

# Summary of SaludAmericas 1999 Philadelphia, Pennsylvania October 7-8, 1999

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For Latin America, 1999 was an eventful and difficult year. Mexico was the only major economy able to sustain reasonable economic growth, in part because of its strong trade and investment relationship with the U.S. Meanwhile, Brazil, Argentina and even Chile struggled with recession, high unemployment rates and sharp drops in liquidity.

The economic recession focused new attention on the shortage of resources devoted to healthcare in the region. Resource constraints in the public sector make a mix of public-private functions all the more compelling, and argue for faster growth of private services, albeit in accordance with an intelligent regulatory policy. Contrary to popular belief, recent information indicates that income levels in some Latin American countries are sufficient to allow 75 percent of the population to seek private healthcare. If governments were to concentrate their limited resources on the remaining 25 percent service and coverage could be dramatically improved.

Salud Americas is the Institute of the America's leading annual conference on Latin America's health policies, regulation and investment climate. In 1999, the conference was held in Philadelphia. Participants represented healthcare providers, major financial institutions, managed care and pharmaceutical companies, among others. Conference sessions examined experiences with integrated delivery systems and managed care, physicians' changing roles, the pharmaceutical industry and intellectual property, the effects of new technologies on the healthcare field, marketing and research funding, problems of resource constraints and opportunities for private investment, and public policies in the U.S. and the region. This paper summarizes the key findings of the conference, organized as follows:<sup>1</sup>

- [Integrated delivery systems in the US: key challenges](#)
- [Organization of physicians](#)
- [Pharmaceuticals and intellectual property](#)

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<sup>1</sup> The full text of each presentation is available on the Institute of the Americas' at <ftp://132.239.192.118/Health/>

- Current issues in the U.S. healthcare market
- Healthcare and the Internet
- Marketing and fundraising in healthcare
- How profitable is health care?
- Conclusion

## **Integrated delivery systems in the US: key challenges**

*In the U.S., employers have driven profound transformations in health care systems, changes in the economy, and government policy—all of which have shifted more and more risk to the private sector.*

Truly integrated delivery systems represent an industrial revolution in medicine--a totally new approach to accountability for the health of our population. An integrated delivery system creates a continuum or “spectrum” of care by providing prevention, primary care, acute care or inpatient hospital care, chronic care, rehabilitation and supportive care.

**Integrated delivery systems are created in the following stages:**

- Participating hospitals and physicians are brought together
- Consensus is developed among providers regarding clinical practice in order to limit variations in treatment (clinical integration)
- Information and data systems are organized and centralized (client data, performance feedback, current research, etc.)
- Evaluation systems are established to measure each component of the system

Accountability is essential to the success of integrated delivery systems, and has been a major challenge in implementation in the U.S. Managed care has posed particular challenges for physician accountability, as the doctor’s former role as patient advocate has changed to incorporate resource management as well. Health care professionals must balance their treatment of each patient with the wellbeing of an entire population of patients. Economic risks have been transferred to physicians via capitation, giving them responsibility for allocating financial resources within a defined population. Physicians are thus accountable for medical and financial decisions affecting entire populations, and they rely upon the following tools to guide their judgements:

- Profiles of individual physicians’ practices (use of tests, outcomes and associated costs)
- Outcomes research comparing doctors’ own performance with peers
- National or regional benchmarks (now available on the Internet)

- Evidence-based medicine

Physicians are also accountable to individual patients to provide quality care. The U.S. Institute of Medicine in Washington D.C. defines quality as: *the degree to which health services for individuals and populations increases the likelihood for desired health outcomes, and are consistent with the current professional knowledge.* To provide quality care, doctors must ask patients how they feel and what they believe about the care they are receiving, in addition to applying current scientific knowledge to their treatment plans. For physicians, the tension between professional autonomy and the need for public accountability is resolved by providing the best quality of care at a reasonable cost. High quality care costs less *and* outcomes improve if prevention is paramount and appropriate treatment is provided in a timely manner.

The drive to establish integrated healthcare delivery systems in the US, as elsewhere, has been the rising cost of healthcare. Employers and governmental agencies have been at least partially successful in fighting against rising costs through a variety of mechanisms. The 1980's witnessed the gradual adoption of managed care approaches by private sector employers. During the 1990's, HMOs have grown rapidly, gaining market mass, and forcing providers to consolidate. The new dominance of managed care organizations has resulted in shrinking provider reimbursements, greater HMO control over referrals to specialists, increasing bureaucracy, declining coverage of medical conditions and limitations on access to specialized care.

Today, at the beginning of the 21<sup>st</sup> century, we are undergoing a third phase in the evolution of U.S. health care. Managed care's share of the market has peaked, and both providers and consumers are seeking more flexible and responsive solutions to rising costs. Providers are demanding greater autonomy and are organizing to increase their leverage with HMO's, while consumers are demanding broader benefit plans, expanded access and greater choice.

While the nineties witnessed rapid growth in large, national managed care firms, the Clinton administration began to focus on returning power to the consumer, exemplified by new laws to protect patient rights. U.S. HMOs came under increasing political and financial pressure to reform their practices, a trend likely to be played out in other societies where they have taken hold. In general, we see that physicians are now better able to negotiate, have better access to information and a clearer understanding of the risks faced by private capital in this sector. Consumers and providers are now the most important agents of change in the health sector. They advocate an outcomes-oriented approach and an integrated rather than adversarial relationship between providers and payers.

The greatest lesson from the U.S. for policymakers in other countries is the recognition that health insurance is a powerful economic mechanism that forces providers to become

competitive. In the U.S., employers have driven profound transformations in health care systems, changes in the economy, and government policy—all of which have shifted more and more risk to the private sector.

Although the U.S. system enjoys new technologies and the best care in the world, particularly for those who can afford it, Latin Americans should recognize that the U.S. does not have a comprehensive health policy but a budgetary policy. Too often, policymakers take action or adopt policies without accounting for other governmental and private initiatives. The result is a pluralistic system loosely based on notions of managed competition and managed care which vary greatly from state to state, with differing and even conflicting financial incentives.

Should Latin America embrace the hazardous and complex road of managed care, ridden with chaos and implementation problems? Yes. Every society is faced with limited resources, and managed care not only helps contain costs, it can enhance the quality of care and assure that healthcare is delivered in the right setting and at the right time. Managed care must be implemented within the context of a public policy framework that balances market forces and incentives with basic ground rules.

Managed care in the U.S. introduced a competitive element to price setting. Enabling consumers to shop around for prices and quality, managed care was able to curb price increases and forced providers to become price-conscious. Managed care is expected to rationalize the delivery of care to make it even more efficient. It is likely the best mechanism for disease management and prevention programs, which are essential to an organized delivery system. This will result in higher quality care and potentially lower costs. But the industry has been disappointing in its attempt to employ management to improve healthcare, instead of focusing on cost reduction. The industry will be hurt more substantially if it fails to harness the Internet and other information technologies to provide information to consumers and physicians.

## **Organization of physicians**

*Aligning incentives with physicians is a prerequisite for success*

Health care in the U.S. has improved substantially, yet there is much unhappiness among both patients and physicians. With the transition to managed care, physicians who were independent found themselves impotent in this new market, and resolved to group together in order to gain strength vis-a-vis payers, hospitals and suppliers. Physician organizations increased dramatically in the late 1970s along with pre-paid care. Loss of the traditional relationships among patients and physicians, and physicians' inability to treat the patient independently were perhaps the most traumatic effects of the new system, particularly when patients were forced to leave their physician if he/she did not belong to the managed care system.

PSOs allowed physicians to contract directly with companies, but most have failed. Independent Physician Associations (IPAs)—mostly made up of primary care physicians—allowed doctors as a group to contract, purchase supplies and bill clients, which was previously not allowed due to antitrust laws. Management Services Organizations (MSOs)—the management arm servicing IPAs— and Physician-Hospital Organizations (PHO) also emerged, with pros and cons. Most PHOs have failed, particularly when the hospital had more control or when their motivation was primarily to lure patients to the hospital. Buying physician practices has also been unsuccessful, due in great part to the companies’ failure to align incentives and rewards based on performance.

Successful new forms of organization have been those with clear vision and good leadership, traits not understood by many physicians who have only been involved in treating patients and are unfamiliar with business concepts. Successful groups built trust and well-developed infrastructure. Solid financing has also been a key issue in the success or failure of these organizations. In the U.S., physician organizations are a response to market pressure, competition, managed care, and the high cost of care. Some frustrated physicians are pushing for new laws that will allow them to unionize. Until a clear picture appears, we will not know what form of organization will succeed. Pre-paid plans tend to limit care while fee-for-service creates incentives for too much care. A blended payment mechanism may be a better alternative.

### *Physicians in Latin America*

As in the U.S., rising healthcare costs and lack of access in Latin America point to a need for managed care. But while resistance to managed care in the U.S. has stemmed from doctors’ fear of losing income or autonomy and from patients’ loss of choice, in Latin America physicians’ income and autonomy are not at issue. Latin American consumers are more concerned with access than choice. To successfully implement accessible managed care in Latin America, attention must be given to countering corruption and establishing transparent regulatory and legal frameworks. The most effective feature of managed care in the U.S. has been requiring uniformity to eliminate variations in services; this feature would be particularly important in Latin America and could be monitored by physicians’ organizations.

Physicians’ quality of life in Latin America is lower than what they might expect given their training. Few have formed networks and most are employees of the public system and/or have a solo practice. They lack capital to build their offices or groups and often lack the skills to run their practices as businesses. The labor market outlook for the majority of physicians is pessimistic. National coordinated efforts to better match training of physicians to patient needs must be effected—efforts that will become increasingly important as new techniques become available and the roles of physicians change.

Most physicians are salaried, receiving less than \$1,000 per month. Education and stipends are used to compensate physicians. Since financial incentives are weak, status, personal goals, and other non-financial incentives may motivate doctors. Physicians charge fee-for-service, based on whatever patients can pay. Capitation can be dangerous in Latin America because of the inability of some to pay and the public's lack of knowledge about healthcare costs. In the few instances where doctors have formed a group, shared income distribution has worked well.

Most countries have little or no regulations or uniform standards for medical practice, and training in medical schools is generally poor. Licensing is the only means of controlling quality. Merit-based systems might work well in Latin America, such as increasing doctors' participation in decision-making, and providing training and promotions based on specific qualifications. Increasing hospitals' autonomy and human resource planning are also extremely important to successful reforms. In addition, the region is expected to develop clinical guidelines, measurement tools and financial incentives. Combating corruption and the power of unions are perhaps the toughest challenges. The trend in Latin America is to continue the separation of financing and delivery, to allow more competition, and to move toward more private participation in healthcare.

## **Pharmaceuticals and intellectual property**

### *Harmonization should bolster foreign investment*

Pharmaceuticals are one of the most important and growing areas within the healthcare sector. They account for 30 percent of healthcare spending in developing countries, 8-10 percent in the U.S., and 12-20 percent in European countries. They are the most rapidly growing component of healthcare spending and are projected to soon overtake hospital spending as the largest share of the premium for some HMOs. The two primary contributing factors for this growth have been an unprecedented number of new products and increased patient demand for them. Fear of higher prices, at least in the U.S., has been exaggerated, where the price of pharmaceuticals has not risen significantly.

There are now fewer hospital admissions, but they are more costly, due to reliance on expensive technology, and huge increases in outpatient pharmacology. The per capita cost of prescriptions for the chronically ill ranges from \$12,000 to \$100,000 per year in the U.S.

The pharmaceutical industry is expanding rapidly since the FDA reduced approval time from 30-plus to 12-15 months. Pharmaceuticals companies' spending for R&D grew from \$8 billion to \$24 billion in 1999. Almost 700 new drugs are for cancer treatment, over 200 for cardiovascular disease, 150 are in the vaccine category and 100 each in a variety of other categories—a total of

over 1,500 new agents in the development pipeline. Such an explosion makes it very difficult for physicians to keep track of new drugs and increases tensions between drug manufacturers and health plans.

Higher demand for pharmaceutical products is fueled both by the supply side, eager to apply new technology in order to compete for patients, and by consumers, driven by direct consumer advertising--a new element in the U.S. market. The advertising dollars spent to promote specific drugs has increased fourfold. Billions are now spent in direct advertisement, increasing the growth in demand. The number of field personnel hired by pharmaceuticals to visit and sell to physicians has increased from 40,000 to 60,000. Product positioning is used to eliminate competition and gain preferred status.

Pharmacy cost increases of 12-15 percent translates into 2-3 percent increase in the profit differential of premiums. This, paired with additional costs, has resulted in decreased managed care profits and even losses. In response, managed care organizations are implementing formularies, cost shifting, and lifetime or yearly maximums.

Contracted third parties at preferred rates--such as Pharmacy Benefit Management (PBM) companies--have emerged to facilitate claim transmission, online verification of plan membership, and online pricing at pre-negotiated rates. This third party role has become more important as pricing intermediation and containment systems give companies tangible control of pharmaceutical usage and access to data useful in creating disease management programs. They have brought rationality to the system not available before. Because the top four PBMs encompass over 75 percent of the insured, they have considerable pricing leverage nationwide.

Major pharmaceuticals are shifting their managed care focus to a consultative role. Emerging agents are seeking to engage managed care early on in the process to decide whether products would be accepted, included in the formulary, be a pharmacy benefit or a medical benefit, and where they would be delivered.

The industry is also looking to engage larger managed care organizations in trials by identifying and using a better-targeted population. The industry has vested interests in helping providers succeed, and helps them understand risk modeling, offering information systems, clinical practice improvement, activity-based costing with correlated claims and encountered data, patient satisfaction surveys, and outcomes analysis.

The pharmaceutical industry also has a strong vested interest in helping managed care companies succeed, as increases in the number of eligible insured will increase drug sales. The industry

needs to promote affordability of drugs being prescribed as well as compliance to avoid more expensive medical cases.

Consolidation will continue, increasing purchasing power through managed care organizations' group purchasing, aided by PBMs. Most likely, there will be a few years of crisis management within HMOs, since they lack understanding of drug use management. There will be an increased role for consumer advocacy and government legislation to improve accountability, and expansion of drug coverage into the Medicare product line.

New technologies and new scientific developments are revolutionizing pharmaceutical products. Today there are various categories of therapeutic products. For example, drugs have been around for a long time, but over the last 10-15 years, biologicals--used in cell therapies such as bone marrow transplants--have been growing. The latest development is the use of genes as therapeutic agents. The best way to understand gene therapy is to look at DNA as a drug. Treatment consists of inserting a functioning gene into the somatic cells (non-reproductive cells that only affect the individual and not future generations) of the patient.

Gene therapies were conceived for the treatment of approximately 5,000 genetic and rare diseases (five percent of all diseases) such as cystic fibrosis and hemophilia. The first clinical trials started in 1990 and to date, nearly 3,000 patients have been involved worldwide. After ten years of research, unequivocal evidence of efficacy has not surfaced in phase one trials involving testing for safety and toxicity. (Trials have not yet been conducted to measure efficacy, rendering the term "therapy" a misnomer.)

Trials are inordinately expensive and funding is a principal challenge. Tests on just six individuals can cost over half a million dollars. Such high costs make market size a crucial factor for companies entering this field and few will be interested in the research on treatments for diseases that are so rare. Although gene therapy was conceived as a potential treatment for single gene or monogenic deficiency diseases, of the 300 trials conducted so far, 62 percent have been for cancer treatment. Of the remainder, 12 percent are marking trials meant to answer questions about human biology, and about nine percent are for AIDS research, using gene transfer to inhibit replication of the virus. A variety of other studies involve heart disease.

Companies are interested in gene therapy for cancer treatment because the disease is quickly becoming the primary cause of death in the U.S, and is expected to surpass cardiovascular diseases in 2,000. In the case of orphan drugs, government intervention and incentives are needed, and as well perhaps a new model for product development that compresses phase I and phase II trials, or even phase III, because a limited number of patients are available for testing. There is even potential for introducing genes into stem cells, which are long-lived cells capable

of self-renewal. A challenge will be to price a new product of that nature, to be administered on a limited basis. There are no answers to this and many other questions in this emerging field.

### *Global harmonization and intellectual property*

A patent is a legitimate monopoly, requiring full disclosure of the invention so that at the end of its life, more cost-effective products can be produced. Harmonization requires consensus on the owner of a patent or agreement that the patent holder is the inventor who first files. The high cost of obtaining a patent worldwide favors big companies who can afford to file for protection. Expense, along with the difficulty of worldwide enforcement, are the two main challenges to harmonization. A third unresolved problem is the export of products to a country where they are not patented, a practice currently allowed only by Canada and Israel.

The last ten years have witnessed rapid acceleration of intellectual property harmonization, but an affordable international patent process is still far away. Obtaining worldwide patent protection today costs between five hundred thousand and one million dollars. The World Intellectual Property Organization (WIPO) is responsible for coordinating the Paris convention and the Patent Cooperation Treaty (PCT), which established an international application for patent protection. The Standing Committee on the Law of Patents (SCP) has drafted a patent treaty aimed at easing the process of securing an application. The treaty will establish guidelines for deadlines and online filing. Nonetheless, separate applications are required in each country where a patent is sought. (The one exception is the European Patent Convention (EPC), which allows for one application to be used in all 19 signatory countries.)

The Trade Related Aspects of Intellectual Property Rights Agreement (TRIPS), incorporated into the World Trade Organization negotiations (Uruguay Round), require that signatory governments enact separate legislation for patent applications and enforcement. TRIPS established that nations could not discriminate against any type of technology, and the patent life of many brand name products was extended to 20 years from the date the patent was granted. Higher prices and a negative effect on the generic drug industry have resulted. The World Trade Organization is a forum where countries dissatisfied with TRIPS can voice their concerns and file complaints about either a country or a procedure.

Harmonization should bolster foreign investment in several countries. For example, immediately after enacting patent protection, Brazil received \$750 million in foreign investment commitments.

## Current issues in the U.S. healthcare market

Key issues in the U.S. market may be summarized as follows:

- Dramatic changes are taking place across the sector, but at this point it is difficult to discern a national pattern or predict the shape of the new system that will emerge.
- Consumers and providers are demanding more than proposed legislation will be able to deliver.
- HMOs are retreating from a highly managed system to a more loosely managed product with broader networks and higher proportions of physicians and hospitals. They are experimenting with new products that allow patients to go directly to a specialist, rather than the traditional HMO “gate keeper” mechanism. Consumers have demanded and pay more for the ability to go outside of the network.
- Capitation is not growing to the degree expected a few years ago. Many plans are unwilling to sign capitated contracts with providers because they lack confidence that providers have a low risk management system. Providers are also wary about capitation because they have lost money, often due to inadequate management. Cost increases outside of the control of the managed care organization (growth in pharmacy spending, regulatory changes mandating additional services, open-access products where patients may go outside of the network) have placed tremendous pressures on profitability.
- Managed care organizations that had attempted to integrate hospital care, physician services and financing are being forced to dis-integrate in the face of competition from plans selling access to physician practices and primary care clinics. Hospitals are also starting to disaggregate their services (some with more success than others) and sell plans that provide more options and choices to consumers.
- Horizontal consolidation, on the other hand, has continued with the development of regional entities formed by mergers of geographically dispersed firms. Such mergers are driven by the need to find alternatives to vertical integration that will provide scale economies and reduce costs.
- Mergers among hospitals appear to be slowing. In some cases markets have reached their natural limits, or anti-trust measures have been enforced. In other cases, such as Columbia HCA, no major threats necessitate a merger.
- Provider intermediaries (physician practice management companies mediating physicians or physician group practices and health plans) have stumbled. Intermediaries have suffered from high overhead costs compared to the benefits they provide, and physician productivity has dropped dramatically under these arrangements.
- Intermediaries have moved toward independent practice associations (IPAs) and medical service organizations (MSOs). IPAs are organizations of physicians owned by entrepreneurs or physicians. IPA physicians are independent and may view the hospital as an adversary. Because of low physician reimbursement, they maintain low overhead.

- Hospital-physician partnerships have suffered from lack of clout with health plans. Plans could contract physicians directly, bypassing hospitals. Physicians' lack of trust in hospitals may also have played a role.
- Single specialty organizations have emerged in which physicians practice the same specialty. Single specialty groups have consolidated to gain clout with both insurers and hospitals as well as to reduce costs.
- Free standing ambulatory care facilities have been created, often linked to a specialty. "Surgicenters" have proliferated, as well as specialized hospitals in areas such as cardiovascular treatment. The hospitals are owned by a specialty group practice, a partnership of specialists, or a joint venture involving specialists and a Physician Practice Management company.
- Care for the poor is inadequate. Despite low unemployment, the numbers of uninsured continue to grow. Safety-net providers have been threatened by the loss of their best paying customers, which may also be viewed as a major accomplishment for Medicare. Greater competition in the health market has been driven by the need to increase profits in order to subsidize health care for the poor.
- Premium increases have been extremely low (prices are still below 1980's levels) but will increase. Pushing for higher premiums are pressures on health plans (from employers, legal and regulatory environments) to manage less; emphasis on choice of providers, affording them more leverage; and technological changes, particularly among pharmaceuticals who market directly to consumers. However, employer and buyer pressures will moderate premium increases.
- Nationally, fiscal health and political sophistication (i.e., policies crafted to avoid alienating insurance companies or the opposing party) are contributing to a resurgence of proposals for universal healthcare.
- Health care costs in the U.S. continue to rise due to higher labor costs and research and development expenses. Direct marketing to consumers by pharmaceutical companies has resulted in both increased demand and higher costs.
- Consumers will have growing access to information via the Internet. The impact of this revolution in availability of medical information is unknown.

#### *Issues to watch*

- How much of an increase in premiums will employers tolerate?
- Will physicians practice more efficiently and/or increase their leverage through the new organizations that are expected to emerge?
- What will be the effect of the backlash to managed care?

- Will the 1997 Balanced Budget Act (limiting Medicare and Medicaid spending to reduce the federal health budget by \$200 billion by 2000) pressure some hospitals, home health providers or nursing homes out of business?

## Healthcare and the Internet

*Successful applications will take advantage of the reduced cost of electronic relationships with business partners, customers, the workforce and sources of intellectual capital*

The information technologies that are revolutionizing U.S. health care could have an even more dramatic impact on Latin America, allowing for broader coverage and higher quality care with less infrastructure investment. New technologies have been crucial to the emergence of broad networks for information sharing and disease management systems that emphasize wellness and prevention (as opposed to more costly treatment). Firms that fail to integrate themselves into this new paradigm, whether providers or insurers, are unlikely to succeed in an era of high customer expectations for flexibility and responsiveness. Nevertheless, financing and affordability will remain key concerns.

Technology and the Internet are not solutions but enablers. They cannot and will not preclude good management and the making of difficult decisions. What they can do is provide access to information and compress the speed at which it is accessed, creating both clinical and business advantages. The new technologies will allow providers to measure customer experience and satisfaction. The Internet creates tremendous value by informing consumers and patients about medical conditions and treatment, by processing transactions, facilitating outsourcing, and even restructuring care. In the future, the Internet may be used to enhance the delivery of care by sharing clinical protocols and information worldwide to facilitate timely, efficient and cost effective delivery of care. Transfer of information over the “net” is quite safe. Brand awareness is and will continue to become important. And higher levels of consumer-specific profiling will decrease the costs of prevention or direct patient care, for example.

When patients search among the vast sources of medical data available on the web, credibility of data is particularly essential, since misinformation poses dangers. The true arbiters of healthcare delivery, the physicians, have reservations about the Internet, but they cannot ignore the fact that information transmitted over the Internet is fast and cost effective. The Internet will not replace physicians. In fact, doctors will be able to use information about a patient to use his/her time better and reduce costs of delivering care. Best practices will be distributed worldwide. The safe transfer of electronic medical records will be possible in the future, as will uniform medical records, licensing and accreditation procedures.

The biggest return on investment in the Internet, however, will be its business-to-business applications, revolutionizing the way business is done. Business applications will move beyond superficial marketing to develop content, connectivity, and commerce. Successful applications will take advantage of the reduced cost of electronic relationships with business partners, customers, the workforce and sources of intellectual capital.

## **Marketing and fundraising in health care**

*Small, locally based businesses must move beyond a limited market, cooperating with each other in order to compete for today's more knowledgeable consumers.*

Business management structures are changing rapidly to respond to changing markets and demands. Only those who can adapt will thrive. Available technologies to reach consumers and suppliers are unprecedented, and are also constantly changing, as are methods for gathering data. Public relations, strategic planning and marketing have ceased to be cyclical activities. Previously, campaigns for brand awareness, to develop market share or for competitive positioning were executed in a pre-determined timeframe. Today campaigns reach out to customers, suppliers, and the public on a permanent basis. Businesses reach ever greater numbers of people using a limited number of venues through the new media. In global, fast-changing economies there are no safe industries. Small, locally based businesses must move beyond a limited market, cooperating with each other in order to compete for today's more knowledgeable consumers.

New technologies can be used in customer satisfaction surveys to test image, evaluate or rate services, determine demand for new services and build a constituency vis-à-vis the competition. Following up with open-ended questions to obtain the "why" when answers are negative is very important, particularly in health care, as is evaluating quality of services. Influence interviews and focus groups are also very useful, as well as interviews with community leaders to gauge emotion and intensity from the focus groups. Targeted surveys for women, low income and hard to reach groups enable businesses to reach markets that are more and more specific and stratified. Products reaching specific segments must be differentiated from the competition, and clear communication of the organization's competitive advantage will result in customer preference. In Latin America, the most important feature may be accessibility at a reasonable cost. However, where there is choice and stiff competition, developing a recognizable image is still key to success. A hospital must create an appealing presence and corporate personality to attract philanthropic dollars and consumer preference.

To effectively identify and serve key markets, businesses must constantly measure and monitor the marketplace by using surveys and other tools. To assess, for example, hospital preference, consumers should be asked to judge physician expertise, hospital trustworthiness, clinical

outcomes, caring of the nursing staff, and medical leadership. For physicians, a caring nursing staff is of primary importance because they influence patients' responses and affect physicians' reputation. For the contracting company, cost and competitive pricing would be the most important indicator, although companies might be willing to pay a premium of up to 10 percent for customer preference, convenient location, comprehensive services, or physician expertise. Hospitals can leverage dollars by forming partnerships with others in the community such as sports teams, the media, and other organizations with the ability to reach wide audiences.

## **How profitable is health care?**

*For-profit plans are growing, even though revenues and stock prices are declining*

In 1980, HMOs covered nine million people, 15 percent belonging to for-profit plans. By 1998, HMO enrollment had increased to 79 million with almost two-thirds in for-profit plans. Most of the large HMOs in the U.S. are for-profit. Among the exceptions are some of the 30-40 companies within the Blue Cross/Blue Shields umbrella, which are becoming increasingly for-profit, and the Kaiser system. Enrollment (over 70 percent) is highly concentrated in the top ten managed care companies. For-profit plans are growing, even though revenues and stock prices are declining, and the largest not-for-profit plans are facing serious economic problems. Nevertheless, new companies continue to emerge, compensating for the high rate of mergers and overall consolidation. There were 650 purely HMO plans in 1990, 651 in 1997, and 652 in 1998.

Declining profits are the result of:

- Inability of hospitals and doctors to further discount prices
- Increase in government regulation, such as the Patient's Bill of Rights (PBR) which gives consumers the right to sue for lack of services as well as pain and suffering (There is no evidence yet that the PBR will result in increases in lawsuits.)
- Higher costs of new technologies, drugs, therapies and procedures
- Inadequate information systems--good information technology is vital to success
- Consumer pressure

Prospects for future profits:

- Premiums may increase by 8-15 percent
- Client education may lead to greater acceptance of managed care
- Providers may fail to maintain their coalitions against HMOs
- Mergers of HMOs

Factors that do not bode well for profitability include:

- Physician unionization
- Consumers' continued complaints

- Increased regulation of managed care
- Employers' rejection of premium increases and disillusionment with managed care as a means of limiting medical expenses
- Dramatic volatility among small plans lacking a large risk pool

## Regional report-Finance Models

*Similarities exist in the distribution of public/private expenditures for healthcare*

In Latin America, government expenditures are concentrated in urban areas and hospitals, rather than on prevention and basic services, resulting in high inequity and subsidies for the rich. Currency devaluations have increased the costs of technology, equipment, quality of care, and access to health care, and have decreased incentives for local investment. Large, public, direct-delivery systems operate alongside social security systems that hire private providers to deliver services. Excess demand and limited supply of public health services has led to the proliferation of private providers in many countries. Latin America's problem is not so much reducing costs but proper utilization of its healthcare resources--its systems and infrastructure are still inefficient.

Private sector development, in health as in other fields, is uneven and unstructured throughout Latin America, with exceptions such as in Brazil, Chile, Colombia, and to a lesser extent, Argentina. But the private sector throughout the region is becoming more proactive. There is enormous growth potential in Latin American markets for international private participation, but achieving results will require patience. North American companies, in particular, are not likely to make investments that will not produce timely returns. The problem is compounded by currency devaluation, economic and political stresses.

## Conclusion

Participants in the conference concluded that healthcare reform, regardless of country or region, must incorporate access to care, affordability, high quality, and improvement of the health status of the *overall* population.

The Institute of the Future (with 20 years of demographic data), the Center for Disease Control at the University of California in San Francisco, and the Schools of Public Health and Medicine at Berkeley, conducted a recent study that defined "determinants of health." The study showed that in the U.S. 50 percent of our health depends on lifestyle, 20 percent depends on who our parents were, 20 percent is environmentally influenced, and 10 percent depends on what we think influences our healthcare. More importantly, the study showed how health care expenditures are

allocated among the above determinants. In the U.S, the bulk of resources is spent on what we think influences health care. That is, of the trillion dollars spent on healthcare, less than 1.4 percent goes to the lifestyle category, the major determinant of our health. The study found that future responsibility for healthcare financing will weigh heavily on the shoulders of individuals, and lifestyle choices will determine much of the cost of that care.

Outside the U.S., the struggle will lay in balancing the roles of the private and public sectors in the healthcare system. Clearer definition of private/public roles is needed to distribute responsibilities for health care financing, public education and quality services. The other topics discussed in the Salud-Americas 1999 conference--management, information systems, training, credentialing, accreditation, integration, the Internet, are all tools or means to that end.

Healthcare is capital intensive. In both private and public systems, alignment of incentives will be the key to providing optimal care to the greatest number of individuals. Doctors, the nucleus of health care, must be motivated to save money *and* deliver quality care, and patients must be motivated to take the best care of themselves.