

PRIVATE HEALTHCARE IN LATIN AMERICA EMERGING OPPORTUNITIES

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The Institute of the Americas, in collaboration with the International Finance Corporation (IFC), will be holding a roundtable in July 2000 entitled “Financing Private Healthcare in Latin America: Experiences and Challenges to Overcome in a Dynamic World.” In anticipation of the event, this report has been prepared to provide a conceptual setting for discussions and debate at the roundtable. The report outlines emerging growth areas and trends for investment in key Latin American countries as also presents successful cases of investment and financing. The report also describes challenges that investors are facing in the planning and implementation of their investment strategies and raises provocative questions for discussion. As its focus is on emerging opportunities, this report provides neither an in-depth market analysis nor a comprehensive study of health reform in the region.

Background

A wave of health sector reform has spread throughout Latin America over the last two decades, particularly in the 1990s. Fiscal constraints, demographic and epidemiological pressures and the demand for more efficient health care have prompted governments to make sweeping changes not only in financing but also in delivery of health services. The scope and pace of reforms vary country by country. Brazil, Colombia and Costa Rica have embarked on comprehensive reforms, while Mexico, Chile and Argentina have attempted more piecemeal approaches.

Central to these reform efforts is the transition from a public-sector-dominated industry to a market-driven one with increased private sector participation. The public sector is now looking to the private sector to cope with some of the challenges posed by insufficient coverage of health services to the general population, poor technical quality, allocation inefficiencies, disjointed provider networks, rising costs and deficient management. The public sector, no longer viewed as the sole provider, is increasingly used to facilitate the private delivery of health care. Governments also are allowing private health insurance providers to play a larger role as the monopolistic system of social insurance is ending. The following is a summary description of the private health sector in the main Latin American economies.

Brazil:

Brazil's health system is composed of public and private subsystems. The public system, the Sistema Único de Saúde (SUS, Unified Health System) is a decentralized single payer system, financing about 70 percent of all healthcare services. The SUS comprises all health care and services provided by public institutions at all three levels of government (federal, state and local), as well as private institutions that provide services under contract to those systems. The SUS is the first healthcare system in Brazil that has attempted to integrate a variety of public providers, including hospitals and primary health centers belonging to federal, state, and local governments. It also includes private for-profit and nonprofit providers under contract to the public system.

The private system is known in Brazil as the "supplementary medical system." Although legally all the health services rendered in the country come under the framework of the SUS, the supplementary medical system is still not integrated within the SUS framework. Public health authorities have only recently been given authority to regulate the private system. It is still unclear how the two systems will interact.

Approximately 42 million Brazilians (25 percent of the population) are covered by private health care plans, with spending for private healthcare estimated at \$20 billion annually. Private health coverage is provided in the following four ways:

- ◆ Healthcare assistance companies: These are HMO-type organizations that deliver services through their own providers or through a contracted network of providers. About 740 healthcare assistance companies cover about 18 million enrollees, operating with about 27,000 hired doctors and 88,000 contracted physicians. These companies own approximately 225 hospitals and contract with another 2,000. About 80 percent of enrollees are workers and dependents whose employers provide for their health plans; the remainder are individuals that pay out-of-pocket. Total annual revenues for the healthcare assistance companies are estimated at about \$4 billion.
- ◆ Cooperatives: These are also HMO-type institutions formed by cooperatives of doctors, hospitals and associated hospitals offering closed network products. They cover about 10 million enrollees. There are about 370 cooperatives organized nationally through an entity called Unimed, based in Sao Paulo. Unimed has almost 90,000 physicians affiliated with it as owner-providers and has its own network of hospitals. These medical co-ops contract directly with employers and offer pre-paid health plans to consumers. Total annual revenues for these cooperatives are estimated at \$3.5 billion.
- ◆ Self-insured schemes: These are self-management plans generally offered by large corporations to their employees. Examples of such schemes can be found among the U.S. and European

automakers. Their plans cover about 9 million enrollees. Such plans are often administered by third-party administrators (TPAs), insurers or private assistance companies. Total annual expenditures are estimated at \$4.5 billion.

- ◆ Medical insurance plans: These indemnity plans, offered by multi-line insurers, specialist insurance companies and banks, cover about 5 million enrollees through forty companies. Total annual revenues are estimated at \$4 billion.

The private insurance market in Brazil is fragmented and dispersed, with over 1,200 entities participating. More than 60 percent of the private health plans have 10,000 enrollees or less, while only two percent have 200,000 or more. This market lacks a sound regulatory framework. Until last year, only indemnity insurance was regulated, leaving healthcare assistance companies, cooperatives and company self-management plans without a specific regulatory framework. Legal reforms were introduced in 1998 (Law 9656/98) to expand the scope of regulations and level the playing field for all entities. New regulations enacted in 1999 required that all categories of private health plans adopt an insurance-based structure incorporating specific capitalization and solvency levels, standard benefits, protection of consumers, transparency of information, etc. In addition, there are new requirements to expand the levels and terms of coverage. The strict terms are forcing consolidation in the industry due to lack of funds, expertise and other resources.

Most healthcare in Brazil is delivered by private providers. There are over 4,300 private hospitals with almost half a million beds in Brazil. The private sector segment that contracts with the public system accounted for 79 percent of hospital beds, 83 percent of publicly-funded admissions and 87 percent of hospital reimbursements by government in 1994.

Argentina:

Argentina's health system includes three major subsectors:

- the state sector, providing care to about 12 million people through general taxation;
- the union-run and not-for-profit social insurance funds (*obras sociales*), covering about 21 million people including retirees; and
- the private sector, covering about 3 million people.

Argentina spends about nine percent of its GDP on healthcare, of which 40 percent is private expenditure. Of a total of about \$25 billion spent annually, the state sector accounts for about \$5 billion; *obras sociales* account for about \$7.5 billion; pre-paid plans account for about \$2.5 billion; and about \$10 billion are out-of pocket expenditures.

The state-run system has about 1,200 hospitals and almost 6,000 outpatient clinics run by the national, provincial and municipal governments. In the social security sector, there are over 200 *obras sociales* that operate primarily as a financing system collecting mandatory contributions from employers and employees and contracting services with private providers. Most *obras sociales* are small, with the five largest providing over 50 percent of coverage.

The private sector is dominated by some 200 pre-paid medical care plans (Prepagas). These Prepagas offer services through their own network of providers or through a contracted network of provider facilities. About half of the enrollees are concentrated in the largest fourteen Prepaga companies. Prepagas have operated in a virtual legal vacuum. Though they are subject to certain regulations and controls issued by the secretary of commerce (relating to coverage, benefit limitations, forms of payments, etc.), they are not strictly or effectively enforced. Draft legislation is being proposed to regulate the functioning of these entities to place them under the jurisdiction of the regulatory entity in charge of the *obras sociales*.

Private hospitals account for about 45 percent of all hospitals but less than 40 percent of all beds, with approximately 2,000 inpatient facilities and 6,800 outpatient clinics. Few private hospitals have high-tech equipment such as ultrasound, tomography or magnetic resonance. Only 60 percent of hospitals have information systems, and even those that do may not meet current standards.

Since the early 1990s, Argentina has reformed its health care system by revising regulatory policies and deregulating services. The reforms include:

- offering choices to customers among the different *obras sociales*;
- creating a standard healthcare benefits package;
- improving technical standards and efficiency within the industry.

The lack of an effective and credible regulatory framework, as well as political and union resistance have limited the effectiveness of these reforms. However, there were important effects: many of the weaker *obras sociales* were forced to shut down or merge with stronger ones. The new De La Rúa administration issued a decree in June 2000 providing for full competition between *obras sociales*, excluding PAMI, and Prepagas. The changes will become effective in January 2001.

Mexico:

Mexico's health system has three components:

- the state sector, covering about 40 million people, including the IMSS-Solidaridad program for the uninsured;
- the social security sector with two major social security institutions, IMSS and ISSSTE covering about 40 million and 10 million respectively, and various parastatal social security schemes; and
- the private sector.

Mexico spends about 5.3 percent of its GDP on health, with over half of that for out-of-pocket expenditures to private providers.

In 1995, reforms were introduced to allow users to opt in or out of IMSS. Opting in would allow subsidized coverage to informal workers and the self-employed. Opting out would allow IMSS beneficiaries to choose providers other than the IMSS delivery system. The opt-out provisions were expected to create an enormous market for private insurers and providers. However, opting out has not been put into effect due to political and financial considerations and the lack of an effective regulatory framework.

The private health insurance market includes:

- ◆ Banks, where historically employees are allowed to opt out, the largest being Bancomer and Banamex.
- ◆ Indemnity companies such as Seguros Comercial America and Grupo Nacional Provincial (GNP). In 1999, GNP was a traditional pure indemnity insurer covering about 400,000 lives. GNP is looking to expand its small managed care market through the ownership of clinics and the construction of a hospital network through contractual arrangements.
- ◆ International companies such as Aetna Inc., which owns 49 percent of Seguros Monterrey Aetna, provides managed care for 90,000 people, mainly employees at Bancomer.
- ◆ Smaller managed care plans like Red Medica Internacional and others along the border with the U.S., offering plans for professional employees in maquiladora assembly plants.
- ◆ Hospital Groups, like Grupo Angeles and Grupo Pulsar.

On the provider side, the system is also dominated by the public sector. With limited regulation of the healthcare delivery system, private clinics and hospitals account for only 18 percent of the nation's hospital bed supply. Private inpatient services comprise about one-fourth of the national supply of services, with private outpatient services accounting for about one-third of the total. Hospitals register

with the government, but are not required to maintain minimum standards for safety or effectiveness of medical equipment, and doctors are not required to be certified.

Chile:

Chile, the flagship country for health reform, instituted in the 1980s a system of private health insurance companies (ISAPRES) and allowed Chileans to redirect mandatory healthcare contributions to the new ISAPRES instead of the National Insurance Fund (FONASA). Chileans were obliged to enroll in one of the two subsystems, the public FONASA or the private ISAPRES. In addition, those who continued to contribute to FONASA were allowed a choice between public and private providers. Since 1980 there has been significant (though lower than expected) growth in the private insurance sector. Today, close to thirty-five ISAPRES cover 3.5 million people (24 percent of the population). Some ISAPRES provide health services through their own hospitals or clinics, a PPO model or staff model relationship. Other ISAPRES act as indemnity carriers. Chile's public health network includes 180 hospitals, over 300 surgical centers and over 2,000 rural medical clinics. The private health network has less than 50 hospitals but almost 1,000 clinics, polyclinics and medical centers.

Emerging growth opportunities for private health investment in Latin America

As reported in *The Economist* earlier this year, Latin America leads the developing regions of the world in per capita income, despite the economic crises of the 1980s and 1999. The increasingly powerful trend towards economic globalization has given rise to massive increases in world foreign direct investment (FDI) in the region. Most economies in the region have restructured their development policies to stress trade liberalization, market deregulation and more stable growth patterns, and in the last decade, Latin America retained its position as one of the most significant recipients of capital. For the eighth consecutive year, FDI flows into the region have increased sharply and have had a very strong impact on its economic performance. The U.N. Economic Commission on Latin America and the Caribbean (ECLAC) Unit on Investment and Corporate Strategies estimated that in 1997, US\$65.2 billion poured into the economies of Latin America and the Caribbean. FDI flows to Latin American countries in 1998 were estimated roughly at US\$58.1 billion, not far from the 1997 figure.

Since 1991, following the "lost decade" of the 1980s marred by debt crises, Latin America has been the recipient of substantial and increasing FDI. In absolute terms, the larger economies of Latin America have been the largest recipients of FDI flows in the past few years. In 1997, Argentina, Brazil and Mexico accounted for 62 percent of total flows to the region, with Venezuela, Peru, Colombia and Chile accounting for another 26 percent. Macroeconomic stabilization, trade liberalization, wide-ranging

privatization programs, deregulation of foreign investment policies (both domestic and foreign), greater political stability in some instances, and advances in regional integration all help to explain the region's attractiveness to foreign investors.

The health sector, with an estimated \$150 billion industry region-wide, is one of the recipient sectors of these inflows. With the increasing role of the private sector and greater openness towards foreign capital, foreign investment has been significant, particularly in the major economies of Mexico, Brazil and Argentina. The media portrays the expanding private health sector in Latin America as the next gold rush for healthcare investors, or liken it to the "good old days" in the United States when hospitals were building facilities and adding services at a rapid clip. Though exaggerated and perhaps counterproductive, these portrayals fairly state that almost every health sector is in a state of change in Latin America, creating new opportunities for investments.

As previously summarized, reforms extend to the financing and delivery aspects of the health sector. Greater competition and consumer choice have been introduced in the public/private health insurance sector to secure sustainable financing, contain costs and balance budgets. In addition to health financing, there have been reforms in service delivery organization and management. In an effort to increase efficiency, these reforms have sought to adopt contracting arrangements between financing agents and providers, granting autonomy to the management of public providers and allowing outsourcing of services.

Investment opportunities in the regions' health sectors have attracted not only private companies, but also international financial institutions and private funds, including the IFC, a member of the World Bank Group, the Inter-American Investment Corporation (IIC), a member of the Inter-American Development Bank, and Latin Health Care Fund, a private equity investment fund devoted to healthcare in the region.

The following sections of this report present areas of potential growth and investment, with emphasis on hospitals and clinics, telemedicine, managed care and medical equipment and devices.

International Finance Corporation (IFC) is a member of the World Bank Group. IFC was established in 1956 to encourage private sector activity in developing countries. IFC carries out its goals primarily through three types of activities: (i) financing private sector projects, (ii) helping companies in the developing world to mobilize financing in the international financial markets, and (iii) providing advice and technical assistance to businesses and governments. IFC offers a full array of financial products and services to companies in its developing member countries including long-term loans in major currencies, equity investments, quasi-equity instruments, guarantees and standby financing risk management. IFC can provide financial instruments to ensure that projects are adequately funded from the outset. IFC can also help structure financial packages, coordinating financing from foreign and local banks and companies and export credit agencies.

Inter-American Investment Corporation is a member of the IDB group. The IIC was established in 1986 to encourage private sector activity in the Latin America and Caribbean region. Its specific purposes are to encourage the establishment, expansion and modernization of private enterprises, preferably those that are small and medium-scale. As the IFC, it provides financing, facilitates access to capital and delivers advice and technical assistance.

In its first ten years of operations, the IIC has approved over \$ 1 billion for more than 200 projects in a diversity of sectors.

Latin Healthcare Fund is a joint venture between executives of the former Advantage Health Corporation, a Massachusetts-based outpatient and rehabilitative services company that was sold to HealthSouth in 1996, and the Washington-based Global Environment Fund, which provides venture capital for infrastructure improvements in Latin nations. It started operations in 1997.

The Fund invests in companies that may include hospital chains or ambulatory care systems, integrated health care delivery systems, HMOs and other managed care companies, and ancillary health service companies such as laboratories, imaging, rehabilitation and distribution. The Fund has \$55 million of committed capital to make direct investments of \$3-\$15 million. In addition, the Fund has access to additional funds via co-investors which enables the Fund to mobilize as much as \$50 million per investment. The Fund seeks significant minority equity positions.

Healthcare providers

Hospitals, clinics and home care

Significant infrastructure investments are generally needed in hospitals, outpatient centers, ambulatory surgery centers, laboratories and other healthcare service providers. As more people are covered by insurance plans, the demand for quality healthcare services will increase. There will be a need for additional acute care hospitals and the development of alternative healthcare facilities such as community and tertiary-care hospitals, ambulatory surgery centers, rehabilitation centers, extended care centers, senior living centers, physician practice management groups, home healthcare and stand-alone diagnostic facilities.

Some of the foreign investments in this area include:

International Finance Corporation (IFC)

(a) Argentina: Hospital Privado de Cordoba

In its first health sector project in Latin America, IFC made a US\$9.6 million loan in 1998 to Hospital Privado de Cordoba in the city of Cordoba, Argentina. The project included constructing a new three-story building, upgrading existing facilities, acquiring new medical equipment, creating satellite health centers and improving management information systems.

(b) Brazil: Sociedade Hospital Samaritano

IFC made a US\$20 million loan to Sociedade Hospital Samaritano for a project estimated at about US\$79 million. The investment is to assist Hospital Samaritano with the reorganization, rehabilitation and expansion of inpatient rooms and operating theaters, as well as formation of a new day clinic, new operating theaters, new expanded intensive care facilities, a diagnostic center, and additional garage/parking spaces. The project is designed to increase the hospital's outpatient services capacity, providing a larger client base for Samaritano's services, and increase the hospital's inpatient services capacity and improve its efficiency. The hospital's facilities will be reorganized and rehabilitated to improve flow of activities and the surgery rooms. The intensive care unit and patient rooms will be expanded and refurbished. As a consequence, the hospital's capacity will increase by 40 percent to 257 beds.

(c) Brazil: Laboratório de Análises e Pesquisas Clínicas Gastão Fleury S/C Ltda. ("Fleury")

IFC's investment of \$15 million is part of a project estimated at about US\$58 million. The Project is for the expansion of Fleury's operations, through the establishment of up to eight new Collection and Diagnostic Centers (CDCs or "units") in the next two and a half years in various towns in Brazil. These CDCs will provide high quality diagnostic and medical services tailored to market needs in each area. In addition, the Project calls for the construction of a new laboratory complex which will provide additional capacity to serve a growing demand for Fleury's clinical trial services. The Project will include the renovation of the existing CDCs.

(d) Brazil: Icatu Health Services (IHS), January, 1999

IFC's investment will be up to US\$6.25 million, representing 25 percent of the initial capitalization of Icatu Health Services (IHS). IHS is a holding company which will support new ventures and the early stage development of companies that will provide services intended to improve the cost efficiency and service quality of the Brazilian health care industry. IHS target activities will be in areas such as home care, occupational and preventive medicine, prescription benefit management, public and private hospital management, rehabilitation centers and outsourced hospital services such as laundry. The proposed starting capital base of US\$25 million will enable IHS to make a number of small investments in health care service companies.

(e) Mexico: American British Cowdray Medical Center I.A.P. (Hospital ABC)

IFC has made an investment in Hospital ABC through three separate loans amounting to \$44 million. The project involves the construction by Hospital ABC of a new US\$81.8 million facility in the Santa Fe section of Mexico City. The new facility will include the establishment of a specialized ambulatory center, including day surgery, a 100-unit medical office building, all related diagnostic services such as laboratory and imaging centers and a preventive medicine center to address the occupational health needs of a growing number of companies in the Santa Fe area. The facility will also include a 24-hour emergency department, a welfare clinic intended to deliver services to the poor as per Hospital ABC's mandate, and it will include 60 beds of hospitalization to complement the 200 beds at the Observatorio facility. The Santa Fe facility has

been designed to include a rehabilitation center, an oncology center and additional hospitalization.

(f) Mexico: Consorcio S.A. de C.V.

IFC has invested US\$20 million in this project. Consorcio S.A. de C.V. was established in 1992 for the purpose of developing, owning and managing private healthcare facilities in Mexico. Hospitals are operated by Consorcio under the CIMA brand name. The Project is designed to strengthen Consorcio's existing operations and provide it with the necessary capital to further expand its activities. The Project consists of Consorcio's investments in affiliated hospitals, the restructuring of the debt of CIMA Hermosillo and the construction of a medical office building adjacent to the CIMA Hermosillo hospital and the construction of a new CIMA hospital and medical office building in Puebla.

Inter-American Investment Corporation (IIC)

(a) Mexico: Hospital ABC

IIC has made a \$12 million loan this year to partially finance the expansion of Hospital ABC in Mexico City. The IIC loan will be used to purchase equipment and to construct a new hospital in the Santa Fe area in the city of Mexico.

(b) Argentina: Desler S.A.

IIC made a \$6.64 million loan in 1999 to Desler S.A., a small joint venture engaged in the handling and safe disposal of medical and industrial waste.

Latin Healthcare Fund

(a) Mexico/Central America: Consorcio International Hospital S.A.

Owned by Dallas-based International Hospital Corporation, Consorcio is a Central American hospital company that develops, builds and operates high quality hospitals. Consorcio has opened two hospitals in Mexico (one in Hermosillo and the other in Chihuahua) and a third hospital in San Jose, Costa Rica. Currently a fourth hospital is under construction in Puebla, Mexico. The approximate investment of the Fund is \$4 million.

(b) Brazil: Medicina Diagnostica Delboni Auriema

This Brazilian company is the largest clinical laboratory and diagnostic imaging company in Sao Paulo, Brazil in terms of number of tests, and the second largest in terms of revenues. The approximate investment of the Fund is \$6.5 million.

(c) Brazil: Vita

Vita is a hospital company in Sao Paulo, Brazil with four facilities under ownership or management. The approximate investment of the Fund is \$10.5 million.

(d) eHealth Latin America

This is a company specialized in healthcare internet solutions, e-commerce and connectivity. The original investment was \$1 million. An additional \$15 million has now been raised.

Other Investments

(a) RT 21 Radiation Systems Corp.

This is a Miami-based venture to develop state-of-the-art radiation therapy and cancer facilities in the region.

(b) Salomont-Bailis Ventures

This is a Massachusetts-based venture to develop eldercare services in the region.

(c) Rural Metro Corp.

This U.S.-based ambulance company owns ECCO (Emergencia CardioCoronarios), an Argentine enterprise providing in-home physician care, primary care services in its own clinics and life support and emergency transport to hospital facilities.

Pharmaceutical physician practice management (PPM) company

The Latin Healthcare Fund has already made an investment in a Chilean PPM, Farmacias Ahumada S.A. Farmacias Ahumada, S.A., is a retail pharmacy chain in Santiago, Chile, with more than 140 pharmacies in Chile and a market share of 30 percent. The Company has also expanded into Peru and became the largest chain of retail pharmacies with more than 35 locations. It also has the first and largest pharmacy benefits management company in Latin America and is pursuing acquisitions in Brazil. The approximate investment of the Fund is \$9 million.

Healthcare Suppliers - Medical equipment and devices

With the move towards greater private sector participation in the health sector, the region's markets for medical equipment and devices have expanded significantly. Many private hospitals and clinics throughout the region are adding to their present facilities or projecting new construction and, thus, are in need of more medical supplies.

In Brazil, for example, the 1998 law regulating private health plans is stimulating the construction of new hospitals and clinics around the country. Brazil's market for medical equipment was about US\$2.9 billion in 1997, according to U.S. government reports. Argentina's market was estimated to be at \$ 365 million in 1996 with long-term prospects for devices such as radiology, ultrasound, medical imaging equipment, disposable medical products and implants/prostheses. With the continued expansion of the private health care sector, this market holds promise for investors and companies interested in exporting medical equipment and devices such as computerized tomographers, ultrasonic scanning devices and angiographers.

In addition to opportunities created by the growing private sector, foreign exporters can also take advantage of the many government projects in need of supplies. The Costa Rican Social Security System (CCSS), for example, is involved in a major US\$35 million project involving the construction of a new hospital and includes equipment needs that are estimated at US\$9-10 million. The Brazilian Ministry of Health has announced plans to concentrate investments in basic medicare and remodel the existing 2,138 hospitals. The Chilean government as well has been working on a complete overhaul of the public health

system and has instituted a “Health in Action” Program that has already involved an investment of over US\$1 billion for the reconstruction and modernization of hospitals.

Healthcare insurers and managed care

From the late 1980s, indemnity insurers, faced with severe financial troubles, have been looking to the managed care business to expand their markets. By the late 1990s, many insurers in Latin America had adopted elements or techniques of managed care such as forming close commercial links with healthcare providers, or changing methods of provider contracting and reimbursement.

The opportunities for indemnity insurers lie first in the substantial amount of out-of-pocket health expenditures in these countries. For example, in Mexico some estimates put out-of-pocket expenditures around \$10 billion dollars. Experts argue that customers do not have the ability to duplicate the payment made to social security but many could afford a managed care type product, particularly if it is designed to cover the 1½ level coverage. Mexico’s market presents other favorable factors for managed care: the Mexican population is accustomed to a closed system, with a limited choice of providers; sooner or later the IMSS “opting out scheme” will be implemented due to financial pressures; and the ongoing shift from traditional indemnity insurance to managed care. Estimates for this potential market are about \$3 billion with significant potential for growth. This does not take into account any change in ISSSTE or other parastatal health plans like PEMEX or the electric utilities.

Currently indemnity companies such as *Grupo Nacional Provincial* (GNP) are moving to the managed care business. According to GNP officials, their management strategies will be to develop new contracts with price discounts, contain drug costs, expand ancillary services and improve monitoring of hospital performance. On the clinical side, they will work towards facilitating greater use of second opinions, screening, home healthcare, outpatient surgery, generic drugs, virtual clinics, clinical pathways, case management and utilization management.

In Argentina, new deregulation measures have given rise to new potential for growth in managed care with opportunities to participate with international companies establishing new carriers and in providing management technologies to the industry. Consolidation is anticipated as competition increases and regulations are issued and enforced. This will present opportunities for international companies with superior systems, management expertise and controls. The new opt-out decree also broadens the potential market considerably.

In Chile, ISAPRES are also looking to expand their managed care business. Experts believe that the very survival of the private sector is at stake. The ISAPRES market grew quickly in the 1980s but they have run into problems lately, with revenues reaching a plateau and even shrinking in 1999. ISAPRES have introduced some cost-containment measures, but current profits remain meager. ISAPRES may not survive if they do not implement stronger cost-containment models.

Managed care companies

U.S. and other foreign insurers have invested heavily in Latin America.

Brazil: U.S. companies operating in Brazil include AIG, Aetna, Cigna and International Healthcare Holdings (IHH). Aetna has a \$375 million joint venture with Sul America, a local health insurer, called Sul America Aetna. The health plan covers about 2,000,000 enrollees. Cigna is associated with Golden Cross, a health plan in Rio de Janeiro with 1.2 million enrollees and acquired AMICO, a 300,000 enrollee HMO in Sao Paulo. AIG is associated with Unibanco Seguros in an arrangement valued at \$460 million. Cigna has withdrawn from the management of Golden Cross but remains in control of AMICO. IHH bought Med-saude, a small HMO in the city of Curitiba.

Argentina: Foreign companies have established or acquired interests in Prepagas. These include Banco Santander and Adeslas (Spain), Amil (Brazil), Vida Tres and Colmena (Chile), Docthos (U.K.) and Aetna, MCA, EXXEL Group and Principal Financial Group (U.S.). Adeslas (Spain) purchased 51 percent of the Bazterra clinic which has its own prepaga covering 75,000 people. This will be added to 90,000 people already covered by Adeslas through other prior acquisitions. Aetna purchased in 1999 AMSA, the largest Argentine prepaga. MCA operates the *obra social* for the banking sector (OBSA).

Mexico: U.S. companies operating in Mexico include Aetna and Cigna. Aetna Inc. owns 49 percent of Seguros Monterrey Aetna which provides managed care for 90,000 people, mainly employees at Bancomer. Cigna bought 45 percent of the managed care company Mediplan, based in southern Mexico.

Chile: U.S. Aetna has purchased interests in local ISAPRES and covers about 60,000 members. CIGNA also operates an ISAPRE with coverage of about 100,000 members.

Information Technology and Telemedicine

(a) Information Technology

For private industries and public institutions to deliver efficient services they must develop or invest in information systems and technology. The strength of reliable information networks to track costs, patient information, purchasing and contracting patterns as well as to draft budgets for health care providers will contribute to fiscal efficiency. As private hospitals expand and add more beds, they will benefit from the ability to institute quality monitoring, implement user identification systems and provide faster and higher-quality information to the patients and to the administration and financiers.

The information infrastructure of Latin America is poorly developed and ranks just above that of Africa and some Eastern European countries but the growth of information technology in the region has been consistently the world's highest since 1985. This growth, along with the consolidation of the Latin American health care industry, brings many opportunities for information technology. Throughout most of the region, there is great demand for the development of reliable information networks that track patients, services rendered, payments incurred, and the overall hospital budget. Many of the region's Ministries have embarked on the computerization of their health services, aiming at providing better information for management and service delivery.

In Argentina, a recent IDB project earmarked US\$4.7 million for improvements in information systems, including the purchase of hardware and software and the hiring of specialized consultants. With the ability of consumers to choose among the *competing obras sociales*, and now the private pre-paid plans, to fit their needs and preferences, competing health care service providers will need to tailor to the customers needs and distinguish their services. They may do so by analyzing user-registration information such as socioeconomic data and information on past treatments and costs. In addition, as private hospitals expand and are modernized (as in the case of IFC's participation in the financing of a private hospital in Cordoba, Argentina), their efficiency and success may depend in part on how well they manage patient and other administrative information.

There is a strong demand in Latin America specifically for electronic data interchange (EDI) standardized card technology (which enables claims processing, authorization and referral) that is easily adaptable to local situations since the management of patient information is so important to managed care. Brazil and Colombia have been working on establishing standardized medical "smart card" specifications. Another example of a growth area involves the use of management information systems to support the process of consolidation within all segments of the health care industry. One example of this is IMS Health unit Sales Technology/Walsh, which has developed advanced sales force automation systems for pharmaceutical firms in Brazil. Local healthcare information systems companies do exist in Latin America but they are not very successful and customer satisfaction is low. Thus the market seems primed for foreign direct investment.

(b) Telemedicine

As governments across Latin America continue to decentralize health care delivery institutions, as well as telecommunications industries, the industry of telemedicine will continue to develop. Over the last ten years, most Latin American countries have deregulated and privatized what used to be the state-owned telephone empires. This in turn has allowed the telemedicine industry, among others, to begin operating throughout Latin America.

The term “telemedicine” is a term that changes meaning as technology expands and improves both in the United States and abroad. California’s 1996 Telemedicine Development Act defined telemedicine as the “use of information technology to deliver medical services and information from one location to another.” The Feedback Research Services in the United States defines telemedicine as “any technology that incorporates electronic delivery of health care, especially use of computers, networks, and video communications to assist patients who are located at some distance from the sites at which medical professionals are working.” Telemedicine has become an umbrella term that includes private consultations between two physicians to e-mail communication between a physician and a patient.

Telemedicine is an ideal health delivery service for countries with the demographic variety found in Latin America. Several Latin American countries have begun to develop telemedicine programs including facsimile and email components. According to an article published in *Telemedicine Today*, Argentina began using some form of telemedicine in 1994 by setting up web sites for education and clinical consultations. In Chile, the private sector is developing and implementing telemedicine applications. Indisa, a privately owned hospital in Santiago, is using telemedicine. Also Saval laboratories, a pharmaceutical company, has a telemedicine network between its Santiago offices and 14 clinics in the rural regions north and south of the city.

Allegheny Hospital established a telemedicine link in 1997 with Brazil’s Albert Einstein Hospital for two-way consulting on specialist diagnosis and treatment in neurology, oncology and orthopedics. Argentina, Chile, Costa Rica, Mexico and Uruguay now have active programs in place for clinical or educational purposes and some even have specialty programs integrated in their sites for areas such as radiology and pathology. In the mid-1990s, an Arizona telemedicine network linked a hospital in the United States to Mexico, allowing physicians to examine biopsy specimens on a monitor at a remote site. However, these same countries must from the outset follow a strategic path to avoid as many technical and financial problems as possible.

Pharmaceuticals

Latin Americans spent an estimated US\$20 billion on pharmaceutical drugs in 1998. This massive sum makes Latin America the fourth largest pharmaceutical market, after the U.S., the EU, and Japan. Brazil, Mexico, and Argentina rank among the twelve largest pharmaceutical markets in the world. In Brazil alone, pharmaceutical sales reached US\$10.3 billion in 1998.

A good deal of the expansion in the pharmaceutical market can be explained by the new policy of market liberalization and rising drug prices. For decades, price rises were limited by strict government-imposed price controls. Now almost every country in the region has abandoned the idea of state-initiated ceilings on prices. Because local firms are small and fragmented, foreign investors have taken advantage of these changes. In Mexico, for example, as much as 83 percent of pharmaceutical production was in the hands of multinationals in 1997. Some markets, like Ecuador, are already almost entirely dominated by foreign operators.

The adoption of patent laws throughout the region has generated much controversy. Ecuador, for example, signed a bilateral agreement with the U.S. for retroactive protection of patents granted elsewhere, as exists in Brazil and Mexico. But the Ecuadorian parliament never approved the agreement and the Andean Court of Justice found the retroactive recognition in contradiction to the “novelty principle” under patent law. However, despite such political controversies, the Latin American patent laws have in several ways already made a positive impact on pharmaceutical markets.

Market barriers have allowed local pharmaceutical companies to keep profit margins and prices artificially high. But as patent protection increases, opening the way to greater competition, and more citizens get access to private insurance likely to cover pharmaceuticals, demand will rise and prices will fall. Moreover, patent protection has paved the way for a policy of strategic alliances between national firms and multinationals wanting to expand in the region. When patent legislation is fully implemented, the influence of foreign direct investment is bound to grow.

Challenges and Issues in Health Sector Investments

This paper does not examine the full range of factors governing investments in the health sector--ranging from policy frameworks, macroeconomic and political stability, tax and trade policies to market considerations. The paper does highlight challenges and issues to be considered at the upcoming roundtable as a starting point for debate. The issues presented pertain to institutional settings, and more specifically, to transactional settings in particular areas of investment.

Institutional Setting

Inadequate Legal and Regulatory Frameworks

Inadequate legal and regulatory frameworks present serious challenges to a growing and sustainable private health care sector. This problem has two dimensions: enacting rules and enforcing compliance. First, governments must establish sound rules that govern the functioning of the private healthcare sector. Second, governments must make sure that those rules are enforced consistently and that private players have confidence that the rules will not be changed overnight.

Laws and regulations, in general, are inadequate in the region. In Chile, the ISAPRES flourished in the 1980s and early 1990s in a regulatory environment with few restrictions. ISAPRES enjoyed the right not to renew members' contracts. Customers with costly chronic illnesses could simply be dropped. The Argentine Prepagas also operated in a virtual legal vacuum with no adequate financial and consumer protection safeguards. In Mexico, there has not been a level-playing field, with a dual regime, one for indemnity insurers and another for HMO-type entities. Healthcare laws and regulations are also limited in quality control including certification of doctors, hospital standards, safety and effectiveness of medical equipment and devices and medical malpractice. Colombia, and more recently Brazil and now Mexico, have introduced regulations to govern the private health insurance market. These regulations introduce basic medical plans and financial requirements including reserves and solvency margins.

While countries are making some progress by adopting formal rules, law enforcement is weak. New regulations are legitimized only as the institutions that support it are credible, efficient and predictable. It is not enough to issue new laws and regulations. For example, in Colombia, while the law forbids discrimination, private insurers continue cherry-picking. There is also weak enforcement and supervision regarding compliance with the basic medical plan. Rules be applied in a fair and consistent manner, there must be protection from arbitrary government action and dispute

resolution mechanisms must be reliable. Closing the gap between the laws on the books and how they are actually enforced is essential to a sound health system.

Questions to be addressed:

- ◆ How sustainable will the private insurance sector be without a strong regulatory scheme?
- ◆ What minimum regulations will balance the need to encourage investment with the state's duty to ensure access and equity?
- ◆ How should private investors promote stable and sound legal and regulatory frameworks?
- ◆ How can independence and accountability be built into regulatory frameworks?
- ◆ How are consumers able to protect and enforce their interests?
- ◆ Should consumers sit on the boards of health insurance companies?

Fraud and Corruption

Fraud and corrupt practices are critical impediments to foreign investment in the health sector. Many countries are reported to suffer from this severe problem. Social security sectors, such as the *obras sociales* in Argentina, noticeably lack transparency. Recently, a former head of the largest *obra social* (PAMI) was indicted on several counts of fraud against the Argentine state. In other countries, providers are engaged in a vicious circle of fraud; doctors take advantage of the fee-for-service system by either charging insurers for operations twice or by charging for operations that never occurred. Pharmacies also charge insurers for prescribed drugs that were never dispensed.

Corruption is not unique to any one country or to the health sector. All countries are affected in some way by corruption, and difficulty in combatting it is undermined by the perception that it is standard practice. The greatest concerns lie with systemic, rather than isolated, corruption. Isolated corruption occurs rarely and unpredictably within a system where non-corrupt behavior is the norm. Where most institutions in the private and public sectors support integrity in public life, isolated cases of corruption may still exist, but should be relatively easy to identify and punish. In contrast, corruption appears to be systemic in many health sectors throughout the region.

Systemic (pervasive or entrenched) corruption is where such practices are seen as simply part of the process of interaction between private entities and public officials. Bribery and other types of fraud may be illegal, but informal rules accept them as routine in public-private transactions. Systemic corruption is often associated with an implicit equilibrium in which the incentives are strong for firms, individuals and officials to comply with and not fight the system. Systemic corruption may be confined to one or a few agencies of government, or in extreme cases may occur uniformly across the public sector with the tacit approval, and sometimes encouragement, of the top leadership.

Fraud and corruption are the worst taxes on attracting foreign investment. Investors point out three ways in which fraud and corruption impact investments. First, corruption represents an increase in the cost of a project. As a simple example, consider a firm with a target twelve percent annual rate of return on all its projects. In the absence of corruption, a one-year project that will produce revenues of \$112 million in year one will be approved if its cost is less or equal to \$100 million in year zero. If a ten percent bribe has to be paid for the project to take place, then the project would only be approved if its *ex-bribe* cost was less than or equal to \$90.9 million in year zero (assuming revenues in year one do not change).

This means that if this project has a real *ex-bribe* cost of \$95 million, it would be approved for the country without corruption, but would not be approved for the country where corruption takes its share of the return. This shows, in a simplified depiction, one way in which corruption decreases private investment. But the impact of corruption may be felt not only on the cost equation, but also on the revenue equation of a firm. If part of a firm's profits must be given to regulators or tax inspectors, once again investment calculations will be directly affected.

In addition to affecting cost and revenues of projects, corruption also impacts foreign investment decisions by increasing risks to investors. Corruption augments risks by creating uncertainty on two levels. On the micro level, firms are uncertain about when government officials may find opportunities to extort them or when competitors may gain advantages because of corruption.

On the macro side, pervasive high-level corruption may increase the political vulnerability of a country's regime. In these cases, by increasing the risk premium expected by investors, corruption will decrease the present value of investments. Finally, a third effect of corruption on investment is that increasingly firms are afraid of the bad publicity created by cases of government corruption. With increased oversight by vigilant boards of directors and the important role played by NGOs, the press and watchdog groups, companies are less willing to invest in countries where bribes are an inevitable part of the economic system.

Questions to be addressed:

- ◆ Is corruption one more cost of doing business or can something be done to change it?
- ◆ Are effective mechanisms in place to deal with fraud and corruption in the health sector?
- ◆ Are regulators independent?
- ◆ How much of the problem is due to badly constructed incentive systems?
- ◆ Will opting-out schemes, such as the recent measure by the De La Rúa administration in Argentina, help curb corruption in the health sector?

Transaction Setting

We now turn to issues and challenges arising at a transaction level and in particular areas of investment.

(a) Equity versus Debt Financing

Questions to be addressed:

- ◆ What are the appropriate criteria for equity financing?
- ◆ How does the equity investor ensure protection against malpractice and associated liability?
- ◆ What type of security/collateral is obtained by financiers?
- ◆ Are the lending terms of IFC and other financiers, particularly maturity, consistent with the nature of the business?

(b) Due diligence

Investors identify serious shortcomings in carrying out due diligence of a potential investment, particularly with small and medium-sized companies. Relevant data is difficult to obtain. Investors find that financial and accounting data is non-existent or maintained in sub-standard fashion. Investors, worried about hidden contingent liabilities, therefore shy away from potentially good deals.

Questions to be addressed:

- ◆ What are the best strategies for obtaining reliable data?
- ◆ Does involvement of a local partner help?
- ◆ How much of this problem is an issue of cross-cultural perception or misperception?

(c) Deficient collateral systems

Financing of investments are restricted or less accessible because of shortcomings in the rules and procedures to create, perfect and enforce collateral.

Questions to be addressed:

- ◆ What are the strategies and techniques used in the market?
- ◆ Is it feasible to establish floating liens or fiduciary accounts?

(d) Deficient information systems

Investors find a lack of infrastructure data, including coding and membership structures. Without good medical records and databases, managed care companies struggle to calculate price and risk.

Questions to be addressed:

- ◆ How should investors determine what infrastructure, including IT infrastructure, needs to be created or imported and what elements of the local healthcare operations can be allowed to proceed as they are?
- ◆ What approach should be taken with respect to the medical coding system?
- ◆ How should systems support be arranged?
- ◆ What are the best strategies for training of health workers?

(e) Poor local management skills

The healthcare field has a short supply of skilled managers. It took Latin Healthcare Fund three years to find a hospital company in Brazil with competent managers.

Questions to be addressed:

- ◆ How significant is the training component in investment costs?
- ◆ Which strategies are best for on-going training?
- ◆ What kinds of training are required and who is best-equipped to provide the required training?

(f) Managed-care: specific barriers

Specific challenges for managed care operations include customer resistance to gatekeepers, resistance of the medical community (“doctors don’t like managed care”) and the financial instability of local HMO-type companies.

Questions to be addressed:

- ◆ Have any lessons been learned on educating doctors and consumers about managed care? Should education precede investment?
- ◆ Should managed care be renamed?
- ◆ How important is consumer protection?
- ◆ What kind of consumer protection is required?

(g) Medical equipment/devices: specific barriers

Specific challenges in the area of medical devices/equipment are complex regulatory requirements, unreasonable rates of reimbursement and bans on importing refurbished equipment.

Questions to be addressed:

- ◆ Which specific problems are found in the local registration of medical devices and equipment?
- ◆ Are there substantial delays and, if so, what are their causes?
- ◆ Are there other unreasonable requirements imposed on firms selling to public healthcare institutions?
- ◆ How significant a barrier are low rates of reimbursement?

(h) Telemedicine: specific barriers

Specific challenges which may delay the growth of the telemedicine industry in Latin America include technical problems, legal restrictions and lack of funding.

Questions to be addressed:

- ◆ How reliable are the local telephone lines and services?
- ◆ Is information technology widely available?
- ◆ Do health institutions provide ongoing training and a technical staff to maintain the level and quality of telemedicine services?
- ◆ How sophisticated is the ability to collect individual data from patients?
- ◆ What are the restrictions on setting up data connections?
- ◆ Are telemedicine related services excluded from private insurance health plans?
- ◆ How are privacy concerns addressed?

(i) Pharmaceuticals: special barriers

Questions to be addressed:

- ◆ How significant is counterfeiting?
- ◆ Is patent protection adequate?
- ◆ Which are the shortcomings/loopholes in patent legislation?
- ◆ How prevalent is self-medication?
- ◆ Is there an active/regulated “generic” market?

This brief report outlines how opportunities in the emerging healthcare landscape present special challenges at both institutional and transactional levels. While Latin American governments have committed themselves to liberalizing the region’s healthcare markets, several questions remain. How quickly will markets expand? What shape will industry trends take? Which competitors are already in position? How will remaining regulatory issues be resolved? How will the sub-sectors of the healthcare industry become more integrated? The July Roundtable should provide an excellent forum for the exchange of ideas and information about investment opportunities and related challenges, resulting in innovative proposals for sustainable expansion of the private health industry in the region.