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# Exploring H. M. O. Feasibility in the Korean Health Care Delivery Settings

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It is a fashion among health professionals, nowadays, to express their views on the reforming health delivery system in Korea. However, it is obvious that they have failed to provide a unified and definite direction. Introduction of new modes of health service delivery like H.M.O. is by no means easy, although a few professional surge the necessity to introduce prepaid group practices as a possible means of reorganizing our chaotic health systems. This study indicated that only 17 percentage of private medical practitioners have heard of the term H.M.O. (Health Maintenance Organization) and/or prepaid group practice. It is clear from the finding that there is no need of mentioning how many of them really know about what H.M.O. is.

No system of health services delivery can be transplanted wholesale across national borders. Medical Society, here and abroad, is a typical example of the most conservative professional circle. A new mode of medical practice needs to be adapted to the pre-existing patterns of health care delivery in order not to create unnecessary conflict. It is, however, inevitable that the suggested changes would be confronted with the vested rights of the interested group. Therefore, it is more realistic to apply an innovative measure on an incremental basis rather than on a drastic one. Such is the case for H.M.O. in Korea.

H.M.O. is defined as an organization which provides comprehensive health care to a voluntarily enrolled consumer population in return for a fixed-price prepayment. Structurally, it combines a financing mechanism of prepayment with a particular mode of health service delivery, group practice, by means of managerial-administrative organization.

The essential elements of H.M.O. concept can be summarized as follows:

1) an organization that makes a contract with consumers or employers in their behalf,

2) prepayment by subscribers on a capitation basis,

3) voluntary enrollment concept, and

4) a comprehensive plan providing benefits with a broad spectrum of health care.

There is no standard H.M.O.. A prepaid plan can exist in a variety of organizational configurations from the loosely structured Foundation for Medical Care (F.M.C.), an individual practice type of H.M.O., to the more highly structured hospital oriented H.M.O., a group practice type of H.M.O.. H.M.O's also can vary in terms of health care benefits offered and the population segments enrolled. In all of its various organizational diversities, the H.M.O. perfo-

rms the mission of ensuring the availability of health services to its subscribers through a rational allocation of health resources to meet the existing health needs. H.M.O. is found exclusively in the United States. Actually, the United States is exporting the idea of H.M.O..

H.M.O. is a competitive model of health service provisions. A competitive H.M.O. model must be somewhat hypothetical as Ellwood indicated, because although prototype of H.M.O's exists a truly competitive health market does not, and the model assumes that marketplace forces would alter the performance of all health providers. In the competitive H.M.O. model, consumers could purchase health care either on a fee-for-service basis from conventional provider or on a capitation basis from H.M.O. contracts. Competition over prices and benefits would be encouraged and monopolies would be discouraged. It is generally accepted that capitation prepayment has the following advantages over fee-for-service payment:

1) for patients, it removes obvious financial barriers to seeking care and encourages early diagnosis and treatment, and

2) for physicians, it offers the freedom to alleviate the concern regarding patient's ability to pay, and the benefit of income security in the sense that their income is not dependent upon the numbers of patients they see or upon the services they provide.

Numerous evidence is available for H.M.O's economy in the total cost of health services, andfor the provision of quality care in the light of its lower cost. The main success that H.M.O's can claim is cost reduction. It seems true that H.M.O. can provide a package of services at lower cost than identical services would cost in conventional pattern of care. H.M.O. reduces cost of health services by lowering the use of services by its members, and by limiting the supply of beds for inpatient care, which is to lower the availability of services. Utilization statistics shows that Kaiser members spend half as many days in the hospital as a similar population of other plans, such as Blue Cross/Blue Shield. The cost containment is advocated as efficient by H.M.O. proponents. They maintain that the savings would not result in the reduction of subscribers' indispensable medical care utilization, but would come from the curtailment of excessive, redundant, and inappropriate utilization. Actually, there is poor evidence that such reduction would bring about lowering the health status of H.M.O. members. In the meantime, some others do not stop criticizing that the profit incentive included in H.M.O. operation leads private H.M.O's to limit services by hiring an inadequate number of physicians and other personnel. The pros and cons both sides apparently seem logical but both lack further empirical evidence to support their argument.

With all the controversies in mind, it is worthwhile to take into account that no country is free from the escalation of medical care prices and the scarcity of available health resources. Thus, H.M.O. can be considered, an alternatve delivery system in order to relieve the shortage of helath resources and curb medical care price increases.

It is pertinent to review the existing health care system to which an alternative health delivery is to be introduced. This study has pointed out and discussed some basic problems of the health system in Korea with particular reference to the H.M.O. feasib-

ility. Such problems include cumbersome intergovernment health organizations in exercising public authority between the Ministry of Health and Social Affairs and the Ministry of Home Affairs, stinginess of public expenditures on health services in addition to the low purchasing power of consumers' spending on personal health, a fragmented private medical sector dominated by the solo practitioners in cottage businesses, a shortage and maldistribution of health resources in cottage businesses, in terms of health manpower and facilites, low medical care utilization in general and heavy reliance on pharmacist use in particular, the absence of adequate community base financing mechanism in the provision of health services and lack of some institutional devices to control the quality of care, and so on.

The researcher maintains that H.M.O. at its best modification in the Korean situation is unlikely to be much different from the private health insurance demostration programs currently under operation. Many similiarities exist: prepayment; defined population on a voluntary enrollment basis; capitation system; comprehensive benefit structures in terms of integrating preventive and curative medical services; and the concept of quality of care. Thus, it is helpful that in introducing H.M.O. the Korea health insurance program has had twelve years of management experience. In other words, the basic concept of H.M.O. is not completely new to some segments of the urban population as well as the rural population, although the term H.M.O. has not explicitly been used, and some health care providers are also familiar with the notion of a prepaid health care program.

In the United States, it is known that, assuming no major change in the role of government, the future of prepaid group practice will depend primarily on three factors: its ability to cover a broad spectrum of society, its ability to satisfy consumers of medical care, and its acceptability to health professionals, especially physicians. The same can be said in our case with the possible modification of an active government role in dealing with alternative delivery systems of health services. In fact, the Korean government is vigorously trying to restructure its health service delivery in a responsive manner to adequately meet the substantial amount of health care need of its population. Free provision of medical care to the indigent (a public assistance medical care program such as Medicaid in the United States) since January 1977 and compulsory application of the employees health insurance program for those engaged at industries with more than 500 workers and for their dependents since July 1977 are two good examples showing the intention of the government. Also, government scholarships and grants-in-aid program for medical students are in effect in order to directly manipulate the geographical maldistribution of physicians. It is officially reported that the government plans to borrow a large-scale loan for hospital bed construction in the needed areas.

The planning process for the development of an H.M.O. can be thought of as a series of decisions. These decisions involve a large number of issues that are critical to the formation of a viable H.M.O.—marketing, medical, social, and legal issues to name a few. Therefore, caution must be used in making a decision to implement the H.M.O. or not. This study is primarily concerned

with constraints limiting the introduction of H.M.O. to Korea.

1) In the United States, prepaid group practice is essentially an urban phenomenon. Most of the groups are centered in the large cities. This comes from the fact that financing difficulties owing to rural poverty and population dispersion create obstacles to prepaid group practice plans in rural areas. However, small developing countries like Korea seem to be less likely to face population dispersion problems, but are more likely to encounter unbalanced distribution of medical manpower and facilities; doctors and hospital beds are simply not available in rural areas. Contrary to the finding in the United States, income differential is not remarkable between the urban and rural area. Most statistics, in fact, show that the income of rural household is more rapidly increasing than that of the urban in Korea. Therefore, it is obvious that any health resources shortage in rural area limitsan introduction or expansion of H.M.O..

2) Existing medical care utilization pattern is another constraint. It is generally agreed that more than 50% of the people use drugstores as their primary source of medical care, especially in their first contact. This phenomenon can culturally be understood as a heritage of the traditional utilization behavior of herbalists by Koreans. In a more realistic term, they may possess inadequate means to purchase physician care as an alternative to a drugstore visit. It may also be attributable to easy access to a drug-sto re at the corner of the street. Anyway, the primary concern is the present patient behavior which is not physician oriented, and this will interfere with the ability of the proposed health maintenance strategy to meet health care needs as was suggested by Dr. Paul Zukin, the vice-president of the Kaiser International.

3) The attitude of consumres toward H.M.O. should be considered. It is difficult to measure the degree of consumer satisfaction with respect to H.M.O.. Prepaid group practice seems to limit consumers' free choice of physician, and changes the traditional doctor-patient relationship which is significant in the treatment of illness in which emotional and social factors play an important role. The trend had been changing toward a break-down of doctor-patient relationship in the organized modern medical care. The author believes there appears to be less side effects from the modification of the doctor-patient relationship or in switching from the existing delivery system to another, because the tradition of family physician care has not been firmly established in the Korean society. In order words, people tend not to retain belief in the notion of the "family doctor". Consumer dissatisfaction, however, is more likely to originate from economic reasons. Service statistics show that approximately one third of premiums have not been collected in the private health insurance demonstration plans.

4) Acceptability of group practice prepayment to physicians is another crucial constraint. The ability to recruit and to retain an adequate number of well-qualified, suitably motivated physicians is a prerequisite to substantial growth of prepaid group practice. Although there has not been any organized medicine's opposition in Korea, we have not had sufficient experience in group practice.

The Council on Medical Service of the

American Medical Association has defined medical group practice as the delivery of medical services "by three or more physicians formally organized to provide medical care, consultation, diagnosis, and /or treatment through the joint use of equipment and personnel, and with the income from medical practice distributed in accordance with methods previously determined by members of the group". It has long been recognized that the practice of medicine through group practice-be it single specialty group or general practice group or multi-specialty group-is a more efficient method of providing care than that offered by an isolated solo practice. The simple idea of group practice has been experimented several times mostly in the urban areas, but few attempts have ever succeeded in making a prosperous group practice in Korea. It really is one thing to know the advantages and is quite another to implement them. To what extent the Korean physicians will participate in group practice is a difficult question to answer. The root of the problem is that Korean physicians have not been sufficiently trained to work with under the spirit of team work approach which calls for mutual cooperation and conscientious partnership as its imperative. This was well acknowledged among the professors of schools of medicine in charge of physicians training programs and some remedies have already been introduced by the revision of medical curricula. Thus, it is fair to say that the younger physicians, particularly those who are working as salaried employees, have more favorable attitudes toward group practice than the established older solo practitioners. It was reported last year that solo practitioners were no longer increasing in urban metropolitan area (Seoul) despite the increment of the number of physicians working in Seoul. One study indicated that the average annual income of physicians in medium-size cities was higher than that in metropolitan areas. As the income of solo practitioners is not increasing as much as they expect, more physicians are talking about group practice as an outlet to their common problem. In fact, their economically worse-off is one of the hottest issues and several group practices are under formation. In spite of these tendencies, it is too early to conclude that group practice is on the rise among all physicians in Korea. Obviously, the organizational patterns of H.M.O. will look like either hospital-based one or F.M.C. style if we fail to obtain sufficient number of physicians under group practice in near future.

5) H.M.O's are organizations which provide comprehensive health services on the assumption that the physicians who work for such programs can put more emphasis on keeping patients healthy and out of hospital through early diagnosis and treatment, and saving on costly inpatient care. These savings can then be transformed into more comprehensive ambulatory care benefits that are less expensive to provide. Therefore, prepaid health programs should have fewer limitations on the extent and duration of coverage for a particular patient or illness. Preexisting medical condions are rarely excluded, so that patients can enjoy more comprehensive medical benefits. In short, out-of-pocket expenditures at the point of service would be minimal or, at least, less in H.M.O. members than others.

Legal barriers sometimes operate as arti-

ficial and external constraints on H.M.O. development. According to the Implementation Decree 34 of the revised Health Insurance Law, it is stated that those employees needing ambulatory care can share up to 40% of their medical expense and their dependents up to 50%. In the case of inpatient care direct partial payment of the employees can't exceed 30% of total medical expenses and that of their dependents can't exceed 40%. The percentage amount of partial payment at the point of service actually differs plan by plan as it is designated in the articles of a health plan. This measure was adopted to prohibit members from abusing medical care utilization, and to protect the financial risk of a health plan at the initial stage of development. Because of this clause, industrial health plans as well as community health plans are prone to provide less comprehensive sort of care for the prevention of unexpected fiscal loss. In the process of the governmental authorization on a health plan, plan organizers are strongly advised to follow the above regulation. The author's study showed that the out-of-plan expenditures of the members of the Busan Blue Cross Medical Insurance Cooperative reached about 40%. Thus, the element of comprehensiveness in H.M.O. cannot but be modified in the Korean setting. Otherwise, the chance for H.M.O. implementation would remakably decrease. This comes from our knowledge that in Korea it is most difficult to raise the dues just enough to meet the comprehensiveness.

6) A more serious constraint derives from the implication of the current law that indirectly limits the size of a health plan. The law divides health plans into the two independent entities: industrial employees health plans, the first class, and self-employed health plans, the second class. All the industries with more than 500 workers are forced to organize the first class health insurance plan. Industries are encouraged either to make contracts with the existing medical facilities, or to establish their own medical facilities for the provision of medical care. Social institutions such as hospitals or clinics are encouraged to form community health plans primarily within the geographical jurisdiction of local administration. Therefore, most of the newly organized health plans seem to have less than 5,000 members.

The size of a health plan is extremely important in the sense that once in operation, a self-supporting plan must be sufficiently large to achieve economies of scale. It is estimated that minimum size necessary for economic survival ranges from 25,000 to 50,000 subscribers, and these figures are sufficient only to overcome operating deficits. Anyway, membership size is a crucial factor determining the success of a health plan. The current law functions as a constraint because it discourages the appearance of big H.M.O's.

7) Lastly, H.M.O's will face tremendous difficulties in obtaining sufficient capital to initiate and to expand their operations. In their organizational phase, the plans need funds for feasibility study, planning, and for initial outlays for building, equipment, and personnel, and for financial stability during the first several years of inevitable operating losses. It is not only capital that is deficient, but also personnel with expertise in the organ ization and management of H.M.O's to cope

with difficulties anticipated in the start-up period, and in the subsequent development. Therefore, unless some outside source of funds is available, and unless qualified administrators are found, a plan may be doomed to failure.

Notwithstanding the constraints above mentioned, there exists ample value in the establishment of H.M.O's if it is recalled the nature of the present health care delivery system in Korea and the present system's inability to cure its defects. There is substantial uncertainty about the best way to reorganize health services in general, and to develop some alternative delivery to the present fee-for-service system in particular. One thing is clear that the experience of the current health maintenance strategy in the United States can not be exactly replicable as it is. It is, however, true that those lessons from H.M.O. launching in the United States are illuminating some basic directions to the crisis of a typical traditional liberal medical care system such as ours by combining prepayment of a financing mechanism with a particular mode of delivery, group practice.

As I believe the future of unorganized fee-for-service solo practitioners is quite uncertain because of the difficulty in achieving cost efficiency, cost effectiveness, and income security, and the present system is not able to adequately meet the future demand of health care, I have to maintain the necessity of a H.M.O. experiment as an alternative. This experiment will deal with consumers' and medical care providers' acceptance of and willingness to participate in H.M.O's, and studies to assess the likelihood of success of specific forms of H.M.O's in various circumstances, and studies to identify the conditions under which an H.M.O. will be able to operate on a self-sustaining basis, and the like.

As a student of health service administration and a proponent of H.M.O., I hope that, in our country, the more organized and coordinated health care delivery system will solve the problem of cost, resource shortage and maldistribution, inaccessibility and quality issue.

## H.M.O.의 導入可能性에 關한 硏究

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識者들은 우리나라의 現行醫療制度를 改革해야 한다는 데 意見을 모으고 있다. 그러나 어느 部門을 어떻게 改革할 것인지에 대해서는 意見의 統一을 이루지 못하고 있다. 그도 그럴 수 밖에 없는 것이 醫療制度란 一朝一夕에 만들어지거나 改造되는 것이 아니며, 그동안 意見의 統一을 얻어 내기에 充分한 硏究가 뒷받침이 되어온 것도 아니기 때문이다. 醫療制度란 歷史的 傳統과 文化的 影響과 社會的 試鍊을 거쳐서 今日에 이른 過去로 부터의 遺産이다. 따라서 새로운 制度의 導入에는 各 利益集團의 利害關係가 複合的으로 얽혀있기 때문에 그 內容에 있어서 急進的인 改革보다는 漸進的인 補完이 現實的으로 說得力이 强하기 마련이다. H.M.O.의 導入은 後者보다는 前者에 屬하는 일이다. 왜냐하면 報酬支給方式에 있어서 診療行爲別 報酬制가 아닌 定額先拂人頭制의 導入과 單獨開業이 아닌 集團開業의 形成이란 旣存 醫療傳達體系에 對한 正面 挑戰이 아닐 수 없기 때문이다. 그러므로 現段階에서 H.M.O.는 醫療制度의 改革過程에서 小規模의 實驗的인 示範事業形態로 고려될 수 밖에 없음이 분명하다.

代案的 醫療體系로서 H.M.O.의 價値는 醫療資源의 合理的 利用과 H.M.O. 組織에 內在해 있는 醫療經濟性에의 構造的 誘引이 빚어내는 H.M.O.의 實績과 그 可能性에 있다. 醫療費의 급격한 昂騰은 國際的인 趨勢이고 가장 根源的인 問題이므로 이에 制動을 거는 作業에는 手段과 方法을 가리지 않고 새로운 模索과 硏究가 뒷받침 되어야 한다. 즉 可用 醫療資源의 稀少性때문에 H.M.O.가 보여준 費用의 經濟性은 追求되어야

하며 우리나라 實情에 맞도록 修正 補完되어야 할 것이다. 우리나라 醫療體系의 缺點을 補强시켜 줄 수 있는 代案的 醫療體系의 摸索에는 H. M. O.와 같은 새로운 接近方式을 實驗해볼 必要性이 있음에는 再論을 要하지 않는다. 왜냐하면 H. M. O.는 自他가 公認하는 經費節約型 醫療傳達體系의 하나이기 때문이다.

第4次 經濟開發 5個年 計劃에서 政府가 推進하고 있는 第1種 醫療保險事業의 擴大 實施로 1977年末까지 人口의 10%정도가 醫療保險의 受惠者가 될것이다. 또한 이미 實施하고 있는 醫療保護事業을 爲해서 政府는 96억원의 豫算을 確保해 두고 있다. 이처럼 國民들이낸 稅金과 保險加入者와 企業家들이 낸 保險料負擔으로 總國民保健醫療費가 급격히 增加되고 있다. 現在까지의 統計資料에 依하면 우리는 國民總生産의 2.8%를 保健醫療費로 使用했는데, 이상과 같은 莫大한 資金의 流入은 保健醫療費의 國民總生産에 對한 比率을 上昇시키고 同時에 醫療費 上昇을 加速化하는 要因으로 作用할 可能性이 짙다. 이와같은 狀況에 즈음하여 醫療費를 節減할 수 있는 代案의 探索이 더욱 절실해 졌다. 國民들이낸 稅金이나 保險料는 한푼이라도 浪費할 수 없는 性質의 것이며, 國民 1人當 保健醫療費는 좀 더 效果的으로 使用되어야 하겠기에 그러하다.

우리나라의 醫療制度는 非組織的 構成을 그 特徵으로 하고있다. 非組織的으로 孤立分散되어 있는 醫療機關은 그 規模에 있어서 小規模이고 相互間에 分業과 協業을 期待할 수 없는 형편이다.

H. M. O.는 大單位의 醫療의 生産, 分配 및 消費機構이다. 最小限 2萬名정도의 加入者들을 對象으로 하는 大規模의 醫療傳達體制이므로, 大規模의 組織이 갖는 規模의 經濟를 追求할 수 있을뿐더러 體系的인 醫療傳達과 豫防保健事業에 內實을 도모할 수 있다.

H. M. O.의 强點은 組織의 多樣性에서도 찾아볼 수 있다. H. M. O.는 醫療人, 病院, 消費者團體, 地方政府一般企業體, 商業保險會社, 또는 醫科大學 等에 各已目的에 따라 알맞게 組織할 수 있어서 效率的인 醫療傳達體系의 開發에 관한 多樣한 實驗을 계속할 수 있다. 특히 우리나라는 零細한 醫院中心의 診療體制에 依存하는 바가 크므로 單獨開業과 診療行爲別 報酬制를 維持保存할 수 있는 開業聯合型 H. M. O. (Foundation Style)의 開發이 開業街의 醫療人들에게 說得力이 클 수 있다. 實際로 一部 醫療人들이 新興都市나 中都市에서 集團開業을 構成하려는 傾向을 보이고 있는 것은 H. M. O.와 聯關시켜 볼때 좋은 조짐으로 볼 수 있다.

H. M. O.는 醫療의 質에 대한 評價機轉을 그 構成要因으로 갖출 것을 前提로 하고 있다. 따라서 우리나라의 醫療問題에 있어서 가장 關心 領域의 바깥에 놓여있는 醫療의 質에 대한 評價作業은 H. M. O.와 같은 組織的인 醫療傳達方式이 아니고서는 體系的인 接近이 어렵다. H. M. O.는 明確한 數의 加入者를 分母로하고 利用者에 대한 一體의 診療記錄이 한데 모아져 있어서 容易하게 利用할 수 있다. 뿐만아니라 同僚 醫療人들의 協力을 얻기가 쉬우며 相互 監視와 診療依賴에 의하여 醫療의 質을 向上시킬 수 있다. 앞으로 醫療需要의 增加에 따라 醫療事故와 紛爭이 比例해서 늘어날 것이 豫想되므로 保險醫療의 審議와 審査에 대한 專擔機關의 出現이 確實視 된다. H. M. O.의 醫療評價機轉은 自體診療水準의 向上을 爲한 內部調節裝置가 될것이다.

醫療資源의 分布異常을 是正하는데 H. M. O.가 어떤 도움을 줄 수 있을까 하는 것은 對答하기가 무척 어려운 質向이다. 現在 政府는 外國借款을 들여와서 우리나라의 不足한 病床을 建立하는데 使用할 計劃으로 있다. H. M. O.는 總 可用病床數의 制限과 病床利用率의 提高로 經濟性을 追求한다. 그러므로 H. M. O.와 같은 體系가 導入되면 病床의 效率的인 利用을 保障할 수 있음은 勿論이다. 病床이 모자라면서도 남아 돌아가는 道立病院의 現實은 反復하지 말아야 할 前轍이다.

그러나 H. M. O.를 導入하는 데는 많은 制約要因이 따른다.

旣存 自營者 醫療保險組合은 保險料 徵收에 問題가 있어서 定額先拂制度의 導入에 暗影을 드리우고 있고, 集團開業의 普遍化 역시 平坦치 않으리라는 것은 쉬 짐작할 수 있다. 現在와 같은 醫療消費者들의 意識水準으로서는 H. M. O.의 必要性을 認知하는 데 오랜 時間을 所要할 것이고, 새로운 醫療傳達方式에 關한 啓蒙과 敎育이 없이는 H. M. O.類에 대한 强制加入은 抵抗意識만을 심을 것이다. 한편 「팀웍」을 이루어 함께 일하는 訓練은덜 되어 있지만, 새로운 醫療傳達方式에 魅力을 느끼는 醫療人들이 增加하고 있다는 證據는 到處에서 찾아볼 수 있어서 多幸스럽다. 療機醫關의 大型化現象, 集團開業의 出現, 定額俸給生活을 바라는 젊은 醫療人의 增加 및 醫療保險事業에의 積極參與 等은 大都市 醫院經營을 拋棄하고 中小都市로 分散하는 傾向과 아울러 醫療業과 周圍環境與件이 同時에 急變하고 있음을 보여 주는 實例가 된다. 그러나 이러한 狀況에 促進劑가 되어줄 施設融資金과 稅制上의 惠澤은 아직 찾아 볼 길이 없으며 未來의 醫療制度에 對한 靑寫眞은 提示되어 있지 않다. 더구나 開業醫들의 定額先拂 集團開業에 대한 認識은 극히 稀薄해서 새로운 醫療傳達制度에 대한 啓蒙敎育부터 해야할 實情이다.

H. M. O. 開發에 所要될 財源이 모자란다는 것과 H. M. O. 를 運營하는데 必要한 管理情報나 管理人이 모자란다는 것은 너무도 明確하다. 그러나 이러한 것 이외에도 現行 醫療保險事業의 높은 一部 負擔金의 壁은 H. M. O. 에서 意圖하는 包括的 醫療에의 길이 遼遠함을 意味한다. 따라서 H. M. O. 는 그 最上의 形態로 導入이 되어도 韓國的 風土속에서 상당히 修飾 變質될 수 밖에 없음을 알 수 있다. 特히 現行 醫療保險制度는 大型 H. M. O. 의 出現을 抑制하는 要因들이 많아서 더욱 그러하다.

定額先拂이라는 財源調達 手段과 集團開業(또는 聯合開業)이라는 醫療傳達機轉을 結合한 H. M. O. 의 理念은 너무도 嶄新하다. 一般消費者의 積極的인 參與와 權益을 最大로 保障할 수 있으며, 醫療人들로 하여금 費用을 意識하게하는 經濟的 誘引이 作用하는 制度는 醫療經濟上의 革新으로 볼 수 있다. 그러나 이러한 革新이 갖는 無限한 可能性은 H. M. O. 導入에 따른 現實의 制約要因앞에서 衝突을 避할 길이 없다. 경우에 따라서는 그 可能性의 많은 部分이 끝내 可能性으로만 끝나고 말 수도 있다.

經濟社會開發에 熱을 더해 가고 있는 開發途上國인 우리나라에 H. M. O. 를 導入하는 것이 可能할 것인가? H. M. O. 導入에 관한 科學的인 現地妥當性調査를 해보기 前에 이런 課題에 대하여 言及하는 것은 時機尙早일 수 있다. 그러나 現 段階에서의 本硏究者의 對答은 조심스런 肯定이다. 그것은 韓國社會의 發展이 前述한 制約要因들을 하나하나 除去해 나갈 것이고, 우리나라 醫療制度가 지닌 難題들이 그 深刻性을 더해 갈수록 H. M. O. 가 지닌 可能性은 빛을 더해 갈 것이라는 믿음 때문이다.