# Healthcare as a market-good in America: A critical analysis

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## Introduction

This paper examines the reasons for the failure of embedded liberalism and the adoption of neoliberalism in the American Healthcare Industry. It explores how healthcare evolved into a profit-making commodity over the course of history, and the consequences of this transformation. This is done to consider potential solutions to bring back importance on public welfare, and to 'construct some sort of class compromise between capital and labour in order to ensure domestic peace and tranquillity' (Harvey 2005).

## The Adoption of Neoliberalism

After World War II, countries were eager to avoid a repeat of the economic and social conditions of the 1930s and thus adopted the system of "embedded liberalism". While this ensured high levels of growth during the 1950s and 60s, it did not guarantee long-term economic progress, as unemployment and inflation were both high during the 70s (Harvey 2005). This resulted in 'stagflation,' which challenged the traditional belief on the inversely proportional relationship between inflation and unemployment. Institutional failure to address economic problems through welfare mechanisms created fertile ground for big corporates and businesses to push for a 'rollback of the state' through measures such as curbing state intervention, reducing welfare provision, and promoting privatization. This ideology triumphed, resulting in the adoption of neoliberalism (Hall 1984).

Neoliberal ideas were responsible for the restructuring of the healthcare industry. The idea of universal health coverage (completely government funded healthcare) was popular during the 1930s and 40s. President Roosevelt's dream of a national health insurance program was never realized as the next decade brought World War II (Pentecost 2007). President Truman continued this endeavour. However, while he had popular support from the people, the idea received strong opposition from the American Medical Association (AMA). The AMA and the (albeit young) pharmaceutical industry funded million-dollar campaigns painting the idea that Truman's government had communist sympathies, and naturally the plan was dropped due to the politics of the Cold War era. Had either Truman or Roosevelt succeeded, America would have achieved UHC at the same time as many European countries (like Britain with the NHS in 1945) (Gaffney 2005).

## Consumer-Driven Health Plans (CDHPs)

Friedrich Hayek, one of the first and most influential advocates of neoliberalism, believed that the fundamental flaw in the arguments backing UHC was the idea that people's medical needs could have "an objectively ascertainable character." By this he was not referring to the idea that different people might prefer different courses of care despite potentially having similar

circumstances, but rather that different people were willing and able to trade different degrees of material comforts to be able to afford healthcare. He thus believed that people should be able to choose the kind of healthcare plan best suited to their needs, treating it as a regular commodity in a free market, and viewed any regulatory government involvement as a disruption in the workings of the market by the bureaucracy (Gaffney 2005).

The other line of reasoning, the moral hazard argument, comes from economists like Mark Pauly, who essentially gave an economic reasoning to back Hayek's philosophical argument. He believed in the idea that patients would use health care unnecessarily just because their insurance made it free, and since healthcare would now be valued at 0 instead of its original cost, it was a loss for society as a whole. He meant that people would avail free healthcare services for 'minor' or 'insignificant' reasons that they would otherwise not have considered spending on, and the extra expenditure is thus considered as a loss incurred on a system funded by the government and tax payer money. He thus advocated for a system where insurance was availed only for 'necessary' circumstances while patients paid for healthcare incurred for 'trivial' reasons, which led to the creation of Consumer Driven Healthcare Plans (CDHPs). This meant the rise in deductibles and the decrease in the amount availed for insurance (Gaffney 2005).

The practical applicability of the theory was confirmed, supposedly, by the Rand health insurance experiment (HIE) that the government helped fund in the 1970s. This involved some 2,750 families (consisting of 7,700 individuals) that were randomly assigned to one of five different health insurance plans- one "free plan" and four others with varying levels of cost sharing, and their healthcare decisions and expenditures were tracked for years. The actual results were oversimplified, and popular discourse portrayed that people in the higher cost-sharing plans go to the doctor less and are hospitalized less, but nonetheless have the same health overall. However, the study's actual findings were rather troubling; it revealed that some people (like the poor) were in fact adversely affected by the cost-sharing plans as it also reduced the overall use of healthcare with its categorization of 'appropriate' and 'inappropriate' care as they were avoiding necessary healthcare as well. Nonetheless, this was ignored and the HIE was often cited as the proof for the implementation of cost-sharing systems (Gaffney 2005).

## Legislative Measures

The implementation of programs like Medicare (universal healthcare for those over 65 years) and Medicaid (coverage for the poorest) by President Lyndon B. Johnson in 1965 saw the expansion of the welfare state. However, the Reagan administration pivoted to neoliberal principles. Deregulation by giving more freedoms to state and local governments was expected to increase competition and decrease prices. Cuts to Medicare and Medicaid funds were also implemented (Orme and Guyer 1992). Privatization through investor-owned, shareholder-driven, for-profit companies became common in health care for the first time. They focused on revenue and profit maximization, not cost control (Frankt 2018).

President Obama's Affordable Care Act (ACA) in 2010 vastly expanded Medicaid coverage to millions of people, imposed restrictions on insurance companies regarding claim denials, and expanded the benefits that could be availed via insurance (Kenton 2025).

The Trump administration has made several efforts to repeal the ACA and has significantly cut funds for Medicaid (Galewitz and Appleby 2025).

## Criticisms

The aforementioned ideas have been heavily criticized, both on the grounds of theoretical economics and real-world consequences. Hayek's idea disproportionately affects the poor, as some would be willing to trade holidays while others would have to trade rent (Gaffney 2005). Kenneth Arrow pointed out that the healthcare market could not be compared to a regular market due to what he called 'information asymmetry.' According to him, doctors possess more medical knowledge than both patients and insurers- thus there was a possibility of an over prescription of care, leading to 'moral hazard.' Furthermore, there was 'uncertainty' as the timing, degree and specific necessities arising from a disease/condition were unpredictable. Thus, to protect themselves from this risk of uncertainty about the cost of premiums, insurance companies increased deductibles, and government intervention was necessary to counter balance the fallout of it (Cogan Jr. 2021).

Pauly countered earlier critiques by arguing that consumers did not value 'free' health care at zero due to carelessness or irrationality, but because assigning zero value to a freely available good is a rational and expected economic response. According to Pauly, this behavior was not an anomaly but an inevitable outcome of insurance coverage itself (Cogan Jr. 2021). To support his argument, he employed a partial equilibrium analysis, a model that examines equilibrium within a single market while holding all external factors constant, thereby isolating the relationship between two variables. This model is inherently static, reflecting conditions at a fixed point in time and failing to account for broader societal or systemic changes (Cogan Jr. 2021).

The analysis considers only two variables—patient demand and the price of medical care—while excluding the roles and responses of medical providers and insurers. It also ignores changes in the wider health care and insurance environments. Pauly further acknowledged that the model applied only to routine and predictable illnesses, excluding chronic or catastrophic conditions. This limitation is particularly significant given that nearly 90% of U.S. health care spending is attributed to individuals with chronic illnesses. Additionally, the model provides no insight into how providers might adjust prices in response to changes in demand or cost-sharing. The RAND Health Insurance Experiment has been criticized on similar grounds (Cogan Jr. 2021).

While privatization improves the efficiency and growth of formerly public-owned firms across a wide range of countries, sectors, and modes of implementation, there is a paucity of evidence on the corresponding effects for consumers. The evidence on hospital privatization appears to be even more scant. Since the early 1980s, the share of available acute care beds at public hospitals has declined from 36% to 21%. Studies have shown that private hospitals, especially for-profits, are less likely than public hospitals to admit Medicaid, uninsured, and other unprofitable patients. The aggregate decline in Medicaid volume is concentrated among markets with greater poverty rates. In these markets, a statistically significant 9% decline in Medicaid volume was found. Privatizations over 1997–2013 document improved hospital

profitability and a decline in Medicaid volume. Hospitals– particularly non-profit hospitals– bear the cost of un-insurance in their market in the form of uncompensated care. Data shows that public hospitals in California received a differentially greater boost in revenue due to the ACA mandated Medicaid expansion because of higher baseline uninsurance levels. Studies have concluded that without public control of hospitals, expanding Medicaid coverage may not be sufficient to maintain access to hospital care (Duggan, Gupta, Jackson, Templeton 2022).

These limitations are also responsible for driving up healthcare prices in the US, which is the main reason for high expenditure. Studies have shown that hospitals in competitive markets decreased the amount of uncompensated care they provided in response to the introduction of increased price competition, as derived from the evidence of prospective payment and managed care lowering costs by increasing price competition (Propper and Leckie 2011). However, nearly half of U.S. hospital markets are highly concentrated, one-third are moderately concentrated, and only one-sixth are not concentrated. Mergers and consolidations have produced highly concentrated markets for hospitals, and empirical studies show that concentrated markets drive up prices, as hospitals in concentrated markets are able to negotiate more favourable payment terms with insurers, without showing any increased efficiencies or economies of scale that would benefit consumers. CDHPs require competition to drive prices down. Absent meaningful competition, CDHPs have no power to drive down hospital prices (Cogan Jr. 2021).

The “Big Beautiful Bill” passed on 1 July 2025 by the Trump Administration would cut $930 billion from Medicaid, Medicare and Affordable Care Act funding combined over 10 years, with more than 11 million people losing coverage by 2034. Experts have calculated that, taken together, the cuts will lead to more than 51,000 additional deaths per year by decreasing people’s access to health care. The bill includes two main Medicaid-related provisions. One increases the requirements people must meet to qualify for and remain on Medicaid: this would drive down the total number of people who receive benefits, Cole Brahim says, leaving more people without coverage. The second provision reduces the amount of money the federal government sends to the states to fund Medicaid coverage. This will cause great variability in how different states handle the cuts because each state will have authority to make its own choices about whether to try to secure alternative funding to close the gap and maintain Medicaid access. This is extremely harmful, as studies show that Medicaid covers about one in five people, and the majority of people in the United States will have had Medicaid at some point in their life (Bartels 2025).

## Current Scenario

While more than 90% of Americans have health insurance, over 137 million U.S. adults now face medical financial hardships. One in four Americans say they or someone in their household had trouble paying their medical bills. Medical debt is the top reason debt collectors contact Americans. Nearly two-thirds of people who file for bankruptcy cite medical issues as a key contributor to their financial downfall. According to one study, 43% of insured patients reported that they or a family member delayed or skipped physician recommended tests or treatments because of high out-of-pocket costs. CDHPs have hit the chronically ill even harder. Three-

quarters of patients with chronic conditions who face very high deductibles (at least $3,000 for an individual or $5,000 for a family) report that they skipped or postponed necessary medical care or prescription drugs for cost reasons. Moreover, the toxicity of medical debt is so profound that more than three-quarters of insured families burdened by medical debt cut back spending on food, clothes, housing, and other household essentials (Cogan Jr. 2021)

Denial of insurance claims is also a major issue. In 2023, the federally facilitated ACA marketplace on average denied 19 percent of health insurance claims, amounting to 73 million claim denials (Vankar 2025). According to data collected from the top 5 private health insurance companies in 2024, AvMed and United Healthcare showed top denial rates at 33% (Vankar 2025). This is especially important to note, given the recent assassination of United Healthcare CEO Brian Thompson, allegedly over insurance claim denials, and the widespread public support it gained (Daher 2024)

## Conclusion

The adoption of UHC (especially not excluding chronic or severe conditions) is one of the obvious solutions for the aforementioned situation, with private insurance only being a supplement to the public plan mostly for those seeking higher quality of services, with strict price ceilings on premiums and deductibles (Blomqvist 2011). This is only possible through a change in the conventional thinking towards health economics through a universal acknowledgement of the repercussions of neoliberalism.

Funding for UHC could possibly be raised through equitable general taxation, whereby higher income groups contribute more, which when done on a national level, could lead to equitable distribution of funds for states. The Social Insurance model is another possible way, with funding for universal insurance provided through mandatory contribution from employers and employees proportional to a person's salary. This, however, should be done in an way without disincentivising from earning higher incomes, which can potentially be achieved by using this model to partially fund the system (Blomqvist 2011)

Ultimately, striking a balance between corporate and public interests to guarantee both economic progression and public welfare.

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