Globalization and Health Care

HOW THE UNITED STATES EXPORTS MANAGED CARE TO DEVELOPING COUNTRIES

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As their expansion slows in the United States, managed care organizations will continue to enter new markets abroad. Investors view the opening of managed care in Latin America as a lucrative business opportunity. As public-sector services and social security funds are cut back, privatized, and reorganized under managed care, with the support of international lending agencies such as the World Bank, the effects of these reforms on access to preventive and curative services will hold great importance throughout the developing world. Many groups in Latin America are working on alternative projects that defend health as a public good, and similar movements have begun in Africa and Asia. Increasingly, this organizing is being recognized not only as part of a class struggle but also as part of a struggle against economic imperialism—which has now taken on the new appearance of rescuing less developed countries from rising health care costs and inefficient bureaucracies through the imposition of neoliberal managed-care solutions exported from the United States.

In December 1999, Archbishop Desmond Tutu, Nobel Peace Prize winner from South Africa, gave the keynote address for an important conference in Miami Beach: the International Summit of Managed Care. The price for attending this conference, excluding travel, room, and meals, was $1,395. The conference was sponsored by the American Association of Health Plans and the Academy for International Health Studies, and was targeted at "chief executive officers, presidents, board chairs, chief financial officers, directors of marketing, and business development officers." In addition to Tutu, ostensibly progressive participants at the meeting included former Congressman Ron Dellums, whose legislative

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efforts for a U.S. national health service have inspired health activists since the mid-1970s. Dellums took part in his new role as president of Healthcare International Management.

Although it received far less attention than the World Trade Organization (WTO) events one week earlier, the Miami Beach Summit manifested the same trends toward economic globalization to which protesters objected in Seattle. The World Bank, International Monetary Fund (IMF), and U.S. Agency for International Development (USAID) used the Summit to promote an expanded role for multinational corporations in health care throughout the world. Representatives of these multilateral lending agencies emphasized the privatization of public health systems and social security funds in Latin America, Africa, and Asia. Participants from the World Health Organization (WHO) and the Pan American Health Organization (PAHO) played prominent roles. Also participating were officials from Mexico, Brazil, Argentina, Chile, Colombia, Uruguay, Paraguay, India, Nepal, Thailand, Indonesia, the Philippines, Singapore, Nigeria, Zimbabwe, South Africa, Cameroon, Oman, United Arab Emirates, Romania, Canada, Germany, the Netherlands, Switzerland, and Australia. Little dissent was expressed about policies that call for public-sector cutbacks, privatization, and greatly expanded activities for multinational managed care organizations (MCOs) throughout the developing world.

SOME BACKGROUND

Managed care can be defined as health care services under the administrative control of large, private organizations, with "capitated" financing (which means that an employer—private or public—or a public agency prepays the MCO a negotiated sum of money per covered person per unit of time, typically a month). Copayments are made by the insured persons. Most insured persons in the United States are now covered by an MCO.

As proprietary managed plans grow in the United States, the rate of profit predictably begins to fall as the market becomes increasingly saturated. As this process occurs, corporations must develop strategies to increase their profits. These strategies might include raising the productivity of labor, diversifying into new product lines, and searching for new markets. As the president of the Academy for International Health Studies noted in 1996, "By the year 2000, it is estimated [that] 80% of the total U.S. population will be insured by some sort of MCO. Since 70% of all American MCOs are for-profit enterprises, new markets are needed to sustain growth and return on investment" (1). In the United States, for example, for-profit MCOs have entered the public-sector programs of Medicare and Medicaid. In some

geographic areas, these organizations have dismantled their programs after three or four years, having made extensive short-term profits from capitated patients—that is, those for whom the payer has made per-person, per-time-period payments to the MCO. Having received the money, the MCO can reap large profits by keeping costs (such as services to patients) as low as possible. This rapid entry into and exit from public markets has left patients and their public insurance programs vulnerable and needing to scramble for new, publicly funded alternatives.

Now, however, the emphasis is on the search for foreign markets. During the 1ate 1980s and early 1990s, Europe looked like a good bet. Reforms in several European national health programs also introduced principles of managed care, market competition, and the privatization of public services. These reforms received the strong support of the Thatcher government in Britain, as well as varying degrees of enthusiasm from conservative parties in other countries. Alain Enthoven and his disciples, who orchestrated the managed-care proposals that shaped the Clinton administration's ill-fated efforts for a national health program, served as consultants for European governments undertaking these reforms. However, the popularity and successes of public-sector programs in Europe proved to be powerful disincentives to privatization. Since the mid-1990s, European countries such as the United Kingdom, the Netherlands, and Sweden have reversed many policies that attempted to privatize their national health programs. In addition, managed care has become increasingly unpopular in the United States.

With managed-care saturation taking place domestically and with limited prospects in Europe, the managed-care corporations have turned their eyes toward developing countries, especially those in Latin America. In the tradition of tobacco and pesticides, U.S. corporations are exporting to developing countries—in the form of managed care—products and practices that have come under heavy criticism domestically. The exportation of managed care is also receiving enthusiastic support from the World Bank, other multilateral lending agencies, and multinational corporations. On the receiving end, developing countries are experiencing strong pressure to accept managed care as the organizational framework for privatization of their health and social security systems. Already, U.S. MCOs and investment funds have rapidly entered the Latin American market, and this experience is serving as a model for the exportation of managed care to Africa and Asia.

In 1995, we initiated a study of managed care in Latin America, its exportation from the United States, and its varying impact on health care delivery and public health services. The research focused on the exportation of managed care by investor-owned, for-profit corporations that pass on financial risk to physicians, hospitals, and clinics, as opposed to those that simply sell commercial indemnity

insurance.[1] Our results show that the health care and social security funds of developing countries have become a major source of new capital and high rates of profit for these corporations, especially through the investment of prepaid capitation payments. We found that the rhetoric for the policy changes that are occurring throughout the developing world emphasizes the ideology of the private market as a route to more efficient and accessible services (a rhetoric which, by the way, can—along with the sizable honoraria and consulting fees—become quite seductive for progressive leaders like Tutu and Dellums). However, the evidence that such market reforms actually improve problems of inefficiency, costs, and access is slim indeed within the United States and virtually nonexistent elsewhere. That the rhetoric gains acceptance so easily by leaders in developing countries portends tragedy. As public systems are dismantled and privatized under the auspices of managed care, multinational corporations predictably will enter the field, reap vast profits, and exit within several years. Then developing countries will face the awesome prospect of reconstructing their public systems.

MANAGED CARE AS A SILENT REFORM

Managed-care reform generally focuses on health care costs as a crisis. To enable those entities that pay for health care to cut costs, the reform calls for an intermediary between providers and users, to separate financial administration from the delivery of services. Proposals for managed care imply the introduction of enterprises (state, private, or mixed) that administer financing under the concept of shared risk and that contract with managers for the inclusion of state-supported services.

In the widely debated 1993 World Development Report, entitled *Invest in Health,* the World Bank argued that inefficiencies of public-sector programs hindered the delivery of services as well as the reduction of poverty (3). This report advocated incentives for private insurance, privatization of public services, promotion of market competition, and emphasis on primary care and prevention. Through this document and subsequent policies, according to Latin American critics, the World Bank has promulgated an ideology that "health is a private matter and health care a private good" (4).[2]

[1] The institutions and investigators participating in the WHO-sponsored study of managed care in Latin America were the University of Buenos Aires, Argentina (Celia Iriart, Silvia Faraone, Marcela Quiroga, Francisco Leone); the University of Campinas, Brazil (Emerson Elias Merhy, Florianita Coelho Braga Campos); the Group for Research and Teaching in Social Medicine (Grupo de Investigación y Capacitación en Medicina Social), Santiago, Chile (Alfredo Estrada, Enrique Barilari, Silvia Riquelme, Jaime Sepúlveda, Marilú Soto, Carlos Montoya); the Center for Research and Consultation in Health (Centro de Estudios y Asesoría en Salud), Quito, Ecuador (Arturo Campaña, Jaime Breilh, Marcos Maldonado, Francisco Hidalgo); and the University of New Mexico (Howard Waitzkin, Karen Stocker). The study's overall coordinators were Celia Iriart and Howard Waitzkin. For an earlier report on this work, see 2. The U.S.-based research was also supported in part by the Agency for Health Care Policy and Research (1R01 HS09703).

[2] For a critique of World Bank policies in the context of India, see 5; for Africa, see 6.

Specifically, the World Bank has supported managed-care initiatives that convert public health care institutions and social security funds to private management or ownership, or both. These initiatives entail new loans and thus increased foreign debt for participating countries. Access to capital held by public-sector social security funds has become an important incentive for investment by multinational corporations.

The pronouncements of the World Bank on the public sector in general and publicly supported health care in particular must be seen in the light of the financial crisis faced by most Latin American governments in the 1990s, and the desire by global corporations to convert this crisis into money-making opportunities. As these governments turned to agencies such as the World Bank for loans to alleviate the crisis, they were pressured to accept certain conditions. These conditions implied increased debt, the opening of national economies to multinational finance capital, and the restructuring of the state via privatization and decreased public expenditures. Access to new loans requires acquiescence to such plans for "structural adjustment." In the health care environment, structural adjustment implies the acceptance by Latin American governments of the reform projects initiated by these lending agencies, especially the World Bank. By consenting to the requirements of structural adjustment, the governments gain access to loans but also must agree to carry out major cutbacks in public services.

Such reforms facilitate a new discourse, linked to the crisis of the welfare state. Gradually, "common sense" is transformed, as it concerns the conceptualization of health, illness, and health care services. In the official pronouncements we have studied, health care no longer remains a universal right whose fulfillment is the state's responsibility, but becomes a good of the marketplace. This kind of thinking makes it easier for politicians to implement health care "reform."

In the construction of the public-sector budget, new policies respond to demand rather than supply of services. In other words, health care will be available only as demanded. Theoretically, this approach allows a reduction of fixed costs and a more efficient management of resources, since excess services are controlled and financing is directed toward providers of presumably higher quality. According to this logic, to obtain financing, providers are forced to lower their costs and to offer higher quality services. Discourses supporting these policies emphasize the assumption (following a consumer sovereignty model) that, if purchasers feel in control of their contribution or payment for the service, they will comprise a natural regulator of costs and quality, since purchasers choose providers that offer the best services at the least cost.

Managed-care reforms usually produce fundamental changes in clinical practice. These changes involve the subordination of health professionals to an administrative-financial logic. The same reform proposals aim for drastic reduction of independent professional practice, since professionals have to offer their services to insurance companies or the proprietors of large medical centers.

The political process that accompanies these reforms is usually a silent one, restricted to the executive branch of government. This process generally segments the policy-making process and therefore reduces political conflict. The desire to achieve silent policy-making was expressed as an explicit decision by such informants as an official of the World Bank's delegation in Argentina and a high official of the Ministry of Health and Social Action of that country. Reform policies are directed sequentially toward the public sector, the private sector, or the social security system, but they do not adopt a unified approach to the health care system as a whole. In general, policy implementation bypasses discussion in the legislative branch.

At each stage of this silent political process, the actors involved are only those who participate in each subsector (public, private, or medical social security); this approach hinders a societal perspective on reform. Within each subsector, participants try to accommodate the reform processes, without recognizing the impact on other subsectors. Nevertheless, the current reform processes actually achieve a profound articulation of the three subsectors (not achieved previously in most Latin American countries, despite a long-expressed need for this articulation), but under the command of private interests and especially of multinational finance capital.

ECONOMIC MOTIVATION FOR EXPORTING MANAGED CARE

Executives of corporations entering the Latin American managed-care market report substantial rates of profit relative to investment, predict strong profit margins in the next several years, and expect high rates of return for investors. Officials responsible for the exportation of managed care emphasize its positive financial implications and rarely refer to preventive care or quality control, which historically have been valued by some health maintenance organizations (HMOs) in the United States. Support for education and research, also valued by some HMOs, has not emerged as an explicit goal.

In explaining their financial motivations for entering the Latin American marketplace, managed-care executives consistently refer to the importance of access to the social security funds within these countries. In contrast to the United States, most Latin American countries have organized social security systems that include health care benefits as well as retirement benefits for many employed workers in large private or public enterprises. Employers and workers contribute to these social security funds. For workers who are not covered by social security, and for unemployed people, most Latin American countries also have established public-sector health care institutions, including public hospitals and clinics.

Throughout Latin America, the social security systems have become very large funds, which are managed by government or publicly regulated agencies. North American executives see these Latin American social security funds as a major

new source of finance capital. For instance, a managed-care executive—whom the EXXEL Group, a multinational corporation based in Argentina, recruited from Indianapolis—has noted: "It's a very lucrative market. . . . The real opportunity here for an investor-owned company is to develop tools in the *prepagas* [prepaid] market in anticipation of the *obras sociales* [social security] market" (7).

Privatization of government health programs and social security systems has permitted major capital expansion for MCOs and investment funds. Public-sector programs in such countries as Colombia and Argentina previously have suffered from inefficiency, escalating costs, and corruption. Arguments supporting privatization that cite such problems have resembled those favoring managed care within the U.S. Medicare and Medicaid programs. As an example, the Chilean constitution of 1980, initiated by the Pinochet dictatorship, permitted the diversion of government health care and social security funds to privatized managed-care institutions (Instituciones de Salud Previsional, ISAPREs), which then could be bought by multinational insurance companies. Access to privatized social security funds—recently termed "the mañana pension bonanza" in a trade journal—creates multibillion-dollar capital pools available for reinvestment by participating corporations (8).

Economic globalization also has facilitated multinational investment in managed care. Previous trade barriers have fallen, through such treaties as the General Agreement on Tariffs and Trade (GATT), the North American Free Trade Agreement (NAFTA), and the Common Market of the South (MERCOSUR), covering the southern cone of South America. The global operations of multinational corporations have led them to seek managed-care benefits for employees based abroad. For example, corporations with Mexico City operations, including IBM, Johnson & Johnson, Bristol-Myers Squibb, and Hewlett-Packard, have formed a consortium to enhance managed-care efforts (9).

IMPACT ON HEALTH CARE AND PUBLIC HEALTH PROGRAMS

As in the United States, concerns about managed care in Latin America have focused on restricted access for vulnerable groups and reduced spending for clinical services as opposed to administration and return to investors. Copayments required under managed-care plans have introduced barriers to access and have increased strain on public hospitals and clinics. In Chile, approximately 24 percent of patients covered by ISAPRE MCOs receive services annually in public clinics and hospitals because they cannot afford copayments averaging 8.6 percent of ISAPREs' overall collections. Self-management (*auto-gestión*) in Argentinian and Brazilian public hospitals requires competition for capitation payments from social security funds and private insurance, as well as patient copayments. To apply for free care at these public institutions, indigent patients now must undergo

lengthy means-testing; at some hospitals, the rejection rate for such applications averages between 30 and 40 percent.

Public hospitals in Argentina that have not yet converted to managed-care principles are facing an influx of patients covered by privatized social security funds. For instance, in 1997, public hospitals in the city of Buenos Aires reported approximately 1.25 million outpatient visits by patients who were covered by the privately administered social security fund for retired persons. Before turning to public hospitals, these elderly patients had encountered barriers to access due to copayments, private practitioners' refusal to see them because of nonpayment by the social security fund, and bureaucratic confusion in the assignment of providers.

Latin American MCOs have also attracted healthier patients, while sicker patients gravitate to the public sector. In Chile, ISAPREs have aimed to capture capitations for younger workers without chronic medical conditions. As a result, only 3.2 percent of patients covered by ISAPREs are over 60 years old, in comparison to 8.9 percent of the general population and 12 percent of the patients seen at public hospitals and clinics.

RESISTANCE TO MANAGED CARE AND ALTERNATIVE PROPOSALS

The exportation of managed care is encountering opposition, which varies among countries. In Ecuador, a coalition comprised of unions, professional associations, educators, and Native American organizations is resisting the introduction of private managed-care operations within public services. During 1995, this coalition organized voters in preparation for a national plebiscite that elicited the population's preferences concerning the privatization of eleven sectors of the economy, including health care, petroleum, transportation, and public utilities. For all eleven propositions in the plebiscite, approximately two-thirds of Ecuadorian voters opposed privatization. Since the plebiscite, the coalition has continued to work actively to resist privatization and has organized educational sessions concerning managed care as a component of initiatives to privatize health care and public health services.

In Brazil, physicians and public health activists have resisted the introduction of managed care. For instance, activists affiliated with the Brazilian national Workers Party (Partido dos Trabalhadores) have opposed privatization of public services under MCOs. Government officials representing this party, elected in Brasilia, Santos, Rio de Janeiro, and other cities, have worked to oppose privatization policies and to implement alternative proposals that strengthen public services at the municipal level. Members of the Workers Party and other political activists have emphasized that the revised Brazilian constitution of 1988 specifies access to health care as a right of citizenship, to be provided through a "unified health service." Organizing in the national and state legislatures has

called attention to the contradiction between the constitution's mandates and privatization policies that encourage the introduction of managed care under for-profit corporations. In addition, large organizations of physicians have challenged managed-care principles and have worked together to enhance their power to bargain collectively with MCOs. One example involves UNIMED, an organization of health professionals which has established itself as an economic "cooperative" whose members include thousands of physician practitioners. UNIMED has succeeded in limiting the control of large MCOs over the conditions of medical practice and also has tried to oppose some of the initiatives that would privatize public-sector services under the auspices of managed care.

Managed care organizations have encountered less organized resistance in other countries like Argentina, Chile, and Colombia, where prior dictatorships or authoritarian governments have facilitated the privatization of public services. On the other hand, professional associations and unions have organized campaigns against the entry of MCOs into public systems. In Chile, the national medical association (Colegio Médico) has resisted the expansion of the ISAPREs through the use of the public national health fund (Fondo Nacional de Salud, FONASA). In Argentina, health professionals have collaborated with a national organization of labor unions (Central de Trabajadores Argentinos, CTA) in educational efforts to encourage debate concerning privatization and managed care. As a result of these efforts, an intense social movement in the Argentine province of Córdoba has impeded the privatization of public health and social security services. An international coalition of unions representing public-sector workers, Public Services International, also has helped organize opposition to managed care in several countries.

THE POLITICAL RECONSTRUCTION OF COMMON SENSE

As their expansion slows in the United States, MCOs predictably will continue to enter new markets abroad. Investors view the opening of managed care in Latin America as a lucrative business opportunity. As public-sector services and social security funds are cut back, privatized, and reorganized under managed care, with the support of international lending agencies, the effects of these reforms on access to preventive and curative services will hold great importance throughout the developing world.

Ideologically, there is an attempt to forge a new "common sense" which will become a socially shared truth. Many of those referred to as experts in the health care environment contribute to the construction of this new common sense by promoting the following eleven fundamentals from which to rethink the system:

1. the crisis in health stems from financial causes;
2. management introduces a new and indispensable administrative rationality to resolve the crisis;

3. clinical decisions should be subordinated to this new rationality if cost control is desired;
4. efficiency increases if financing is separated from service delivery, and if competition is generalized among all subsectors (state, social security, and private);
5. the market in health should be developed because it is the best regulator of quality and costs;
6. demand rather than supply should be subsidized;
7. making labor relationships flexible is the best mechanism to achieve efficiency, productivity, and quality;
8. private administration is more efficient and less corrupt than public administration;
9. payments for social security are each worker's property;
10. deregulation of social security allows the user freedom of choice, to be able to opt for the best administrator of his or her funds;
11. the transition of the user/patient/beneficiary to client/consumer assures that rights are respected.

These ideological claims represent a profound reconstruction of common sense. Diagnoses that speak of inefficiency in the management of state institutions and social security, of shortages in resources that restrict access, of excessive bureaucratization, of limited capacity to respond to the population's demands, of escalating costs—all become self-evident truths increasingly shared by users and health care workers as part of their lived experiences. They are then turned into justifications for reform proposals. This makes possible the transformation of common sense concerning the processes of health, illness, and services—little by little, making the commercialization of all the relationships established in these processes appear natural. Assumptions that were sustained during many years, especially for public health advocates, and that conveyed the idea that health was a state responsibility and a public good, have given way to the "complex" discourses of privatization, economic restructuring, and fiscal conservatism. Would-be progressives often come to accept these discourses even while trying to distance themselves from the neoliberal project.

Against these discourses, it is important to show that such interpretations do not constitute truth, but rather the imposition of views defined by financial interests. Reform, as sought by official discourses, is not the only option, nor the best, from the perspective of a population's health. Many groups are working on alternative projects which defend health as a public good. These movements are stronger in some Latin American countries than in others. Similar movements have begun in Africa and Asia. Increasingly, this struggle is being recognized not only as a class struggle, but also as a part of the struggle against imperialism—which has now taken on the new guise of rescuing developing countries from rising health care costs and inefficient bureaucracies through the imposition of neoliberal

managed-care solutions exported from the United States. In this realm, as in many others, the need for international solidarity among those resisting the logic of the global system is paramount.

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