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Perspectives

What If We Woke Up to Realize We Don't Need Health Insurance Companies—We Need Each Other?

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How To Cite: Michel, J.; Schönenberger, P.; Soenderberg, N.; et al. What If We Woke Up to Realize We Don't Need Health Insurance Companies—We Need Each Other? *Global South & Sustainable Development* **2026**, *1*(1), 3.

Received: 24 November 2025
Revised: 15 January 2026
Accepted: 17 January 2026
Published: 20 January 2026

Abstract: Imagine a healthcare system rooted not in profit margins, but in community care. Globally health care costs are rising while patient outcomes are not. How about eliminating health insurance middlemen and saving costs by removing administrative overheads and profit-driven pricing? Could this combat loneliness by encouraging people to need people, appreciate each other, local care networks and building communities from the inside out? Economically, this challenges the market model of healthcare where life is viewed in terms of costs. Realistically speaking how much does a life cost? The current health economic models of viewing health care as a cost rather than an investment need to be reviewed. The work ethics in healthcare; 15-min consultations have robbed the health care systems of the value of empathy, time, and long-term relationships over patient quotas and revenue targets. A shift of focus from treatment to prevention and well-being is overdue. What people seem to want is a health system where people are seen and heard, where preventive care flourishes, not as a cost-saving afterthought, but as the nucleus of a social, healthier and more connected society. It seems it takes people waking up from a certain state. Initiatives Buurtzorg-Neighborhood Care give us hope.

Keywords: skyrocketing health insurance premiums; market model health care; profit over people; people need people; loneliness pandemic; social prescribing; community based and driven health care models

1. Background

Globally, health care costs are rising and becoming unsustainable as costs are shifted to the employees and their families through high premiums and out of pocket expenditures [1]. Health is wealth and secure economies depend on health [2–4]. The world over, many patients are being forced to choose between going to the doctor and paying for essentials like food and rent, skip or delay getting the care they need because of costs. Is that not an indication we have lost the plot [1,5,6]?

Health insurance companies were originally designed to help people afford care in times of need, pooling risk and spreading costs. Over time, they have evolved into powerful gatekeepers of the healthcare system influencing what kind of care is delivered, how much time providers spend with patients, and how much everything costs. While they were meant to facilitate access to health care services and protect us against financial impoverishment while accessing care, they now arguably seem to obstruct this by prioritizing profit over people [7].

Primary Health Care (PHC) is the first level of contact with the health system [8,9]. Many PHC systems are fraught with challenges, failing to comprehensively meet the needs of the people, including the users and providers, the very key-stakeholders who should be at its centre [10]. A transparent, community-based and driven system could empower patients and providers again. Healthcare systems have grown more fragmented and impersonal, making patients to feel like numbers, with health care provider burnout reaching record levels [10]. In addition, the focus on treatment rather than prevention has led to a rise of chronic diseases, mental health issues, and loneliness-symptoms not just of individual choices, but of a system that is glaringly no longer serving its most basic purpose: keeping us healthy [10]. The current health economic model of viewing health care as a cost rather than an investment needs to be reviewed and a shift of focus from treatment to prevention and well-being is overdue [11].

Our view is inspired by the Tallinn Charter: Health Systems for Health and Wealth, where the Charter sets out seven commitments that should drive efforts to strengthen health systems. Of utmost importance is the emphasis is on solidarity, equity and participation as the first commitment [12]. The member states committed to promoting shared values of solidarity, equity and participation by making sure attention is paid to the needs of the poor and other vulnerable groups. This in our view is in contrast to the rising out of pocket payments and health inequity being seen globally. The intended effects of health insurances of pooling risks and spreading costs is clearly not working well.

The three overarching themes that guide health systems for prosperity and solidarity are INCLUDE—improving coverage, access and financial protection for everyone, not only the rich and those who can afford out of pocket payments; INVEST—making the case for investing in health systems and not health insurances; and INNOVATE—harnessing innovations and systems to meet people's needs. The needs of societies to day range from mental health, burn out and loneliness among others [12]. The loneliness and mental health epidemics among others clearly point to unmet needs in our society today.

This view point is guided by this framework; include, invest and innovate. The purpose of this view point is to stimulate debate and encourage all key stakeholders, patients, communities, health care workers, researchers, politicians, business people and people from all walks of life to ask themselves the question, "What If we woke up to realize we don't need Health Insurance Companies—we need each other?" We hope this will lead to the needed debate and action (include, invest and innovate) towards the building of healthcare systems that are built on solidarity (we need each other), that keep us healthy, that focus on well-being and pooling of risks as initially intended. Initiatives like the Nordic Health 2030 movement can inspire us.

2. Loneliness as a Public Health Crisis globally

WHO defines health as a state of complete physical, mental and social well-being, and not merely the absence of disease. One of the most overlooked aspects of health is social connection. Social health refers to the adequate quantity and quality of relationships to meet an individual's need for meaningful human connection [13]. Loneliness and social isolation is a challenge in all regions of the world [13]. What have we forgotten to do as people? The same health care systems that have alienated and failed us are now coming up with solutions such as social prescribing, which refers to non-clinical interventions, such as social activities and social services, to empower individuals and improve their health and wellbeing in a well meant, but paradoxical remedy for a system design failure. The rise and uptake of the app-are you dead in China should make us all uncomfortable. Loneliness is not confined to the elderly only. Many young people check in with this app every two days just to confirm they are alive. If they do not check in the app will notify their next of kin [14].

3. Social Prescribing as the New Knee-Jerk Reaction

An attempt to remedy shortcomings and system-failures has led the system to recreate societal needs as a service upgrade. The evolution of social prescribing—while well intended—is one initiative that can be seen as a symptom of how the healthcare system is no longer fit for purpose, and an inability to truly use methods like asset-based community development as an approach to solve health issues by focusing on social and other determinants of health [15]. We seem to be forgetting and losing attributes that make us human. Consider new interventions among others, breathing and laughter therapy [16]. Are these not things we would naturally do if were connected as a community?

Our health and well-being is affected by both medical and non-medical factors with non- medical factors accounting for over 80% of health outcomes [17]. How then did we get to this focus on medical factors that only contribute and account for 20% of our health outcomes? The maths does not add up. A system designed around mutual care, social connection and communities, like elder care networks, peer health support groups, and neighbourhood wellness hubs automatically, without much effort promote health and well-being [18,19]. What if

we were to realize that what we need is each other and that needing each other could be just as vital as replacing insurance with care?

In other words, if relying on formal systems like health insurance or medical institutions, has brought us this far (loneliness), recognizing our interdependence and collective care could be the wake-up call we need. This in reality would play out as rediscovering mutual care-taking responsibility for one another's well-being; social connection- investing in people and forming strong relationships and networks that protect against isolation and; community health systems-local hubs and peer groups that make support accessible and sustainable, bypassing the middleman (health insurances with their focus on profits and huge administration costs) [20–23]. This aligns with research showing that social support and community belonging are powerful determinants of health, sometimes even more influential than access to medical care alone [21].

4. The Market Model of Health Care Challenges

Profit orientation and the treating of health as a commodity has warped priorities, leading to overtreatment, defensive medicine, and high-cost interventions at the detriment of upstream causes of illness. Needing each other could reframe health as a public good. Needing each other could reduce loneliness and cut back the billions of money spent on loneliness induced conditions, ranging from smoking, drug abuse to cardiac conditions and mental health [13]. The constant stress we find ourselves in and constant hypervigilance to social threats, alters psychological and physiological functions including sleep, leading to ill health and ultimately increased morbidity and mortality [24]. Needing each other can make us feel safe and secure, reducing perceptions of social isolation, loneliness and heightened feelings of vulnerability contributing to better health and well-being [24].

5. Alternatives to Insurance Driven Health Care Systems

Several community-based and driven approaches have been implemented in several countries. See Table 1 below.

Table 1. Community-based and driven approaches.

Initiative	Country	Scaling Strategy	Success Factors
Buurtzorg ("Neighborhood Care") revolutionized home care by using small, self-managed teams of nurses.	Netherlands	It bypassed traditional management hierarchies, reducing overhead by 60%.	By focusing on patient independence rather than billable hours, they reduced total care hours per patient while achieving the highest satisfaction rates in the country.
Costa Rica's EBAIS Model. Costa Rica restructured its entire health system around the *Equipos Básicos de Atención Integral en Salud* (EBAIS).	Costa Rica	The government mandated a primary care team for every 4,000 citizens, regardless of location.	This model integrated public health (vaccinations, sanitation) with clinical care, leading to life expectancy rates that rival the United States at a fraction of the cost.
ChenMed/Upward Health (United States) These entities operate on "capitated" or "risk-based" models, receiving fixed payments to manage total patient health.	United States	Upward Health**,** which ranked as one of the fastest-growing private companies in 2025, uses a "home-based" primary care model for the most complex, high-risk patients.	By bringing care directly to the community and addressing social needs (housing, transport), they achieve dramatic reductions in emergency room visits and total costs, proving that community models can scale rapidly when backed by risk-based contracts.

5.1. Integration of Social Determinants of Health (SDOH)

Community led and community driven systems are cognizant of the importance and role of social determinants of health for example allowing Medicaid and Medicare to fund "non-medical" interventions such as housing stability or nutritional support. The CMS Innovation Center (CMMI) for example is testing models that bridge the gap between clinical care and social services. For example, a doctor could "prescribe" an air conditioner for an asthma patient or a grocery delivery for a diabetic, which is often cheaper and more effective than a hospital visit. Global budgeting is being experimented with: Instead of paying for each aspirin or X-ray, hospitals receive a fixed annual budget to care for a specific population. This is currently being pioneered in Maryland and Vermont, and as of late 2025, has been expanded through the CMS AHEAD Model (Achieving Healthcare Efficiency through Accountable Care and Design) [25,26]. This model, now extended through 2035, incentivizes states to manage the "total cost of care," turning "more patients" from a revenue source into a cost, thereby rewarding hospitals for keeping people healthy and out of the ER.

This is in line with the Astana declaration a Global Conference on Primary Health Care in held in Kazakhstan in October 2018 that endorsed a new declaration emphasizing the critical role of primary health care around the

world. The declaration aimed to refocus efforts on primary health care to ensure that everyone everywhere is able to enjoy the highest possible attainable standard of health. Some hailed this declaration as a demonstration of renewed political commitment to primary health care from Governments, non-governmental organizations, professional organizations, academia and global health and development organizations. The fruits are yet to be seen.

5.2. Nordic Health 2030 Movement

This initiative was started when participants acknowledged the need and value of turning towards preventive health. In line with our title, it takes people waking up from a certain state. It took a waking up that led to a desire to shift from sick care to preventive health that ensures longevity and improved quality of life [27].

The movement is not exclusive to specific organisations, health system actors or decision makers making it every-body's business to commit to better health at individual and societal levels. Jointly they explored future scenarios and how to best shape the future of health in the Nordics. Everyone does what they can to contribute through engaging in more preventive health activities in everyday life, to working to develop and implement better healthcare policies. The Movement rests on three sets of principles that aim to make personalised and preventive care a reality for all:

- Everyone should contribute; nobody should be left behind-balancing the responsibility that we should all bear together. In other words, we need each other.
- All individuals and professionals should be able to experience meaningful input and output of health-related data in real-time.
- All organisations providing health care should be incentivised and rewarded for preventive efforts provided to individuals [27].

These principles seem to counter the current health insurance models, that are hospicentric. They are preventive and community oriented. This gives us hope.

6. Why the Dysfunctional Systems Persist

As illustrated above, alternatives to insurance-driven, fee-for-service healthcare systems exist and despite the proven superiority of community-based, preventative models, systemic inertia has been identified as an obstacle. Economic and political structures and interests associated with the insurance driven health care systems have created a lock-in effect. Lock in effect is defined as a situation where a person, user or company becomes unable or unwilling to change from a particular choice despite ample evidence pointing at benefits of alternative systems [28].

6.1. Political Economy Lens

Utilizing the political economy lens this could be explained as follows;

- The Sunk Cost of Infrastructure: Billions have been invested in massive hospital complexes and specialized equipment for high-volume interventions. Transitioning to community care renders these assets not only obsolete but will also lead to financial losses, hence the resistance
- Lobbying and regulatory capture: The insurance and pharmaceutical industries are among the largest political donors thereby benefitting from the loyalty, complexity and high costs of the current system.
- The Wrong Pocket Problem: A community program might save money for the healthcare system, but the costs are often borne by a different budget (e.g., social services). A lack of integrated funding is currently acting as a disincentive
- The Pilot Trap: Innovation is often relegated to small, time-limited grants. Scaling requires a fundamental long-term funding commitment. This is against the current focus on quick wins and hype. To achieve this, political will and a society wide movement is needed.

In summary, the transition is not a failure of evidence, but a failure of institutional design. Scaling good ideas requires not just proving they work, but dismantling the financial architecture that makes them unprofitable and the political infrastructure that benefits and consequently shields them.

6.2. Additional Barriers to Uptake and Scale up of Good Community Based and Oriented Ideas

6.2.1. Technology and Social Atrophy

Another touted obstacle is what is termed as social atrophy, a paradox quietly eating away at contemporary life. Mankind today live in the most connected era in human history, yet loneliness is widespread as alluded to earlier. Scrolling feeds and faces on screens is the order of the day and yet we struggle to name three people we

could call at three in the morning. This should send shivers down our spine. People long for belonging, for community, or for simply being part of a village. Every-one seems to want all the benefits of community without accepting the responsibilities that make community possible. Each of us want a village, but we are unwilling to be a villager [29].

The challenge seems to be that everyone wants convenience without annoyance, inconvenience, and unpredictability. The latter are unfortunately the price we should be willing to pay as a villager. Annoyance, inconvenience and unpredictability are part of and not flaws in community [30]. People have tried to separate the two, framed as self-care and emotional maturity. We have increasingly structured lives around strong personal boundaries, optimized schedules, and minimal interruption. hyper-independence, exactly where health insurances and other similar systems come in. Boundaries though important, if rigid, stop protecting us and start isolating us [29].

Mankind has dismantled the infrastructure of belonging by the desire to never be bothered and this has slowly eroded conditions that allow care to emerge in the first place. The result is mankind is has become socially undertrained [29].

6.2.2. Convenience is Seductive and Comfort Has Consequences

A system designed to eliminate inconvenience also eliminates opportunities for spontaneous connection. When we erect boundaries to protect our peace, we also block potential pathways to belonging, becoming more comfortable and lonelier at the same time. Mankind today is paying for convenience with disconnection. Societies have traded the messiness of community for predictability, not realizing that the mess was the thing that made community possible [29].

7. Rebuilding Our Capacity for Connection

What if we woke up to realize we need each other. When we do so we recognize that strong communities are not built from convenience, but from presence, showing up when it would be easier not to, staying with awkwardness instead of immediately retreating, choosing people over efficiency, at least some of the time. The village starts with you and I. Structural forces have made community harder while capitalism has monetized and hollowed out shared space. Technology on the other hand has offered endlessly convenient alternatives to being together. We are not powerless. Third places can be rebuilt one interaction at a time, when we wake up and realize, we need each other. Community gardens, libraries, neighbourhood dinners, require time, patience, and a willingness to be interrupted, but most importantly require villagers [29].

7.1. A Shift to Work Ethics Rooted in Compassion, not Throughput

Our proposal aligns with the World Health Organization Council on the Economics of Health for all, calling for radical economic thinking that leads to the prioritization of health for all and not a select few. The WHO Councils report recognizes that structures embedded within most national economies are producing poor health outcomes and inequalities difficult to justify, calling for a re-imagining of traditional views about the relationship between economics and health. The report further argues that maximizing human, planetary wellbeing and equity should take precedence, calling for new metrics that measure broader outcomes such as attachment, security, enjoyment, role and control-challenging the commonly used metrics of quality adjusted life years (QALYS) [23].

In today's insurance-driven system, clinicians are often pressured to prioritize productivity metrics over patient relationships. Imagine a healthcare system rooted not in profit margins, but in community relationships and care. One of the consequences among others, could be eliminating health insurance middlemen. This could lead to significant cost savings by removing administrative overhead and profit-driven pricing, challenging the current market model of healthcare which has glaringly let us down. The very act of attaching monetary value to a life could be at the root of our challenges today. Can we truly put a price tag to a life?

If we realized we needed each other, the ethos of healthcare could shift back to its roots: empathy, trust, and long-term commitment with health care providers empowered to spend more time with patients, focus on listening, and engage in truly holistic care. If we realized we needed each other, communities could take the lead in their own health, care for our planet, focus on prevention, drive whole foods movement, sustainable farming and production among others [30,31]. Community health promotes collective ownership of health outcomes, leading to stronger motivation for lifestyle interventions. Prevention isn't just cheaper; it is simply more humane. Initiatives like the Nordic Health 2030 Movement [32] and the Movement Health Foundation [33] demonstrate the usefulness of envisioning future health ecosystem designs that prioritise health literacy and investment in people, balanced with access to preventative and curative services that use data insights to co-create solutions with

dignity and with quality of life as a key focus. These initiatives and models provide a valuable way to rediscover the true ambition and aspiration of health.

Adebowale et al. [34] concurs with the above and proposes social productivity. This involves fostering well-being and value within communities by shifting from purely economic metrics to include social contributions among them volunteerism, caregiving, and community support. Social productivity values citizen-led public services, active participation, and the creation of collective benefits that empower individuals to shape their lives and communities with the aim of increasing overall social value and well-being [34]. This is also in line with being a villager again, a needed shift.

7.2. Complexity Calling for Multi-Pronged Approaches

The forces driving people apart are numerous, among them, profit interests, lack of political will and conflict of interests, technology, the increasing dependence upon outside, professionalized helpers and not community, ebbing at the sense of efficacy based on our interdependence [22]. Recent public health crises like Ebola, COVID-19 and anti-microbial resistance reinforce the need for working together, shifting from medicalized models to people centred health services and increased public involvement in decision making [12]. The Tallinn Charter: Health Systems for Health and Wealth, sets out seven commitments that should drive efforts to strengthen health systems throughout. In line with our proposal, the emphasis is on solidarity, equity and participation as the first commitment to ensure the needs of every-one, including the poor and other vulnerable groups are met. Our current model in our view has brought us to this point where unsustainable health care costs are shifted to employees and their families through high premiums and out of pocket expenditures, hence the notion, the system is not serving us as initially intended [1,12].

Appeal to the Humanity in Each of Us

We keep trying to solve what is broken with more of what broke it. We are treating the collapse in the society as a compliance problem when it is a civilizational condition. The architecture that made rules meaningful has dissolved and one can only get exhausted if we perform belief in dead institutions while others gain power through abandoning them [35].

Irrespective of our roles, class and positions, we are human-beings at the core. We can be politicians during the day but we are privately fathers, brothers and sons. We need novel, humane ways of engaging, without masks but a humane level. Our children are suffering, so are our parents and we all agree, the current way of doing things is not working. Technology has ceased to be a tool and now controls us. Money has ceased to be a tool and now controls us. Artificial Intelligence, you name it. What we need are not gadgets but people and each other. What is needed to wake us up? A third world war, a sun flare that plunges the world into darkness, another pandemic?

8. Conclusions

We all can see, feel and agree that our health care systems are failing us. The rise of apps like, “Are you dead,” even among young people, should serve as a wake-up call. What if we stopped asking how to afford health care, stopped being hyper-independent and started asking how to build a society that keeps us healthy in the first place? Are we powerless. Alternatives exist and so this is not a failure of evidence, but a failure of institutional design. Initiatives mentioned above like the Nordic Health 2030 Movement and the Movement Health Foundation give us hope. Socially, this shift could combat loneliness, one of the biggest and silent pandemics of our time. A system that organically and not through prescription encourages people to need people, appreciate each other, our communities, local care networks and community health workers and ultimately a feeling of safety and well-being. Do we need a tragic event to wake up? Building communities from the inside out, healthcare systems built on solidarity, pooling of risks as initially intended—is this not what we have wanted all along? Our hope is that irrespective of our roles, politically or otherwise, we are still humans. Let us wake up to that.

Author Contributions

J.M. had the initial concept, wrote the first draft, created tables, edited and wrote the final draft. P.S., N.S. and L.M. reviewed the first draft and provided comments. M.T. was involved in the discussing of concept, writing of the original draft, editing and supervision. All authors have read and agreed to the published version of the manuscript.

Funding

This research received no external funding.

Institutional Review Board Statement

Not applicable

Informed Consent Statement

Not applicable

Data Availability Statement

Not applicable

Conflicts of Interest

The authors declare no conflict of interest.

Use of AI and AI-Assisted Technologies

No AI tools were utilized for this paper

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