Healthcare and Multinational Corporations in the United States and Latin America

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Globalization raises several problems regarding healthcare and public health. Influenced by public policy makers in the United States, such organizations as the World Bank, International Monetary Fund (IMF) and World Trade Organization (WTO) have advocated policies that encourage reduction and privatization of healthcare and public health services previously provided in the public sector.[1-5] International financial institutions and multinational corporations have influenced reforms that, while favorable to corporate interests, have worsened access to needed services and have strained the remaining public sector institutions.

Here we present evidence that multinational corporations, based in the United States and focusing on healthcare, have expanded worldwide, especially in Latin America. Managed care organizations (MCOs), healthcare consulting firms, and pharmaceutical and medical equipment companies have

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entered foreign markets. As MCOs have faced declining rates of profit in US markets, they have entered foreign markets in Latin America and world wide, usually seeking access to public social security funds designated for healthcare and retirement benefits.[2] At the same time, large healthcare corporations have abandoned numbers of unprofitable patients in the United States. Health policy reforms in Latin American and other less developed countries, supported by international financial institutions, have facilitated corporations' entry into these markets. Such strategies have culminated in a marked expansion of corporations' access to social security and related public sector funds for the support of privatized health services. Later, as profitability in Latin American has decreased, the same corporations have begun to abandon those markets . We focus especially on two corporations, Aetna and CIGNA, for two reasons: they are major MCOs in the United States, and they have maintained large presences in markets abroad until recently, Aetna having sold its international operations in 2000.

Methods

We reviewed the research and archival literature, published and unpublished, with the purpose of tracing the actions and strategies of multinational corporations in the United States and in the Latin American healthcare market. The search included professional journals, business journals, newspapers and magazines, and corporate records in the public sphere, such as filings with the US Security and Exchange Commission (SEC). Although we focused primarily on multinational corporations such as Aetna and CIGNA, we also investigated documents and reports that could shed light on the role of international financial institutions such as the IMF

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and the World Bank in facilitating the penetration of Latin American markets by multinational corporations. Two of us (RJ-A, HW) conducted research in Mexico during January through March 2003, while another (AL) carried out research in Brazil during 2002-2003, including structured interviews with health professionals, to investigate specific practices of corporations and respondents' perceptions of these practices.

The Rise and Fall of Managed Care Profitability in the United States

For this work, we have operationally defined managed care as healthcare services under the administrative control of large private organizations with prepaid and capitated financing. In general, managed care seeks to separate financial administration from the delivery of services, and requires an intermediary (a state, private, or mixed entity) between providers and users. This intermediary administers financing under the concept of shared risk (with each insured person paying the same fee, the so-called 'capitation.')[2] Through managed care, insurance companies hoped to control the rapidly increasing healthcare costs generated by traditional payments practices such as fee-for-service. By the late 1980s, managed care was favored in US health policy decisions. Insurers formed their own MCOs in an effort to respond to employers' demands for a choice of benefit plans.[6-7]

The MCOs initially reaped major earnings by paying hospitals a fixed capitation for each patient at a low negotiated rate.8 However, the rate of profit fell as the market became increasingly saturated.1 By 1996 private health insurance premiums were rising at a much lower rate than MCO costs. The managed care industry struggled with higher medical costs, insufficient premiums, heavier than expected Medicare costs, and an increasingly competitive market.[9-14]

Despite MCO strategies to enhance their bargaining position, for example through large mergers, the managed care industry's problems persisted. The organizations failed to bridge the tensions between cost control and patient choice, the same issue that had contributed to the failure of President Bill Clinton's proposed national health plan in 1994. At that time, private sector advocates argued that they could do a better job than a government-dominated plan in holding down costs by steering patients to cost-effective doctors and hospitals, thereby curbing wasteful expenditures. But by 1998, health plans began to raise premiums several points above the 2.5 percent inflation rate, citing an inability to control medical costs as much as predicted. This increase proved dramatic when compared to the premium increases of 1 percent or less offered in the mid-1990s.[14]

The main government healthcare funding programs, Medicare and Medicaid, also proved less lucrative than industry officials had anticipated. The initial profits from Medicare had been large because federal payments for Medicare MCO members had risen as much as 10.5 percent per year. But in 1997 Congress limited future years' premium increases to just 2 percent. Concern grew about MCOs' ability to manage costs within these stipulated premium increases. In the Medicaid market, many states ratcheted down

their payments to MCOs.[14]

Changes in the value of company stocks reflected the financial difficulties of the managed care industry. From 1990 to 1995, MCO stocks surged an average of 33 percent a year, far ahead of the overall market. By 1997, worsening stock market values – including those of large MCOs – disappointed analysts and investors.14 This weaker position in the stock market would persist for the next several years, only beginning to showsigns of recovery in early 2004.[15]

US MCOs' International Expansion and Exit from US Markets

Two major MCOs, Aetna and CIGNA, greatly expanded in Medicare and commercial markets in the United States during the mid- and late 1990s. However, since this expansion took place despite a falling rate of profit overall, it is not surprising that eventually Aetna and CIGNA began to leave these markets.

According to its 2000 Securities and Exchange Commission (SEC) report (p. 6),16 Aetna exited certain unprofitable Medicare markets during 1999, yet the membership by the end of the year was larger than the previous year's. This net increase indicates that the company dropped members in unprofitable markets and acquired new members in more profitable areas. Subsequently, Aetna continued to exit from unprofitable Medicare as well as commercial markets, a fact reflected in declining membership. For CIGNA, increases in both commercial membership and Medicare for the period 1994-1998 contrasted with a decline in Medicare and Medicaid membership thereafter.

MCOs exited from managed care programs in multiple geographical regions. The American Association of Health Plans (AAHP) estimated that at least 711,000 Medicare beneficiaries would be affected starting 1 January 2001. According to these estimates, Aetna's pull out affected 355,000 members in eleven states, while CIGNA's pull out affected 104,000 members in thirteen states.[17-18] By the end of 2001, Aetna's exit from numerous Medicare markets affected an additional 105,000 members – a number equivalent to 38 percent of its Medicare membership. Several other companies, including PacifiCare Health Systems and Health Net, also were exiting selected Medicare plans across the country, leaving approximately 500,000 subscribers to seek new medical coverage.19 According to Lankarge (2001)20, the total number of beneficiaries who lost their plans during 1999-2001 rose to more than 1.7 million.

MCO withdrawals from Medicaid markets also occurred in multiple states, including both urban and rural areas. MCOs dropped about 1.2 million enrolees during 1997-99. Dropped subscribers faced the burden of selecting a new health plan and discontinuity of care if required to change providers.[21]

Managed care has remained a troubled industry. According to an administrator at the Healthcare Financing Administration (HCFA, currently the Centers for Medicare and Medicaid Services or CMS), private-sector Medicare MCOs received more than enough federal payments to provide the basic Medicare benefits. However, the formula set by law did not always pay enough to cover the extra benefits provided and to produce profits. MCOs also complained that the Balanced Budget Act

of 1997 capped reimbursement increases at 2 percent annually, a rate which did not keep pace with rising medical costs.[22] MCOs like Aetna tried to address their high costs by increasing premiums when renewing contracts and by evaluating markets and products with the intention of exiting when financial or strategic purposes were not met.

As MCOs faced declining rates of profit in US markets, they entered foreign markets, seeking access to public social security funds designated for healthcare and retirement benefits.[23] Aetna's rapid expansion into foreign markets, notably Latin America, occurred during the period 1996-1999. In 1997 CIGNA expanded into Brazil, a market that other US companies such as American International Group and Liberty Mutual Fund Group had just entered. The timing of these expansions coincided with ongoing or imminent reforms to privatize health services and pensions in the targeted countries. Aetna highlighted these reforms as important steps in the company's strategy to expand in emerging markets.[24-31]

Corporations and International Healthcare Markets

Corporate Expansion into International Markets

As the US domestic market became more contentious and less attractive, a transition from national to multinational managed care emerged. Multinational corporations, including pharmaceutical companies, long-term care corporations and MCOs, turned to the international service sector as an alternate source of profits.[32] US-based corporations exported managed care as the main organizational format, rather than other forms of commercial insurance, because managed care had become the dominant form of healthcare organization in the United States and had emerged as the most profitable framework for commercial organizations to provide health insurance.

The Latin American healthcare market presented very lucrative opportunities at the time.[33-35] Still untouched by the privatization wave that had swept the region in the previous years, the healthcare sector was about to undergo reforms that would open the door to private capital.[33] After implementation of reforms, favorable economic conditions under this scenario would fuel a long-term boom for investors. By 1999, Latin America had become ripe for US companies' investments and operations.[8]

Corporate Strategies in International Expansion

One strategy followed by corporations to export managed care is investment in joint ventures with local companies. The joint ventures provide an already established clientele and help corporations circumvent national laws that restrict foreign ownership. These arrangements include some degree of financing from social security funds and the private management or ownership of previously public programs.[23,36]

Between 1996 and 2000, Aetna entered into joint ventures with domestic companies in Mexico, Brazil, Venezuela, Argentina, and Colombia. The strategy encompassed not only expanding into but also exiting from certain international markets – such as Canada and some European countries – that had

become inconsistent with the company's focus on the high growth potential of the world's emerging markets.[27, 30] Aetna's SEC reports often emphasized the company's intentions to invest in emerging and other selected markets outside the US that showed the potential for favorable long-term returns.

The main international operations of CIGNA have focused on Japan, although beginning in the late 1990s it began expanding operations in Latin America and several Asian countries. In 1997 and 1998, CIGNA invested in Brazilian healthcare operations, which included the acquisition of an MCO serving approximately 337,000 members. CIGNA made several acquisitions in Chile and Mexico and established offices in selected emerging markets, notably China and India.[37]

A second corporate strategy to export managed care is a "trade show" approach. Corporations organize conventions or presentations at professional meetings to build interest in managed care principles.23 Attendees at such meetings have included Latin American healthcare leaders who have received financial assistance from corporations, the World Bank, or both. The World Bank and IMF have required reforms favoring the privatization of health services in developing countries that have benefited US and European corporations.[38-40, 36, 2, 23, 8] International organizations like PAHO and WHO also have favored these programs and reforms.[39]

A third strategy for corporations to expand in international markets involves the use of their own governments to influence international trade organizations such as WTO. Governments exert this influence by setting agendas at meetings of trade organizations and ensuring commitments from other countries that benefit corporations, usually based in the United States and Europe. The US and European governments exert disproportionately influence on WTO policies that advance their own economic agendas, as compared with the governments of smaller or less developed countries.[40-42]

Under the General Agreement in Trade and Services (GATS), for instance, the United States and European Union have proposed that country members of the WTO grant greater market access in financial services, by eliminating or lowering restrictions on investments by foreign companies. These proposals run counter to national legislation needed to prevent"cherry-picking," which involves corporate decisions to provide services to young, healthy, and financially advantaged segments of the population while excluding older people, sick people, and the poor.[42]

US Corporate Withdrawal From International Markets

By 1999 Aetna was experiencing problems of corporate instability and declining stock value. Although SEC reports showed international operations to be profitable, Aetna began selling its joint ventures. In December 2000 the company sold Aetna International and Global Financial Services to Amsterdam-based ING Group NV. Aetna's officers emphasized that the sale aimed at consolidating the corporation's activities in the US healthcare market, which had become relatively inefficient and unprofitable, and at enhancing stockholders' confidence and stock value.[43] Substantial additional assets resulted from the sale of Aetna's foreign subsid-

iaries.[44]

Also in 1999, CIGNA withdrew from its traditional healthcare operations while continuing in the managed care business.[37] CIGNA's profits in Brazil's private healthcare markets decreased in 2001-2002.[45] In January 2003, citing growth potential below the company's long-term expectations, CIGNA sold its remaining healthcare operations to a Brazilian company, Amil,[46] after extracting substantial revenues from prepaid capitation fees.

The behavior of these corporations, which rapidly entered and then exited foreign markets, remains somewhat puzzling, although the level of profitability clearly contributed to these corporate decisions. The wealth in Latin American social security funds was created with contributions from the government, employers, and employees during decades of job growth and economic expansion. Privatization in Latin America was accompanied by massive unemployment, which drastically reduced contributions. Healthcare reforms further diminished these contributions (as described in the following sections). From this perspective, the social security funds represented an initially lucrative opportunity; later Latin America proved not to be "the goldmine that it looked like it would be during the heady days of policy reforms at the beginning of the 1990s."[47]

The domestic US market also has played a role in withdrawal from Latin American markets. In the case of Aetna, stockholder pressure directed the company to focus its attention on the US market. As the new Medicare legislation was being formulated in 2003, it became clear that changes in the law would benefit health insurance companies. The legislation approved in December 2003, will transfer approximately $46 billion to private insurance companies and managed care organizations, in part through higher payments to attract seniors into private health plans.[48] Anticipated annual premium increases have reached 10.6 percent, the level at which managed care made its highest profits in the early and mid-1990s.49 Not surprisingly, Aetna has strongly advocated Medicare reform.[50-51]

The Role of International Financial Institutions and Health Policy Reform

Armada et al.[39] have documented how international financial institutions (IFIs) intervene in social policy making by requiring major healthcare and social security reforms. Loan conditions and renegotiation of external debt payments have comprised the major tools of political leverage used by IFIs. "Letters of Intent" that debtor countries submit to the IMF provide evidence of how health and pension reforms become embedded in major economic policies, as the following excerpt from a Letter from the Mexican government of June 15th 1999 shows:

> The Government intends to continue with the process of structural reforms, particularly in the areas of banking and social security… The Government is studying various options to strengthen further the recent reforms to the social security and healthcare systems. The Government plans to relax investment restrictions … With regard to healthcare, the

most immediate objective is to ensure the efficient operation of the public healthcare reform implemented in 1997-1998.52

Reform in Mexico

Mexico's healthcare system contains two subsystems, the Social Security System and the Ministry of Health. Social security is mandatory for workers in the formal labor sector, both rural and urban; participants pay according to their income but receive services according to their need.[53] The Mexican Institute of Social Security (IMSS) covers private sector workers (and to some extent their families), while the Institute of Security and Social Services for Workers of the State (ISSSTE) covers the public sector. The Ministry of Health, in theory, is responsible for the healthcare of the uninsurable or open population. Although the Ministry traditionally has provided a variety of services, comprehensive healthcare has not reached the entire eligible population. During recent years, for instance, about 10 million Mexicans have lacked access to any type of healthcare (Laurell, this volume, examines the Mexico City government's efforts to tackle this lack of access.)

The Mexican government presented the basic characteristics of its planned reform to the World Bank in June 1995, five months before presenting it to Congress.[54] They included the following proposals: a) to change from progressive, mandatory, employee-employer contribution rates to flat rates; b) to allow employers to opt out of the Social Security system, provided that the employers provide access to MCOs for their employees; and c) to permit uninsured people with regular incomes to buy into Social Security. The final goal of the reform was "to have the public Social Security institutions finance but not provide services;"55 in other words, to use the public funds collected by Social Security to finance managed care A new social security law enacted in July 1997 made this transition. The reform's proposals opened the door to multinationals because MCOs could compete for IMSS-insured clients, receive funds from the Social Security Health Fund, and purchase services from IMSS specialty hospitals or the public National Health Institutes.[53]

Interviews with Mexican respondents revealed a perception that the reform moved public resources into the private sector in several ways: a) by allowing unequal competition between the private and the public sectors, where the former can select healthy and younger patients while the latter continues to be responsible for chronically ill, more expensive patients; b) by allowing tax exemptions for employers who offer private health insurance to employees (in this fashion the government forsakes tax revenues that could be used to strengthen social security but that instead subsidize private companies); and c) by requiring that the IMSS return contributions made by employees when they choose to receive healthcare elsewhere. Interviewees also suggested that the private sector possessed insufficient capacity to provide care for large numbers of people.

Reform in Brazil

In Brazil, pressure from IFIs and particularly the IMF forced the gov-

ernment to reduce social spending. A broad package of controversial measures reduced the 1999 health budget by $854 million.[56] In Letters of Intent to the IMF, the government committed itself to seek alternatives that permitted multinational corporations to gain access to public social security funds.[57]

The Brazilian health system has functioned as a mixed public-private system. The public system both finances publicly provided services and – where no public services and/or facilities are available – reimburses services provided by private entities. The private system is called a supplementary system, with services financed and provided in the private sector.58 About 24.5 percent of the Brazilian population holds private health insurance.

A large proportion of the services in the public system are provided by reimbursing private entities under contract with the government. Most inpatient services are provided under this system, since about 80 percent of hospitals that deliver services to the public system are private. In contrast, public establishments provide about 75 percent of outpatient care.[59] Because healthcare is a constitutional right – guaranteed by the State for all Brazilians,[60] about 43 percent of the privately insured population have also utilized the public system, especially for more complex and costly procedures.[56] Despite the large proportion of the population that has obtained services from the public system, this sector has increasingly become more fragmented and underfunded.[61]

Brazil's 1988 Federal Constitution sought to implement the Unified Health System.[62] The SUS was promoted throughout the country, partly as a criticism of the prior model that financed the private sector with public resources while undermining the public sector.[63] Under the 1988 Constitution, private enterprises could participate in the SUS, but only in a supplementary manner and by means of public contracts and agreements. Such enterprises were to provide services free of charge to the population when services were financed by the SUS. Allocation of public funds to aid or to subsidize profit-oriented private institutions was forbidden.[60]

Measures to establish the mechanisms of funding allocation and to define the managerial model for the SUS emerged during the 1990s through such ministerial regulations as the Basic Operational Norms.[61] (Normas Operacionais Básicas – NOB 91, 93, 96). NOB 96 proposed implementation of the Family Health Program as a condition to transfer financial resources from the federal government to municipalities. The program was compatible with the basic health services packet for the poor that the World Bank had actively promoted in developing countries.65-66. NOB 96 also allowed for large public hospitals to be managed as Social Organizations (Organizações Sociais), a model which dissociated public institutions from municipal governments and facilitated implementation of managed care in the public sector.[62] The introduction of competitive managed care to capture financial resources in the Brazilian public sector, however, conflicted with the principles of universality and integrity enacted through the 1988 constitution.[66]

Effects of Reform in Mexico

As noted previously, IFIs play crucial roles in the reforms that take place in debtor countries, where multinational corporations often benefit from these reforms. In Mexico, the World Bank supported health reform with loans of $700 and $25 million.[39] The reform facilitated the penetration of multinationals into the social security system by allowing patients to "opt out" of coverage by the social security system and into coverage by private MCOs. The World Bank itself pointed out the reform's potential to weaken the social security system's financial underpinnings due to adverse selection and "cream skimming." These tendencies involved moving "good risks" from the social security system to MCOs, while leaving the social security system with the relatively "bad risks," which contributed less to the system but made more use of it.[55] In spite of these concerns, one of the World Bank's conditions for awarding the loan was that some MCOs would be operating by the year 2000.[53]

Mexican health reform included a free package for the "uninsurable" population in rural or poor urban areas. Although proponents portrayed the measure as an "essential health package" which would provide universal coverage, the package in reality contained fewer services than those traditionally provided to the poor by the Ministry of Health. In concrete terms, this gap in coverage meant that all services not included in the package would be charged directly to the patient or financed by state governments with limited capacity to make independent decisions and to collect taxes. Services not included in the package had to be contracted through public or private insurance.[53-54] This "essential health package" closely resembled the basic packages promoted by the World Bank in developing countries.

Effects of Reform in Brazil

Health corporations in Brazil implemented several classic features of managed care. For instance, they employed mechanisms to restrict utilization of health services, including denial of care, refusal to reimburse physicians for certain procedures, arbitrary termination of contracts with physicians, and preferred private provider networks. Private health insurance plans increased, as did the number of patients' complaints due to service denials.[67] The 1998 Health Plans Law – Lei 9,656 – was introduced to protect consumers from the arbitrary practices of insurance companies, yet issues about rising premiums, restrictions on physician visits and hospitalizations, and contracts not conforming to the legislation continued. New contracts frequently did not cover the minimum services required by legislation. At the same time, insurance companies reported high profits.

By late 2000 a special commission appointed by Congress initiated financial investigations concerning the practices of these companies.[68] Legislation eventually caught up, forcing companies to comply with lawful insurance plans and curtailing "cream-skimming" and "cherry-picking" practices. This change increased costs for companies – which may have played a role in CIGNA's exit – and the companies then raised premiums to maintain profits. A decrease in the number of privately insured people from 41 million in 1998 to about 35.1 million in 2003 reflected the inability of many clients to afford these higher pre-

miums and the public system's financial difficulty in absorbing them.[69] Disinvestment in the public sector led to inadequate service provision. Paradoxically, specialized and expensive medical procedures still took place largely in the public sector, and those covered by private insurance utilized public facilities when they needed such services.[61] The increasing mix of private-public financing in public hospitals, according to our respondents, led to reduced access for those who depend only on the public sector.

Privatization and the opening of public sector services to corporate participation therefore have exerted major effects. IFIs and multinational corporations have promoted continuing reforms that while favorable to corporate interests, worsened access to needed services and strained the few remaining public sector institutions, despite research verifying predictions of worsening access and healthcare outcomes among the most vulnerable populations. Reforms supported by the World Bank and other IFIs threatened the social security systems while providing "packages" of basic services that left many needs unmet.

Conclusion: Theory and Praxis

Globalization and 'Silent Reform'

Linkages between economic globalization and health deserve more critical attention. A growing network of professionals and advocates has drawn attention to the new policies affecting health and health services that derive from new conditions of global trade. In most Latin American countries, privatization policies, decided after consultation with IFIs reach implementation usually through executive decrees or changes in regulations rather than through new laws debated in the legislative branch. These policy changes receive little attention among lawmakers, in the public media, or in professional associations and consumer groups. The political process that accompanies such reforms therefore is usually a silent one, restricted to the executive branch of government.

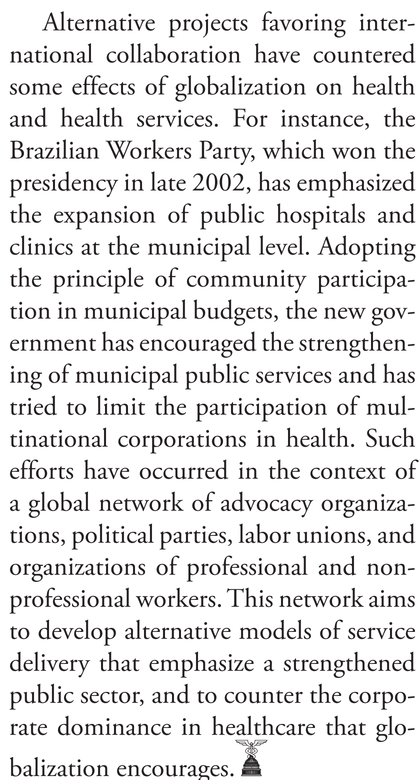
Through "economism," Pierre Bourdieu argues, policy makers choose reforms based on technocratic assumptions that market processes - the "confidence of the markets" - achieve the broadest good across social classes in both economically developed and less developed countries.[70-71] From this view, technical experts in IFIs and corporations call upon political leaders to take their advice, rather than relying on democratic, consensus-building processes to evaluate policy reforms. The economism that accompanies globalization has led to increasing acceptance that -- to the extent that it interferes with trade both within and across national boundaries -- the state must be dismantled.[70] This dismantling involves cutbacks of public-sector services and reversals of laws and regulations that restrict trade in health services within the private marketplace.

Praxis

Action informed by theory, or praxis, has focused on the detrimental effects of economic globalization on health and healthcare, as well as alternative projects that aim toward improvements in health conditions.[72-73] Opposition to policies which generate adverse effects on health and health ser-

vices has increased worldwide. Specific examples of organized resistance have shown that such policies can be blocked or reversed. For instance, a campaign to eliminate users' fees in public-sector health services and education led to a major change in the World Bank's policies of enhancing privatization and corporate trade in services. Through a series of protests, a coalition of health professionals, non-professional health workers, and patients who use public hospitals in El Salvador have blocked, at least temporarily, the privatization of those institutions.

Alternative projects favoring international collaboration have countered some effects of globalization on health and health services. For instance, the Brazilian Workers Party, which won the presidency in late 2002, has emphasized the expansion of public hospitals and clinics at the municipal level. Adopting the principle of community participation in municipal budgets, the new government has encouraged the strengthening of municipal public services and has tried to limit the participation of multinational corporations in health. Such efforts have occurred in the context of a global network of advocacy organizations, political parties, labor unions, and organizations of professional and non-professional workers. This network aims to develop alternative models of service delivery that emphasize a strengthened public sector, and to counter the corporate dominance in healthcare that globalization encourages.



Acknowledgments

This work was supported in part by grants from the National Library of Medicine (1G08 LM06688), the New Century Scholars Program of the US Fulbright Commission, the John Simon Guggenheim Memorial Foundation, the Roothbert Fund, the US Agency for Healthcare Research and Quality (1R03 HS13251), the National Institute of Mental Health (1R03 MH067012 and 1 R25 MH60288), and the United Nations Research Institute for Social Development. The views expressed in this article do not necessarily represent those of the funding agencies. We are grateful to Ron Voorhees, Carolyn Mountain, Francisco Mercado, Ellen Shaffer, Cristina Laurell, Celia Iriart, and Lori Wallach for their contributions to this project. An earlier version of this article appeared in: Mackintosh M, Koivusalo M, eds. Commercialization of Health Care: Global and Local Dynamics and Policy Responses. New York: Palgrave Macmillan and United Nations Research Institute for Social Development, 2005.

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