

## ***Socialized Healthcare vs. Market Segmentation***

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### **Introduction**

The debates in socialized and politicized medicine pricing, where the drug price control policy won and is still in effect for 8 months now, has temporarily subsided. The policy is projected to remain in place up to the end of the term of the current political administration, and the new administration coming in by June 30 will consider to either retain and even expand it, or abrogate it.

For now, the focus of public discussion in healthcare is on a socialized health financing issue. In particular, the politicized government health insurance system. This is triggered by the observation that many poor Filipinos do not avail of healthcare services because of lack of knowledge and institutional restraints, and that out of pocket (OOP) expenses by the public, especially by the poor, remains high, about half of total public spending on healthcare.

The other day, there was a big conference called the “First Health Financing Summit” held at the GT-Toyota Asian Center Auditorium, University of the Philippines (UP) Diliman, Quezon City. It was jointly sponsored by 4 academic institutions (UP, Ateneo, La Salle and the Asian Institute of Management, AIM), and attracted a huge audience.

There were 12 speakers and reactors in the event, mostly from government (DOH, WB, WHO, British Embassy, a Mayor) and the academe (UP, Ateneo, La Salle, AIM and the National University of Singapore, NUS). There was one patient group or health NGO, but there was no speaker from the private health insurance industry, an important player in the health financing sector. Given such composition of the speakers, there was a general bias towards more government participation and intervention in health financing.

This paper will attempt to join the public discourses on the subject by providing some conceptual framework. It will refrain from producing empirical data as most literatures, past and present, dwell on empirical studies of the subject. Providing an alternative conceptual framework would provide some value added to the on-going public discourse and debates.

## **Healthcare is primarily personal responsibility**

In a number of public discussions on healthcare and health financing that this writer has attended, it is seldom discussed or hardly mentioned the personal and parental responsibility aspect of healthcare. The dominant thinking is that healthcare is a collective and government responsibility, that healthcare is a right and a citizen entitlement, that there is massive market failure in healthcare delivery to the poor, that government failure in the past to deliver what it faulted the market for is forgivable, and that more government intervention is the solution to past government failures.

It is not a good arrangement if some people will over-drink, over-smoke, over-eat, over-sit, or over-fight, or live in dirty and unsanitary houses and environment, then when their internal organs are dilapidated, they run to the government to demand health financing like cheap or free medicines, hospitalization and healthcare, asserting that "healthcare is a right." Such situation is a perfect opportunity for opportunist politicians, tax bureaucrats and vested lobbyists to raise taxes, or retain existing high tax rates, to help finance such transfer of accountability from personal responsibility to government responsibility.

There seems to be no literature yet estimating how much of sickness and deaths are attributable mainly to personal irresponsibility and abuse of body by the patients. It may be small. But one indicator that it may be significant, is the fact that about 6 or 7 of the top 10 causes of mortality in this country are directly or indirectly related to smoking. And lung cancer (mainly from over-smoking) and liver cancer (mainly from over-drinking) is a growing disease among many people.

Such "moral hazards" problem of complacency and dependence on government provision of socialized healthcare should be minimized. Not only to reduce the waste of personal and social resources, but also to minimize the corruption of the people's mind that it is alright to rely on other people's resources and savings as forcibly pooled and accumulated by the government, for their healthcare and other personal and household needs. Encouraging people to live a healthy lifestyle as well as taxing higher and regulating further alcohol and tobacco products, should be a good function for the government.

## **Health insurance deregulation and market segmentation**

There are proposals to expand the coverage and mandatory contribution to the government-owned Philippine Health Insurance Corporation (PHIC or simply PhilHealth). The new goal is to reach out to those in the informal sector of the economy, the poor and indigents.

It is the contention of this writer that PhilHealth should only cover what it is covering now, no more, no less. Its focus is to provide hospitalization benefits for patients. If a patient is not confined in a hospital for at least 24 hours, he/she is not entitled to PhilHealth coverage and reimbursement. Some exceptions to this rule are granted to the indigents though.

What government should do, is to further deregulate and liberalize the private health maintenance organizations (HMOs) or private health insurance industry, and allow for market segmentation – different healthcare services for different annual premium for different people with different health needs and different budget. This second and “add-on” health insurance is on top of PhilHealth membership and contribution.

Here’s an illustration of market segmentation.

Some poor people can get private health insurance for only P1,000 per year per person for a limited coverage, say only X number of physician consultations + Y number of diagnostic tests., no hospitalization benefits. Some can get at P5,000 per year per person for wider healthcare coverage, while those rich enough can get P100,000/year if they want to, for unlimited health coverage, and so on.

Consider food. A poor man’s meal in a carinderia can cost only P20, while a meal in a fastfood chain can cost P200, and a fanciful meal in a fanciful restaurant with good music or live entertainers can cost P2,000 or more, and so on. The point is that there is a market for everyone, rich, middle class, poor.

If the poor will find the P1,000 per year per person health insurance still expensive, there are a number of civic groups, corporate foundations and private charity organizations that are willing to shoulder such expenses. Or local governments or some national agencies (DOH or government-owned gaming corporations Pagcor or PCSO) can pay and sponsor the poor.

The advantage of this arrangement is that people who tend to abuse their body, like those who over-eat or over-drink and over-smoke, or those who are just sickly due to genetics and other biological factors, will become less burdensome to the rest of society. Those who tend to abuse their body and still wish to have a longer and healthier life should get a private health insurance with wider services. Treatment of certain diseases like liver cancer due to over-drinking, or lung cancer due to over-smoking, should not be passed to the rest of population against their will. So if those people will get hospitalized, they can draw on two sources, their private health insurance + Philhealth.

With regards to patients, rich and poor alike, with genetic and biological problems that make them weak and sickly, there are a number of people who put up voluntary social solidarity schemes through their civic and charity organizations, who can help such patients.

Some rich local governments also have their own city or provincial hospitals that provide free or highly-subsidized healthcare services, both for in-patient and out-patient services. Examples are the provincial and district hospitals, the Ospital ng Makati (Osmak) and the Ospital ng Muntinlupa (OsMun).

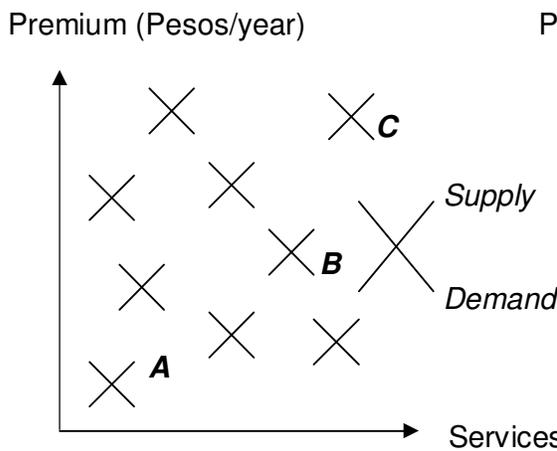
This writer though, has a personal bias against expanding Philhealth coverage and hence, higher annual premium. The last time he got hospitalized was about 30 years ago. And he has been paying Medicare, now Philhealth for nearly 3 decades now, but never ever benefited from it. Siblings and parents are themselves PhilHealth members. On the other hand, he greatly and clearly benefits from his private health insurance. There is annual general check-up, which is preventive healthcare; quick

physician visit for general diseases like hard cough and fever, undergo certain diagnostic tests like X-ray and blood test, all for free because of the insurance. It is very useful.

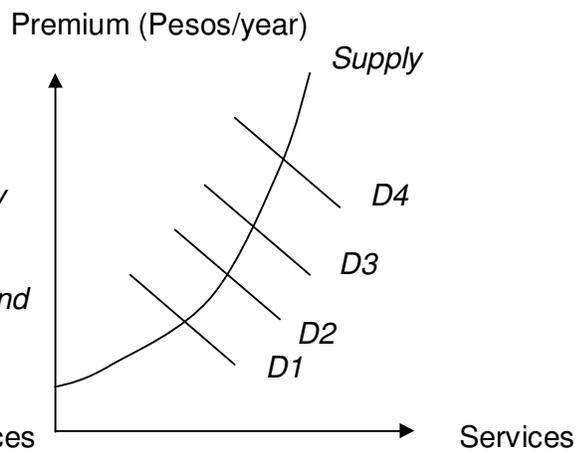
Here is another illustration of market segmentation with the use of a graph. For readers who are not familiar with basic supply-demand graphs, the supply curve or line is upward-sloping or going upwards, to reflect supplier or seller behavior that as the price goes higher, producer is willing to supply more of a good or service in order to make bigger sales and/or profit. The demand curve is downward-sloping or going downwards, to reflect consumer behavior that as the price goes down, his/her demand for a good or service goes higher.

**Graph 1. Market segmentation and service differentiation vs. socialized and homogenized market.**

A. Market Segmentation



B. Socialized and Homogenized Market



Under market segmentation, there are various “equilibrium points” where supply meets the demand. Each intersection or equilibrium point represents a market for different individuals or group of individuals, say a corporate package or village package. Thus, point **A** has lower premium for fewer services. Point **B** has higher premium for wider healthcare coverage, while point **C** has the most expensive premium but much wider services coverage.

Under a socialized system, supply of health services and/or health insurance is homogenized or monopolized by the government. A moral hazards problem (complacency and tendency to abuse and be less responsible among members) is often encouraged. When something is given for free or at a very low price, the tendency is to over-demand a service, anyway it’s very cheap or free. For instance, someone with an ordinary headache might demand lots of diagnostic tests and medicines before he leaves a clinic. This puts strain on the supply of those services, and some patients will possibly be denied such free or subsidized service and/or medicines.

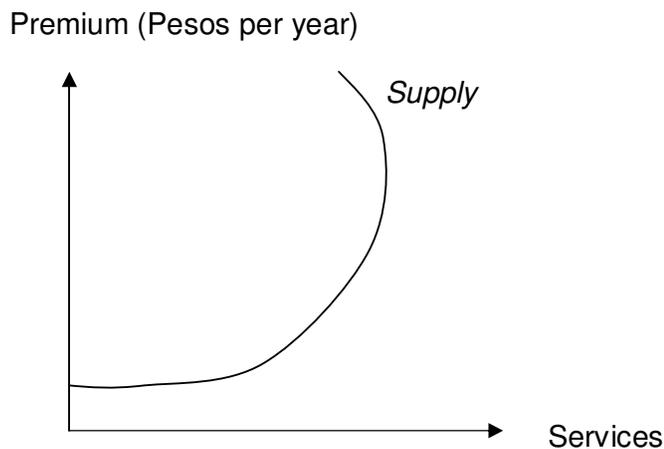
One result is that the supply curve of many services will move upwards. Meaning as supply is strained due to high demand by some patients, represented as D1 to D4

and so on in the above graph, who abuse the free/subsidized services and/or free/subsidized medicines, the cost of the program goes higher.

A worse situation is that of a backward-bending supply curve. Here, the credibility of the program is in question and under heavy suspicion of being unable to keep its long-term sustainability. So the tendency of the supplier, the government, is to ration services and medicines. Some patients will be provided with healthcare services, others will be denied and still, the overall cost of the program keeps rising.

Below is an illustration of this situation.

**Graph 2. Backward-bending supply curve when there is abuse or over-demand for services that are free or very cheap.**



Factors that contribute to this situation is corruption in government, abuse by physicians and other health professionals, and abuse by some patients. An example would be this situation.

A recovering patient who can be discharged from the hospital after 2 or 3 days would opt to stay for 7 or more days, anyway he/she will pay only very small amount as the government will pay the bulk of such cost. Some physicians and private hospitals will also like this situation as there is bigger revenue and professional fees from this patient alone.

Government fund for highly-subsidized hospitalization and other health services to other patients will be drained easily. So government reaction is to ration the services, deny some patients of a service that was given to other more influential patients, overall service is limited if not shrinking, but the cost is rising as a result of various wastes and inefficiencies, including corruption and robbery by certain government personnel administering and monitoring the program.

## **Concluding Notes**

There is a loud dictum reverberating in many discussion halls and academic or public policy literatures, that “No one should die because he/she cannot afford the cost of healthcare”.

This is a powerful, even emotional, call that few people would dare contradict. But if taken literally, adoption of this policy will result in huge cost and even waste in resources, both personal and societal. Abuse of socialized health financing should be avoided.

In an environment of bad governance culture in the country, giving more power and money to the politicians and various government bureaucracies would only tend to perpetuate and even worsen the situation. Repeated discussion of “market failure” is often a convenient excuse to cover up government failure in keeping up with the mandate assigned to it in public healthcare promotion.

Finally, matching the personal responsibility aspect of healthcare with market segmentation and provision of healthcare is an ideal public policy that minimizes waste and inefficiencies. This is not to say that government should pull out from public healthcare provision and monitoring, but to limit government involvement in the sector. Like the prevention of contagious diseases outbreak, and helping those who are clearly indigent, but never to the point of committing huge public resources to treat near hopeless or very expensive cases, to the detriment of other functions and mandate of the government that need to be implemented and sustained. .

## **Added References**

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