PREPAID MEDICINE: AN ALTERNATIVE MODEL FOR HEALTH CARE IN MEXICO

Samuel Garcia, MD

DR. WILLIAM BAKER: Our next speaker is no stranger to us. Dr. Samuel Garcia has been a long time member of our organization, traveling from Mexico to wherever we have our meetings, representing the Association of Medical Directors of Mexico. A number of us and the Executive Council had the privilege of holding our meeting this past March in conjunction with the 50th anniversary of the Association of Medical Directors of Mexico.

We were treated to an absolutely great time, with hospitality, excellent program, excellent weather and excellent scenery and we all appreciated their efforts to make this most enjoyable.

I've asked Sam to come and talk to us today, partly in recognition of the 50th anniversary. It's still the anniversary year for all of us to recognize the Association of Mexican Medical Directors. And also he has something to say to us about managed care as it's appearing in his country.

DR. GARCIA: Thank you, Bill, for your words and for this nice introduction. I bring many greetings from our medical society to all of you and unfortunately, very few attended our international congress. We were missing you. Here, I am representing again the Mexican association.

I think that many of the subjects that I will deal with, have been presented in some way since yesterday and very well presented. I apologize if I commit mistakes in my speech but I am not so used to talking to a big auditorium audience in English.

I will be saying that a few decades ago, talking about health care was mainly a medical topic, handled by physicians and people interested in the field of public health.

Nowadays the meaning of health goes beyond the mere absence of disease and healthcare is not the simple act of vaccination or immunization to prevent infections or curing illness by medical or surgical procedures. The current scope of both terms is much wider and linked to many other social, political or economical activities. The definition of the World Health Organization about health, saying it is the full status of physical, social and mental welfare, fits very well with what I am going to say.

Health care in addition involves the settlement of policies and community education programs intending to change negative habits and lifestyles among inhabitants that may deteriorate the mental or physician conditions. Special attention must be given to the psycho-social and cultural structure of individuals as well as members within a family or within a society.

Health care should be addressed mainly, and everybody agrees, to preventive actions and primary care. Less importance in a certain way has been this missing second level and the level should be separated because it's very expensive and if we, as Mexico for instance, have not resolved yet many problems, health problems, of an underdeveloped country when we are confronting new problems of countries overdeveloped.

The investment in health now has been considered as a human capital investment which is a new concept more or less. Human capital has to be considered in relation with all with what I have said and giving special attention to these aspects, psycho-social, cultural structure of the individuals, families and society.

In this relatively new concept our two converging forms to conceive a human being; first, as an invisible biocycle, social and cultural entity and as a source of income. In this form, human capital is the linkage between economy and health.

Nobody ignores the tremendous problems that healthcare systems are having today. The costs are well known, the astonishing advances in medicine and technology, continuous rising demand for services, increasing complexity in diagnostic and treatment procedures, and spiraling cost as a common denominator.

As a matter of fact, on TV, magazines, specialized literature, long spaces are dedicated to this because the increasing health expenditure growth in GNP terms in the USA, as long as I know, it's 14 percent and somebody said that in 2030 it will 100 be percent if things don't stop. In Canada it's around 9.3, in Argentina, 8.9, in Chile, 4.7 and in Mexico, 4.8, more or less.

There's also the urgent need of cost containment preserving or even enhancing quality and efficiency in the provision of services at the same time. New terminology, at least for me, such as
managed care and accountability, has been introduced lately into the health care administrator’s and provider’s daily language. Being the latter, the more recent.

Managed care indeed is not easy to be defined, as Dr. Nigel Roberts says in his editorial article in the fall of 1991. To some, as he says, it’s a way of life, a religion to others, and to understand and participate it is necessary to be a believer. Well, I am a believer but in the process of achieving full understanding.

President Clinton’s health care reforms introduce the term accountability. Spanish translation has been difficult. I couldn’t get very much success consulting dictionaries. It means responsible in Spanish which means responsibility in English or a response to something in the sense of being reactive or sensible.

Obviously this is not what accountability means. So I consulted with economists, lawyers and a friend of mine who happens to be a psychiatrist gave me an explanation, and he told me that it had something to do with some theories of Sigmund Freud and it was a kind of sexual reaction or something like that.

(Laughter.)

DR. GARCIA: So I better not talk about this issue with my colleagues in Mexico for the time being. At the end of the century the healthcare system in Mexico is sharing most of the problems experienced in the rest of the world, in the public as well as in the private sector, affecting payers, providers and consumers.

However, certain circumstances are given to Mexico, mainly derived from government policies that have generated additional problems. I’m convinced that government participation in health care is necessary in poor as well as in rich countries, complementing individual efforts. Nevertheless, individuals themselves should be primarily concerned with their own health care needs and satisfaction in an equal manner as they do with education, dwelling, nourishment and so forth.

On the other hand, people should be free to select the affordable system and suitable coverage complemented or not by employers or government. Taking into account the existing differences in health services, structure, financing, funding and provision in Mexico, compared to those in the US and other countries here represented, further explanation must be given.

HEALTH CARE IN MEXICO

Health Ministry

Mexican public and private health care organizations are structured as follows. I will begin with public institutions. It’s represented first by the health sector head which is the secretaria de salud, health ministry.

Functions are mainly regulatory, preventive, dedicated to environmental control and medical assistance. Most are primary and second level care to, as we call open population and indigents, open population is uncovered by Social Security. And most of installments have exceptions made of some cursory level facilities, mainly in large cities, are dedicated to this primary and second level care.

The Health National Institute that also belongs to the ministry of health are composed of ten large hospitals located, all of them, in Mexico City, providing highly specialized medical attention.

They do a lot of training, medical and research in the fields of cardiology and cardiovascular surgery, nutrition sciences, internal medicine disciplines, neurology and surgery, oncology, psychiatry, respiratory diseases, public health. And there are two hospitals dedicated to children’s care.

Financing is mostly supplied by government using tax funding. Consumers, unless indigents, pay out of pocket quotations according to their income level and those collected quotations are sent to the Ministry of Finance and now they are more used as a second source of finance in those organizations, institutes and primary and second level care installations.

External funds might come from national sources, some donations of private organizations or from foreign sources, basically for specific fields for research or building some special area of hospitals for some special kind of care.

According to the 1990 statistical reports and based on financial resources, the Ministry of Health coverage capacity is around 34 percent of the total population. It means 39.5 million inhabitants more or less. Mexico has now a total population of about 86 million people.

Social Security

The Social Security is represented by several institutions that are the second and the most powerful in financial resources and coverage and all of them are more or less similarly structured, mainly represented by the Mexican Institute of Social Security which provides full care services to private companies, employees, workers and dependents.

They cover 55 percent of total population which is a lot, 44 million inhabitants. Financing is supplied by employers in 69.5 percent and employees by 25.3 percent, which is 94.8 percent of obligatory contributions. Government provides only the 5.2 percent. So this is a triple payment system.

There are some other institutions like the Instituto de Seguridad. It is the Social Security and Services of State Workers. This is also a full health care service but restricted to government workers and dependents. The coverage is around nine percent of the total population which means 7.5 million inhabitants. Financing is supplied by government, as the employer, 79.5 percent and workers through monthly payroll discounts, 20.7 percent.
There are also other Social Security systems for special groups of population, those belonging to Armed Forces, Navy, PAMEX which is the Mexican company, that have their own Social Security administrative systems and installations being of minor importance from the funding and coverage standpoint.

Private institutions

Private medicine has not been formally organized and has been contributing to the health sector in a dispersed and atomized participation in health care. At least 2,500 medical units in 1992 representing 18 percent of available consulting rooms and 30 percent of available beds at the national level are under the private medicine.

Unfortunately, many resources that have been of first class haven't been used by the public sector. I don't know why. Because every system wants to have their own property and are competing to see if the neighbor has a little more than the other one, etcetera, no matter that they are expending a lot of money that could be shared or at least diminish the cost of the services if taken advantage of, in this case private medicine installations.

Expenditure is in the range of 43 to 52 percent compared to the expenditure of the public sector. This is according to two sources of information, but it shows clearly the importance of private medicine in health care expenditure and coverage.

Private insurance has been undeveloped mainly caused by probably the lack of insurance culture among people and it is also the result of Social Security side effects because the tremendous growth of the Social Security made the population feel the lack of necessity of additional coverage in health.

Many times the health insurance is offered by insurance companies and agents as a complement to other kinds of policies. There was only two percent of insured population in 1990, but a substantial increase to four percent in 1993 shows a rising awareness of its benefits among the middle class population and I think it will continue growing in the next years.

Social Security's monopolic role together with its attention to specific population groups has led to a loss of liberty for free elections, people's segregation even though we are talking all the time about the integration of the population, that all inhabitants are the same, etcetera, etcetera. The government is doing a very important segregation, grouping people under different systems.

This obviously is the cause of lack of incentives for competition, an equal distribution of services and user satisfaction. There are many inquiries in those institutions and the results are amazing. For instance, in the State of Wahaca, only 16 percent of the physicians say hello to the patient. Just imagine, just like cows. Open your mouth, I want to see your tongue, etcetera. And they don't even say hello.

So the dissatisfaction is a big problem. Consequences of this mess that I presented to you in the system are duplicity. It means that the resources simultaneously are delivered to different funds. They might go be delivered simultaneously to Social Security and either to private funds or private insurers or both. Waste of resources and services is a common occurrence due to different provider agencies' co-existence.

For instance, within small areas there might be a Social Security hospital and another for the workers of the government and another installation of the oil company and also a private hospital, co-existing all together. It's even worse when two or more of those are also supplied with underemployed sophisticated equipment and over-specialized personnel.

This is an example of inefficiency.

Demand overlapping happens when the use of installations are made for uncovered populations, are made by insurance and vice versa. This mainly is due to better geographical locations in emergency cases or because of better technological facilities in Social Security hospitals or less common to dissatisfaction with public assistance services which have been more poor in resources usually give more care, as Dr. McAfee was talking about yesterday, a real care of the patient.

Multiple quotation or contribution is more commonly seen in large cities. It is the case, for instance, of married couples or family members receiving protection from two or more Social Security agencies depending on working source and when, in addition, one or more of them possesses private health insurance coverage. Furthermore, a certain number of selected employees working for government or private companies or for the University of Mexico, for instance, receive incentives which may be in the form of a health insurance policy, premiums being frequently shared with employees.

On the other hand when ambulatory services are needed, private providers will be used and as long as professional fees are generally lower than deductibles, out of pocket payments should be done. It's dramatic, isn't it?

So five times the single family has to pay for the same coverage, health coverage. Even more, employers by means of rising company products or services, will transfer to the public employees' benefits costs, expenses that also will be reflected in salaries. Employees in turn, as potential consumers of those, might contribute in a certain proportion their own benefit payments.

Government financial support until recently has been oriented to delivery of high cost, low effective services which is another ever in the system, obviously happening for political reasons. If subsidies were directed to the demand instead of the offer, providers offering higher standards by means of a free election system would be financed by satisfied users, thus generating incentives derived from competition and rendering higher quality and warmer services.

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It is quite clear that substantial modifications shall be done to achieve equity, efficiency, cost containment and quality enhancement, promoting settlement of managed care systems, as a daily work philosophy, provoking change in authority's attitude and complemented with education programs focused at payers, providers and consumers for better utilization of health care services now under a new organizational framework.

A long time ago, Dr. Fernando Molina-Font, after medical training in England, realized the urgent need of private Mexican companies for the provision of good quality medical services to their employees and their dependents. With that purpose in mind, in 1931 he established in Mexico City the pioneer prepaid medical organization, 12 years before the founding of the Social Security Institution, giving it the name of Servicio Medico Social: SMS (Social Medical Service), which still exists to date and is currently the owner of Clinica Londres, one of the most prestigious private hospitals in Mexico City, fitted with modern installations and the most advanced medical technological equipment.

Incorporation of a growing number of private companies into this system—mainly foreign and local banking organizations—soon began, receiving ambulatory and hospital services based on employer premium payments for employees and dependents. Providers' professional fees as well as hospital costs and services were agreed in advance. A parallel growth of installations and facilities as well as the number and professional quality of physicians was observed for a number of years, making a profitable business of the SMS.

As costs began to rise, companies were reluctant to increases premiums in proportion to, leading to a change in the terms of agreements, so the pay-per-service model was transiently adopted. In the last two decades, some other private hospitals have been providing medical attention on a similar prepaid basis, although at lower premium rates and with the consequent reduction in quality. Underemployment of services due to user dissatisfaction have produced attractive revenues to these providers.

At the end of the 1970s and during the first half of the 80s, a series of events took place in Chile causing substantial changes in the prevalent healthcare system. Among the most important that were brought are the following:

a) elimination of previous existing grouping segregation between "workers" and "employees" that were attended by two separate government systems;
b) legislation authorizing workers access to the "free election system;"
c) agreement permitting medical attention in private hospitals;
d) modernization of government healthcare structure by administrative decentralization and service regionalization;
e) legislation favoring the creation of private care institutions—Institutos de salud previsional, ISAPRES—and employees freedom for the delivery of obligatory health contributions to any private institution, unless wishing to remain under state protection;
f) federal subsidies provided in amounts proportionally inverse to income levels; and
g) establishment of typical private sector incentives, improving management efficiency in the public sector.

The ISAPRES, thus established have given origin, at least in Latin America, to a healthcare model which has been followed by many other South American countries. Modifications to the original model have been made according to local policies in different countries.

Remarkable advances in healthcare matters have been registered in Chile after an experience of almost 14 years under this system, positively reflected in the quality of medical attention, satisfaction levels among users, and economy standards in healthcare centers. An increasing number of beds, modernization of equipment, construction of new hospitals, academic improvement of health staff, teaching and research are, among others, the result of this healthcare system reform.

In the last six years Mexico has experienced substantial changes in government policies and is now an active participant within the framework of the global economy. Increasing optimism is partly the consequence of NAFTA and the commercial opening to the rest of the world. Healthcare is not exempt from the needs of change and the private sector could easily be the first to adopt new management systems.

In recent years, several prepaid healthcare organizations have been trying to establish business in Mexico, facing some difficulties mainly due to insufficient information and to some distrust among employers and providers towards the change, in spite of the urgent need of cost containment and expense control. Nevertheless, taking advantage of successful experiences in other countries like Chile, Argentina, and Brazil, we felt confident about the advantages and feasibility of the prepaid system; its increasing acceptance is only a matter of time. Introduction of similar policies and management techniques into the public sector are not excluded.

The Prepaid Health System (PHS) is based on insurance outlines that may be applied to company employees and dependents, family groups, or to individual bases. PHS agencies may act as health funding administrators only, or carry out funding administration together with the organization and control of the provider's network, or as healthcare providers themselves.

PHS operation is carried out under the following general bases:

a) financing obtained through annual or periodic membership fee payments from employers, families, or individuals;
b) members' choice of plans and prices according to their needs and financial resources;
c) free election of professionals and installations within the provider network—payments for services received out of network will be made at the same rates agreed in the purchased coverage plan, amounts in excess paid by users;
d) apart from emergency cases, PHS agencies, upon users' request, will issue checks in advance, to cover expenses for services to be received, when those are plainly justified and no exclusion clause has been considered within the plan;

e) subscribers' co-payment, usually in the range of 10 to 30 percent of the cost of services, is a helpful measure for expense control; and

f) freedom to choose the PHS agency of preference or to switch to another agency due to dissatisfaction, seeking more attractive plans, better quality of services or lower costs, thus favoring competition.

Advance financing of services, including all kinds of ambulatory procedures and medical consultations, covering fees from $0 and up, no age restrictions and anticipated analysis of medical actions to be performed, thus preventing misunderstandings on pre-existence concepts, make some of the differences between PHS and traditional health insurance.

In case of pre-existing chronic or recurrent diseases, like diabetes mellitus, or peptic ulcer, for instance, two options can be offered: exclusion of coverage for the disease and its possible complications or acceptance of coverage through a higher premium rate, previously calculated according to nature of disease and based on statistical experience. In certain well documented cases (peptic ulcer is again a good example), coverage can be offered at standard rates if no relapse has occurred during a determined number of years, provided clinical evaluation and current studies show no evidence of active disease.

A common practice among prepaid care agencies is to fix a first coverage limit, usually around $25,000 to $30,000 for incurred medical expenses, paid directly by agencies to users and providers. Medical expenses exceeding this amount, as well as catastrophic occurrences, will be covered by stop-loss and/or excess of loss reinsurance treaties previously contracted. In the first case a top limit will be fixed beforehand (typically it could be $100,000 in excess of $25,000) and if this limit is reached the PHS will be liable for the costs above it. In our experience, and considering our medical costs, few cases reach the upper limit.

The cost per person in a PHS should be based on actuarial calculations using previous statistical experience, which will have to include a large number of individual medical histories during a span of time of no less than 10 years and defining the risk by age and gender.

There are four key elements that must occur in order to guarantee the success of a prepaid health system: agreements with providers of services, access to the system, information, and medical audit.

Agreements with providers of services

Cost of hospital services as well as medical fees must be agreed upon, as they will be the basis for putting together health plans and establishing their costs. As was mentioned beforehand, any one who has contracted with the PHS and wants to use health services outside the network provided by it, must pay any extra costs incurred.

Access to the system

PHS comprises the necessary infrastructure and its organization in order to facilitate to users easy and quick access to the system. For instance, large clients of the PHS could have a service module installed in their premises, with administrative and paramedical personnel and computer workstations linked with the central office files, so that in a very short time administrative information such as whether that particular person is covered, medical history, pre-existing conditions, etc. can be known. The paramedics with this data can determine the nature of the health problem and the type of medical attention that it needs—general or specialized—and will provide information on the medical roster active in the net, office hours, and addresses. The appointment can be made by the service module and if the fee payment check can be given to the patient if no restrictions and/or limitations were detected.

The same procedure can be followed for other services, such as clinical analyses, imagenology, etc., which in most cases will be ordered by a medical doctor in a previous consultation. The patient will pay the percentage of the cost that is determined in the specific plan that has been contracted. In certain cases the payment can be made in full, and the percentage can be discounted from the next salary check.

Information

All the pertinent data on the services provided, preliminary causes and definitive diagnosis, treatments, medicines prescribed, and dates of occurrence will be registered in the main computer.

Special attention must be given to medical procedures and their cost that arise from hospitalization, checking the material used, if the medicines prescribed are in accordance with the pathology diagnosed and taking care that expenses not generated by the specific medical treatment (family expenses, toiletries, telephone calls, and even medical fees not connected with the actual illness) are detected and eliminated. The entry and discharge diagnosis will be clearly indicated, as also specific medical and/or surgical treatments and their corroboration through clinical analyses, including histopathological ones if any kind of tissue extraction has been done.

When the PHS has been contracted for by a corporation, monthly detailed information will be given concerning total cost, payment to services purveyors, individual diagnosis, medical procedures, cost per employee and their dependents (total and individual), number and type of medicines prescribed, and the comparative ratio between expected and real costs.

With these controls, deviations from the norm, abuses and misuse by the users; also errors, abuse and actual fraud by providers
of services can be detected on time in order to apply corrective measures and sanctions to eliminate disruptive factors.

Medical audit

Every medical action will be subjected to a rigorous analysis in order to validate and classify it, control the number of instances it was used, the prescription of medicines and other medical material, etc. Each and every one of these medical actions should be backed by a checkable diagnosis through laboratory, imagenology and histopathology studies approved by the supervisors, especially in doubtful or marginal cases.

It is practically impossible to see its whole scope, but I consider that the ideas expressed and the all to brief information presented, should raise questions and open up new areas to implement more effective systems in the integral health schemes that should have new points of attack.

(Applause.)

DR. WILLIAM BAKER: We have a couple minutes for questions. If you'd like to ask Dr. Garcia, come to the center microphone.

Sam, I have a question. I've been getting a couple of mailings in the past few months about a conference that's going on in California about American investors and how they can put money into these medical equipment companies and health care delivery companies, to invest in Mexican enterprises and are going to export all of our expertise down to you and you have lots of money to buy this and we're going to make lots of money by doing this. Have you heard about this? What's happening?

DR. GARCIA: Yes. In fact these days there's a group of HMOs visiting Mexico and trying to find out some things about the market and the procedures to be involved as investors in Mexico. I don't remember the rules and the proportions that at the beginning are required for foreign investments in this particular field. But Mexico is open to this investment. You remember some years ago it was more difficult.

Humana, a chain of hospitals, opened a beautiful large hospital in Mexico which I had the opportunity to be the medical director and it didn't work at that time. The things have changed a lot in the last ten or 11 years and now it's easier and many other organizations are looking for this kind of investment.

DR. WILLIAM BAKER: We're going to take a refreshment break and we will reconvene here at 10:15. Thanks again, Dr. Garcia. Congratulations to the association.

(Applause.)

(A recess was taken.)