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**PREPAID HEALTH INSURANCE
PLANS IN THE
INTERNATIONAL SETTING:**

**Market Forces and Steps
to Implementation**

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**HEALTH CENTRAL MEDICAL
TRADING COMPANY**

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1. INTRODUCTION

This monograph will attempt to explain the ingredients which go into creating health maintenance organization in Third World countries. For the purposes of this presentation, the definition used of a health maintenance organization (HMO) will be broad, allowing for a wide variation in organization and scope of the HMO: An HMO is an entity which "assumes a contractual responsibility to provide or assure the delivery of health services to a voluntarily enrolled population that pays a fixed premium that is the HMO's major source of revenue" (taken from the Department of Health Education and Welfare: Health Maintenance Organization, Federal Register 39:37308-37323, October 18, 1984)

A principal component of this paper will be the description of how a U.S. private sector company would approach participation in a Third World HMO project, as an equity investor. Two U.S. companies have actually done this: Hospital Corporation of America and Health Central International. There seems to be growing interest in the Third World about how to attract U.S. HMO technology, know how, and capital. This monograph will attempt to expose the thinking and consideration which guides the decision-making process a U.S. company goes through. In the process, the ingredients which make up fertile ground for HMO development will be revealed.

There are several factors at work today in the Third World which are dramatically influencing the world of health services delivery systems. These factors are contributing to an increase in the demand for new vehicles for delivering health services with the kind of efficiencies required in the 1980's. Those efficiencies are cost and service delivery oriented. One of these new vehicles, which is efficient in both cost and delivery, is the HMO. The HMO, however, has a strong private sector origin. It is in this area, private sector relative to public sector, where the challenge of acceptance and application begins.

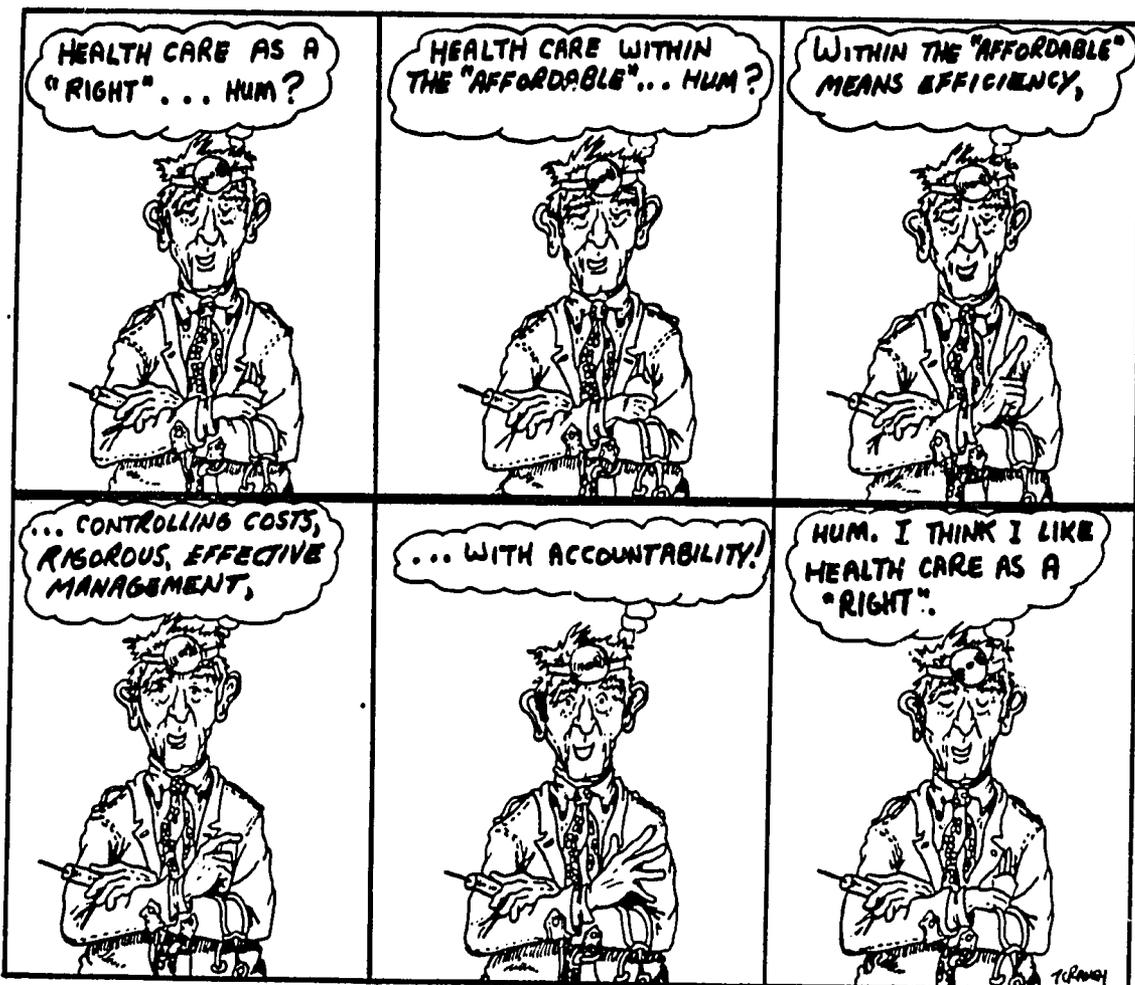
An HMO, or pre-paid health insurance program, is a form of health insurance. HMO's have been developed to the largest extent in the U.S. in the private sector. The majority of them are profitable. One must not assume that because of this the prime motive is profit, and that a side-result will be reduced quality or quantity of care available.

By and large, outside the United States, the vast majority of health systems are public sector oriented. It is unfortunately true that the public sector health services are often managed inefficiently. Resource allocation and utilization levels in health services vary enormously between countries, according to social, economic, and political factors. Health services are normally rationed using one or both of the factors of ACCESS and COST. For example, in the U.K. use of the public system is controlled by limiting access, hence long waiting times for procedures. Other countries design co-payments for health services at the point of use, thus rationing through cost.

HMOs generally offer a comprehensive package of services with fairly strict utilization review to determine appropriateness of care, and rely on

extremely "tight" and effective budgeting and management of the system of finances and health service delivery. These principles are sound and can be apply to the public sector as well as to the private sector.

Because health care in most countries is public sector oriented, the population at large (the consumer), and the physicians (the providers), feel that the provision of health is a right and obligation rather than something to be purchased and selected. The result of this concept is the creation of extreme difficulty in introducing new concepts which suggest choices, the need for patients to pay for care, and a reduction in services from what the public is accustomed to. It also creates another problem which is that of political repercussions. For example, when a government suddenly suggests dramatic reform in the health care delivery system from public sector responsibility to private sector responsibility, that may be viewed as government rejecting its obligation to deliver health care. It may be viewed as looking to the private market place as the solution to the problem. In Third World countries in particular, this perception may be accompanied by negative political connotations. Those connotations are capitalism versus socialism; public rights versus consumerism; absolute access versus limited access; and all forms of class repercussions as a function of ability to pay rather than obligation of the state to provide.



These dilemmas of cost and delivery have been generated by a number of trends which have dramatically altered the marketplace in health services. In particular is the improved state of health in the developing countries, aided by medical advances. It has made quantum leaps. This realization suggests tremendous pressure and enormous change being placed upon the health care delivery systems of Third World countries. The drama with which these things have occurred, in a very real sense, suggests an emerging revolution of sorts in the provision of health services, or in the marketplace which demands how these health services will be delivered.

In an attempt to find different ways of responding to these increasing pressures, there has been pervasive talk throughout the Third World, and in some cases action, for transferring health services from the public sector to the private sector. It reflects a trend which has to do with the power shifting from those who provide to those who pay for the services. Those who pay for the services, whether they are employer or employees, are upset at the degree to which health care costs continue to escalate while service deteriorates. Health care is one of the few service industries, if not the only service industry, which has not leveled off its cost in a reasonable fashion with the growth of the rest of society.

A much proclaimed solution to this changing situation is the "health maintenance organization" or "HMO." This has occurred in part because of the success the HMO has enjoyed in the U.S., not only in terms of cutting costs and delivering quality patient care, but also as an investment. However, there are tremendous distances to be traveled between the HMO's success in the U.S. and its potential development internationally.

If the development of HMOs internationally is dependent on attracting U.S. expertise and equity participation, then one must understand how the U.S. private sector approaches involvement in developing countries. Once that is understood, then one must look carefully at how an HMO is started and structured.

What is presented in this paper represents the cumulative experience of the Health Central Medical Trading Company and Health Central International in international health care business development, investment and formation of health maintenance organizations. The intent is to provide a very simple and understandable presentation. There are other approaches and formulas. This paper could also become a tome if it were to comprehensively treat the full range of the proposed subject matter. This is not the intent. If the reader has gained a basic understanding of some of the key considerations and concepts in launching an HMO overseas, with U.S. private sector involvement, then the task will have been met. What you are about to read are structures and approaches which have worked for us.

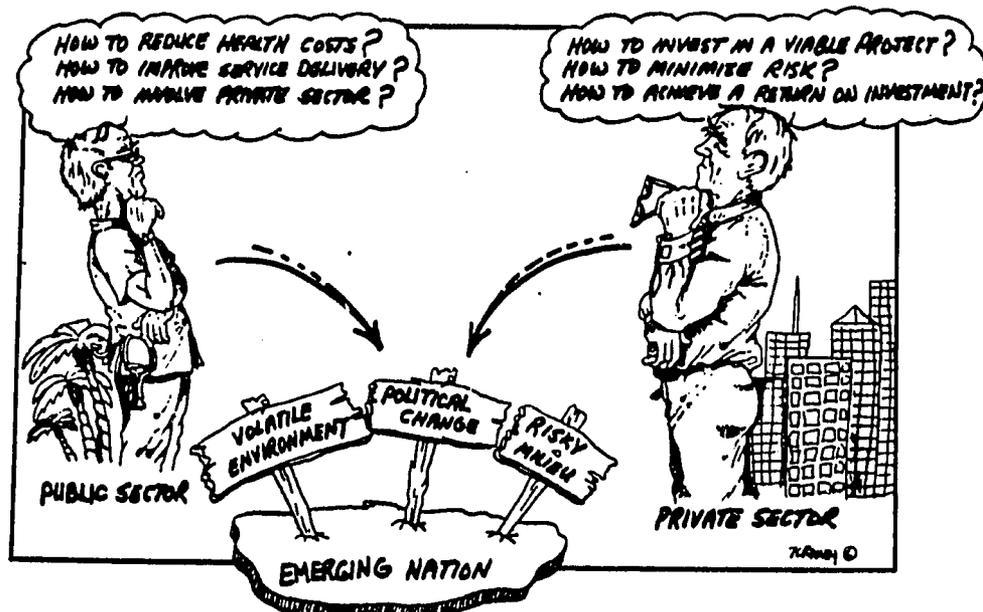
2. AN OVERVIEW OF FACTORS TO BE CONSIDERED IN INTERNATIONAL HMO DEVELOPMENT

The creation of a private sector based HMO begins with considerations and activities which occur long before the HMO is actually launched. These considerations and activities are centered around business judgements and assessments made by both the U.S.-based business partner and the country entity with whom the venture is launched. These judgements and assessments are business-based. From the perspective of the U.S. firm they address questions regarding the foreign environment in which investment is contemplated; the firm's goals and how the overseas investment meets those goals; the firm's resource base and its capacity to extend its activities to a foreign country; and the relative return on investment (international compared to domestic). For the host country institution, the issues are similar, but with greater emphasis placed on questions regarding the political and financial pros and cons of an association with a foreign company, the need and degree of dependency on foreign technology, and the capacity to maintain control, albeit with a foreign company as a significant partner.

It soon becomes apparent that setting up an HMO in a foreign country, or any health care business, entails knowledge of not only the technical requirements and structure, but also international business acumen. More often than not, it is the business side of the health care activity which is not properly treated or appreciated. Yet without its proper consideration and treatment, the idea of the HMO outside the U.S. will never get off the ground. The complexities surrounding international business are numerous and challenging.

The development assistance health professional who is concerned about initiating HMO businesses, privatization of health care, and in general, attracting U.S. health care business to work in his country, must first understand the working of U.S. private sector businesses. They must understand how they look at foreign markets, how they arrive at investment decisions and what the levels of expectation are regarding returns on their business ventures. The same elements are equally important in guiding decision-making for host country businesses.

THE PERSPECTIVES



Once these two components are understood, i.e., criteria and considerations guiding U.S. and host country business decisions, then one must look closely at the infrastructure to which one is relating in order to structure an HMO. In other words, look closely at the variables affecting physicians, hospitals, reimbursements from the public and private sector, the performance of laboratories and pharmacies, the cost of health care delivery, the attitude of the Ministry of Health, and the financial conditions guiding the provision of health care in a country.

From these considerations, one then begins to ascertain whether an HMO business is possible or not. Once concluding that it is, one begins the long process, not always successful, of negotiating a business deal (the U.S. and the host country partner together). In the health care professional's mind the paramount consideration is what the delivery of the health service will look like. However, the businessman must work his way through the critical steps to be negotiated with the business partner before any services are delivered, or a deal struck. His concerns are things such as: who invests what amount of capital (cash); who has what percent of stock (reflecting both control as well as future dividend payments); who has how much representation on the Board; who controls management; how will invested capital be protected; how will dividends earned in a foreign country be converted to U.S. dollars and returned to the U.S. partner's headquarters in the U.S., etc.

The point in providing this cursory overview of some of the considerations which are extremely important to private sector decision-making, is to reveal a world which is not typically of concern or, in some cases, even known to many health care professionals. Each of these factors will be considered in detail in the subsequent text.

Forces Driving International Interest in HMOs

There is presently a great deal of interest in the privatization theme internationally. Privatization concepts in international health care have gravitated toward HMOs. The success of HMOs in the United States, as private sector endeavors, have made them particularly visible as possible panaceas to soaring health care cost and service delivery problems overseas. While there is justification for the enthusiasm about HMOs and their suggested potential as possible solutions, there must also be accompanying caution. HMOs in the United States are the consequence of an environment which has:

- * the largest middle class in the world
- * a predominantly private sector based health care delivery system
- * as a population, great elasticity in income
- * a free enterprise based cultural economic tradition

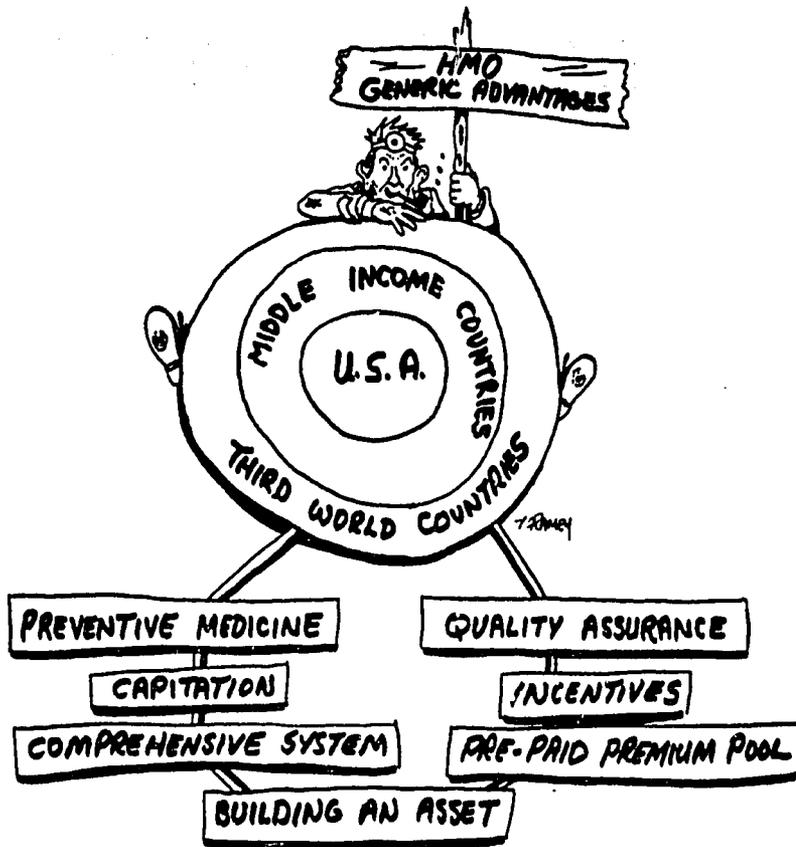
- * economic resources which enable experimentation without irreversible consequences
- * a long successful history of insurance indemnity based programs.
- * a rigidly regulated health care service delivery environment
- * a rigidly regulated investment environment

These variables are generally not found outside the United States. In fact, there are conditions in Third World countries which are dramatically different from those found in the U.S., but which nonetheless are stimulating great interest in the HMO concept. They are:

- * health care as a declared "right," has become too expensive
- * the public sector, which is predominantly responsible for health care delivery, is seeking possible solutions from the private sector, albeit reluctantly and with many misconceptions
- * hard currency is being spent on foreign health care (in Europe or the U.S.) due to lack of confidence in the countries' health care facilities and professionals. This is a significant source of "flight capital."
- * health care is a cost and productivity issue for local manufacturers. Neither the public health system or private sector indemnity health programs are addressing these issues, i.e., keeping workers healthy and on the job.
- * health care services, for the first time, are being seen by countries as a potential source for attracting foreign investment
- * HMOs represent a unique, comprehensive method of engaging a significant transfer of technology.

As one can see, there are differences in the environmental conditions affecting health care outside the United States. Yet, in both the U.S. and Third World health care systems there are a number of generic advantages derived from an HMO-like operation in the areas of efficiency, quality, availability of capital and motivation. These generic advantages give reason for the HMO's existence and success in both environments. They are:

- emphasis on preventive medicine
- creation of quality assurance review systems
- cost containment through capitation and shared risk by providers
- efficiency incentives for providers
- rationalization of services within a comprehensive delivery system
- an asset (the HMO) for attracting marketplace capital investment
- a significant pre-paid pool of working capital.



These eight characteristics, combined with the success of HMOs in the United States and the current obvious need in Third World countries for change in their approach to health care, have all resulted in an interest in attracting U.S. HMO companies to Third World environments. What we have is a demand (in the Third World), looking for the experience (from the U.S.). But before these two can be married, a very important step must be addressed: how to structure a business in a Third World country?

The first step toward structuring a business begins by understanding the market. The following section describes in more detail the market for HMOs in the developing world.

3. THE THIRD WORLD MARKET FOR HMO'S

This section outlines the trends within the health sector in the developing world and subsequently the factors which are generating interest in prepaid health insurance plans in Third World countries.

What are the indicators which suggest an attractive HMO market potential in the Third World? Understanding the overall trends represents the first step toward deciding to take the risk in a Third World country.

One sentence taken from the 1982 "World Development Report" of the World Bank provides insight into the state of health in the developing world in 1985.

"Over the past thirty years developing countries, aided by medical advances, have achieved as much progress as had the industrialized countries in two centuries."

This change in the state of health, combined with the industrialized growth in middle-income countries, changing demographic patterns, and greater economic interdependence through trade and communication, have resulted in a different market place for health activities than seen ten years ago.

The following is a listing of broad health related trends affecting the Third World as they clearly appeared in 1983. This list is accompanied by the consequences of these trends as they affect society.

THIRD WORLD COUNTRY TRENDS

- longer life expectancy
- lower infant mortality rate
- continued migration to urban areas
- fewer infectious and parasitic diseases

CONSEQUENCES

- .Nursing homes, hospital care, social insurance, management efficiencies, more facilities
- social insurance, specialized hospital care, management efficiencies, more facilities
- concentrated client population, easier access to health facilities, greater political demand for services
- less focus on public health and primary health care issues, more on upgrading health care issues

4. THE BUSINESS-BASED APPROACH TO HMO DEVELOPMENT

Incentives, Risks and Rewards for U.S. Companies Investing Overseas

When U.S. businesses look at the international market, they must see opportunities consistent with their corporate objectives. From a purely business perspective those objectives generally fall into six areas. Rarely would one of them, by itself, be sufficient to warrant international investments. The presence of several, however, begins to generate interest and justification for involvements. The six areas are:

- * access to another market
- * return on investment
- * diversification
- * learning
- * reduced cost of product delivery
- * leverage.

Access to Another Market

While the U.S. is considered a significant marketplace unto itself, companies nonetheless are always looking for other opportunities. Those opportunities are judged by experiences which are generally U.S.-based. This means that as the company concerned starts to look at the risk, complications, and the wide array of independent variables affecting business outside the United States, a great deal of caution and skepticism rapidly enters the equation. As a result, though a new market opportunity may be enticing, the perceived benefits must be substantial enough to warrant the risk. Today, one can safely say, many more companies are willing to take the risk they would not have considered ten years ago due to the changing complexity and competitiveness of the U.S. health care market.

Return on Investment (ROI)

This is the financial return a business realizes over a period of time after calculating actual equity (cash) invested, tax benefits, tax holidays, depreciation, dividends, etc. This figure will ultimately determine whether an investment is justified in hard cash terms. If one can see the potential for a higher return on investment internationally than domestically, then an obvious incentive for international investment appears. It is important to remember though that the ROI equation also takes into account the need to balance risk and exposure. As a result, a general rule of thumb is to

have a return on investment which is as a minimum four points higher than the ROI on domestic investments. In very high risk countries, it may need to be as significant as ten points higher.

Diversification

Foreign market opportunities often allow a company to launch an effort under more forgiving circumstances (less competitive, for example, or strength of dollar more advantageous) with a smaller investment of capital than in the U.S. This can be very appealing. Also, it is axiomatic in business that the more diversified one's portfolio the more one's risk is spread out. This axiom often guides the reasoning leading to one's entering the international marketplace.

Learning

Contrary to many ethnocentric perceptions, companies do feel there are things to learn in the international environment which will help them domestically, or elsewhere internationally. Often this learning may simply be through having a modest business in a foreign country which allows company executives and technicians to have an overseas experience.

On a more technical level, techniques and strategies are often transferred from overseas efforts to the domestic operation. Learning as an objective is clearly an area where one tries to get out of the trees in order to be able to see the forest more clearly. It generally seems to work.

Reduced Cost of Product Delivery

Many times because of different legal requirements, different market conditions, or cost of the varied components, the cost of delivering the same product or service internationally is much less expensive than providing it domestically. This can become very attractive, especially if the bulk of the R & D cost has already been absorbed domestically. Conversely, R & D costs may also be less expensive overseas, leading to the ability to develop a project overseas which can be sold internationally and domestically. This holds true for product as well as service industries.

Leverage

This objective may reach further than the immediate consequences of one's activities in a given country. For example, a marginally profitable business venture may be launched in a given region. If one enjoys a modicum of success, there would be a presumed ripple effect elsewhere in the region, thus generating more business. The increased business presumably would take one beyond being marginally profitable to being acceptably profitable.

Image building is another example of leverage. Often losses must be incurred, or substantial risks taken, in order to earn the image profile needed to develop further business.

If one can marry several of these objectives into a justification for international investment and involvement, then the process has begun toward initiating business in a foreign country. With a consistency now between corporate objectives and perceived opportunities overseas, a new set of conditions and concerns enter the picture. These are key points which should be addressed in planning and operating an international business. There are nine of them:

1. Plan for discontinuities: In international operations, a company faces many more discontinuities than in domestic operations, such as fluctuating currencies, economics, politics and other global factors. These elements affect less stable markets and economic systems more dramatically than in the U.S. The company must be flexible enough to plan for and react to these discontinuities and have well thought out contingency plans in order that the company can react quickly as these factors change.
2. Balance risk and exposure: Companies should look for a return on investment higher than in the domestic market. The source of revenues must also be balanced between countries. Organizations should not rely too heavily on revenues coming from one or two particular countries. Also to be balanced are factors such as amount of equity investment, marketing expenditures and employee obligations.
3. Special company organization: Companies should organize to respond quickly to market opportunities and to changes in the environment, relying on well-developed contingency plans. This is true for opportunities as well as crises.
4. The need to build local self-sufficiency in overseas countries: This needs to be done for practical as well as political reasons. Practically, this will cost less and lead to the creation of an independent, self sustaining infrastructure. Politically, this makes a U.S. company less visible and vulnerable to accusations of imperialism.
5. Top corporate management must be very comfortable with international business: Eight out of ten top corporate officers at Honeywell have lived overseas. At General Motors, in contrast, not one of the senior management have lived outside the U.S., and their first attempts to enter the Japanese market apparently were not successful as they were not considered serious by the Japanese. If an organization is serious about developing a significant international business, it must make sure senior management is exposed to the environment of international business.

6. Cross-fertilization of ideas: It is important to bring overseas personnel to the U.S., and vice versa, to achieve this. Most successful international companies practice exchange of personnel, e.g., thirteen of the sixteen senior international executives of Coca-Cola in the U.S. are non-United States citizens. IBM is a close second.
7. Long term staying power: An organization must have a long-term commitment to an overseas country and should not back away from temporarily depressed markets-- the company must have staying power. When a recovery occurs in an international environment, the long established institutions have long memories about which U.S. or foreign corporations stayed the course during more difficult times. In this regard long term planning is important. Long term customers relationships are often important--this is a factor ignored by many companies and often why they have had difficulties in getting established, as they try to link up with groups whose main interest is to make a fast dollar.
8. Organizational structure: How to organize the overseas operations is critical. This should not be done by product, but should be organized to favor geography and regional concerns. A company can still have worldwide product lines and competent teams in the various countries with their own profit and loss center, but in general a regional focus is the most important. The heads of regional divisions or country divisions must be given as much authority as possible, as the company should not want the decision-making in those countries to take on a totally U.S. character. Market share and return on investment overseas, it seems, directly relates to how long a company has been in a certain country or region.
9. Market selection and planning: It is important to have an integrated worldwide strategic plan. It is also key to find someone, or an organization, to work with in a new country, people who have an in-depth knowledge of markets, institutions and organizations, but who need the strength of U.S. companies. There is no substitute for a well-established, credible network of reliable intelligence and business guidance.

All of these factors translate into costs. These are the costs of doing business internationally. When a feasibility study is done to determine whether a pre-paid health insurance project (or any other health services project) is possible, these cost factors of doing business internationally are taken into account. It is important to note, however, that the decision to launch a business does not depend on guarantees that these costs will be covered --there are no guarantees. The feasibility analysis must show, though, that the probability of these costs being covered, plus the ability to earn a profit, is high. Even with this probability established, the risk factor internationally, regardless of what a feasibility study shows, is very high, particularly in the Third World countries.

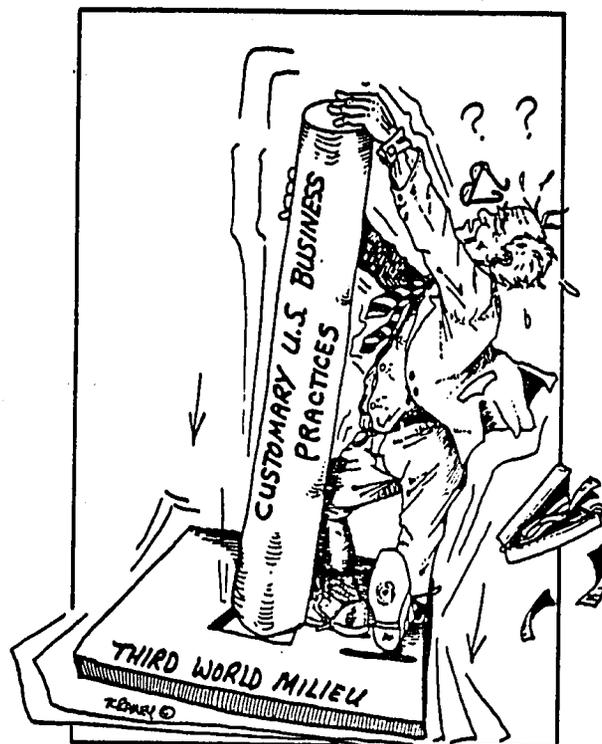
To put risk in perspective let us compare some differences in the U.S. business marketplace with a Third World marketplace.

United States
Marketplace

- * political stability
- * economic stability
- * presence of tightly regulated financial instruments e.g. bonds, mutual funds
- * presence of data
- * large middle class consumer base
- * government by consensus

Third World
Marketplace

- * absence of political stability
- * absence of economic stability
- * fewer instruments, less regulation and stability
- * absence of complete data
- * smaller consumer base
- * government by decree



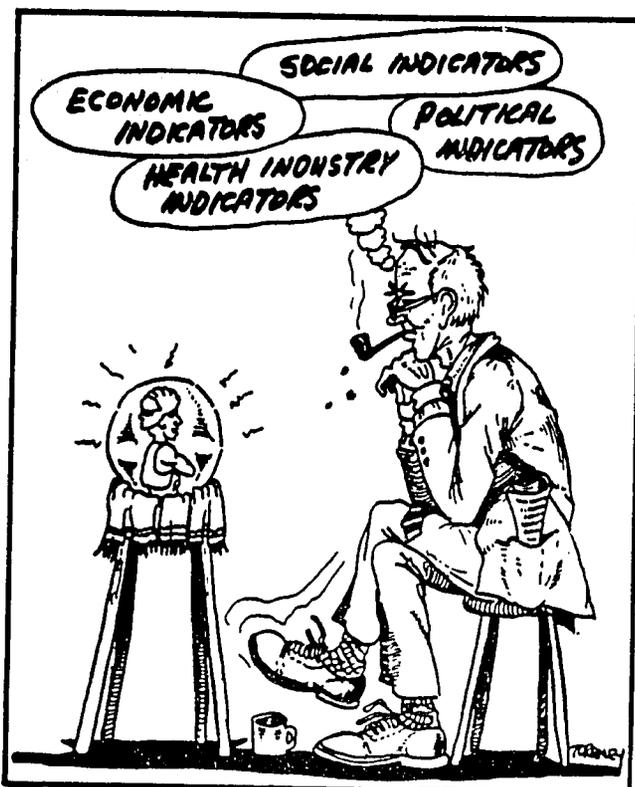
*STRUCTURING BUSINESS IN A THIRD WORLD COUNTRY,
OR, HOW TO PUT A ROUND PEG IN A SQUARE HOLE*

All of the factors discussed over these preceding pages hopefully have served to help the reader appreciate the depth of consideration a U.S. group or company must entertain before entering into business in the Third World. And from this the key word is risk. There is no such thing as equity investment (cash) without the risk becoming even greater. In order for a company to take that risk it must see the potential available on the "up side".

Determining the Appropriate Environment

A further requirement for investment and participation involving a private sector company is a high probability marketing environment. In other words, a country where certain general institutional and statistical conditions are present, indicating factors sufficient to support an HMO operation. There are four categories of indicators the author would suggest to a U.S. company approaching a feasibility study internationally:

- * economic indicators
- * social indicators
- * health industry indicators
- * political indicators



**FOUR CATEGORIES
OF INDICATORS**

Within these four categories there are 14 indicators. The assumptions supporting these 14 indicators are explained:

*** ECONOMIC INDICATORS**

- Annual Growth of Production Rate: this indicator is used primarily to determine a growth capability over a sustained period of time. Such a capability reflects the productive energy and capabilities of an economy and it's potential for the future.
- Gross Domestic Savings as a Percent of Gross Domestic Product: In all Third World countries the ability of its populace and institutions to amass savings has been an indicator of their ability to create internal demand, stimulate production, and foster the creation of banking, and other institutions needed for money management. Savings also indicates a potential financial capacity for consumer choice, a key ingredient in whether pre-paid health insurance projects are feasible or not.
- External Debts as Percent of Gross National Products: External debt has a direct effect on currency exchange policies and availability. While there may be a magnificent business opportunity for a U.S company, it can be suffocated by the inability to move currency out of the country or severe restrictions on capital internally.

*** SOCIAL INDICATORS**

- Minimum Population: This is an arbitrary number arrived at by determining two figures: what number of people is necessary for the critical mass required to make an HMO work? What percent of market share is realistic in order to achieve that critical mass?
- 45% Urban Population: Pre-paid health insurance plans require concentrated urban populations, or trends in that direction. 45% represents a high urban concentration in internal terms.
- 65% Literacy Rate: There is a direct correlation between levels of education and the health services which people demand. Consequently, a high literacy rate is an important indication of potential market demand.
- 60 Years Life Expectancy: The world trend toward increased life expectancy ultimately will create demands for health service based on the needs of an older and changing population. Age 60 life expectancy figure is where this demand will begin to be felt.

* HEALTH INDUSTRY INDICATORS

- 30% or \$45 Million as U.S. Equipment Share of Sales: Either 30% or \$45 million shares of the country market indicates favorable circumstances for U.S. sales. Under 30% means the European and Japanese competition have a very strong position, therefore indicating more marketing effort than cost would justify. If the percent is lower, yet the volume is \$45 million, then even a small percent of the total U.S. share is worth the effort.
- Predominance of Physicians Trained in the U.S.: If the majority of the target country's physicians have been trained in the U.S., the need to educate them about U.S. capabilities is much reduced. Physicians are usually favorably inclined toward the U.S. Training in our institutions reaffirms their positive attitude.
- Presence of Private Sector Hospitals: The number of private sector hospitals reflects the probability of exploring other opportunities based on straight business opportunities. Working with private sector hospitals greatly reduces the insecurity found in responding to government and public sector tenders or contracts.
- Potential for Full Range of Health Services Business: This represents the possibility of diversification, both of services as well as risk. Accompanying this also may be the flexibility a company needs to develop in order to deal more effectively with currency problems.

* POLITICAL INDICATORS

- Receptive to U.S. Industry: A company should not enter a market where from the beginning it will have to fight off expropriation possibilities or face negative political overtones. Rather, a company should seek a warm reception to U.S. business.
- Acceptable Level of Political Stability: Political stability and how it is perceived is riddled with cultural interpretation. Change in a country should not be viewed as synonymous with instability. If basic institutions stay in tact, then one may be looking at a stable environment.
- Significance of Country in the Region: This is an indicator of whether one's activity in one country will leverage business opportunities in other countries. As examples, Singapore and Hong Kong are very important in the Far East; Chile in the southern cone; Colombia in the northern tier of South America, etc.

Once the U.S. company has decided a country is worth considering, the next step is to find an excellent host country partner.

The Role of the Host Country Partner

The host country partner is a key ingredient in structuring an overseas venture. Finding that partner is not an easy task. The partner, ideally, should be someone whom can be trusted, who has a track record and is committed to the objectives of the business plan. The host country business partner should also share a certain "chemistry" with the U.S. partner. That "chemistry" becomes critical as they both begin to negotiate and finally initiate a business, and then share both the good and bad. The characteristics a good host country partner should have are:

- * political clout and access
- * strong financial position in the country
- * established track record
- * experience in the business at hand, or closely related activities
- * willingness to share compatible risk and reward
- * capacity to be flexible under changing circumstances, especially financial conditions
- * compatible "chemistry", one entity to the other
- * a willingness to be open and candid

The host country partner is crucial to any success. They must feel it is their business and their responsibility to make it work in tandem with their U.S. partner. If they do not feel that, then it will most surely not work. Percentages of stock ownership and amount of U.S. dollars committed are key decisions predicted on how adroitly the host country business partner can read the political and economic waters and chart a conservative course toward achievement of the mutually agreed upon business objectives.

In most Third World settings the host country partner would ideally act as the major shareholder. For political reasons it is usually advisable that they be the most visible organization, rather than the U.S. company.

The U.S. partner provides:

- * minority equity investment
- * bulk of technical assistance
 - procedure manuals
 - management information systems
 - quality assurance program
- * senior staff people



HAVE A DEPENDABLE PARTNER

The host country partner would provide:

- * majority equity investment
- * marketing network and sales force
- * mid-level staff
- * physical facilities (through lease, contract, or ownership)

Addressing The Financial Challenge of Third World Market Conditions

The host country and U.S. partner must work very closely together once the business is formed to structure a way of relating to the financial circumstances within the country. The financial conditions found in most Third World countries add yet another dimension to the complexities of investment. Those conditions may be:

- * inflation
- * severe hard currency restrictions
- * absence of stable financial control mechanisms

These three major factors are discussed more fully below:

Inflation:

If inflation is a serious problem, then methods of protecting one's investment will be used which are not known in the U.S. The most commonly used mechanism for keeping base with inflation is indexing. This is where prices and costs are adjusted over short periods of time based on either the preceding months statistical rate of inflation or a projected estimate of inflation, again based on preceding months. This can become extremely complex rapidly, especially when one has also negotiated capitated contracts--this means one has a fixed sum of money for paying a fixed price for services delivered. But, both ingredients (the sum of money and the price) must keep pace with changing costs. Otherwise, physicians, labs, pharmacies, etc., will cease to accept capitated contracts. When that occurs (the rejection of capitated contracts), the pre-payment pool of funds, which is fixed, has to meet payments in a system which then does not have agreed upon prices for goods and services. Inflation will generate an ever-increasing price spiral, which will eventually bankrupt the pool. There are various ways of responding to the inflationary spiral. They are dependent though, on formulas which at best are guess work, especially where hyper-inflation is occurring.

Hard currency restrictions:

Most Third World Countries today are encumbered with enormous hard currency debt problems. These problems equal:

- * absence of hard currency in the country
- * strict limitations on exchange of local currency to hard currency
- * intense government oversight of business transactions affecting hard currency use
- * availability of hard currency and financial circumstances of country subject, in some cases, to the dictates of IMF and international commercial lenders

All of this translates into obstacles to doing international business. First, once one has committed hard currency, in the form of equity to a country, it is very difficult to get out. Second, because of very strict exchange controls (changing local currency to hard currency), it is difficult to acquire hard dollars as a result of one's local business activities (through profits earned or ongoing revenues) to service a foreign debt based on hard currency. In other words, if one had to secure a loan from the U.S. in order to buy medical equipment for outpatient clinics, it becomes quite difficult to convert the money earned in local currency to hard currency.

Without the hard currency one cannot repay the debt. And, even if one could, there is often a significant percentage lost per dollar, as the transaction occurs. For instance, based on official exchange rates, one may only be obtaining, through the conversion, 80 cents U.S., instead of one full dollar.



THE INTERNATIONAL FINANCIAL MAZE

All governments, without exception, state they will assure the integrity of one's investment and the ability to reconvert dollars initially invested in their country, back to dollars again (with certain tax restrictions) if the business activity warrants. The consistency of these promises and laws, though, can change appreciably as governments find themselves under pressure to pay back governmentally incurred hard currency debt. As this pressure mounts, governments will keep the hard currency available in the Central Bank to pay back their debt. Then one is forced to ride out a debt crisis storm (either the government's or one's own!) or find other ways to convert. The "other way to convert" (black market) is where one must be very cautious and keep in mind one's long term business objectives in a country.

Absence of Stable Financial Control Mechanisms:

The ability to capture or organize a pre-paid pool of capital is one of the key factors in making pre-paid health insurance mechanisms work. This is critical because one not only knows what one's cash base is, but one can also use that cash base to leverage other monies. This leveraging is generally done through expert use of existing financial mechanisms. These mechanisms, or instruments, run the gamut from simple generation of earnings via interest rates on savings accounts, to money market funds, bonds, stock investments and even capital development projects. Of course, the security of the investment is of utmost concern. Security in this sense can be interpreted in terms of: national regulatory policies and bodies which oversee these types of activities; stability of the different instruments as reflected in track records of the institutions which provide the framework for investment mechanisms. However, when these two factors are not clear (regulatory bodies and policies; stability of the instruments), then the options available for safely using the pre-paid pool's capital are limited. When they become limited this generally means less can be leveraged by use of the pool's capital due to the need to be cautious. All of this translates into an inability to earn as much as one could, for instance, in the U.S. or Europe under similar circumstances. This in turn means less margin for error in the project. Many will say an inflationary environment lends itself to opportunities for speculation, for example. While true, one must remember that the objective of the pre-paid pool of funds is a contractual obligation to deliver agreed upon services. One, therefore, must be quite conservative and cautious with the funds. Conservative use of money does not allow for speculation.

Whether there is inflation or not, outside of Europe, the U.S., and obvious countries in Asia (Singapore, Hong Kong, Japan), the viability of financial instruments is questionable. Consequently, one must be very careful about how the pre-paid pool of funds is used. One also must thoroughly understand the country's financial structure to be sure assumptions about "the pool's" ability to leverage are not out of synch with the reality of the milieu.

The Business Approach Summary

In summary, there are six general factors which have led to the focus on HMO's as potential solutions to Third World health care delivery problems

- * Health care has become too expensive
- * Public sector is seeking cost control and efficiency solutions via the private sector
- * Use of hard currency as "flight capital" to purchase health care abroad
- * Health care as a cost and productivity issue for Third World businesses is not sufficiently addressed

- * Health care services seen as a potential source for attracting foreign investment
- * HMO's provide comprehensive transfer of technology.

Although there is demand, U.S.-based corporations must see a combination of the following objectives as a result of their response to the demand:

- * access to another market
- * return on investment
- * diversification
- * learning
- * reduced cost of product delivery
- * leverage

The cost of doing business internationally is different than in the U.S. This cost is based on a significant increase in the risk one takes, the need to behave different corporately, and other vagaries of the international marketplace.

A host country partner is a sine-qua-non for doing international business. That partner should have:

- * political clout and access
- * strong financial position in the country
- * established track record
- * experience in the business
- * capability to be flexible
- * compatible "chemistry"
- * willingness to be open

Generally the U.S. company provides the following in a Third World HMO project:

- * minority equity investment
- * bulk of technical assistance
- * senior staff people

The host country partner would provide:

- * majority equity investment
- * marketing network and sales force
- * mid-level staff

The key words to be noted in this review are complexity and risk. The process of deciding to launch a business in a Third World country is very complex, from the original concept paper, to the commitment of hard cash, to the actual business activity. Its complexity is compounded by the ubiquitous presence of risk.

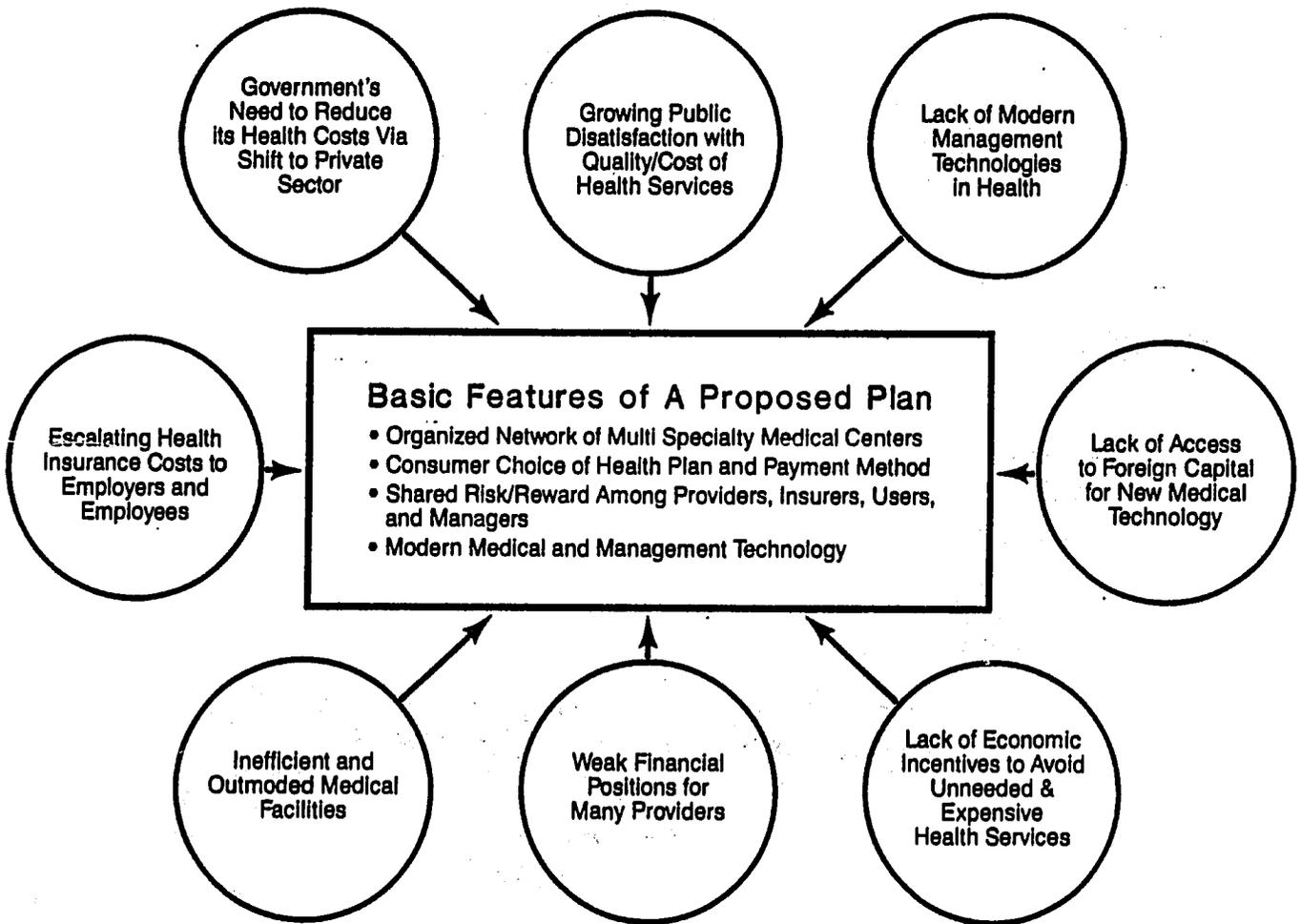
Presuming a positive reading of the proposed country of operation has occurred, and it appears the relevant corporate criteria have been met, it is then time to set up the HMO. The subsequent section outlines the actual steps in the development of an HMO.

5. THE DEVELOPMENT OF AN HMO

Basic Features of a Typical Plan

The following plan for an imaginary country will provide some insight into how an HMO may be set up on an inexpensive, simple basis. Its simplicity is what makes it adaptable.

**BASIC FEATURES OF PROPOSED HEALTH PLAN
WITHIN A THIRD WORLD ENVIRONMENT**



A number of factors within a Third World environment will influence the plans and financial performance of a proposed prepaid health plan.

As indicated in the exhibit, there are eight major factors which structurally influence basic features of a proposed prepaid health plan.

1. Government's need to reduce its health costs via shift to private sector:

Ministries of Health recognize that their past investments into the publicly owned and financed health system are not bearing adequate returns. Ministries of Health also recognize that they do not have adequate financial resources to meet the demand for services occurring within the public system. Ministries of Health are therefore anxious to explore alternative ways of organizing and financing health services for all economic segments of the population. They are looking for a different balance between the public and private sector role in financing and delivering health services.

2. Growing public dissatisfaction with quality/cost of health services:

Market research studies conducted with physicians and employers indicate that the employers and individuals with health insurance coverage are becoming increasingly dissatisfied with the amount of out-of-pocket expenses they have to make for health care services. Accessibility to physician and hospital services are difficult. Individuals frequently need to make multiple trips to accommodate their diagnostic and treatment needs because very few outpatient clinics have complete services under one roof. While costs of receiving health care in the public sector hospitals are considerably less than in private hospitals, the physical environment and maintenance of these facilities is not positively viewed by the public.

3. Lack of modern management technologies in health:

Public and private hospitals and certainly private physician offices have not yet embraced modern management practices or computer-assisted decision-making tools for financial management and business decision-making. Standard operating procedures, policy and procedure manuals and various structured systems are not being utilized. The result of this situation is that cost-effective health services and productivity are not high. This creates both an opportunity to improve cost-effectiveness through application of modern management techniques and practices, but also suggests that without strong modern management the operating costs for the pre-paid health plan would be higher as they attempt to buy services from inefficient physician or hospital providers.

4. Lack of access to foreign capital for new medical technology:

The ability to procure new medical technology and equipment from outside is difficult. The procurement of external technology requires U.S. dollars. Competing for U.S. dollars in soft currency environments creates delays and may serve as a major obstacle for keeping pace with technology advances. The strength of the U.S. dollar relative to Third World economies also makes it difficult to repay the expense of debt service if it is in U.S. dollars.

5. Lack of economic incentives to avoid unneeded and expensive health services:

The current private health system in most Third World countries is a retrospective fee-for-service payment system. This structure does not encourage either the patient nor the provider to avoid unnecessary utilization of health resources. In fact, the economic incentive is to use more services rather than less. There is also no particular incentive to use less expensive services in contrast to expensive inpatient or outpatient diagnostic services. A pre-paid health plan will help rationalize this decision-making process by negotiating new risk sharing arrangements among employers, employees, and the providers.

6. Weak financial positions for many providers:

It is difficult to secure working capital from either physician or hospital providers to fund a new prepaid health plan. The current economy and reimbursement mechanisms within most countries have created significant financial hardships for the hospitals. Physician providers frequently do not operate in groups and therefore do not take advantage of economies of scale and shared overhead costs also resulting in relative weaker financial postures for the physician providers.

7. Inefficient and outmoded medical facilities:

Many physician offices and hospitals are operating in old facilities that are poorly maintained and designed. This creates a potentially negative image to the marketplace as well as creates inefficiencies and unnecessary operating costs. A new health plan will need to help enhance the physical environment of participating physicians and hospitals in a new medical network. Remodeling and redecorating investments will probably be necessary to enhance public image and therefore attract additional utilization.

8. Escalating health insurance costs to employers and employees:

Because there are virtually no controls on efficient use of health care services, and because economic incentives encourage inappropriate utilization, many employers and employees are having to continually pay higher insurance premiums. Insurance companies currently do not have any way of sharing the risk with the providers and therefore pass all increased costs on to their customers, the employers and the employees. This creates an opportunity to offer a new pre-paid health insurance product in the marketplace and compete not only on quality of services, but on the cost of service. It indicates that aggressive cost controls by a pre-paid health plan can avoid rapidly escalating premium costs and minimize out-of-pocket co-payment by employees.

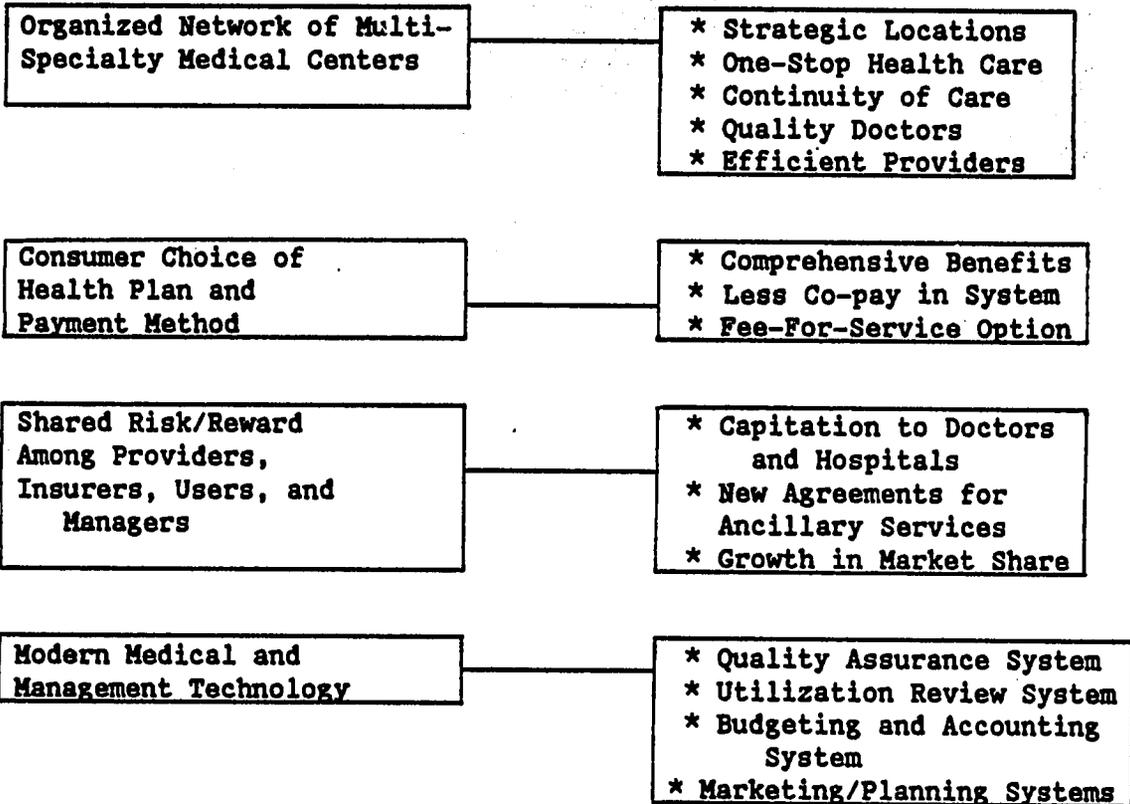
To respond to the above features the proposed pre-paid health program will need to have characteristics such as:

- * offer an organized network of multi-specialty medical centers;
- * provide consumer choice of health plan and payment methods;
- * structure shared risk and reward among the providers, insurers, users and managers for the health program; and
- * make available modern medical and management technology to help assure the cost-effectiveness of the delivery system.

KEY COMPONENTS OF A PROPOSED MODEL SYSTEM

FOUR BASIC FEATURES

KEY COMPONENTS



The "key components" are elements which would be results of the identified "features." An elaboration follows:

- Strategic locations: Facilities would be located in or near major enrollee residential or working areas. Access via major transportation links would also be crucial.
- One-stop health care: Rather than be sent from one side of the city to another for a doctor visit, followed by lab tests, pharmaceutical purchases, etc., all of these tasks would be accomplished at one site.
- Continuity care: All of one's health care needs would be treated, monitored and followed up within one health care system.
- Quality doctors: The system itself would carefully select the participating physicians.
- Efficient providers: The system will not only provide the above, but also have an extensive management information system and management team overseeing the efficiency and cost of all activities.
- Comprehensive benefits: Rather than offering one service, or a range which one must choose from, the HMO offers a comprehensive package for one fee.
- Less co-pay in system: The co-payment, if there is one, is less than in indemnity plans. Co-pay is generally used as a restraint to over-utilization.
- Fee-for-service option: One may opt within this system, as a choice, to pay a fee for services rendered.
- Capitation to doctors and hospitals: These are agreed upon price ceilings for services delivered.
- New agreements for ancillary services: Radiology labs, pharmaceutical, etc., will also be contracted via capitation or discount agreement as part of the system.
- Growth in market share: The unification and coordination of all the different components of health care delivery, under the aegis of one system, purchased through a simple premium schedule, will be a significant client magnet.
- Quality assurance: To ensure the attractiveness of the system in terms of services delivered, there is a constant review of the quality of services.
- Utilization review: To control costs as well as appropriateness of services, a constant review of utilization is structured into the process.

- Budgeting and accounting system: To ensure everyone participating as providers or investors in the system is aware of costs and achievement of benchmarks, a very tight and constant budgeting and accounting system is put in place, applied daily as a watchdog.
- Marketing/Planning Systems: Both of these elements are crucial to ensure growth of market share, reinforce the preventive side of health care delivery, and to keep costs under control relative to revenues.

In the final analysis, the four basic features incorporate components which:

- cut costs
- monitor quality
- make health care more accessible
- put providers at risk
- provide professional incentive-based management.

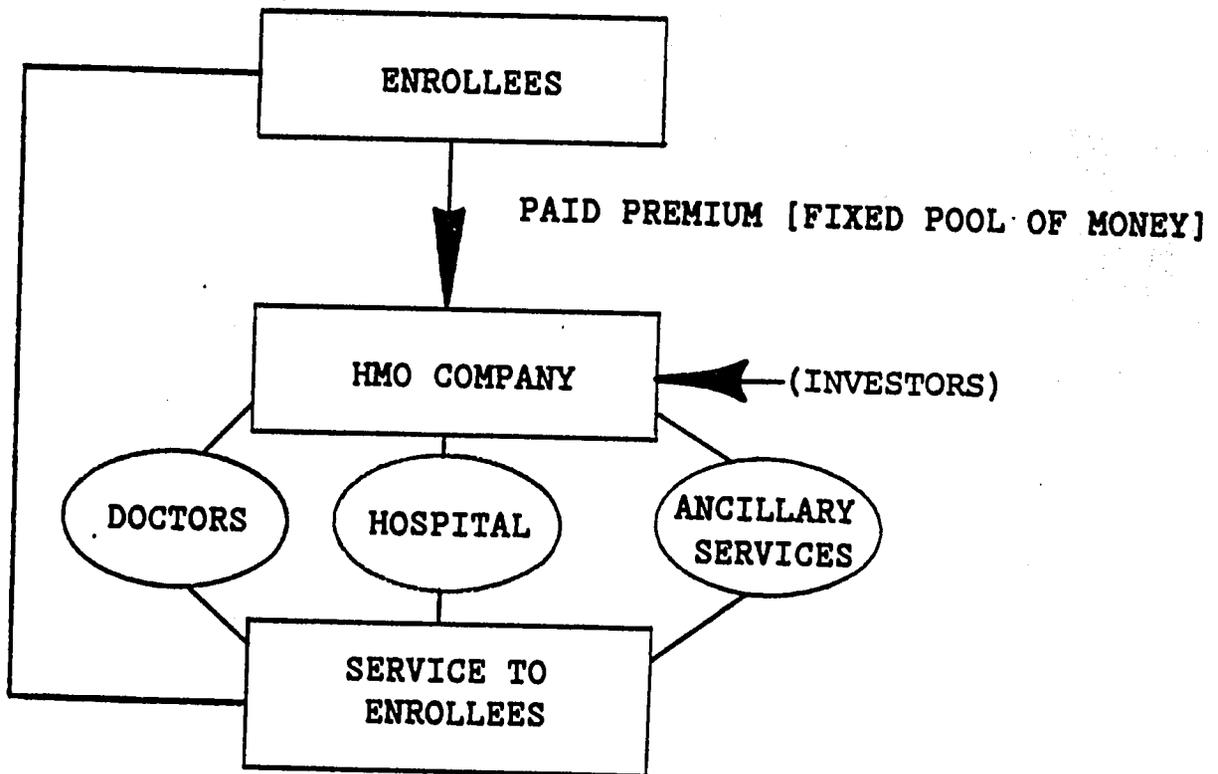
These points will be treated in greater detail as this paper progresses.

Starting an HMO

An HMO is a business. It is managed as a business. Its business is a contractual responsibility to provide, or assure, the delivery of health services to a voluntarily enrolled population that pays a fixed premium which is the HMO's major source of revenue. In order to do this, and make it function as a business, there are several key ingredients required:

1. ENROLLEES- It must have a critical mass of enrollees in order to form the premium base and risk ratios necessary to meet the assumed contracted obligations and effectively deliver the stated health services.
2. HEALTH FACILITIES INFRASTRUCTURE- There must be lab, X-ray, and outpatient and inpatient facilities to serve the range of patient needs.
3. PHYSICIANS- Without physicians, an HMO is merely a shell management company. Physicians must be involved both in sharing the financial and service delivery risk and gain. They also must be committed to the idea of preventive medicine.
4. INVESTORS- These may be the physicians themselves, an insurance company or independent investors. This is the origin of the initial source of capital. Simultaneously, it (they) may also provide the initial access to an enrollee market.
5. HMO MANAGEMENT COMPANY- all of the pieces are brought together and managed via the HMO management company. It is this company which negotiates the capitation contracts, manages the delivery system, manages the premium pool, and generally oversees and insures the viability of the business.

The parts would fit together as presented in the following graphic.



In order for this structure to be established, a feasibility study must be conducted addressing the following issues:

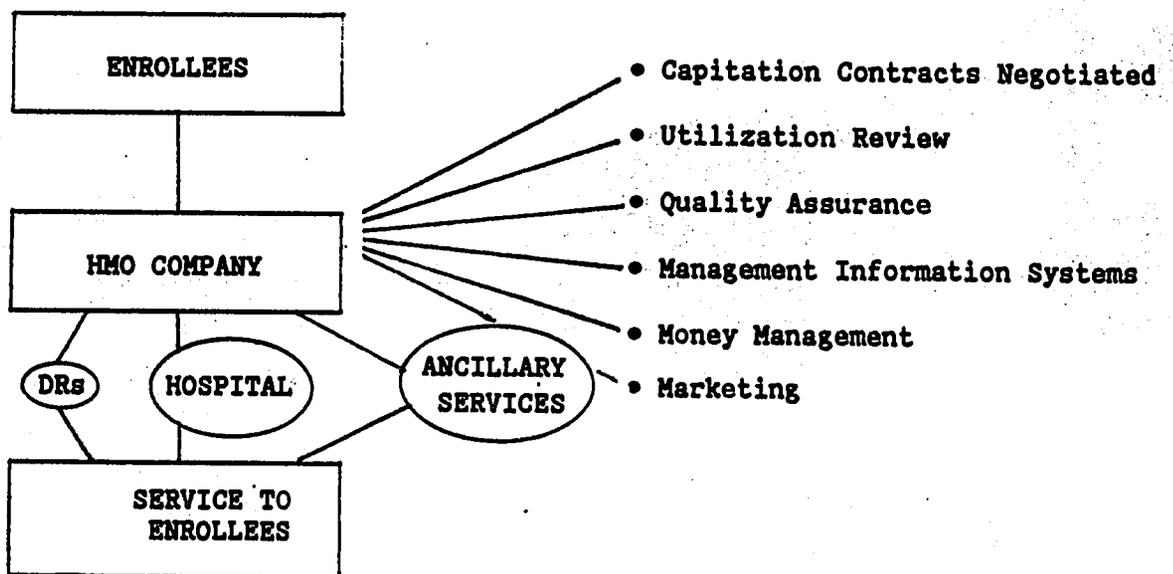
1. local legal requirements
2. market potential (demand forecast)
3. provider attitudes
4. percent of general community desirous to make it work
5. comprehension of the idea
6. hospital census (beds/occupancy)
7. cost of health care procedures and services
8. cost of lab, x-ray, pharmacy
9. daily hospital cost
10. physician to population ratio
11. capital required/capital available
12. enrollment potential
13. nature of existing health insurance plans
14. actuarial health statistics
15. financial instruments and infrastructure available for management for premium pool
16. utilization rates per unit of service

Some general rules of thumb for determining whether it is feasible to launch an HMO are:

- * Availability of Capital: generally a minimum of \$150,000 U.S. is needed in cash to launch an HMO. \$250,000 to \$750,000 should be the minimum capitalization. (This of course depends on the scope of the operation. For Health Central International, the Chile experience was more expensive because it involved two major hospitals; the case of Jamaica was less expensive because it involved primarily out-patient activities.)
- * Excess of Physicians: This translates into a willingness of physicians to be more competitive and innovative and also to be employed in the HMO. It also means greater ease in reaching agreement on capitated contracts.

- * Enrollment: 10,000 enrollees is most often the break even point. If administrative costs exceed 10% then the enrollees base must increase.
- * Insurance Reserve Requirements: by having an insurance company as a partner, the need to gather large sums of money as a reserve to meet a country's insurance licensing requirements is generally avoided. The insurance company can also provide reinsurance to cover the risk and potential large exposure while the Plan is still small.
- * Presence of Health Care Indemnity Insurance: exposure of the public to health insurance plans, albeit indemnity-based, means awareness of pre-paid concepts. This also means physicians and ancillary services have had exposure to the world of paper work, co-payments, and reimbursements which accompany indemnity insurance plans.

The idea of the HMO as a business possibility now starts to evolve its parts, as it moves beyond feasibility to actual formation. The basic graphic we previously saw, now assumes more parts and starts to expose the elements which make for a true HMO.



- * CAPITATION CONTRACTS NEGOTIATED - the HMO company negotiates with physicians, hospitals, and the ancillary services an agreed upon price for the provision of their various services. The physicians, hospitals and ancillary services, for their part, receive a contract from the HMO company guaranteeing them a fixed income based on their enrollee service load. Consequently, if a physician admits fewer patients to the hospital, prescribes only necessary drugs and tests, he should realize a net savings within the context of the fixed income/cost contract. This represents money in his pocket.

For the consumer, capitation means a control on costs. It also means an incentive for physicians and other providers to practice preventive rather than solely curative medicine.

- * UTILIZATION REVIEW - this is a formal process structured into the HMO structure which is constantly reviewing the use of services, scanning for abuse as well as trends. In both cases the intent is to control costs.
- * QUALITY ASSURANCE - this is a review process, wherein the professional staff studies the medical activities and services of the HMO system to be sure quality health care is being delivered.
- * MANAGEMENT INFORMATION SYSTEMS - a key to making the HMO work is the ability to coordinate, daily, all the different administrative and management factors involved in delivering cost-effective, quality-based health care. The MIS system is the vehicle for linking all the parts together to ensure their harmonious functioning.
- * MONEY MANAGEMENT - the premium pool, paid in advance, is the capital base for the HMO's operation. As in any insurance company, this capital must be managed extremely well, to assure enrollees receive the services they contracted for. Additionally, capital is a source of leveraging further money via use of appropriate financial instruments. The HMO company must be very good at managing its resources.
- * MARKETING - to build its premium pool, grow as a business, and reduce risk by expanding its enrollee base the HMO company must market very aggressively, normally to groups of employees of companies and institutions.

We now have a business, as described, which is concerned with cost-containment and quality assurance with utilization review. These are critical for consumer protection as well as business growth. If an HMO is offering services of lesser quality, it will not thrive as a business. Therefore, the practice of quality health care is essential.

At this point, it is important to introduce the concept of shared risk and shared gain. This concept has two ingredients:

1. capitated contracts
2. premium pool.

Capitated contracts: These are contracts which define, in absolute terms, the cost of the services to be provided. They also detail the risk a physician, for example, will take if his provider costs exceed the capitation agreement.

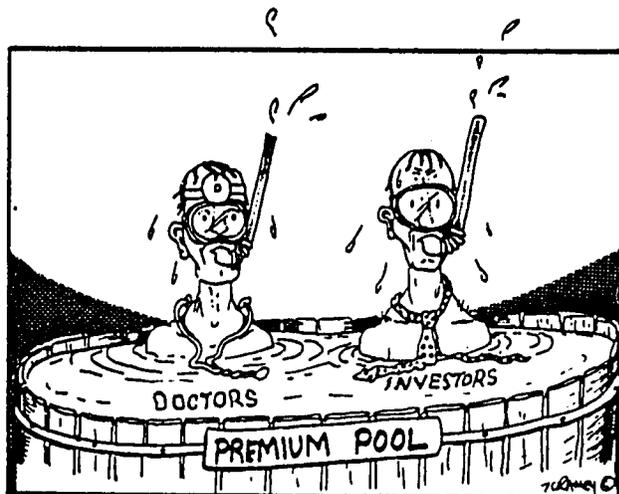
Payments to the capitated contracts are made out of the claims reserve fund. In the case of break even or a surplus, the contracted physicians, hospitals, etc., would be paid their full 100% fee. In the case of a loss, or default situation, they would, for example, be paid up to 80%. In turn, they would have to provide the remaining 20% difference out of their own pocket.

The structure then is one where the gain is a guaranteed income, regardless of how many patients are seen. The risk is an accrued cost, because of inability to meet the capitation objectives resulting in a financial loss, for which the physician, hospital, etc., is responsible.

Reinsurance is issued to cover the loss eventuality. To protect the physician against the financial risk of excessive utilization, the HMO typically purchases two types of insurance:

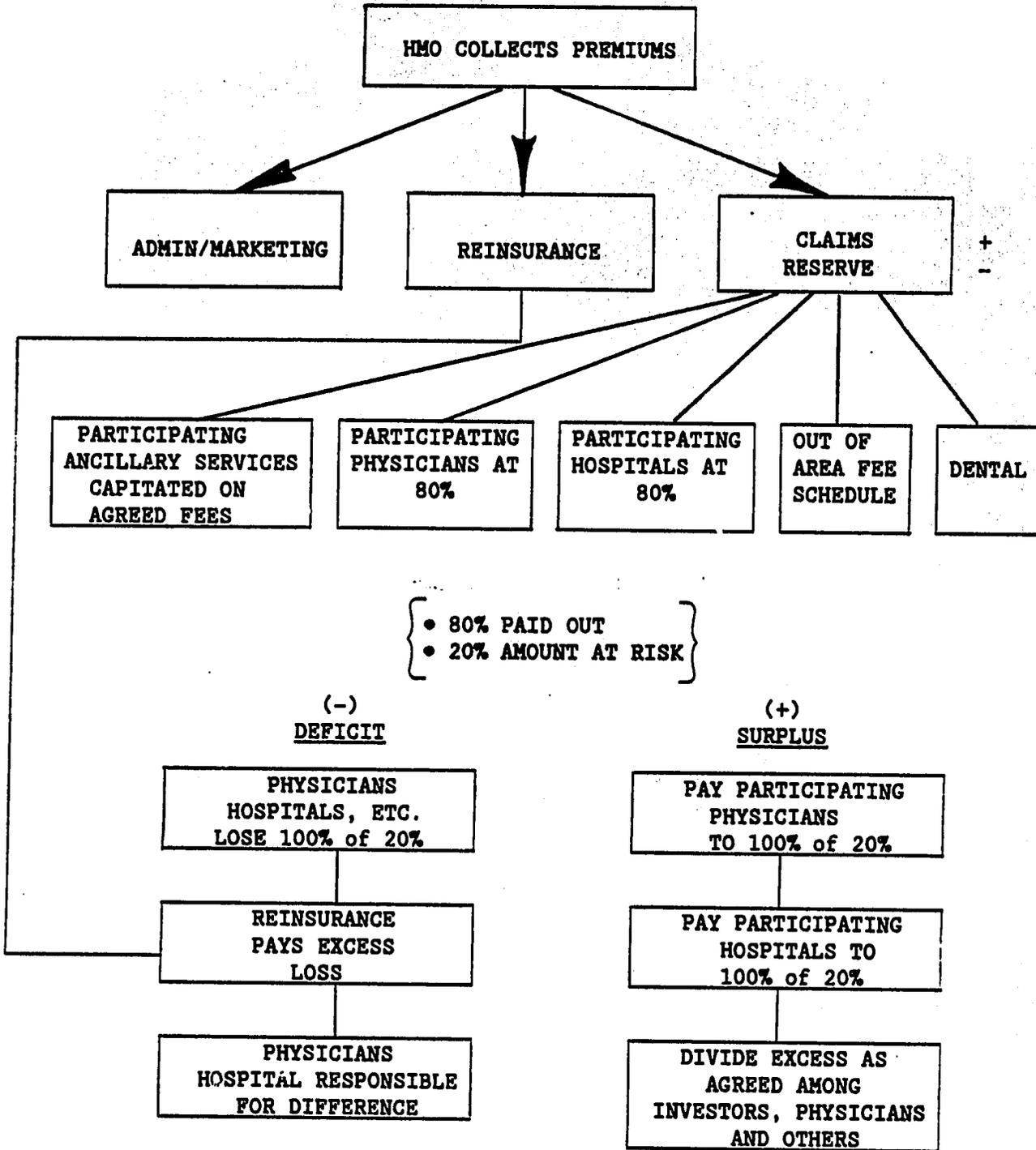
- a specific stop-loss insurance which goes into effect when the total usual, customary, and reasonable expenses of an individual HMO member exceed a certain amount in a one year period;
- an aggregate stop-loss insurance covering 90% of the total HMO charges exceeding 115% of income.

Premium pool - Beyond the capitation agreement there is a pool of money collected through the payments of premiums. If the HMO has done an effective job of containing costs and delivering services then there should be a pool of money left at the end of the year. This pool of money may be divided in a variety of combinations between investors, physicians, hospitals, etc. This is another incentive to be cost-effective as well as provide a quality service. The result will be a pool of money to be divided among the risk takers -- the bases for the risk being a conviction that if one can control costs, be competitive, and deliver quality services, one will realize a surplus.



INCENTIVE TO KEEP HEAD ABOVE
WATER

One model of this arrangement and how it is structured might look like the following:



The steps of the evolution of the use of the premium dollar are:

1. The HMO collects the premiums from its enrollees.
2. The premium dollar is then used for administrative and marketing costs, reinsurance, and claims reserve.
3. The bulk of the premium dollar goes for the claims reserve. This reserve is used to cover the costs of services delivered. However, where there are capitation contracts, up to 80%, for example, of the claims will be paid out of this reserve. The remaining 20% is the doctors' (or hospitals') responsibility -- during a time frame (yearly or quarterly), the capitated providers will be paid the remaining 20% of the claims reserve, if they have kept their costs within the capitated amount.
4. If, however, they have exceeded that amount, they then must pay the difference. The former represents a surplus, the latter a deficit.

Risk Management

The return on invested capital to the investors and participants is contingent upon managing the following risks:

1. Physician willingness to:
 - assume the risk of health care on a capitated basis,
 - cooperate in structured Quality Assurance (QA) and Utilization Review (UR) system which reduces use of drugs, unneeded doctor visits and hospitals admissions,
 - enter into "Administrative Support Agreement" with the HMO company at a percent of gross billings.
2. HMO ability to achieve its financial pro formas, contingent upon:
 - availability of initial working capital for development of new systems for Quality Assurance, Utilization Review, Management information and Physician Practice Management and Marketing,
 - success in marketing "The Medical Network" to new clients at levels and timing shown in pro formas,
 - ability to achieve income as defined within the related HMO financial pro formas,
 - the HMO product (benefit package and perceived image) must be uniquely attractive to target markets via price, quality and range of services,

- aggressive marketing program by HMO that yields enrollment at the level and timing indicated within the financial pro formas,
 - ability to charge a premium structure at least as high as shown in the pro formas, plus a 10% co-payment income stream,
 - HMO provider relations success in managing down unneeded service utilization.
3. HMO provider relations management success is contingent on the availability of modern practice management systems in areas of financial management, Quality Assurance, and most importantly, aggressive practice marketing and business development, skills and protocols brought from the U.S. by the U.S. partner.

Conflictive Tensions in HMO Development in Developing Countries

Having reviewed the key components of HMOs and the ingredients in an imaginary structure, we are now prepared to review the conflictive tensions in HMO development in developing countries -- the tension between:

- social objectives versus business objectives
- image versus profit
- low probability of self financing versus high probability of self financing.

Without government reimbursement schemes, investment incentives or other forms of substantive support, it is very difficult to set up a low income based HMO and services as a business. Probabilities for business success increase dramatically as one serves higher income levels. Nonetheless, any private sector endeavor should take seriously into account the need to explore ways to make its business activity enhance the development of better health care services for all.

Host governments as well as international development and lending institutions hopefully recognize by now how complex and precarious the creation of an HMO in a developing country can be. Therefore, if they seek to derive benefits for the total population they must be willing to find ways to mitigate the risk of the investors. "Mitigating the risks" helps address the complexity and risk issues U.S. private sector business faces as raised in the first half of the paper; it also addresses the experimental nature of the HMO concept in developing countries. HMOs, as a concept, enjoyed aggressive financial support from the U.S. government in their infancy. Without it they may not have evolved to the success they are today.

In most developing countries something as basic, yet absolutely critical, as accurate health actuarial data simply does not exist in any credible way. This is only one example of the uncertainty of the environments found in developing countries. There are many more.

The following graphic attempts to highlight the tensions and identify some of the consequences setting up HMOs present in developing countries. The illustrations of the socio-economic groups (peasants, blue collar, white collar) simplistically differentiate the rungs of society. The white collar population more adequately can afford to pay for health insurance out of disposable income; peasants, on the other hand, must depend (or so suggests conventional wisdom) on assistance in some form from the government or concessionary financing.

In countries where the vast majority of people are in the lower income group, one's social and political image is greatly enhanced by assisting this group. Yet, in order to achieve a self-sustaining business, probability of success is higher if one is dealing with upper income people. The question then is how to walk the tightrope between the need to relate to the lower income sector, yet keep risks to a minimum. Addressing that question is where we get to the categories noted in the graphic:

- Facilitators
- Services
- Clients
- Cost Controls

Each of these categories will reflect on how the HMO business is finally set up and who it reaches. There is not a third column for blue collar worker in the middle, because it is assumed an HMO business will end up somewhere between the two extremes, i.e., between peasants and white collar. How that is finally structured is dependent on each country and the business partners.

Facilitators: These are arrangements, either through legislation, decrees or financial structures which encourage (or discourage) an HMO business to relate to certain clientele. If, for example, all risk and all incentives are solely the responsibility of the investing company, it will do its best to seek the highest probability of success population, i.e., white collar. Conversely, if the government and/or development entities provided special legislation, a company may be more willing to take risk with lesser income groups. This arena obviously entails great thought by the host governments. This is particularly true of health insurance since it generally does not fit any of the sector development laws in developing countries.

Service: The organization's client base determines its level and range of services.

Clients: These two examples in the graphics were meant only to show how client groups also may vary with different population objectives.

Cost Control: Again, this is where government may help or hinder. Regardless, what one's structure must realistically reflect is risk and the revenue stream.

Critical Ingredients: This is meant to identify, at the risk of repetition, what are absolute "musts" in order for the HMO to work.

CLIENTS

PEASANTS

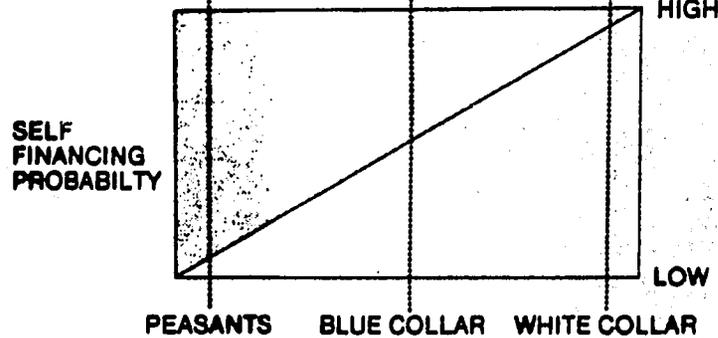
BLUE COLLAR

WHITE COLLAR



- SOCIAL OBJECTIVES
- IMAGE

- BUSINESS OBJECTIVES
- PROFIT



FACILITATORS:

- REIMBURSEMENT
- SOCIAL TRUST FUND
- SPECIAL LEGISLATION
- FEES
- FINANCIAL CONCESSIONS
- SUBSIDIES

- INVESTMENT INCENTIVES
- REPATRIATION/CONVERTABILITY
- SPECIAL LEGISLATION
- INVESTMENT INSTRUMENTS

SERVICES:

- PARAMEDICAL
- PRIMARY HEALTH CARE

- HOSPITAL CARE
- FULL RANGE OF SERVICES

CLIENTS:

- COMMUNITIES
- COOPERATIVES

- EMPLOYERS
- EMPLOYEES
- INDIVIDUALS

COST CONTROLS:

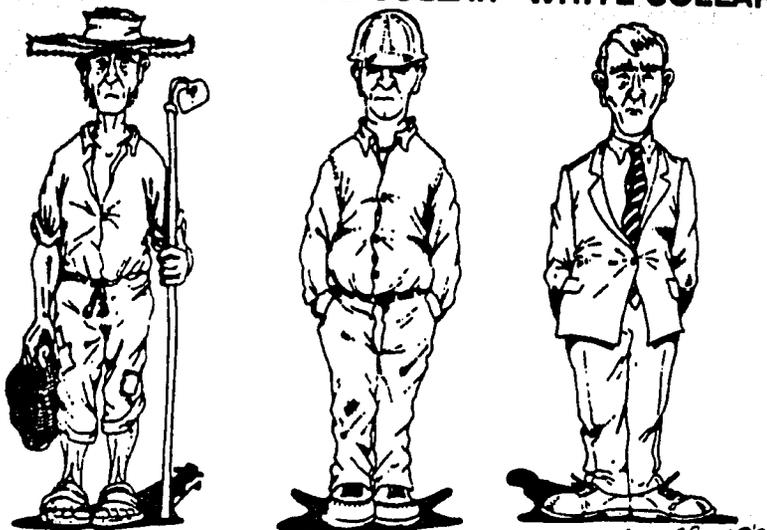
- CONTRACTS
- GOVERNMENT REIMBURSEMENT
- BASIC SERVICES
- FEE MANAGEMENT

- CONTRACTS
- PHYSICIAN INVESTORS
- INSURANCE COMPANY INVESTORS
- QUALITY CONTROL
- ACTUARIALS
- RISK MANAGEMENT

CLIENTS

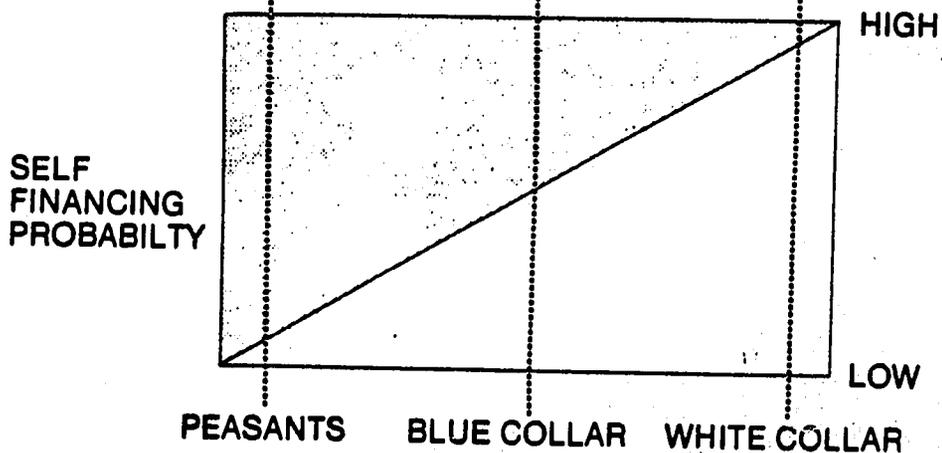
PEASANTS

BLUE COLLAR WHITE COLLAR



- SOCIAL OBJECTIVES
- IMAGE

- BUSINESS OBJECTIVES
- PROFIT



CRITICAL INGREDIENTS:

- INFORMATION
- MARKET
- MARKETING
- SERVICES
- FINANCIAL MANAGEMENT
- QUALITY CONTROL

and

"THE FLOAT"

- WELL NEGOTIATED CONTRACTS = \$
- GOOD COST ACCOUNTING/REPORTING = \$
- ADROIT FINANCIAL MANAGEMENT = \$
- QUALITY OF SUBSCRIBERS = \$
- PREVENTIVE HEALTH CARE = \$

6. OPPORTUNITIES FOR THE PUBLIC/PRIVATE APPROACH TO HMO DEVELOPMENT IN DEVELOPING COUNTRIES

It is clear that key strategy in HMO development internationally is the potential of a combined public/private sector approach. The combination of both private and public sector initiatives, in tandem, should eventually foster the creation of an environment in which the two can meet mutual objectives harmoniously. Both sectors, though, must realistically appreciate the constraints under which they are working.

Private Sector -- need to realize acceptable return on investment, reduce risk, work with a degree of predictability.

Public Sector -- respond to the needs of all of society, fairly distribute opportunities, minimize waste of limited resources.

These "constraints," by definition, mean that both sectors will have to compromise if they are to work together. This is particularly true if emerging nations wish private initiatives to unfold in arenas heretofore considered to be the responsibility of the public sector.

International development agencies can be extremely helpful in guiding the private and public sector toward the acceptable areas of compromise. Compromise may mean a government offers tax holidays or developmental financing for a health services business; business, on the other hand, may have to tackle creative approaches to offering some range of services to those on the lower end of the socio-economic ladder.

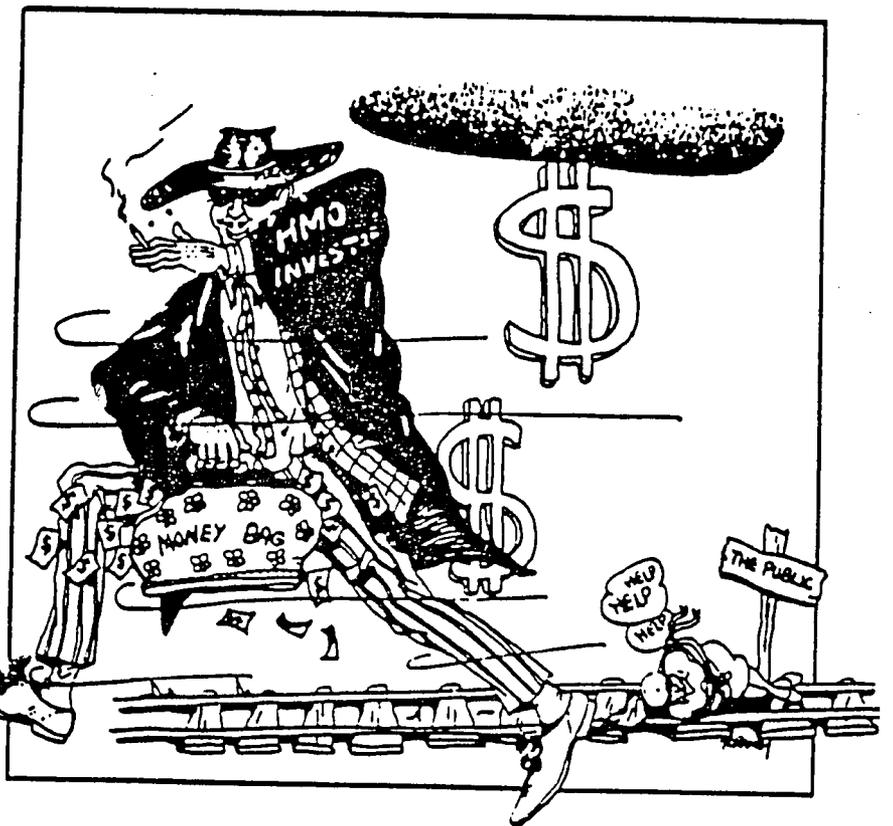
Development agencies, if the encouragement of privatization and transfer of technology is part of their mandate, should try to anticipate what the incentives and conditions needed might look like, and seek to put them in place, rather than wait for a company to come in cold -- they may never thaw out.

The Overseas Private Investment Corporation (OPIC) and the Bureau for Private Enterprise/AID are two very significant activities within the U.S. government for encouraging and supporting private sector activity overseas. Both entities can assist in structuring loans and providing feasibility study money. Additionally, OPIC provides a range of insurance options which will protect one's investment against expropriation, inconvertibility, acts of war, etc. OPIC has a long established track record and operates with a genuine understanding of the private sector. Both entities are extremely interested in supporting innovative, yet self-sufficient, approaches to key developing countries.

Entities of this sort are critical to encouraging and supporting private sector initiatives. It is not enough to mandate privatization. One must comprehend the complexities of international business, investment, and risk. Vehicles and means must also be created to ensure that investment of one's capital overseas in a business enterprise is a fair opportunity. To put this in perspective, the reader need only ask himself, if presented with the



HMOs ARE NOT PANACEAS ...



... NOR ARE THEY GRASS ROOTS VENTURES

opportunity to invest his own money in a project that would produce the same return, whether in the U.S. or in an LDC, assuming conditions do not change, where would he invest? The phrase which of course guides the answer is "assuming conditions do not change." The probability of change is much higher in a lesser developed country than in the U.S. So either your return must be far greater than in the U.S., or someone must structure vehicles or incentives to mitigate the inherent risk of investing in less stable environments.

These considerations must be seriously addressed before development institutions can ask private investors to not only invest, but also assist the lower economic segment of society.

Pre-paid health insurance projects have all the ingredients of being able to better provide health care to the lower classes, due to their preventive health care motivation, out-patient care focus, and simple payment schemes. But, in emerging nations, this income group is also a less healthy group. It is a group for which there are not accurate statistical tables. It is a less well-educated group, which means higher education and marketing cost for the insurance plan. The list goes on. Yet, it is a group which, in most countries, represents the majority of people (and with that, the majority of costs). Due to sheer numbers the lower income groups must be addressed by the HMO experiment. How?

There are three approaches which could serve to bring HMO services to this citizen group:

1. government reimbursement program
2. trust fund
3. alternative range of services.

1. Government Reimbursement Programs -- an HMO could be set up specifically for the government's needs, or an existing one contracted. But, rather than the consumer paying premiums out of their disposable income, the government would pay for the premiums.* In this process, the government could possibly even negotiate the lease of its numerous health facilities to the HMO group. In doing this the government turns over health care delivery (at least a portion of it) to the private sector. This scheme allows it to contract with an incentive-based approach, which should stand in absolute contrast to the inefficiencies of government and difficulties with government employees in the delivery of health services.

* Government legislation can mandate a set percent of income to be allocated to health, which is transferred to an operating HMO or one of several competing HMOs.

The objective would be to keep all the incentives of the HMO structure intact. Except, in this case, as part of a lower economic bracket, the enrollees cannot afford the cost. Therefore, the government is providing a subsidy. This subsidy, it should be noted, is being provided anyway within the current delivery system. Consequently, this approach is merely using the same pool of money to reach the same group of people, but through a different and more efficient strategy.

2. Trust Fund -- a trust fund could be set up by an existing private sector HMO based on a percent of profits (the HMO has to be realizing significant profits in order to finance this approach). This money could be matched or enhanced in some fashion by the host government. The purpose of this trust would be to partially subsidize the premium payment of the lower income strata.

For this mechanism to work, the host government would probably have to grant a meaningful tax credit to the HMO which would make the trust fund operation an attractive alternative to the normal way of doing business. Additionally, the approach should only be implemented after the regular HMO has been operational for a couple of years in order to give it the experience and economic base it needs. The experience base is obviously needed before tackling another program for lower income groups; the financial base is required to ensure the trust fund structure does not debilitate the economic base of the original HMO.

The trust fund approach means the government can point to the success it has had in attracting private sector participation. It also helps dissuade the public sector physicians of their hostility toward new approaches. For the private sector, it offers the opportunity to demonstrate a good faith and commitment to the country and its problems.

3. Alternative Range of Services -- this is a situation where an existing HMO would offer a policy to low income groups, but the range of services would be reduced commensurate with the projected premium package. In other words, it would probably be limited to basic out-patient services.

In many countries where the public health care system simply does not work, this may be a viable alternative. Barter could be a form of premium payment. Or even a minimal premium payment subsidy by the government, complemented by an enrollee contribution to provide the basic minimal care the enrollees would need in order to satisfy their immediate health care needs. Delivery of services, in this instance, reflects the provision of some services in the absence of none whatsoever. In other words, an HMO approach where the government's system has broken down completely.

This approach would at least initiate a new rationalization of services based on what is affordable and manageable. As more data and experience are collected, an enhancement of services might be feasible. It is important to remember in this process that one is forging new terrain. This means breaking old patterns and introducing new methodologies. There is nothing worse than offering too much and losing the chance to make it work. This option is about qualified experimentation. Once one level works, then another can be added.

7. SUMMARY

The intent of this presentation has been to expose some of the thinking and considerations which guides the decision making process a U.S. company goes through when looking at the international business environment. And, then, with that as a backdrop, look closely at the ingredients which govern the creation and implementation of an HMO.

Hopefully the reader has concluded that there is a great deal of risk in investing and operating in the international environment. Another important observation would be the complexity of the items which must be weighed in order to launch a viable business overseas. These are very complex hurdles, entailing judgments which are critical to whether one is successful or not.

Once the business decision is made, then one enters the phase of actually setting up the HMO. The approach in this presentation was modeled on the assumption that a host country insurance company would have to be involved as a principal investor. Also, it was assumed that the HMO would be run by an HMO company, which both the insurance company, the U.S. firm and others would own. Of course, there are numerous ways to structure an HMO and investments. The structure may change, but the concepts, however applied, will not deviate too greatly from the prototype presented.

HMOs offer exciting possibilities for treating severe health care delivery problems, both in terms of the cost as well as the range of services. Much of this can be attributed to the preventive medicine focus found in HMOs; it is not just lip service, but rather a function of the incentive to keep costs low and revenue high, and the conviction that the approach is ethically correct.

The standard complaint about HMOs, as they are applied in lesser developed countries, is their tendency to only be affordable for middle class people and above. One must remember, though, that these experiences are with HMOs supported wholly by premium payments from the disposable income of their enrollees. This leaves all sorts of room for experimentation with government reimbursement and subsidy programs, special financial incentives to encourage HMOs to work with people on the lower end of the socio-economic spectrum, and creative contractual arrangements with governments. The concepts forming HMOs are sound and proven. The challenge is to find the appropriate way to enable those same concepts to reach all segments of society.

Governments, international development banks and institutions can play a particularly important role in responding to the challenge of enabling HMOs to reach all rungs of society. In their respective searches for clues and solutions to the inadequacy of health delivery to lower socio-economic groups, these institutions need to be creative as well as assume some risk. Public institutions working in tandem with the private sector can do a great deal to enhance and accelerate the discovery of new solutions and mechanisms for serving society at large. If, however, they elect to distance themselves from private sector endeavors or simply remain neutral, the private sector will continue to do as it has done to date: make rational judgments based on risk and return. If governments and development institutions introduce other variables which mitigate risk, in high risk areas, then the motive for jointly seeking out solutions to mutually identified problem areas is acceptable.

The application of HMO concepts to lesser developed countries is in its infancy. There is enormous room for experimentation. This experimentation should be launched with great haste. The problems of health service delivery systems in lesser developed countries are only going to get worse. The only unanswered question is: "How much further will they deteriorate and over what period of time?"

HMOs offer an attractive potential alternative because they have positive features for everyone: the enrollee reaps advantages because health care is less expensive, more accessible and prevention-oriented. The physician gains by his practice becoming more efficient and productive, by building a capitalized asset, by earning more through a group effort rather than individually, by being able to focus on the practice of medicine rather than medical management.

The government benefits by having an alternative health care delivery service mechanism with incentives for lower overall costs and effective management, which is available as a model for replication. The HMO also relieves some of the pressure on the demand for public services by creating an attractive option for medical care which will keep people from traveling abroad for health care, and offers doctors an alternative to keep them from leaving the country in search of other options. The investors derive benefit by being able to launch a new venture which has been successfully developed elsewhere -- they do not have to reinvent the wheel. They are providing a less expensive form of health care which also has enormous profit potential. They are responding to the country's needs and they are developing a very growth-oriented asset. The public benefits by being the beneficiary of a form of health care which is preventive medicine based, which has quality assurance and utilization review as key critical components, by having a choice of medical care, by having a delivery service mechanism which has as an objective cost efficiencies, by having an alternative model.

If governments and international development entities are eager to have the private sector take the lead in the development of HMOs, then they must be responsible for their part in this effort. As discussed earlier, this is very complex business, accompanied by risk, especially when carried out in developing nations. There is no doubt about the demand for the development of HMOs. Currently there is tremendous experimentation worldwide in terms of what this concept may hold as an alternative or solution to some health care delivery problems and costs. A tremendous boost could be given if the collective minds of the Agency for International Development, the regional development banks, and international health organizations such as The World Health Organization, worked together on describing what type of legislation, capitalization and structure would be essential to encourage the creation of HMOs via the private sector in developing nations. This type of white paper would help ensure that, as was said earlier, the wheel is not invented again. More importantly, it would expedite the creation of opportunities for the launching of HMOs outside the U.S.

No one knows for sure just how successful HMOs will be outside the U.S. environment. As noted earlier in this paper, the U.S. environment is unique. However, the principles are of universal importance and relevance. They should be given a chance.

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