S ince 1988 this writer has penned several articles about "reinventing" the Philippine and American healthcare and hospital industries, as well as the medical profession. Some of the articles were published in the now-defunct *Philippine Journal* and *Manila Standard* publications in Los Angeles, California, the *Filipino-American MegaScenes* magazine of Chicago, Illinois, and the www.pinoyonboard.com of New York City. Lately, I met with Alexander Kim, the deputy director of the Los Angeles Office of Gov. Arnold Schwarzenegger. Both Governor Schwarzenegger and the California Assembly and Senate are in the process of "reinventing" the healthcare industry of the Golden State. I promised Mr. Kim that this online publication would run an updated series of the articles that I have written about the topic as my input to the present legislative process. Mr. Kim assured me that he would bring to the personal attention of Governor Schwarzenegger my proposals.

So here is Part One of the revised series:

T oday we shall discuss the problems of the United States insofar as healthcare is concerned. As of March 2004, there was an estimated $25 trillion (spelled with a " **T**") in unfunded liabilities in Social Security and Medicare. It has been reported that more than 50% of hospitals in California are virtually bankrupt and are in danger of closing shop. What is happening to California hospitals is also occurring in other states. The primary reason for the financial collapse of many private hospitals is the lack of medical insurance of a growing number of patients. Another factor is the now-prohibitive cost of medical-malpractice insurance. Even

public hospitals are suffering financially and, thus, contributing further to the budgetary crisis of most county and state governments.

American Patient's Bill of Rights

Sometime in February 1994 I sent a letter to Dan Rather, then the CBS Evening News' anchor. It was about his report on the growing health bill of illegal immigrants and undocumented aliens. Then and even now American healthcare facilities never ask if patients, especially those being brought to the Emergency Rooms, have valid immigration papers and whether they have medical insurance. Federal laws mandate that hospitals treat patients without preconditions and do later the billing for the medical services performed and medical supplies provided. All of these regulations are part of the American Patient's Bill of Rights.

What I proposed then to Mr. Rather was the solution for the unpaid medical bills of illegal immigrants, undocumented aliens and even tourists with valid visa. I suggested then that the respective state and county governments send to the State Department the said hospital bills. The local governments should ask that they be deducted from the American military aid and economic assistance that are given to the home countries of these foreign patients. I will still make the same suggestion.

Tourists who validly enter the United States and who get sick are treated at American hospitals in the same way that American citizens or legal immigrants are dealt with. There have been cases of foreign tourists collapsing in some Las Vegas (Nevada) casinos who were flown to California hospitals for treatment of heart ailments or even previously undiagnosed cancer or aneurysm. Some hospital bills for these tourists exceed $200,000 per patient. At the end of the hospital stay, the county and/or state governments absorb the bill in their budgetary system. It is not fair for California taxpayers to be paying Federal taxes that fund American military and economic aid sent to Country X and then get hit with the medical bills of Country X's citizens

who visit or overstay in their state. The present practice is the equivalent of a financial "*double jeopardy*
."

In line with my proposal sent to Mr. Rather, I proposed also for the Philippine government to send to the home government of foreign patients who incur hospital bills in the Philippines. My initiative would have made no exception for the refugees who are forced to stay in temporary refugee centers in the Philippines (or in the United States) on account of civil war or unrest in their native countries. If the foreign country could not or refuse to pay the medical bills, my proposal would have mandated that the hospital bills be sent to the United Nations for remedial action or reimbursement by international aid agencies.

Reinventing the Medical-Malpractice Insurance

Nowadays some American neurosurgeons pay more than one-million dollars in medical-malpractice insurance premiums per year. The premium rates are getting unconscionable. Medical-malpractice lawsuits (MML) are skyrocketing in number. Despite caps in many states, jury awards for physical pain and suffering are still going through the proverbial roof. There should be a way to "**reinvent**" the system while still protecting the rights of patients to seek compensation for the incompetence of, or wrongful diagnosis or treatment by, their attending physicians or hospital personnel.

What I have proposed for the Philippines might be applicable in the United States. Here's how my proposal would have addressed the problems of the Philippines insofar as the MMLs are concerned.

My idea would have expanded the function of the Medicare, so that it would manage a pool of all the private insurance companies engaged in medical-malpractice insurance. Then there will be an automatic arbitration in settling the MML. It would also provide that all awards resulting from MML be payable to the Medicare or to the victim's health-maintenance organizations

(HMO). In turn the Medicare or HMO would credit the account of the member concerned. The credits can be used for medical treatment, retirement-home or nursing-home stay, medical supplies and health needs such as medicine, dietary supplements or even the items required by dependents such as infants and minor children. The MML-based credits can be made transferable to any kin or friend and used for similar mandated purposes. These credits may also be used to settle tuition fees of medical or nursing students. If the patient engages the services of an attorney in cases where actual lawsuits are allowed as exceptions, then the jury awards shall still be made in the so-called MML-based credits. This means also that the attorney's fees shall only be settled in form of the MML-based credits.

The lawyer may use it also for his own or kin or office staff's medical or hospital requirements. This suggested practice might discourage many attorneys from engaging in ambulance-chasing practices. Not too many lawyers will like this proposal and we are sure that lawyers' groups will lobby hard and long to defeat this proposal. I argue that if the MML were settled in a manner that will not involve cash settlements, then very few attorneys would be as aggressive in filing lawsuits.

My proposal would have provided exceptions under extra-ordinary circumstances. It would have also added the option of depositing the MML-based credits to one's Medicare or voluntary-indemnity accounts. The credits may be paid also to an existing accident/disability insurance policy (ADIP) or a hospital-confinement indemnity policy (HCIP) that has been issued by a private insurance company.

***To read Part Two of this series, please go to

Reinventing the American Healthcare Industry (Part II)