

Shaping Both the Big Debates and the Many Sub-Debates in Health Policy

Jared Rhoads

Most health policy debates skip past the question of goals entirely and dive straight into mechanisms: How do we expand coverage? How do we control costs? How do we regulate insurers? How do we fund entitlements? These are important questions, but they are downstream of a more fundamental one, which is: What is the overall goal of health policy?

For a free society, the proper goal of health policy is to achieve a set of conditions in which individuals are able to pursue health as an important value in their lives (if they so choose). On this view, health is not primarily something that happens to you. It is something you do. It is an ongoing effort to understand your body, make informed decisions, manage tradeoffs, and live in a way that supports your ability to act, produce, and enjoy life. A good health system is one that empowers individuals to pursue this project effectively, in accordance with their own values, priorities, ambitions, and constraints. (And of course it is one that enables other people to freely produce and sell you the health-related goods, services, procedures, and care that you seek.)

American health policy has not moved toward this goal because political figures, scholars, advocates, and others participating in these debates have firmly affixed healthcare upon a different foundation, using premises that are almost uniformly favorable to government control. Until these premises are pulled into the light and challenged directly, advocates of freedom will continue to fight on terrain that has been shaped to favor the other side.

Checking Premises

There are many premises worth examining, but let's pick three that deserve particular scrutiny.

One premise is that healthcare is fundamentally different from other goods and services. As the conventional thinking goes, markets might work for cars or smartphones, but healthcare is special. The stakes are too high, the information asymmetries too great, the complexities around professional trust too problematic. Normal economic incentives don't apply, it is said. These ideas are frequently traced back to Kenneth Arrow's seminal 1963 paper on medical uncertainty, which examined information asymmetries, uncertainty, and externalities in medical markets.¹ In many ways, Arrow was just raising important questions, and it was later commentators who hardened his analysis into a case for government intervention that goes beyond what Arrow would have argued. Economist John Cochrane and others have pointed out that many of Arrow's

concerns, such as information asymmetries, exist in other markets as well, and that market institutions have developed effective ways of addressing them.² But the idea that markets are supposedly different nevertheless persists, unhelpfully.

Another unhelpful premise is that insurance coverage is synonymous with care and security, and that the proper goal of health policy is universal coverage. If everyone has an insurance card, the thinking goes, then everyone has access to healthcare. But empirical research has repeatedly challenged this assumption. For instance, even the famous Oregon Health Insurance Experiment, which randomly assigned Medicaid coverage to low-income adults, found that while coverage increased healthcare utilization and reduced financial strain, it produced no statistically significant improvements in measured physical health outcomes over the first two years.³ Having an insurance card is not the same as having access to quality care, and having access to care is not the same as being healthy.

Yet another premise that steers people to look to the government to steer healthcare is that individuals cannot be trusted to make good decisions about their own health. Healthcare is too complex and the power imbalance between patients and providers too great, according to this view. People need experts and institutions to guide them, protect them, and sometimes override their choices for their own good. Left to their own devices, for example, people might not save enough. After all, behavioral economics researchers have found that cognitive biases distort individual decision-making.⁴ But instead of concluding that experts should therefore make decisions for individuals, we need to remember that regulators and policymakers are subject to their own biases, and even more importantly, they lack the distributed, personal knowledge that individuals possess about their own bodies, circumstances, and priorities.

The sneaky thing about these and other premises is that most of the time, they aren't argued for explicitly. They function as the background assumptions of the debate—the water in which policy discussions swim, to invoke the metaphor of writer David Foster Wallace.⁵ When you argue for market-based reform, you are implicitly arguing against these premises. But if you don't pull them into the light and examine them directly, you enter a debate in which the ground has been shaped to favor the status quo.

An Alternative Framework

What would it look like to replace these premises with different ideas?

One way to do it is to think about what kind of goal we want in modern health. Holding the goal of policy as maximizing coverage, or protecting people from their own choices, or providing "security against the hazards and vicissitudes of life"⁶ is not very forward-thinking. It is actually reminiscent of stale 19th- and 20th-century thinking. A proper goal for modern health is to make the pursuit of health and well-being a positive project that anyone can engage in, just as practically everyone in America today can engage in markets for cars, cell phones, electronics,

and other modern goods. Policy changes are needed to transition from the status quo to a new vision where individuals can pursue and produce health as part of a life well-lived. That means a pursuit that is followed actively, rationally, and in accordance with their own values and priorities.

Research supports the value of this approach. Studies on "patient activation"—the knowledge, skills, and confidence to manage one's own health—have consistently found that patients with higher activation levels have better health outcomes, better care experiences, and lower costs.⁷ When patients are given information and involved in treatment choices through shared decision-making, they often make different decisions than their physicians would have made for them, report higher satisfaction, and show better adherence to treatment plans.⁸ Not that the idea of modern health couldn't have been advocated for prior to such studies, but the case for it is made all the more stronger by having measurable results to point to.

Another important element of an alternative framework is a different view of individuals. Conventional wisdom treats patients as passive recipients of care. They are consumers to be protected, with risks to be managed, and whose costs must be controlled. A modern approach that acknowledges the need for freedom treats individuals as capable, thinking agents who are able to make decisions about their own bodies, their own risks, and their own tradeoffs.

To be sure, people make mistakes. They sometimes have poor information or bad judgment. But the question is not whether individuals are perfect. The question is whether anyone else, *in government*, has the knowledge, the incentive, and the right to make those decisions on their behalf. The answer for the vast majority of us is no. The information relevant to any individual's health situation is spread across that person's unique circumstances, preferences, symptoms, and life context in ways that no central authority can fully grasp.⁹ The person who knows the most about your values, your priorities, your constraints, and your life is you.

A final element is a clear-eyed view of freedom and free markets. Freedom is the arrangement that treats individuals as ends in themselves rather than as instruments to the ends of others. A health system built on compulsion, with government telling people what coverage they must buy, who they may see for care, which treatments they may access, which innovations may come to market, is not simply inefficient. It is a statement that the individual cannot be trusted with his or her own life.

Consider what free markets have delivered in every sector where they have been allowed to operate: rapid innovation, falling costs, and better availability of goods and services. Where there are markets, there is a diversity of options that matches the diversity of human needs and preferences. The sectors of healthcare that most closely resemble normal markets—such as cosmetic surgery, LASIK eye surgery, and to some extent even orthodontia—have seen consistent quality improvements and price reductions over time, even as the rest of healthcare

has experienced relentless cost increases.¹⁰ That is what markets do when they are allowed to function.

Reversing the Burden of Proof

Sure, healthcare has some differences in degree from other markets, but it is not different in kind. The stagnation, cost explosion, and the one-size-fits-all rigidity we see today are not evidence that markets have failed in healthcare. They are evidence that markets have been systematically suppressed. The American health system is one of the most heavily regulated sectors of the economy, with the Code of Federal Regulations containing thousands of pages of healthcare-related rules.¹¹ If regulation were the solution, we should be doing much better than we are.

Examining these and other ideas, along with how they play out in specific policy issues, helps to change the terms of the debate. Instead of defending every market-oriented proposal against the charge that it will hurt people, the burden of proof can be placed where it belongs: on those who would restrict freedom.

This is not a rhetorical trick. In a free society, if someone wants to restrict what you can buy, who you can see, what treatments you can access, or what risks you can take with your own body, they should need to justify that restriction.

This standard is almost never applied in health policy debates. Proposals for new regulations, new mandates, and new coverage requirements are evaluated on their intentions rather than their effects. If a bill is drafted with the intent to help people, and even more so if it is given a flowery name, then it is presumed to be good. Unintended consequences, second-order effects, and tradeoffs are treated as afterthoughts, if they are considered at all.

To apply the thinking of Frédéric Bastiat, a freedom-oriented approach asks: What are the full costs of this intervention, not just the visible benefits?¹² How many people will be priced out of insurance by this new mandate? How many treatments will never be developed because the regulatory pathway is now too long, too expensive, or too uncertain? How much innovation will be suppressed by rules that freeze current practices in place?

These are the documented effects of decades of regulation. For instance, studies have estimated that FDA drug delays cost thousands of lives annually by keeping effective treatments off the market.¹³ Certificate-of-need laws, which require government approval before healthcare facilities can be built or expanded, have been shown to protect incumbent providers from competition and drive up costs without improving quality.¹⁴ Scope-of-practice regulations prevent qualified nurse practitioners and other professionals from delivering care they are trained to provide, reducing access particularly in underserved areas.¹⁵ Mandated benefits force people to

buy coverage they don't want or need, pricing many out of the market entirely.¹⁶ A full accounting of past policy choices must include these costs.

It is time to look forward. Over the past century and a half, life expectancy has roughly doubled. Diseases that once killed millions are now preventable or curable. Surgeries that once required weeks of hospitalization are now outpatient procedures. Pain that was once unavoidable can now be controlled. Yes, there have been remarkable scientific and technological breakthroughs. But much of our gains have come despite our approach to policy, not because of it.

If we want more progress, more cures, more options, and greater well-being, we need more freedom for innovators, entrepreneurs, providers, and patients. We need a system where new ideas can be tried, where successful models can scale, where failed experiments can be shut down without requiring an act of Congress. We need prices that reflect real costs, so that resources flow to their highest-valued uses, and we need competition that forces providers to earn business by serving patients well.

Summary

The path forward in American healthcare is not just about taking on one issue at a time—insurance mandates, scope-of-practice laws, certificate-of-need requirements, and so on. It also entails articulating a vision of health as something individuals actively pursue rather than passively receive, and by placing the burden of proof where it belongs: on those who would restrict freedom rather than on those who would expand it. A modern vision of health treats each person as a capable agent with the right and the responsibility to make decisions about his or her own body and life. It treats free markets not as a threat to be contained but as the engine that produces the innovation, the choices, and the falling costs that make better health possible for everyone. By continuing to develop, advance, and implement these ideas, advocates of reform can begin to shift both the conversation and the policy landscape in a direction that is genuinely fit for a free society.

About the Author

Jared Rhoads is Director of the Center for Modern Health.

Email address: jared.rhoads@centerformodernhealth.org.

Declaration of Conflicting Interests

The author has declared no potential conflicts of interest with respect to the research, authorship, or publication of this article.

Copyright

©2026 Center for Modern Health. All rights reserved. <https://centerformodernhealth.org/>

References

1. Arrow, Kenneth J. "[Uncertainty and the Welfare Economics of Medical Care](#)" *American Economic Review*. (1963).
2. Cochrane, John H. "[After the ACA: Freeing the Market for Health Care](#)" In *The Future of Healthcare Reform in the United States*, edited by Anup Malani and Michael H. Schill. Chicago: University of Chicago Press, 2015.
3. Baicker, Katherine, et al. "[The Oregon Experiment: Effects of Medicaid on Clinical Outcomes](#)" *New England Journal of Medicine*. 368, no. 18 (2013): 1713–1722.
4. Thaler, Richard H., and Cass R. Sunstein. *Nudge: Improving Decisions About Health, Wealth, and Happiness*. New Haven: Yale University Press, 2008.
5. Wallace, David Foster. "[This Is Water](#)" Commencement Address at Kenyon College. May 21, 2005.
6. Roosevelt, Franklin D. "[Message to Congress on Social Security](#)" January 17, 1935.
7. Hibbard, Judith H., and Jessica Greene. "[What the Evidence Shows About Patient Activation: Better Health Outcomes and Care Experiences: Fewer Data on Costs](#)" *Health Affairs*. (2013): 207–214.
8. Stacey, Dawn, et al. "[Decision Aids for People Facing Health Treatment or Screening Decisions](#)" *Cochrane Database of Systematic Reviews* 4 (2017).
9. Hayek, Friedrich A. "The Use of Knowledge in Society." *American Economic Review* (1945).
10. Herrick, Devon M. "Medical Tourism: Global Competition in Health Care." National Center for Policy Analysis. 2007.
11. McLaughlin, Patrick A., and Oliver Sherouse. "[The McLaughlin-Sherouse List: The 10 Most-Regulated Industries of 2014](#)" Mercatus Center. 2016.
12. Bastiat, Frédéric. "[That Which Is Seen, and That Which Is Not Seen](#)" 1850.
13. Philipson, Tomas J., et al. "[Assessing the Safety and Efficacy of the FDA: The Case of the Prescription Drug User Fee Acts](#)" *EconStor*. Working Paper No. 217. (2007)
14. Stratmann, Thomas, and Jacob W. Russ. "[Do Certificate-of-Need Laws Increase Indigent Care?](#)" Mercatus Center. 2014.
15. Kleiner, Morris M., and Kyoung Won Park. "[Battles Among Licensed Occupations: Analyzing Government Regulations on Labor Market Outcomes for Dentists and Hygienists](#)" NBER Working Paper No. 16560, National Bureau of Economic Research. 2010.
16. Bunce, Victoria Craig, and J.P. Wieske. "Health Insurance Mandates in the States 2010" Council for Affordable Health Insurance. 2010.