PN-ABE-846
ISN 65630

January 16, 1985

Dear Colleague:

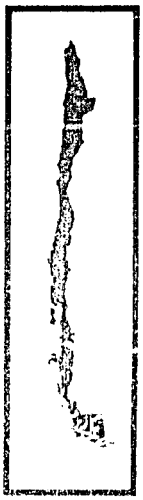
We believe you will be interested in this "Executive Summary" of a recent U.S. Agency for International Development supported seminar regarding public policy experiment for prepaid health care in Chile. While an incomplete review of the issues, this brief paper is intended to help accelerate our collective work between the public and private sectors to find cost effective ways to achieve "health for all by year 2000."

We hope you find the following pages provocative. Please share with us your reactions to our summary.

Sincerely yours;

James A. Rice

James A. Rice
President
Health Central International



CONTENTS

Summary of Proceedings:

The Chilean experience in prepaid health plans; considerations for developing prepaid health plans in other countries.

PAGE NO.

1. Introduction
   A. Purpose of Seminar 1
   B. Seminar Participants 2
2. Socioeconomic Background of Chile 5
3. Development of the Chilean health sector and the formation of "ISAPRES" 9
4. Case Study -- *ISAPRE Banmedica* 11
5. Conclusions for Developing Countries from the Chile Experience 15

1. INTRODUCTION

A. Purpose of Seminar:

The Seminar was sponsored by the U.S.D.A. International Graduate School and U.S. Agency for International Development to provide:

- A forum to continue AID's Study of prepaid health plan concepts and experience, in order to define strategies for future AID initiatives in this area of health services development.
- To clarify issues and questions rather than to find concrete solutions.
- An opportunity to use the Chilean Case study as a vehicle to stimulate discussion, and for interested parties to exchange ideas about HMO feasibility and applicability in developing countries.

Forums such as this are becoming increasingly important as virtually all countries struggle to find more cost effective ways to invest scarce public and private sources into health care.

Common Issues Facing the Health Sector in Developing Countries

The following common issues are creating an environment in developing countries conducive to new forms of HMO like programs:

- The continued escalation of health care costs.
- Deterioration of public health services infrastructure.
- Overcrowded public health services facilities.
- Insufficient means to finance national health expenditures.
- Uncoordinated provision of health services between public, social security, voluntary religious and private sectors.
- Uncontrolled service utilization.

Many governments are concerned about their ability to afford the continuing escalation of their investment in health care, and are, therefore, debating alternative policies to secure better returns on their investments in health. Experiments to contain costs have been developed since the mid-70's, more recently in the area of prepaid health insurance, such as the Chilean experiment and other experiments in Latin America and in Europe.

In many of these experiments, government officials have concluded that (1) innovation in operating efficiencies is frequently stifled within the rigid constraints of public sector bureaucracies and

civil service employees, and (2) change within the health sector will be maximized if there is change within the basic economic incentives of the system, i.e., change in how providers are paid for services rendered. There is, therefore, a growing international movement to experiment with public policies in health that simultaneously:

- Encourage private sector leadership and initiatives in the delivery and financing of health care; and
- Alter the financing and payment system to install new economic incentives to reduce unnecessary use of health services, i.e., move from retrospective, fee-for-service payment to prospective per capita payments.

Increasingly, these policy debates have been encouraging policy makers to look to the predominantly private U.S. health care sector for alternative strategies. The U.S.' twelve years of experience in prepaid health plans or HMOs may offer particularly useful ideas. A Health Maintenance Organization, or HMO, can be defined in generic terms as:

> *"An* **organized** *system of health care, providing a* **comprehensive** *array of health care services through a* **group of providers** *on a fixed fee* **prepayment** *basis."*

While this definition is one commonly used and accepted in the U.S., it should be recognized that care must be exercised in the use of the term "Health Maintenance Organization," as many "HMO-like" organizations may have one or a combination of the features described above.

As we explore new ways to continuously transfer U.S. health financing technologies to other interested countries, we must first look to the experiences in HMO-like organizations already existing within selected developing countries. That is the focus of this paper.

B. Seminar Participants:

1. PRESENTATION PANEL BACKGROUND

MODERATOR

James A. Rice: President of Health Central International, a division of the Health Central Corporation, which is a diversified non profit health services corporation based in Minneapolis. Health Central International provides management support service to the health facilities and prepaid health plan of the Caja Bancaria de Pensiones and other clients throughout Latin America, the Caribbean and the Pacific Basin.

SPEAKER

Eduardo Fernandez: President and General Director of the Caja Bancaria de Pensiones (a 30 year old private pension and social welfare organization) of Chile and President of the ISAPRE Banmedica. He is in addition chairman of the National Association of ISAPRES in Chile. St. Ter-

nandez has been an attorney in private practice and chief attorney of the Caja Bancaria de Pensiones.

SPEAKER

Maximo Silva: Managing Director of Administradora de Salud, the management company for the Caja's health facilities and a current member of one of the Government of Chile's regulatory commissions. He was previously Minister of Labor and Social Security for Chile and a professor of Labor Law.

SPEAKER

Jorge Valdivieso: Executive Vice President of ISAPRE Banmedica. He is a member of the Board of A.D.S. and has a background in financial management and banking.

2. SEMINAR PARTICIPANTS: AUDIENCE

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Health and Human Services

2. SOCIOECONOMIC BACKGROUND OF CHILE

Area

The Republic of Chile is located along the southern half of the west coast of South America, between the Andes mountain range and Pacific Ocean. Its average width is little more than 175 kilometers. It is bordered on the north by Peru and along the east by Bolivia and Argentina. Chile covers a total land area of approximately 750,000 square kilometers (Exhibit 2).

Demography

The population of Chile was estimated in 1980 to be 11.29 million, of which 49.52% are male and 50.48% are female. Between 1960 and 1970 the average annual growth of population was 2.1%. Between 1970 and 1979 this figure declined to an annual rate of 1.7%.

Santiago, the capital of Chile and the political, cultural, and economic center of the country, has an estimated population of 4.36 million, representing around 38% of the country's population.

Economy

The present government of General Augusto Pinochet has been following a cautious policy of reducing the role of the public sector and encouraging market forces to be a major influence in the allocation of resources in the economy. Consequently, a transformation of previously state owned enterprises has taken place in Chile since 1980; most notably in the privatization of social security and pension funds and the formation of prepaid health insurance companies (ISAPRES).

The government still plays an important role in the economy of Chile through the ownership and management of major enterprises, such as copper production, iron and steel production, the electricity sector, the exploitation of energy resources (gas, petroleum and coal), air, rail and sea transportation, the mass media.

The Chilean economy has been in a period of recession since early 1982, with levels of inflation rising to over 20%, unemployment over 25%, and a growing deficit due to deteriorating trade conditions catalyzed by the world recession.

Income Distribution

Exhibit 3 shows numbers of workers in various taxable income levels for Chile in 1984. Over 68% of the working population earn less than 20,000 pesos ($220 U.S.) per month.

EXHIBIT 1
Map of Chile

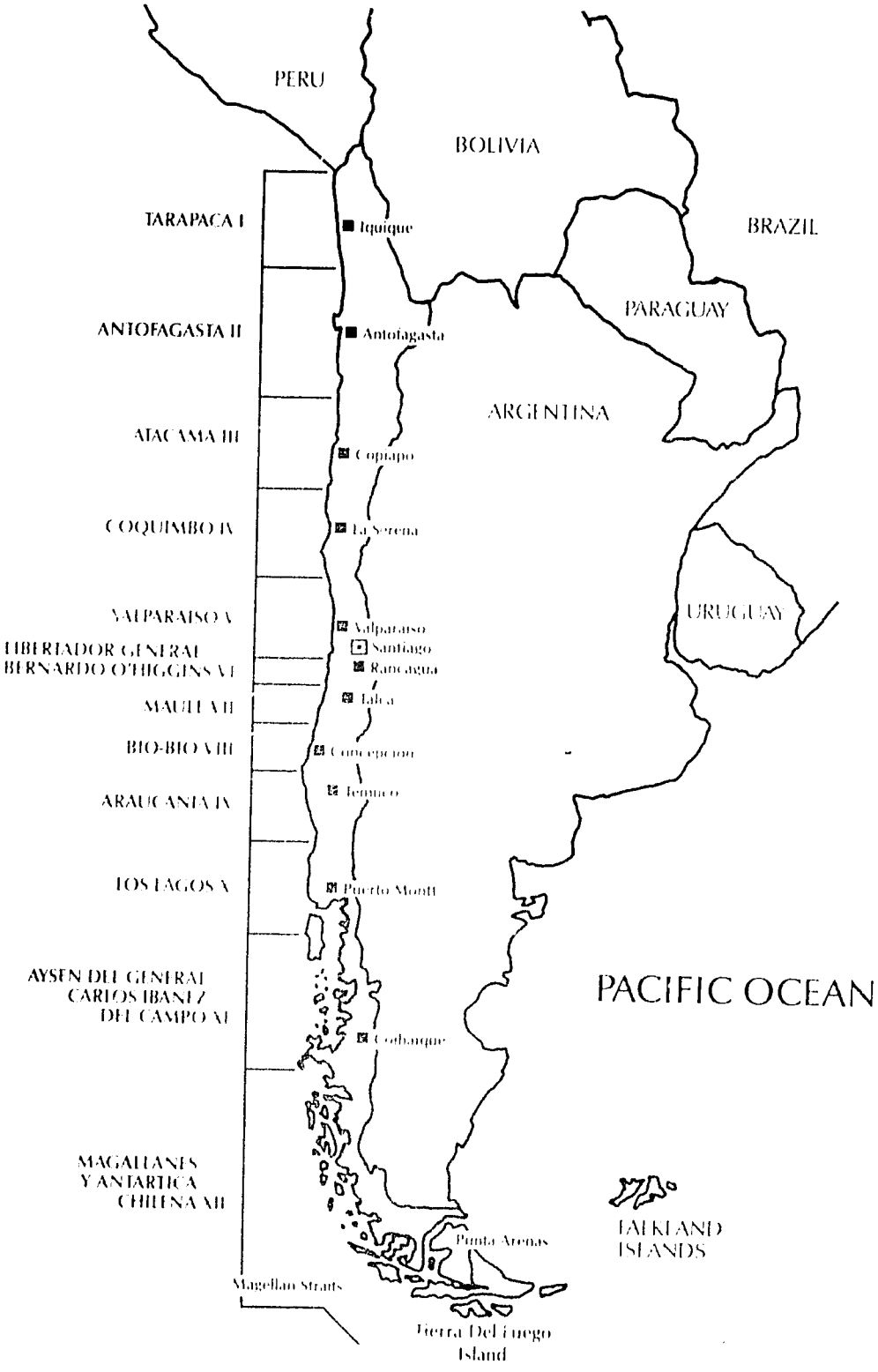


EXHIBIT 2

Taxable Income — Chile
February 1984
(Pesos)

	Less than $10.000	10.001 to 20.000	20.001 to 30.000	30.001 to 40.000	40.001 to 50.000	50.001 to 60.000	60.001 to 120.000	More than 120.000	TOTAL
No. of Workers	734.783	492.682	207.103	113.835	66.028	42.034	146.307	1.262	1.804.035
% of Total	40.73	27.31	11.48	6.31	3.66	2.33	8.11	0.07	100.00

Source: Corporation Internacional Desarrollo Para America Latina

EXHIBIT 3

Distribution of Population of Chile Among Health System Components August 1984

	Aprox. No. Persons	Percent
Self-Employed/Private Pay	1,200,000	10.9%
ISAPRES	300,000	2.9%
FONASA		
• "White Collar" Bono System	3,000,000	27.3%
• "Blue Collar" and Indigent	6,000,000	54.6%
Armed Forces	500,000	4.5%
	11,000,000	100.0%

Source: Fondo Nacional de Salud; Chile

3. DEVELOPMENT OF THE CHILEAN HEALTH SECTOR AND THE FORMATION OF "ISAPRES"

Chile has one of the oldest national health systems in the Western hemisphere. Over 90% of the population is covered by the national health system, 90% of the hospital beds are owned by the government, and 90% of expenditures for health are allocated to the public health sector. Under this system, general and infant mortality have continued to decrease during the last two decades despite marked political, economic, and organizational changes.

In the last two decades, Chile has experienced important political and economic changes which have influenced all spheres of activity. The Christian Democratic government of Eduardo Frei (1965-70), the socialist government of Salvador Allende (1970-73), and the current military goverment of Augusto Pinochet (1973-present) have each maintained a strong commitment to such goals as universal health coverage with an emphasis on preventive, maternal, and child care. While agreement on general goals has existed, each government has taken quite different approaches to the means to accomplish the goals.

Structure of the Chilean Health System 1952-81

Prior to regulatory changes in 1981, health care services in Chile were mainly provided through two public sector programs — the National Health Service and National Medical Care Service, (SERMENA), supported by a small private sector, covering about 10% of the population and services for the armed forces.

In July 1981 the Ministry of Health in Chile stated that "the key issue in the government's health policy was to provide incentives for the development of a private health sector which would complement the public sector so as to form a mixed health system."

The three basic measures adopted to provide greater incentives for the development of the private sector were:

1. The limitation of private practice in publicly owned hospitals.
2. The formulation of a new fee

schedule for health services provided by public institutions.

3. The creation of private health insurance organizations called ISAPRES – Instituciones de Salud Previsional.

Objectives of the Government Plan

In creating the ISAPRES system the government of Chile had three major goals:

1. To grant the Chilean people the freedom to choose between the public health services system and private health care facilities;
2. To reduce the burden of demand for services in public institutions, and thus improving accessibility and the quality of medical care for lower income groups;
3. To encourage private sector investment in health services infrastructure, thus moderating the requirements for capital investment by the government into public hospitals and clinics.

The proportion of the population to be covered by ISAPRES was originally estimated to grow to a level of 40% of the population, or 400,000 contracts, within 3 years.

The Formation of "ISAPRES"

In May 1981, Law No. 3500, DFL 3 and DFL 4 established new organizations called ISAPRES – Instituciones de Salud Previsional. This initiative was one component of a restructuring of the social security system in Chile, this larger change affecting the entire population.

Financial Mechanisms

The regulation established that 4% of gross salary of employed workers in the country must be used to cover health benefits for themselves and their dependents. (the 4% was subsequently raised to 6% in 1983.) Employers retained this amount from the worker's salary and sent it to whatever organization or agency the worker had chosen for his or her health care coverage – this could be the government National Health Fund (FONASA) or to a private ISAPRE to purchase a health insurance plan.

If 6% of the employee's salary is insufficient to purchase a private insurance plan through an ISAPRE, he/she can supplement the amount from their own funds.

Reimbursement of treatment costs are generally based on a fixed percentage of the total costs, with upper limits established either by an average historical cost per patient, or by a multiple of the charges published by INS relating to public sector subsidies under the FONASA program.

Exhibit 3 provides a profile of the distribution of the population among various components of Chilean health system, as of August 1984

4. CASE STUDY — ISAPRE BANMEDICA

Introduction

Banmedica is an ISAPRE developed by the Caja Bancaria de Pensiones (CBP), one of the oldest and most well-established pension funds of Chile which has served bank employees throughout Chile since 1946. When the CBP made the decision in 1981 to form an ISAPRE, it already had a long tradition in the delivery of health services to its affiliates, or "bancarios." The formation of Banmedica in June 1981 built on that health service tradition, and in effect opened up the health services of the CBP to the general population through their ISAPRE — "Banmedica."

Descriptive Characteristics

Exhibit 4 provides operating highlights of the Banmedica organization. Banmedica is the largest operating ISAPRE in Chile, with contracts covering approximately 87,000 enrollees (the number of enrollees includes dependents of those holding contracts). In August 1984 it had 35.9% of the ISAPRE market, including "closed" ISAPRES which serve specific employers. It is one of the few ISAPRES with its own health services infrastructure (2 hospitals and 2 clinics, located principally in Santiago, the capital city of Chile). Exhibit 5 provides illustrations of the growth of the Banmedica ISAPRE in terms of numbers of affiliates and market share, to over 35% of the market.

Health Services Infrastructure of ISAPRE Banmedica

The Health Services Infrastructure of Banmedica is managed by a Chilean management company — Administradora de Servicios de Salud LTDA (A.D.S.). This company has been a joint venture partnership between the Caja Bancaria de Pensiones and Health Central International, a U.S. based, diversified health services company. A.D.S. is responsible for the effective management of the health services infrastructure of the C.B.P. Banmedica is the only ISAPRE in the country to be making significant investments in health services infrastructure through its parent company, C.B.P. The Clinica Davila (113 beds) which is currently undergoing extensive remodeling and upgrading, including the upgrading of diagnostic and patient care technology and equipment. The infrastructure of services is also available to patients other than Banmedica employees. Approximately 35% of this delivery system's revenues are derived from the ISAPRE Banmedica. The remaining service demand comes from fee-for-service private pay patients of middle and upper income groups.

EXHIBIT 4

Banmedica — Highlights
September 1984

ISAPRE (BANMEDICA)

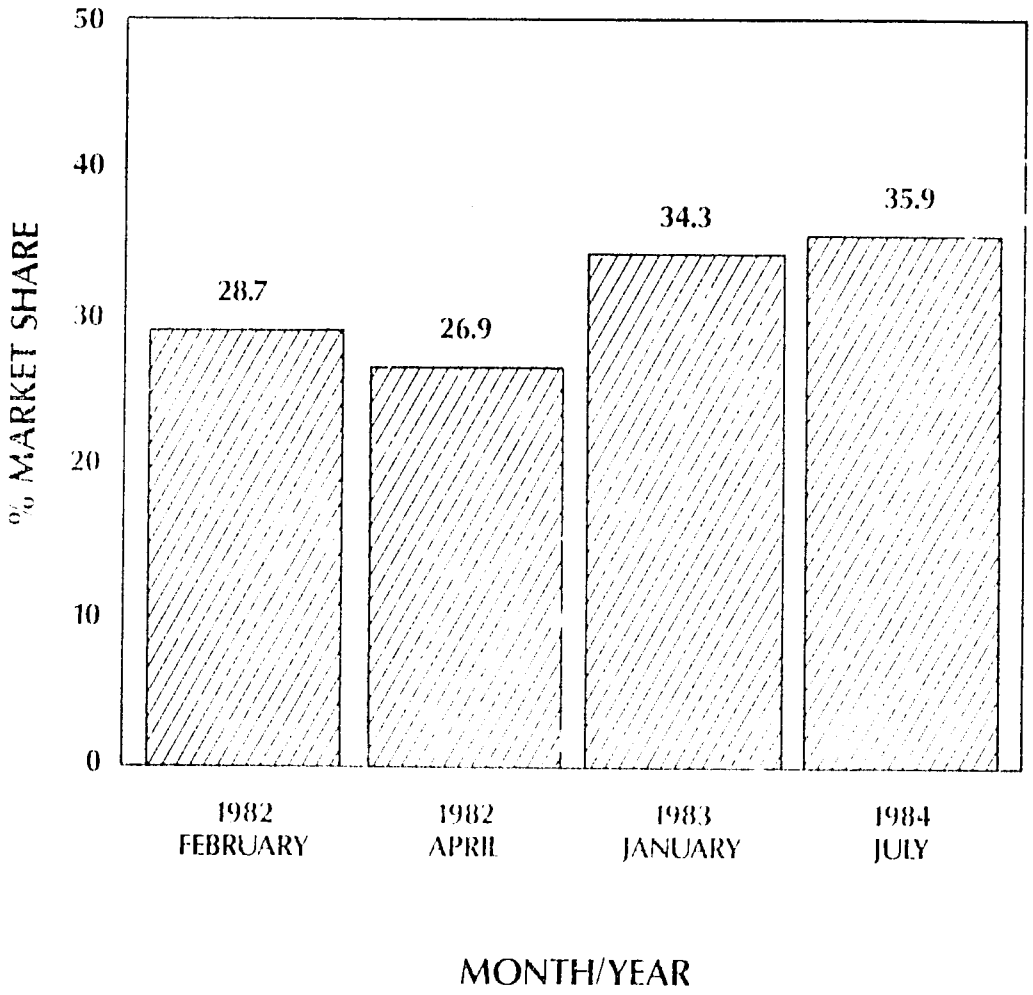
No. of Affiliates	: A 38.355
No. of Enrollees	: 87.005
Family Group Size	: 2.27
Date of Creation	: June 11, 1981
Staff	: 475
Annual Sales 1984 (Est.)	: US$ 25.0 Million
Annual Benefits Paid 1984 (Est.)	: US$ 4.6 Million
Health Exp.	: US$ 10.2 Million
Sick Compensation	: US$ 4.3 Million

HEALTH INFRASTRUCTURE (A.D.S.)

	No. of Beds	Staff	Annual Sales/1984 (Est.)
Clinica Davila	115	307	US$ 4.9 Million
Clinica Santa Maria	132	357	US$ 4.6 Million
Servicio Medico Monjitas	———	66	US$ 1.1 Million
Servicio Medico Vina	———	15	US$ 0.2 Million
			US$ 10.8 Million

EXHIBIT 5

Growth in Banmedica's Share of the Total ISAPRE Market February 1982-July 1984



5. CONCLUSIONS FOR DEVELOPING COUNTRIES FROM THE CHILE EXPERIENCE

A. The Chile Experience

Tentative conclusions on the recent ISAPRE experiment in Chile can be found in terms of both progress toward the originally established goals of the program and in its enrollment effects on health services delivery to the population. This section of the report addresses:

- *Progress toward government ISAPRE goals;*
- *Improvements evident in the Chilean Health System*

When reviewing the following conclusions, it is important to recognize that the Chilean program is still evolving; the concept was initiated during a period of economic growth, which changed rapidly to one of economic recession, experienced worldwide. In addition, the ISAPRE movement is only three years old, and has been forced to develop in a depressed economic climate. Additional longitudinal analyses will be necessary to follow this unique public policy initiative in health.

1. Progress Toward Government Goals

There are three major goals for the ISAPRES experiment. Progress in all three is becoming evident, even though the program is just now moving into "adolescence."

Goal 1:

To grant the Chilean people the freedom to choose between public health services and the private sector.

This goal has been achieved, but with results (3% coverage of the population) less than the anticipated enrollment level of 40-45% of the population within three years. The Chilean population does now indeed have the choice, many do not yet have the available disposable income to take advantage of these new health insurance programs. More people than anticipated have chosen to stay in the public FONASA system than was originally envisioned. The pervasive problems of a weak Chilean economy and high unemployment suggest that a significant group continues to use the public system rather than incur the added premium costs of the private ISAPRES.

Goal 2:

To reduce the burden of demand for public health services, thus improving the quality of medical care.

It is difficult to assess the extent to which the ISAPRE movement has reduced demand for public services — many ISAPRE enrollees came from a section of the population who would have elected for private services and previously self-paid. Again, the economic position of the country has prevented many people from rising to an income level where they can move from public services and programs to the ISAPRE alternative.

Goal 3:

To encourage private sector investment in health services infrastructure.

Only the Banmedica ISAPRE has invested significantly in the development of a health services infrastructure. Banmedica is fortunate to have available the resources of the Caja Bancaria de Pensiones in both a historically developed health system and the capacity to invest further in a developing network of facilities. Many other ISAPRES have lacked capital resources to develop such infrastructures.

2. Improvements to The Health System

Absolute outcome measures (mortality, morbidity rates, etc.) for the Chilean population are not available segmented by health system component, e.g., FONASA, ISAPRES, etc. They are available only on an aggregate national basis and are therefore not able to be used in generating comparisons between the different operating components of the health system. However, interviews were carried out with significant individuals and leaders of the Chilean health system, leading to the following conclusions:

Access

ISAPRES enhance access to medical and health services — there is no wait for medical attention, admission to hospital, or complicated financial approvals as through the present FONASA voucher system. Access is often available to the physician or facility of choice.

Quality

Quality of care is higher than in the public sector in terms of hotel and ancillary support services and surroundings. There are fewer delays and inconveniences and a higher ratio of professionals to patients. Objective indices of health status improvements do not yet exist.

Cost

Compared to the subsidized public system, premium cost to an ISAPRE enrollee is high, with individual workers often having to augment their 6% salary contribution in order to purchase coverage. ISAPRE system costs, however, compared with the free-standing private sector are likely to become lower due to recently instituted utilization review programs.

3. More Cost Effective Delivery System if Possible

ISAPRES are considered to encourage cost effective care delivery as the incentives are to reduce system costs through reducing the health care expenses component of the prepaid premium.

Structured interviews with leading Chilean health personnel further suggest that the Chilean experiment is generating important observations:

a. State governments can experiment in a different balance of public and private sector roles in the financing and delivery of health services by enacting legislation or regulations which either: a) enable HMO organizations to be formed; b) facilitate growth in the enrollment by several socioeconomic groups into these new HMO like organizations, e.g., mandating payroll deductions but offering a choice in how to spend the deductions within the mixed public/private health sector.

b. Different socioeconomic groups can be targeted for various types of health provision through the mechanism of a sliding scale of direct deduction from workers' salaries, with associated government subsidies. The Chilean government could elect to open up ISAPRES to the poor by purchasing all or a portion of their ISAPRES premiums of behalf of the poor.

c. Effective health services coverage for varied socioeconomic groups can be organized through privately operating and competing entities. Competition between ISAPRES is causing price competition, advances in benefits offered, and improved access via outpatient service centers.

d. It is possible that a population familiar only with payment at the point of service and the right to free choice of medical provider can move to completely new prepayment schemes which may constrict the choices of provider.

B. Transposition to Other Developing Countries

As with any operating health system, transposition of one country's health system into an entirely different cultural and socioeconomic setting is problematic. Nevertheless, there do seem to be selected lessons from the Chile experiment which can be considered for cautious adaptation into other countries. More rigorous studies of a longitudinal nature will be needed to define exactly what lessons might be the most valuable to selected countries.

Health Central International's experience with U.S. MNO organizations, the recently described Chilean experiment, and similar programs in other countries suggest that a search for lessons can best be distilled from the study of our critical questions:

1. What factors are important to any successful HMO experience?
2. How can the HMO concept best work to serve lower income populations?

3. What role can HMOs play in efforts to find a new balance of the public and private sector roles in health care?

4. What roles should lending and aid organizations play to encourage and monitor HMO initiatives?

Each of these four issues will be considered in turn.

1. What Factors are Important to a Successful HMO Experience?

A. Policy Implementation

The introduction of HMO-like organizations into a country's health system will probably require public policy changes, normally at the national government level. These initiatives are necessary to support the introduction of a new conceptual model of health services delivery and financing for the health sector of a country considering these systemic changes. In the U.S., this occurred in 1972 through Congress' passage of the HMO Assistance Act.

Examples of such policy support from the U.S. and Chile experience:

U.S.A.

Legislation to enable HMO development, enacted by Congress in 1972.

Federal grant and loan programs offered to over 200 local groups.

Exemption from certain state level medical practice laws and insurance regulations.

Technical assistance available from the Federal government.

Private sector stimulocation to invest via advertising.

Chile

Acceptance of need for change in health and health services delivery.

Regulations enabling development of "ISAPRES," as part of a movement to encourage private sector involvement.

Reform of Social Security system, legislating use of 6% of employee's salary for health and offering choice of public or private to citizens.

Enable employer to deduct insurance premium from employee and pay directly to ISAPRE, not through the government.

providers, including physicians and hospitals.

- Risk sharing — financial incentive programs for participating providers.
- Marketing expertise — particularly in countries where the HMO concept itself requires communication, in addition to individual HMO entities.
- Actuarial analysis — to determine risk and premium structures for covered populations.

2. How Can the HMO Concept Best Work to Serve Lower Income Populations?

Extension of the HMO concept to serve the needs of lower income groups is possible and desirable. Its benefits to lower income groups should parallel the generic benefits found in prepaid health plans in the U.S. and in Chile:

- *A more cost effective means of health service delivery than the traditionally fragmented and fee-for-service systems.*
- *The integration of insurance and provider functions to assure better coordination of access to reasonably priced services for enrollees;*
- *Capitation fee system helps insulate doctor's clinical decisions from remuneration.*
- *Encourages competition for enrollees on quality, range of services in the benefit package, and price.*
- *Attracts investment capital for new facilities and services.*
- *Rewards are available for efficient administration and delivery of services at the least intensive level of care that is feasible.*

Modifications are necessary, and issues exist in the application of the HMO concept to serve low income groups. The HMO movement as developed in the U.S. and other countries has been a phenomenon principally of the private sector of health care, or as a health insurance and delivery system for upper middle income employer-based groups. Only after its role in the private sector has been well established is it generally possible to extend the concept to encompass low income or publicly assisted patients. For example, the Medicare and Medicaid populations are now being increasingly covered by HMOs in the United States, but only after eight years experience and experimentation.

Alternative models of government support of HMO's for low income groups:

Each of the alternative models proposed will obviously require public policy and legislative involvement:

- Government purchases a benefit policy from an existing HMO or HMOs on behalf of a lower income population.
- Government owns the HMO and designs its own economic incentives and risk sharing systems.

B. Environmental Factors

In addition to enabling legislation or governmental policies, certain environmental conditions have been recognized as necessary for successful HMO development. These are listed below. The exact numbers and nature of these variables which must be in place obviously cannot be predetermined, and will depend upon the local country situation. However, the more these predisposing environmental factors are prevailing, the more likely HMO programs are to succeed.

- **A continuing and sustained increase in health care costs in the country**, i.e., the government is anxious to change in order to gain better control over its health care expenditures.
- **Physician support for the HMO concept.** This physician support may be provided due to their needs for superior services provided by an HMO which are not provided by the public sector; due to the potential for enhanced financial rewards, or to a desire to work in a well organized and structured system of health services delivery.
- **A market of interested employers employees** who may be disenchanted with current health services systems and insurance coverage.
- **An increasing number of physicians**, and proportion of physicians to population, thus enabling negotiation with physician providers seeking new patient markets (i.e., physicians competing to render care will make them more receptive to new forms of delivery and payment).
- **A familiarity within the population with traditional indemenity health insurance**, or with receiving care from an employer or employer-sponsored group, e.g. a pension fund system. Convincing population to join a prepaid plan is easier if they are already used to the process and concept of budgeting or paying in advance for care that they may not need or use.
- **Some level of competition** between traditional insurers and between provider and provider groups.
- **Incentives to encourage local and foreign investment**, and tax incentives which encourage investment in HMOs.
- **A disposition of the government to experiment** in the area of health services financing and delivery.
- **A significant population base** whose numbers can sustain HMO development.
- **An economy which allows effective cash flow management**, i.e., the prepayment "float."

C. Management Expertise/Systems:

HMOs must have management and operational strength in the following areas to have succeeded in the development of an effective insurance delivery system:

- Data — effective systems for clinical and financial data for management decision making.
- Capable Management — experienced in finance, cost control, budgeting, marketing and negotiation.
- Control Systems — to monitor service utilization trends and thus cost control of participating

- Government provides financial incentives to existing HMOs to serve lower income groups.

Additional issues to be addressed when applying the HMO concept to lower income groups are:

- How can the government pay the HMO premium on behalf of the low-income individual?
- Who delivers the service — an existing or specially organized HMO?
- What restrictions will be placed on the HMO system in terms of abuse of services and use of a controlled "list" of providers?
- Will existing health services infrastructure be used, or a reorganizing of resources be necessary?

3. What Contribution Can HMOs Play in Efforts to Find a New Balance of the Public and Private Sector Roles in Health Care?

HMOs can potentially:

- Attract private sources of capital into predominantly public sectors, if there is an availability of cash flow from HMO operations and the interest income earned on large, prepaid insurance "floats" or cash flows.
- Relieve pressure from a strained public health system which has limited and diminishing resources by enabling selected groups to "opt-out" of the public sector to seek care in the private.
- Introduce new management systems and economic incentives leading to efficiencies, which can be transferred to public sector facilities and services.
- Create "Foundation" or "trust" funds from HMO earnings, using these monies to fund services for low income groups.
- Provide different levels of service for lower income levels, from a range of options.

4. What Roles and Strategies Should International Lending and Aid Organizations Play to Encourage and Monitor HMO Initiatives?

A number of initiatives, some already underway and sponsored by the U.S. Agency for International Development, and other international finance agencies, could yield positive results in HMO developments in developing countries. These actions include:

- Seminar sponsorship to expand knowledge, skills, and attitudes toward concept of prepaid health plans.
- Publish case studies on HMO-like experiences in other developing countries to show a) it can be done, and b) how it can

be done to maximize benefits to the population.

- Publish policy and procedure manuals for HMO development.
- Grants and low interest loans for start-up planning and operations.
- Publication of model legislation and regulation, to launch HMO initiatives.
- Publication of model contracts between government and HMO, HMO and enrollee and HMO and providers which describe useful policies and procedures for quality control, service use, and service payments, and cost containment.
- Provision of consulting support to start-up HMOs.

The HMO organization has generally been successful in the private sector. Through its experience in a number of developing countries, the authors believe that the HMO concept can be applied to more than the private sector population, if sufficient public policy support and the necessary external and internal factors are present within the local country's socioeconomic context. While the Chilean experiment is uniquely designed for the Chilean people and culture, parts of the system can be applied to other developing countries both within and outside Latin America.

Please send your questions and reactions on this case study to either:

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Health Central International, Inc. manages and provides consulting services to hospitals and health care organizations throughout the world. Currently, it manages two hospitals, four clinics and an HMO in Santiago, Chile; provides development assistance to organizations in Cali, Colombia, and is exploring new projects in Saudi Arabia, Equador, Taiwan, the Middle East and Southeast Asia. Health Central International has also established Health Central Medical Trading Co., a joint venture company involved in marketing Health Central International's service overseas, and in the import and export of health care products and services. Health Central International also provides management support to the Children's Heart Fund, a non-profit organization that brings needy children to Minneapolis from outside the U.S. for heart surgery.