# Towards a Social Health Insurance

## Response to the Draft of the Proposed Health Insurance Bill, as of 28 January 1994

**First Policy Paper of the Federation of HAMIS Winners in the Philippines, Inc.** [1]

### 1. Basic Concerns

For the time being, health insurances can not be built upon the Philippine´s existing health services and the existing local government units. They have to be based on community organizations from the basic community units nationwide for the very reasons that:

1. **Local Governments are neither ready** nor properly prepared to support a national health insurance scheme.

   a On one hand, local governments are not yet people-oriented; they have few mechanisms to respond properly to the needs of the communities. On the other hand, people are still passive and not yet empowered to influence local governments in their policy making. Education and conscientization of the majority of the population have not been undertaken so far. Mechanisms are needed in order that people's expression of their needs for effective services may be heard and transferred into actions. They are not yet in place.

   b A comprehensive health orientation of local governments is still lacking or not yet palpable. Local government executives are not yet supportive of the preventive and promotive aspects of health care. Health care is often equated only to the curative aspects of it. A genuine interest in Primary Health Care - people's participation and services being accessible, adequate, efficient, affordable, acceptable and sustainable - can not be assumed.

   c Local governments very often have very low interest and regard for people and communities in the periphery. Their interests are concentrated onto the centers of power and population which is often in the capital towns or cities. It results in low or no access to communities in the same way that communities have low or no access to local governments. The same holds true for government personnel and programs. The national government health services are also often not visible in the periphery where health care is most needed.

   Therefore, presently, not all LGU's can provide the necessary mechanisms to build up local health insurance organizations. They lack the capability and functional infrastructure to do this. Many LGU's still need the necessary preparation to participate fully and effectively in this undertaking.

2. **Health services at local levels are not yet effective**, efficient and equitable nor are they appropriate and accessible. At present, they provide a very weak matrix for building up health insurance organizations for all Filipinos.

The development of health organizations should start from already existing people's initiatives; it should not be imposed by government. Imposing health care policy such as the draft of this health insurance bill normally elicits people's participation out of fear rather than out of interest and genuine concern for the common good. Health care policies ought to be developed with the active participation of people's organizations and communities. Trust and credibility are important elements in developing health insurance organizations. Imposition of laws and bills and bureaucracies does not ensure its viability. Community organizations represent the interest of the people. LGU's and other formal organizations often do not. Too often, they are entrenched in bureaucracy and foster dependency rather than equity and sustainability.

### 2. Integrated Health Care

The spirit of Alma Ata asks that primary health care (PHC) looks into community and personal health care in its entirety. Both services have to be provided in a complemented and coordinated way. Preventive and promotive community health services are primary functions of people's organizations and/or DOH, preferably in a way that these services complement each other. The draft of this Health Insurance Scheme will effectively sever this linkage and would tend to

[1] The Federation of HAMIS Winners is the self-organization of those innovative health care and health management projects that had been awarded prizes of excellence by the President of the Philippines. Those projects were selected by the HAMIS contest of good management in health and health care.

cover personal health care only. Lack of coordination would lead to limited prevention and overuse of curative services. It is imperative that DOH and/or community organizations develop an integrated approach for health care delivery.
Funds have to be made available especially for the community health services. This is so because people will not opt to pay for it. Therefore the income from personal health care (e.g., through Local Health Insurance Organizations) has to be used to support and sustain community health services and programs.

### 3. Community Health Insurances

There are already quite a few existing community organizations that are providing health services in an integrated way, i.e. have developed preventive, promotive, curative (primary, secondary, tertiary) and rehabilitative services. Many of them have already incorporated health insurances, emergency health funds and loan arrangements for catastrophic emergencies. These can be found all over the Philippines. Some of the examples are:

> **Batangas Province**: Premium collection for members that can avail of an interest free loans and managed referral in case of illness. The premium is 12 Pesos a year per family.

> **Bukidnon Province** and in other areas: Medical ambassadors organize people to support their own primary health care clinic (manned by barangay health workers) and boticas sa barangay. A barangay health committee manages the program.

> **Butuan City**: Loans with low interests are given to families with good health behaviour, i.e., complete immunizations, safe family planning, school enrolment. Thus health behaviour is thus the collateral for being creditworthy and not the material wealth of a family.

> **Cebu Province**: Kauswagen Community Health and Social Development Center is a shool-based primary health care project including a strong livelihood support with the following components: community organizing, health services, students community exposure, training of volunteer health workers, income generating projects. Some support for health care is available for members of the Barangay Livelihood Association.

> **Lucena City**: A community based cooperative - Mount Carmel - offering low interest loans on livelihood and providential needs of members. Cooperative health emergency assistance program (CHEAP) is extended as hospitalization assistance upon paying 55 Pesos annual dues. Also provides continuous education to its membership on cooperatives.

> **Lucena City:** A voluntary association of diabetic patients provides and incorporates a health insurance scheme called "LDPA DAMAYAN" to help members shoulder some economic difficulties on their health. An annual premium of 100 Pesos covers the member for death, hospitalization and disability benefit. The association also provides services in the preventive, curative, informative and rehabilitative aspects of the disease - diabetes mellitus.

> **Quezon Province**: Establishment of barangay health worker station and "paluwagan" among community members for interest-free loans for medical emergencies. The contributions are even less than 10 Pesos.

> **Quezon Province**: Outreach medical care in far-flung areas for small consultation fees that are deposited on a savings account in the name of the patients family so that they avail of a loan after surpassing the ceiling that allows them to be members of a nearby cooperative. The consultation fee is 10 Pesos per case.

> **Surigao City**: 10% of the proceeds of income generating projects are channeled into a health fund for covering emergency expenses in case of illness free or at least interest free. This is just one component of a wide ranging set of preventive, promotive primary health care activities that are in the hands of a federation of mother clubs in the many island barangays and the mainland. Mortuary funds are another component of this incarnation of the real meaning of community health.

> **Tawi Tawi Province**: Premium collection from members of a health club who have to use preventive care to be entitled to get free or at least interest free managed curative health care. The premium is 10 Pesos a month per family.

> **Tondo in Manila**: Stimulated by an enlightened group of medical students, urban poor in a community of garbage collectors in Manila realized cost sharing through donation of some seed money. This enabled voluntary community health workers to provide some preventive and medical care that was complemented by services of volunteer doctors. Additionally, they collect a contribution of 10 Pesos per month from families so that they can avail of a 50% discount of the factory prices when buying prescribed drugs in the cooperative store. Others in the catchment area get drugs at prices below

retailers price. The contributions are according to family income but not according to family size thus having a progressive component of risk sharing. The lesson of this project is that self-organization and cooperation can save money for not just for the members of the cooperative but for all in the catchment.

A complete listing of the 52 HAMIS Winners can be found elswhere. What are the preliminary lessons for health insurances? There should be distinguished three valid starting points that could be used as strong pillars for a social health insurances.

> **Community Loans**: Very often, the need for borrowing money starts with the event of severe illness, needing cash to purchase very expensive drugs, or spend it for travel expenses to transport a patient to the hospital. Community loans offer an alternative for the poor to avoid one of the most persistent evils of society: the continuous impoverishment of the poor resulting from loans provided by profit-hungry neighbors and pawn shops.

> **Community Cooperatives**: These are efforts to pool together community resources to serve the needs of the group rather than the individuals. These cooperatives could be for mothers, fathers, patients, children or any other group with a certain cohesiveness and social control over the use of their resources. They could also be cooperatives of barangay health workers together with the hospital staff and the communities they serve.

> **Community Insurances**: Communities have a feel of what affordability means for them. Benefit packages are tailored to their needs and therefore assuring their relevance and effectiveness. In one area this might mean P50.00 from each member for a family if the breadwinner dies; in another it might mean managed care and interest-free credits; still in another, it might mean cash money for the boat fare to the next hospital and back.

There seems to be a magic ceiling for loans repayment and cooperative premiums and health insurances for the poor. Ten Pesos a month is an affordable and acceptable level. It does not cover all expenses but it covers essential needs. It assures the poor that they need not fall into the hands of private pawnshops or profit hungry usurers. It is basically a cooperative activity of concerned citizens for getting interest-free or at least very soft loans for their health care. Is this a model for Medicare 2? Let us call it Medicare 10 for short. The allegory is that there are many Medicares, not just one or two or three.

Indeed, they do have different coverages, benefit packages, target groups, philosophies and approaches. This reflects the creative ways of communities conceive innovative approaches to health care according to the prevailing circumstances and characteristics of the communities as well as the paying capability of the participating groups - reflecting the spirit of Alma Ata. This creative variety of innovative and responsive approaches has to be encouraged, strengthened, maintained and used as a backbone for a health insurance for all Filipinos. It is an authentic response to the needs of the Filipino people and not patterned after fashionable ideas abroad. It is conceived and developed in the Philippines.

Community organizations as such have to be harnessed because government can not shoulder to do it alone. There is such a rich reservoir of creativity and talents in such organizations. Any other solutions will be less effective, less efficient and less equity-oriented. Significant number of needy populations are covered by such community organizations.

According to the draft of the proposed bill such organizations at community levels will be dismantled for two reasons: first, local health insurance organizations will be set-up at the levels of local governments and will disrupt larger scale non-governmental and community organizations, e.g., Medical Ambassadors of the Philippines, community drug insurances, etc. The health insurance bill would split such organizations into non-viable units since it does not foresee national federations or associations of such types of insurances. Second, the proposed bill does not allow benefit packages that are limited to one aspect only, e.g., drugs, emergency cash, preventive activities, etc. These community initiatives will be taken over by larger, more powerful and profit-oriented systems.

## 4. Bureaucratic Health Insurances

Endeavors of health insurances in the Philippines thus far have been examples of lack of concern, effectiveness, efficiency and equity. They cater to the well-off and they are in favor of partial curative services. Thus, they have not improved the health status of the majority of population especially those in poverty. They often thrive on double payments through premiums and direct out-of-pockets payments. They are insurances for the providers rather than for those who are in need of the health service. There are many examples of inefficient management of the existing health insurances.

1. **The problem of overuse**: The basic rules of Medicare encourage people to want to be hospital-ized regardless of the fact that their illness could be well taken care of at an outpatient clinic. Hospitalization allows them to avail of Medicare benefits. This is the exact opposite of the idea that prevention, early detection and treatment are the

best and least costly ways of primary health care. Medicare is espousing a health consciousness that is exactly the opposite of the spirit of the Alma Ata. Here is an example of a health insurance that is encouraging disease and disregarding the issue of health promotion and prevention of disease. We can not and should not share this philosophy.

2. **The problem of misuse**: All over the Philippines, stories with concrete evidences of the misuse of Medicare provisions and benefits are rampant. We, at the grassroots and in touch with community action and health care, see this daily. We are getting sick and tired of it. We are further intimidated when some providers and officials laugh about the stupidity of not having an effective misuse control, i.e., people making personal profits behind the back of the premium payer and at the expense of the patient. Until now, we have not noticed any serious and earnest endeavors to stop the misuse. We are still waiting for sanctions to have more teeth on violators and cheaters in the government and its institutions who pretend to provide health care but in reality are just self-service boutiques for too many.

3. **The problem of abuse**: Overcharging the patient and Medicare is one of the daily practices of several health care providers. Over-extending the length of stay of patients in hospitals is another example of abuse within a health insurance system that has gone out of control. The sad part is that this is common knowledge and yet we do not see any convincing efforts to remedy our concerns.

4. **The problem of fake and ghost patient**: Since hospitalization entitles a member to Medicare benefits, it is not uncommon that people fake being in a hospital or for doctors/hospitals to claim for benefits of non-existing patients. The money being used to pay for benefits of fake and ghost patients is coming from an institution that has already lost its credibility and trust of the people. Therefore, it is not even looked upon as an immoral act (stealing money and resources). Not only does it cover up the low occupancy rate of some hospitals, it also becomes important for their survival. We can not accept this. And we do not want to be integrated in organizations that condones and perpetuate such misdoings.

5. **The problem of non-representation**: Communities and people's organizations especially in the rural areas are not properly represented in nearly all formal organizations to make decisions that affect their lives. This is a disadvantage for both- the communities and the organizations. Such organizations could learn much from the creativity and ingenuity of the poor and of poor communities who have discovered/learned good management of meager resources and not affected by bureaucratic apathy. They can be best teachers of good management practice. The very fact of non-representation tends to strengthen the organizations which in turn are strengthening those who are already strong. This seems to hold true with Medicare and its recent modifications.

6. **The problem of inaccessibility**: Most health providers situate themselves in towns and cities. A large portion (70-80%) of the population lives in rural areas where the cost of transportation is prohibitive for a patient to reach the nearest hospital. This is true for those who might need health care but living in island municipalities and in hinterlands. This is geographic inaccessibility. Some ethnic groups are not used to avail of services that could alienating. In this particular instance, we have an experience of social inaccessibility.

7. **The problem of the rights of the consumers**: Health is a human right. Therefore, discussions on human rights should also be on the agenda of health providers and intermediaries like health insurances. It is good that one section of the bill specifically deals with this issue. There have been many complaints on the disregard of patients' rights. But they are not usually taken care of because of the position of power of the poor consumer viz-a-vis the position of power of the providers enshrined by the bureaucracy. the latter seem to be preoccupied with other things rather than dealing with this issue.

8. **The red tape problem**: Red tape is a chronic disease and an ugly sore of large organizations run by bureaucratic technocrats rather than human beings. While community organizations are relatively free of it, large corporations have to invent ingenious mechanisms to avoid it. The existing health insurances are plagued with red tape. This defeats the purpose of why they were created.

9. **The problem of lack of check and balances**: In a multi-cultural, multi-lingual and multi-island country like the Philippines there has always been a lack of effective communication. This has its advantages and also its disadvantages, especially when monitoring and control is the issue. This confounds the issue of overuse, misuse and abuse of Medicare provisions and benefits. HAMIS winners are suggesting that sanctions on corrupt cheaters should have more teeth.

10. **The problem of indigents**: There is no clear-cut definition of indigency. Those who are really indigent could not avail of the health services. By and large, those who could be considered indigents are found in the periphery. It is economically impossible for them to avail of health services that are usually found in town centers or cities.

Indigency is also relative. One catastrophic illness could throw a middle class family in the brink of sustained indigency. This is issue has to be studied extensively. It is not only a matter of mean-tested income. Rather, it is a matter of compassionate health promotion and prevention on the part of any social organization.

11. **The problem of disabled and mental health patients**: Many insurances do not cater to the disabled or mentally ill. Such groups are most in need of health care services. When uncared for, they would fill the ranks of the indigents and would have to be subsidized by another program of the same government.

12. **The problem of the chronically ill and the elderly**: The explanatory note of the draft of the proposed bill says: "Even as the Philippines continues to wrestle with pervasive communicable diseases, there is a gradual but visible aging of the population with the concomitant rise of chronic and degenerative diseases". But there is no provision of health services for this group of people in the proposed bill as home and rehabilitative care are excluded from personal health care services. In the experience in one of the HAMIS winners, some chronic patients have already organized themselves as in the case of the Lucena Diabetic Patients Association. Associations like that one show that grouping together chronically ill patients can bring about private and public savings.

13. **The problem of self-employed and the unemployed**: They represent a high percentage of the population in the Philippines. There is no clear health insurance policy that is affordable to them and to the whole enterprise. It needs careful study on how best their needs could be met. HAMIS-type community health insurances, cooperatives and community loan arrangements seem to be the most appropriate way to integrate these groups into a social network of social health assurance.

14. **The problem of ceilings and severe illness**: In reality as well as in the proposed bill benefits (services and drugs) are limited. Cost-effective highly-expensive procedures can be excluded. The patient has to pay for health care in case of severe illnesses as the expenses go beyond the imposed ceilings on benefits. If the ceiling would be patterned after Medicare provisions the proposed bill could not be called a "health insurance" since it would be more of an insurance for health providers. This is because pre-payments usually will not be paid back if not used. If they are used, then they cover expenses only up to a certain ceiling. A health insurance scheme has to avoid the mere shifting of the savings of the poor for the benefit of the providers.

15. **The problem of profits**: According to the draft of the proposed bill, Health Insurance Organizations subsidized by the government can choose to have any kind of organizational structure. It can either be an organization for-profit or non-profit. This might lead to the taking over of low-risk areas by for-profit organizations and high risk- areas will be left alone. In addition, the inclusion of for-profit insurances brings about an unwanted redistribution of non-profit premiums to the for-profit organizations and thus draining out community health endeavors.

16. **The problem of investments**: In the Philippines, for health insurances like Medicare there seems to be no limit of for-investment disbursements. It has turned an instrument of health care policy into an instrument of fiscal policy for the government. Health institutions turn into being investment agencies. Our solution would be to limit the profit from investment to a small margin of earnings and to keep a reserve earmarked just for health care.

17. **The problem of corporational omnipotence**: Creating a megalomanic corporation for more than 60 million Filipinos as planned by the proposed bill is drawing us back to the time before the devolution. It is taking over the responsibility for all Filipinos by one single institution as if it were realistic and practical. An association or federation of smaller institutions will be more reasonable. It would introduce the elements of reasonable choices, options, alternatives, healthy competition and compassionate bargaining and negotiation.

These 17 points mentioned above revolve around bureaucratic inefficiencies that we see in existing organizations pretending to be health insurances for the people. Such inefficiencies have to be tackled before a new health insurance can be built up. We know that many of such insufficiencies would not occur if there is a competent and competitive cooperation between community organizations and other institutions that understand "social" health insurance as a social policy based on a newly found trust and credibility. It has to be a network of lean and clean organizations rather than one all-encompassing corporation.

## 5. Recommendations

We recommend a step-by-step approach to build up a social health insurance system. This is not an effort to delay any kind of initiatives. It is an effort to make them stronger and to learn from our achievements. Our achievements have undergone a long process of trial and error. We are willing to share our experiences to build up a social health insurance that is not just for the officials and the workers but for all Filipinos, i.e., for

the self-employed, the unemployed, the fishermen in the remote islands, the farmers in far-flung areas, the chronically ill and mentally retarded. This is why we choose to call it social health insurance and not just health insurance.

**STEP 1** A series of public hearings, consultations, conferences dealing with the tabled proposal for a health insurance bill is very much needed. It will be useful to take this as a starting point for further discussions on health insurance, primary health care, prevention and promotion. Health insurance can not be dealt with in isolation. This will be even more useful if the unrepresented and the underrepresented groups would have access to these discussions. Taking health in our hands also means willingness to take health insurances into our hands.

**STEP 2** Time is a very important resource needed for discussions to happen at all levels. We know that government officials, barangay captains, mayors, municipal health officers and different partners in health and health care are willing to participate in such discussion. We can learn much from their experiences. Clarifications and consensus meetings at such levels are mechanisms for empowering us and our partners, for enlightening them to understand that health is wealth and that small scale income-generating projects are more needed than additional hospital beds. Time for extensive discussions is not wasted time even if would take two or more years. It would be a good investment to learn from social realities and processes rather from academic studies and surveys.

**STEP 3** The inefficiencies, bureaucratic rigidities and loopholes in our government insurance and/or Medicare need carefully to be studied. It would not be easy to get proper insight into this murky area. But if we would not understand all the ways and means how an existing health insurance organization is being abused and misused we will not be able to manage the future of a "social" health insurance for the benefit of the honest and humble people in need.

**STEP 4** Especially essential is an orientation of Local Government Units on objectives, mechanisms of operation, coverages, etc... The Local Government will play an important role in health care in the future. The major focus of our endeavors will be to empower and enlighten them. Health care management is a biog concern for all Filipinos. The political representatives of the barangays, municipalities, cities and provinces will have to know what effective, efficient and equitable health care management really means. They should be elected on these grounds.

**STEP 5** We are recommending the accreditation of HAMIS providers by the most appropriate level of DOH endorsed through the lowest possible level of the LGU. We also ask that approved accreditation standards. Priority should be given to providers that have comprehensive health care approaches based on empowered populations and using PHC standards. Standards would include all the criteria met by HAMIS winners that qualified them as excellent health care managers: quality, effectiveness, efficiency, equity, innovativeness and sustainability. We, HAMIS winners, have an approved set of 66 criteria for looking into the standards of good health care management. They could be used for building up a social health insurance.

**STEP 6** Details of the health insurance will have to be discussed objectively: the advantages and disadvantages of different benefit packages and coverages the different premiums for the different target groups, the definition of terms, e.g. effectiveness, efficiency, equity, benefits, indigency. This is not just a technical step to be prepared by insurance specialist, economist, mathematicians, etc. A broader participation of concerned citizens and community organizations and non-governmental organizations should be included in this step.

**STEP 7** The pilot testing of different models is an essential feature of a smooth development process towards a social health insurance. Demonstration projects and evaluation of on-going endeavors will be centers for pilot testing and evaluation. The many existing models of health assurance and health insurance and the many ways and means of formal and informal social security and safety nets will be reviewed. the same process was done with more than 30 HAMIS winners that underwent intensive case studies. There is not just one option for pilot testing, e.g., Medicare 2. There are many other options and alternatives that might be combined into a network of approaches rather than into one streamlined bureaucratic entity.

**STEP 8** Such models work against a backdrop of real existing public and private health services which have to be reviewed at local levels in terms of effectiveness, efficiency and equity and in terms of the capacity and willingness of local governments to run them.

**STEP 9** The lessons of these collective and social learning processes should not be applied nation-wide immediately. There should be an on-going phasing and review based on the principle: the best health benefits for the poor and for the needy through the best combination of existing and emerging organizations.

**STEP 10** The assessment of organizational alternatives might result in the option that is in the form of Federations or Associations of Insurances at the most appropriate levels of organization. A possibility is that existing non-profit or social health insurance can be organized at regional or even at national levels as deemed appropriate by them. Then they will attach to the corresponding level of organization of the Department of Health or any kind of mother agency that cares for comprehensive primary, secondary, tertiary health care on the basis of an improvement of the socio-economic background (i.e., pre-primary health care). The members will be the ones to decide if they are to be integrated into the local, regional and even national level of organization.

The HAMIS WINNERS' CLUB on Health Insurance will start drafting a bill that is according to the principles stated. At the same time, we will incorporate as many elements as possible into the proposed "Angara Bill" on health insurance. And we are actually working on the finalization of our policy position paper on local health care financing.

More power!