Understanding Health Policy

A Clinical Approach

Thomas S. Bodenheimer
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a LANGE medical book

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first edition

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Understanding Health Policy

Preface

Understanding Health Policy: A Clinical Approach is a book about health policy, but it is also about individual patients and care givers and how they interact with each other and with the overall health care system.

We, the authors, are practicing primary care physicians, one in a public hospital and clinic and the other in a private practice. We are also analysts of our nation's health care system. In one sense, these two sides of our lives seem quite separate. When treating a patient's illness, health expenditures as a percentage of gross domestic product or variations in surgical rates between one city and another seem remote, if not irrelevant. But they are neither remote nor irrelevant. Health policy affects the patients we see on a daily basis. Managed care referral patterns determine to which specialist we can send a patient, the absence of outpatient medications in the Medicare benefit package affects how we prescribe medications for our elderly patients, and the failure of our nation to legislate universal health insurance influences which patients end up seeing one of us (in the private sector) and which the other (in a public setting). In *Understanding Health Policy*, we hope to bridge the gap separating the microworld of individual patient visits and the macrouniverse of health policy.

The Audience The book is primarily written for medical students, physicians in training, and practicing physicians, who we feel will benefit from understanding the complex environment in which they work or will work. Because of this choice of audience, physicians feature prominently in the text. In the actual world of clinical medicine, patients' encounters with nurses, physician assistants, nurse practitioners, and other health care givers are an essential part of their health care experience. Physicians would be unable to function without the many other members of the health care team. Patients seldom appreciate the contributions to their well-being made by public health personnel, research scientists, educators, and many other health-related professionals. We hope that the many nonphysician members of the clinical care, public health, and health science education teams, and students aspiring to join these teams, will find the book useful. While the book focuses on physicians, we understand that nothing can be accomplished without the combined efforts of everyone working in the health care field.

The people for whom we are writing *Understanding Health Policy* influence some of the words we use. One specific issue of terminology involves the commonly used expressions medical care and health care. In one usage, medical care refers to clinical and therapeutic measures that health professionals and medical systems provide for people who are sick or worried about being sick (Susser, 1993; Sidel and Sidel, 1983). According to this usage, health care is a larger category than medical care and involves all influences on the health of a population, including medical care, public health measures, and broad social policies that improve overall social well-being (Sidel, 1994; Terris, 1986).

Many physicians and nonphysicians caring for patients, however, see themselves as health, rather than medical, care givers—as members of a health care team. They tend to use the terms health care and medical care interchangeably. We have chosen this second approach, and use both terms to refer to preventive, diagnostic, and therapeutic measures that health care givers and medical systems provide for people who wish to remain healthy, who are sick, or who are worried that they are sick.

The Goal of the Book *Understanding Health Policy* attempts to explain how the health care system works. We focus on basic principles of health policy in hopes that the reader will come away with a clearer, more systematic way of thinking about health care in the United States, its

problems, and the alternatives for managing these problems. Most of these principles also apply to understanding health care systems in other nations.

Given the public's concerns about health care in the United States (see Chapter 1), the book concentrates on the failures of the system. We spend less time on the successful features because they need less attention. Only by recognizing the difficulties of the system can we begin to fix its problems. The goal of this book, then, is to help all of us understand the health care system, so that we can better work in the system, use the system, and change what needs to be changed.

Clinical Vignettes In our attempt to unify the overlapping spheres of health policy and health care encounters by individuals, we use clinical vignettes as a central feature of the book. These short descriptions of patients, physicians, and other care givers interacting with the health care system are based on our own experiences as physicians, experiences of colleagues, or cases reported in the medical literature or popular press. Most of the people and institutions presented in the vignettes have been given fictitious names to protect privacy. In three cases that have received widespread publicity, the actual names are retained: Brent McRae and John McGann in Chapter 3 and the Lakeberg twins in Chapter 12. Some names used are emblematic of the occupations, health problems, or attitudes portrayed in the vignettes; most do not have special significance.

Our Opinions In exploring the many controversial issues of health policy, our own opinions as authors inevitably color and shade the words we use and the conclusions we reach. We present several of our most fundamental values and perspectives here.

The Right to Health Care: We believe that health care should be a right enjoyed equally by everyone. Certain things in life are considered essential. No one gets excited if someone is turned away from a movie or a concert because she or he cannot afford a ticket. But sick people who are turned away from an emergency room can make headlines, and rightly so. Health care is viewed by most people in developed nations as a human right. This right is difficult to translate into reality; it requires the establishment of a network of health care institutions accessible to everyone and a method of financing those institutions that allows everyone to obtain needed services without regard for ability to pay. The right to health care means universal access to health care.

Naturally, this right has limits (see Chapter 12). Were everyone to receive yearly total-body magnetic resonance imaging (MRI) scans, health care costs would go through the roof. A widely accepted formulation of the right to health care reads something like this: The right to health care means that society has a duty to allocate an adequate share of its total resources to health-related needs, and that each person is entitled to a fair share of such resources as determined by medical need rather than by income, political power, or social status (Fein, 1986; Daniels, 1979). A simpler statement would be as follows: All people should have equal access to a reasonable level of health services, regardless of ability to pay.

The Imperative to Contain Costs: We believe that limits must be placed on the costs of health care. Cost controls can be imposed in a manner that does relatively little harm to the health of the public.

The rapidly rising costs of health care are in part created by scientific advances that spawn new, expensive technologies. Some of these technologies truly improve health care, some are of little value, and others are of benefit to some patients but are also inappropriately used for patients whom they do not benefit. Eliminating medical services that produce no benefit is one path to "painless" cost control (see Chapter 7).

Reduction in the rapidly rising cost of administering the health care system is another route to painless cost containment. Administrative excess wastes money that could be spent for useful purposes, either within or outside the health care sector. While large bureaucracies do have the advantage of creating jobs, the nation and the health care system have a great need for more socially rewarding and productive jobs (eg, home health aides, drug rehabilitation counselors, childcare workers, and many more) that could be financed from funds currently used for needless administrative tasks.

There is a growing consensus that health care cost increases are bad for the economy. Employers complain that the high cost of health insurance for employees reduces international competitiveness. If government health expenditures continue their rapid rise, other publicly financed programs essential to the nation's economy (eg, education and transportation) will be curtailed because government budgets are limited by the public's willingness to pay taxes.

Rising costs are harmful to everyone because they make health services and health insurance unaffordable. For example, the health care expenses of companies that provide health insurance to their employees increased by about 20% per year in 1988 and 1989. As a result, many companies are shifting more of these costs onto employees. As government health budgets balloon, cutbacks are inevitable, generally hurting the elderly and the poor. Individuals with no health insurance or inadequate coverage have a far harder time paying for care as costs go up. As a general rule, when costs go up, access goes down.

For these reasons, we believe that health care costs should be contained, using strategies that are as painless as possible (ie, that do the least harm to the health of the population).

The Need for Population-Based Medicine: Most physicians, nurses, and other health professionals are trained to provide clinical care to individuals. Yet clinical care is not the only determinant of health status; standard of living and public health measures may have an even greater influence on the health of a population (see Chapter 3). Health care, then, should have another dimension: concern for the population as a whole. Individual physicians may be first rate in caring for their patients' heart attacks, but may not worry enough about the prevalence of hypertension, smoking, elevated cholesterol levels, uncontrolled diabetes, and lack of exercise in their city, in their neighborhood, or among the group of patients enrolled in their practices. For years, clinical medicine has divorced itself from the public health community, which does concern itself with the health of the population.

Currently, health maintenance organizations (HMOs) see themselves as responsible for their enrollees who seek health care; an expanded orientation would broaden that responsibility to the provision of comprehensive preventive health care services to the entire population enrolled in that HMO. We believe that health care givers should be trained to add a population orientation to their current role of caring for individuals.

Acknowledgments We could not have written this book by ourselves. The circumstances encountered by hundreds of our patients provided the insights we needed to understand and describe the health care system. Moreover, numerous health care professionals and academics read parts of our manuscript, made wise and helpful suggestions, and encouraged us to proceed. Any inaccuracies in the book are entirely our own responsibility.

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Conclusion This is a book about health policy. As such, we will cite technical studies and will make cross-national generalizations. We will take matters of profound personal meaning—sickness, health, providing of care to individuals in need—and discuss them using the detached language of "inputs and outcomes," "providers and consumers," and "cost-effectiveness analysis." As practicing physicians, however, we are daily reminded of the human realities of health policy. *Understanding Health Policy: A Clinical Approach* is fundamentally about the people we care for: the uninsured janitor enduring the pain of a gallbladder attack because surgery might leave him in financial ruin; or the retired university professor who sustains a stroke and whose life's savings are disappearing in nursing home bills uncovered by her Medicare or private insurance plans.

Almost every person, whether a mother on public assistance, a working father, a well-to-do physician, or a millionaire insurance executive, will someday become ill, and all of us will die. Everyone stands to benefit from a system in which health care for all people is accessible, affordable, appropriate in its use of resources, and of high quality.

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Introduction: The Paradox of Excess & Deprivation

1

Louise Brown was an accountant with a 25-year history of diabetes. Her physician taught her to monitor her glucose at home, and her nutritionist helped her follow a diabetic diet. Her diabetes was brought under good control. Diabetic retinopathy was discovered at yearly eye examinations, and periodic laser treatments to her retina prevented loss of vision. Ms. Brown lived to the age of 83, a success of the United States health care system.

Angela Martini grew up in an inner-city housing project, never had a chance for a good education, became pregnant as a teenager, and has been on public assistance while caring for her four children. Her Medicaid card allows her to see her family physician for yearly physical examinations. A breast examination located a suspicious lesion, which was found to be cancer on biopsy. She was referred to a surgical breast specialist, underwent a mastectomy, was treated with tamoxifen, and has been healthy for the past 15 years.

For people with private or public insurance who have access to health care services, the melding of high-quality primary and preventive care with appropriate specialty treatment can produce the best medical care in the world.

The United States is blessed with thousands of well-trained physicians, nurses, pharmacists, and other health care givers who compassionately provide up-to-date medical attention to patients who seek their assistance. This is the face of the health care system in which we can take pride. Success stories, however, are only part of the reality of health care in the United States.

Excess & Deprivation The health care system in the United States has been called "a paradox of excess and deprivation" (Enthoven and Kronick, 1989). Some persons receive too little care because they are uninsured, inadequately insured, or have Medicaid coverage that many physicians will not accept.

James Jackson's Medicaid benefits were terminated because of state cutbacks. At age 34 years he developed abdominal pain but did not seek care for 10 days because he had no insurance and feared the cost of treatment. He began to vomit, became weak, and was finally taken to an emergency room by his cousin. The physician diagnosed a perforated ulcer with peritonitis and septic shock. The illness had gone on too long; Mr. Jackson died on the operating table. Had he received prompt medical attention, his illness would likely have been cured.

Betty Yee was a 68-year-old woman with angina, high blood pressure, and diabetes. Her total bill for medications, which were not covered under her Medicare plan, came to $140 per month. She

was unable to afford the medications, her blood pressure went out of control, and she suffered a stroke. Ms. Yee's final lonely years were spent in a nursing home; she was paralyzed on her right side and unable to speak.

Mary McCarthy became pregnant but could not find an obstetrician who would accept her Medicaid card. After 7 months, she began to experience severe headaches, went to the emergency room, and was found to have hypertension and preeclampsia. She delivered a stillborn baby.

Some people receive too much care that is costly and may be harmful.

At age 63, Daniel Taylor noticed that he was getting up to urinate twice each night. It did not bother him much. His family physician sent him to a urologist, who found that his prostate was enlarged (though with no signs of cancer) and recommended surgery. Mr. Taylor did not want surgery. He had a friend with the same symptoms whose urologist had said that surgery was not needed. Since Mr. Taylor never questioned doctors, he went ahead with the procedure anyway. After the surgery he became incontinent of urine.

Consuelo Gonzalez had a minor pain in her back, which was completely relieved by over-the-counter acetaminophen. She went to the doctor just to make sure the pain was nothing serious, and it was not. The physician gave Ms. Gonzalez a stronger medicine, indomethacin, 3 times a day. The indomethacin caused a bleeding ulcer, requiring a 9-day hospital stay at a cost of $17,000 to her health insurer.

Too Little Care: Between 35 and 40 million people in the United States have no health insurance (Friedman, 1991). Many are victims of the changing economy, which has shifted from a manufacturing economy based on highly paid, fulltime jobs with good fringe benefits toward a service economy with lower paid jobs that are often parttime and have poor or no benefits (Renner and Navarro, 1989). In 1987, 77% of the uninsured were in families with an employed adult. Lack of insurance is not simply a problem of the poor but has also become a middle-class phenomenon, particularly for families of people who are self-employed or work in small establishments.

Underinsurance is also a major issue. The elderly pay over 50% of their medical bills out of pocket (Rice and Gabel, 1986). In 1984, 26% of the privately insured population under age 65 had health insurance coverage so inadequate that a major illness would create severe financial hardship (Farley, 1985).

Too Much Care: In contrast to the deprivation created by absent or inadequate health insurance, the health care sector is beset by two varieties of excess: administrative and medical. Administrative costs are rising more rapidly than the costs of the medical care being administered. In the words of Steffie Woolhandler and David Himmelstein (1991):

> Medicine is increasingly a spectator sport. Doctors, patients, and nurses perform before an enlarging audience of utilization reviewers, efficiency experts, and cost managers. A cynic viewing the uninflected curve of rising health care spending might wonder whether the cost-containment experts cost more than they contain... (Excerpted from information appearing in the New England Journal of Medicine: Woolhandler S, Himmelstein DU: The deteriorating administrative efficiency of the US health care system. N Engl J Med 1991;324:1253.)

The price tag for administrative costs in the United States comes to an extraordinary 19–24% of the total dollars spent on health care. The United States General Accounting Office (1991) estimated that $67 billion of administrative spending in 1991 was unnecessary.

The quantity of medical excess may be even larger. According to health services expert Robert Brook (1989):

> . . . almost every study that has seriously looked for overuse has discovered it, and virtually every time at least double-digit overuse has been found. If one could extrapolate from the available literature, then perhaps one-fourth of hospital days, one-fourth of procedures, and two-fifths of medications could be done without. (Copyright 1989 American Medical Association: Brook RH: Practice guidelines and practicing medicine. JAMA 1989;262:3027.)

Careful research has documented examples of inappropriate and potentially harmful care:

(1) In 1982, the number of days spent in the hospital per capita was 44% higher in Boston than in New Haven, even though the populations were similar in socioeconomic attributes and illness rates. The lower rate of hospital use in New Haven was not associated with any increased mortality rates (Wennberg et al, 1989).

(2) Researchers at the RAND Corporation developed a method to study the appropriateness of medical interventions. They found that 17% of coronary angiograms (invasive x-rays of the coronary arteries) should not have been performed and an additional 17% may have been inappropriate. For carotid endarterectomy (surgery to improve blood flow to the brain), 32% of the operations were inappropriate and another 32% questionable; only 35% of these potentially risky surgeries were performed with unequivocally valid justification (Brook, 1989).

(3) Electronic fetal monitoring during labor is widely performed, and the results are often used to justify cesarean deliveries. Yet randomized controlled trials have shown that routine fetal monitoring in uncomplicated labor confers no demonstrable benefit to the fetus (Grimes, 1993). Since the advent of electronic fetal monitoring 2 decades ago, the rate of cesarean sections has quadrupled; many thousands of these procedures each year are unnecessary (Stafford, 1991).

Another aspect of medical excess is the oversupply of specialized facilities. In many metropolitan areas, there are many hospital beds, computerized tomography (CT) and magnetic resonance imaging (MRI) scanners, and cardiac surgery units that are not used to capacity. Evidence that has come to be known as "Roemer's law" suggests that excess capacity breeds excess use (eg, the more hospital beds in an area, the greater the rate of hospitalization). The other side of this problem is that underutilization of facilities greatly increases the price per unit of care. Downsizing of excess facilities and reduction of inappropriate medical interventions could save many billions of dollars each year.

Fueled by a variety of factors, including an aging population, price increases, technologic advances, and growth in medical and administrative waste, health care expenditures in the United States have risen in a seemingly uncontrollable manner. From 1980 to 1992, health costs as a percentage of the gross national product rose from 9% to 14%, with total health care expenditures increasing from $250 to $840 billion. In 1994, national health expenditures are projected to approximate the $1 trillion mark.

Public Dissatisfaction With the Health Care System Many people view the paradox of excess and deprivation as indicative of serious failings within the health care system.

Health care in the United States encompasses a wide spectrum (Fuchs, 1992), ranging from the highest-quality, most compassionate treatment of a complex illness to the turning away of a sick person because of lack of ability to pay; from well-designed protocols for prevention of illness to inappropriate high-risk surgical procedures performed on uninformed patients.

Broad agreement exists that the system is in a state of crisis. In 1992, the Kaiser Family Foundation and The Commonwealth Fund commissioned Louis Harris and Associates to conduct a nationwide poll on the public's view of the health care system. Of the people surveyed, 12% reported that they or a family member had been refused health care during the previous 12 months because of lack of insurance or inability to pay, a figure substantially higher than the 2% reported in a 1982 poll. Thirty percent said that they postponed seeking health care for financial reasons. Sixty-one percent feared that health insurance would become so expensive that they would be unable to afford it. Twenty-six percent were dissatisfied with the care they received; this percentage was 13% in 1987 (Smith et al, 1992). Public opinion survey data collected from 10 industrialized nations in 1988 and 1990 and analyzed at the Harvard School of Public Health reveal that the United States ranked tenth out of the 10 countries surveyed in the level of public satisfaction with the health care system. Only 10% of people in the United States felt that "the health care system works pretty well." (Blendon et al, 1990)

Health Care as a Right or a Privilege Legally, health care is not a right in the United States (Curran, 1989; Sidel, 1987). Much of the public is uncomfortable with this state of affairs. Polls conducted in 1968, 1975, and 1978 asked: Is adequate health care "a privilege that a person should have to earn, or a right to which he is entitled as citizen?" In all three surveys, over 75% said health care should be a right (Shapiro and Young, 1986). A 1986 poll asked: In general, do you think all Americans should have access to the same quality of care regardless of ability to pay for it? Eighty-six percent answered yes (HMQ survey, 1986). In a 1988 Harris poll, 90% of respondents felt that everyone is entitled to health care "as good as a millionaire could get." Sixty-eight percent of physicians agreed (Medical World News, 1988). The United States population shows a clear sentiment for the proposition that health care should be a right.

Moreover, the United States is surrounded by nations that have enacted entitlement to health care into their legal systems. A large number of countries in the Western Hemisphere include the right to health services in their constitutions (Curran, 1989). Donald Berwick and Howard Hiatt (1989) recently observed that "Americans have no right to health care. In this respect, we stand almost alone among the industrialized nations of the world." The Universal Declaration of Human Rights, passed by the United Nations General Assembly, affirms a right to medical care.

Understanding the Crisis In order to understand the origins of excess and deprivation in the health care system, and in order to correct the weaknesses of the system while maintaining its strengths, it is necessary to understand how the system works. How is health care financed? What are the causes and consequences of incomplete access to care? How are physicians paid, and what is the effect of their mode of reimbursement on health care costs? How are health care services organized and quality of care enhanced? Is sufficient attention paid to the prevention of ill health, and what are different strategies for preventing illness?

How can the problems of health care be solved? Can costs be controlled in a manner that does not reduce access? Can access be expanded in a manner that does not increase costs? How have other nations done it—or attempted to do it? How might the health care system look in the United States of the twenty-first century?

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2 Paying for Health Care

Health care is not free. Someone must pay. But how? Does each person pay when receiving care? Do people contribute small amounts in advance so that their care will be paid for when they need it? When a person contributes in advance, might the contribution be used for care given to someone else? If so, who should pay how much?

Health care financing in the United States evolved to its current status as a series of social interventions. Each intervention solved a problem but in turn created its own problems requiring further intervention. This chapter will discuss the historical process of health care financing as solution-creating-new-problem-requiring-new-solution.

MODES OF PAYING FOR HEALTH CARE

The four basic modes of paying for health care are out-of-pocket payment, individual private insurance, employment-based group private insurance, and government financing (Table 2–1). These four modes can be viewed both as a historical progression and as a categorization of current health care financing.

Out-of-Pocket Payments

> Fred Farmer broke his leg in 1892. His son ran 4 miles to get the doctor, who came to the farm to splint the leg. Fred gave the doctor a couple of chickens to pay for the visit. His great-grandson, Ted, who is uninsured, broke his leg in 1992. He was driven to the emergency room, where the physician ordered an x-ray and called in an orthopedist who placed a cast on the leg; the cost was $580.

In the nineteenth century, people like Fred Farmer paid physicians and other health care practitioners in cash or through barter. In the first half of the twentieth century, out-of-pocket cash payment was the most common method of reimbursement. This is the simplest mode of financing: direct purchase by the consumer of goods and services (Figure 2–1).

People in the United States purchase most consumer items, from VCRs to haircuts, through direct out-of-pocket payments. This is not the case with health care, and one may ask why this is so. Economists such as Robert Evans (1984) and Kenneth Arrow (1963) have discussed some reasons why health care is not considered just another typical consumer item.

Need Versus Luxury: Whereas a VCR is considered a luxury, health care is regarded as a basic human need by most people (see Chapter 1).

> For 2 weeks, Marina Perez has had vaginal bleeding and has felt dizzy. She has no insurance and is terrified that medical care might eat up her $250 in savings. She scrapes up $30 to see her doctor, who finds that her blood pressure falls to 90/50 mm Hg upon standing and that her hematocrit is 26%. The doctor calls her sister, Juanita, to drive her to the hospital. Marina gets into the car and tells Juanita to take her home.

Table 2–1. Health care financing in 1991.[1]

Type of Payment	Percentage of Personal Health Care Expenditures
Out-of-pocket payment	22%
Individual private insurance	5%
Employment-based private insurance	27%[2]
Government financing	43%
Total	97%[3]
Principal Source of Coverage	**Percentage of Population**
Uninsured	14%
Individual private insurance	9%
Employment-based private insurance	52%
Government financing	25%
Total	100%

[1] Data extracted from: Letsch SW et al: National health expenditures, 1991. Health Care Fin Rev 1992;14(2):1; and Levit KR, Olin GL, Letsch SW: Americans' health insurance coverage, 1980–1991. Health Care Fin Rev 1992;14(1):31.
[2] This includes private insurance obtained by federal, state, and local employees, which is in part purchased by tax funds.
[3] Total expenditures add up to only 97%; philanthropic and other private funds account for the other 3%.

NOTE: For out-of-pocket payments, the percentage of expenditures is greater than the percentage of the uninsured population because out-of-pocket dollars are paid not only by the uninsured but also by the insured in the form of deductibles and copayments and payments for uncovered services. Because private insurance tends to cover healthier people, the percentage of expenditures is far less than the percentage of population covered. Public expenditures are far higher per population because the elderly and disabled are concentrated in the public Medicare and Medicaid programs.

If health care is a basic human right, then people who are unable to afford health care must have a payment mechanism available that is not reliant on out-of-pocket payments.

Unpredictability of Need and Cost: Whereas the purchase of a VCR is a matter of choice and the price is known to the buyer, the need for and cost of health care services are unpredictable. Most people do not know if or when they may become severely ill or injured or what the cost of care will be.

> Jake has a headache and visits the doctor, but he does not know whether the headache will cost $45 for a physician visit plus the price of a bottle of aspirin, $1200 for an MRI, or $70,000 for surgery and irradiation for a brain tumor.

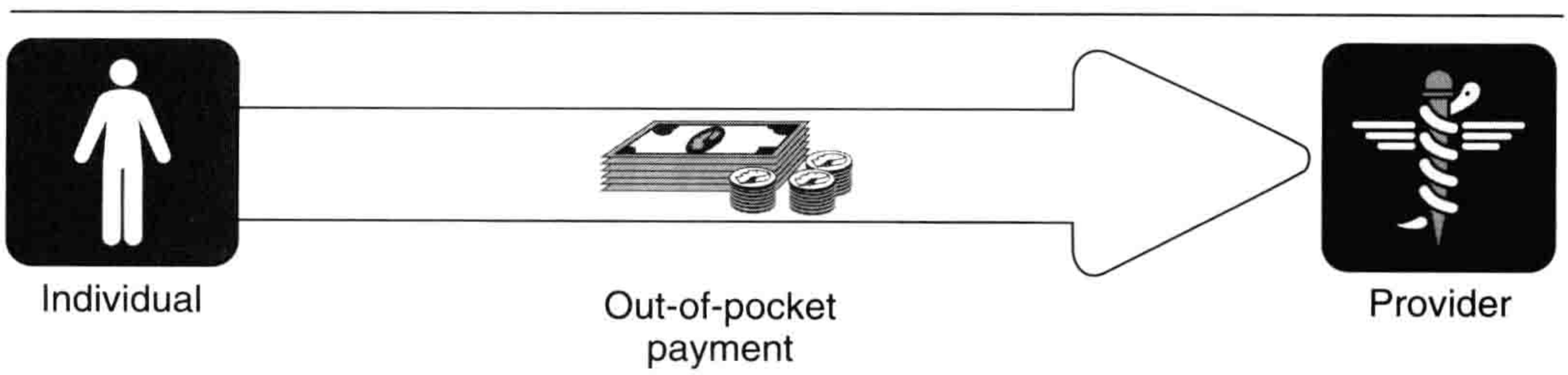

Figure 2–1. Out-of-pocket payment is made directly from patient to provider.

The unpredictability of many health care needs makes it difficult to plan for these expenses. The medical costs associated with serious illness or injury usually exceed a middle class family's savings.

Patients' Need to Rely on Physicians' Recommendations: Unlike the purchaser of a VCR, a person in need of health care may have little knowledge of what he or she is buying at the time when care is needed.

> Jenny develops acute abdominal pain and goes to the hospital to purchase a remedy for her pain. The physician tells her that she has acute cholecystitis or a perforated ulcer and recommends hospitalization, an abdominal sonogram, and upper endoscopic studies. Will Jenny, lying on a gurney in the emergency room and clutching her abdomen with one hand, use her other hand to leaf through a textbook of internal medicine to determine whether she really needs these services, and should she have brought along a copy of Consumer Reports to learn where to purchase them at the cheapest price?

Health care is the foremost example of asymmetry of information between providers and consumers (Evans, 1984). A patient with abdominal pain is in a poor position to question a physician's ordering of laboratory tests, x-rays, or surgery. When health care is elective, patients can weigh the pros and cons of different treatment options, but even so, recommendations may be filtered through the biases of the physician providing the information. Compared with the voluntary demand for VCRs (the influence of advertising notwithstanding), the demand for health services may be partially involuntary and is often physician- rather than consumer-driven.

For these reasons, among others, out-of-pocket payments are flawed as a dominant method of paying for health care services. Because the direct purchase of health services became increasingly difficult for consumers and was not meeting the needs of hospitals and physicians to be paid, health insurance came into being.

Individual Private Insurance

> Bud Carpenter is self-employed. He recently purchased a health insurance policy from his insurance broker for his family. To pay the $250 monthly premium, he had to work some extra jobs on weekends, and the $2000 deductible meant he would still have to pay quite a bit of his family's medical costs out of pocket. Mr. Carpenter preferred to pay these costs rather than take the risk of spending the money saved for his childrens' college education on a major illness. When his son became ill with leukemia and the hospital bill reached $50,000, Mr. Carpenter appreciated the value of health insurance. Nonetheless, he had to feel disgruntled when he read a newspaper story listing his insurance company among those that paid out on average less than 50 cents on health services for every dollar collected in premiums.

With private health insurance, a third party, the insurer, is added to the patient and the health care provider, who are the basic two parties of the health care transaction. While the out-of-pocket mode of payment is limited to a single financial transaction, private insurance requires two transactions: a premium payment from individual to insurance plan (sometimes called health plan), and a reimbursement payment from insurance plan to provider (Figure 2–2). (With indemnity insurance, the process requires three transactions: the premium from