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A Replacement for Health Insurance

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ABSTRACT

Not only are medical costs increasingly excessive, but the costs to administer the financing of medical services are excessive. This article argues that this situation is not the fault of providers, medical device companies, insurance companies or poor management, but rather the natural outcome of using insurance as the outmoded packaging mechanism for the delivery of medical services. We argue that most health care is not insurable according to the basic principles of insurance. Insurance is contrasted with procurement and entitlements as a framework for financing health care. A system is then suggested for the delivery and financing of health care which balances procurement and entitlements.

This paper was submitted as partial requirements for a course at the University of Minnesota entitled "Risk Management and Insurance" taught by Professor Andrew Whitman. Some material has been deleted. Many of his comments have been incorporated into this revision. Most of this material is from the 1990s and very relevant. There was some updating in October, 2019.

INTRODUCTION

It has become platitudinous to say that the costs of medical services and the cost to administer the financing of medical services have become excessive. While occasionally a writer will maintain that relative to our economy health care costs are not a problem (Baumol), most writers see the increasing costs of medical services as detrimental to American competitiveness and headed towards absurdity as a proportion of the gross national product (Reinhardt). This could be called a crisis, except that a crisis by definition does not extend over several years as is the case for this cost escalation. We would argue that there has been a great deal of operational or conventional thinking and relatively little strategic thinking when it comes to designing the financing of health care delivery systems. When a paradigm is obsolete in a given application, tweaking the mechanics without challenging basic assumptions or exploring new ways of structuring the delivery system will not resolve the problem. Since it is the old solutions which created the problems, perfecting the old solutions only intensifies the problems. Even such major changes as health maintenance organizations, managed care, utilization review, prospective payment, and resource-based relative value scales lie embedded in the assumed framework of insurance.

Health care costs are a direct result of the paradigm in which they are packaged. Common assumptions that if component players each act in their own self-interest, the system will work doesn't work because the system is dysfunctional. People's perceptions of reality and choices are filtered through the paradigms used to present goods and services. Whether health care is financed and delivered through insurance or through procurement vitally affects the decisions that people perceive, have and make. To think that institutions automatically develop in a way that is most functional for society is naive. Our thesis is that most contemporary medical services are not insurable. Because of this the insurance paradigm is the primary driver in the escalation of medical costs. An alternative paradigm can equitably achieve superior outcomes at less cost.

Many Americans are led to believe that their health is insured. Naturally so, since health insurance is a pervasive term. The term promotes the perception that health is an entitlement and a deserved right. In reality, health is neither insured nor assured. Health insurance is actually an oxymoron. People are not compensated for their loss of health. It is the cost of medical services which has been insured and financed.

Influenced by the insurance paradigm, medical services focus more upon cure than care. Health care is much broader than medical cure. Health promotion, health clubs, nursing homes and a host of other services are part of the health care industry but not part of curative medicine with services performed by or supervised by licensed physicians. Most care or treatment for the mentally ill and chemically dependent is health care but not the application of medical technology or medical services. The appropriate balance and incentives for integrating medical practice and health care is disturbed by the financing model of insurance.

It is not so much the insurance companies but the very concepts of insurance which have insidiously impacted the structure and conceptual underpinnings of medical practice. The viability of any product or service is pervasively shaped by packaging and distribution channels.

Companies and whole industries often thrive or fail, not based on the value of their product or service but because of how the product is configured, presented, priced and delivered to the customer. Guideline-based medicine with its focus on doing what is correct according to protocol rather than according to professional judgment is an important part of conforming to a defined benefit shaped by insurance principles. If medical science was fully incorporated into insurance benefit guidelines, we could have technicians gather the clinical data and feed it into the computers where the scientific/benefits criteria would decipher the proper treatment and a technician or the consumer could implement the prescribed action. Benefits do not keep up with science and as part of insurance, are aimed at cost control and curing the disease rather than positive health outcomes. Creating a new model not based on insurance is a shift in paradigms. This is not an easy process. But because delivery systems and financing are so crucial to health care, a critical examination of fundamental premises is important. Creative thought as to alternative paradigms only begins when the old is seen as untenable (Barker). The first major section of this paper, "Health care is not insurable," argues the case that insurance is an untenable financing mechanism for most of health care.

The Affordable Care Act did little to change the basic paradigm responsible for the crises of access, efficiency and effectiveness. While the Canadian system is held out by many as a model, it too is an insurance delivery system and is facing escalating costs. In the United States approximately 47% of medical services are currently financing by government dollars. Merely moving the numbers on the payroll stub to different lines such as by adding the medical benefits to the Medicare withholding or in other ways routing the premiums through government channels, does not necessarily change the fundamental incentives and dynamics of the delivery system. The insurance focus upon the assumption of risk undermines the ability of physicians, other providers, consumers and purchasers to be oriented towards health in a cost-effective way.

Employment has been a major institution in the United States for financing health care. We begin from the position that this is problematic and given changes within the organization of the American workforce, going to become increasingly problematic. This leads us in the next section to examine health care in relation to the principles of insurance and conclude that neither the workplace nor insurance are appropriate vehicles for financing health care. This is not a paper about employer benefits or corporate productivity, but rather about a framework and system for the financing of health care as a social goal. At a conceptual level we then contrast insurance with procurement. From that we move into presenting a possible organizational structure for the delivery of health care services.

EMPLOYERS AS PAYERS OF HEALTH CARE

Why is it that employers in general have done so little to actually manage levels of health or to be prudent buyers of health care services? Employers buy medical coverage to attract and retain valued employees. However outside of taxes, employers have no other comparable expenditure with less precision as to what is purchased and the degree to which this expenditure serves corporate business objectives. We ask, "Is there a functional reason for employers to continue to be involved as a major player in financing health care delivery?"

There are several reasons for reducing the role of employers in the purchase of health care.

1. Purchasing health care services, rather than merely health care coverage, is a very complex process requiring expertise beyond the capabilities of most employers. Buying health care services is not the business of most employers. Experience in health care delivery is a prerequisite for competence in prudent buying as the focus changes from buying coverage to buying health care services.
2. The number of people who work for a major employer capable of prudent purchasing of health care services is decreasing dramatically. While 19% of employees worked for a Fortune 500 company ten years ago, less than half that number do so today (1995). Thirty five percent of the workforce is either self-employed or do not have a permanent employer. More and more people are working out of their homes and working for themselves or very small employers. Expecting employers to be prudent purchasers doesn't fit the composition of today's work structure.
3. Some employers are involved in providing automobiles for their employees; some pay for housing and some pay for room and board in certain circumstances. In general, employers are pulling back from providing such perks. Employer involvement in relocation, for example, has been dramatically reduced. There are really no more logical reasons why employers should provide for medical services "in kind" or as a benefit than that employers should provide groceries, cars, recreational facilities or housing for their employees.
4. A typical two-adult family has each adult working for a different employer. To provide medical services through the workplace often results in multiple health care providers serving the same family. Having the whole family receive medical services through the same health care provider might ensure more efficient and better coordination of services.
5. Having medical benefits connected to the workplace has inhibited the freedom of employees to change employment in response to the best economic deployment of their skills and interests.
6. The current environment of some employers providing health care benefits and some not provides an uneven competitive environment, especially internationally. It also facilitates a lot of cost-shifting between various payers of medical services.
7. There is no practical way to have universal access and employer sponsored health care plans.

The alternative delivery and financing structure proposed herein would dramatically change the role for employers in financing health care. Employers would be involved in paying only a small portion of those medical costs directly attributable to workplace causes. Employers would work with health plans, state agencies, non-profit organizations and for-profit vendors with whom they might contract for the purpose of ensuring and promoting safety at the workplace. Employers should continue to be involved in various health promotion and health education efforts. This might be similar to current involvement

in educational programs regarding personal finances which are offered through the workplace, or to the United Way campaign which functions through the workplace. Employer involvement in wellness programs might be based upon the same rationale that employers are involved in providing food and cafeteria services. It is a benefit that facilitates healthy productive employees. Employers might be involved in the financing of health plans to the extent they are currently involved in financing Medicare, government services and local schools. That is employers would pay their income, property and other taxes and be an administrative mechanism for withholding taxes (Fossum).

HEALTH CARE IS NOT INSURABLE

Many insurance companies are already abandoning the medical insurance product. Most large insurance companies sell more non-risk Administrative Services Only (ASO) than actual medical insurance. However, even when employers are self-insured (a real oxymoron), the insurance paradigm is still operative, and it is that paradigm which is the focus of this analysis. Health insurance is actually more metaphor than reality, although that does not change the powerful impact which the metaphor exerts upon costs and services.

Insurance Works When ...

Insurance is appropriate when something definable, uncontrollable and unwanted might happen and one needs specifiable outside financial resources to cope with the loss. These are elementary principles of insurance. Most health care services do not fit this package or delivery mechanism.

Insurance Prerequisites

1	Something Definable that is	*	An Objective Event
2	Uncontrollable and Unwanted	*	Without Moral Hazard with
3	Might Happen	*	Statistically Predictable Risk and
4	Requiring Determinate Outside Financial Resources.	*	Specifiable Compensation made Feasible by Spreading the Cost through Premiums.

Insurance Requires an Objective Loss and Objective Obligations

The insured event, related losses and insurance liability needs to be definite in both time and place. Insurance is inappropriate if the loss is indefinable in objective terms. To administer life insurance, one has to be able to objectively determine and verify if the person is dead or alive. A similar verification of loss is an essential component of all property and casualty insurance administration. Objective documentation is often part of the science of medicine, such as the need for repair of a laceration or fixation of a fractured hip. Situations in which the condition is definable, and the solutions are known, supported by evidence and agreed upon are very amenable to insurance administration even if not catastrophic in nature. These tend to be the types of medical analysis and decisions which could be done by computerized algorithms if technicians entered the proper data and then executed the prescribed treatment. However, the early stages of many diseases are characterized by more ambiguous descriptions. Yet this is a very efficacious time for intervention. Similarly, the decision to utilize psychotherapy may be subjective in that it is based upon mutually defined goals and the commitment to reach those goals rather than an objective loss or incapacity. The absence of diagnostic reliability between multiple evaluators and the fact that each provider may work with a different style to help

accomplish different results does not necessarily detract from the value and validity of their respective services. However, it does preclude packaging the product as insurance.

For purposes of insurance administration, medical necessity can be an ambiguous term. The majority of medical interventions have never been subjected to the appropriate control studies to determine their true effectiveness. Interventions can be effective and still not necessary, in that alternatives may be equally or more effective at less cost or with fewer side effects.

Insurance requires that not only must the disease or insured event be objectively definable, but the obligations of the insurance company must be legally definable through an insurance contract. Life insurance pays the value of the life insurance contract when the person is legally dead. Should a medical plan be responsible to spend whatever necessary to achieve a 40% rate of recovery? If double the expenditure would bring the recovery rates to 60%, should health insurance pay for that? The insurance obligation is not defined, other than what is judged to be medically necessary or written in the plan document. Currently $10,000 to increase cancer recovery probabilities from 40% to 60% is viewed very differently than the same investment and probabilities in treating substance abuse.

Questions of obligation become more difficult when conditions are characterized by denial. An insurance company does not assume responsibility to proactively seek out claimants in order to increase insurance company loss ratios and reduce their profits. Particularly in behavioral health, a great deal of mental illness and chemical dependency is characterized by denial with the result that only a small proportion of eligible persons actually seek services. Access is far too passive a concept for dealing with the health of people having serious illnesses characterized by denial. If the health of these people is a goal, then proactive marketing of services to target populations is appropriate. This should be similar to most sales efforts which deal with consumer resistance to everyday products in our economy.

A major problem in administering medical insurance is that the boundary between medical services and supporting health services is ambiguous. For example, why is food covered in the hospital as a health service but not covered elsewhere? How does a nation say that health is a right but food is not? Is it feasible to insure against hunger as a component of health insurance? The requirements of insurance for definable benefits are difficult to administer when the boundaries between medical services, broader health services and related social services are very ambiguous.

Moral Hazard, Causality and Incentives

Insurance is appropriate to give financial protection in the event of catastrophes over which one does not have control. Insurance does not work if the insured can control whether or not there will be a loss, or even has an incentive to produce a claim. Insurance would consider such incentives to be a moral hazard. Since approximately 50% of health problems are directly related to individual lifestyle or individual behavior and actions, these are really not insurable conditions (Rosen). A good tool in the wrong application does an injustice to insurance and to health services. Insurance tends to solidify an archaic concept of illness as a catastrophic, uncontrollable risk.

The presence of insurance should not produce an incentive for a claim. It should always be better for both the insurer and the insured to not have a claim. As it turned out, my money last year on life insurance was wasted from my perspective. This is okay with me, and with my life insurance company. That is the way it should be for all insurance. Once the underwriting commitment is contracted, insurance companies ordinarily desire minimal claims to maximize their loss ratios and profit.

The principle of loss prevention would hold that it should be to the mutual advantage of the insured and insurer for the insured to do what is feasible in order to reduce the possibilities of catastrophe and

consequent claims. In this way the causal basis of any kind of potential insurance claim should always be avoided or minimized. Such preventive actions themselves are not the basis for a claim, since they are not based upon a loss. Filing claims to prevent subsequent claims is fundamentally inconsistent with the principles of insurance, even if such a claim would lower consequent claims. It is confusing a purchasing transaction with an insurance transaction. In purchasing services or products one makes decisions to buy because the usefulness or value of what is purchased exceeds the cost. In contrast, insurance claims are paid strictly because of contractual obligations in the face of objective loss rather than because something is prudent or will achieve positive results. Preventative services are and should be purchased separately from insurance. Indeed, it is common practice in casualty insurance and very appropriate that certain preventative actions be taken to qualify for the insurance. Insurance does not invest heavily in loss control or prevention because if the loss events are really preventable, the very premise for needing insurance is destroyed. That premise is that insurance is there to offer financial protection for statistically predictable events over which one has no control.

Insurance Paints the Patient as Victim

One implication of insuring for uncontrollable and unwanted events is that this paints medical services as an undesirable necessity in the face of a catastrophic loss. Insurance paints the patient as victim. One never wants to have a loss or have to file a claim. One only files claims for those things beyond ones control. Doctors are therefore there to deal with catastrophes rather than health. This may not be the context in which physicians would like to be viewed. Physicians will continue to be victims of the financing metaphor which shapes the context for the delivery of their services until they understand the power of the insurance paradigm. Insurance is a serious disservice for the physician interested in goal-oriented health rather than being structured to eradicate disease and morbidity.

Causality Determines Legitimacy of Claims

The principles surrounding moral hazard are crucial to insurance. Actuaries are uncomfortable calculating statistical probabilities based upon individuals voluntarily choosing to access an appealing and valuable product. Insurance assumes the occurrence of an undesirable catastrophic event consistently followed by a claim and appropriate payment. If either the insured event or the claim varies depending upon the actions or wishes of the insured, actuaries begin to wonder about the objectivity of the factors driving their predictions. This concept of causality introduces a dynamic of moral judgment to the delivery of health care. If someone is dying of lung cancer caused by smoking, does she or he have a legitimate claim for services? Or should the claim be denied on the basis of moral hazard?

The claimants' rights should not be based upon the vagaries of theoretical causality. For example, the actual needs of the mentally ill are not based upon whether the theoretical understandings of causality are genetic, physical, environmental, spiritual or moral. Typically such people need medication and with their families need a broad array of social and supportive services. Should the legitimacy of these needs be subject to prevalent or competing concepts of causality? The issue surfaces most frequently where there are specific benefit exclusions, such as a different level of benefits for mental illness. One recent ruling that congenital encephalopathy be paid according to the general medical coverage rather than the limited mental illness benefits creates financial incentives to explain events in certain ways and to pursue specific kinds of remedies (Philips).

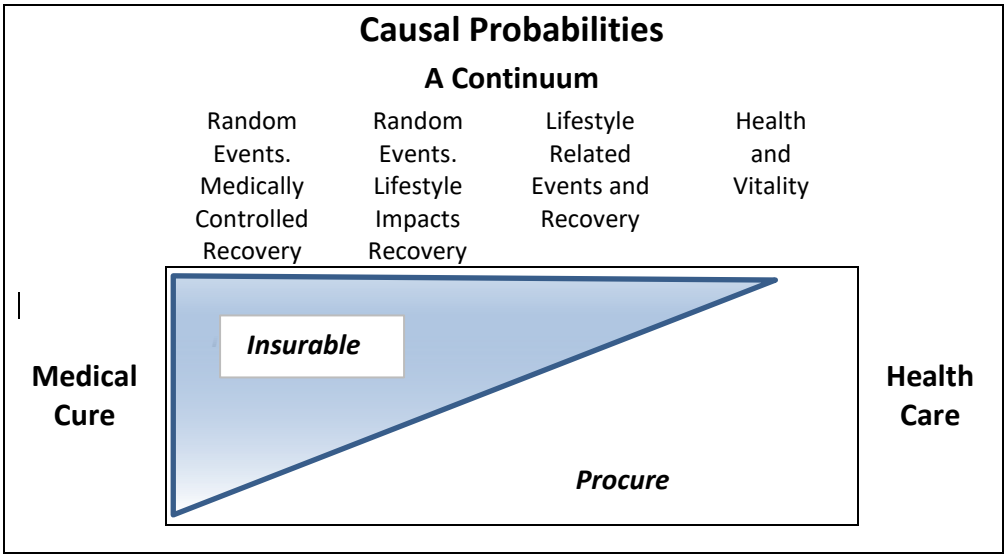
Insurance Doesn't Fit Complex Causalities

Insurance administration works best when causes are identifiable, singular, simplistic and Newtonian. Complexities such as necessary but insufficient cause or the probabilities of risk factors make for difficult

issues around moral hazard and claims determination. Chaos theory is helping us understand the patterns and complexities of the real world. Should the physician as scientist have to accept a singular theoretical understanding of cause and effect in order to facilitate payment? Insurance as the package for service delivery impacts more than incentives; it gives pervasive direction to the models and paradigms used for understanding a situation, determining what needs to be done and how to formulate action. The world view is that the cause is outside the individual's control, as is the solution. One becomes a "patient" and the physician affects the cure as part of the insured benefit.

The interest in outcome is not supported by insurance, which is inherently indifferent to outcome. Does life insurance care what happens with the beneficiary dollars? Under insurance the goal is to have minimal claims while complying with the provisions of the contract. Outcome research is facilitated by a financing system based on purchasing services rather than a system of insurance offering coverage. In purchasing, rather than insurance, the goal is to achieve optimal results at minimal cost.

The Cause Continuum



Attributions of medical cause can be arranged on a continuum of four major groups. First are the random catastrophic events. Insurance works fairly well for the acute curative requirements in these situations. Second are situations where the individual did not cause the incidence, but significantly affects the recovery. Third are medical conditions in which individual or societal factors contributed as risk factors to the probabilities of the disease or injury. The individual may have varying impacts on the management of such conditions. Fourth are actions oriented towards improved health and vitality. Some of these are for their own inherent and immediate value, and some are means of minimizing the risk of future morbidity. Insurance with its need for a binary determination of pay or not pay has difficulty with this continuum. Actually, only the first grouping of major incidents caused by factors beyond individuals' control and solved by variables beyond individuals' control are insurable. Most medical services are a response to situations which could have been avoided or significantly reduced if people took appropriate responsibility for their health. And the effectiveness of most medical treatment is highly dependent upon personal health management.

Second Dimension of Cause

Distinguishing between cure and care adds a second dimension to this causal understanding. Generally, the function of insurance is to compensate or restore in the event of loss. The general function of medical insurance is to pay for medical treatment necessary to restore health or the treatment thought necessary for cure. Typical medical insurance frequently excludes conditions not amenable to cure.

People with chronic conditions have been served an injustice by structuring medical services through insurance with its focus on cure rather than care. People with chronic conditions often need minimal medical services but need extensive nursing, social and educational services. Prior to insurance and the marvels of modern medicine, hospitals offered mostly care rather than cure. There is a place for care.

The extent to which social services and services for chronic conditions requiring minimal medical services and expertise should be funded through medical and health plans is a major issue. Generally when high technology competes for resources with low technology, high technology wins. Obviously, people in nursing homes need care, but are the services medical and to what extent should they be financed through medical insurance? Medicare implementation has required an answer to this question in terms of available benefits. The answer is often a surprise to people.

One should not assume that health promotion is for healthy people while the disease-oriented, cure-the-passive-patient approach is for sick people. Whether people are sick or healthy is one continuum. Whether one refers to people as clients, patients or consumers reflects another independent continuum reflecting on people's responsibility for their health regardless of whether they are ill or well. Insurance as a mechanism for finance tends to frame sick people as patients and non-sick people as subjects for prevention. Insurance is not a prerequisite way of buying services for either sick or healthy people. The conclusion from this causality analysis is that insurance tends to restrict the scope of medical practice to a small part of the health care market, that being random events where the physician attempts to attain a cure using medical interventions. A system is needed to purchase comprehensive and integrated health care rather than to insure a medical cure for insurable catastrophes.

Wellness for the Healthy & the Sick

	Cure	Wellness
Sick	a ***Patient***	b ***Empower***
Health	c ***Prevention***	d ***Educate***

Cause as a Factor in Behavioral Health

The moral hazard prerequisites of insurance are particularly problematic in behavioral health services such as counseling, psychotherapy and treatment for addictive and mental illness disorders.

The need for such services is almost always derived from a very complex combination of causal factors. Individuals do not have control over many of these factors, such as life events or genetic and physiological dispositions. However, many of the causative factors have been or are subject to the individual's control. Previous, current and potential responses are subject to varying degrees of choice or perceived choice. Nearly always the realities are subject to widely varying interpretations and indeed are very often not even perceived. The result is widely varying perspectives between individuals, family members, different providers and insurance adjudicators. Quite often psychotherapy is precipitated by some loss, the significance of which is more dependent upon how the subject frames or makes meaning of that loss than upon the actual loss itself. For example, the death of a parent which is an objective event has widely varying impacts upon the mental health of different individuals. While psychotherapy is usually precipitated by some loss, to be effective it needs to focus upon goal attainment rather than obsessing with the loss. Quite often the goal of the consumer and the provider is to achieve some positive state of mental health which might be far superior to the level of adaptation existing prior to the loss event, as if all of this is objectively measurable and verifiable.

Chemical dependency treatment is particularly ill suited to insurance because of the moral hazard implications. While the disease has definite genetic risk factors and can be reliably and objectively diagnosed, the treatment itself usually consists of very paradoxical affirmations about surrender and taking responsibility for one's past and future actions. While one may not have a choice about having the disease, one certainly has a choice about how to respond to the disease. If one adds to this the impact of denial upon who receives treatment, the applicability of insurance becomes even more problematic. Very few health plans are providing treatment for more than 3 per 1,000 and almost none beyond 5 per 1,000, yet surveys generally reveal incidence rates from 70 per 1,000 to 119 per 1,000 and above. How would a life insurer price life insurance if only 5% of those with a legal entitlement to a claim actually submitted a claim? Pricing the product based upon historical claim submission data exposes the insurance company to a very large exposure should the media, public education, advocates or some other dynamic suddenly change the rate at which legitimate claimants file claims.

For insurance to function effectively, the volume of claims must approximate the incidence of loss. Situations and conditions characterized by denial are not amenable to insurance.

Statistically Predictable Risk

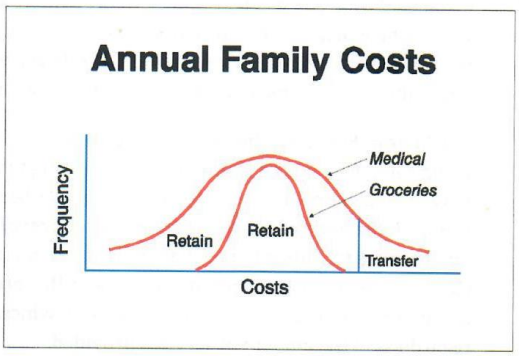
Insurance is appropriate for major events and catastrophes which are statistically predictable. Insurance is not appropriate for normal events which will most certainly happen, such as regular and routine trips to the doctor for normal medical care.

One prerequisite of insurance is the predictability of losses through the law of large numbers. However, the variations in medical costs are driven very directly by the availability of insurance and financial resources rather than by the law of large numbers. The majority of medical expenses are fairly predictable. For example, the cost of medical services for our family has varied between $2,000 and $5,000 for the last twenty years. While there has been the possibility of a need for medical services far in excess of that amount, which could be appropriate for insurance as one option in financing, for the past twenty years the variation has not been significant enough to merit an insurance claim if insurance is there to finance costs which an individual family could not sustain.

If individuals or families were to insure against the risk of medical costs (which is not where we are going in this paper), the logical way according to the principles of insurance for this to happen would be for the family to determine the maximum cost of services which their budget could sustain. This would be retained, and insurance would be purchased for the excess. For example, assume a family has normal medical costs of $4,000, with one year out of 5 the costs may go up to $8,000. The family has decided that any costs up to $10,000 could be paid for through tapping savings or other financial resources. The family should then insure for medical costs in excess of $10,000. Theoretically, we should no more insure for all routine medical costs than we should insure for the cost of automobile repair or the cost of groceries and restaurants. Indeed, one could argue that food is a statistically more critical ingredient for health than medical care. In my own case of over fifty years, I have benefited from public and private health services, but medical services have never been essential. Yet, food is a daily prerequisite for my health. Why isn't food covered by health insurance?

According to the principles of insurance, the graph of what is retained and what is insured should look something like the diagram on the next page. At the low end of the bell-shaped curve are families that spend very little on the examples of groceries or medical costs. Most families spend about a median amount. The exact boundary between what is retained and what is transferred could be adjusted according to an individual's perception of risk and financial capability to sustain unexpected loss. Any

event which is likely to occur every year should not be insured unless the loss sustained with that event is highly variable, being nominal in most years and catastrophic only on relatively rare occasions. Of course, if the policy were administered according to the principles of insurance, any claim which was not accidental and for which the individual had a significant role in precipitating should be excluded from coverage as self-induced. Insurance is not for manageable events. Insurance is for events which might happen, not for those events which one knows will occur or knows will not occur. Insurance is appropriate for risk or variation in the possibility of negative outcomes that could occur over a specified period in a given situation (Williams & Heins, p. 8). Without a significant variation insurance is inappropriate.



Insurance is appropriate for events which might happen, rather than for events which one desires to make happen or is hoping will happen. Insurance is designed for pure risk rather than speculative risk (Williams & Heins, p. 13). Just as the owner of a business cannot insure for a profitable year, doing nothing else but collect premiums if operations are not profitable, it is not appropriate to insure health which is a positive state of well-being rather than a loss. It is the cost of medical treatment which is insured. In this sense insurance and management are opposites and mutually exclusive. One insures against the possibilities of catastrophes over which one has no control and manages events over which one does have control. One administers an adjudication process and manages a business, including an insurance company. Managed care, not in the common sense of the term but in the sense of business management, is antithetical to insurance, as we will describe later in more detail. Most of the difficulties with managed care are the result of confusing what is insurance and what is managing and delivering services.

Most athletic games and competitive events are divided into offense and defense. The role of the offense is to make things happen; the role of the defense to protect against things happening. The role of the entrepreneur, the innovator and most managers is to make things happen. The role of insurance is to provide funding for the consequences of uncontrollable and unwanted events, which is essentially a defensive function. While a good defense is an essential part of every good game plan, one cannot win the game only with defense.

If one looks at corporate medical insurance programs, it is rare to find a positive, quantitative statement of objectives undergirding these expenditures. Outside of taxes, no other aspect of corporate America has such large expenditures that are not shaped by quantitative objectives and expected return on capital. Line managers are under extreme pressure to control costs, yet the significant expenditures per employee per year for medical benefits have very few defined requirements as to the results of those expenditures. American employers spend .9% as much on health promotion as they do for medical insurance (Ashley Files). If aggregate buyers spent more to achieve health and redesigned how they go about purchasing health and medical services, they could spend far less on insurance covering the loss of health. Employers spend all their money on defense rather than offense. Few businesses would survive if they followed the same proportions in the delivery of their principle goods and services.

Ironically, the companies least likely to require measurable evidence of health promotion programs affecting corporate financial returns are most likely to establish a successful program (Riedel and Frank).

Companies implement such programs out of a belief that unhealthy employee lifestyles lead to impaired work performance. A typical statement of this belief is from Theodore Brophy, a retired Chairman and CEO of GTE, "We know from our own experience that if we feel well, we do a better job than if we feel poorly. And if employees are sick, they will cost you a lot of money." (Rosen, p. 169).

The seven characteristics of companies that successfully implemented health promotion programs are: (Riedel and Frank)

1. A belief that health promotion, in and of itself, was a good thing.
2. Expectations were moderate to low.
3. Measurable evidence of lowering medical costs was not expected.
4. The program had a strong, well placed advocate within the company.
5. The program had a competent internal coordinator.
6. The company itself was healthy and stable.
7. When results are down, planning and action were taken to correct the program.

Regarding statistically predictable risk, the writer asked the chief financial officer of a utility company, "What would be your ideal annual expenditure for mental health and chemical dependency treatment?" With his fingers he shaped a zero. This is natural enough for in anticipating losses, the goal is always to have minimal losses and minimal claims. While the insurance company expects losses in the range of 60% to 80% of premiums, and indeed hopes for some losses in order to validate the need for continued sales, for the insured the goal under insurance is for zero or as few claims as possible. Insurance is for what might happen, and one would hope that the hazards would not happen (Consultation with InterState Public Power, 1992). However, as the team reviewed their situation further they decided that the incidence and need was there, regardless of claim rates, and that a wise business decision was to provide services to people in need of such services. Without the paradigmatic questioning, insurance as the financing vehicle would have influenced the goals towards minimal service provision. Instead, when they shifted to a purchasing paradigm rather than an insurance paradigm, they were able to set realistic goals for service provision and managing their risk.

Specifiable Compensation Feasible by Spreading Cost through Premiums

The final prerequisite which we will note here is that the hazard has to be of sufficient potential economic significance to warrant the issuance of an insurance contract (Wenzel, ISP, 1994, p22). To insure against minor losses results in administrative costs being excessive. Alternatively, if everybody in an insurance plan suffers a catastrophic loss at the same time, the insurer needs to have the financial capability of paying all the claims and remaining solvent. The insurance company must guard against this possibility through dispersed underwriting, holding necessary reserves or reinsurance. Also, the cost of premiums must be perceived by the consumer as reasonable in relation to the perceived risk and within the financial capabilities of consumers. Otherwise no one will buy the policy and private insurance could not survive.

The cost of medical insurance has exceeded what many people and many employers are willing to pay for it. The natural market force for most products in our society that are not perceived to be worth their price is that no one buys them. As volume thus decreases, the cost per unit often increases making the product even less competitive. With medical care, the uninsured with medical crises are often provided services paid for by various cost-shifting mechanisms, which only increases the cost for those paying for medical insurances.

The provider response to the medically uninsured situation in the United States is to say that if people won't buy our products, we should pass a law requiring that they buy the product. How many other ventures, unable to sell their products, would not like a law requiring people buy their products? Maybe we could solve homelessness by passing a law that everyone had to either own or rent housing. Or we could mandate insurance for homelessness.

Many people receive access to medical services even without paying for it, but many do not. It is not at all clear whether efforts towards national health reform are in the interest of people not having access to medical services, in the interest of parties who feel that they pay too much, or in the interests of providers and related parties who want to expand their revenue. Instead of framing the medically uninsured or underinsured with such moral indignation, perhaps the shapers of delivery systems should examine how appropriate service levels could be provided at a cost that people are willing and able to pay.

PROCUREMENT AS A CONTRASTING FRAMEWORK TO INSURANCE

Not only is insurance inappropriate for regular and fairly predictable medical costs, but cash flow requirements in the face of unpredictable and expensive medical costs do not necessarily require an insurance product. Health care services can be budgeted and delivered in an equitable way through other means. To select insurance as the payment vehicle merely because a prepayment or reliable payment system is required by providers is inappropriate. Insurance has too many other prerequisites which we have just reviewed. There are other tools for spreading costs over time. There are other tools for transferring costs when people's ability to pay does not correlate with their need for services. A health plan can provide services of the healing arts to a given population without an insurance contract and without a defined benefit plan (since the benefits are not definable). A health plan itself may have need for insurance without selling insurance to individuals, employers or government purchasers. Insurance just happens to be the track taken years ago as the way to manage a cash flow problem when medical catastrophes were seen as unpredictable events. Since then, medical and health care needs have changed dramatically. Medical and health care services today require management rather than insurance.

In order to understand the essential and enormous differences between insurance and managed procurement, it is important to contrast these two very different paradigms. This contrast is not about medical insurance versus the procurement of medical services, but rather about insurance in general in contrast to procurement as financing systems for the exchange of goods and services.

	Procurement		Insurance
Buy	Services	-	Coverage, Policy
Purpose	Improve	-	Compensate, Restore
Motivator	Acquisition	-	Catastrophe
	Fulfillment	-	Fear
Goal	See People	-	Not See People
Point of Sale	When Use Begins	-	Before Need
Terms	Specifications	-	Schedules
Defined (Pensions)	Contribution	-	Benefit
Aggregate	Budget, Contract	-	Capitation
Cost Control	Budget & Manage	-	Uncontrollable, Actuary
Decision	Purchasing	-	Paying
	Purchasing Dept	-	Accounts Payable
	Balance Cost/Value	-	Necessary by Contract
	Manage	-	Administer, Adjudicate
Payment	Purchase Order	-	Claims
	Invoice	-	Reimburse
Results	Outcomes	-	Compliance

Buying services and buying coverage

The first essential difference between buying insurance and buying services is that in insurance one buys coverage and in procurement one buys services. In buying coverage one is buying a policy that provides specific guarantees should specific undesirable events take place. Those events must be predictable according to the probabilities of large numbers and for any given instance during any given period, both the insurer and the insured must hope that these events will not take place. In buying coverage one is buying the possibility of services but may well not receive any services whatsoever. The difference is as significant as taking a job with a possibility of compensation versus taking a job with a salary.

The Code of Ethics for the health care profession of social work prohibits its membership from being compensated for selling coverage, although the provision is commonly violated and has never been enforced. The Code of Ethics prescribes that social workers shall be compensated solely on the basis of the value of services delivered. Actually because the Code also provides for charging according to the client's ability to pay, the literal proscription is to not charge a client unless services are performed. Under this provision it is unethical for a social worker to accept a fee per case as is commonly done, in which the social worker is paid a flat rate per case regardless of the amount of services provided.

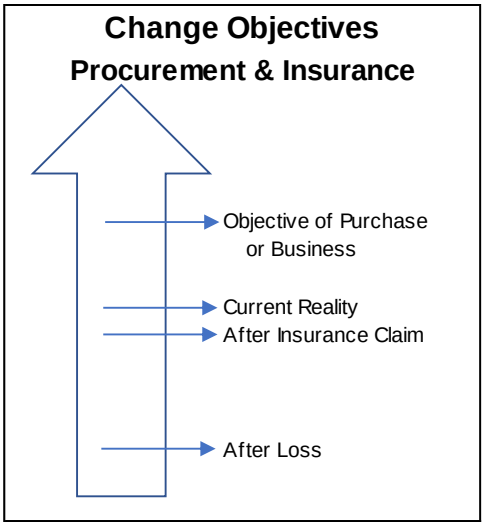
To elaborate upon the example from above in which the CFO was asked about the desired spending level for behavioral health, his answer of zero brought an immediate cry from across the table. The vice president of human resources and the benefits manager began talking about the prevalence of stress, chemical dependences and mental illness manifestations within their organization. The organization has known costs and risks resulting from alcoholism and other chemical dependencies. They began talking about vehicular and other accidents, liability costs, life insurance costs, customer relations issues, etc. They were aware of some of the research documenting the measurable savings resulting from the provision of such services (Worner et. al., Kertesz, Stuart).

Obviously, these people from across the table were coming from a different paradigm. They were aware that capitated managed mental health plans could buy the risk but leave the costs and consequences of inadequate treatment with the employer. From their perspective, setting numerical targets for utilization, spending and outcomes was a way of containing costs and enhancing company performance and profitability. The result of this confusion between buying coverage and buying services is that few employers, or government buyers for that matter, have decided if they want to buy these services or not, and if so, in what amounts and at what desired costs. For example, employee assistance programs, drug testing and other health promotion programs are instituted for the purpose of identifying and solving personal and health problems. The goal is to find people needing help. At the same time and like an isometric exercise, the corporation has placed treatment services in an insurance package having the goal of minimal claims and losses.

Respective purposes

The purpose of health insurance is not to make people healthy. Rather, the function of every insurance policy is to compensate or restore in the event of catastrophic loss. One does not take out insurance to make things better. For example, one does not take out fire insurance to have a better house or collision insurance to have a better car. The goal of medical insurance is not to improve or enhance health, but rather to finance the medical treatment costs of illness or injury. The purpose of medical insurance is to restore rather than to make the status quo better. The function of insurance should be to provide financial protection or means to recreate the current state should a catastrophe occur. Insurance can

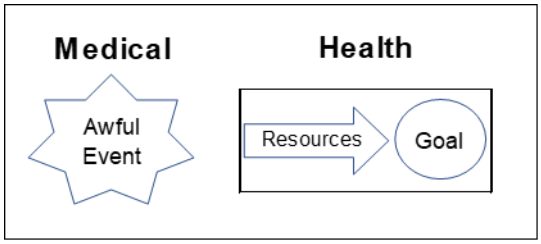
fund rehabilitation, but theoretically should not fund habilitation for the person wanting to achieve a state of health never achieved before.



Theoretically the person born with a congenital defect should not have insurance pay for corrective surgery in that there actually is not a loss. It is habilitation rather than rehabilitation. However, most citizens believe that the existence of previous health is irrelevant to the provision of such services. Insurance is purchased out of some sense of fear or at least apprehension.

In contrast, procurement operates out of hope. One expects that whatever is purchased will make life better and produce more than enough value to offset the cost. This is true whether one is buying a business, hiring a consultant or buying a retail item.

Because of insurance, medical services are oriented to eradicating disease or injury rather than oriented towards health. Even prevention is oriented toward avoiding the negative. By contrast, the purpose of management is always to achieve some goal, such as health. The purpose of a managed health plan would be to provide for interventions to make one healthier as well as provide for services in case of failure. Paying for medical services through insurance has perpetuated an orientation of working to get rid of the awful events, such as disease or injury, rather than working to achieve health. We have a sickness system rather than a health system. This negative orientation of working to get rid of a problem rather than working to achieve a goal has resulted in services being reactive rather than proactive. The difference is as profound as education to avoid ignorance rather than for the excitement of learning or working in a business to avoid a loss rather than to achieve a goal and a profit.



The insurance financing mechanism has introduced a false dichotomy between curative services and wellness services. A procurement framework could support having curative and wellness services being provided through a common seamless system. The distinction could disappear.

Maximize or minimize service levels?

Most people and organizations selling their products or services believe that they can benefit a large number of people and are anxious to sell their products and services. Usually profitability increases with an increased volume of sales. Under insurance arrangements, the revenue is already fixed by the sale of the policy, and the provision of services in the form of claims is an expense to be subtracted from the cost of providing insurance. Maximum profitability on an existing contract occurs when there are no claims or are minimal claims. Maximum profitability over time occurs when there are sufficient claims to validate the need for insurance, but not enough claims to surpass 70% or so of the premium revenue.

Under traditional indemnity plans, providers sold their services to consumers with financial incentives to maximize the volume and price of their services. Either the provider or the consumer would then submit a claim to the insurance company, which theoretically had an incentive to minimize claims but in actuality profited from essentially being in a cost-plus business. In reality the cost of these claims, which

by definition are uncontrollable, were passed on in the form of higher premiums. When payers began objecting to this cost escalation, some insurers began scrutinizing and denying claims. Insurers also began passing the risk on to providers. Under such arrangements health plans and provider groups would be paid a fixed fee for all "needed" services. While this in effect was a form of insurance, many of these risk-transfer arrangements were and still are outside of insurance regulation. Suddenly the financial incentives for the provider are reversed. Profits are maximized by minimizing services within a reasonable range while managing the impression of value in the form of coverage. Indemnity plans that were averaging $10 per member per month for behavioral health benefits, when the risk is reversed are able to enrich the benefit design and simultaneously cut their level of "necessary" service levels to $2 per member per month and in some cases, much less.

Coverage does not equal services. A typical indemnity plan provides benefits of twenty percent copayment on inpatient services for behavioral health and a fifty percent copayment for outpatient services. This coverage is much less than that provided by most Health Maintenance Organizations (HMOs). When the provider is placed at risk such as through an HMO, inpatient is paid at 100% and outpatient services have perhaps a $15 per session copayment. Comparing plans at open enrollment time, the HMO plan with the best benefit schedule provides service levels at twenty percent or less of the leaner indemnity plans. All of this is possible because of difficulty in objectively defining the legal basis of a claim.

Many people argue that it would be cost effective for insurance plans to invest in preventative services in order to reduce consequent claim levels. The reality might well be that the insured person will be in someone else's plan next year, making such an investment not very wise. However, the real problem with this argument is that it is asking insurance people to think and behave from a procurement paradigm, which is contradictory. Insurance is not there to save money, but to pay contractual obligations and pay only obligatory claims for defined benefits.

Point of sale

Insurance and procurement are very different in the respective point of sale. The point of sale for an insurance product is when buying and renewing the policy. Once the policy is in force, the sale has been made. Paying for services is a matter of expediting the contract. At that point, the decision to pay a claim is not whether the services are worthwhile or worth their cost, but whether the services meet the legal requirements of the insurance contract or Summary Plan Description. In administering a life insurance contract, the claims adjudicator does not ask whether the beneficiary needs the $100,000 or whether the funds will be used for a worthwhile purpose. The funds are paid according to contract.

Typical medical insurance administration is not oriented toward results, which would be a procurement model, but whether the conditions of the contract require payment. Is the person eligible for benefits? Is the provider an eligible provider? Is the condition a valid medical condition? Do the terms of the benefit schedule, such as deductibles, co-payments and caps require payment? It would be uncommon for insurance claims adjusters to say to beneficiaries, "We have paid your claim and we want to now follow-up with you regularly to make sure that your problem is resolved. We will do this not only as a service to you, but so that we can use that information in helping future customers in finding the right help for their problems." Customer satisfaction in insurance usually has to do with the payment processes rather than solving the customer's problem which originated the claim.

In contrast, the point of sale for procurement is when acquiring services or products. What under insurance is a payment decision under procurement is a purchasing decision. The difference is as

profound as the difference in responsibilities within an organization between administering an accounts payable function and managing a purchasing function. In purchasing, the decision is not one of legal compliance, but one of choosing the best resources considering cost and probable outcome for solving a problem or achieving a goal.

Insurance contracts are administered; procurement is managed. Matching claims information to criteria is not a management process. Imagine hiring a manager and giving a job description which says "Your job is to match these data to these criteria and issue decisions." Such a mechanistic task might be assigned to a clerk; more likely it should be done by a computer. The task of any manager is not so much to make decisions as to frame what decisions need to be made.

The language we use is instructive. There are no claims in managed care taken literally, only purchase orders and invoices. It is startling how after detailed presentation and discussion of the differences between insurance and managed purchasing, someone will decide to go with purchasing services and then ask who will pay the claims. Ideas that in the abstract seem very clear, in the implementation fall back into old language and procedural habits.

The differences between a claim and an invoice are significant. In terms of the point of sale, claims are for past events while purchase orders are for future events. With a claim the service to be paid for has occurred but the economic transaction has not yet occurred. The provider is hoping to get paid. Many consumers have obtained pre-certification only to be confused and angry when their later claims were denied. While their eligibility and coverage may have been confirmed, that does not constitute a commitment for payment. The result is that at the time of crises and vulnerability, the financial realities accompanying services are often very uncertain. This puts providers in a very precarious and ambivalent position, wanting to provide a needed service but being uncertain of compensation. The provider cannot repossess services the way an automobile can be repossessed.

Insurance, being in the position of making claim decisions after the fact, is by nature in the position of accepting or denying rather than creating the reality. It is hard to manage retroactively. Granted, insurance has tried to adapt through granting extra-contractual benefits when they are of lower cost, but this still runs contrary to the fundamentals of insurance. Many managers have discovered that being the one to approve or deny decisions is not the most effective way to make things happen according to plan. Creating the vision and determining the options are much more powerful ways of creating the future than ruling on payment decisions for events that have already occurred. Quality by inspection is passé in manufacturing. The revolution in quality will not occur in health care until there is a paradigm shift from insurance to procurement.

Terms of the sale

Looking at the terms of the sale is a clear way to distinguish in practice whether the agreement is for insurance or a purchase of services agreement. Services are purchased with quantitative specifications. A procurement manager in charge of fleet services would never negotiate a fixed fee for "enough trucks to meet our needs" the way medical insurance is purchased with "medical necessity" being the principle definition for what of value is to be delivered by the contract. Whether one was buying ten trucks or a hundred would be noted in the agreement. The agreement would also have considerable detail regarding the features and performance requirements of the purchase. Purchasing is characterized by specifications, while insurance is characterized by schedules. Purchasing services for the administration of insurance services may have specifications such as for payment timeliness, but the insurance itself is described by schedules rather than specifications. If one could specify the exact amount to be paid by

the insurance, it would no longer be insurance. Insurance agreements are filled with "what if" statements and payment conditions such as copays, deductibles, out-of-pocket maximums and caps.

Defined contributions and defined benefits

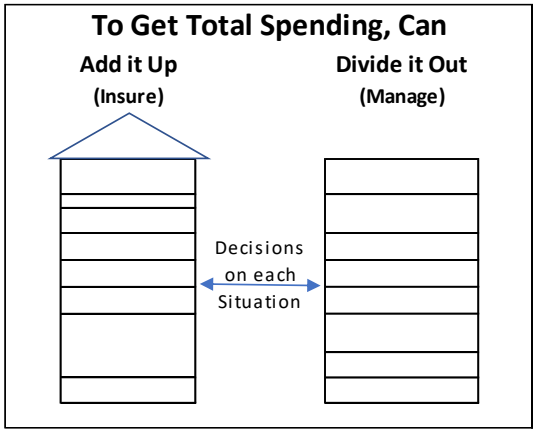
In pensions the concepts of defined contributions and defined benefits are very familiar. Under defined contributions, the employer or other contributor pays a defined amount, such as three percent of salary, toward the plan. The value of that contribution at the point of retirement is not guaranteed to the recipient and is dependent upon how it is invested and managed during the interim. A defined benefit plan focuses not on what the pension benefits cost the contributor but guarantees a specific payment or payment plan at a later date.

Since most medical services and costs are manageable and medical necessity is difficult to define in an insurance contract, a defined contribution arrangement is compatible with a managed procurement plan. The payers can contribute specific funds to the health plan responsible for services, and the plan is then responsible to manage its business within the constraints of its budget and in accordance with its goals of health for all members. The exact benefits and services or even the level of benefits is not defined.

Controlling Costs and Cash Flow

Insurance is purchased to make sure that the necessary cash flow is there should an insured event occur. The function of insurance is to make sure that matters of cost and cash flow will not be barriers to replacing the loss. The reason for buying insurance is to transfer the cost problem to someone else. *It should not be surprising that this device designed to provide immunity from cash flow constraints is then not responsive to cost considerations.*

Insurance works from an incremental basis. Each event or payment is made based upon whether the claim matches the conditions of the policy. The total cost of these accumulated decisions is what actuaries are paid to predict. Rates should be set accordingly. The system is driven from the bottom up.



Procurement or management is driven from the top down. An overall budget is determined, and the individual purchasing decisions are made within the context of objectives and budgetary status. Where insurance costs are based upon adding up each claim, managed purchasing is based on dividing up the budget into individual decisions. While total costs in insurance are predicted based upon uncontrollable but statistically predictable events, in purchasing the total costs are decided first and management then shapes decisions in relation to performance and financial goals.

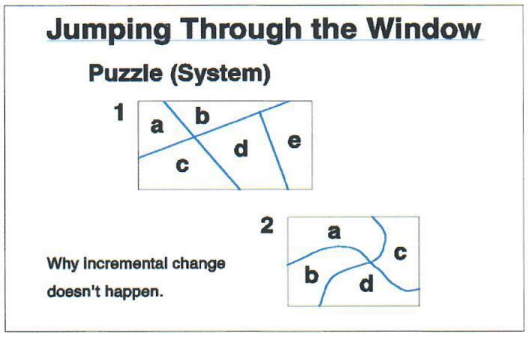
The situation is comparable to a family or a business buying things based strictly upon criteria as to what is necessary or unnecessary. Most of us have found that that can lead to cash flow problems.

Conclusions from contrasting procurement and insurance

These two packages – insurance and procurement – are so fundamentally distinct and different that efforts to blend the two inevitably results in confusion, conflict and waste. To combine insurance and procurement is like engineers working from a rear wheel drive car design wanting to add features of a

front wheel drive car. One does not do this gradually, one wheel at a time. Nor does one add the requirements of the new system to the old, unless a four-wheel drive is desired. But a four-wheel drive is considerably more complex than either a rear-wheel drive or a front-wheel drive, runs with less efficiency because of the additional complexity, and requires quite different engineering than either a rear-wheel drive or a front-wheel drive vehicle.

The purchasing of health care has added many overhead gadgets, formalities and bureaucracies. For government and corporate buyers as well as providers, the buying mechanisms are too complex, are often inappropriate and do not make for agile and efficient purchasing. Too many of our social institutions have been designed by intuition and the politics of a committee rather than the systemic thoroughness required to create something that will work. If the purchasing of health care had the systemic design going into building a manufacturing plant or the strategic thinking going into new product development, we could eliminate most of our problems in buying health care. Very complex systems result from tagging on pieces of contradictory systems, plus adding all the components necessary to bridge the contradictions. One cannot always go from system "1" to system "2" by gradually changing each of the parts. Even a small child with two jig-saw puzzles is aware that each system has its own components that fit in a certain way. The laws of homeostasis keep things going back to the old system (the original puzzle pieces). Sometimes it is necessary to "jump through the window" or simultaneously move from one system to another.



Aggregate buyers need to use a discerning ability to see through the packaging and define actual requirements. If quality is conformance to requirements, we cannot begin to talk about quality until those requirements are defined.

ENTITLEMENT AS A CONTRASTING FRAMEWORK TO INSURANCE

Definition

Insurance and entitlements are often confused because of the many similarities. What is actually an entitlement is often referred to as insurance. So we first need to provide some clarification and definition.

The premiums for an insurance policy are based on the risk to the policyholder. One can buy an individual medical insurance policy if one is approved by underwriting. If a small employer buys medical insurance for its employees, and underwriting determines the risk of medical claims individually for each employee and then assigns a premium, the employer has purchased medical insurance. However, if each employee pays the same amount for the coverage, the employees have an entitlement, not insurance. Their individual cost is not based upon their individual risk.

Anytime the cost is not directly proportional to the probability of benefits gained, we have entitlements and not insurance. Most of what is referred to as employer sponsored health insurance is an entitlement and not insurance. While the employer may have insurance to cover unusual costs for the

plan, the high risk and low risk employees usually all contribute the same amount even if their probability of claim costs are very different. One could refer to this as socialism in the private sector.

We have many entitlements that provide goods and services for daily life. Anytime one joins a club or association, one is paying a fixed fee for the right to access goods or services. Examples might be joining a health club, a country club or Costco. Almost always the fee is fixed while the availability of services is highly variable. Membership in a family is an entitlement. Children grow up in families within the economic framework of entitlements to both necessary and unnecessary goods and services.

On a larger and public scale, entitlements such as public roads are provided because it is not feasible for everyone to own their own road, and the administrative cost and complexity of having tolls for all public roads would be prohibitive. Libraries and public schools are entitlements, as is Social Security. While insurance is always to compensate for a loss, entitlements may or may not be there to cover a loss or catastrophic event.

Access to some entitlements requires a supplemental fee, such as parking at national or other parks. The fees provide cost-sharing by those who choose to use the amenity, without requiring them to bear the full cost of a subsidized service. Fees are useful in limiting over-utilization of goods and services which do not have a natural saturation of demand such as most library services and most roads. If the fees are too high an unfair situation develops where people are taxed to support a subsidy they can't afford to access. Many taxpayers resent paying taxes for entitlement amenities they would never use, such as stadiums.

Stigma attached to entitlements particularly becomes an issue when entitlements are attached to income criteria. The words welfare and even unemployment insurance often elicit moral judgments with historical roots going back to Elizabethan England and the distinctions between the deserving and undeserving poor. In writing the original Social Security Act, the Abbott sisters were influential in having the amount of services to dependent children be determined by the judgment of caseworkers, while eligibility for retirement benefits is not means or need tested. One result has been that healthy, financially comfortable people in their late sixties collect Social Security without stigma, while many children live in poverty and endure stigma with the limited payments received. Eligibility based on mechanistic, objective criteria usually carry less stigma than services determined by discretion. Feminist philosophers have written about the distinctions between needs-based and rights-based access, with needs-based being more feminine and rights-based being more macho.

Stigma also correlates with the proportion of a population accessing the entitlement. One study that found that stigma dissipated when more than twenty seven percent of a population saw themselves as potential users of the entitlement.

Mislabeling entitlements as insurance is one deceptive way of avoiding stigma and the reality of the transfer transaction. The truth is that the controversy in the debate about national health reform is not about health services as much as who should pay for the services. The issue is all about entitlements, not insurance. This comes down to the question of to what extent can and should one bear the cost of one's own health services. Most of the flashpoint is around the transfer issue. Calling the transfer insurance makes it more palatable. But dealing with the transfer issue by means of the insurance framework has created a cost-plus system with few constraints, thus accentuating the inability of individuals to finance their own services.

PROPOSED DELIVERY SYSTEM STRUCTURE

Envisioning a Different Paradigm

To move from abstractions to concrete models, it is helpful to think in terms of what systems would look like if one took the package from one industry and applied it to the services of another.

An illustration would be if educational services were delivered through an insurance package. The way this might work is that teachers and other educational specialists would set up private clinics to perform assessments and less intensive tutorial services. The cost for such services would be billed to an educational insurance policy and paid according to "educational necessity" as determined by prevailing professional standards. From the assessment centers, individuals would be referred to institutions (schools) where the same professionals had staffing privileges. Since teachers controlled access to students and funds, they would have considerable influence in shaping school policy, just like doctors influence hospital policy. Once at school, teachers and the school would each bill insurance companies separately. The itemized billing would assure accurate reimbursement, if not efficiency. If a hospital bill can list an aspirin, imagine what educational claims might look like with invoices listing each sheet of paper utilized or each teachable moment as an episode of instruction! The transactions alone could spawn a whole new industry, providing significant enhancement to the financial processing industry and related hardware and software. Changing the package from purchasing to insurance could provide for a dramatic increase in the tools and equipment necessary to eradicate ignorance; ignorance being actually more prevalent than illness. In no time at all, the average teacher's compensation could match that of physicians.

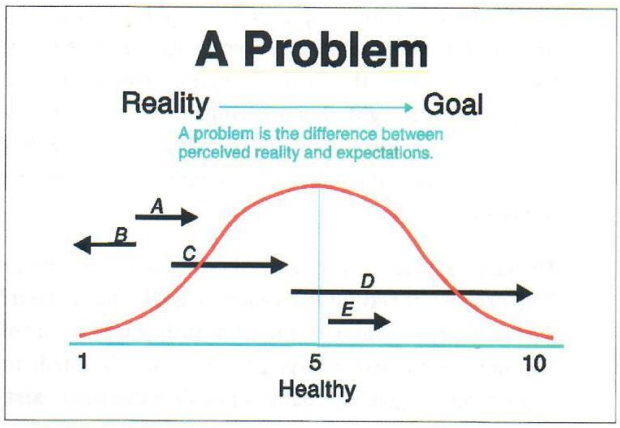
This illustration is not meant to be merely amusing or tongue in cheek. It is intended to be an example of the powerful influence exerted by the packaging paradigm. Historically we developed public schools, a system very familiar to us. Historically in the thirties the delivery of medical services encountered a cash flow problem. Blue Cross and Blue Shield were developed as insurance products to supplement funding from public bodies, sectarian organizations and consumer cash. Chaos theory states that a very small cause can have an enormous effect. One wonders how health status, health care costs and the health care industry would be different if medical care would have been developed in the same pattern as either public education or public health.

Begin with the end in mind

Steve Covey's phrase of "Begin with the end in mind" has become common parlance both for people managing organizations and in personal management of one's life and career. Restructuring of medical and health care delivery and financing must be premised upon redefining the end goal. To clarify these distinctions as they affect health care practice we need to give a conceptual background for how the goals of medical and health care practice are shaped.

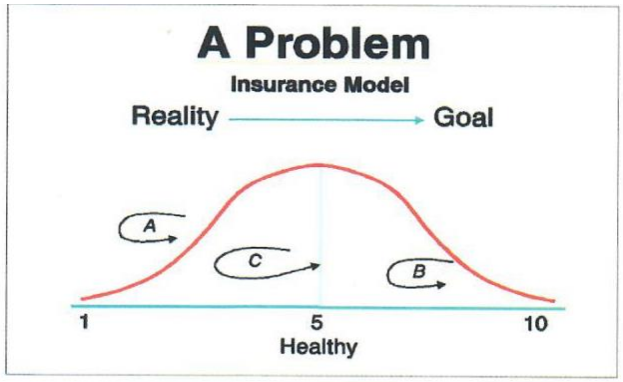
People go to a doctor or other health care provider when they have a problem. In terms of severity, people go to providers with a wide variety of problems. And people have widely differing goals and expectations about the state of health which to them seems reasonable.

If we take the generic perspective of a problem from the diagram on the next page, person "A" has a severe problem with limited expectations of things getting better. Person "B" has a terminal illness and is looking at deteriorating health. Person "C" is expecting medical services to help restore a nearly average state of health, while person "D" is probably Norman Cousins who, faced with a very serious illness, decided through a very rigorous program of humor and intensive application of attitude to work



towards a high state of health. Person "E" is healthier than average but wants to become even healthier. Actually, the person with the biggest health problem is person "D" in that the problem line is the longest.

As we have said, the function of insurance is to compensate or restore in the event of loss. For most insurance, such as property and casualty insurance or auto collision insurance for example, if there is a loss the obligation is to compensate or restore in relation to the value existing prior to the loss. If one has a $5,000 car that is completely destroyed, the insurance does not replace the value of an average car, or according to some estimate of what a professional might think is necessary. Similarly, one would think that a person such as "A" in the second diagram, who has never been very healthy, would have insurance sufficient to restore a previous state of health. Person "B" who is very healthy might have more expensive insurance to provide the guarantee for the extra level of health. Just like some people take out life insurance for $10,000 and some for $1,000,000, one might expect that medical insurance would be based upon the level of health one wanted to insure and maintain. However, most medical insurance operates like "C" in the diagram. Regardless of one's previous state of health, the level of medical services provided through insurance is oriented towards achieving an average level of health, as determined by customary medical practice.



Medical insurance has been there to pay for injury or illness. The focus is inherently more on morbidity than health. Even prevention services for healthy people are placed in this context of avoiding morbidity. What is a realistic level of health is not well defined by medical insurance practice. The usual standard is the amorphous phrase of "medical necessity." Many people concerned with health find that traditional medicine is too limited in its expectations of what health should be for people. Influenced by the nature of insurance, the goal for much of medical practice has been to bring everyone up to a state of average health, if that is possible. Shifting back to education, this is like bringing all students up to an average or "C" level. Special programs for the gifted or aspiring would not merit the investment. The many students who could pass minimum competency requirements without any education would be "discharged." Such action would be consistent with the paradigm, but not necessarily cost-effective for them or society.

The challenge for any structural redesign is to embed a positive goal orientation in the design. This process of setting and reaching goals should be inherent for each individual, an essential part of every provider-client relationship, and a part of how aggregate purchasing is done in the funding of services for large groups of people. Medicine is too focused on the illness and not enough on the goal. Actually, a problem does not exist unless one has some simultaneous cognizance of both the goal and the current condition. "How much health is a person entitled to?" becomes a critical question whenever services are to be subsidized through transfer payments.

The contract between an individual and a health plan should focus more on what health should look like and what each is willing to do to achieve that state of health than upon what specific services are covered or not covered. The contract between participant and health plan should be a mutual agreement to achieve specific goals related to health. The health risk appraisal should be turned around from what are the risks to one's health to what are the actions one can and will take to manage and improve health, as well as the benefits of that action. Similarly, aggregate payers should be buying results in terms of measurable health status.

My personal response to these incentives is to use Medicare Advantage and my medical provider for medical needs such as bicycle rash and stitches while paying cash to health providers such as my nutritionist and chiropractor. I find that doctors agree with me that physicians do a superb job at practicing medicine but a very poor job when it comes to health. Witness the diabetes epidemic.

Other key variables

In addition to balancing the focus between morbidity and health, there are several other key variables which need to be taken into account in the redesign of a health care delivery system. The creative function is to work within the framework of each of these requirements to design a structure that maximizes what is important for each variable. We have listed some of these critical variables.

1. Health goals and health risk
2. Medical versus non-medical services
3. Consumer financial capability
4. Incentives for quality
5. Incentives for efficiency
6. Administrative efficiency
7. Access, including being proactive
8. Role of employers
9. Role of government
10. Insurance versus procurement
11. Optimum size of provider and health plan organizations

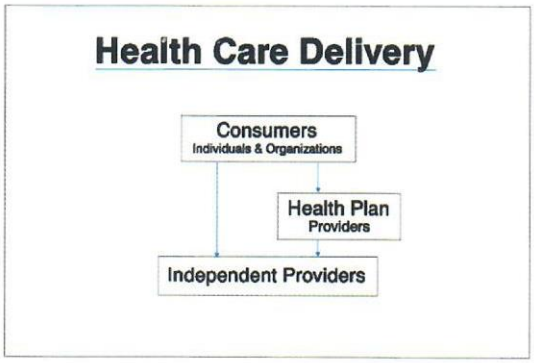
While indeed any one of these topics could provide more than enough complexity for a thesis, to say nothing of a paper such as this, we have maintained that it is critical to have a workable overall strategy or structure as to how these may fit together. Premature analysis of any one of these in isolation will not provide the basis for a workable system. We also assume that financial systems are a very critical determinant of what services are provided or not provided. Whether or not there is money involved makes a difference in what people will do or not do on a continuing basis. Systems for payment are a critical factor in any health care delivery system and are the primary focus of this analysis.

We will first present an overall structure or organizational flow chart and describe in general terms how the component organizations might fit together and function as part of a system patterned more upon the principles of procurement which we have outlined above. We will then examine in more detail some premises regarding how key principles such as access, choice, self-responsibility and quality might be incorporated into the functioning of this proposed structure. We will also want to look some at what dynamics and incentives might affect how the various organizational components of the health care delivery system work together. Any such proposal regarding fundamental changes in a large complex system necessarily leaves many unanswered questions regarding specific details and the impact upon current aspects. The considerations here focus more on the criteria and vision for an optimal system

than on the political and tactical requirements to achieve that vision. We will close by identifying only some of these remaining questions.

The primary focus of this paper is the analysis of compatibility between insurance and health care services. It is that analysis which defines the constraints for the process of assembling a design for a viable delivery system. The advocacy of this paper is that these constraints need to be accommodated in any design. The particular design suggested below is merely an example of many possible designs which could configure the essential components of a viable system.

Independent Providers and Health Plan Providers



In the structure proposed, individuals would be purchasers of health care services and products. Organizations would also purchase health care services and products, such as an employer buying occupational health services, health promotion services or safety consultation. Health care services and products would be provided either by independent providers or by large health plans.

Access to independent contractors may either be done directly, or through a purchase order from one's health plan. Examples of direct access would be if an individual went to a pharmacy and purchased non-prescription health care products, went to a psychotherapist and paid the bill, or purchased health foods from either a local grocery or specialty outlet. Nothing in this proposal precludes independent providers from selling their services and products in the marketplace, subject to normal safety and ethical regulations.

Services not paid for directly by the consumer are made available through large health plans. Everyone would belong to a vertically integrated health plan for access to normal medical services as well as managed provision for catastrophic medical services. The vertically integrated health plan encompasses physician and other medical service providers, clinics, hospitals and the financing of such services. Except for very isolated areas, everyone has a choice between at least two vertically integrated health plans. Within the plan, people have maximum discretion in choosing between providers within the plan and in shaping their own treatment plans.

Health plans may provide services directly through their own staff or may purchase services from independent providers. These independent providers may work within the health plan facilities and operations, making it not apparent to the consumer when services are provided by health plan employees and when services are provided by independent contractors. This would be a continuation of current practice of many physicians and entire departments being independent contractors within health care delivery organizations. Health plans would be free to follow economic forces in making decisions to either employee or contract for services. Presumably health plans would encourage group practices, perhaps some very large practices, as part of the health plan.

Or the health plan may make referrals and issue purchase orders for services from independent providers and the difference in identity would be more obvious to the consumer. The health plan may authorize services from a specialty psychotherapist, may send someone to a health promotion class, or may send someone to a tertiary medical facility, such as a Mayo Clinic, the Cleveland Clinic, the Leahy Clinic or a university hospital. Consumers have a right to subsidized services only as provided by or

authorized by their health plan. Providers not employed by health plans would receive purchase orders from health plans and submit invoices. Neither consumers nor independent providers would be involved with claims or claim forms. The health plan would need both aggregate and specific stop-loss coverages to insure their ability to financially provide appropriate services to their enrollees. However, such claims would probably be for losses of seven figures or more and would not be part of everyday operations. Note that it is the plan that needs to have insurance, not the consumer. The consumer is offered an entitlement, not insurance.

The purchase orders from health plans to independent providers may be for specific services or may be for specific results. For example, the health plan may purchase ten hours of service, or may issue a purchase order for all necessary services for a given individual on a flat payment basis. However, the health plan must retain responsibility and liability for the adequacy and quality of services delivered. This would limit the ability of the health plan to "transfer the risk" and thus in effect make independent providers responsible for insurance coverage. Everyone has the option of belonging to a health plan, just as everyone has an option of attending public educational facilities or using public parks. Usage fees apply, just as they often do for education and parks. However, in most areas of our economy there are becoming competitive options between for-profit and non-profit organizations, and in the non-profit sector the distinctions between governmental and non-governmental providers are becoming more diffuse as various hybrids and contracting relationships evolve. Health plans would be non-profit organizations, as are HMO's in Minnesota. They may buy multiple goods and services, including management services, from the private sector. They may or may not be government or semi-governmental organizations.

Health Plan Ownership and Governance

The health plans could be conceived of as mergers of medical clinics, health maintenance organizations, preferred provider organizations, hospitals and insurance companies. The health plans could also be compared to school districts. People have universal access. The plan has a responsibility to proactively seek out people needing services and maintain quality standards for the community, just as school districts have a responsibility to provide education for all students until their sixteenth birthday and are evaluated according to the percentage of students graduating, their test scores and job placement and college entrance records. The health plans would be large enough to absorb normal variations that individuals and populations have in their costs for medical services, just like school districts absorb the variations in costs for educating students with different and special needs. While the variations in medical costs are certainly greater than the variations in educational costs, these variations are certainly within the financial capability of large health plans when supplemented with the health plan's insurance requirements mentioned above.

One possibility to explore would be the feasibility of having a third party with statistical and health management expertise collect data or administer a health risk assessment on each individual and then assign annual compensation to the health plan for the individual's enrollment. This would mollify concerns about adverse selection. The annual revenue from that enrollee would consider the cost of projected medical services in that community and appropriate health or goal-oriented services. The cost to the individual relative to the cost from subsidized sources such as government could be determined by the individual's health practices (moral hazard), income and assets. This would introduce insurance components absent from individual costs for current benefits. (See more about this below, page 29.)

Revenue may be derived from local, state and federal sources as is the case in education. However, this may be in very different proportions than is the case for education. Citizens at the local level would

participate in governance, similar to the way they elect school board members, serve on school boards and participate as volunteers in schools and hospitals. Health plans would be non-profit, if not sometimes governmental entities. They may be managed by for-profit organizations. This is similar to the way health maintenance organizations are structured in Minnesota. However, the governance of such entities would need greater citizen involvement and public regulation than currently exists for Minnesota HMOs.

Physicians would have a clear responsibility for the quality of medical practices in such organizations. They should not have a similar responsibility or control over the management and finances of health plans. This is one place where modeling a health care delivery system upon public education breaks down. The dominant professions in both education and health care have in many ways impeded the efficient and economic overall delivery of services. Medicine is quickly moving towards an employment relationship, which appears positive. However, this should not be modeled upon education in that the labor market for teachers within education is much too rigid. Compensation is based upon status and longevity rather than productivity. Teachers do not have viable competitive options for changing employment without drastic reductions in compensation.

Health plan budgets should be determined by:

* Success in soliciting enrollees.
* Success in collecting consumer fees.
* Success in gaining support for taxation at local and state levels.
* Success in selling services to other organizations, i.e. worker comp, auto liability cases, employers.
* Other sources of revenue, such as endowments, real estate rentals, research grants, fees for training of professionals, etc.

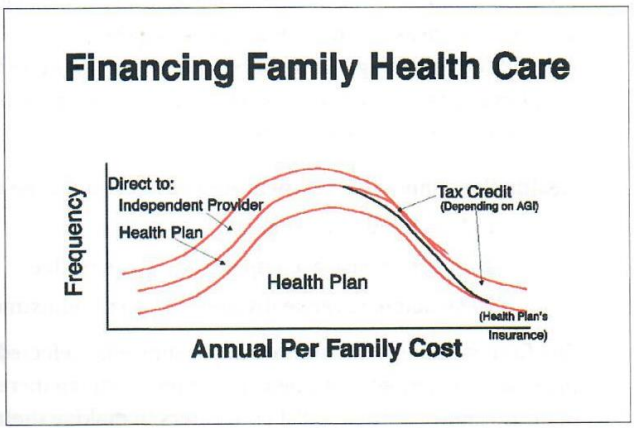
With that overview of a delivery system structure, it is time to discuss in more detail the financial relationships which might fund such a delivery system.

Consumer Fees

Everyone should pay at the point of service. This is a radical departure from the current narcissistic attitudes held by both consumers and providers that somehow medical services are so crucial and important that they are above economic considerations and contaminations. If providers are going to be financially compensated, money is a part of the equation. Money is the language used to communicate value for the exchange of goods and services. The relationship between users and providers of medical services needs to be grounded in this communication about the value of the goods and services exchanged. For every consumer to pay something for all goods and services is a means for instituting provider accountability to consumers. It provides incentives for valuing the services and taking ownership of health and health services. It limits the provision of unnecessary services and helps manage costs.

We would suggest that payment at the point of service should be from ten to twenty-five percent of the cost to actually deliver the goods or services. This fee could be adjusted by the health plan in order to provide incentives for good health practices. There should be no "deductibles" or services provided by the health plan without subsidy. Similarly, there should be no "out-of-pocket maximums" or services provided to the consumer without a fee. The consumer point of service payments should be made affordable and progressive through income tax adjustments. This would allow low income people to have access to medical services and assure medical services even in catastrophic situations where the consumers' share of the costs would exceed their financial capability. As an example of how this might

work, consider that medical fees from ten to twenty percent of one's adjusted gross income might have a tax credit equal to 50% of the fees paid. Medical fees in excess of 20% of adjusted gross income might have a tax credit of 75% of the fees paid. The exact percentages and numbers are not significant to the discussion here as we are only proposing structure. The formulas could be negotiated over time. In fact, adjusting such formulas is the kind of thing that politicians and plan designers are most capable of and love to obsess about.



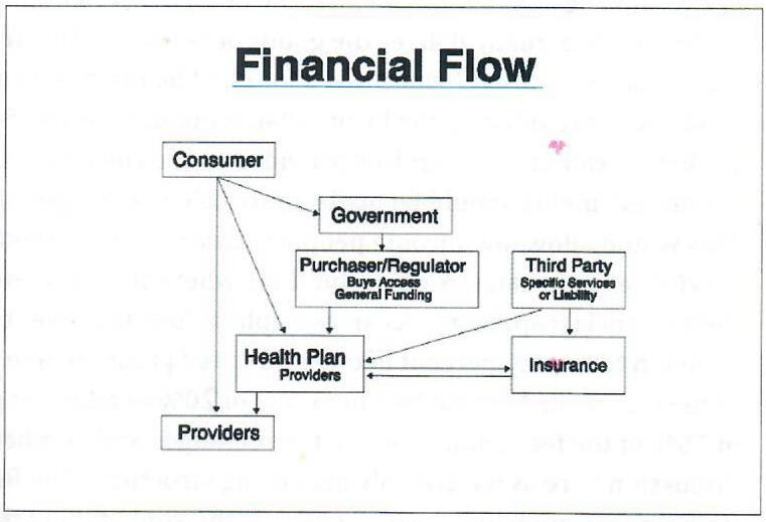
This might result in a payment profile such as shown in the diagram.

Consumer fees could be reimbursed by employers or others. That is their business. However, such reimbursements would be excluded from eligibility for tax credits.

So far we have identified independent providers and health plans, with consumers belonging to health plans. Consumers may receive services from their health plan or have services purchased on their behalf by their health plan from independent providers. They also have the option of buying services directly from independent providers. And to promote cost as a consideration of the economic implications of all health care, consumers should pay something for all health care goods and services. We are now ready to propose a way for managing and expediting that part of paying for health care goods and services beyond the individual payments at the point of sale.

Triple-Payer Plan

Rather than a single-payer or dual payer plan, we would propose a triple-payer plan. The first payer is the consumer paying a fee at the point of service. The second payer is aggregate funding sources which fund the vertically integrated health plans such as governmental or quasigovernmental agencies. The third payer is employers, associations and other organizations which would continue to buy and pay for services beyond what consumers would pay for directly and beyond the services paid for through a person's health plan.



We will discuss the second payer financing mechanisms and then turn to the third-payer financing.

Government agencies, i.e. IRS and county property tax collections, are efficient at collecting and dispersing funds. For a system of health and medical services to be universal in providing access to services and universal in sharing the cost, government agencies should be the primary conduit for collecting and dispersing revenues. A system is then needed to equitably and economically arrange the

transfer of funds from these public sources to the health plans responsible for service delivery. Health plans should be compensated based upon three variables.

1. Number of enrollees.
2. Financial risk and goals accompanying each enrollee.
3. Available revenue divided by a goals adjustment factor ($ per goal).

The first variable is the number of persons who selected to enroll with the health plan. Health plans would compete for open enrollment, with an increasing amount of independent sources of performance data to assist consumers in making their selection of health plans.

The likely cost of providing services to different individuals can be highly variable. In the past, this has resulted in recruiting healthy or low risk individuals while discouraging sick or high risk individuals from joining. This has the paradoxical effect of health care providers making the most profit by targeting their services not to people whom they can best serve, but to the people who least need their services. This is a natural consequence of their primary product being coverage rather than services. Alternatives for coping with adverse selection have been to negotiate risk adjusted rates with either individuals or aggregate purchasers.

Financial risk factors attributable to each enrollee would compensate for adverse selection. The financial risk factor could be based on each enrollee's medical history, demographic variables or health risk appraisal. This risk factor determination would not determine whether or not a person would be accepted into the plan, but rather the rate at which the plan would be compensated for that enrollee. The plan is responsible for either providing or purchasing all necessary services. This definition of necessary services and the means for measuring conformance to those standards would be negotiated with the funding sources.

The third variable in compensation would be an adjustment factor. The revenue/goals adjustment factor would proportionately adjust the enrollees' risk to the goals desired and the revenues available. The adjustment factor would also be used to determine aggregate funding levels for alternative plans within the same geographic regions. The adjustment factor could also take into account incentives for quality and exceptional services.

To give an example, a health plan has 400,000 enrollees in a geographic area centered in a metropolitan area and covering parts of three states. Enrollees from each state might have a different adjustment factor based upon citizen group decisions in each state as to the tax rate they were willing to accept in order to pay for medical services. If the adjustment factor were too low, the health plan could choose to not provide services in a specific market, or contract to provide a lower level of services for some enrollees. This might mean a farther distance to a facility or older facilities. All enrollees in the same geographic area selecting the same health plan would have access to a comparable quality and level of services. Health plans serving a specific geographic area would be compensated with the same adjustment factor, meaning that variations between plans would be based only upon variances in enrollment and in risk factors.

Health plans would not be compensated based upon a Resource Based Relative Value Scale (RBRVS) as this is basically a cost-plus system. What matters is the value of services delivered, not the cost to generate the service.

Currently health plans must compete at the individual and group levels. Health plans now sell their coverage or services directly to individuals and families. Health plans also compete for group plans to be made available by an employer, association or government program. Once a plan is offered by the

employer or group, the health plan then must usually compete for individual enrollees in that many groups offer limited options between alternative health plans. Under this proposal all health plans providing services to a given geographic area would be funded by, negotiate with and be regulated by a single entity for that geographic entity. We will call that entity a health district, comparable to a school district or a park district. In order to make some level of access to services universal, and in order to insure efficiency of administration and some consistently high quality in negotiating specifications for health care services (rather than administrative services), this district for each geographic region would be the negotiator with health plans for the funding of services to people enrolled in their plans.

Government entities would collect revenues. This might be some combination of federal, state and local levels. This would parallel the way school and park districts have their revenues collected by county mill levies and state and federal income taxes. This would be the function of the government box in the diagram of financial flow. These funding sources would then be managed by the health district to purchase services from the health plans. This funding of health plans would be based upon budgets constructed from formulas taking into account the factors enumerated above of enrollment, health risk and variances which balance the goals desired and the revenues available. This entity would not be comparable at all with traditional insurance companies which approve, negotiate and make payment for specific itemized services or claims. Such health districts would be comparable to a school district which instead of being a provider of educational services contracted with private organizations for the delivery of educational services.

Note that this is government subsidized health services with market-based private delivery systems. It could be seen as an extension of Medicare Advantage. It would not be a system of government price controls and rationing as is traditional Medicare.

We have briefly discussed consumers as the first payer and health districts as the second payer. The third payers would be employers, associations and other organizations. For our purposes, we can classify these third parties into those having synergies in integrating health care delivery with services they provide, and those having liability reasons for financing health care.

An example of synergistic health care delivery is the eight thousand nurses providing health care based from religious congregations across the United States. Some of these are funded by the local congregations, some work as volunteers, some are funded by related non-profit organizations (Lutheran Social Services, Catholic Charities), some are funded by local hospitals and most are at least partially funded by government grants (Andrews).

Another example is health care provided through schools and family multi-service and social service centers attached to or affiliated with schools. There are strong reorganizational efforts taking place to link education, health care and social service delivery systems. One example is John C. Lincoln Hospital & Health Center in Phoenix which funded a full-time nurse practitioner (my brother) to provide diagnoses, medications and health care services to children in five different schools. (Sexton). Consortiums in Minnesota are moving towards radically restructuring the linkages between educational, health care and social service organizations.

A third example might be an employer buying occupational health services from either a health plan or an independent provider.

In all of these relationships, the funds could flow to or from the health plan and the actual services could be delivered at health plan facilities, at the third-payers' facilities, or at another location. In general, the

third-payer would not be paying for the full cost of such services, but would be rather paying for a value-added in order to make services more accessible and synergistic with their program goals.

While some third-payer funding of health plans would be for purposes of service-delivery synergy, other funding would be for reasons of liability. When the cause of increased medical costs lies clearly with other organizations, a portion of that cost should be compensated by such third parties. As examples, automobile insurance liability and worker's compensation should pay a portion of the costs attributable to such causes. Such relationships are currently very complex. This complexity has evolved from long and often local, legal and labor histories. The premise of this paper is that these histories and the concept of liability should not be the driving forces in shaping health care delivery systems and financing. What is needed is a comprehensive design and structure adapted to achieving health at minimal costs. From that base, accommodation can be made to requisite changes in systems of medical liability. We would foresee a system with decreasing involvement of liability factors. However, there would still be a need for insurance to cover worker's compensation and automobile accidents, even if the liability would be dramatically reduced.

The health plan has primary financial responsibility for the health care services of all enrollees. When the cause of medical costs is clearly a result of negligence, we would see the health plan being compensated for a portion of that cost (perhaps fifty to seventy-five percent). In effect, the health plan assumes responsibility for individual variability in medical costs. Where someone works is only one of the factors in that variability. The health plan thus has financial incentives to work aggressively with employers in safety programs. The health plan has an incentive to work with schools and other organizations to minimize auto accidents. Health plans might have a very active lobby regarding legislating safety standards. Health plan involvement with product safety could take on new dimensions, probably through an association of health plans.

The same principles that apply to individuals regarding health risk, responsibility for health and payment for health services should apply to organizations as well. Most of the variable costs in health care utilization are borne through a public financing mechanism. Individuals and organizations wanting or needing services pay a percentage of the cost when such services are congruent with the goals and responsibilities of the health plan. When they are not, the individuals and organizations are free to purchase services from independent providers.

CONCLUSIONS AND REMAINING QUESTIONS

Even after this extensive analysis, there are many questions which have not been addressed at all, and many other questions which have not been adequately addressed. Any significant change will produce as many questions as it resolves. We list some of these issues here to lay an agenda for fact finding, debate and further refinement.

Are preventive services, diagnostic testing and lack of a consumer fees cost-effective in lowering overall medical costs?

A reexamination of the proposal to require a point-of-sale fee for all services would be appropriate if there is solid evidence that the total cost of medical services is reduced by not having consumers pay any fee whatsoever for certain services.

How should resources be balanced between cure and care?

Curative services requiring highly technical medical equipment and services have generally had a higher priority and access to funding than ongoing services for people with chronic conditions who are not

amenable to a cure. Policies and appropriate incentives need to be designed to balance curative services and appropriate ongoing health care for chronic conditions requiring special services. This allocation between cure and care should not be made according to the political clout of departments or physicians within the health plan as was the case with many Health Maintenance Organizations (HMO's).

Many of the special services required by people with chronic conditions are educational, custodial or social services rather than medical services. Mechanisms need to be designed to provide for the funding of a comprehensive and balanced array of services. Structuring many of these educational, custodial or social services through medical delivery systems is often inordinately expensive and inflexible. These services need a financing system comparable to and integrated with the system which purchases medical services.

How should the economies of scale be balanced against the flexibility and innovativeness of small organizations?

Sometimes the large comprehensive health plans can deliver services more economically than the small solo practice or small group practice. However, sometimes just the reverse is true. One would hope that in such situations the health plans would purchase services from the independent providers.

What is the fallout from the disintermediation of stand-alone insurance companies and third-party administrators (TPA's)?

Insurance companies are becoming health care providers. Health plans are acquiring financial administration capabilities. Much of what is proposed here is already well on its way to happening in many places. We may take the implications of this trend a little farther than has already occurred. The main intended contribution of this paper is to provide a conceptual framework for analyzing trends which are taking place and for framing future developments.

Should universal access be limited to catastrophic and essential medical care?

From one perspective, one might ask why there should be universal access to medical services when we don't have universal access to other essential services such as food, housing, transportation or communications (telephone). In line with the philosophy, one could limit universal access to medical services only to the extent that such services are life-critical. While this limits the public transfer of financial responsibility for services, it also produces a system which requires the progression of problems to advanced stages before treatment would be available. Having money for only advanced medical problems encourages a dual delivery system, one for health and another for cure. This is contrary to good public policy regarding the economical achievement of health. Universal access should be available, but with everyone paying some portion of the costs for all services.

Should health plans have the option of selling coverage more comprehensive than the level funded at the universal level?

Under such a scenario, individuals might have a withholding from their wages to pay for their plan, pay a point-of-service fee, and also pay a regular fee to the plan of their choice. This would be similar to consumers today having a Medicare withholding, having copayments, and paying health care premiums. The difficulty in having additional fees comparable to current premiums is that it creates complex systems for distinguishing what each person is entitled to and from whom. Supplemental plans such as for Medicare undermine the plan goals to encourage prudent purchasing through consumer participation.

How can we achieve integrated delivery between components essential for health, such as:

Safe water and sanitation systems
Public health
Health education, health promotion, health clubs
Occupational health
Health as well-being; social services
Psychological services, psychotherapy, counseling
Dental services
Routine medical services (<$1,000/year)
Episodic medical services
Tertiary treatment
Chronic care

How can we end the incentives for the medicalization of almost everything, especially counseling and social services?

The current system of Medicaid revenue sharing provides strong incentives for non-medical counseling services to be medicalized in order to qualify for federal reimbursement. We will not really begin to deal with the problems of medical costs, access and quality until we develop adequate systems for providing important social and educational services. While paying for social services through medical insurance may curtail service volumes and therefore costs, it is far less efficient in terms of meeting human needs. It implements a whole different conceptual system for social workers based on medical diagnosis rather than person-environment fit.

SUMMARY

Most health care services do not fit the prerequisites of an insurable risk. Because of the incongruities between health care services and insurance as a mechanism of financing, health care services should be purchased rather than insured. This would allow for a goal-oriented approach towards equitably and efficiently maximizing health status.

Comprehensive health plans should provide universal access to subsidized health care services. Independent providers would sell their services to health plans, and on an unsubsidized basis, directly to consumers. Health plans would be financed by a combination of consumer fees, tax revenues and a minimal amount by third-party organizations wanting special services or making partial payments for liabilities they incurred. Health districts would be the principal aggregate purchasers for health care services. In addition, a point-of-service fee would be paid by consumers which would vary between ten and twenty-five percent of the actual cost for products and services. This fee should be made progressive through provision of income tax credits.

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