

## Health Insurance Fallacy

From a health system's perspective, the Nation's preoccupation with health insurance coverage and payment mechanisms perplexes me. The current debate regarding whether we should expand health savings accounts or advance a single payer system is especially enigmatic. Both concepts have potential merit; both have consequences, positive and negative. My confusion centers on how we largely discuss these concepts as competing total system reform solutions in a vacuum. The discussion is usually absent any clear definition of the exact changes (except broad platitudes such as increased personal responsibility and universal coverage) we want to accomplish and the consequences we are willing to accept.

Of course, the whole concept of health insurance - as currently constituted - makes little sense to me. I understand home, building, liability, workers' compensation, and auto insurance. Everybody insured throws a few dollars into the risk pot so if one of us suffers an expensive and unfortunate event we also do not suffer a financial catastrophe. Since we all want to limit how much we have to throw into the pot, we have an incentive to try to limit the number of these events. I can also accept (and support) the concept of universal *catastrophic* health insurance; such insurance would be consistent with the concept of these other insurances.

I also believe that as a compassionate society we should assure individuals have access to basic preventive and primary care consistent with a fair determination of their ability to pay for such care. However, I have no understanding of why we choose to employ an insurance mechanism (private, government, single, or multiple payers) to pay for these relatively high

volume, low per unit cost services for the majority of Americans. Most of us could receive these services with little hassle and pay for them with a health (or regular) debit or credit card for a few pennies in administrative fees. We also would have an incentive to be prudent purchasers, i.e., get our money's worth, as well as take care of ourselves to limit how much we have to spend.

Instead, we elect to hand our money over to the government or a third party to purchase these predictable, high volume, low per unit cost services for us. We then end up hassling with the people to whom we gave the money regarding whether we in fact need the service, what service is most appropriate for us, where we can and cannot get the service, how much of the cost of the service for which they will pay, etc. The practitioner, vendor, or institution from which we elect to get the service also hassles with the insurer. The insurer also enacts various roadblocks, e.g., deductibles, co-payments, so that we do not over consume these services; we also hassle over these.

Meanwhile, this hassling means those buying these services on our behalf need to hire many people, as do those who are seeking payment for the services provided to us. Large bureaucracies and companies are required headed by high paid executives. In the private sector, these companies also demand a return for their investors. In many instances, those of us insured end up settling for whatever those to whom we gave our money will pay for, not what we need or want. The percentage rate of financial administrative and human emotional costs of this process is enormous and obscene per unit of service delivered. Unless we address this issue, I am not convinced a single payer system will contribute much in the way of savings.

It could also reduce options and further frustrate health care consumers.

Whenever I think about the absurdity of using an insurance mechanism to assure the provision of high volume, low per unit cost health services, I recall my favorite line from the movie "Cold Mountain". Ruby comments upon the cloud created over the land by exclaiming: "But they made the weather and then they stand in the rain and say 'S\_\_\_ it's raining.'"

The rationales offered are many and varied. Some believe average people on their own are too ignorant – and/ or incapable of being trusted - to purchase these low per unit cost health services they or their family need. They are afraid people will spend their money for recreation or other items that some believe should be lower priority. Many practitioners, vendors, and institutions believe the same thing; they are afraid absent first dollar insurance for low per unit cost services they will not receive payment. Some fear exploitation and gouging of individuals unless they are part of a large purchasing plan that can negotiate favorable per unit costs on their behalf. Others believe health plans are often better able to determine what an individual needs than the individual and his or her physician. Some people believe that when they purchase such services (directly or indirectly by an employer) through a third party they are "free", whereas they would otherwise have to pay for them. There is some truth and some fallacy in most of these justifications. Moreover, the merits of the justification for some rests in one's individual political persuasions regarding personal autonomy and responsibility, i.e., whether they believe someone else can better determine what they need and get. Furthermore, one can satisfactorily address some of the concerns, e.g., price gouging, by mechanisms other than insurance.

Some of us elect to purchase a maintenance or insurance policy on high priced household items, e.g., lawn tractor, central air conditioner. We weigh the cost of the insurance against the cost of replacement and the probability the item will need repair or replacement within a specific time. Few of us can – or elect to – insure our linens, towels, trashcans, hand mixer, toaster, blender, throw rugs, and other relatively low cost items. It is predictable that over time we will need or want to replace most of these items. Few of us could imagine hassling with the insurance company about whether our sheets or towels really need replacement, the allowable thread count of replacements, the participating or preferred purchase centers we can use, etc. The paper work and related costs of operating such a household maintenance system would be enormous and obscene per predictable replacement item or maintenance service. Yet, within the health care arena, rather than only elect to insure high priced items - weighing the probability and other factors noted - we insure everything, accepting the hassle and obscene per unit costs. Moreover, our incentive to maintain our sheets and other items decreases as long as they are covered.

Obviously as a compassionate society, we will need to assist the poor and unfortunate pay for even the most basic services. There are many ways to do this in addition to insurance and some of these other approaches may be more effective and efficient. Moreover, we need to address this issue separately from that of providing first dollar coverage for those of limited income who choose – or would prefer - to spend their disposable income on cigarettes, recreation, or other non-essential items in lieu of health care. Some argue that removing this choice from such

individuals, and placing it on society as a whole, is sound public policy. They contend society will avoid greater costs by assuring people receive timely, necessary primary and preventive services thus obviating the cost of providing more costly curative services at some point in the future. There is some merit in this contention but much fallacy since receipt of such services involves far more than financial access. Moreover, removing personal responsibility in this regards decreases the incentive for the individual to maintain their health and purchase services prudently.

At the opposite end of the spectrum is the issue of terminal or end of life care – as well as the provision of certain high cost procedures - that consume a huge amount of health care resources with a very low probability of maintaining or improving the functional quality of life. As in the Schiavo case, many insist that ethically the individual and family must exclusively make decisions in such cases. I agree. However, some contend that to maintain the integrity of society (and the concept of human dignity) all such decisions be made in an atmosphere devoid of economic consideration, i.e., the individual's or family's ability or responsibility to pay for such care.

If this means an individual or family insists upon the provision of futile care, society as a whole must foot the bill to provide such. They would argue that this is somewhat analogous to releasing a guilty felon on a technicality or because the burden of proof (e.g., beyond a reasonable doubt) was not met. This is even though the felon is likely to prey on an innocent victim in the future. They argue that the principle of protecting the personal liberty of citizens is so sacrosanct, that the cost of occasional releasing such a thug is worth it in terms of maintaining societal

integrity. They would argue that maintaining societal integrity also requires society, if necessary, to pay for all futile care an individual or his or her family would demand.

I disagree with the corollary for several reasons. First, society does execute individuals and remove their personal freedoms for the rest of their lives when a body of their peers meets the burden of proof. Thus, society does have a mechanism to protect the collective well-being of society in such cases. There is no reason society should not exercise a similar high burden mechanism to protect the collective good when it is being asked to assume carte blanche responsibility to pay for futile care.

Second, and somewhat related, is an equity concern. Society does not pay for all care and procedures, futile or not. In fact, currently it pays universally for certain care and procedures, e.g., kidney dialysis, even in futile situations but not for other care and procedures, even if they have a high probability of maintaining or restoring the functional quality of an individual's life. There are many examples but heart, liver and bone marrow transplants are a few common high cost ones. Why do these individuals and their families have to weigh economic considerations while those with other, often futile, conditions do not?

Third, again related, as long as the total amount of resources dedicated to health care are limited and finite - and society elects to pay for futile care as a priority - someone else fails to receive the best available care. It could be a child asthmatic or diabetic, perhaps the grandson or granddaughter of the individual to whom society provides futile care as a priority. I often ponder if most such recipients were alert and competent whether they would elect to receive such futile care in lieu of

providing the highest quality care to their grandchild. Society makes such decisions everyday. It just does so indirectly, insidiously and haphazardly.

Finally, there is no limit to demand if one accepts the corollary. What is futile? There is always a story of an individual who emerged from a coma after 20 years. At times, society errs. It executes or withdraws the personal liberties of an innocent person. The same will occur on occasion if it denies payment in certain instances for futile care. A cryo-crypt preserves the remains of Baseball legend Ted Williams. He is unconvinced his condition is futile and believes that some day a cure will allow him to regain a meaningful functional quality of life. Does this mean society should pay for cryo-crypts for all whom believe likewise?

I am not convinced that a single payer system – or any health insurance reform per se – will address the issue of futile care. If it does not, but still adds millions of individuals to insured status guaranteeing their access to futile care, the current crisis will accelerate.

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