Policy and Pluralism in the Age of Modern Medicine

As options expand, we need freedom to achieve pluralism in individual choices.

Jared Rhoads

For most of human history, the idea that ordinary people might someday choose to live somewhere other than Earth would have sounded like fantasy. Yet it is no longer difficult to imagine a future in which some people find life in an orbital habitat, a lunar settlement, or even on Mars deeply meaningful and worth the danger. For them, the risk and hardship would be part of the point: a chance to build, explore, and participate in something audacious. Others will look at the same prospect and decline without hesitation. They will see the danger, confinement, expense, and fragility of off-world life and conclude, reasonably, that the better choice is to remain on Earth and devote their ambition to flourishing here.

Either decision regarding how to live one's life can be rational, assuming it is pursued thoughtfully and not recklessly or by whim. As such, we ought to respect the choice that people make, and not use policy and institutions to try to keep everyone on a single approved track.

As it is with space travel and space settlement, so it is with modern medicine.

All sorts of scientific and technological breakthroughs are starting to make their way into our decision paths: genetic sequencing, personalized pharmacology, continuous biometric monitoring, cell and gene therapies, and more. Many of these are perhaps best described as "promising but not yet proven." The point is, they multiply the number of legitimate choices a person might make about how to pursue health.

One person may want aggressive screening, early detection, and frequent data collection. Another person may prefer only a small number of routine screenings and otherwise wish to live without constant medical surveillance. One person may eagerly pursue an experimental longevity intervention on the frontier of evidence. Another person may reasonably decide that the uncertainty, expense, and psychological burden are not worth it. One person may want every available opportunity to reduce risk, even marginally. Another person may accept more uncertainty in exchange for simplicity, calm, and less medical intervention in everyday life.

In other words, one person could reasonably get very excited about cutting-edge options and want to pursue them; another person could reasonably say, "no thanks, at least not now." In this option-rich world, the only way to respect each of their decisions is to avoid encoding anything into policy that either steers people toward one direction over another through incentives, or that

forces one group of people to share in the costs of the decisions that the other group makes.

This is going to require that we change our approach to policy. For roughly the last century, American healthcare has largely been organized around a model that assumes relatively standardized needs and relatively standardized solutions. Insurance plans pool people together into broad risk classes. Regulatory institutions determine which interventions count as legitimate. Medical licensing regimes define who may provide care. Public and private payers decide what is medically necessary, what is cost-effective, and what is worth covering. There have always been variations within this system, of course, but as a whole it has operated by channeling people through a fairly narrow set of approved pathways.

In many ways, we've been working under a model of medical paternalism. Medical paternalism is the idea that experts, institutions, or policymakers should decide on behalf of individuals what is best for their health and then structure the system accordingly. In American healthcare, sometimes this has been explicit; sometimes it has been built quietly into benefit design, payment rules, licensing restrictions, or coverage mandates. However it appears, the underlying assumption is the same: health can be centrally defined well enough that institutions may legitimately direct people toward the "right" choices.

Medical paternalism was never a good approach, but it is even less appropriate the more options we have in medicine, and the more personalized our individual pursuits of health can become. A one-size-fits-all approach to medical decision-making is as inadequate as a one-size-fits-all approach to healthcare financing.

A world of branching medical possibilities is very hard to square with the ideal of a single comprehensive insurance arrangement appropriate for everyone. If people genuinely want different things from medicine, then forcing them all into the same insurance design means either under-serving some of them or requiring some to subsidize choices they would never make for themselves.

Take a simple example. Suppose one person wants an insurance product centered on catastrophic coverage and a relatively conventional standard of care: proven treatments, basic preventive services, and protection against major unforeseen medical expenses. Another person wants robust coverage for cutting-edge diagnostics, off-label longevity therapies, concierge monitoring, advanced imaging, and rapid access to emerging interventions. Those are not just different consumption preferences in a trivial sense. They reflect different philosophies of health.

Why should these two people be compelled into the same plan? Why should either be required to subsidize the other's approach?

What's needed is a pluralist approach in which people can pursue their own paths to health without forcing others to live by their choices. As a guiding principle, the proverb "Take what you want and pay for it" becomes newly relevant. This means each person bears the costs of his own decisions,

leaves others free to make theirs, and ensures that experimentation in medicine doesn't come at the expense of the unwilling. It also means that the caution of some doesn't become a veto on the ambitions of others.

Policy pluralism recognizes that as the number of viable life paths increases, the job of policy changes. It becomes less about policymakers identifying and designing a single best pattern of behavior for everyone. Instead, what we need from policy are strategies and solutions for moving us from where we are, to a new place that lets different people pursue different conceptions of the good life under conditions of freedom.

In American healthcare, that means moving away from large centralized programs designed to set the tone for how all of healthcare works, the way that Medicare today influences everything from billing codes to what is deemed medically necessary, and more. It means more freedom to choose among levels of coverage, styles of care, provider relationships, and risk tolerance. It means freer markets in insurance and medical services. It means recognizing that innovation depends not only on discovery in the lab, but on the existence of people who are allowed to draw from their own resources to try out new possibilities.

Many things that now seem ordinary first looked dangerous, luxurious, or absurd. Early air travel was risky, expensive, and inaccessible to the masses. Medicine follows that pattern, too. Cataract surgery was once an exclusive, high-cost procedure before intraocular lenses and other innovations made it quick, safe, and accessible to the mass market. In the modern context, some people will be early adopters of advanced diagnostics, personalized therapeutics, and longevity interventions. Others will sensibly wait.

Increasingly, not being able to accommodate the preferences of both groups is causing tension. It is leading us to a kind of healthcare politics in which every new possibility immediately becomes a battle over whether it should be approved for all, covered for all, subsidized by all, or forbidden to all. That approach invites endless conflict because it turns every medical disagreement into a zero-sum political contest.

As our options expand, we need a better approach to policy. A good society is one that allows people to design lives worth living according to their own values, while respecting the equal freedom of others to do the same. That is the direction in which policy should go.

About the Author

Jared Rhoads is Executive Director of the Center for Modern Health. Email address: jared.rhoads@centerformodernhealth.org.

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