

Improving access to good health care: More private and cooperative HMOs, Don't expand PhilHealth ¹

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1. Introduction

Improved access for all to quality health care is a vision dreamed by almost all people in the world and is thus perfectly rationale. Resources though, are limited: the supply of well-trained doctors and other health professionals, the presence of good quality hospitals and clinics with sufficient laboratories and diagnostic instruments, the supply of safe and effective medicines and vaccines, are limited. While the demands for such health services and medicines are unlimited.

This is where the initial problem of access to quality health care arise. Add the fact that some people are too irresponsible to take good care of their own body and that of their own family, like those who drink and smoke heavily, take illegal drugs and fatty foods excessively, live in dirty places and do not observe personal hygiene, get into frequent fights, have sedentary and promiscuous lifestyle, etc.

There are three options to cover medical costs: (a) the State-run Philippine Health Insurance Corporation (PhilHealth), (b) health maintenance organizations or HMOs, both corporate and NGO, and (c) out-of-pocket (patients have to pay their own way).

This paper is a preliminary attempt at testing the hypothesis that for the Filipino people to have improved access to quality health care, there should be more role

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to private and cooperative type of health maintenance organizations (HMOs), and PhilHealth coverage should remain as it is for now, it should not be expanded as proposed in some legislative proposals.

2. PhilHealth coverage limitation

PhilHealth covers members who are confined in hospitals for at least 24 hours. It covers the cost of treatment and room expenses under specified rates for room and board, drugs and medicines, X-ray/laboratory/other diagnostic tests, and professional fees. PhilHealth also covers limited outpatient services, like day surgeries, dialysis and cancer treatment procedures like chemotherapy. It also covers mothers giving birth up to 4th normal delivery. The excess expenses that are not covered by PhilHealth will be covered by the company's or the individual's HMO, and/or out-of-pocket expenses.

The State health insurance corporation, however, does not cover annual physical check-up. It has little preventive health care function, therefore. The focus is on curative health care, when a patient is too sick or too injured to rest at home and needs hospital confinement. Undergoing annual physical check-up is a preventive practice because the results will tell the person what are the likely disease/s that will hit him/her in the future as almost everything is checked up while he/she is not sick – eyesight, hearing, blood, urine, stool, chest X-ray, buttocks, genitals, any lump/s in the neck, breast, body and groin, etc. Should negative results show up, further diagnostic tests and preventive measures will be taken. These will help prevent a brewing disease from becoming serious.

Thus, being a Philhealth member alone is not sufficient. One, it does not cover outpatient consultations; two, it does not cover annual physical check-up; and three, its expense cap may not be enough to cover total expenses for serious diseases. Most medical needs by patients involve ordinary physician visits, like if one has a headache or flu or other body pains. People would prefer to go home later and rest as staying in hospitals is not only expensive, it's also cumbersome and time-consuming for family visits.

The case of heavy medicine advertising by some pharma companies can also be partly traced to this. Since many people do not have an HMO card, when they are not feeling well, as much as possible they do not see a doctor and resort to self-medication. A visit to government hospitals and physicians (either free or low fees) means long queue, while a visit to private physicians and clinics means high costs in physicians' fee and possibly diagnostic tests. So to cut costs or avoid long queuing, people self-medicate and buy medicines that are most popular, as advertised in tv, radio, newspapers and outdoor billboards. Pharmaceutical companies, domestic or multinational, know this, so some of

them spend a lot of money on advertising, which leads to higher medicine prices, aside from possibly exaggerating the claims of beneficial power of their medicines.

One factor that can limit PhilHealth's healthy expansion is its being a government body: it is prone to political pressures and interference by politicians.

There was a sudden rise in PhilHealth membership among the poor in 2004 where there were national (especially Presidential) and local elections, and decline of membership the next year after the elections are over. This cannot be explained by the poor suddenly having lots of money during the elections and joined PhilHealth, then back to being poor and did not pay their membership contributions to PhilHealth by 2005. It was national and local politicians plus some cash-heavy national government bodies like PAGCOR, that paid for the PhilHealth contributions of the poor. Of course there is expectation of political and electoral support by the national and local politicians who gave the health cards.

3. Getting private HMOs

Getting a private HMO, on top of being a member of PhilHealth since membership in this State-run program is mandatory and by coercion anyway, is a good set up. This would assure bigger coverage and is also more cost-effective that limits the doctors' fees in exchange for the doctors having plenty of patients.

May I share my experience with our office HMO early this year. I got a bad cough, partly due to the prolonged cold front that affected almost the entire country for several months. I went to my HMO. The doctor suspected there could be something wrong with my lungs because my cough came back in a matter of weeks. So he requested for a chest X-ray. He did not prescribe any medicine for me to buy, advised me to take more water and juice and wait for the result. When I went back to him after a few days with the X-ray result (which showed that my lungs were clear and fine), my cough has subsided. He said that I should continue drinking lots of fluid, no medicine, go home and get more rest. I got well.

A person not feeling well and has a private health card does not automatically buy any medicine, he sees a physician first. After the initial check up, the physician may not even prescribe a medicine yet and request for some diagnostic tests (blood test, urine test, x-ray, etc.), wait for the result, before prescribing (if necessary) any medicine.

Having a private HMO (many companies do this for their officers and employees) will save people from unnecessary stress when they sick. This gives them some peace of mind. For many poor people who do not have health insurance when they get sick, the first thing they do is to self-medicate: go for some herbal products, buy the “usual” and cheap medicines, and see a doctor only when the pain gets worse, perhaps because they bought substandard or counterfeit medicines that failed to check the virus in their body, or took medicines that were inappropriate or could trigger some side effects to other diseases.

The HMO sector should be deregulated by the government so that more companies, local and multinationals, should be attracted to come and provide additional competition in the field, so that various income brackets can be served. For instance, richer people can pay P20,000 per year or higher for wider health coverage, middle class people can get P6,000 to P15,000 per year, others can charge P1,000 to P5,000 per year for narrower health coverage (say maximum P20,000 hospital bill in one year, X number of free physician visits, Y set of free diagnostic tests, and so on). The point is that even poor people can get health insurance on top of their PhilHealth membership to encourage them to see a health professional first before they buy any medicine. This will also neutralize any untruthful claims by heavy drug advertising as patients will listen more to their physicians, not to advertisers.

Right now, there is a fair level of competition among the various HMOs in the big cities, but not in the smaller cities, and practically zero in many rural villages. When there is clear competition, the companies involved are therefore forced to make their services to their clients more efficient and much quicker. This is because most or all contracts with HMOs are for one year only. When the clients are not satisfied, they can choose not to renew the contract and seek another HMO which is more than willing to provide a more efficient service.

4. Cooperative-type HMOs

Some groups and individuals are not comfortable with allowing more private HMOs because they see such enterprises as principally driven by profit and not by genuine and efficient public service, that is why they lobby for bigger government-run health insurance. This is despite their recognition of the inefficiencies, wastes and corruption involved in many government programs and projects, including the health agencies.

A middle ground option is to encourage the emergence of cooperative-type of HMOs. Big NGOs, people’s organizations (POs) and existing big cooperatives

can form their own HMO that is more tailored to the needs of the people affiliated with such civil society groups.

It should be noted here that one problem with private and corporate HMOs is that patients cannot choose the physician who will attend to them. Only the physicians contracted by the HMO can see them. Although there are some rare cases where the HMOs allow certain patients to see other physicians not in their contract, and the HMO will pay said physician/s.

There are a few existing social insurance type of NGOs. If they are doing well, then they should be encouraged to expand.

Aside from the potential savings from putting up their own HMO, the NGOs and POs will also experience the kind of bureaucracy that ordinary enterprises will have to undergo with various government agencies before they can start any business, including the business of taking care of the sick and dying.

Such NGOs and POs will gain direct experience in dealing with the Securities and Exchange Commission (SEC), Cooperative Development Authority (CDA), Bureau of Internal Revenue (BIR), Social Security System (SSS), PhilHealth (even physicians and staff of private HMOs have to become members of PhilHealth because it is mandatory, membership there is by coercion, not voluntary contribution), government housing insurance (Pag-IBIG), Department of Health (DOH), Department of Labor and Employment (DOLE), Department of Trade and Industry (DTI), Insurance Commission (IC), other national government agencies. Then there are local government bureaucracies from the barangay up to the city or municipal Mayor's business permit.

5. A note on PhilHealth membership claim

PhilHealth officials say that their membership coverage is around 80 percent of the population already as of April or May 2009. What they do, they multiply all PhilHealth members, currently at around 17.2 million people, with the average family size of around 4.3 members per household, children or old dependents, and they get 74 million total individuals covered. That is 80.4 percent of the projected 92 million total Philippine population as of middle of this year. Since the target of "full coverage" is 85 percent of the population, then PhilHealth is nearing its mandated target.

But this method is wrong. Not all PhilHealth members are married and/or have children and old dependents. Many PhilHealth members are still single, like those newly-grads who are working. Or people may be married but some do not have children. Or those married have 2 to 4 children, but if both husband and

wife are working in the formal sector and hence, are mandatory PhilHealth members, then even if their actual family size is 4 to 6 (couple + 2 to 4 children), the PhilHealth multiplication system says there are 8.6 or 9 members covered.

The oldies and retirees, PhilHealth also count them as members. But they too, their numbers are also multiplied by 4.3.

Based on the latest labor force survey by the National Statistics Office (NSO), there were 35 million employed Filipinos as of April 2009. The total PhilHealth membership of 17.2 million, even up to 18 million, is only half of the total employed Filipinos. Thus, an 80 percent membership coverage nationwide is really impossible.

6. Concluding Notes

The HMO sector should be encouraged to expand and be as competitive as much as possible. Hence, it should be spared from current and future attempts at more government regulations and taxation. Regulations by nature mean prohibitions. They are meant to create paralysis, even temporarily. Government regulators say, “Don’t move, don’t start anything, until you pay various taxes and fees, until you get our signatures and permits first.”

Government health insurance monopoly through PhilHealth, by virtue of its being a monopolist with guaranteed income from forced contributions, is prone to be inefficient. There is very little possibility of losses. And should huge losses show up later, there is no possibility of bankruptcy because there are always billions of pesos of tax money to bail it out. Thus, moves to expand PhilHealth and inject with more tax money should be skipped at the moment. Let that State corporation work on its current mandate.

More than bigger government taxation, regulation and monopolization in health care, what is needed is more individual and parental responsibility for preventive health care, plus a competitive business environment where private health care providers – corporate and cooperative type – can compete with each other in providing the safest, the most reliable and most cost-effective health care to the people with varying health needs and varying financial resources.

Finally, PhilHealth needs to be more honest in producing realistic figures for their total membership coverage. To claim 80 percent membership coverage at this time is not correct.

Annex:

List of Clearance to Operate, HMO Health Maintenance Organizations (HMOs),
CY 2007

1. Medicaid Philippines, Inc. (<http://www.medicardphils.com>)
2. Getwell Foundation, Inc.
3. Mancare Health Systems, Inc.
4. Medocare Systems Inc.
(<http://www.medobserver.com/mar2005/indnews.html>)
5. Fortune Medicare, Inc. (<http://www.fcarehmo.com.ph/>)
6. Blue Cross Health Care Inc
7. Metro Care Health Systems Inc.
8. Asalus Corp (Intellicare)
9. Kaiser International Healthgroup Inc
(<http://kaiserhealthgroup.com/images/faq.htm>)
10. Philamcare Health Systems Inc.
(www.philamlife.com.ph/philamcare/html/corp/aboutus/companybg.html)
11. St. Patrick's Healthcare Systems, Inc (SPCARE) (<http://www.spcare-ph.com/>)
12. Maxicare Healthcare Corp
13. Medical Services Marketing and Development Inc. (MedServ)
(<http://medserv.com.ph/index.php>)
14. Prudentiallife Healthcare Inc.
(http://www2.prudentiallife.com/prudentiallifecare/acc_hospitals_clinic.asp)
15. Value Care Health Systems, Inc (<http://www.valucare.com.ph/>)
16. Health Maintenance, Inc. (first HMO in the country)
17. Insular Life Health Care Inc (<http://www.insularlife.com.ph/wwa7.html>)

Source: Bureau of Health Facilities and Services, Department of Health