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A Review of
Alternative Financing Initiatives:
Applications for ANE Health Programs in the 1990s

by
Jeremiah Norris
for
Devres, Inc.
7201 Wisconsin Avenue, Suite 500
Bethesda, MD 20841

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A. Introduction

In February 1989, the Administrator of AID sent a report to the Congress entitled "Development and the National Interest. U.S. Economic Assistance into the 21st Century". This report stated that the "biggest challenge facing the health sectors of most developing countries in the next century will be finance. Easy solutions to isolated health problems, which have dominated donor assistance programs for the past ten years, have run their course. As people in developing countries live longer, reduce their family size, and become more urban, their needs will change. And these needs will be more costly than in the past". Given the Administrator's challenge, the ANE Bureau is now actively engaged in developing a strategic framework to assist countries initiate finance as a major component of their health sectors.*

B. Definition of Finance

Finance is not, as in the traditional AID terminology, an intervention. Finance is the foundation of resources which underlies and makes possible a course of events, rather than an intervention. Thus ANE's project concept must relate to encouraging or facilitating the broadening of that foundation of resources, using the leverage affect of AID resources to do so. In this sense, it reflects a new approach for AID, a new design in program development which views and relates to broadening the financial underpinnings of public administration, in this case for health services.

In the 1990s, AID's funding documents (Project Papers) must take a forward-looking view of finance issues, structures, problems and opportunities. They must articulate the need to address these issues in light of rapidly changing demographics, labor force shifts to industrial sectors, urbanization and urban poverty, increasingly market-oriented economic policy in developing countries, changing epidemiology, and the unit cost (and therefore finance) implications of new morbidity and mortality patterns, and, given all of the above, rapidly changing donor roles which must increasingly rely on leverage to maximize limited resources.

* Throughout this text, the term health will be used in its generic context, which encompasses population and nutrition activities. U.S. health industry firms, particularly HMOs, provide population (family planning) and nutrition services within their standard benefit packages.

C. Health Finance Experiences in the United States Through Prepayment

There are many similarities between emerging prepayment systems in ANE countries and in the United States prior to passage of the HMO Act of 1973. Up until that year, prepaid health care in the U.S. was a very small percent of the market, certainly no more than 3%. Kaiser was the largest group, but there were others such as the Group Health Association in Washington, D.C., Group Health of Puget Sound (Seattle), and the Health Insurance Plan (HIP) of New York. The main motivational force behind the HMO Act of 1973 was cost containment. When Medicare/Medicaid was passed in 1965, the U.S. was spending 5.5% of GNP on health services. The next seven years saw this percentage climb to 8.3%. To medical providers, this era is referred to as "the golden age of medicine" (with good cause), while those concerned with public policy referred to it as "the Great Treasury Raid".

During this period, service delivery was basically a cottage industry predominated by fee-for-service practices. Employers paid more attention to the purchase of paper clips than they did to health insurance, and insurance companies simply paid the "usual and customary" charges submitted by hospitals and providers.

As national costs increased, government became concerned. It was then joined by industry. Thus, the two largest payors of health care came together as one force in an attempt to break the upward costs of health care in the U.S.

Up until this time, both preventive care (including family planning), and most primary care were paid out-of-pocket by individuals as they were not considered covered benefits in indemnity insurance plans. Insurers insisted that these were not cost-effective, and that there was little demand for them in any regard. Kaiser and the other prepaid plans did include them as standard provisions in their comprehensive benefits under the theory that effective PHC programs reduced hospitalization.

The largest of the prepaid plans was in California. When Nixon came to the White House in 1968, his first two Secretaries of Health were from California.

Dr. Paul Ellwood, often called the "Father of HMOs", crafted the HMO concept from the California experience. With the backing of the Secretary of Health, he was given the opportunity to make the HMO case directly to President Nixon. Subsequently, Nixon presented the idea in his State of the Union address in 1970, and it became legislation in 1973.

The proponents of HMOs set out to prove three important concepts:

1. HMOs could offer a comprehensive set of benefits for one fixed rate at a price competitive to or less than indemnity insurance companies;
2. HMOs could offer needed competition in a then relatively closed market;
3. And, that HMOs could change hospital and provider behavior patterns by both financing and delivering health services under one organizational umbrella.

When the Act was passed. Congress appropriated \$375 million for HMO planning, development and implementation over the following five years. These funds were directed to the Secretary of Health. Now the government had money but no expertise to implement the legislation, and outside of the aforementioned groups, there was precious little capacity in the U.S. health sector to undertake implementation. The Secretary went to a trade association, the Group Health Association of America (GHAA), which at that time held its annual meetings in a local McDonalds restaurant. (It now needs several large hotels.)

A marriage of convenience was arranged wherein the GHAA would assemble development teams to provide the technical assistance for local groups to form HMOs. At the same time, the GHAA would provide to the Secretary's Office of Health Maintenance Organizations Legal and Regulatory Assistance in support of the legislation, and technical guidance in the form of Quality Assurance, Federal Certification, Loan Approvals, etc.

The teams assembled by GHAA worked with four key groups:

1. Community leaders
2. Union leaders
3. Professional medical community
4. Business community

The Act not only cleared the path for HMO development, it also provided the necessary impetus for progress of the movement on a national scale. Specifically, the Act provided this impetus in three ways:

1. It provided federal grants and loans for developmental costs which may not have been available otherwise. Bankers and private funding institutions were reluctant to provide loans for risky independent ventures. The federal government could reduce those risks by providing or guaranteeing funds only for those entities which became "federally qualified", i.e, met detailed federal requirements designed to assure fiscal responsibility and quality of care.

2. It removed a major roadblock to HMO development by over-riding conflicting state legislation. The Act superceded existing state legislation in approximately 20 states which would have restricted this type of organized health care delivery. For example, the Act eclipsed state "Shield Laws" which prohibited physicians from establishing exclusive organizations, and other laws which prevented companies from engaging in the "corporate practice of medicine". By overriding these laws, the Act opened the doors to HMO development in all states.
3. It created an immediate pool of potential members by forcing employers to offer HMOs as alternatives to traditional employer-covered health plans. Through a federal mandate known as "dual choice option", HMOs were made available to the majority of private and public employers.

In terms of the three goals HMO proponents set out to prove: (1) almost all of the major indemnity insurance companies (Prudential, Equitable, CIGNA, etc.) now offer their own HMO plans at prices competitive to other HMOs; (2) last year, of the 26 plans offered to federal employees in Washington, D.C., 23 were HMOs; and (3) because HMOs have maximized their purchasing power, hospitals and physicians compete for their business. HMOs have reduced bed-day use in hospitals by approximately 33% over the rate of ten years ago. Nationally, U.S. hospitals have an occupancy rate of approximately 65%. Unfortunately, this means that some hospitals have had to close.

Since 1982, the federal government has been out of the direct funding of loans or grants to HMOs. Once the idea was demonstrated to have commercial application, the private investment community entered and took over the government's role. Today, there are approximately 33 million members of HMOs, most of who are represented through their trade association, the GHAA. Membership is now growing at 12-15% per year.

In 1985, the government permitted Medicare members (over 65 population) to enroll in HMOs on an optional basis, and some states (Arizona, Pennsylvania, etc.) are enrolling their Medicaid (the poor) into HMOs. The reasoning is basic and fundamental: federal and state governments get a better bang for their tax dollar from HMOs than from fee-for-service practitioners.

It is important to note that the level of benefits and costs to employed members of HMOs is no different that to Medicare or Medicaid members. And, particularly for the latter group (the poor), providers have no way to tell how this person's premium is being paid. All members have the same identification card and are entitled to the same benefits.

D. Adaptation of the HMO Model to Development Countries

The evident success of HMOs as private sector enterprises in the United States has recently made them the subject of intense interest from abroad. They have attracted much attention both from providers and from health policymakers seeking solutions to the problems of health services delivery and steeply rising costs.

Although health maintenance organizations have so far developed and flourished most rapidly in the United States, their organizational and finance characteristics offer substantial benefits to the development of national health care systems of other countries. By directly linking the financing of health care to the organization of its delivery, HMOs afford an opportunity both to reduce costs and to rationalize the provision of health care to a given population. Financial incentives to providers motivate them to give attention to prevention of disease and promotion of health behavior as well as to the diagnosis and treatment of illness. While a wide variety of organizational forms and financing methods are possible under what are now more broadly termed "managed health care" benefit plans, the key distinction of such plans is the assumption of some financial risk by the provider(s) through the acceptance of a fixed, prepaid per-capita fee in return for delivery of an agreed-upon package of health care benefits.

1. The Appeal of the HMO Concept

It is the evident success of HMOs as private sector endeavors in the United States that have made them noteworthy as possible solutions to the problems of health services delivery and steeply rising costs abroad. However, the societal forces which have been responsible for the success of HMO development in the United States are not typically found in other countries, particularly in developing countries. Nevertheless, there are conditions in some Third World countries, and even in many industrialized countries, which are stimulating interests in the HMO concept. Among the most important conditions and factors are the following, with some being more relevant to conditions in advanced health care systems and some being more relevant to conditions in developing systems:

- o budgetary pressures on public health authorities are causing policymakers to look for ways to incorporate incentives for cost containment into their methods of organizing delivery, or for ways of using private sector mechanisms for delivering or financing certain health care services;
- o foreign exchange costs of health care services are rising extremely rapidly in some countries, fueled by one or more of three main causes: (1) increasing demand for high-cost, high tech medical equipment which must be imported; (2) excessive prescription practices by physicians not subject to management or budgetary controls, raising the import bill for foreign

medicines; and (3) an increasing tendency by higher income persons to travel abroad for specialized diagnosis and treatment--an expense too often heavily subsidized by government health benefits programs for civil servants;

- o local manufacturers are beginning to view employees' health care as a cost and productivity issue, and are observing that neither the public health system nor available private sector alternatives are addressing this issue, that is, keeping employees healthy and productive workers;
- o rising personal incomes in urban areas are increasing demand for alternative sources of quality health care, which in turn is stimulating rapid growth in the private sector, which can lead to a fragmented, unregulated, and expensive delivery system; when national policy constrains private sector response to this increase in demand, popular discontent with the system can rise and inequitable nonprice rationing can occur; and
- o changing demographic and epidemiological conditions in many populations are radically altering the patterns of illnesses and injuries requiring diagnosis and treatment, leading to increasing proportions of retired person in beneficiary populations and to increasing expenditures on treatment for the chronic and degenerative diseases to which they are more susceptible.

The existence of one or more of these conditions in numerous countries has stimulated great interest in the applicability of the HMO concept. The robust character and broad base of the global market for the HMO concept has grown even where health officials recognize that the environmental conditions affecting their health care delivery systems are radically different from those in the United States. They seem to realize that the potential benefits of HMO development -- even in some adapted form -- derive from generic advantages inherent in its organizational and financial characteristics in the areas of efficiency, quality, and provision of capital and appropriate incentives. They see that advantages of the HMO concept, even when cross-bred with indigenous varieties of health care organization and financing -- give promise for success of some adapted form of HMO development in diverse environments.

There seems to be a rapidly growing appreciation, in health care markets abroad, that HMOs offer significant advantages compared to existing service delivery and financing arrangements:

- o rational service management within a comprehensive delivery system for a defined population;

- o focus on promotion of healthful behaviors and prevention of disease;
- o cost containment through sharing of risk by providers and capitated prepayment;
- o possibilities for implementing efficiency incentives;
- o capability of instituting uniform quality assurance review mechanisms for the beneficiaries;
- o availability of a pool of capital (from capitated prepayment of fee) and creation of an asset which attracts additional capital investment.

2. The Broad Base of the Global Market

Markets in which these features of HMOs are making an impression can be classified into three basic groups:

- (1) advanced industrialized nations with highly development health care systems;
- (2) developing nations with relatively mature modern health care systems and markets; and
- (3) developing nations with rapidly growing but still relatively underdeveloped health care systems and markets.

The first group includes European countries plus Japan, the oil-rich Arab states, Singapore, and Hong Kong; the second includes most of the countries of Latin America; and the third comprises the more advanced countries in North Africa, the Near East, an Asia - - such as Morocco, Tunisia, Egypt, India, Thailand, Indonesia, and the Philippines.

While it would be oversimplifying matters to claim that the U.S. experience in HMO development is "exportable" to these markets in the usual commercial sense, there is ample evidence in each of the three classes of markets that health care officials and providers are seriously interested in exploring the relevance of the HMO concept for their own service delivery and financing systems. HMO concepts have been adapted for applications in many countries, and interests from many others has been expressed. The following is a brief review of the evidence in this regard in each of the three market groups.

a. Highly Developed Systems in Fully Industrialized Nations

Despite the fact that some form of national health insurance is well-established in almost all other Western nations except the U.S., virtually all of them continue to face the common problems

related to efficient and equitable allocation of scarce health care resources. A recent article by Rodwin (1987) documents that HMOs are appreciated more and more -- at least by policy analysts if not political decisionmakers -- as a potentially beneficial innovation in health care organization and financing. He noted:

Given the range of common problems in different health systems, what is most striking about how they are currently dealt with abroad is the extent to which a number of fashionable American themes have drifted north to Canada and across the Atlantic to Western Europe...The idea of privatization has provoked heated debate...Above all, HMOs have attracted the greatest attention from specialists in the health policy field.

He goes on to note that, whatever the explanations for this interest,

the idea of introducing HMOs into national systems that provide universal entitlement to health care usually involves two reforms. It spurs policymakers to combine regulatory controls with competition on the supply side, and it encourages them to design market incentives for both providers and consumers of health care."

Although implementation of proposed innovations involving HMO concepts are evidently not yet underway, Rodwin's examples of how the HMO concept was adapted in proposals for three countries show the potential. In France, the concept of a HMO was translated as a "reseau de soins coordonnes (RSC) -- a network of coordinated medical services. The RSC concept, proposed by Rodwin (1981) and a French physician, was founded on Alain Enthoven's (1980) Consumer Choice Health Plan for the U.S. Whereas Enthoven's plan was designed to use the HMO as a principal element of a NHI proposal for the U.S., the RSC proposal is largely a strategy to promote supply-side efficiency within an already existing NHI system.

An innovative proposal to modify Canada's NHI system has been proposed by Stoddard (1982) for the province of Ontario. A proposal for "Publicly Finance Competition" would create three different payment modalities on the supply side: private practice in a fee-for-service modality, private practice for a prepaid, capitated fee, or salaried practice in a community health center. Referral services would only be available through a primary care provider practicing in one of these three modalities, and all patients would have to select a provider for a specified period of time. While the financing of health care through premiums and taxes would remain unchanged, only the least costly modality would be fully covered under the plan. Patients enrolled in the two more costly modalities would themselves have to pay the difference between the cost of the baseline modality and the higher premium. This proposal links the incentives on the supply side to consumer

choice on the demand side, and relies on the use of market forces without abandoning the benefits of a compulsory and universal NHI program.

For England, Enthoven and Maynard have proposed promotion of "internal markets" and HMOs within the existing system of entitlements provided under the National Health Service (NHS). Enthoven's (1985) plan would empower District Authorities to receive per capita revenue and capital allocations for consumers from a neighboring district who choose to enroll. The District Authorities would remain responsible for providing care to District residents and would receive the necessary allocation for doing so, but their ability to purchase health services for non-residents transforms them, in effect, into HMO operations each competing with neighboring District Authorities for their residents' patronage. Maynard's (1984, 1985) proposal would give vouchers from the NHS which entitles them to sign up with a general practitioner of their choice. The voucher generates a per capita payment to the GP in return for the provision of comprehensive health care for a year. Since GPs would be responsible for purchasing hospital services, they would need to hire managers to assist with HMO formation. Needless to say, both Enthoven's and Maynard innovative proposals would lead to substantive reorganization of the health sector in Britain, which Prime Minister Thatcher formally proposed in January 1989.

While the probability of any of these proposals being implemented on a very wide scale depends critically upon system-wide political decisions being taken at high levels, the proposals themselves are evidence of the ferment of ideas for change in the way health services are organized and financed in these three countries. The existence of private market forces in these systems, and prospects for growth fueled by significant consumer demand, hold out the promise that development of HMO-like organizations may soon begin to take hold in these countries.

In addition, any country in which large parastatal companies own and operate health delivery systems for their employees may become interested in adaptation of the HMO-like concepts to suit their cost containment needs.

b. Mature Health Systems In Advanced Developing Countries

Developing countries which have reached an advanced stage of the industrialization process have relatively mature systems of health care services based on decades of investment in training health care personnel and in social-insurance-based health services. Most if not all of the countries in this group are in Central and Latin America, where large modern, urban-based health care systems have been financed through wage-based social insurance schemes.

The current status of prepaid managed health care in Latin America and prospects for further development have been amply documented in a recent GHAA report to AID's Health and Nutrition Division of the Bureau for Latin America and the Caribbean, Managed Prepaid Health Care in Latin America and the Caribbean: A Critical Assessment. The report confirmed the conventional wisdom that the level of economic and social development has been the major positive influence on the prospects for HMO development; but it found that European immigration has also played a significant role.

Countries where HMOs have assumed significance in health system development include Brazil (with over 150 HMOs reaching almost 10% of the population), Uruguay (50 HMOs reaching 45% of the people), Paraguay (25), and Argentina (10). The study found three factors which contributed to interest in, and growth of, HMOs.

- o presentation of community-based organized social structures could be utilized for organizing HMO;
- o an excess supply of physicians; and
- o perceived inadequacy of publicly-provided health services.

The study also identified promising prospects for HMO development in Mexico, Panama, Guatemala, and the Dominican Republic. Major health care companies involved in managed health care in the U.S. are currently exploring possibilities for investment in HMOs in all of these countries.

c. Maturing Health Systems In Industrializing Countries

Probably the most robust markets for HMO development exist in those industrializing countries in which the rapidly growing purchasing power of the urban, wage-based populations has helped to support even more rapid growth of private medical care system. In a number of middle income countries, these private systems have been maturing rapidly during the past decade, both in terms of size, diversity, and quality of care. Paralleling the stimulus from the growth in purchasing power of urban workers has been the impact from changing patterns of disease: the higher incidences of chronic and degenerative diseases has increased the demand for acute care services.

The high rates of urban growth have thus brought with them a number of serious problems--rising prices, utilization, and costs being chief among them. Health policymakers and managers--in both private and public sectors--are now looking seriously for ways to deal with the unprecedented problems in organization and financing faced by the ever greater demands being put upon the health delivery systems.

Delegates to the 1987 World Health Assembly in Geneva in May heard workshop speakers at the WHO Technical Discussions on health care financing and risk coverage and for the private sector to assist the public sector in meeting the resource needs for health services in developing countries. schemes in Bolivia. In Indonesia, AID's support for the study of the feasibility of converting the health system of PERTAMINA--the state oil company--into an HMO has been given broad national health policy implications as a potential exemplar for the development of other HMOs in the public and private sectors. Similarly, AID's effort in the Philippines is designed to leverage a private sector investment into an HMO--should the study find such an investment to hold promise as a business proposition.

There thus appears to be a growing market for HMO development in a number of countries abroad. Some centralized coordinating institutional mechanism would greatly facilitate an effort to translate and transfer the applicable U.S. experience, expertise, and technology regarding managed health care to other countries.

E. Managed Health Care: A Comparative Advantage For The U.S.

As system of prepaid managed health care proliferate in this country, it is increasingly clear that the U.S. has developed a substantial body of knowledge and experience in a field that is unparalleled in other countries of the world. While the distinctive feature of the U.S. health care system is the substantial if not dominate role of the private sector, the comparative advantage enjoyed by the U.S. in the overseas market for prepaid managed health services and systems is not necessarily limited to countries with large and vibrant private sectors. Even in the U.S., the birth and growth of an HMO industry was nurtured by federal legislation which enabled many HMOs to start up in the early 1970s, as stated earlier. In a broad variety of socio-economic environments, U.S.-based expertise in this field is likely to find opportunities for adapting its experience simply because no other country has had the opportunity--as afforded in the growth of the HMO market--to integrate systems for financial control and accountability with systems of patient management for the full range of health needs and medical problems.

The U.S. comparative advantage is being underscored currently by the upsurge in interest on Wall Street in the prospects of companies--both large and small, established firms and start-ups--who are moving aggressively into the prepaid managed health care market. Both large hospital management companies and conventional indemnity insurers are moving to purchase or develop HMO-like companies or products. Those companies that become successful in the market will be those whose cost-containment efforts and management methods are most effective. It is precisely these kinds of expertise which are sought most by overseas health service delivery groups--public and private--which are coming under

increasing pressure to expand health care services without increasing costs and without sacrificing quality.

F. Trends And Consequences For Finance In ANE Countries

ANE countries need to find finance solutions uniquely suited to their own environment. The following is a listing of broad health related trends affecting ANE countries. This list is accompanied by the consequences of these trends as they affect

<u>HEALTH AND SOCIAL TRENDS</u>	<u>CONSEQUENCES OF CHANGING DEMAND</u>
- longer life expectancy	Nursing homes, hospital cares, social insurance, management efficiencies, more facilities, extended care facilities.
- lower infant mortality rate	social insurance, specialized hospital care, management efficiencies, more facilities.
- continued migration to urban areas	concentrated client population, easier access to health facilities, greater political demand for services, prepayment for wage-based groups, expansion of outpatient clinics.
- fewer infectious and parasitic diseases	less focus on public health and primary health care issues, more on upgrading health care delivery systems.
- increase in chronic diseases	demand for hospital care, nursing homes, new technologies and management techniques, new facilities, health insurance to cover costs, and outpatient care.
- emerging wage-based class	greater demand for quality hospitals, ability to pay for services, access to efficient outpatient services.
- health care costs increasing	search for more efficiency, better technology, and renovation of delivery systems.

G. Some Examples Of Technical Assistance For Developing Alternative Health Financing Schemes

1. Indonesia - In 1986, a group of officials from the PERTAMINA Oil Company asked to visit HMOs in the U.S. ANE arranged for them to meet with CEOs in Los Angeles, San Deigo, Colorado Springs, Kansas City, Boston, and Washington, D.C. Following this visit, ANE asked the reach project to design a business plan for PERTAMINA which would covert its health benefits program for 250,000 employees, dependents, and retirees into an HMO operation.

Three significant facts emerged from our field study which convinced PERTAMINA officials of the need for HMO operations:

- o When PERTAMINA started its health benefits program 25 years ago, all of its investment went into material and child health care, immunizations, and portable water. The success of this preventive program changed mortality patterns. Now, 52 percent of mortality is due to heart, stroke, cancer, and accidents.
 - o The changed pattern of disease in the PERTAMINA population has increased the health benefits program from \$7 million in 1976 to \$72 million in 1986, although the size of the work force remained relatively stable.
 - o In 1985, the retired population and their dependents were permitted access to the health system, though no costs studies were performed. By 1987, the retired population was consuming 35 percent of total health services, yet it constituted only 12 percent of PERTAMINA enrollees.
2. Tunisia - In 1987, the Minister of Health requested an American firm to consider how a newly completed 250-bed public hospital could be placed in operation through a private contractor. The Ministry did not have sufficient funds to open this facility nor to provide for its recurrent costs. The Hospital Corporation of America International responded to the Minister with a view towards a management contract with the Ministry. Earlier, Tunisia had built an 850 bed facility; it is still un-opened. The Yemen Arab Republic has a 550 bed facility completed but not yet opened. Trinidad has a 650 bed facility waiting to be opened. And the list goes on. Capital construction funds are available, particularly through the donor community. But operating funds must come out of current accounts and these are increasingly unavailable.

3. Morocco - Tetuan is located on the coast, just across from Gibraltar. Here, a 19-member group practice, which owns and operates a 135 bed private facility, asked USAID/Ragat to assist in the development of HMO-type operations. Tetuan is a growing resort area, with new condominium construction, Club Med facilities, and other commercial activities which mirror earlier developments on the coast of Spain and France. The transfer of health care technology and organizational know-how is an important consideration to this group practice as it restructures its service delivery capability to meet the needs of the commercial development and expansion and to service the health needs of government employees.
4. Brazil - Hospital Corporation of America International operates the world's largest off-shore HMO, with over 800,000 enrollees, in Brazil. Only one HCA employee from the U.S. headquarters is on-site. Since purchasing this HMO in 1979, when it has 460,000 members, HCA has successfully Brazilianized its field operation.
5. Singapore - On March 1, 1988, HCA was asked by the Ministry of Health in Singapore to undertake a contract for privatizing their largest teaching hospital, a 1,650 bed facility. The government had reached the point where the continued provision of free health care for all was placing in jeopardy its ability to provide for the most needy.
6. Spain - The American International Healthcare - In December 1987, it initiated HMO operations in Spain, anticipating an enrollment of 40,000 members by the end of year one, and 300,000 by 1991. Earlier, it had initiated HMO operations in Chile and Jamaica. AIG is presently assessing investment opportunities in Hungary, Italy, Hong Kong, New Zealand, Singapore and Indonesia.
7. Pacific Islands - Family Health Plan - Located in San Diego, California, this firm has operated HMO plans in Guam and Saipan over the past ten years, and is now considering new operations in the U.K.
8. Malaysia - Through a contract with the Asia Development Bank, Birch & Davis Associates has been developing a framework for a national health insurance plan. Due to the sensitivities of the physician community, details of this plan have not yet been made public. The plan is expected to be released in the near future.
9. The Philippines - In September 1988, USAID/Manila signed an agreement with a local firm, PhilamLife, to undertake an assessment to determine if this life insurance company

could increase its benefit package to include outpatient care and prevention and promotion activities. USAID paid 80% of the costs, and PhilamLife (which has a joint venture with a U.S firm) covered the remainder. As part of the USAID contract, PhilamLife agreed to invest in a subsequent project should it uncover a commercially viable opportunity. On April 24, it in a report to the Mission, PhilamLife stated that it would invest \$2.127 million to expand its benefit package and to construct 15 outpatient clinics. This is the first example in ANE, as well as within AID, of a Mission leveraging its resources with the private sector.

10. South Korea - In 1975, AID initiated a program to test out alternative delivery systems in the private sector which featured health insurance and prepayment schemes. Today, 85 percent of the population is covered by health insurance, financed by mandatory contributions from payroll or household taxes. In 1978, the Ministry of Health privatized its largest teaching hospital, a 1,650 bed facility at Seoul National University. In 1988, this hospital had \$103 million in revenues from health insurance or private fee-for-service patients. Only 1 percent of all revenue came from the Ministry of Health for indigent care. The Ministry still funds capital costs (renovations, equipment, etc.), but almost all of the recurrent costs are not financed by the private sector.
11. Morocco - The Hospital Corporation of America is presently working with a local group to develop the country's first private hospital, a 220 bed specialty facility. Funds for capital construction have been raised through local pension funds and insurance companies, while the International Finance Corporation (IFC) is preparing to advance the foreign exchange for equipment. The Ministry of Health is actively supporting this project, as is the Ministry of Finance, for the following reasons.
 - a. the cost of speciality services in public teaching hospitals is draining the MOH budget; and
 - b. the flight of foreign exchange to France and the U.K. to finance specialty care has become too great a burden for the government.
12. Hungary - Although not an ANE country, Hungary exemplifies the extent to which governments -- even socialist governments, have had to re-evaluate the role of publicly sponsored health delivery systems. In September 1988, the Ministry of Health in Budapest

requested an insurance company in New York, the American International Group, to draw up a national plan for restructuring the health delivery system. At present, all service delivery is in the public sector. However, the government is unable to continue the costs of supporting this system of guaranteed health care from cradle to grave. AIG completed the proposed strategy in October, signed a contract with the government in December, and initiated Phase I operations in January 1989. It is now in the program design phase of a market-oriented national insurance system to finance health care. Pluralism will be encouraged, allowing the public sector to do what it does best -- public health, and the private sector to emerge with various forms of service delivery -- HMOs, indemnity health insurance, PPOs, cooperatives, IPAs, etc.

In this example, as well as the one in Singapore, it is interesting to note that both governments came directly to U.S. private health industry sources rather than to donors, such as the World Bank or the Asian Development Bank. In both cases, technical assistance was accessed with a minimum of "project appraisal" time, and with what both governments felt was their full control over the firms selected to carry out the effort.

In item (11) above, the IFC has signaled the Moroccan investors that its participation is dependent on HCA International endorsing the feasibility of the specialty hospital undertaking and agreeing to manage the facility once it is constructed.

H. Annotated List of U.S. Health Industry Firms

The following firms are representative of the technical assistance available from U.S. health industry.

1. The University of Maryland Medical Center, Baltimore.

The Center used to be a major teaching hospital for the University. Recently, it was privatized and now has its own Board of Directors and is thus not subject either to the University's president or General Assembly in Annapolis. The physicians in the medical school set up a private practice association, which served to a) lower the medical school's operating overhead, and b) maintain expert faculty by allowing them private income. Because these two non-profit endeavors have been successful, they are now forming a for-profit entity called "Maryland Medical" to market their technical capabilities to a wider audience.

This model might have application with MOH and Ministry of Education teaching hospitals in Cair, Tunis, and Casablanca. The Minster of Health in Morocco is interested in privatizing two specialties in the teaching hospitals of Casablanca and Rabat: cardiology and radiology. These hospitals have a total of 3,300 beds. Removing the most costly beds from financing through tax generated funds could be a substantial savings to the country.

2. HCA International

HCA has operations in Brazil, Saudi Arabia, England, Italy, Australia, Panama and Singapore. In Singapore, it is working with the Ministry of Health to privatize its largest teaching hospital, a 1,640 bed facility. HCA has 4.5 years to remove this hospital from health financing through general tax revenues. Already, all hospital physicians/nurses have resigned from the MOH and are now being paid through the generation of patient fees. Because this is a MOH facility, the model has some application with ANE. Although HCA is a for-profit firm, it is also the largest provider of hospital management services to non-profit hospitals in the U.S. Presently, it is working with 240 such hospitals, helping them to move their operations out of the red and into the black.

HCA will now send a team to Morocco for an assessment of the country's first private facility. HCA will have a team in country May 25-31. The purpose of HCA's visit is to do a field assessment and determine if it should enter into a co-venture with Moroccan developers of the hospital. If so, HCA would then manage the facility as well as put in an equity investment. For the past 24 months, the International Finance Corporation has maintained an active interest in this project, but has not gone forward with co-financing because of its concern over a lack of U.S. management expertise. If HCA goes forward, it will provide a "housekeeping seal of approval", and the IFC will probably follow suit.

Local development groups, such as in this example, want access to U.S. technology and know-how. That access brings in other co-financiers, i.e., the IFC (which is looking for health projects). ANE's role could be to forge this linkage and leverage substantial health investments without having to provide continuing AID financing.

The major drain on health financing in ANE countries is their hospital sectors. ANE doesn't have to get into the hospital business . . . but it can help locate the investment opportunities in this sector for U.S. health industry.

3. American International Healthcare (a subsidiary of the American International Group.)

AIH was formed 2 years ago. Presently, it has a large HMO project in Spain, with an expected enrollment of 400,000 by 1991. It also has a prepaid program in Singapore, and has under review projects in the Philippines, Japan, Taiwan, Israel, Hungary, and Italy. AIG is in 130 countries of the world, and it has recently capitalized AIH to undertake a substantial health investment program abroad. Thus, it is looking for commercial investment opportunities in the international arena.

AIH also has a U.S. branch which has substantial investments in prepaid health care management and operations, and extensive contracts with Blue Cross systems, the Harvard Community Health Plan, and Medicaid.

4. Cleveland Clinic Foundation.

The Clinic in Cleveland's largest single employer, with over 10,500 employees. In 1985, it began to look for international opportunities. Since then, it has started projects in Sao Paulo, Brazil; Istanbul, Turkey; Bethal, West Germany; and London, U.K.

The Clinic is only rivaled by the Mayo Clinic in terms of reputation. Along with the experience listed above, it had earlier assisted in King Faisal Specialist Hospital in Riyadh, Saudi Arabia to get up and running. The Clinic has an excellent reputation in the Arab world; it is the referral center of choice for Arab physicians.

The Clinic could provide the technical expertise needed to privatize the cardiology and radiology specialty practices at the teaching hospitals in Casablanca and Rabat.

5. Harvard Community Health Plan, Boston

The Plan was initiated in 1969 by staff of the Harvard Medical School. Although the university maintains its interest in the HMO, which now has 355,000 members in Massachusetts, New York, and New Hampshire, control is in the hands of a separate Board of Directors. The committee to nominate candidates for the position of the HMO's Medical Director may include a member selected by the Dean of the Harvard Medical School. The HMO now operates as a free-standing, non-profit, commercial entity. However, in recognition of Harvard's original role, the HMO sponsors the Harvard Community Health Plan Foundation, a separate non-profit corporation funded by a portion of the premium paid by each HMO member. In fiscal year 1987, \$2.2 million was received by the Foundation and used by the Medical School for a variety of teaching programs.

This model might be of interest to Ministries of Education which run most of the teaching hospitals in ANE countries. It demonstrates how, over time, a medical school can initiate new forms of health services delivery and financing, shelter it in its early formative years, then spin it off in the commercial sector while retaining some ties and receiving some income to expand the central mission of the medical school.

6. University of Texas Health Systems, Austin

The UT System is one of the largest single providers of health services in the country. In Houston alone, it has over 55,000 employees. Alongside of operating major teaching hospitals, clinics, research programs, medical schools, nursing schools, schools of public health, and dental and pharmacy schools, UT Health Systems manages the health plan for all state employees. To do this, it entered into a contract with an insurance company that would offer state employees options ranging from HMOs to indemnity health plans.

Texas is making a major investment in developing UT as a center of excellence in health services. For some time, it has had worldwide recognition for its pioneering work in cardiac surgery. Because Texas is in the oil business, it has had long and continuing relationships with the Arab world. Over the years, many Arab physicians have received their training in Texas and they in turn refer many of their patients back to Texas for complicated surgical procedures. In addition, the student body in many of the state universities has a high percentage of Arabs in all disciplines.

UT might be particularly useful in AID's new project with the MOH in Egypt, as well as the teaching hospitals of Morocco and Tunisia.

7. Seoul National University Teaching Hospital, Seoul, Korea

This is an example of what other countries in the region are doing in response to health financing difficulties. Ten year ago, the MOH permitted Seoul National to privatize. Last year, total operating revenues were \$103 million, of which only 1% was provided by MOH for indigent care. Thus, this 1,640 bed facility was almost entirely removed from general tax revenue financing. The MOH still funds capital financing, i.e., renovation, expansion, etc., but it does not control day-to-day operations. That is done by private Board of Directors, and all hospital personnel are employees of that Board and are not on the government payroll. The Administrator of the hospital was educated at Yale (M.D. and Ph.D.), and was on the original team that developed DRGs for the U.S. He, perhaps with the Minister of Health/Perm.

Secretary, Singapore, could to an excellent workshop in Cairo for the new AID project.

8. Group Health Association of America (GHAA)

The GHAA is the trade association for most HMOs in America, representing some 30 million members. When a HMO joins GHAA, it pays yearly dues of \$.18 cents per member. These dues are used by GHAA to finance lobby efforts on the Hill, legal and regulatory assistance to HMOs at the state level, short-term training courses for managers and administrators, and a publication program, etc. The GHAA is a non-profit, 501 (c)3 organization.

The GHAA can provide AID access to its members for: visits to senior executives by Mission personnel or MOH/private sector groups wishing to learn more about HMO operations, and short-term technical assistance to the field.

9. Group Health Association (GHA)

The GHA both finances and delivers health services to its 145,000 members. Although it is referred to as an HMO, it is a cooperative. That is, the members elect the Board of Directors and, in effect, they own the HMO as a non-profit organization.

The GHA is the granddaddy of the prepaid movement in the U.S. When it was organized in 1937, the District of Columbia Medical Society succeeded in barring its physicians from practicing in area hospitals. The GHA took the issue to the Supreme Court, which ruled in 1941 that the Medical Society was acting in violation of the Sherman Anti-Trust Act (restraint of trade). Thereafter, the legal precedent was set for other prepaid groups to organize similar delivery systems in the U.S. Thus, from a regulatory and organizational standpoint (cooperative ownership), GHA would be of technical interest to the ANE program.

11. George Washington University Health Plan (GW)

The GW University Health Plan is now part of a joint venture with American Medical International (AMI), a for-profit group. The HMO both finances and delivers health services on a prepaid basis. AMI's role is to manage the HMO effectively and to turn it from operating in the red to a profit center. Before AMI came on the scene three years ago, the physicians and administrators at GW's HMO were tied to the faculty salary system. Thus, for instance, the administrator was limited to a faculty salary of \$45,000 per annum while his colleague at number (10) above was receiving \$150,000. To be competitive in the HMO marketplace, AMI came on. Physicians from the

medical school and administrators receive competitive salaries because they now show up on AMI's payroll rather than GW's.

12. The Health Care Financing Administration (HCFA) serves as a fiscal intermediary between the Congress and HHS. All of its funds are derived from the Social Security Trust Account, and used to reimburse medical payments under Medicaid and Medicare.

a. Medicare - Of the 15.02% contributed to employer and employee from payroll, 2.9 percentage points are placed into a Social Security Medical Account to pay for health services when the employee retires. This contribution pays for Part A under Medicare: Hospitalization. The retiree then has an option for supplementary coverage under Medicare, Part B, for physician reimbursement, drugs and catastrophic health care. Part B is voluntary and costs \$24.80 per month per person. Even at that, Part B requires additional public financing from general tax revenues. Thus, private payments from the retirees social security check cover about 25% of total costs and general tax revenues finance the remaining 75 percent of retirees' health costs under Part B.

b. Medicaid - This is a State/Federal health care financing initiative for the poor. Depending on the per capita income of state residents, each state is billed differently by HCFA. Across the board, states pay approximately 52 percent of all Medicaid costs, the Federal Government pays the remainder. Poor states, i.e., Mississippi which contributes 40 percent, have less of a cost-share burden with the Feds.

HCFA contracts with private organizations to handle billing and administration of both Medicare and Medicaid. For instance, Blue Cross in, say, New York, processes all the claim forms for Medicaid beneficiaries and pays the physicians or hospitals for the health services provided. In turn, Blue Cross is paid 10 percent by HCFA of the value of each claim processed.

Most of the ANE countries have social security health financing (Morocco, Tunisia, Egypt, the Philippines, etc.) HCFA is an example of a fiscal intermediary which deals with public health financing, while the beneficiaries use private sector delivery systems for personal health care services.

13. National Center for Managed Health Care Administration, University of Missouri

The National Center trains mid-level managers of HMO programs. It was formed last year by Prime Health, a Kansas City HMO that moved from a non-profit status to a for-profit one. In

return for the state's permission to convert its status, Prime created an endowment and funded the Center through the University.

Only two places now offer training in health financing/management to AID sponsored participants: MSH and Boston University. The National Center could be a third such place. Its Executive Director, Michael Wood, has had substantial international experience with ANE. He participated in a Health Finance Seminar in the Philippines in 1985; both of the HMO feasibility studies in Indonesia; and, conducted a senior group of Moroccan officials on visits to U.S. HMOs.

14. Kaiser Health Systems (four legal entities)

Kaiser Health Plans is one of four components of Kaiser Health Systems. Kaiser Health Plan is the group which designs, develops, markets, and manages a prepaid package of health benefits to enrollees. It is a non-profit entity. Kaiser Hospitals, also non-profit, provides hospital based services. Kaiser Permanente is the physicians' group. It is set up much like a law firm with partnerships, etc. It is a for-profit organization. The three groups service exclusively Kaiser enrollees, and each year the three groups negotiate the terms of a new contractual relationship. Today, Kaiser is the largest HMO in the U.S. with approximately 5.6 million members from coast to coast. The fourth entity is the Kaiser Foundation. This group is non-profit and provides research capabilities and long-range strategic thinking for the other three groups. It also runs a publications program.

Kaiser Health Systems evolved from Kaiser Aluminum Industries after World War II. Because the model is industrially based, many ANE countries can identify with it. When Indonesian and Moroccan health officials were on the HMO seminar to the U.S., they readily identified with this model. Too, it is the only delivery system in the prepaid field which permits -- encourages, creative tension between managers of the insurance plan, administrators of hospitals, and physicians to operate independently of each other and yet at the same time to operate exclusively for each other. All other HMOs and prepaid plans which might be doing well with high numbers of enrollees have difficulty either controlling their physicians or with cost containment at the hospitals. Kaiser allows a thousand flowers to bloom. In the go-go days of HMOs floating stocks on Wall Street for expansion, much pressure was put on Kaiser to go private or go under because of this competition.

Kaiser stayed with its basic model and financed capital expansion from members' premiums. Today, it is the only HMO Group in the U.S. to be debt free.

I. CONCLUSION

As these examples illustrate, the U.S. has an emerging comparative advantage when it comes to trade in health care systems development. ANE can take a leadership role in marshalling this expertise as an exportable technology. The ability to act as a catalyst in this regard can attract financing from Japan's foreign aid program, the Asian Development Bank, and I.F.C. to fund creative and innovative health development projects in ANE countries. Those who have the money to finance these development efforts don't have the technical know-how. ANE can access that know-how and thereby attract the necessary financing to carry off the project, whether that financing be directly from external groups, i.e., Japan or U.S. investors, i.e., the American International Group, as in the Philippines project (item (9) above), after ANE helps them find the investment opportunity. ANE funds might seem limited, but ~~they~~ can provide tremendous leverage to expand public and private service delivery in the region by taking a proactive role in health development assistance.

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