extraction is eliminated.

Cultural and Theological Implications

International healthcare models reveal cultural values embedded in system design. Countries treating healthcare as a human right rather than market commodity demonstrate different understandings of community obligation, individual vulnerability, and social solidarity. These values align closely with theological concepts of covenant, justice, and mutual responsibility.

Scandinavian systems particularly embody "Sacred Economy"-economic arrangements that serve human flourishing rather than capital accumulation [20]. These societies have created what might be understood as secularized versions of religious community, where care for the vulnerable represents collective spiritual practice.

Embodied Theology and Healing

Jewish mystical tradition offers profound resources for reimagining healthcare through the concept of tzimtzum-divine contraction or withdrawal that creates space for finite existence [21-22]. Tzimtzum provides a framework for understanding therapeutic encounters as spaces where divine presence and absence intersect.

In therapeutic contexts, tzimtzum suggests that healing occurs not through divine intervention but through divine withdrawal that creates space for human agency and encounter. The physician's role becomes facilitating this sacred space rather than imposing technical solutions. This theological perspective reframes medical practice from mechanical intervention to spiritual accompaniment.

The tzimtzum model offers direct relevance to healthcare economics: just as divine contraction creates space for finite existence, profit withdrawal creates space for authentic healing relationships. When economic imperatives no longer dominate therapeutic encounters, clinicians can attend to patients' full humanity rather than their billing codes.

Divine Presence in Suffering

The kabbalistic concept of Shekhinah in exile-divine presence dwelling within human suffering-provides theological grounding for understanding illness and healing [23-25]. Rather than viewing disease as divine punishment or random misfortune, this tradition recognizes suffering as a location of divine encounter requiring presence rather than explanation.

Shekhinah consciousness transforms therapeutic relationships from technical transactions to encounters with divine presence manifest in human vulnerability [26]. This understanding demands what he terms "Sacred Listening"-attention to the holy within mundane clinical presentations [27-28].

The Shekhinah theology directly challenges profit-driven healthcare by asserting that divine presence cannot be commodified. When healing encounters become financial transactions, the sacred dimension becomes invisible, and both patient and provider lose access to healing's deeper sources.

Ethics of Infinite Responsibility

Emmanuel Levinas's philosophical ethics provides crucial bridges between Jewish theology and medical practice through his concept of infinite responsibility to the Other [29]. Levinas argues that encountering another person's face creates unlimited ethical obligation that cannot be reduced to contractual arrangements or calculated exchange.

In healthcare contexts, Levinas's ethics demands that therapeutic relationships operate outside market logic. The physician's responsibility to patients is infinite and cannot be mediated by insurance formularies, billing requirements, or productivity targets. This infinite responsibility aligns with covenantal rather than contractual understanding of medical practice.

The integration of Levinasian ethics with clinical practice reveals how profit motives systematically violate the face-to-face encounter that constitutes ethical relationship [29]. When economic calculations intercede between practitioner and patient, the ethical foundation of medicine collapses.

Embodied theology emphasizes that healing involves the whole person-body, mind, spirit, and community-rather than isolated organ systems [30-31]. This holistic understanding challenges biomedical reductionism while providing theological rationale for comprehensive healthcare approaches.

Embodied theology supports integrative medical practices that address patients' physical, psychological, social, and spiritual needs [32-33]. Such comprehensive care becomes economically impossible under profit-driven systems that reimburse procedures rather than relationships, acute interventions rather than preventive care.

The embodied approach also recognizes healing as communal rather than individual process. Health emerges from relationships, community connections, and social conditions rather than primarily from technical interventions. This understanding supports healthcare models that address social determinants rather than merely treating disease symptoms.

From Contract to Covenant

Removing profit motivation fundamentally transforms healthcare relationships from contractual arrangements to sacred covenants. Contractual relationships operate through mutual obligation-services exchanged for payment under legal enforcement. Covenantal relationships transcend calculation through unlimited commitment to mutual flourishing.

The covenantal model recognizes patients not as consumers purchasing healthcare services but as partners in sacred relationships characterized by vulnerability, trust, and mutual responsibility. This shift profoundly impacts how healing encounters unfold: from efficient service delivery to patient accompaniment through suffering and recovery.

Narrative medicine scholarship demonstrates how illness stories reveal deeper truths about human condition, meaning-making, and healing processes [34-35]. Profit-driven systems lack time and space for these narratives, reducing patients to diagnostic codes and billable units. Covenantal medicine creates space for story, meaning, and encounter with mystery.

Sacred Listening

Fishbane describes theology as fundamentally about attunement-practice of listening for sacred resonance within human experience [31]. Clinical theology demonstrates how this attunement becomes central to healing relationships when profit pressures are removed

[27-28].

Sacred listening requires time, presence, and attention that profit-driven systems cannot economically justify. A fifteen-minute appointment slot cannot accommodate the patient's story, the physician's discernment, or the sacred encounter that constitutes healing. Covenantal medicine prioritizes presence over productivity, depth over efficiency.

This attunement extends beyond individual encounters to systemic transformation. Healthcare systems organized around covenant rather than profit create space for "Sacred Architecture"-institutional arrangements that support rather than compromise healing relationships [36].

Justice and Healing

Biblical and rabbinic traditions consistently link healing with justice, understanding both as expressions of divine concern for human flourishing [37-38]. Prophetic literature condemns systems that advantage the wealthy while neglecting the poor's health needs. This theological tradition provides moral foundation for universal healthcare access.

Healthcare justice demonstrates how profit-driven systems systematically violate biblical justice principles by creating healthcare apartheid based on economic status [39-40]. Such systems represent what liberation theologians recognize as structural sin-institutional arrangements that perpetuate oppression while obscuring moral responsibility.

Covenantal healthcare embodies justice through universal access, comprehensive care, and attention to social determinants of health. This approach recognizes health as divine gift requiring collective stewardship rather than individual commodity subject to market distribution.

Pandemic Revelations

The COVID-19 pandemic starkly illuminated profit-driven healthcare's structural vulnerabilities while providing glimpses of covenantal alternatives. Market-based supply chains collapsed under stress, creating critical shortages of personal protective equipment, ventilators, and essential medications that compromised both patient care and provider safety [41].

For-profit hospitals reduced services, laid off staff, and curtailed charity care precisely when communities most needed healthcare capacity [42]. This behavior revealed how profit imperatives systematically undermine healthcare systems' public health functions during crises.

Conversely, nonprofit hospitals demonstrated greater resilience, maintaining charity care programs and community services despite financial stress [42]. These institutions' mission-driven orientation enabled responses guided by health needs rather than profit calculations.

Nursing Home Performance and Ownership Models

Gandhi et al.'s comprehensive study of nursing home performance during COVID-19 revealed striking differences based on ownership structure [43]. For-profit facilities experienced significantly higher mortality rates, staff turnover, and infection rates compared to nonprofit institutions.

These performance differences reflected deeper organizational priorities: profit-maximizing facilities had systematically understaffed, reduced quality measures, and delayed safety investments to enhance returns. When pandemic stress tested these systems, their vulnerabilities became fatal.

The nursing home study provides microcosm of broader healthcare dynamics: organizations prioritizing profit over mission compromise care quality even during normal operations, with devastating consequences during crises.

Community Solidarity and Alternative Models

The pandemic also revealed remarkable examples of healthcare guided by covenant rather than profit. Healthcare workers' extraordinary solidarity, community-based mutual aid networks, and volunteer distribution of protective equipment demonstrated healing relationships motivated by care rather than compensation [44-45].

These grassroots responses embodied "Sacred Economy"-economic arrangements serving human flourishing rather than capital accumulation [46]. Communities created healthcare resources through solidarity, sharing, and mutual commitment to collective wellbeing.

Religious communities particularly demonstrated covenantal healthcare through food distribution, elder care, mental health support, and community organizing. These responses revealed alternative economic logics based on abundance, sharing, and divine grace rather than scarcity, competition, and profit maximization.

Transforming Medical Pedagogy

Transitioning to covenantal, profit-free healthcare requires fundamental transformation of medical education and professional formation. Current medical training primarily emphasizes technical competence while neglecting the spiritual, ethical, and communal dimensions of healing [34-35].

Narrative medicine must become central rather than peripheral to medical education, teaching practitioners to recognize illness stories as sacred texts requiring interpretation rather than mere data requiring analysis [47]. This hermeneutical approach to medical practice aligns with theological traditions of textual interpretation while honoring patients' full humanity.

Our educational philosophy emphasizes integrating theological literacy with clinical competence, developing practitioners who can recognize divine presence within human vulnerability while maintaining scientific rigor [48-49]. Such formation requires educational environments that model covenantal relationships rather than merely teaching about them.

Liberation Theology and Medical Practice

Liberation theology's emphasis on solidarity with marginalized populations provides crucial resources for medical education reform [37]. Farmer's analysis of "Pathologies of Power" demonstrates how health inequities reflect systemic injustice requiring structural rather than merely individual interventions [38].

Medical education must prepare practitioners to address health's social determinants rather than merely treating disease symptoms. This preparation requires understanding how economic systems, political arrangements, and cultural patterns shape health outcomes. Students need formation in social analysis alongside anatomical dissection.

The integration of liberation theology with clinical practice reveals how healthcare providers can function as agents of social

transformation rather than mere service providers [49]. This prophetic understanding of medical vocation aligns with biblical traditions while addressing contemporary health challenges.

Medical Training

Medical education must prepare students to recognize and resist the moral injury that profit-driven systems inflict on healthcare providers [6-11]. Students need frameworks for understanding how economic pressures compromise ethical practice and strategies for maintaining moral integrity within problematic systems.

This preparation involves developing "Theological Immunity"-spiritual resources that enable practitioners to resist systemic corruption while continuing to provide compassionate care [50]. Such formation requires integration of contemplative practices, ethical reflection, and community support.

Medical schools must also model alternatives to profit-driven healthcare through their own institutional arrangements. Educational environments that prioritize learning over productivity, depth over efficiency, and formation over information provide lived examples of covenantal alternatives to market logic.

Financial Modeling and Resource Allocation

Contrary to conventional assumptions, covenantal healthcare models demonstrate superior economic efficiency compared to profit-driven systems. Single-payer systems consistently achieve better outcomes at lower per-capita costs through reduced administrative overhead, rational resource allocation, and preventive care emphasis [14-16].

Himmelstein and Wool handler's economic analysis indicates that eliminating profit extraction from American healthcare could save over $500 billion annually while expanding coverage and improving quality [17-18]. These savings emerge from reduced administrative costs, rational pharmaceutical pricing, and elimination of duplicate services.

More profoundly, covenantal systems generate what economists' term "Positive Externalities"-benefits extending beyond immediate healthcare delivery. Universal healthcare systems support economic productivity, entrepreneurship, and social cohesion by removing health insecurity that constrains human potential.

The notion of "Sacred Economy" reveals how covenantal relationships generate abundance rather than scarcity [20]. When healthcare operates through gift exchange rather than market transaction, resources multiply through reciprocity, gratitude, and community investment.

Sacred economy recognizes that healing cannot be commodified because it emerges from relationship, presence, and mystery rather than technical intervention alone. Communities investing in healing relationships discover enhanced resilience, reduced disease burden, and improved quality of life extending far beyond medical metrics.

This abundance model challenges scarcity assumptions underlying profit-driven healthcare. Rather than rationing care based on ability to pay, sacred economy creates care through community commitment to collective flourishing.

Sustainability and Stewardship

Covenantal healthcare embodies stewardship rather than extraction, creating sustainable systems that serve future generations rather than maximizing current profits. Profit-driven systems systematically underinvest in prevention, public health infrastructure, and practitioner wellbeing to enhance short-term returns.

Stewardship models prioritize long-term community health through environmental protection, social determinant improvement, and healthcare workforce development. These investments require patient capital unavailable to profit-maximizing entities but accessible to mission-driven organizations.

Theological traditions of stewardship provide frameworks for sustainable healthcare that serves creation rather than exploiting it. These traditions recognize human health as interconnected with environmental health, community wellbeing, and intergenerational justice.

Divine Concealment and Therapeutic Presence

Theological scholarship reveals how divine concealment rather than divine absence characterizes therapeutic encounters [51]. Drawing from kabbalistic traditions, he argues that God's hiddenness creates space for human agency while remaining present through suffering and healing.

This concealment theology transforms how practitioners understand their role: rather than divine agents imposing healing, they become facilitators of encounters with hidden divine presence manifest in vulnerability, suffering, and recovery. Such understanding requires contemplative rather than merely technical training.

The concealment framework also addresses theological questions raised by medical practice: why do good people suffer? Why do healing efforts sometimes fail? Rather than providing answers, concealment theology creates space for mystery, presence, and accompaniment through uncertainty.

Our hermeneutical approach to medicine demonstrates how patient histories can be read as sacred texts requiring interpretation rather than mere data requiring analysis [52-53]. This approach honors the sacred within mundane clinical presentations while maintaining diagnostic rigor.

Reading patients as texts requires what rabbinic tradition terms peshat, remez, drash, and sod-literal, allusive, interpretive, and mystical levels of meaning. Clinical encounters become opportunities for encountering divine presence through human vulnerability rather than merely solving medical problems.

This textual approach also transforms how practitioners understand disease: rather than mechanical breakdown requiring repair, illness becomes meaningful disruption requiring interpretation, accompaniment, and integration within life's larger narrative.

Contemplative Practice and Clinical Competence

Mystical traditions recognize contemplative practice as essential preparation for encountering divine presence within ordinary experience. Our integration of contemplative practice with clinical medicine demonstrates how spiritual disciplines enhance rather than compromise medical competence [54-55].

Contemplative practitioners develop attention, presence, and discernment that enables deeper clinical observation, more accurate diagnosis, and more effective therapeutic relationships. Meditation, prayer, and reflection create space for medical intuition that complements but transcends technical analysis.

Healthcare systems supporting contemplative practice report improved practitioner satisfaction, reduced burnout, and enhanced patient outcomes. These benefits emerge from practitioners' increased capacity for presence, reduced reactivity, and enhanced empathy developed through spiritual practice.

Technology and Sacred Encounter

Contemporary healthcare faces unprecedented challenges from artificial intelligence, technological automation, and digital transformation. The analysis of AI in medical practice reveals both opportunities and threats to covenantal healthcare [56-57].

Technology becomes problematic when it displaces rather than supports human encounter. Electronic health records that reduce patients to data points, algorithms that replace clinical judgment, and telemedicine that eliminates physical presence threaten the sacred dimensions of healing.

However, technology can also enhance covenantal relationships when designed to support rather than replace human connection. AI tools that provide decision support while preserving practitioner autonomy, digital platforms that improve access while maintaining relationship quality, and diagnostic technologies that reveal rather than obscure human mystery serve healing rather than dominating it.

Institutional Change

Transforming healthcare from profit to covenant requires comprehensive structural reform extending beyond individual practitioner behavior. Our analysis of institutional coercion reveals how current systems constrain even well-intentioned providers through economic pressure, regulatory requirements, and organizational culture [58-65].

Reform must address financing mechanisms, regulatory frameworks, educational institutions, and cultural values that currently prioritize profit over healing. This transformation requires political mobilization, economic analysis, and spiritual renewal working in coordination.

Successful reform also requires alternative institutions that demonstrate covenantal healthcare's viability. Community health centers, faith-based hospitals operating according to mission rather than margin, and cooperative medical practices provide models for scaling covenantal alternatives to profit-driven systems.

Covenantal healthcare extends beyond national boundaries to encompass global health solidarity. Profit-driven pharmaceutical companies that charge differential prices based on national wealth, medical tourism that exploits international inequities, and patent systems that prevent essential medication access violate covenantal principles.

Global covenantal healthcare would ensure essential medications' universal availability, share medical knowledge across national boundaries, and support health system development in resource-limited settings. Such solidarity requires transformed understanding of national interest that includes global flourishing.

International examples of covenantal healthcare include Cuba's medical internationalism, Médecins Sans Frontières' humanitarian medicine, and global vaccination campaigns that prioritize need over profit. These examples demonstrate covenantal principles' viability at global scale.

Conclusion

Healthcare without profit represents both economically viable policy direction and theologically compelling vision of human flourishing. By removing profit as healthcare's organizing principle, medical practice can recover its deepest vocation: honoring human vulnerability, enacting justice, and witnessing divine presence through compassionate care.

Global healthcare models, theological traditions, and lived experiences during contemporary crises converge to demonstrate this alternative vision's viability. Embodied theology provides robust framework for healthcare transformation, revealing that healing without profit constitutes not merely policy preference but sacred calling honoring both human dignity and divine presence.

The profit motives and physician moral injury demonstrates the urgent need for this transformation [6-11]. Current systems systematically compromise healing relationships through economic coercion, creating moral distress that serves neither patients nor providers. Covenantal alternatives offer pathways toward healing that serves human flourishing rather than capital accumulation.

The path toward covenantal healthcare requires sustained commitment to justice, careful attention to implementation challenges, and ongoing theological reflection on healing's meaning within human community. Yet accumulating evidence suggests this vision represents realistic alternative rather than utopian dream-practical possibility that could serve both human flourishing and fiscal responsibility more effectively than current market-based approaches.

Ultimately, healthcare without profit embodies ancient wisdom that healing cannot be bought or sold because it emerges from relationship, presence, and encounter with mystery transcending economic calculation. Recovering this wisdom requires not merely policy reform but spiritual renewal that recognizes healthcare as sacred calling rather than market opportunity. Such renewal becomes both individual and collective work: personal transformation of practitioners who recover their vocation's sacred dimensions and systemic transformation of institutions that support rather than compromise healing relationships.

The future of healthcare depends not on technological advancement alone but on remembering healing's sacred foundations while creating economic and political arrangements that honor these foundations. This remembering and creating constitute theological as much as political work-recovery of divine presence within human vulnerability and construction of earthly institutions that reflect heavenly values. In this convergence of ancient wisdom and contemporary reform lies hope for healthcare that truly heals [66-69].

References

1. OECD 2023 Health at a Glance 2023. Paris: OECD Publishing https://librarysearch.colby.edu/discovery/fulldisplay?docid=alma991032005399408041&context=L&vid=01CBB_CCLIBRAR:COLBY&lang=en&adaptor=Local%20Search%20Engine&tab=Everything&query=sub,exact,Public%20health,AND&mode=advanced&offset=0.
2. Relman A (1980) The New Medical-Industrial Complex. N Engl J Med 303: 963-970.
3. Arrow KJ (1963) Uncertainty and the Welfare Economics of Medical Care. Am Econ Rev 53: 941-973.
4. Centers for Medicare & Medicaid Services (2024) National Health Expenditure Data. Baltimore: CMS
5. Marchildon GP (2013) Canada: Health system review. Health Syst Transit 15: 1-179.
6. Klein R (2019) The New Politics of the NHS. Oxford: Radcliffe https://www.taylorfrancis.com/books/mono/10.1201/9780429088964/new-politics-nhs-seventh-edition-rudolf-klein.
7. Johan Fritzell, Bjorn Hvinden, Mikko Kautto, Jon Kvist, Hannu Uusitalo, et al. (2001) Nordic Welfare States in the European Context. London: Routledge https://www.routledge.com/Nordic-Welfare-States-in-the-European-Context/Fritzell-Hvinden-Kautto-Kvist-Uusitalo/p/book/9780415241618?srsltid=AfmBOoql_CFXqrC8IOTrhmA3-j-0AwN2fkmzuR_sznF8wUktH9_qgQ5X.
8. Horwitz JR (2005) Making profits and providing care: comparing nonprofit, for-profit, and government hospitals. Health Aff 24: 790-801.
9. Himmelstein DU, Woolhandler S (2016) The Current and Projected Taxpayer Shares of US Health Costs. Am J Public Health 106: 449-452.
10. Woolhandler S, Himmelstein DU (2017) Single-payer reform: the only way to fulfill the President's pledge of more coverage, better benefits, and lower costs. Ann Intern Med 166: 587-588.
11. Starr P (1982) The Social Transformation of American Medicine. New York: Basic Books.
12. Reinhardt UE. Divide et impera: Protecting the growth of health care incomes (costs). Health Econ 12: 625-629.
13. Berwick DM, Nolan TW, Whittington J (2008) The triple aim: care, health, and cost. Health Aff 27: 75969.
14. Porter ME, Teisberg EO (2006) Redefining Health Care: Creating Value-Based Competition on Results. Boston: Harvard Business School Press https://www.hbs.edu/faculty/Pages/item.aspx?num=21319.
15. Wolfson E (1994) Through a Speculum That Shines: Vision and Imagination in Medieval Jewish Mysticism. Princeton: Princeton University Press; 1994 https://archive.org/details/throughspeculumt0000wolf.
16. Idel M (1988) Kabbalah: New Perspectives. New Haven: Yale University Press https://archive.org/details/kabbalahnewpersp0000idel_w3g0/page/n5/mode/2up.
17. Ungar-Sargon J (2025) Divine Presence and Concealment in the Therapeutic Space. jyungar.com 4: 01-10.
18. Levinas E (1969) Totality and Infinity: An Essay on Exteriority. Pittsburgh: Duquesne University Press 49: 445-468.
19. Brill A (2015) Judaism and Healthcare: Healing and Holiness. New York: SUNY Press.
20. Fishbane M (2008) Sacred Attunement: A Jewish Theology. Chicago: University of Chicago Press https://press.uchicago.edu/ucp/books/book/chicago/S/bo5884921.html.
21. Wiesel E (1995) The Trial of God. New York: Schocken Books https://honeyburnbooks.com/products/1995-the-trial-of-god-elie-wiesel-schocken-books-new-york?srsltid=AfmBOop11YXm3_R91EtJOEgHCgQYWmSElkuhFiEe8ZnHi1SFqCcV8GJ4.
22. Rubenstein RJ (1992) After Auschwitz: Radical Theology and Contemporary Judaism. Baltimore: Johns Hopkins University Press https://www.press.jhu.edu/books/title/1072/after-auschwitz?srsltid=AfmBOopfBkXy7HzU3FTAVYvYuT9UaKa1QHxmq7p-qelwUMtXbtN0Z7Dn.
23. Koenig HG (2012) Religion, spirituality, and health: The research and clinical implications. ISRN Psychiatry 278730.
24. Puchalski CM, Ferrell B, Virani R, Otis-Green S, Baird P, et al. (2009) Improving the quality of spiritual care as a dimension of palliative care. J Palliat Med 12: 885-904.
25. Sulmasy DP (2002) A biopsychosocial-spiritual model for the care of patients at the end of life. Gerontologist 42: 24-33.
26. Pellegrino ED (1979) Toward a reconstruction of medical morality: The primacy of the act of profession and the fact of illness. J Med Philos 4: 32-56.
27. Beauchamp TL, James Childress (2019) Childress JF. Principles of Biomedical Ethics. 8th ed. New York: Oxford University Press 19: 9-12.
28. Kass LR (1975) Regarding the end of medicine and the pursuit of health. Public Interest 40: 11-42.
29. Ungar-Sargon J (2024) Capitalism and Health Care: A Critique. Japan Journal of Medical Science 5: 174-184.
30. Charon R (2006) Narrative Medicine: Honoring the Stories of Illness. Oxford: Oxford University Press https://psycnet.apa.org/record/2006-05640-000.
31. Frank AW (2013) The Wounded Storyteller: Body, Illness, and Ethics. 2nd ed. Chicago: University of Chicago Press https://press.uchicago.edu/ucp/books/book/chicago/W/bo14674212.html.
32. Gutiérrez G (1973) A Theology of Liberation. Maryknoll: Orbis Books chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://s3.amazonaws.com/arena-attachments/1648419/893d957d3d4a0d4e94c6a66f3cf1da98.pdf?1516898451.
33. Farmer P (2003) Pathologies of Power: Health, Human Rights, and the New War on the Poor. Berkeley: University of California Press https://www.ucpress.edu/books/pathologies-of-power-2/paper.
34. Marmot M (2005) Social determinants of health inequalities. Lancet 365: 1099-104.
35. Wilkinson RG (2006) Pickett KE. Income inequality and population health: a review and explanation of the evidence. Soc Sci Med 62: 1768-1784.
36. Gandhi A, Song Y, Upadrashta P (2022) Does ownership matter? Nursing home quality during the COVID-19 pandemic. J Health Econ 82: 102591.
37. Bai G, Anderson GF (2016) A more detailed understanding of nonprofit hospitals' community benefit expenditures. Health Aff 35: 1225-1233.
38. Ranney ML, Griffeth V, Jha AK (2020) Critical supply shortages - ventilators and personal protective equipment during the Covid-19 pandemic. N Engl J Med 382: 41.
39. Horton R (2020) Offline: COVID-19 is not a pandemic. Lancet 396: 874.
40. Ungar-Sargon J (2025) The Influence of AI in Medical Ethics and Warfare. American J Neurol Res 4: 1-4.
41. Ungar-Sargon J (2025) AI and Spirituality: The Disturbing Implications. J Med - Clin Res & Rev 9: 1-7.
42. (2021) World Health Organization. Building health systems resilience for universal health coverage and health security during the COVID-19 pandemic and beyond. Geneva: WHO chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://iris.who.int/server/api/core/bitstreams/c67e7a15-e6e6-487a-8292-8af49d3bd790/content.
43. Ungar-Sargon J (2025) The Compromised Healer: Moral

Ambiguity in the Physician's Role Through Literary and Historical Lenses. The Journal of Clinical Review and Case Reports chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://ecronicon.net/assets/ecne/pdf/ECNE-17-01225.pdf.

44. Ungar-Sargon J (2025) Navigating the Depths: A Framework for Caregiver's Grief Work. Journal of Behavioral Health 14: 1-9.
45. Ungar-Sargon J (2025) A New Vision for the Physician-Patient Relationship: Integrating Spiritual, Intuitive, and Holistic Dimensions. Advance Medical & Clinical Research 6: 75-82.
46. Ungar-Sargon J (2025) Divine Presence and Concealment in the Therapeutic Space. EC Neurology 17: 1-13.
47. Ungar-Sargon J (2025) Hermeneutic Approaches to Medicine: From Objective Evidence to Patient as Sacred Text. Advanced Educational Research & Reviews 2: 40-45.
48. Ungar-Sargon J (2025) Shekhinah Consciousness: Divine Feminine as Theological and Political Paradigm for Human Suffering. EC Neurology 17: 1-15.
49. Ungar-Sargon J (2025) A Critical Review of Pharmaceutical Industry Fraudulent Practices. Chemical & Pharmaceutical Research 7: 1-12.
50. Ungar-Sargon J (2025) The Profit Paradox: A Critical Review of Pharmaceutical Industry Practices in Modern Medicine. International Journal of Nursing & Healthcare 1: 1-13.
51. Ungar-Sargon J (2025) Beyond Theodicy: The Physician's Existential Crisis. Advance Medical & Clinical Research 6: 102-105.
52. Ungar-Sargon J (2025) Mysticism in Practice: Integrating Jewish Spirituality and 12-Step Wisdom into Therapeutic Care for Healthcare Professionals. Advanced Educational Research & Reviews 2: 56-59.
53. Ungar-Sargon J (2025) Sacred Spaces, Clinical Encounters: Integrating Theological and Medical Perspectives. Journal of Behavioral Health 14: 1-7.
54. Ungar-Sargon J (2025) Bridging Neural Circuits and Sacred Spaces: Integrating Neurobiological Mechanisms with Intangible Experience. Medical and Clinical Research: Open Access 6: 1-11.
55. Ungar-Sargon J (2025) Beyond Reductionism or Wishful Thinking? Tensions between Evidence-Based Practice and Spiritual Frameworks in Contemporary Healthcare. Trends in Internal Medicine 5: 1-10.
56. Ungar-Sargon J (2025) Motivating Healthcare Workers in Non-Hierarchical Spaces: A Sacred Architectural Framework for Sustainable Engagement. Japanese Journal of Medical Research 3: 1-12.
57. Ungar-Sargon J (2025) The Patient as Parable: Highlighting the Interpretive Framework: Applying Mystic Hermeneutics to Patient Narratives. The International Medical Journal 25: 41-50.
58. Ungar-Sargon J (2025) Beyond the Iron Cage: Institutional Coercion and the Imperative for Transformative Healing Spaces. American Journal of Medical and Clinical Research & Reviews 4: 12-21.
59. Ungar-Sargon J (2025) Beyond Race: Toward an Ethically Integrated Model of Healthcare Justice. Journal of Behavioral Health 14: 1-6.
60. Ungar-Sargon J (2025) Against the Current: Reclaiming Medical Ethics in a System of Greed. Advanced Educational Research & Reviews 2: 65-75.
61. Ungar-Sargon J (2025) Spiritual Crisis and the Crisis of Psychiatry: Rethinking Diagnosis at the Intersection of Madness and Meaning. British Society for the Contemplation of Religion 7: 27-42.
62. Ungar-Sargon J (2025) The Art of Sacred Listening: Divine Presence and Clinical Empathy in Contemporary Medical History Taking. Review of Theology 25: 85-97.
63. Ungar-Sargon J (2025) Insubstantial Language and the Space Between Healer and Patient. Int J Psychiatr Res 8: 1-13.
64. Ungar-Sargon J (2025) Primordial Silence and Therapeutic Presence: Theodicy and the Paradox of Divine Concealment in Clinical Practice. Biomed Sci Clin Res 4: 1-10.
65. Ungar-Sargon J (2025) Beyond the Iron Cage: Institutional Coercion and the Imperative for Transformative Healing Spaces. Journal of Behavioral Health 14: 1-9.
66. Ungar-Sargon J (2025) Shekhinah Consciousness in the Therapeutic Space: From Incarnation to Redemption in the Sacred Space of Healing. HSOA Journal of Psychiatry, Depression & Anxiety 11: 059.
67. Ungar-Sargon J (2025) Toward a Sacred Economy of Care: Reimagining Healthcare through an Integrative Moral Lens. Global Journal of Critical Care and Emergency Medicine 2: 1-13.
68. Kleinman A (1998) The Illness Narratives: Suffering, Healing, and the Human Condition. New York: Basic Books https://www.scribd.com/doc/288329496/Arthur-Kleinman-the-Illness-Narratives-Suffering-Healing-and-the-Human-Condition.
69. McGilchrist I (2009) The Master and His Emissary: The Divided Brain and the Making of the Western World. New Haven: Yale University Press https://www.researchgate.net/publication/257636891_Iain_McGilchrist_The_master_and_his_emissary_the_divided_brain_and_the_making_of_the_Western_world_New_Haven_and_London_Yale_University_Press_2010.