PRIVATE SECTOR AND HEALTH CARE DELIVERY IN DEVELOPING COUNTRIES: DEFINITION, EXPERIENCE, AND POTENTIAL

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Resources for Child Health Project

REACH

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The Private Sector and Health Care Delivery in Developing Countries: Definition, Experience, and Potential

by
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FOREWORD

The overall goal of A.I.D.'s health assistance effort is to improve health status as demonstrated by increased life expectancy. Health assistance is seen primarily as an investment in support of developing national self-sufficiency in achieving and maintaining improved levels of health status. While the specific health sector objectives of A.I.D. emphasize reducing infant, child, and maternal mortality and morbidity, they also emphasize the need to ensure the sustainability of the achieved improvements in child survival and health.

Sustainability of program benefits goes beyond simply sustaining project activities and does not automatically follow from donor investment in infrastructure development, human resources training and support, nor from individuals' willingness to pay for health services. Sustainability requires changes in national priorities, as demonstrated by changes in the quantity and distribution of resources within the health sector and allocation of more government resources to health.

The ability of governments to reallocate resources is limited by general economic and political constraints, but these constraints are often compounded by a lack of planning and ineffective and inefficient use of existing resources. The goal of sustaining improvements in child survival outcomes requires not only direct support for projects, but also support for strengthening national capacity to generate and manage health resources more effectively. Enhancing national capacity is the basis for the A.I.D. effort in health care financing (HCF) and its implementation is the central focus for the REACH (Resources for Child Health) Project.

The goal of HCF activities is to increase the amount of resources available to support priority health programs. Achieving this goal requires both choosing appropriate strategies and implementing them well. These tasks require analytic support and the ability to draw on the accumulating worldwide experience in health care financing. The REACH Project was established by A.I.D. to support the sustainability of health outcomes in the developing world.

In order to carry out its mandate, REACH provides a wide variety of technical assistance. A major and growing responsibility of REACH has been to synthesize and disseminate findings from HCF studies in ways that will have an impact on the success of financing activities. The REACH Project technical and policy discussion papers are one response to this need.

This policy discussion paper addresses the role of the private sector in health care financing. The growing recognition of the scale and importance of private sector health activities for both service delivery and financing of health services in many countries, has demonstrated the need to review the experience of the private sector in developing national policies to enhance health status. While the importance of the private sector and the form of its involvement in public health policy must be established within the specific context of each country, policy-makers should be aware of the wide variety of experience which has been only recently recognized and acknowledged. This policy discussion paper, commissioned by REACH, represents one overview of the growing private sector HCF experience.

As in all REACH policy discussion papers, the specific opinions are those of the authors and do not necessarily reflect policy positions of A.I.D. or the REACH Project. Policy discussion papers are designed to "nourish" the policy discussion, not to resolve it. The wide range of experience and insights incorporated into this document can help support the evolving efforts to fulfill the promise of improved health status in a world of scarce resources. To that end, the REACH Project welcomes response, comments, and additions from readers as well as suggestions for other areas of health care financing policy which might usefully be explored.

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I. INTRODUCTION

The private health care sector existed before public health systems were ever organized, and it continues to operate alongside public efforts. Public health care systems have been established in developing countries to : (1) ensure that all income groups have access to sound health care; (2) ensure a minimal level of health status for the population; and, (3) make modern health care accessible.

In order to achieve these objectives, decisionmakers in most countries have decided to provide most services directly so that public objectives can be most easily met. As a byproduct, this has meant that government decides what kinds of services to provide, in what manner and in what locations. In other words, government makes the resource allocation, location, and investment decisions that define the modern health care system in much of the developing world. How important these decisions are in terms of the total supply of health care available is a function of the size and sophistication of the private sector in each country; in some countries the public system is the only source of modern medicine, in others it is just one of many actors.

The public sector in most developing countries has made an official commitment to provide free health services either across the board to all citizens or for some designated portion of the population. The desire to ensure that all citizens have access to health care regardless of income or area of residence, led to the WHO "Health for All" pledge and the establishment of primary health care systems to reach isolated communities.

The WHO-led campaign to bring basic health care to all people, has been limited by insufficient public resources to develop and support the needed

services. Part of the problem is that the expansion of health care implied by "Health for All by the Year 2000" has coincided with international financial difficulties in much of the developing world. The financial crisis has resulted in budgetary cut backs in most government programs, and this has affected the health budget in most instances because of its high recurrent costs. Thus to afford to both continue existing efforts and adequately support primary health care (PHC) initiatives,[1] and to continue to afford subsidized services for at least some segment of the population, additional resources need to be tapped.

The options for spreading the cost of care include: user fees in public facilities, alternative financial and delivery mechanisms for public programs, or shifting additional burdens to the private sector for those who can afford to pay. This paper is primarily concerned with the latter option, however, the discussion also addresses some of the issues contained in the alternative financial and delivery mechanisms. The paper is meant to be a background document that discusses experiences and evidence on the private sector and health, and suggest areas for possible A.I.D. activity.

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1. Regardless of the desirability of shifting resources from existing health programs to PHC, politically this option is usually not viable.

II. DEFINITION OF THE PRIVATE SECTOR IN HEALTH

The first issue of importance is the definition of the private health sector. What is the private sector, what does it encompass, and how does it differ from public sector providers? How does private sector activity differ from privatization? The private health sector consists of non-government actors that produce, distribute, or deliver health care services or inputs. Private groups encompassed by this definition include both non-governmental organizations (NGOs) as well as for-profit entities: private physicians, clinics or hospitals, traditional healers, and pharmacies. These two entities, NGOs and for-profit groups, are quite distinct in their objectives, operation, and benchmarks of success.

The range of private providers includes private physicians; private hospitals, clinics, dispensaries or other outlets; private health and family planning associations; non-profit health providers; pharmacies, and shops selling pharmaceutical products (e.g., contraceptives or ORT); and, traditional healers. The delivery mechanisms include an additional mode that is both public and private: social marketing. The importance of social marketing in the provision of contraceptive and other pharmaceutical products is such that it needs to be included here as another method of health service delivery. These three modes of delivery, for-profit, NGO and social marketing, while all are non-public are quite different:

-- The for-profit sector functions entirely outside the public sector, relies exclusively on market forces and returns on investment. For-profit firms invest in producing health care products or drugs, or in delivering services in response to consumer demand. These firms are dependent upon adequate financial returns for survival, and the profitability of a health care delivery investment is key to the involvement of for-profit firms. The for-profit [illegible] is necessarily

affected by government through regulation and legal constraints, which allows public health objectives to be met, but through oversight rather than direct involvement. The for-profit sector may also be affected by large procurement or distribution contracts negotiated with international donors or governments that affect production, cost and ultimately pricing decisions especially for drugs. Consumer demand, pricing, political and economic stability, and regular and reliable access to supply inputs are key elements in determining profitability; without these, returns may be inadequate to attract or keep private investors. Excessive governmental oversight can also be discouraging to private entrepreneurs because it raises the cost of doing business and therefore of the products and services to consumers.

-- The non-governmental organizations, although not purely market driven (and sometimes not at all affected by markets), typically offer health services for a specified price; subsidies from external sources often supplement revenues, which modifies the nature, incentives, and operation of NGO activities. Altruism and charity drive some NGOs and the need to cover costs or ensure efficiency of operation are generally not binding constraints, although some cost recovery is typically expected. In many cases, the objectives of NGOs and governments are very similar: to improve health status and ensure access to preventive and curative services. Thus the financial constraints of for-profits do not define the activities of NGOs; the efficiency of NGO operations are generally not of concern either, and their overall cost effectiveness has never been measured objectively or thoroughly (Lewis, 1986).

-- Social marketing is a hybrid of public and private investments that uses market incentives to distribute and market supplies and services through private channels, but provides a public subsidy up-front that covers some of the cost of the distributed products and up to the total cost of advertising, management, and administration.[2] Pharmaceuticals, ORT and contraceptives are the products most commonly distributed through social marketing.

Thus the private sector encompasses a wide variety of providers that are conceptually and practically quite distinct.

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2. See Binnendijk (1985), Behrman (1985), Lewis (1985), and Chester (1986) for additional details on social marketing experiences with contraceptive distribution in developing countries.

Privatization

AID policy defines privatization as "the transfer of a function, activity, or organization from the public to the private sector" (A.I.D., 1986). The President's Private Sector Survey on Cost Control (1983) defines it as turning "over a Federal (i.e., public) activity, or part of a Federal activity to a non-Federal entity, allowing Government to provide services without necessarily producing them" (PPSS, 1984).

Privatization of public health services is different from private activity that occurs in response to market forces. Privatization means that the government hires or encourages the private sector to undertake a discrete task or set of tasks for the government. This can take the form of contracting out, monopoly franchises, management contracts, or leasing arrangements.[3]

For example, government can contract with a clinic or hospital to provide a full range of health services to a government designated population, or provide them access to sophisticated services that are not available through the public facilities, or can hire private firms to take on functions such as laundry services for a hospital (contracting out); or, allow private health provider(s) to produce all health services in a given area and disallow other providers to operate legally (monopoly franchise). Similarly, the public sector can provide services but contract out elements such as (hospital) billing or accounts to a private organization (management contract); and, as an alternative to providing services directly, government could provide the

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3. See Roth, 1987 for additional detail on these categories in health in developing countries.

indigent with vouchers that reimburse private providers for providing voucher holders with health care services with little or no copayment (voucher).[4]

What Private Sector Promotion Is Not

Equally important to the definition of the private sector and health care services is what it is not. Promoting the private sector does not include paying private entities to undertake tasks or activities that would be undertaken anyway without government intervention or investment. For example, providing grants to companies to undertake feasibility studies is a questionable endeavor where the benefits have clear financial benefits to a firm, management is aware of the benefits, and, most critically, the firm could afford the studies and would eventually carry out the study even if donor funding were not available. In this case, the public sector is subsidizing a private entity for a task the firm can afford and will undertake. The subsidy is therefore unnecessary and an inappropriate use of government resources. Subsidizing multinational corporations or wealthy parastatals through grants funding is inappropriate. Providing access to loan capital for feasibility or management assessments can be justified and does promote private enterprise. Multinational corporations and parastatals, however, generally can obtain capital, so such programs are apt to reach the small, indigenous investor who has limited access to capital and requires funds to determine if an investment is potentially profitable.

Supporting studies that demonstrate the value of providing, say, health care benefits to employees, or of adding preventive services to the range of

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4. The U.S. Medicaid health insurance system is similar to a voucher program in that it reimburses private providers for health care to the indigent and allows the beneficiary to select among providers.

products offered by purveyors of pharmaceutical products provides firms or entrepreneurs with information about services or products not previously offered to beneficiaries or consumers. It is quite different than either subsidizing an already planned activity or paying a firm to undertake a feasibility study where the benefits to them are already clear and affordable to them.

Similarly, charitable contributions from corporations to support health objectives, while noble, do not promote or constitute private sector involvement in health care delivery. Donations (e.g., of vaccines) fall under the same category of charity, and cannot be construed as a private sector activity.

Why Promote the Private Sector?

The point of private sector promotion is to encourage private individuals, companies, and groups to invest in health, so that some of the financial burden for health care is shifted from the public to the private sector, at least for that segment of the population that can afford to pay. Moreover, how government chooses to subsidize health care for the indigent can include or exclude the private sector.

Governments even in some industrialized countries are having difficulties paying for health services for the entire population, and most developing countries simply cannot afford to pay for all services for all citizens. Unless some of the costs can be shared with users, either directly or indirectly through third party payers, services will deteriorate, be reduced in scope, or some services may be abandoned entirely. Since hospitals are politically important, those services cannot be abandoned. It is far more likely that primary health care services will be sacrificed since these

services are more difficult to manage and they serve a more disparate and less politically powerful population. Moreover, if hospitals are available, these services tend to be used more intensively anyway and in eliminating PHC networks, the government can claim that it has retained the highest tier of the PHC system: hospitals.

Most governments have pledged to pay for the health care needs of the poor. The free service facilities meet this pledge, but there are other means to achieving the same end that include a strong reliance on private rather than public providers. These options are discussed in detail below.

Thus the issues for the government are: who to subsidize, what to subsidize, when to subsidize, and how to subsidize. These parameters define the scope of public responsibility and the nature of the public-private relationship in the delivery of health care.

III. WHY THE PRIVATE SECTOR IN HEALTH

The economic rationale for public involvement in the provision of health care revolves around the negative externalities experienced by the community from the presence of an individual suffering from a preventable communicable disease or the presence of disease vectors such as mosquitos or black flies. In these instances, public interventions to provide immunizations and vector control services are public goods, since the community benefits equal or exceed those of the individual. Moreover, because the problems affect the community and not individuals the latter would be subsidizing the neighborhood if they invested in solutions, and the rest of the community would be "free riders." Individuals do not have the incentive or capacity to address community problems, and it falls to government to resolve them.

Health services where the individual is the only beneficiary (e.g., curative and some preventive services like prenatal care) are not public goods. The rationale for extending curative health care services to low income households in LDCs is that of merit goods. Merit goods or services are goods that have merit for the population but are consumed in insufficient quantities without government intervention due to lack of information, cost or access. Therefore, public subsidies can promote consumption of merit goods, and since consumption provides information, a subsidy on health care as a merit good should be phased out once its value becomes apparent and internalized by the target population. ORT, pre- and post-natal care, and other preventive services are examples of merit goods. Subsidizing curative services is more difficult to justify on economic grounds since they are not public and are rarely merit goods (ORT is an exception) (Roth, 1987; de Ferranti, 1985; Lewis,

1983). Thus broad subsidies should focus on public and merit goods, leaving the bulk of curative care to either the private sector or to fee-based care in the public health system. This is the "what" that government should finance, for those who cannot pay, and the private sector should serve the rest.

Can People Pay for Health Care?

Who to subsidize is a thorny problem, especially for governments that have committed themselves to free universal care. However, the common rationale for free services, insufficient private supply or the unaffordable nature of health care, especially for low income households, are not supported by the evidence on consumer purchases of private health services.

Consumers already pay for health care in developing countries, and as in every society, it is virtually only curative services that are purchased. How much of this expenditure is for catastrophic care is not known. Table III-1 shows the proportion of total health expenditures that are private in selected developing and developed countries. Although based on data of varying quality, the figures in the table suggest that a good deal of health care is obtained from private providers. Even more striking is the fact that some of the poorest countries -- for example, Bangladesh, Afghanistan, and India -- have some of the highest proportions of private expenditures. Just under half of the sample of developing countries shows that 50 percent or more of all expenditures are from the private sector. In contrast, only one industrialized country obtains over half of all health expenditures from private providers, and in 70 percent of industrialized countries a quarter or less of all health care is obtained outside the public health systems. Thus in the aggregate, patients in developing countries are more likely to be buying health services from private providers than are those in developed countries. And this is

Table III-1

Private Health Expenditures as a Proportion of Total Health Expenditures in Selected Developing Countries[a]

Country	%	Country	%	Country	%	Country	%
DEVELOPING COUNTRIES							
Asia		**Latin America**		**Near East**		**Africa**	
Afghanistan, 1976	88	Argentina, n.d.	69	Jordon, 1982	41	Botswana, 1978	48
Bangladesh, 1976	87	Bolivia, n.d.	14	Syria, n.d.	76	Ethiopia, n.d.	54
China, 1981	32	Colombia, 1978	33	Tunisia, n.d.	27	Ghana, 1970	73
India, 1970	84	Ecuador, n.d.	45			Kenya, n.d.	52[b]
Indonesia, 1982/83	62	Haiti, 1980	65			Lesotho, 1979/80	12
Korea, South, 1975	87	Honduras, 1970	63			Malawi, 1980/81	23
Pakistan, 1982	58[b]	Jamaica, 1981	40			Mali, 1976	54
Philippines, 1985	74	Mexico, 1976	31			Rwanda, 1977	37
Sri Lanka, 1982	45	Paraguay, n.d.	22			Senegal, 1981	39
Thailand, 1979	31	Peru, 1984	40			Sudan, 1979	41
		Uruguay, n.d.	66			Swaziland, n.d.	50
		Venezuela, 1976	58			Upper Volta, 1982	19
						Tanzania, n.d.	23
						Togo, 1979	31
						Zambia, 1981	50
						Zimbabwe, 1980/81	21
INDUSTRIALIZED COUNTRIES, 1983							
Australia	34	Japan	25				
Austria	38	Netherlands	21				
Belgium	8	Norway	11				
Canada	26	Spain	18				
Denmark	15	Sweden	8				
France	29	Switzerland	8[c]				
Germany	20	United Kingdom	12				
Italy	16	United States	58				

Source: De Ferranti (1985); Poullier (1986); Akin (1987); Zschock (1986)

a. Except as noted, "private" includes, in principle, expenditures on health services by (1) individuals, excluding regular contributions to government schemes (e.g., payroll deductions for social security), (2) employers on behalf of their employees, (3) private voluntary organizations (e.g., mission hospitals), and (4) private practitioners—all taken net of government subsidies and other transfers (e.g., items (2), (3), and (4) should be net of fees collected). In practice, however, many figures are crude approximations. "Total" health expenditure encompasses all private, public and quasi-public (hence government insurance scheme) outlays—again in net terms. Because sources use different definitions of "private," data for some countries are not directly comparable.

b. Percentage of recurrent costs only.

c. 1982 data

Note: n.d indicates no date available and are the most recently available figures as reported in Akin (1987).

despite considerable public investment in health care delivery in developing countries.

Additional evidence on the extent of relevance of the private sector, but taken from family planning consumption data, is indicated in Table III-2. These data are probably good proxies for drug purchases, although because family planning has a long history of considerable donor and host country investment the figures may be biased toward public provision relative to drug purchases. Nonetheless, the data show that the private sector serves a large segment of the contracepting population in most countries, especially for nonclinical methods.

Another source of information is the health demand studies in Kenya (Mwabu, 1984; 1985) and the Philippines (Akin et al., 1985), which show that private providers are valued and consulted in both rural and urban areas, often in combination with public services. Thus this evidence serves to reinforce the information provided in Table III-1 that the private sector is already an active and important source of health care in developing countries.

The private sector provides some benefits to patients not extended in the modern public sector. First, traditional providers will treat a host of spiritual problems that are outside the purview of modern health care (although psychiatric care might substitute). Second, payment in kind is often an option that is not available in public systems where user fees are in place. Third, traditional medicine is often understandable and the patient-provider relationship is already well established.[5] Moreover, in traditional societies

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5. A similar phenomena occurs in developed countries. In the U.S., patient resistance to health maintenance organization's prepaid group practices is grounded in a desire to select ones physician and remain with the same care giver overtime.

Table III-2

Contraceptive Methods by Source Among Current Users for Selected Countries

Country (Year)	Contraceptive Prevalence Nationwide	Government (Percent)	Commercial[a] (Percent)	NGO (Percent)	Other[b] (Percent)
Africa					
Kenya (1984)	17	58.3	8.4	32.2	1.1
Liberia (1986)	6	31.1	18.3	48.2	2.3
Senegal (1986)	12	45.0	50.0	—	5.0
Zaire (1984)		64.1	28.7	3.6	3.5
Zimbabwe (1984)	38	42.8	9.2	46.2	2.0
Asia					
Bangladesh (1985)	25				
Korea (1985)	70	58.0[c]	42.0[c]		
Nepal (1981)[d,e]	15	73.9	2.7	20.4	2.9
Pakistan (1985)	9	66.8	26.5	—	6.7
Sri Lanka (1987)	55	84.4	7.9	2.9	4.8
Thailand (1984)[e]	65	78.0	19.7	0.7	1.6
Latin America					
Barbados (1985)	37	34.4	33.6	21.6	10.4
Belize (1985)	37	38.0	30.0	—	30.0[f]
Bolivia (1983)	26	7.0	93.0	—	—
Brazil (1986)	65	15.0[g]	85.0[g]		
Colombia (1986)[e]	68	34.0	43.6	21.6[h]	1.1
Costa Rica (1985)	68	68.0	21.5	22.1	1.4
Dominican Republic (1986)	46	44.0	44.0	4.0	4.0
Ecuador (1987)	40	37.4	39.2	15.4	6.5
El Salvador (1987)	46	49.7	38.1	—	12.2
Guatemala (1983)	25	31.8	16.1	30.3	11.7
Haiti (1983)	7[i]	32.9	67.1	—	—
Honduras (1984)	35	27.9	22.0	32.9	2.4
Jamaica (1983)	51	66.9	30.2	—	2.9
Mexico (1978)	48[j]	15.8	77.4	0.0	6.4
Panama (1979)	63	65.9	23.4	—	10.7
Paraguay (n.d.)	36	—	100.0	—	—
Peru (1986)	41	56.0	33.0	—	11.0
Near East					
Egypt (1984)[e]	30	30.0	69.4	1.3	1.1
Lebanon (1984)	53	1.2	40.0	58.8	—
Morocco (1984)[e]	26	58.4	40.0	—	1.6
Tunisia (1983)	41	77.7	21.4	—	0.8

Source: Lewis and Kenney (1988) based on Contraceptive Prevalence Surveys and Demographic and Health Surveys.

a. Includes private physicians, hospitals, pharmacies, and any other private, non-NGO.
b. Unspecified source, may encompass NGOs when private, nonprofits are not a category, and may include commercial where it is not a separate category.
c. Source allocation data are for 1979.
d. Based on nonusers as well as users.
e. Includes currently married women only.
f. Thirty percent uncertain as to source of contraceptives.
g. Source allocation data are for 1983.
h. Profamilia only.
i. Only 40 percent of users use modern contraceptive methods.
j. Prevalence data is from 1982.

where elders provide the spiritual leadership, they have more credibility than do the younger, more technically oriented physicians. Fourth, patients often are suspicious of free services, and quality is considered to be poor in public facilities. Fifth, patients who are making the decision of who to see are not experts (as is the case everywhere) and thus will frequently try multiple providers if the last one was unable to treat the symptoms of the illness, as was found in Kenya (Mwabu 1984 ;1985). Although much of the preference for private care is based on traditional medicine, the same preferences may be transferable to the modern sector, especially for physician services.

Thus people are already paying for health care, and, when an illness or accident is serious, demand for medical care is inelastic, that is, patients will pay almost anything to obtain treatment. When they need to they can pay. The equity implications of these figures are masked by their aggregate nature, however, for those countries with a small proportion of private use it is uncertain who is paying and who is receiving subsidized care. In those countries with a high proportion of private purchases of health services, a good many low income households are purchasing services. Thus there are some resources to pay for health services.

The mere fact of paying does not indicate that households can pay for their health care, however, since income constraints will limit purchase of all needed health services. Thus, although households show expenditures on health no information is available on foregone expenditures due to insufficient resources. It is this population that foregoes expenditures that requires subsidies if they are to meet their health care needs. Thus, equity objectives (should) define the target group needing health subsidies.

The issue from an equity standpoint is what group to subsidize and who can and should purchase from the private sector. The specifics of this issue, are beyond the scope of this paper. In narrowing eligibility for subsidized care, however, some means of promoting and encouraging private sector, health care supply must be established to ensure that modern services are available to compensate for reduced or restricted public services. Similarly, alternative means of financing health care need to be promoted so that individuals dependent on private providers will not have to absorb the full risk of illness on their own. In other words, promoting a greater private sector role involves efforts aimed at both expanding suppliers, and providing greater access to alternative financing to foster demand. These issues are discussed further in the following section, which expands on the question of how to subsidize health care.

How to Subsidize Health Care

From an economic standpoint, therefore, there is a strong rationale for having the private sector meet most curative and some preventive health care needs. In addition, evidence from the U.S. points to the greater efficiency (lower cost) and responsiveness of private entities in providing health care in the marketplace. The only federal, publicly provided health care in the U.S. is extended through the Veterans Administration (VA), Department of Defense and Indian Health Service. Comparisons between VA facilities and those of private for-profit and non-profits groups show dramatic differences between public and private providers in a number of areas.

Comparisons of public versus private employee scales showed consistently higher salaries at VA hospitals when compared to private hospitals (Smith, 1977). The President's Private Sector Survey on Cost Controls (PPSS, 1984),

Volume on Privatization examined the cost differences between VA and nonprofit hospitals affiliated with medical schools, and found significantly higher construction costs for public facilities. Operating costs were also much higher in VA hospitals, with the average cost for case mix adjusted acute inpatient care at 24.3 percent higher for medicine, 5.9 percent higher for surgery, and 15.5 percent higher overall. The study also found higher lengths of stay and higher inventories -- two measures of the degree of cost containment in any given facility -- at VA facilities when compared to the non-profit sample of hospitals. Some of the cost discrepancies may have to do with the severity of illness of patients in the VA versus the non-VA system. Severe chronic conditions are more likely to rely on the free VA system.

Lindsay (1975) in an earlier study also found discrepancies between VA and private hospitals, including consistently higher lengths of stay in the former for all procedures, and considerable inefficiency in the operation of the VA hospitals stemming from excessive bureaucracy and operational rigidity. Cost estimates for VA care were found to be at acceptable levels for general hospitalization but dramatically higher for nursing home care. Net per diem costs were 50 percent higher in private hospitals when compared to VA hospitals in 1973; however, the quality of VA Hospitals was considered much lower than private care, and staff shortages were severe and chronic in all VA facilities. Nursing home care was considerably higher at VA facilities in each of the 15 communities sampled, with the average difference almost 100 percent higher in VA nursing homes. Moreover, Lindsay notes the awkward distribution of Veterans Administration Hospital and the resulting low utilization of some facilities, which further raises costs.

Inefficiency in production, erosion of quality and generally high costs documented for VA hospitals has supported arguments that call for alternative methods of financing health care. This experience and evaluation is instructive for developing countries where most hospitals and lower level facilities are government operated and financed, as are the VA facilities. The track record of public provision in the U.S. when compared to private or nonprofit experience suggests that contracting out, if not some variant on vouchers or social insurance, might well improve effectiveness and reduce costs within the VA system. The same may well be true for the LDCs, but the issue has not yet been examined.

Government can affect the cost of care by relying on the private sector to serve certain segments of the population and to take on some of the public sector's current responsibilities. The evidence above from the U.S. experience suggests that there are clear benefits to using private rather than public institutions to deliver health care. Whether government, individuals, or private institutions pay for care, it is more effective and efficient (less costly) to have health care privately provided. If government allows the private sector to deliver care but finances health for the indigent it can spend less and improve quality of care, based on evidence from the U.S. experience.

The private sector has an important role in meeting the health care needs of those able and willing to pay, and can work with public entities to deliver care to the indigent. Structured properly, subsidizing health care through private providers can simultaneously promote private sector delivery of health services and narrow the population who receive subsidies. Vouchers or reimbursement systems allow both objectives to be met and bring to bear the

benefits to be derived from the efficiency and quality of private providers. These issues are discussed in considerable detail in subsequent sections.

IV. A.I.D. EXPERIENCE WITH PRIVATE SECTOR HEALTH ACTIVITIES

Although A.I.D. has had a long tradition of government-to-government transfers in the health sector, the last few years have seen a shift toward a more active consideration of collaboration with the private sector. AID policy in this area is articulate in the Privatization Determination 14 (A.I.D., 1986a). The Health Care Financing Guidelines (AID, 1986b), drawn up by S&T/Health and approved and distributed by the Administrator, lay out key issues and approaches in financing, but there has been no health-specific policy directive in the area of privatization or the private sector. Health officers have interpreted AID's private sector emphasis and the Health Care Financing Guidelines and developed some country specific activities, however.

By and large, these efforts have taken the form of feasibility studies, assessments of the size and nature of the private sector, studies of various elements of the private health sector, and workshops to promote the notion of public-private partnerships in health care delivery and financing. The need to understand the private sector and to assess carefully how best to approach a public-private partnership requires review, particularly where no established track record exists to guide project development. So these interventions represent an essential first step. Several health projects have focused specifically on the private sector and privatization; increasingly project components address either financing in general or the private sector in particular. However, financing and private sector are not synonymous -- the latter is a subset of the former (See Section V on what constitutes private sector intervention).

Table IV-1 summarizes the major completed undertakings of the missions and AID/W in private sector activities as of mid-1987.[6] A good deal of effort has gone into understanding the nature of the private sector and feasibility studies. HMOs have generated the greatest amount of interest, although very little real experimentation has occurred, at least in the health field. Insurance and privatization have received almost no attention -- outside of a few isolated examples -- even at the feasibility or study level.

The Portugal project is the only full fledged AID effort in insurance, and privatization is only documented for Jamaica and Zaire. In Jamaica, the government has privatized laundry and housekeeping services in four large Kingston public hospitals; in Zaire, the government has divided the country into zones and given responsibility for preventive and curative care to the zones who oversee health care delivery by a PVO.[7]

Despite the small number of ongoing projects, a number of missions are planning to launch private sector projects or are adding health to their privatization/private sector agenda. The Dominican Republic, Ecuador, Egypt, El Salvador, Indonesia, and Pakistan have all identified private sector projects to begin in 1988 or 1989. As part of the project preparation, a number of reviews, surveys and studies have been completed or are ongoing, and will serve as bases for the evolving project. For example, the Dominican Republic funded a set of studies on the private sector as background for their project paper; Indonesia has had a number of consultants assist their project

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6. See Lewis (1987) for more extensive descriptions. The Jamaica and Dominican Republic experiences are based on discussions with the mission.

7. The Zairian case is included because the government transfers funds to each zonal PVO to help defray costs. Thus the government is effectively hiring the PVOs to carry out government objectives.

Table IV-1

Summary of A.I.D. Private Sector Activities

Country Region (Source)	Type of Activity				Subject of Private Sector Activity				
	Study	Project	Assessment Feasibility Study	Handbook/ Workshop/ Conference	Private Sector (General)	Impedi-ments	Pre-payment HMO	Insurance	Priva zatio
GENERAL									
LAC (Zukin, 1985)				X			X		
LAC (Cleland, 1984)			X				X		
LAC (Ramey, 1984)				X			X		
S&T Support Project		X	X		X				
AFRICA									
AFR (JDM Consulting Group, 1984)	X				X				
Sudan (Bekele, 1985)	X				X				
Sudan (Bekele & Lewis, 1985)	X				X				
Zaire (SANRU, 1984)		X							X
ASIA									
India (Elkins, 1987)	X			X	X[a/]				
Indonesia (Norris et al, 1984)			X				X		
Philippines (PRITECH, 1985)				X			X		
EUROPE Portugal		X						X	
NEAR EAST									
Near East (Uber-Raymond & Glauber, 1983)	X			X	X	X			
Near East (Washuck, n.d.)	X				X[b/]				
Egypt (Cole et al., 1985)	X				X[b/]				
Jordan (HMG, 1982; Ferster, n.d.)			X				X	X	
Jordan (Cole et al., 1982)	X				X[b/]				

Table IV.1 (continued)

Country Region (Source)	Type of Activity				Kind of Private Sector Activity				
	Study	Project	Assessment Feasibility Study	Handbook/ Workshop/ Conference	Private Sector (General)	Impedi-ments	Pre-payment HMO	Insurance	Privat: zation
LATIN AMERICA									
LAC (GHAA, 1985)		X					X		
LAC (Harrison, 1985)				X	X		X		X
Bolivia (MSH documents)		X			X[a/]				
Dominican Republic (Ugalde, 1982)	X				X		X		
Dominican Republic (McGriff et al. 1978)			X				X	X	
Eastern Caribbean (Jeffers et al., 1984)			X		X		X		
Ecuador (TRITON, 1985)			X		X				
Ecuador (Habis, 1984)	X				X	X			
Jamaica (Project Hope, 1985)				X	X		X		X
Jamaica (Technical assistance; Swezy et al., 1987)		X	X		X	X	X	X	X
Peru (Bates et al., 1983)			X		X[a/]	X	X		

a. Involves cooperatives.
b. Pharmacies only.

development process; and Peru and Mexico have added child survival services to the cost effectiveness studies undertaken for private firms by TIPPS and the Enterprise Program to demonstrate the economic value of offering family planning (and preventive health services with the child survival addition) to employees. Thus there is growing experience, and increasing amounts of information collected, although these efforts have not yet been documented; that task will very likely be part of the planned projects, however.

In addition to discrete projects that will address the private sector and health, a number of efforts are underway that attempt to harness the private sector. The best example of this is social marketing of health products, notably oral rehydration salts. For nonclinical supplies and services, commercial distributors are ideal, just as they are for nonclinical methods of contraception. Social marketing programs are planned or ongoing in Bangladesh, Egypt, Gambia, Ghana, Honduras. Frequently these piggyback contraceptive marketing networks which have already demonstrated their effectiveness.

The social marketing of pharmaceuticals, that is distributing subsidized products through commercial networks with the normal profit percentage going to distributors, has been successfully accomplished in Sudan (Bekele and Lewis, 1986) and a variant is under design in Ghana (SOMARC documents). Given the high cost of drugs and the inefficiencies and ineffectiveness of free-drug policies, the social marketing of generic or even brand-name products can increase the availability and affordability of pharmaceuticals.

The Office of Health's Support Project has supported feasibility studies for potential private sector investment in oral rehydration solution (ORS) production and distribution, and has taken the innovative step of making loan funds available to firms interested in initiating ORS production.

Family Planning and the Private Sector

Although a vertical and much more narrow program, A.I.D.'s Population Office has launched a number of efforts that are relevant to health, although none has received the necessary evaluation to conclude very much about their cost effectiveness. The longest running program is the social marketing program that was mentioned above.

The two-year-old Technical Information on Population for the Private Sector (TIPPS) project has used various means to demonstrate to companies the value of providing, subsidizing or just improving employee access to family planning. Through small surveys of employees, business analysis (cost benefit analysis) of the net benefits from increased use of family planning, and arrangements to help companies buy services from family planning associations or obtain the necessary skills to provide family planning directly through company health services, TIPPS is assisting companies add family planning to their employee benefit plans. In Peru, the TIPPS project expanded to include health and child survival concerns (see discussion in Section V.C on insurance and employee benefits).

In addition to TIPPS, the Office of Population's Operations Research Division supported a TIPPS-like study of the AMICO HMO in Brazil to assess the benefits and costs of family planning provision. A summary of findings may clarify the purpose and approach of these efforts. The AMICO study concluded that in the low fertility, high contracepting HMO population, the company's savings would come from fewer induced abortions and cesarean section deliveries, with no discernable increase in contraceptive prevalence. It was concluded that provision of family planning would more likely introduce a subsidy for the large number of users who are currently paying for services

rather than induce couples to begin contracepting; however, given the number of contraindications to oral contraceptive use among current users, a family planning effort would improve the quality of services and perhaps the choice of method. It was estimated that net benefits would not accrue until year 3.

The year-old Enterprise Program is: (1) assisting companies to extend family planning services to their employees; and, (2) assisting PVOs to become more market oriented, that is, helping them to improve their financial management practices, and to reduce their costs. The former takes the form of training existing staff in family planning methods, providing contraceptives in some instances, and assisting benefits programs to establish family planning counseling and services.

Although family planning provision through private providers is simpler than health care provision, its experience is instructive. The TIPPS and Enterprise Program focus on benefits programs which are also relevant to health, and there is scope in assisting companies to take a more preventive stance.

There have been very few efforts to address the private sector and health through employee benefit programs. One of the first attempts is an outgrowth of the TIPPS project in Peru that given its uniqueness and promise is summarized here.

TIPPS family planning business analysis was adapted for child survival and applied in a company mining town northeast of Lima. The business analysis for introducing preventive care into health services delivered as an employee benefit assessed the status of child health in the community, health utilization behavior, and appropriateness of treatment at the mining company health facility (Foreit and Lesevic, 1987). The analysis showed a high

incidence of child morbidity, and common over-prescription of pharmaceuticals at the health facility. The subsequent business analysis costed out establishment of a preventive pediatric health program and greater reliance on ORT. It was estimated that the first year's cost of US$ 16,045 would be offset by an estimated US$ 10,600 - 12,600 savings in drugs, and in subsequent years costs would decline.

Whether the company is planning to alter its health program is unclear, but A.I.D. has provided an analysis that demonstrates the benefits of introducing child survival services into the employee benefit package. As such it is a useful analysis at a modest cost ($26,000), that may simultaneously meet A.I.D.'s private sector and child survival objectives while minimizing any long term U.S. or host country subsidies.

This is the only documented effort in this area, but it has potential applications in other settings. The value of this endeavor is that it provides a strong case for a shift in the way that the company provides care, it does not subsidize private health care but provides information that acts as an incentive to the private sector to alter its practices. As such it is preferable to alternative options where the public sector effectively subsidizes private activities.

The interests of missions and the flexibility of the TIPPS and Enterprise Program projects have made adding health and child survival to family planning activities very attractive. Currently, a number of different approaches are being designed and tested, which will assist the Agency to determine the most cost effective approaches to promoting greater private sector responsibility for child survival and family planning.

Thus, A.I.D. has become increasingly involved in private sector activities, and is planning some significant projects that will further the progress already made.

V. PRIVATE SECTOR OPTIONS FOR FINANCING HEALTH CARE

The options for the private sector delivery of health care involve fees-for-service at hospitals, clinics, physician offices and pharmacies where individuals pay for their own care; private insurance, including employee benefits or individually obtained coverage, that spreads risk across the insured group and pays for most services, and thus finances but does not deliver care; and, health maintenance organizations where the provider delivers all health care for a set price to an enrolled patient group that is largely prepaid, and therefore both provide and finance health care. PVOs are a special group of providers in developing countries that constitute an additional component of the private sector.

This section is meant to explain the different forms of private sector, in particular their characteristics, performance, and applicability in LDCs, and discusses how each financing method could be used to finance health care for the indigent. Each financing option has different implications for the quality, quantity and cost of health care, and these are reviewed in each of the subsections. This introduction summarizes the patient issues, which are pursued in greater depth in the respective subsection.

The U.S. experience is drawn upon in great detail in this section because of the dearth of information on private options in developing countries, and the fact that the U.S. is the only country with an extensive and highly heterogeneous experience with a range of private financing options. Moreover, the U.S. has invested heavily in health care financing research, which provides evidence as well as experience with alternative financing mechanisms. As missions assess alternative financing strategies, existing evidence even from

the U.S. can help to guide decisionmaking. This section attempts to clarify what each of the financing options entails, why it is important, how it operates, who it serves, and where it has been introduced in developing countries and with what impact.

The U.S. has the most private health care system among the developed countries, and devotes the largest proportion of its gross domestic product to health: 11 percent. The U.S. has the largest private health insurance system, and together with public insurance (Medicaid for the poor and Medicare for the elderly), covers rougnly 85 percent of the population. The U.S. government only pays for about 40 percent of all health care (Bovbjerg, Held and Pauly, 1987) but delivers 12 percent of it. The lmost 30 percent of the total that is paid for but not delivered by the government is purchased from private providers, offering yet another boost to the private sector. The U.S. is also where a good deal of experimentation in delivering and financing health care has taken place and that experience is drawn upon through this section.

Because the strengths and weakness of each of the options differ, their appropriateness will also differ across settings. Each option can be assessed in terms of efficiency, equity and affordability, and these can most easily be seen within the context of the U.S. experience and in the evolution of the options. Some of these factors are summarized briefly here and are discussed in greater detail in the following subsections.

Fee for service has always existed in the U.S. and does in every community the world over. It is a free market option that can be regulated or unregulated. Private providers set charges at what the immediate market will bear. The price of care tends to be relatively high and households typically seek care when they must and their demand is high and very inelastic with

respect to price (that is, the cost to consumers will not markedly affect their purchase of the service). The cost of care, however, can be an impediment to greater use of private fee for service care where incomes are low. Because costs are set to accommodate the needs of providers, prices and quantity are determined by providers; equity is only addressed as charity and is an uneven and unpredictable element under fee for service systems.

In the U.S., the engine behind the sharp rise in the demand for health care and the affordability of high technology care came from the expansion of health insurance coverage. The expansion was largely in response to government tax incentives of the 1950s, which did not tax company health insurance benefits as income. The result was a rise in quality as well as quantity of care, since any and all services could now be provided and a third party would pay the bills. Not surprisingly, the amount spent per illness rose sharply. An increasing number of sophisticated tests and treatments became affordable, causing a cost spiral that forced the introduction of patient copayments, ceilings on amounts reimbursed, and (higher) deductibles. Nonetheless quality of care was significantly enhanced.[8]

The search for alternatives to maintain the quality and quantity of health insurance while at the same time addressing cost containment and indigent care, led to the development of the health maintenance organizations (HMOs) (Mayer and Mayer, 1985). HMOs have been able to contain costs and have placed pressure on other providers to slow their costs to remain competitive, but they have not proved to be the health care delivery and financing vehicle for meeting the needs of low income households. However, HMOs have recently been

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8. Quality improved due to the affordability of seeing a physician early-on in an illness, of all pertinent diagnostic tests, and of the necessary treatment including drugs and hospital stays.

adapted as part of the Medicaid service program on a pilot basis in two states, and may offer the potential for delivering indigent care. Another benefit of HMOs is the incentive for delivering preventive care, which is lacking in other delivery or financing methods. There have been, however, reported lapses in overall service quality in HMOs stemming from inadequate care (especially hospitalization) as a means of keeping costs down.

Each of these options fits various needs. Insurance, for example, will raise the demand for private services and can shift utilization from public to private providers because the latter becomes affordable. Moreover, private care tends to be of a higher quality while most public care in the developing countries is underfinanced. The problem is the rising cost of care that accompanies expanded health insurance coverage. Additionally, insurance is a complex and skill intensive industry, which may make its applicability limited in some countries.

HMOs can help to address preventive care and cost containment within a managed care system. Problems of management, economies of scale (in terms of the minimal number of enrollees which will allow the company to break even), and perhaps quality (which could be addressed through regulation and government oversight) may inhibit HMO applicability in some areas.

Fee for service will continue to exist alongside these other financing options, and is part of a shift to greater reliance on private health care provision since fee for service providers are the backbone of financing through insurance, and are increasingly the vehicle for HMOs.

Addressing indigent care through the private sector can also be accomplished with a government reimbursement system that uses private providers, or, alternatively, the government could pay the premiums or

capitation payments for certain groups. The latter is more feasible under an HMO since insurance companies need to know the risks associated with the enrolled population before they will insure them, but it is not without appeal or possibilities. These issues are discussed further in the subsequent subsections.

Fee for Service

In developing countries, the bulk of private health care is financed on a fee for service basis, that is, a patient charge is levied for every consultation, treatment, drug, or other intervention. Medicine evolved as a fee for service enterprise and remains so in most countries.

In the U.S., most providers function under fee for service arrangements even though it is rarely the individual who pays them and although health insurance, HMOs, and other financing arrangements have replaced fee for service as the predominate method of financing health care in the U.S., it is still the most common method for paying providers even under social insurance, private insurance and Individual Practice Associations (IPAs) arrangements of HMOs. (See below for a discussion of these financing methods). Physicians, hospitals and other providers are currently reimbursed by insurance companies under their fee for service system.

Characteristics of Fee for Service in Developing Countries

In developing countries, traditional healers are all fee for service providers, as are modern providers who do not work for the government, are in private practice, or work for some organization that pays their salaries. Pharmacists function predominantly under a fee for service system. Table III.1 that listed the proportion of private health expenditures in various developing

and developed countries reflect the proportion of fee for service expenditures in the LDCs, including expenditures for drugs. Although the allocation of those expenditures is not documented, with few exceptions, developing countries have little or no private sector financing beyond fee for service.

Little is known about private health care providers in developing countries, especially traditional practitioners. Claquin (1981) has provided a thorough review of traditional providers in Bangladesh, and Akin et al. (1985) provide a summary of the literature and descriptions of the spectrum of traditional healers, their efficacy, and track record where possible. People in developing countries are willing to pay for these services and in rural areas they are the dominant source of health care under fee for service. Their pricing structure, ability to accept barter as well as other repayment arrangements, and intimate understanding of their community provide a particularly valuable edge in serving their clientele.

The modern public sector, and social insurance systems in particular, are far better understood than the modern private sector in developing countries. Raymond and Glauber (1983) have documented the private sector experience in the Middle East in some detail, Zschock (1986a; 1986b) has described some of the private sector in Peru, and Griffin and Paqueo (1987) have contrasted the public and private health care providers in the Philippines. A pattern that appears to be repeated across countries is that the public sector provides a large proportion of total inpatient care, and although public hospitals have most of the inpatient beds they serve an even larger proportion of the population than that implied by bed distribution. The private sector hospitals tend to be smaller and less sophisticated on average, suggesting that there are constraints to private health care and that public hospitals are the sources of

sophisticated inpatient care. Thus, the public sector pays for the bulk of high cost care.

Pharmaceuticals are a popular source of self treatment. Diagnosis, prescription and sale of pharmaceuticals through unqualified practitioners is also common. Roth (1987) summarizes some of the medical problems and issues in the over- and inappropriate prescription of drugs in developing countries. Such practices are well documented, and there are well understood medical problems that result. In many respects, the inappropriate use of pharmaceuticals is the worst side effect of private medicine. Without oversight or control by government or the medical community, abuses have proliferated, and while medical "treatment" has become more accessible it has also become more dangerous.

Fee for service care is defined and priced by providers. Competition exists across providers but it is unclear whether this has any effect on price. Rationing the number of physicians in modern health care has served to keep the price of medical care high in developed countries and has dulled the effects of competition. In developing countries, where an oversupply of physicians is causing high unemployment among physicians (e.g., Chile, Dominican Republic, Egypt, and Peru), competition across providers is leading to lower prices and a willingness among physicians to make discount arrangements with insurance companies and company benefit managers, and to join prepaid group practices (see Zschock, 1986a for discussion of the phenomena in Peru, and GHAA, 1983 on Chile).

Means of Encouraging Fee For Service to Cover the Indigent

Because fee for service represents the bulk of non-publicly provided health care in developing countries, it is already the source of care for a large segment of the indigent population. Pharmacies are particularly accessible and useful for poor households. Expanding use of private fee for service providers entails de-institutionalizing public health services and establishing a reimbursement system that relies on the private sector to deliver care. Thus the government could take on the role of paying for the indigent and overseeing the quality and effectiveness of private providers. This would have the effect of placing government in a regulatory role and allowing the government to better target its health resources to those who need subsidies. Such a program would entail revamping the system of health care delivery and probably of privatizing some of the secondary and tertiary care network. Hence, it is a major program.

Contemplation of a reimbursement system involves a number of shifts within the government and, as mentioned, a redefinition of roles. It also implies the need to promote alternative means of financing health that assist non-indigents pay for health care, e.g., insurance, employee health benefits, and pre-paid plans). Hence the reimbursement system is just one aspect of a package of reforms that would be politically necessary to adjust the delivery and financing of health care by the private sector. While complex and involved, a reimbursement system that relied on fee for service providers would be a less costly means of providing care to the indigent, than the current government provision model, and would be an ideal mechanism for promoting private sector activity in the health sector, while meeting the health needs of the poorest households.

The experience in the U.S., however, also suggests that the concomitant management requirements of the government are considerable, and the cost of the program is still open ended with regard to the covered population. Thus, reforms that shift users to the private providers also imply some difficulties.

Insurance and Employee Benefits

Health insurance is a means of prepaying for health care and spreading the risk of (substantial) medical care costs across a pool of potential patients. It differs from health maintenance organizations (HMOs) as it arranges only for the financing and not the delivery of health care; and although HMOs are another form for providing employees with health benefits they are discussed in considerable detail in the following section.

There are public forms of health insurance -- such as the U.S. Medicaid and Medicare systems and the social security systems commonly found in Latin America -- as well as private forms, which encompass cooperatives, employee-based insurance, group insurance and individual insurance.[9] This section is concerned with the latter category of private insurance. The balance of this subsection is concerned with the general definitions, characteristics and components of health insurance based largely on evidence from the U.S.), drawbacks in its application, experience, and potential in developing countries.

Insurance is defined as protection through advance payment for unforeseen hazards. Health insurance is protection for the individual against the costs of hospital and medical care or lost income arising from an illness or injury

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9. In many respects the U.S. medical care system is really a hybrid private-public system because the government pays for the insurance but the private sector delivers care.

(Health Insurance Institute, yearly). The financial burden of a costly illness is far greater for an individual than for a group that charges modestly but can afford the major medical costs of catastrophe for a few because of the pooled resources. Moreover, what is unpredictable illness for an individual is predictable for a group. Thus, pooled risk and resources makes catastrophic coverage affordable to the group where it would not be for the individual.

The concept behind health insurance, that a number of individuals spending modest amounts can then cover a few big health bills of the participants, is why insurance typically does not cover the predictable. Akin (1987) suggests that "risk-sharing is most valuable when the event insured against is largely unpredictable, the cost of the event's occurrence is large and the individual is willing to pay for the remedy." Moreover, the event must be rare. Insurance is uneconomical for predictable conditions with modest costs because there is no risk attached to such illnesses and paying the administrative costs to move money through an insurer makes little sense, especially where all the members will claim for the same predictable services.

Insurance is the key to promoting greater private sector involvement in health. Curative care is only needed periodically by the majority of the population, and serious conditions are even less frequent; however, the cost of the latter can be astronomical because of the nature and/or extent of the treatment. It is the high cost of unforeseen illness that provides the major rational for insurance.

Without insurance, treatment at a free or partially subsidized facility is attractive if not essential. With prepaid insurance entitling the patient to private care (with usually some contribution from the patient) selecting other than public treatment becomes affordable and desirable. Evidence from the U.S.

suggests that this pattern of selecting private over public care when patients have health insurance is typical among VA patients (Horgan et al., 1987) as does a recent report on the introduction of proprietary (private) hospitals in Europe (Berliner and Regan, 1987).[10] Thus as insurance coverage rises, the demand for private facilities also rises, even where the public care is an option. Thus, insurance is a key element in efforts to promote private health care in developing and developed countries.

Characteristics of Insurance

In practice, insurance pays the bills when an individual seeks care from a physician who prescribes some treatment, thus the term third-party payer. Health insurance can cover the costs of some or all of the following services either separately or as a package: hospital, surgical (physician fees and related care), regular medical, catastrophic, and disability. The insurance contract or policy sets out the premium paid by the insured individual, or his employer or group, and the benefits to be extended to the insured. The decision to seek care is made by the beneficiary and the "needed" services are determined by the physician; the third-party pays the bill. In theory, the provider can set price and determine quantity and (implicitly) quality of service without any direct interference from the patient or payer, although the patient selects the provider on the basis of perceived quality. [11]

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10. A recent assessment of utilization of free veteran's facilities by Horgan et al. (1987) showed that only about 4 percent of the eligible veteran population take advantage of free, publicly provided care. Those with private insurance are the least likely (only 2.5 percent) to use free VA care.

11. The simplicity of this explanation belies the complexity of the relationship among patients, providers and payers. The strong relationship between providers and insurance companies is often blamed for the spiraling costs, because reimbursement for expenses was automatic at

(Footnote 11 Continued on Next Page

The downside to insurance systems is a rapid rise in medical care usage and costs because there are no built-in incentives to contain expenditures. To try and control costs and minimize unnecessary use of medical services, insurance companies have introduced copayments or deductibles, and have set ceilings on the amounts they will reimburse providers for certain treatments. The former are meant to dissuade patients from seeking care unless they need it, and therefore meant to reduce overutilization. Similarly, copayments where the insured pays a certain proportion of the costs also serves to discourage unnecessary use of the system. Reimbursement ceilings serve to at least contain costs within certain bounds, but because they are based on average costs as set by physicians and other health care providers, they are only marginally effective.

Put simply, copayments and deductibles are incentives to users to restrict purchasing to those services that are more desired, and they are somewhat effective in containing treatment. The system does not, however, provide incentives to contain costs per se. The insurance companies' ceiling reimbursement and refusal to pay for certain things (e.g., cosmetic surgery) has only a minimal effect on cost increases because it affects so few treatments and, as already mentioned, reimbursements are a function of the costs as reported by providers.

Group insurance, where a company, industry, community or some other collection of individuals (or households) obtains insurance for its members, is generally more advantageous since risks, and therefore the insurers costs, can

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(Footnote 11 Continued from Previous Page)
the onset. Efforts to stem this trend with ceilings on what insurance companies will pay, and relying on second opinions have had some effect, but the provider - payer relationship is still at odds with cost containment.

be estimated across a known group where it cannot be across random individuals. Individual policies are more frequently purchased by those who have or have reason to believe they will have health problems. This "adverse selection" costs insurance companies and thus insurance costs are much higher to individuals than to groups who have a better known risk and adverse selection is not possible. Group insurance is more common than individual insurance in all countries.

Insurance Coverage in the U.S.

The U.S. relies almost exclusively on private providers and "social insurance" beneficiaries are served by private providers through a reimbursement system. Only 12 percent of U.S. health care is delivered by the public sector through the Defense Department, Veterans Administration and Indian Health Service facilities. The balance of health care is provided by the private sector financed by public insurance -- either through Medicare (for the elderly) and Medicaid (for the indigent), private insurance, or fee for service.

Growth in insurance coverage in the U.S. was buttressed after World War II by tax breaks to employers who extended health insurance to their workers. In 1977, around 75 percent of Americans under age 65 had some kind of private health insurance coverage, fifty-five percent of them covered by group policies. The most extensive health insurer in the U.S. is Blue Cross-Blue Shield, a non-profit organization whose policies cover hospital care (Blue Cross), and surgery and other physician care (Blue Shield). BC-BS was established by surgical providers and as a result has had a historically strong relationship with providers rather than payers. A number of large employers have also established their own health insurance funds to cover medical care

costs for their employees. Moreover, sixty percent of the elderly had private insurance policies that supplement Medicare coverage (also known as "Medigap" policies). In 1979, 69 percent of health care expenditures were paid for through insurance, 59 percent of that (or 40 percent of the total expenditure) was through public (federal and state) health insurance (Wilson and Neuhauser, 1982).

Health Insurance in Developing Countries

Most insurance in the developing countries is some form of social insurance (e.g., government provided coverage) that either builds and uses its own facilities and staff, or contracts out with private providers to extend care to its members. In the developed world outside the U.S., social insurance is the key form of health care financing.

In developing countries, dependence on private insurance lags behind all other forms of health care financing. Even government provided social insurance does not cover a significant proportion of the population in countries outside of Latin America. In 1980, 40.4 percent of Latin America's population was covered by social security, however the proportions are skewed because of the region's population distribution and the sharp differences in coverage. Ninety percent of Brazilians and 68 percent of Argentinians obtain health care through social insurance, but only 10 percent of Ecuadorians do. The better off Latin American countries provide a significant proportion of their populations with medical care through social insurance. In the few countries for which there are data, private insurance coverage is limited to a small segment of the population. Almost fifteen percent of Jamaicans, 3 percent of Argentines, one percent of Filipinos and less than 2 percent of Peruvians are covered by private insurance (Akin, 1987 for all countries except Peru; Zschock, 1986 for Peru).

Employee Health Benefits in Developing Countries

Health insurance coverage expanded rapidly in the U.S. in conjunction with the emergence of an industrially employed middle class. Although health insurance as an employee benefit is not well documented in developing countries, and industrial is still not the major employer in most developing countries. Roth (1987) provides some indication of the kinds of private insurance in Latin America (see Table V-A1 in the Appendix), but this sample is not necessarily representative of insurance coverage in that country or across countries. The vast majority of these insurance companies insure groups, although some also insure individuals. Frequently health insurance companies are spin offs of and affiliated with life insurance concerns. The companies differ widely in what they will reimburse, required patient copayments and deductibles (some have both others have neither), and the maximum expenditures for any given illness episode (again, some are stringent and others have no restrictions).

In Argentina, a number of companies (all with individual annual premiums of US$ 400) provide full coverage with none of the possible restrictions: reimbursement ceilings, patient deductibles or copayments. A company in Ecuador, Sucre Cia. de Seguros, only pays accident expenses, but pays all its associated costs; Cia. de Seguros La Chilena Consolidada provides health coverage for emergencies with 50 percent reimbursement for surgery (premium is US$ 264 per annum), and as an additional option the company offers an oncology and life insurance policy (US$300 per year). The Argentinian example is a generous, full coverage plan; all of the latter are catastrophic coverage plans, and therefore only serious health problems are covered. Thus it is very difficult to summarize these plans other than to indicate their broad variety

on the points included in Roth (1987). Moreover, since none of these plans have been evaluated from any perspective other than their existence, there is no best or most cost effective insurance approach to recommend. But the variety and number of these operating concerns is an important point.

Information on employer-based health care is not well documented either. Roth (1987) summarizes the nature of some particularly large plans in Sub-Saharan Africa (see Table V-A2 in the Appendix), and Scarpaci (1987) notes their history and prevalence in Chile. Employer-based health care is largely achieved through direct provision by company physicians and through company facilities, although a few reimburse for care obtained through the private sector. Pertamina, the Indonesian oil parastatal provides care, as do a number of large industrial manufacturers in India (Murthy, 1983). The summary table in the appendix (Table V-A2) indicates who provides such services, how these programs are set up, and the size and scope of the plans. Little additional information is readily available.

Community Insurance in Developing Countries

Community level insurance in developing countries is in its infancy and it is not yet clear whether such programs are financially viable. Typically these have evolved out of cooperative arrangements in rural areas. These small scale, essentially cooperative health programs provide an ideal mechanism for catastrophic coverage, although reportedly (Dua and Abel-Smith, 1987; NCIH/(CLUSA, 1984) they typically are geared to the provision of primary health care. Because they do not function as risk-sharing arrangements, these systems may be an inefficient use of health resources for the reasons mentioned earlier regarding use of insurance for expected health care. Their major benefit is that they minimize the problem of adverse selection because the group is

enrolled. Moreover, these experiments make clear that prepayment is not anathema to rural households.

In Peru, of the 2000 cooperatives nationwide 172 reportedly have some form of health service or insurance. Such arrangements are most attractive to agricultural cooperatives (91 out of 172 have something). Most of the cooperatives only cover pharmaceuticals and some ambulatory care because of their small scale. Policies, premiums and coverage vary widely across cooperatives, however (Zschock, 1984).

Table V-1 summarizes the characteristics of the handful of schemes that have been documented in developing countries. Even these have only limited information. The three programs are very different in scope and operation. Two are geared to covering curative care, the Indian cooperative (Halse, 1984) only covers preventive services. Participation ranges from 5-12 percent of possible participants in Nepal (Donaldson, 1981) to 90 percent in China, (Li-Min, 1982), perhaps reflecting social pressures in the latter. The China and Nepal programs both received direct government subsidies, while the Nepal program is supplemented by NGO contributions. Only the China system is well-established with a respectable track record. The India and Nepal programs are narrow and somewhat tenuous.

Although it is subsidized, the Nepal program was the most "privately" organized since it was meant to provide a service for whoever was willing to buy-in. The other two were extensions of already established cooperative arrangements, and demand for health services had either been articulated (India) or was assumed given poor existing access to health care services (China). Thus the Nepal experiment required marketing, financial planning and administration, and public relations, which were not required in the other two.

Table V-1

Summary of Community Insurance Schemes in LDCs

Insurance System, Country (Source)	Summary of System	Number of Enrollees	Premium (U.S.$)	Copay-ment	Reimbursement Ceiling	Public Subsidy
Coopertive Medical Systems, Shangai, China (Li-Min, 1982)	Contributions from participants and the "Collective Welfare Fund" (.5-1.5% of total resources). Provided only curative care and reveues paid barefoot doctors.	360,000 (90% of the population in 238 locales.)	$1.20/ Cooperative Member	yes	Medical care in local health stations covered in full everywhere; most areas reimburse 50% of the costs of care from outside the locale. Thirty percent of the local stations had 50$-$200 ceilings per illness episode.	Yes, for annual revenue shortfall.
Health Post-Based Insurance Schemes Lalitpur District, Nepal (Donaldson, 1981).	The United Mission to Nepal, a PVO, is assisting in the establishment of health insurance schemes in 3 panchayata. Two schemes were tried: (1) drugs insurance helping public health posts buy drugs by supplementing the government's allocation. Enrollees received free consultation and drugs, and non-enrollees received a consultation but only a prescription; (2) and, an insurance card purchase that provided discounted outpatient and a flat-fee charge rather than fee-for-service, for inpatient care at the PVO hospital.	After 3 years, 806 insurance cards purchased; 5-12% of the geographically eligible were participating.	$1.00/household/yr. in 2 schemes and $2.00/ household/ yr. in the other. Payents could be made in installments or in labor.	None at the health post, but $4.00 deductible at UMN hospital per outpatient and $8.00/ inpatient instead of fee-for-service.	None	Yes, PVO for private services; drugs at public health posts.
National Dairy Board, Kaira District, India (Halse, 1984)	In 1980, a non-profit trust, Tribhuvandas Foundation was established to provide MCH and supplementary feeding programs for children under five through VHWs to coop members. Mobile health teams provide immunizations, family planning, and hospital referral.	By 1982, 82 villages participated in the MCH scheme and 30 villages in the feeding program.	The milk coop pays half the cost, raised through withholding a percentage of daily earnings or levying a tax on each liter of milk.	Unspecified (but only half of costs come from coop so members may cover the balance).	none	none

The freedom to select-in on an individual basis in Nepal did result in adverse selection in inpatient care, which is to be expected when individuals rather than groups are enrolled in insurance schemes.

What is lacking in the India and China experiments are some evaluations of costs, copayment ranges, utilization shifts, and extent and nature of subsidies from public and private sources. These, along with issues of financial solvency, are important in understanding whether these systems work and can be replicated. The Nepal study demonstrated the financial viability of a drug insurance scheme as a supplement to government allocations, the ability to market insurance for inpatient care to very poor populations and also require a copayment of them.

Although the evidence from these schemes is modest there are some conclusions regarding community insurance experiments. First, there appear to be some diseconomies of scale. High administrative costs in Nepal and in some quasi-government schemes in Korea (Park, 1984) suggest that as insurance plans expand and subscriptions rise, the cost of administration and management shrink in relation to revenues. Second, the plans do not appear to be feasible without subsidies, and virtually all of the schemes had financial back-up from the sponsoring organizations or the government. Last, with the exception of the Nepal study, data on the feasibility and long term viability of the community insurance schemes is lacking. As a result, very little can really be provided on either the overall soundness of the concept, or the strengths and weaknesses of any of the approaches.

Abel Smith and Dua (1987) note a number of additional schemes in India and Indonesia (Dasa Sehat) for which detailed information is not available; other cooperatives that have developed some kind of coop health program like the

Colombian Coffee Growers Association are equally short on detail. Thus although only a very few privately generated community insurance schemes in developing countries are described here, the extent of this financing method is not really known because of a lack of information.

Impediments to Private Insurance in Developing Countries

Akin (1987) attributes the low level of private insurance in developing countries to: (1) low incomes, because the basic necessities of existence take priority and indigent households rationally choose to risk catastrophy; (2) the administrative costs and complexity of operation may be excessive where infrastructure is poor and management skills are in short supply; (3) the availability of free health care, which provides a disincentive to other mean of financing health care; and, (4)the fact that catastrophic care is frequently paid for even where free services are not available to all.

In a study across countries for all types of non-life insurance, Wasow (1986b) found per capita income to be the single most important factor explaining insurance volume. However, the availability of free care is unlikely to present a deterrent to insurance development where insurance coverage is likely (e.g., employee benefits packages are common or incomes are high), however, as already discussed. However, low incomes and reliance on charity or public resources in the event of catastrophic illness, are very likely to be impediments to demand for insurance, since it is the catastrophic occurrences that are most frequently covered through insurance and the great benefit of insurance. Availability of partial subsidies in non-public facilities was a major impediment to the development of insurance and HMO arrangements in Chile in the 1980s (Scarpaci, 1987).

The complexity and difficulty in administering and managing insurance is also key to the limited supply. Wasow (1987a) cites the high demand for education and specialized skills for effective management of general insurance. Indeed, in comparison to other sectors, insurance places low demands on fixed capital and is the sector with one of the highest demands on skills. As a significant component of overall insurance, these same criteria apply to health insurance.

There are other factors which affect the existence or extent of health insurance as well. Consumer knowledge about insurance, its benefits and arrangements, or where to even obtain such services may pose a problem, especially among the lower middle class where insurance might be attractive. It may also be due to limited supply emanating from the lack of knowledge or technical assistance in how to set up, finance and operate an insurance concern.

Macroeconomic circumstances as well as legal, political and financial restrictions pose impediments to insurance companies and offer strong disincentives to the expansion of risk sharing arrangements. For instance, interest rate ceilings, overvalued exchange rates and high rates of inflation deter development of an insurance industry because of the costs and inherent risks involved in operating under such circumstances; political risks such as nationalization, restrictions on foreign investment, and repatriation of profits will also discourage both national and foreign insurance companies from investing; licensing requirements and other disincentives to the development of private financial institutions will also inhibit the health insurance industry, and will also affect pre-paid group plans like HMOs.

Thus in addition to the disincentives of low income, high administrative costs and complexity, and free health services, institutional constraints, political involvement, and other elements of market interference contribute to few insurance options and minimal coverage by third-party payers in most developing countries.

Abel-Smith and Dua (1987) reiterate the income constraint raised by Akin (1987) as an impediment to the proliferation of prepaid insurance schemes on a community level. They point out, that on the community level where agricultural cycles dictate income flows, prepaid schemes are often difficult to sell and households are willing to take the risk of illness because there is so little discretionary income and returns are deferred as well as not assured. In other words, poor households cannot afford risk averting behavior. The Nepal experience, however, challenges their conclusions, but the paucity of data makes any resolution impossible at this juncture.

Despite these existing impediments, insurance has potential, especially in the more advanced developing countries.

Means of Encouraging Insurance to Cover the Indigent

Government (social) insurance is a common method for subsidizing health care for the indigent in developed and developing countries. As already mentioned, in Latin America, a number of governments extend services through social security facilities and financing. Using private insurance to subsidize services is a very different proposition, and one that has little potential. Although this method of subsidizing the poor has been raised in developed countries, it has never been attempted.

The major complication with the concept is the fact that the poor are not a homogeneous group and estimating their risk of illness, and more importantly of

long term illness, is almost impossible. Since health insurance investments are made on the basis of being able to estimate risks within some acceptable range of accuracy, and therefore on the basis of projected costs, extending insurance coverage to an undefined, potentially high risk population is not an attractive financial proposition. In theory, insurance companies could make some inflated estimate of what it might cost, or base their calculations on a similar population and charge the government on that basis. However, government might also have to agree to cover some of the risk of catastrophic care or reinsurance if costs exceeded expectations, since insurance companies would be reluctant to be at risk for unexpected high costs. Thus while the idea might be possible, it is a difficult and unpredictable approach for financing indigent care with no track record to guide its design or development.

Insurance is a valuable method for increasing reliance on the private sector, but its value is really for those above the poverty line, and most appropriate and affordable as part of an employee benefit package.

Health Maintenance Organizations (HMOs)[12]

The Health Maintenance Organization (HMO) is an alternative strategy to insuring patients and at the same time giving incentives to providers to control costs. The HMO combines the function of the provider and the insurer into a single organization, which is paid a fixed amount per month for each enrollee. This amount, called the capitation payment, is similar to an insurance premium [insurer's payment] but is different from the provider's payment. Unlike the fee-for-service physician, who is responsible only for

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12. This subsection on HMOs was prepared with W. Peter Welch of The Urban Institute.

providing an immediate service, the HMO is responsible for providing health care services for the enrollee population. Like the conventional health insurer and unlike the provider under an insurance system, it bears financial risk in the sense that it is responsible for any cost overruns and benefits from any surpluses.

In the U.S., HMOs are better than fee-for-service in providing preventive care, because there are built in incentives to keep patients healthy. Moreover, quality assurance efforts require attention to both preventive and curative health needs. There is little evidence on preventive services in developing countries. Indeed, interviews with Amico, a Brazilian HMO owned by Hospital Corporation of America, indicate that immunizations are not provided and patients are referred to the public health system for vaccinations. The HMO has only recently considered adding family planning. Conventional insurance in the U. S. often does not cover preventive care, and when it does, it generally requires cost-sharing by the patient. Substantial cost-sharing discourages patients from preventive care (Luft, 1981, ch. 9), but without copayments, controlling costs becomes a larger problem. HMOs can rely less on cost-sharing as a means of controlling costs because the provider already has an incentive to control costs, and thus, does not face this dilemma on preventive care.

It is useful to contrast HMOs with public health systems. Both are responsible for providing health care for a defined population within a fixed budget. To be efficient and operate within their budgets, both must control costs and make decisions among alternative uses of their resources. But only HMOs must attract consumers. Public systems typically receive revenue whether or not consumers use their services. HMOs compete in a market that includes

conventional insurers and other HMOs, whereas the fixed government budgets in public health systems enable them to survive even if their health care is of low quality and high cost.

Urban areas are more promising as locations of HMOs because those areas are more likely to have a number of sellers. Although HMOs are necessarily in the private sector, they are disciplined by the market only to the extent that they have competitors. The advantages of HMOs (e.g., cost containment incentives and investments in preventive care) are seriously diluted outside a competitive environment.

HMO Enrollees

HMOs have roots going back 50 years. They were strongly opposed by organized medicine at their inception, but for at least ten years, they have grown steadily. At present 24 million Americans, 10 percent of the population, are enrolled. Since 1980, enrollment has been growing at 17 percent per year, that is, doubling every 4 years. In Latin America, HMO enrollment is concentrated in Brazil, where 8 percent of the population is enrolled, and Uruguay, where 45 percent is enrolled.

The characteristics of U. S. HMO enrollees are more similar to conventional insurance enrollees than they are different. They are similar in terms of age, education, and health status. There is some evidence that HMOs are particularly attractive to families with modest income, for whom the HMO's cost-effectiveness is especially appealing.

Although the threat of failure disciplines firms, the failure rate for HMOs has not been large. Of the HMOs operating in 1982, five percent had gone out of business by 1984. The failing HMOs had only 1 percent of the enrollment in 1982 (Interstudy, 1982-84.)

In the U. S., most people receive their health insurance through their employment. Those that offer insurance are required by federal law to offer an HMO if one requests it, guaranteeing choice in terms of delivery and financing alternatives.

In Chile, HMO enrollment is also employment-based. All active employees must contribute 6 percent of their wages to social insurance but may channel their contributions into a private social security company called Institute de Salud Previsional (ISAPRE). Under the system, they no longer receive health care from the National Health Service but rather from ISAPRE, which may be an HMO. In Uruguay 67 percent of HMO enrollees enroll as individuals, 23 percent through social security, and 10 percent through their employment. This sharply contrasts with the avoidance of individual enrollment by U. S. HMOs because of high administrative costs and vulnerability to adverse selection.

Types of HMOs

There are two basic types of HMOs. Prepaid group practices (PGPs), exemplified by Kaiser, are HMOs whose physicians are typically full-time workers in the PGP. Individual Practice Associations (IPAs) are HMOs whose physicians see both fee-for-service patients and HMO enrollees and continue to practice in their own offices. In essence, the PGP is much more of a unitary organization, combining both administration and providers. The IPA has two very separate parts: the administrative or insuring arm and the providers (individual physicians or small groups of physicians).

This taxonomy also appears useful for developing nations (Solari, 1985; Scarpaci, (1987). Brazil's HMOs, for instance, are classified as either "beneficencias" (mutual benefit societies), "medicina de Grupo" (PGPs), or "cooperativas medicas" (IPAs). The mutual benefit societies, however,

correspond to U. S. PGPs that are cooperatives. In Brazil PGPs operate their own facilities and care is provided by a limited group of physicians, and IPA physicians work out of their own offices. Uruguay and Chile have both PGPs and IPAs. Jamaica's single HMO has an IPA arrangement with local physicians and hospitals.

Until this decade, IPAs were a minor part of the HMO industry in the U.S. However, their enrollment has grown several times faster than PGP enrollment, such that half of HMO enrollment is in IPAs. They may well dominate the HMO industry of the future (Welch, 1987).

A major reason why IPAs have grown faster than PGPs in the U.S. is the ease with which physicians and consumers can switch to IPAs. Because PGP physicians work full-time for the HMO, physicians joining a PGP must drop their fee-for-service practices; returning to this would be difficult. Because IPA physicians continue to see fee-for-service patients, joining an IPA entails little risk or initial change in their practice. On the other side of the market, consumers that enroll in a PGP must break ties with physicians, a major barrier to enrollment in PGPs in the U. S. (Berki and Ashcraft, 1980) and potentially important in developing countries. Enrolling in an IPA by consumers, on the other hand, is less likely to entail breaking such a relationship.

In both the U. S. and South America, physicians have traditionally opposed HMOs, preferring the autonomy of solo practice. Both areas are experiencing an increase in the supply of physicians, which has facilitated the growth of HMOs in the U.S., Chile and Peru (Scarpaci, 1987; Zschock, 1986a). IPAs have been organized in response to PGPs both in the U. S. and Uruguay.

Physicians in PGPs are primarily paid by salary, although some receive bonuses based on the performance of their physicians as a group. Physicians bear little risk in PGPs. Traditional IPAs have paid physicians fee-for-service at about 80 percent of their normal earnings. If physicians as a group keep costs within budget, the 20 percent withheld is returned to them. Since an IPA may have several hundred or thousand physicians spread throughout a metropolitan area, each physician has little incentive to control his or her own costs. For this reason, modern IPAs put their physicians at some risk. Here it is useful to distinguish between IPAs that contract with individual physicians (direct contract IPAs) and those that contract with physician groups (network IPAs).

Both types of IPAs require the enrollee to select a primary care physician (a category which includes general practitioners, family practitioners, internists, pediatricians, and OB-GYNs) who will manage the enrollee's health care, both preventive and curative. The IPA pays physicians, either as individuals or groups, a fixed amount to cover the services of primary care physicians. It gives physicians financial incentives to control the cost of specialists and of hospitalization because they receive only a fixed per patient amount to cover the cost of keeping patients healthy. This is the system adopted by the 18 month-old Jamaica HMO. In network IPAs, the medical group may bear half the risk of the cost of hospitalization. IPA managers believe financial incentives are necessary to control their costs.

Two HMOs will serve as examples of PGPs and IPAs (Fox and Heinen, 1987). In the Harvard Community Health Plan, a PGP in Boston with 200,000 members, physicians are paid by salary and bonus. The bonuses are not related to individual performance but to the HMO's financial success. Although physicians

have no clear incentive toward excessive or insufficient utilization, quality assurance programs are needed. Quality assurance starts with careful recruitment of physicians. It includes the review of medical records for unusual deaths and readmission to hospitals within three days. Another quality assurance method, automated medical records systems, remind physicians of conditions that require follow-up, such as abnormal Pap smears. Such automation is being expanded to provide data on outcome measures such as birth weight.

Maxicare of Southern California, a major IPA, contracts with groups of physicians who are already practice together. Each group is capitated for basic and specialty care, meaning that it receives a fixed amount per enrollee from Maxicare for physician services and are completely at risk for those services. Another fixed amount per enrollee is set aside for hospital care. Maxicare absorbs all losses for hospital care but splits surpluses equally with the medical group.

This arrangement gives provider groups substantial incentive not only to control utilization but also to provide too little care, as those groups retain all savings from physician services and half from hospital services. The incentive toward underutilization increases the need for quality assurance programs.

HMOs may own their own hospitals but typically do not. This is especially true for IPAs. This and other options are summarized in Table V-2.

Performance

Two major aspects of performance that make HMOs particularly attractive alternatives to traditional delivery and financing of care are the built in incentives for cost containment and quality of medical care. In principle, these can be compared across systems.

Table V-2

Options for HMO Organization

Relations with Physicians	Cost Control Mechanisms (not mutually exclusive)	Relations with with Hospitals	Enrollment Base	Type of Organization
- contract with fee-for-service (IPA)	- utilization review	- own hospitals	employment groups	- for-profit
physician groups	- financial incentives for physicians	- contract with hospitals	social insurance programs	- NGO
solo practitioners	- physician selection	- no special relationship		- public
- "hire physicians (PGP)	- physician education and moral suasion		- individuals	
physicians on salary				
single physician group				

Cost: U. S. PGPs cut costs between 10 and 40 percent relative to fee-for-service, primarily through lower rates of hospitalization (Luft, 1981). Because of their newness, IPAs are less well studied. Tentative evidence, however, indicates that IPAs that give financial incentives to their physicians have hospitalization rates similar to PGPs (Schlesinger, Blumenthal, and Schlesinger, 1985; Welch, 1987).

Quality: The theory on quality in HMOs is ambiguous. On the one hand, HMOs have the incentive toward underutilization of health care services as one way to lower costs. HMO advocates make several counterarguments: (1) fee-for-service has the incentive toward overutilization, because the physician and the hospital are paid only if a service is provided, whether it is needed or not. These unnecessary services, especially surgery, can be detrimental to one's health. (2) As discussed above, HMOs provide more preventive services than conventional insurance, since insurers are not providers but only financiers. (3) By virtue of being a single entity, the HMO can be held responsible for quality (as well as cost) in a way that the fragmented fee-for-service sector cannot. For instance, if in the fee-for-service sector a child does not receive an immunization, his physician is not held accountable--the child may not have a physician. In an HMO, the HMO is responsible. The policy of using HMOs to hold physicians accountable for low quality of care is as yet untried, but the structure is in place.

Quality of care is particular difficult to measure. The comparison between systems varies among studies and measures. In general, PGPs have quality of care as good as the fee-for-service sector (Luft, 1981). As with cost, little is know about quality in IPAs. Schramm et al. (1987) studied medical records of children in Milwaukee to determine whether the appropriate immunizations and

screening were given. They found consistently higher quality in PGPs than IPA. Because 90 percent of physicians in this county are associated with HMOs, primarily IPAs, this is largely a comparison between PGPs and fee-for-service physicians.

Ways of Encouraging HMO Growth

HMOs have been started with a wide variety of sponsors. Kaiser was started by Kaiser Industries in order to provide medical care to workers on isolated construction projects. Major insurance firms such as Blue Cross and Cigna have started large numbers of HMOs in the 1980's. A number of early HMOs were organized by consumers, although they have organized few if any recently in the U.S. In Latin America, some HMOs are mutual aid societies that were first organized by ethnic immigrant groups (Crowley and Strumpf, 1986). All ten of Argentina's HMOs are mutual aid societies, as are a number of Brazil's. In rural Bolivia, Peru, Ecuador, and Colombia, health cooperatives often provide health care, albeit with very limited benefits. Physicians are a major source of sponsorship in the U. S., where most enrollment growth occurring in IPAs, and in Uruguay, where three-quarters of the HMOs are sponsored by medical groups or medical associations (Solari, 1985). In the U.S., physicians have organized IPAs in response to competition from PGPs. Hospitals sometimes have organized IPAs, as they did when Arizona established an all-HMO Medicaid system.

The U.S. government has tried several policies to encourage HMO growth. In the late 1970's it gave grants and guaranteed loans to new HMOs or groups starting HMOs, as well as providing some technical assistance. It gave $220 million in loans and $150 million in grants (Demokovich, 1983). Although private investment was several times the total of $370 million, federal

financial assistance was disproportionately given to new plans. A number of large, successful HMOs, such as the Harvard Community Health Plan, were recipients of support. Not all recipients were successful, but financial support such as this should be viewed as venture capital, that is, as necessarily risky, and therefore likely to experience some failures. The rate of loan default, however, was only 4.4 percent (Iglehart, 1980).

By July 1981, 96 plans receiving financial support were operational and these had 23 percent of total HMO enrollment (Harrison and Kimberly, 1982). Because half of the remaining 77 percent was Kaiser enrollment, which has grown much slower than the industry as a whole, federally subsidized plans probably have substantially more than a quarter of the enrollment in 1987. The policy of financial support appears to have been successful promoting expansion of HMOs.

A second U.S. government policy was certification of HMOs which required that certain criteria be met to receive federal qualification. These criteria include the coverage of a wide range of services and a review of financial viability. Federal qualification served as a "good housekeeping seal of approval," enhancing HMOs' marketability.

Because most health insurance is purchased through employers, as of 1973 the federal government requires employers to offer an HMO to its employees, which was meant to promote HMO development. The requirement applies only if the employer offers health insurance and if a federally qualified HMO requests to be offered. Mandating an HMO option has probably forced many employers to offer HMOs who otherwise would not have, perhaps because of ignorance of HMOs. Even though employers are much more familiar with HMOs today than when this law was passed in 1973, the law may continue to give HMOs access to employee

groups, as evidenced by the HMO industry's concern over proposals to drop this mandate.

No Latin American nation has a grant or loan policy to promote HMOs, but government policy still affects HMO growth. Enabling legislation in Uruguay has encouraged the growth of HMOs (Crowley and Strumpf, 1986). In Argentina recent legislation hurts HMOs by requiring employees to enroll in "obras sociales," which are responsible for the medical care of their members. The Chilean government encouraged HMOs starting in 1981 by lifting restrictions on membership eligibility. Growth has been substantially below projection due to a number of political and economic factors (Scarpaci, 1987).

HMOs and the Indigent

HMOs have concentrated on serving the middle class and played less of a role delivering health care to the poor. In developing countries the poor receive health care from the Central Ministry of Health facilities or occasionally PVO delivery programs, if at all. In the U. S., Medicaid, the state-administered social insurance program for the poor, has typically paid (on a reimbursement basis) fee-for-service for health care. Several states, however, have required Medicaid beneficiaries to enroll in designated HMOs (Freund and Neuschler, 1986), because few enroll in HMOs if fee-for-service remains an option. In these mandatory-HMO systems, beneficiaries select among a number of HMOs. Most enrollment takes place in IPAs, in part because PGPs cannot expand capacity rapidly enough. When a beneficiary switches from fee-for-service to an IPA, the physician may remain the same but the financing mechanism may change. Beneficiaries choose among a wide range of physicians under either mandatory HMO enrollment or traditional Medicaid (Miller and Welch, 1987).

Payment rates to HMOs are usually set as 95 percent of costs of fee-for-service Medicaid, guaranteeing some savings to the state. Arizona sets rates through competitive bidding. It too has saved on the order of 5 percent (SRI International, 1986).

Because of the incentive toward underutilization, quality of care is a major issue with Medicaid HMOs. One quality-of-care strategy is to ensure that HMOs that serve Medicaid beneficiaries also serve middle-class patients, who presumably would leave if quality was low. By law no more than 75 percent of an HMO's enrollment can be Medicaid or Medicare beneficiaries. Another strategy, used in combination with the first, is to monitor quality of care directly. Arizona and Wisconsin, the two states with the largest mandatory HMO enrollment for Medicaid beneficiaries, monitor quality (Schaller, Bostrom, and Rafferty, 1986; Schramm, et al., 1986). This arguably produces medical care of higher quality of care than fee-for-service Medicaid.

Nongovernmental Organizations

Unlike the U.S. where nongovernmental organizations (NGOs) that operate hospitals are almost indistinguishable from for-profit ventures, developing countries host a wide range of charitable NGOs involved in health care delivery. Much of the care is sponsored and subsidized by religious groups as a humanitarian action. Because of central subsidies, these entities do not have to cover their costs and there are few incentives to control costs. NGO services generally have modest fees attached to them that are based on a perception of what people in the catchment area could pay for health care. They reputedly deliver high quality care in the LDC contexts in which they operate.

How well NGOs perform has rarely been assessed. In family planning, Lewis (1986) found little in the way of evaluation other than process assessments. How they compare with government or other private providers is not known, and almost all information about them is based on impressions.

Who NGOs serve, how much money they raise, and the degree of subsidy they receive are generally not documented and no information is readily available. Where they are based in rural communities, the set of potential users is defined, but who takes advantage of the services is not known. These charitable organizations do aim at reaching low income households and communities, and in Zaire they have taken responsibility for providing health care to the majority of the rural population.

The key question is, are they part of the private sector? They are obviously not-for-profit, and are not do not necessarily have to respond to market forces, but at the same time they are not public. In terms of promoting the private sector, NGOs are not the target group since their constraints and those of the private sector are quite dissimilar.

NGOs are a possible alternative to the public sector and may be able to deliver services to the indigent and outlying populations at a lower cost than government, although Zschock (1986a) found the cost per patient in public and NGO facilities to be equal in rural Peru. Using NGOs to deliver care to the government's target population is not unlike contracting out services if the government is providing hospitals with transfers to defray some of their costs. This latter system is used widely in Africa where NGO facilities are often viewed as substitutes for public services.

Thus although NGOs are private they cannot be lumped with the for-profit sector that is the focus of private sector promotion by donors; however, they are an option in terms of privatization.

VI. HOW GOVERNMENTS AND DONORS CAN HARNESS THE PRIVATE SECTOR

Promoting the private sector or privatization of public services are only two of the ways of improving the quantity, and perhaps the quality and efficiency of health care in developing countries. They are not the only ways to achieve these objectives, however, developing private sector projects may be neither appropriate nor what is required in a given setting. While both options for the private sector have potential benefits, they also have costs, and the relevance of either one in a particular setting needs to be assessed within the context of those benefits and costs and the economic circumstances of the country. That said, the balance of this section discusses possible interventions and approaches to promoting private sector investments in health care, and privatization of public facilities.

Definition of Private Sector Initiatives

Promoting the private sector and privatization is not synonymous with health care financing, private sector activities are components of health care financing. For example, user fees are not a private sector initiative. User fees, by definition, are charges imposed for a public service. Hence you have user fees at national parks in the U.S., but private health providers operate under a fee for service system, and these fees are not defined as user charges. Table VI-1 summarizes different kinds of financing activities under three categories: promoting the private sector in health care, privatization, and cost recovery in public facilities. The last column does not represent private sector actions in health, and these entries are not discussed further here. The other two columns summarize various possible actions, breaking them down by promotion of the private sector and privatization. This general summary

Table VI-1

Health Care Financing Options

Private Sector Initiative		
Promoting Private Sector in the Health Care	Privatization	Cost Recovery in Public Facilities
- reduce legal restrictions on private providers and financiers of private health	- contract out hospital service	- user fees
- promote expansion of private alternatives for financing health care: employee benefit services, HMOs, and insurance, through incentives or legal requirements	- lease out management and/or operation of public hospitals	- fee-for-service for upgraded care
- provide health care investors with access to loan capital including foreign exchange	- sell government facilities to private investors	- national health insurance with employee and/or employee contributions
- technical assistance in developing or improving private health sector investments		- subsidized drug sales in hospitals
- reimbursement, voucher or capitation payments for private provision of health care services instead of direct public provision		
- social marketing of pharmaceuticals		

lewis/jamaica/table-options

captures the essence of possible interventions in the private sector and health.

Table VI-1 suggests that donors and governments can work jointly to: (1) promote the private health sector through tax incentives, improve private access to capital, expand technical assistance, relax existing legal and political obstacles, and provide better and better access to information; (2) redesign public financing of health care to reimburse private providers for delivering care rather than direct provision through government-operated facilities; and, (3) hire private contractors to take on functions for the government such as: hospital services, (e.g., food service, laundry and housekeeping), management of the hospital, leasing out hospital management and service delivery or outright selling of public health facilities.

Role of Government Policy and Action and the Private Health Sector

Government policies set the parameters under which private entrepreneurs function. Thus the public sector can set obstacles or enhance the climate for the private sector. For instance, when tariffs are set to discourage imports due to balance of payments difficulties, they will affect private investors' attempts to modernize a private hospital if most equipment must be imported. Overly regulated insurance industries can cramp the expansion of private insurance; restrictions on health care delivery can limit the development of pre-paid group practices (HMOs); licensing and taxation can make health investments unprofitable and unattractive. These kinds of restrictions, while perhaps legitimate to achieve other policy objectives, can create disincentives for other entrepreneurial activities.

Government can promote greater private sector activity through modifications in policy; introducing legislation that encourages and

facilitates private investment in health; and, direct assistance. This can mean either assisting the private sector expand the supply of health care delivery through assistance and removal of impediments (see Table V-2 for examples of these), or through efforts to raise the demand for private care. The latter can be achieved through encouraging alternative financiers of health care, that is promoting insurance coverage, the development of HMOs, and other third parties.

Establishing a reimbursement system to replace or complement direct provision of health care relies on private providers to deliver care while the public sector pays for it. This kind of system obviously expands the demand for private health care, and is another method for both promoting the private sector and reducing the role of public entities. Privatization, where by the government can hire private specialists to undertake certain tasks for the government, is also a means to increase the demand for private health care.

Government Regulations

The other role for government that has not yet been discussed, but becomes important as privatization occurs and the private sector takes on greater responsibility for delivering care, is that of oversight. Whether it is a contract to a private entity or greater latitude for private actors, the government needs to track progress and performance, and regulate activity for the social good.

In contracting out, for example, it is essential that the terms of agreement are met and that the government has some recourse to remove the contractor. This obviously requires human and financial resources. Contracting out has some hidden costs to the government that are not readily apparent. Additionally, if the government decides to let multiple contracts

for a number of small, discrete tasks, the oversight responsibilities become major undertakings. Fewer contracts encompassing a number of different tasks may be preferable and less time consuming because there is one firm to deal with. Regardless of the size of oversight the issue is a very real one for thinly staffed ministries of health.

Regulation of the private sector to prevent abuses, ensure quality and help mitigate waste and control costs are common throughout the developed world, including the U.S. Government regulation of private hospital construction on a community level prevents overproduction, which might reduce occupancy rates and raise overall costs of health care. Acquisition of costly high technology is also typically regulated to prevent overcapacity, which unregulated would raise the cost of care so that all owners could cover the cost of the equipment. Reimbursements for indigent care are priced by the government based on a basic package of services to control costs. Another implicit tool used by governments, especially the U.S., is competition, which helps to control costs. The advent of HMOs in the U.S., for example, has promoted competition and helped to contain costs.

Thus where private providers are active in developing health care, government can help to improve affordability and mitigate limitations of alternative private financing mechanisms through regulations. Moreover, involvement through oversight rather than direct delivery is a far more efficient way to provide health care.

Options in Private Sector

Promotion of private activity involves understanding the legal, financial, and economic climate in which (potential) health care investors operate. First, it is important to identify the incentives and disincentives investors

face in establishing or expanding health care programs. Secondly, the constraints that impede investments, need to be understood and addressed. Government and donor actions are best able to identify and redress the disincentives and constraints, bolster existing incentives, and design initiatives that complement existing incentives and promote new activities. For example, if a fledgling insurance industry is concentrating on life insurance, encouraging companies through tax breaks to provide health insurance to their employees can spur the demand for private health insurance plans. The rise in demand offers an incentive to companies to develop health insurance programs. Similarly, if establishment of a private hospital is constrained by insufficient capital and a shortage of foreign exchange to import medical equipment, then loans in both local currency and foreign exchange are a means of promoting the finalization of the investment.

Although in most respects, adopting a medical reimbursement system implies a total revamping of the financing and delivery of health care, it may be an initiative that appeals to some governments. Such a decision alters the commitment of government to free universal care, and typically narrows the target population to exclude some citizens, presumably those able to pay for health care. In tandem with such a switch, some provision needs to be made both to assist the private sector in gaining access to the resources it needs to develop services, and to promote insurance or other coverage (e.g., HMOs) for the population not covered by the reimbursement system. Hence, the proposition has a number of different facets that need to be considered as a package if the political, medical and economic issues are to be addressed. Portugal has recently established a diagnostic related groups (DRG) system in its hospitals thereby adopting the U.S. model, so a revamping can be accomplished, but it is an involved and lengthy process.

Privatization is an option that is easier to accomplish than establishing a different delivery and financing system, and may also help to improve the efficiency of health care delivery. The Jamaican government with A.I.D. assistance has just completed the transfer of laundry and housekeeping services to a private contractor in four major public hospitals. Government employee unions posed an obstacle in the reforms since the contracting implied firing government employees who were currently carrying out those tasks. A.I.D. paid for an initial clean up of the facilities, and as of late 1987, the private group took over laundry and housekeeping services. The government is also discussing the possibility of leasing out a hospital and hiring managers to run a hospital on an experimental basis. All of these are examples of possible privatization efforts.

A.I.D. assistance in private action can be critical in making consultants available to the government, in developing and financing the process of establishing and carrying out these initiatives, and, most importantly, in evaluating their contribution to reducing facilities' costs and/or raising quality.

Greater specificity in the kinds of initiatives that are potentially useful in promoting the private sector in health is provided in Table VI-2. This lengthy summary gives a list of particular interventions including a description of the options and some explanation of how A.I.D. or the government might approach implementing the option.

Table VI-2

Summary of AID's Options for Privatizing and Promoting the Private Sector in Health Care Delivery

Summary of Options	Explanation and Implications of Options
1. Promoting Private Sector Investment and Activity in Health Care Delivery	
a. provide access to loan capital including foreign exchange to allow private investments (or expansion and improvements) in health.	a. shortages of foreign exchange and limited access to capital can restrict the operation and expansion of health care services. Investments in infrastructure and replacement of (imported) equipment are essential to maintain standards and quality in private facilities. Loan funds can provide these entities with the necessary capital to achieve improvements that keep patients.
b. assist the government in developing and establishing requirements for incentives to cover health care for employees, especially with regard to catastrophic care.	b. encouraging or requiring employers, employee organization to provide health insurance or cover (some part of) health care, especially catastrophic care not only promotes demand for private care, but it relieves the government of costly, long term care for individuals who could afford to pay if risks were pooled.
c. provide modest grants for feasibility or management review of existing private health care investments for indigenous companies. This would not include multi-national corporations.	c. often a simple management review, which private hospitals and clinics typically cannot afford, can improve the financial viability and profitability of private health investments. Because physicians often run medical service companies and health administrators are scarce, this modest intervention can help to maintain the existing private sector.
d. review laws, legal restrictions, regulations, and other impediments to private activity in: investing in the health sector orinvesting in financing and delivering health care.	d. interest rate policies, licensing requirements, tariff barriers and unnecessary restrictions on physicians' and health providers' medical practices, restrictions on financial institutions (such as insurance companies) and implicit discouragement to alternative forms of delivering health care are the kinds of issues that can be examined and addressed to promote greater private sector activity. High cost of capital (high real interest rates) and of imported goods (tariffs) inhibit quality private care. Other impediments that restrict private operations in the health field range from medical to financial issues.
e. assist the government in determining impediments to the expansion of health insurance and other financing mechanisms at both the community and national levels.	e. this is a refinement of 1d above, but is specifically focused on insurance, because this financing mechanism is a key element in promoting demand for private health care. (Wasow & Hill, 1986) describe many of these impediments and most are mentioned in the text in the Insurance and Employee Benefits section).
f. assist the government or parastatals gain access to relevant and appropriate expertise.	f. AID can serve as a broker for government and government bodies in locating and (in appropriate instances for parastatals) supporting technical assistance in how to promote private enterprise in the health sector.
g. assisting cooperatives set-up member access to services through information, technical assistance and loan funds.	g. rural cooperatives provide an ideal community for establishing cooperative health services or at least a risk-sharing pool to cover catastrophic care for its members. Information and assistance in designing, establishing and operating such a system and perhaps access to concessionary loan funds might help develop health insurance for curative care.

Summary of Options	Explanation and Implications of Options
2. Assisting Government to Increase Reliance on the Private Sector in Delivering Health Care to its Target Population	
a. pursue feasibility and viability of alternative financing options for health care delivery for both the indigent and non-indigents.	a. the following are examples of possible intervention: paying the capitation payment for indigents (and perhaps some portion for "near-indigents) to enroll them in private HMOs; developing private-public insurance schemes where government pays some portion of the premium for its target population, and employers and employees contribute (close to) full cost.
b. assist government in exploring, experimenting and evaluating alternative privatization options, including both technical assistance and funding to underwrite the efforts.	b. these encompass privatization efforts and could include: privatizing hospital services, such as: laundry, food service, housekeeping services; management of the facility with the company bearing the benefits of improved efficiency, also could make the company at risk for losses, but it would entail greater private sector control of hospital operations and policy; leasing hospital(s) to a private company to run with the government covering cost of indigent care through some reimbursement mechanism (see below); sell off (part of) the public hospital system to private investors.
c. assist the government in developing a health reimbursement system on a trial basis.	c. reimbursing private providers allows government to finance health care without delivering and allows them to narrow the subsidized group to those who cannot afford health care. Develop alternative reimbursement options: reimburse private fee-for-service; government pays (some part of) HMO capitations fee; government pays (some part of) private insurance premium. The basis of reimbursement must be considered in designing and implementing such projects.
d. social marketing or sale of subsidized pharmaceuticals.	d. subsidizing generic or other needed (essential) drugs and letting the private market distribute them using the profit motive will increase availability and keep costs down; alternative arrangements with the same incentive structure within public hospitals can at least provide a subsidized back-up for "free" drugs, which typically are unavailable; piggybacking other private distribution networks such as those of soft drinks or tea could also help to distribute key items (this is an unrealistic and not particularly effective means of distributing all drugs).

VII. CONCLUSION

This paper has attempted to clarify the meaning and concept of private sector activity in health, and has summarized the salient developing and developed country experiences. The options contained in the previous section offer a sense of the range of interventions that are possible under a private sector program.

Despite the potential complexity of the issues involved in promoting the private sector, there are a number of straightforward actions that can be taken that are appropriate in any setting and that lay the groundwork for possible subsequent interventions. Reviewing impediments to the private sector, and modest grants for feasibility or simple management reviews are examples of appropriate initial steps. Experience with these kinds of activities can not only address some narrow, but important gaps, but can also help point up areas of further interest and need in health and the private sector.

Of course, the kinds of long term intervention that are appropriate in any given setting will depend on that setting. For example, a country with a limited insurance industry is unlikely to be an appropriate site for expanding insurance coverage, and a weak Health Ministry is unlikely to be able to handle a reimbursement system for financing care or any serious privatization effort. This however, does not suggest that private sector interventions are inappropriate, but only that a simpler approach is called for. Privatization of hospital services and alternative reforms in health care finance might be more appropriate options, although prescriptions in the abstract are of limited relevance. In short, the local context is key to determining how to approach promotion of the private sector in health care.

Hopefully this paper will help to identify major areas for possible activity, and will highlight the strengths and weaknesses of alternative options, which in turn will reflect on the appropriateness of any particular action in a given country.

Table V-A1

Selected Companies Providing Health Insurance in Latin America

Country and company	Number of members, years in operation	Coverage	Rates
Argentina			
Omint S.A.	11,107 policies (average 4 members per policy) Medical insurance 16 years	Full	US$700 a year (family plan), US$400 a year (individual), or 4,500 pesos a month
Tim S.A.	5,000 families, 10,000 policies, 16 years, 2 clinics fully owned	Closed system, basic plus orthodontia and psychiatry, full coverage 15 years (special)	US$600 a year (family plan), US$400 a year (individual)
Galeno Provision Médica	14 years, 26,000 members	Full	US$650 a year (family plan), US$480 a year (individual), or 5,000 pesos a month
CEMIC (Centro de Educación Médica e Investigación Clinica)	25 years, First Insurance Co-Foundation (nonprofit)	Full, only for open scheme (own plus other hospitals)	US$500 a year (family plan), US$400 a year (individual)
Medicus S.A.	11 years, operates with 10 not-owned hospitals, 10,000 policies (3–4 family members each)	Basic and full	3,300 pesos a month (family plan), 4,000 pesos a month (individual), 5,600 pesos a month (full)
Skill S.A.	16 years, 30,000 members	Closed system and full	2,400 pesos a month (closed), 4,500 pesos a month (full)
Otamendi	Private (hospital)	Work with private health insurance companies (such as Salud S.A.) and social security members	Market prices, but subject to Ministry of Health approval
Apsot (owned by Tech Int Corp.)	8,000 members, Tech Int S.A. medical insurance for its corporate staff	Full	Fringe benefit for Tech Int's salaried staff
Chile			
Cia de Seguros Consorcio Nacional de Seguros	3,000 (health), 20,000 (life)	Life and health, 55–80 percent reimbursement, pharmaceuticals	300 pesos (US$33) a month package price to enterprises
Cia. de Seguros La Chilena Consolidada	200,000	Life with health coverage for emergencies, 50 percent reimbursement for surgery	200 pesos (US$22) a month; life and oncology insurance US$300 a year
La Sudamerica Cia de Seguros	700 firms	To enterprises only, basic health plan and supplements	US$111 a month, comprehensive life insurance
Colombia			
Compania de Seguros Generales y de Vida	n.a.	Accidents, medical expenses (related only to emergencies)	Rates approved by Suprintendencia Nacional de Seguros

Country and company	Number of members, years in operation	Coverage	Rates
Aseguradora Gran Colombiana	25 years, 1,400 firms (more than 25 members each)	Hospital rooms and services, surgery, medical visits, and diagnosis	Rates approved by Superintendencia Nacional de Seguros; family plan 62,000 pesos (US$609) a year, group rate is lower
Costa Rica			
Agencia de Seguros Edwin Garro	20 years, 150 policies (individual), 20 enterprises (group insurance for companies with more than 8 staff up to 55 years old)	Hospital, maternity, surgery reimbursement up to 70 percent of medical expenses	Instituto de Seguros sets tariffs and prices of medical expenses
Ecuador			
Sucre Cia. de Seguros	44 years	Accident expenses, 100 percent coverage	n.a.
La Nacional Cia. de Seguros	n.a.	Emergencies and accident-related medical services only.	n.a.
Ecuasanitas	16 years in Quito (32 years in Spain), 16,000 policies or approximately 50,000 people insured	100 percent coverage on 44 specialities, medical and accident coverage up to 75,000 sucres.	300 sucres (US$5) enrollment costs, 700 sucres (US$11) a month for each family member
El Salvador			
Pan American Life Insurance Co. (PALIC)	70 years, 8,000 (group)	Tied to life insurance, hospitalization, surgery, X rays, accidents; group insurance, 90 percent reimbursement	1,400 colones a year (US$560), premium set by actuarial appraisal and competition
Guatemala			
Compania de Seguros Granai y Thompson	12,500 members (group), 125 enterprises with more than 15 staff members, 8 years	Illness, hospitalization coverage, 80–100 percent reimbursement	457–700 quetzal (US$457–700) a year for maximum insurance
La Comercial Aseguradora Suizo Americana	60 new members a month	Hospitalization and emergencies only 250 quetzal a week	72.50 quetzal (US$72.50) a year, Superintendencia de Bancos
Mexico			
Banamex Seguros America Banamex S.A.	Group and individual policies	Coverage of medical expenses based on salary; three plans. Coverage: staples 30 percent, medical expenses 15 percent, pharmaceuticals 10 percent, Coinsurance at own expense	Premiums are the same for the three plans
Seguros Monterrey Serfin S.A.	Since 1942	Major medical expenses, 1 percent deductible, 20 percent coinsurance; group insurance, same coverage; Reimbursement scheme: up to US$1600 for surgery, up to 20 percent for anesthesia; US$80 a day for hospital, US$30–60 a visit	Approved by the Comisión Nacional Bancaria; 7,272 pesos (US$38) a year for individuals; 6,000 pesos (US$32) a year for group insurance
Seguros Bancomer	Group insurance (firms) and individuals	Medical expenses (surgery, hospital visits, ambulance, pharmaceuticals) related to illness or accident; accident (medical coverage)	Premium: husband, 24,187 pesos (US$123) a year; wife, 33,869 pesos (US$173) a year; child, 7,654 pesos (US$39) a year

Country and company	Number of members, years in operation	Coverage	Rates
Panama			
La Aseguradora Mundial		Life and accident (medical services insurance) up to 5 percent of agreed coverage amount (fixed with user)	Market prices
Cia. Internacional de Seguros S.A.	40 enterprises, 1,000 members	Hospitalization and medical coverage, two plans: basic and 80 percent reimbursement	Premiums approved by Ministerio de Comercio, Oficina Regulación de Precios
British-American Insurance Co., Ltd.	n.a.	Hospitalization, life, and accident only; hospital coverage up to US$1,500 a day, surgery coverage US$1,500 per intervention	Premiums approved by Ministerio de Comercio, Oficina Regulación de Precios, US$85–90 a month
The Continental Insurance Co	n.a	Emergencies, accidents, surgery only; reimbursement system	Premiums approved by Ministerio de Comercio, Oficina Regulación de Precios, US$68 a month
Cona Seguros	n.a.	Health insurance reimbursement system	Premiums approved by Ministerio de Comercio, Oficina Regulación de Precios
Paraguay			
Santa Clara S A de Servicios Asistenciales	Since 1979, 15,000 members, own hospital	10 plans, up to full coverage, two systems: centralized (provides own service), and decentralized (reimbursement scheme)	Family plan, 5,000 guaranies a month, premium checked by Ministry of Health
Peru			
Compania de Seguros Sud America	65 years, thousands of policies	Three plans (maximum coverage: 8 million, 5 million, or 4 million sales); includes maternity and 1 Xray, excludes pharmaceuticals, no deductibles or coinsurance	Premium: 72,000, 60,000, or 48,000 soles (US$21, 17, or 14) a month
Venezuela			
Seguros Sud America	Each firm has at least 20 staff members	Hospital, surgery, maternity up to 30,000 bolivares a year, reimbursement 80 percent of invoice; accident and extraordinary medical expenses	Superintendencia de Seguros fixes standard rates, insurance companies can negotiate that amount.

n.a. Not available

Source: Roth (1987)

Table V-A2

Employers Providing Health Care in Sub-Saharan Africa

Country and company	*Nature of business*	*Number served*	*Services supported*	*Mechanism*
Angola				
Cities Service Oil Co.	Oil extraction	n.a.	Comprehensive health care	Direct provision for outpatient care
Gulf Oil Co.	Oil extraction	500 employees and dependents	Comprehensive health care	Contract with provider for inpatient care
Botswana				
Anglo-American Corp.	Mining	n.a.	n.a.	Insurance
Bamangwato Concessions Ltd.	Mining	n.a.	Health care: 25-bed hospital	Direct provision with copayments
Botswana Meat Commission	Meat processing	Employees and dependents	Health care: 2 clinics	Direct provision
De Beers Botswana Mining Co.	Mining	n.a.	Health care: 72-bed hospital, clinics, 50-bed hospital	Direct provision with copayments
Côte d'Ivoire				
Impregllo/Kaiser Foundation International	Construction	9,000 employees and dependents	Comprehensive health care: hospital and satellite dispensaries	Direct provision
Union Carbide	Chemicals	n.a.	Annual medical exam and free meals	Direct provision
Ghana				
Volta Aluminum Company and Kaiser Aluminum and Chemical Corporation	Mining	15,000 employees and dependents	Comprehensive health care: 40-bed hospital	Direct provision
Kenya				
Unilever	Agroindustry	n.a.	Nutrition and health education	Direct provision of inpatient care
Union Carbide	Chemicals	Employees	Annual medical exam and free meals	n.a.
Liberia				
Firestone	Rubber plantation and processing	44,000 employees, dependents, and local population	Comprehensive health care: 2 hospitals (340 beds), 7 clinics and dispensaries, 46 first aid centers	Direct provision
LAMCO-Bethlehem Steel-Granges	Mining	Local populations of Bassa and Nimba counties	Comprehensive health care: 110-bed hospital, 150-bed hospital	Direct provision

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