MANAGED CARE IN LATIN AMERICA: THE NEW COMMON SENSE IN HEALTH POLICY REFORM

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ABSTRACT

This article presents the results of the comparative research project, “Managed Care in Latin America: Its Role in Health System Reform." Conducted by teams in Argentina, Brazil, Chile, Ecuador, and the United States, the study focused on the exportation of managed care, especially from the United States, and its adoption in Latin American countries. Our research methods included qualitative and quantitative techniques. The adoption of managed care reflects the process of transnationalization in the health sector. Our findings demonstrate the entrance of the main multinational corporations of finance capital into the private sector of insurance and health services, and these corporations’ intention to assume administrative responsibilities for state institutions and to secure access to medical social security funds. International lending agencies, especially the World Bank, support the corporatization and privatization of health care services, as a condition of further loans to Latin American countries. We conclude that this process of change, which involves the gradual adoption of managed care as an officially favored policy, reflects ideologically based discourses that accept the inexorable nature of managed care reforms.

Key words: Latin America; health policy; managed care programs; health maintenance organizations; privatization; public health; economics, medical.

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Our intention in this article is to contextualize the health care reforms currently taking place in Latin America, and to analyze their social construction at the economic and ideological levels. In many historical periods, the necessity of reforming Latin American health systems has arisen in policy discussions. Most of the concepts that receive attention today (efficiency, effectiveness, cost/ benefit, freedom of choice, decentralization, community participation, etc.) were also used in the 1950s and 1960s, to motivate transformations in health care organization (Merhy, 1992; Iriart et al., 1994).

For instance, two consultant reports on health care organization in Argentina, presented in 1957 by experts of the Pan American Health Organization (PAHO), represent clear examples of earlier policy positions (OPS/OMS Commission of Consultants, 1957; OPS/OMS Pedroso, 1957). These extensive reports recommended that the Argentine government restructure the health care system, starting with decentralization of administrative authority. The reports also argued in favor of training health care personnel to use techniques of cost analysis and related administrative principles. A central purpose was to achieve more efficient institutions that could maintain an adequate cost/ benefit relationship.

Starting from mid-1980s, many technicians and intellectuals in the health care field recaptured these concepts, to respond to a profound crisis of financing systems and health care in Latin America. However, these concepts changed, and their

meaning was determined by the new context in which they were applied (Testa, 1997). Health care systems in previous decades were defined partly within an overall economic model of capitalist accumulation; this model was based on full employment, production of goods and services by state enterprises, and a supply of healthy and educated manpower. In this context, the concepts used in the elaboration of proposals for reorganization of health systems included a conception of the health as a public good and state responsibility.

Current health sector reform assumes a quite different process, marked by a crisis in the model of capitalist accumulation that has occurred since the mid-1970s: intermittent global recession, profound transformations in the forms of production including informatics and robotization, the increasing domain of finance capital in the world economic system, the growing internal and external indebtedness of Third World countries, growth of the fiscal deficit, high inflation, problems in balance of payments, and unemployment (Coriat, 1992; Feletti & Lozano, 1997). This situation implies fundamental changes in the role of the state, since multilateral lending agencies demand contraction of public expenditures, control of monetary expansion, and reform of the state structure itself. The state is identified as the cause of the crisis due to its inefficiency in managing productive enterprises (oil, steel, etc.) and services (communications and transportation), and its growing social expenses (health, education, and social security). Requirements for state reform comprise four main elements, which tend to remain hidden or implicit in policy discourse: a) a need for

private capital to control the areas of production and services that previously were controlled by the state; b) the necessity to invest large surpluses of liquid capital; c) a decrease in the demand for manpower, which derives both from a transformation of production due to developments in computer science, and from a reorganization recognizing that economic consumption expands from diversified production and not from mass production; and d) the need of First World countries to emerge from the crisis in the least traumatic form possible (Feletti & Lozano, 1997).

In this new context, we initiated a comparative investigation of health reforms, carried out by teams in Argentina, Brazil, Chile, Ecuador and United States. The overall objective of the study was to analyze the exportation of managed care, mainly from the United States, and its incorporation in the Latin American countries under study. The results presented here refer mainly to the transnationalization of health policies, advanced through reforms supported by international lending agencies, especially the World Bank. For that reason, we focus on the entrance of multinational corporations of finance capital in the private sector as both insurers and health care providers, as well as their participation in the administration of state institutions and medical social security funds. In the discussion section, we advance some theoretical reflections to understand the current process of reform and to develop alternative conceptualizations. We argue that changes in health systems implied by the gradual adoption of managed care are facilitated by transformations operating at an ideological level, including discourses that accept the inexorability of these reforms within the limits of official proposals.

After describing our methods, we proceed with a further characterization of the context in which these processes take place, offering a synthesis of results from own and other authors' investigations. Many data in this article refer to Argentina and Chile, since these are the countries, among those studied, where transnationalization of the sector health is most advanced.

METHODS

Methods used in the investigation were qualitative and quantitative. In the first place, the published and unpublished literature on managed care in Latin America was reviewed. Each national group had access to pertinent bibliographical collections. The libraries of the national legislatures, of professional associations, and of international agencies of credit and cooperation also were consulted, as well as Internet sites of these agencies and of the ministries of health. These sources contained documents about oral presentations and conferences where leaders in the field of health policy gave their opinions and contrasted their experiences, as well as documents presenting the official positions of governments and international agencies. Critical review of this bibliography emphasized debates, diverse points of view, and controversies.

The second method involved the assessment of archives in the countries under study, especially those located in the ministries of health, foundations, and research centers. These archives included less formal political analyses, findings of investigations, press publications, and journal articles. We gained access to the databases of two newspapers of wide circulation in Brazil and Argentina. In this phase

of the research, the archives were studied critically to understand the evolution of managed care in each country. Again, different points of view and debate were emphasized.

A third method of data gathering involved focused interviews. A protocol of closed- and open-ended questions, focusing on the diffusion and implantation of managed care, was used. In each country, interviews were carried out with recognized leaders of government organizations, members of the legislative apparatus, officials in the delegations of international agencies of credit and cooperation, managers and executives of the national and multinational private sector, union and political leaders, advisers, and consultants. A list of respondents was developed to encompass a diversity of perspectives.

As complementary methods we used quantitative techniques in the analysis of secondary data to estimate the participation of each sector - state, private, and social security - in the administration, financing, and delivery of services under managed care.

RESULTS

Managed care as an axis of reform. Managed care reforms generally are administrative and financial, since they consider growth of health care costs as the main cause of the health sector's crisis. For that reason, the reforms suggest the necessity of an intermediary between providers and users, to separate financial administration from the delivery of services. Proposals for managed care imply the introduction of enterprises (state, private, or mixed) that administer financing under the concept of

shared risk (capitated systems), and contract with managers for the inclusion of state supported services (OPS, 1996; Merhy et al., 1998).

In the construction of the public sector budget, these solutions are planned so that they respond to demand rather than supply of services. This approach allows a reduction of fixed costs and a more efficient management of resources, since excess services are controlled and financing is directed toward providers of presumably higher quality. According to this logic, to obtain financing, providers are forced to lower their costs and to offer higher quality services. Discourses supporting these policies emphasize the assumption that, if purchasers feel in control of their contribution or payment for the service, they will comprise a natural regulator of costs and quality, since purchasers choose providers that offer the best services at the least cost (Bresser Pereira, 1995; Ministry of Health and Social Action of Argentina, 1997). These discources also assume that public-sector services have proven inefficient and unpopular, leading to widespread dissatisfaction among consumers, even though there is little systematic evidence showing more dissatisfaction with public-sector as opposed to private sector services (please see the Appendix for a summary of the literature on dissatisfaction in public versus private sector settings).

Reform proposals, whose frame of reference derives mainly from the United States, tend to produce fundamental changes in clinical practice. These changes involve the subordination of health professionals to an administrative-financial logic, and a drastic reduction of independent professional practice, since professionals have to

offer their services to insurance companies or the proprietors of large medical centers (Waitzkin, 1994; Waitzkin & Fishman, 1997).

The political process which accompanies these reforms is usually a silent one, which is restricted to the executive branch of government. This process generally segments the policy-making process and therefore reduces political conflict. To achieve a silent process of policy making was expressed as an explicit decision by such informants as an official of the World Bank's delegation in Argentina and a high official of the Ministry of Health and Social Action of that country. That is, the policies that implement the reform are directed sequentially toward the public sector, the private sector, or the social security system, but they do not adopt a unified approach to the health care system as a whole. In general, policy implementation bypasses discussion in the legislative branch. For this reason, presidential decrees (for example, iArgentina: Decreto 578/93, Creación del Hospital Público de Autogestión; Decretos 9/93, 576/93, 492/95, 1141/96, 1615/96, 638/97, 1301/97 regarding deregulation of social security) or ministry regulations (Brazil: Normas Operacionales Básicas NOB 91, NOB 93, NOB 96, Medida Provisoria Nº 1591) are used.

At each stage, the involved actors are only those who participate in each subsector (public, private, or medical social security); this approach hinders a societal perspective on reform. Within each subsector, participants try to accommodate to the reform processes, without recognizing the impact on other subsectors. For instance, policy changes directed toward the private subsector are not considered by actors in the

public subsector or in the social security subsector, as within their purview. We observed this tendency in interviews and in numerous documents and public policy declarations, especially by professional associations, professional and non-professional unions in the state subsector, unions that administer social security systems (in Argentina), managers in ministries of health, and business people in the private sector (Salud Para Todos, 3 (23), 1995, Salud Para Todos, 1997, 5 (25). Nevertheless, the current reform processes actually achieve a profound articulation of the three subsectors (not achieved previously in most of Latin American countries, despite a long expressed need for this articulation), but under the command of private interests, and especially of multinational finance capital (examples of this tendency appear later in this article).

Support from multilateral lending agencies. The response of most Latin American governments to the financial crisis of the 1990s was the acceptance of policies initiated by multilateral lending agencies: the World Bank, Interamerican Development Bank, and International Monetary Fund. These policies implied increased indebtedness, the opening of national economies to multinational finance capital and production, and the restructuring of the state via privatizations (affecting both industrial production and services) and decreased expenditures (especially social expenditures) (IDEP, 1992, 1993). This orientation gives impetus to plans of "structural adjustment," on whose execution will depend access to new international financial resources (García Delgado, 1994; Iriart et al., 1995). In the health care environment, structural adjustment

implies the acceptance by Latin American governments of the reform projects initiated by these lending agencies, especially the World Bank. By consenting to the requirements of structural adjustment, the governments gain access to loans but also must consent to major cutbacks in public services.

In Argentina, for example, at the end of 1991, the reformulation of health projects that received financing from the World Bank began. World Bank loans previously were dedicated to four areas: hospital decentralization, development of human resources, a health information network, and health promotion and protection. Under more recent policies, the loans required that new projects be centered in reform of state medical care institutions (hospital self-management) and the deregulation of social security funds. The purpose of these policies was to reduce state participation in the financing, administration, and delivery of services, and to enhance the role of the private sector (Iriart et al., 1993a, 1993b; Ministerio de Salud y Acción Social, Argentina, 1996; cf. Buse & Gwin, 1998).

Projects of health sector reform, carried out with these international loans, have served as a basis for the elaboration of legal norms (laws, ordinances, ministry resolutions) that facilitate the operationalization of a new discourse, linked to the crisis of the welfare state. Gradually “common sense” is transformed concerning the conceptualization of health, illness, and health care services. In the official pronouncements we have studied, health care no longer remains a universal right for whose fulfillment the state is responsible, but rather is converted into a good of the

marketplace that individuals can acquire. This is a fundamental change in meaning, since health stops being a public good and becomes a private good (Laurell, 1995; Testa, 1997). This modification in the common sense manifests itself not only in the discourses emitted in relation to health care reform, but also in the lived experiences of the population. The transformation of common sense pertains to health services and also other areas of collective life.

Principal multinational corporations of finance capital. Penetration by multinational capital has advanced in Argentina and Chile, has begun in Brazil, and is the process of diffusion to Ecuador. At this stage, there is a tendency for concentration in the private and social security subsectors, based on investments coming from multinational corporations. These corporations tend to buy several companies in each country and then to merge them. Such mergers can include participation by finance capital of local origin, depending on legislative obstacles that impede the total purchase of companies by corporations of foreign origin. This process occurs in Brazil, where capital of local origin must control the majority of shares in a given company.

The main multinational companies that are operating in the countries under study are: Aetna, CIGNA, the EXXEL Group, the American International Group (AIG), The Principal, International Medical Group (IMG), Prudential, and International Managed Care Advisors (IMCA). We will refer to the operations of the first three of these corporations, which until the present moment have carried out the most important investments in Latin America.

Aetna. Aetna is operating in three of the countries under study: Chile, Argentina, and Brazil. In Chile, Aetna controls a subsidiary, Aetna Chile Seguros Generales S.A. To operate in health care, Aetna established in 1993 an "Institution of Previsional Health" (Institución de Salud Previsional, ISAPRE), one of the private companies authorized in Chile to receive medical social security funds. The Aetna ISAPRE, called Aetna Salud, has about 60,000 insured subscribers (Stocker et al., 1999). With this company, in the first trimester of 1998, Aetna achieved fifth position in the ranking of Chilean ISAPREs. Currently, Aetna has contracted to acquire all stock in another ISAPRE, Cruz Blanca ISAPRE S.A, with an approximate investment of 90 million dollars. This company occupies the second ranking among ISAPREs. Through this action, Aetna will be positioned among the leading health-care corporations in Chile (Estrada et al., 1998).

In Argentina, Aetna operates through investments in the EXXEL Group (described further below), which recently signed a letter of intention to buy the largest and oldest prepaid insurance plan in Argentina, Asistencia Médica Social Argentina (AMSA). (Diario Clarín, May 10, 1998; Wall Street Journal, August 6, 1998). This prepaid plan, with a 36-year-old history in the market, has 240,000 middle- and low-middle income subscribers. AMSA also has entered into an agreement to manage the services of ten medical social security institutions (obras sociales) that labor unions previously administered directly.

In Brazil, Aetna has purchased 49% of the stocks in Sul América Seguros, a

major private insurance company. Forty percent of this company's billings are in the health area. The company controls 35% of the Brazilian private health insurance market, with two million insured persons (Folha de São Paulo, May 1998).

CIGNA: This corporation operates in three of the Latin American countries under study - Chile, Brazil and Ecuador - while in Argentina it is contracting to invest in the social security fund, Solidaridad (Solidarity), which belongs to the bank workers' union (Diario Clarín, April 29, 1998).

In Chile, the corporation has operated through CIGNA ISAPRE since 1991.

This MCO provides coverage for approximately 100,000 people, controlling 5% of the ISAPRE sector (Stocker et al., 1999).

CIGNA has entered into a joint venture with the Brazilian Banco Excel Económico for the management of Golden Cross, a large prepaid medical insurance corporation, that has 2.5 million members, a network of 14 hospitals and 35 ambulatory care centers, 1,400 affiliated independent hospitals, 10,500 physicians, and 3,800 clinics. CIGNA has invested 48 million dollars in the joint venture (Stocker et al., 1999). For Golden Cross, which was experiencing a major financial crisis, the incorporation with CIGNA led to a restructuring of the plans it offered and of contracting mechanisms, to convert the company to managed care. The process began with an insurance company, Assistência Médica Industrial y Comercial Ltda. (AMICO), which belongs to Golden Cross. Further, within a year after the initiation of managed care, the same process has advanced considerably in the region of São Paulo, with 17 ambulatory

health centers in the metropolitan region and 440,000 subscribers associated with the new method. Meanwhile, in the area of Rio de Janeiro, the installation is slower, but in all its agreements the corporation is implementing capitated payments under the concept of shared risk. The directors of CIGNA/Excel have planned that by 1999, all of the Golden Cross network would be adapted to the model of managed care (Revista INCOR, February 1998). During late 1998, Spain's Bilbao Vizcaya Bank acquired Excel Económico and has begun to renegotiate the joint venture with CIGNA.

CIGNA also is operating in Ecuador, although its activities so far have been limited to general insurance. It commands 31% of the total business within this area (Campaña et al., 1998).

EXXEL Group: This group at the moment operates only in Argentina. However, due to its particular mode of development, rapid growth, and plans to expand its business toward other countries like Brazil, Chile and Uruguay, its operations are important to examine.

The EXXEL Group is an administrator of Argentine and foreign investment funds. Its headquarters are located in the Cayman Islands. This location is attractive for U.S. corporations of finance capital, which therefore can invest outside the control of U.S. regulatory agencies (Stocker et al., 1999). The group began its activities in 1994, when the U.S. bank, Oppenhemier & Co., chose EXXEL to administer its investments in Argentina. Later, other investment funds did the same (Arce, 1997). The entrance of these investment funds into the EXXEL Group has been carried out with a minimum

contribution of about eight million dollars and with the requirement that investors renounce the right to oppose acquisitions by the Group. EXXEL also prevents investors from reclaiming their funds before the first ten years of the investment have elapsed. In this sense, the EXXEL Group can be defined as a long term investment corporation.

EXXEL now has almost 13,000 employees and annual billings of approximately 2 billion dollars. As a result, it figures among the ten largest corporations in Argentina. On its board of directors participate well known local as well as international business people. EXXEL counts among its advisers two former U.S. ambassadors to Argentina. From its long list of investors, the better known ones include: Aetna, Allstate, Brown University, Columbia University, General Electric Pension Trust, Massachusetts Institute of Technology, Memorial Sloan Kettering Cancer Center, Oppenheimer and Co., Princeton University, Rockefeller & Co., The Ford Foundation, The Getty Family Trust, The Riverside Church of the City of New York, and The Travelers.

EXXEL's investments embrace very different fields: health care, energy distribution, restaurant chains, credit card services, music store chains, corporations that sell construction material, private mail companies, airport storage facilities, duty-free shops, and cargo transport companies. In health care, EXXEL has positioned itself in all three subsectors (private, medical social security, and state):

a) It bought three of the most prestigious prepaid health plans, that include approximately 190,000 insured members and that have annual billings of almost 260 million dollars. It also purchased three important inpatient centers and unified these

enterprises under the name of Sistema de Protección Médica (System of Medical Protection), now comprising the second largest prepaid health plan in Argentina.

b) It acquired a small social security fund, Witcel, that previously offered coverage to workers of a paper company that ceased operation. EXXEL's interest in this social security fund came from the prediction that, through its acquisition, the corporation would gain the ability to request approval from the federal agency that regulates the activities of social security funds (Superintendencia de Servicios de Salud) to act as an "open" fund, that is, to receive affiliated members of other union-controlled social security funds when these were opened to members' free choice. Free choice, by which the members of a social security fund can decide that their contribution may go to another fund, was approved through an decree of National Executive Power at the end of 1996. Witcel therefore was authorized to receive affiliated members. During the first transfer that was carried out between May and June 1997, this social security fund controlled by the EXXEL Group, which previously had 300 beneficiaries, received almost 10,000 additional members (ANSES, 1997). Witcel currently is under the administration of the Sistema de Protección Médica.

c) The group also manages the 27 public hospitals in the province of San Luis. By negotiating these management agreements with the provincial government, EXXEL has gained entrance into contracts that provide additional corporate income. The contract permits EXXEL to managed the hospitals' billings to the social security system and the provincial government. In the province of San Luis, the contract with EXXEL

initiates a novel form of billing procedures, by which EXXEL bills the government for patients seen at the public hospitals and retains 20 percent of the payments received. Meanwhile, the physical infrastructure, part of the utilities consumed such as electricity, and the majority of hospital workers are paid by the provincial government.

Modalities for the entrance of finance capital. The current relationships among subsectors (private, public, and social security) has changed the way that multinational finance capital is positioning itself in the field of prepaid insurance. In this field, corporations controlling finance capital can operate as administrators of medical social security funds and of state-supported health services that are in the process of deregulation. This positioning has been accomplished in only a few years - no more than five in the countries under study, with the exception of Chile, where it began slightly earlier. In some cases, these corporations also are constituted as providers of services, with vertical integration, according to the style of managed care organizations (MCOs) in the United States.

The three main ways that multinational corporations invest finance capital in Latin American health systems are through: a) the purchase of already established companies in Latin America that are dedicated to the sale of indemnity insurance or of prepaid health plans; b) association with other companies under the framework of a "joint venture"; and/or c) agreements to manage social security and public sector institutions. For multinational corporations, Latin American investments enter an environment favorable to profit making. This potential for profit is so central that the list

of investors includes some of the largest insurance companies in United States (Stocker et al., 1999).

Many of the companies that are investing in Latin America are subsidiaries of large U.S. and European insurance corporations; others are mutual funds that capture the capital invested by universities, foundations, and corporations of First World countries. Data gathered through interviews and review of publications by U.S. corporations show that an explicit objective of these firms in Latin America is to expand their business operations in the medical social security and public subsectors, since the scope of the private market is limited (Stocker et al., 1999). On the other hand, this trend continues the practice already established in the United States. In that country, as corporations have reached their limit of growth in the private insurance market, they have pressed to achieve changes in public policies. These changes have allowed them to implement programs of managed care and to access the huge funds of Medicare and Medicaid (Waitzkin, 1994).

The reasons that multinational corporations of U.S. origin express to justify their interest in investing in Latin America are: a) the reduced possibilities of expanding their business in the U.S. market and the need for new markets, since they estimate that by the year 2000, 80% of the U.S. population will be insured and 70% of MCOs will be for-profit; b) the growth in the Latin American population without social security; c) the limited coverage that governments are offering to the uninsured population; d) the deregulation that is occurring in the state and social security subsectors in many

countries, which allows the participation of private finance capital; and e) the capability to operate across national boundaries that the free trade treaties established in some regions permit - especially, in the countries of the Common Market of the South (MERCOSUR) (Stocker et al., 1999; Minujin, 1992, 1993; Barbeito & Lo Vuolo, 1992).

Impact on health care and public health programs. As in the United States (Kuttner, 1998; Bodenheimer, 1996; Carrasquillo et al., 1998), concerns about managed care in Latin America have focused on restricted access for vulnerable groups and reduced spending for clinical services as opposed to administration and return to investors. Copayments required under managed care plans have introduced barriers to access and have increased strain on public hospitals and clinics. In Chile, approximately 24 percent of patients covered by the *ISAPRE* managed care organizations receive services annually in public clinics and hospitals because they cannot afford copayments averaging 8.6 percent of the ISAPREs' overall collections (Estrada et al., 1998). Self-management (*auto-gestión*) in Argentina's and Brazil's public hospitals requires competition for capitation payments from social security funds and private insurance, as well as patients' copayments. To apply for free care at these public institutions, indigent patients now must undergo lengthy means testing; at some hospitals, the rejection rate for such applications averages between 30 and 40 percent (Iriart et al., 1998).

Public hospitals in Argentina that have not yet converted to managed care principles are facing an influx of patients covered by privatized social security funds.

For instance, in 1997, public hospitals in the city of Buenos Aires reported approximately 1.25 million outpatient visits by patients who were covered by the privately administered social security fund for retired persons. Before turning to public hospitals, these elderly patients had encountered barriers to access due to copayments, private practitioners' refusal to see them because of nonpayment by the social security fund, and bureaucratic confusion in the assignment of providers (Iriart et al., 1998).

As for-profit managed care organizations have taken over the administration of public institutions, increased administrative costs have diverted funds from clinical services. To attract patients with private insurance and social security plans, Buenos Aires' public hospitals have begun to hire management firms that receive a fixed percentage of billings (Iriart et al, 1998). Administrative and promotional costs account for 19 percent of the Chilean ISAPREs' annual expenditures (Estrada et al., 1998).

Latin American managed care organizations also have attracted healthier patients while sicker patients gravitate to the public sector. In Chile, the ISAPREs have aimed to capture capitations for younger workers without chronic medical conditions. As a result, only 3.2 percent of patients covered by the ISAPREs are more than 60 years old, in comparison to 8.9 percent of the general population and 12.0 percent of patients seen at public hospitals and clinics (Estrada et al., 1998).

Resistance to managed care and alternative proposals. The exportation of managed care is encountering opposition, which varies among countries. In Ecuador, a coalition comprised of unions, professional associations, educators, and Native

American organizations is resisting the introduction of private managed care operations within public services (Hidalgo, 1997). During 1995, this coalition organized voters in preparation for a national plebiscite that elicited the population's preferences concerning the privatization of eleven sectors of the economy, including health care, petroleum, transportation, and public utilities. For all eleven propositions in the plebiscite, a majority of approximately two-thirds of Ecuadorian voters opposed privatization. After the plebiscite, the coalition has continued to work actively to resist privatization and recently has organized educational sessions concerning managed care as a component of initiatives to privatize health care and public health services.

In Brazil, physicians and public health activists have resisted the introduction of managed care. For instance, activists affiliated with the Brazilian national labor party (*Partido dos Trabalhadores*) have opposed privatization of public services under managed care organizations. Government officials representing this party and elected in Brasilia, Santos, Rio de Janeiro, and other cities have worked to oppose privatization policies and to implement alternative proposals that strengthen public services at the municipal level. Members of the labor party but also other political activists have emphasized that the revised Brazilian constitution of 1988 specifies that access to health care is a right of citizenship, to be provided through a "unified health service." Organizing in the national and state legislatures has directed attention to the contradiction between the constitution's mandates and the privatization policies that encourage the introduction of managed care under for-profit corporations. In addition,

large organizations of physicians have challenged managed care principles and have worked together to enhance their power to bargain collectively with managed care organizations. One example involves Unimed, an organization of health professionals which has established itself as an economic "cooperative" whose members include thousands of physician practitioners in the state of São Paulo. Unimed has succeeded in limiting the control of large managed care organizations over the conditions of medical practice and also has tried to oppose some of the initiatives that would privatize public sector services under the auspices of managed care.

Managed care organizations have encountered less organized resistance in other countries like Argentina, Chile, and Colombia, where prior dictatorships or authoritarian governments have facilitated the privatization of public services. On the other hand, professional associations and unions more recently have organized campaigns against the entry of managed care organizations into public systems. In Chile, the national medical association (*Colegio Médico*) has resisted the expansion of the *ISAPRE*s through the use of the public national health fund (*Fondo Nacional de Salud, FONASA*) (Roman, 1997). In Argentina, health professionals have collaborated with a national confederation of labor unions (*Central de Trabajadores Argentinos, CTA*) in educational efforts to publicize a more critical appraisal and debate concerning proposals to privatize public-sector services and to convert them to the auspices of for-profit managed care organizations. Participants in the Latin American Association of Social Medicine (*Asociación Latinoamericana de Medicina Social*) have coordinated

informational campaigns about managed care and have promoted alternative proposals to strengthen municipal public services (ALAMES, 1998). An international coalition of unions representing public-sector workers, Public Services International, has helped organize opposition to managed care in several countries (Public Services International, 1998).

DISCUSSION: THE RECONSTRUCTION OF COMMON SENSE

In Latin America, such experiences have been affected by the economic crisis of the 1980s and by plans of structural adjustment adopted in many countries. Little by little, the population accepts as its own, in a non-reflective manner, the official discourses that specify the necessity of changes in the role of the state to resolve the crisis. Such changes require the privatization of public enterprises and services, and the reduction of social expenditures. This situation is made possible by the dramatic nature of the crisis that has confronted the population (in Argentina the hyperinflation of late 1988 and early 1989 was a disciplinary element in this sense). In the firmness of the emitted official discourses, people find a source of hope and re-encounter a sense of a shared social project that had been lost during the most acute moments of the crisis. Specifically, the shared social project is that required by structural adjustment: to reduce the role of the public sector and to enhance private, market-oriented processes. In this way, social situations recapture their consistency and are lived as necessary, even though at individual level they may be unjust and painful.

The transformed common sense thus recaptures its character as a central

component of the social cement that fills the breaches, softens contradictions artificially, and makes possible the natural coexistence of antagonisms. The population's shared subjective experience of the situation is accomplished, even when individuals occupy very distinct positions in the social structure. This subjectivity becomes a socially shared truth, in the acceptance of a common direction for society as a whole (Benasayag & Charlton, 1993).

In the health care environment, many of those referred to as "experts" contribute to the construction of this new common sense, by sustaining the following ideas as "fundamentals" from which to rethink the system:

a) the crisis in health stems from financial causes;

b) management introduces a new and indispensable administrative rationality to resolve the crisis;

c) it is indispensable to subordinate clinical decisions to this new rationality if cost reduction is desired;

d) efficiency increases if financing is separated from service delivery, and if competition is generalized among all subsectors (state, social security, and private);

e) the market in health should be developed because it is the best regulator of quality and costs;

f) demand rather than supply should be subsidized;

g) making labor relationships flexible is the best mechanism to achieve efficiency,

productivity, and quality;

h) private administration is more efficient and less corrupt than public administration;

I) payments for social security are each worker's property;

j) deregulation of social security allows the user freedom of choice, to be able to opt for the best administrator of his or her funds;

k) the passage of the user/ patient/ beneficiary to client/ consumer assures that rights are respected;

l) quality is assured by guaranteeing the client's satisfaction.

These contextual and ideological changes, pointed out here in a synthetic fashion, reflect the experiences of the countries where these processes have been introduced most forcefully, such as Argentina and Chile. In Brazil and Ecuador these processes are more recent and encounter a civil society more potent to question such neoliberal proposals. In all the countries under study, however, varying degrees of transnationalization, privatization, and reorganization under managed care have been achieved. These changes, supported by multilateral lending agencies, are justified ideologically by the profound reconstruction of common sense, by which the population's lived experiences are interpreted and understood.

The reform of Latin American health systems manifests the logic introduced by multinational corporations of finance capital, starting from the reconfiguration of the capitalist economic system that occurred after the crisis of the mid-1970s. Within this

logic are inscribed the diagnoses and the responses concerning the type of reforms that should be carried out in Latin American countries. This logic applies to those reforms carried out by governments, those carried out by multilateral agencies of credit and cooperation, and those initiated by corporations of national and international finance capital. The proposals convey diagnoses that contain a certain degree of veracity; for that reason, they are accepted at the common-sense level, both for the population as a whole and for many workers and intellectuals in the health care field.

From this perspective, diagnoses that speak of inefficiency in the management of state institutions and social security, of shortages in resources that limit accessibility, of excessive bureaucratization, of limited capacity to respond to the population's demands, of escalating costs, etc. - all these are veracities that increasingly are shared by users and health care workers as part of their lived experiences. These experiences constitute a supportive substrate for the acceptance of the discourse that is taken as the basis for the elaboration of reform projects, because the experiences are integrated into the rationalities manifested in the reform proposals, revealed as natural and evident (cf. Badiou, 1990). This condition makes possible the modification of common sense concerning the processes of health, illness, and services, little by little making appear natural a conception that seeks to commercialize all the relationships established in these processes.

Assumptions that were sustained during many years, especially for public health advocates, and that conveyed the idea that the health was a state responsibility and a

public good, have given up their place to the “complex” discourses of economics. In the latter discourse, people and their problems tend to disappear, and everything is transformed into abstract questions of financial resources and their shortage, or of ineffective administration. From this position, the only important goal is the reorganization of institutions, so that they act efficiently and maintain an appropriate cost-benefit relationship. The central question becomes how to manage state institutions and social security funds.

With certainty about the indispensability of change in the health care system, many actors linked to reform have accepted the instruments developed by MCOs. They have elaborated discourses that, while trying to differentiate themselves from the neoliberal project, in many cases remain trapped in that logic. Technical proposals thus are framed in the possibilism characteristic of postmodern thought. This orientation holds that there are no alternatives to negotiate reality other than those that already have presented themselves (Iriart & Spinelli, 1994; Benasayag, 1996). As a result, discourses that in many instances are not committed to the neoliberal project in its whole nevertheless facilitate the implementation of reform under the leadership of multinational corporations of finance capital.

Against the diagnostic veracities, those that offer solutions on behalf of the general interest but that actually represent the most concentrated sectors of finance capital, it seems important to apply more critical thought. It is important to show that this form of interpreting the situation does not constitute truth, but rather the imposition

of norms defined by financial interests. Critical thought, as analyzed by Benasayag and Charlton (1993), is a reflexive movement of the consciousness regarding commonly enunciated views, the ability to “denounce” these views as they are constructed. Such critical thought is not necessarily oppositional, nor a state superior to common sense, but rather another register of thought. Common sense is perceived as a sixth sense able to apprehend the order of the external world and to enunciate what is “normal and natural," while critical thought turns itself toward commonly enunciated views and problematizes that which seems evident in specific situations (Benasayag & Charlton, 1993).

Reform, as sought by official discourses, is not the only option, nor the best, from the perspective of a population’s health. On the contrary, many groups are working on alternative projects; it is necessary to consider them. In Latin America, numerous organizations exist that defend health as a public good. These groups are attaining more influence recently, and they are offering through their proposals to show that the predominant vision of reform is not the only one, nor the most appropriate to resolve problems of the population's health. These movements are stronger in Brazil and in Ecuador, where they are expressed through the articulation of groups linked to universities, to health care services, to non-governmental organizations, and to political parties. In Argentina and Chile, the resistance is less, but it is deepening as it puts into evidence the results of reform commanded by the neoliberal project. There, articulations also are emerging among groups linked to universities, non-governmental

organizations, and workers' associations. In Chile, the national medical association and non-governmental organizations have formed a nucleus of a movement to contain the advance of the private sector. In Argentina, the national coalition of labor unions (*Central de los Trabajadores Argentinos, CTA*) is trying to unite groups that question the official reform and is working to offer alternatives. We hope to contribute through these analyses to a greater understanding of the reform project as whole. In this way, efforts to build alternative projects, carried out in specific spaces (institutional, community, municipal, or state), will not lose sight of the global processes that now impinge on health care in Latin America.

APPENDIX

The institutions and investigators participating in the WHO-sponsored study of managed care in Latin America are the University of Buenos Aires, Argentina (Celia Iriart, Ph.D., principal investigator; Lic. Silvia Faraone, Lic. Marcela Quiroga, and Francisco Leone, M.D.), the University of Campinas, Brazil (Emerson Elias Merhy, M.D., Dr.P.H., principal investigator; Florianita Coelho Braga Campos, M.A.); the Group for Research and Teaching in Social Medicine (*Grupo de Investigación y Capacitación en Medicina Social*), Santiago, Chile (Alfredo Estrada, M.D., principal investigator; Enrique Barilari, M.D.; Silvia Riquelme, M.D., Jaime Sepúlveda, M.D., Marilú Soto, M.D., Carlos Montoya, M.D.); the Center for Research and Consultation in Health (*Centro de Estudios y Asesoría en Salud*), Quito, Ecuador (Arturo Campaña, M.D., principal investigator; Jaime Breilh, M.D., M.A.; Marcos Maldonado, M.D., Francisco Hidalgo); and the University of New Mexico (Howard Waitzkin, M.D., Ph.D., principal investigator; Karen Stocker, M.A.). The study's overall coordinators are Celia Iriart, Ph.D. (principal investigator) and Howard Waitzkin, M.D., Ph.D. (co-principal investigator).

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APPENDIX: EVIDENCE OF DISSATISFACTION WITH PUBLIC-SECTOR VERSUS PRIVATE-SECTOR SERVICES

To clarify the findings of the published literature regarding this theme, we first searched the Medline data base using the keywords satisfaction, health care services, and Latin America. We found no studies that focused on satisfaction among Latin American users of public- or private-sector services.

We then searched the Spanish- and Portuguese-language literature contained in the database maintained by the Regional Library of Medicine in Brazil, with support from the Pan American Health Organization (www.bireme.br). This database remains the most comprehensive collection of articles, books, and theses concerning health policy issues in Latin American and the Caribbean. The key words were: satisfaction, users, health services, private, and public. Initially, 49 references were found. All references concerned public-sector services, and none pertained to private-sector services. Ten citations concerned satisfaction, contained an abstract, and/or presented explicit results. Five were studies about users' satisfaction with public-sector primary care clinics; the results showed high levels of satisfaction. One citation provided an evaluation of a public-sector home-care program, where satisfaction also was high. Three articles provided data that showed high levels of satisfaction with public hospitals. Two studies sought perception of satisfaction with nursing services; one study found high satisfaction and the other low satisfaction on several indicators.

In summary, the published literature in Latin America does not provide striking

evidence of widespread dissatisfaction with public-sector services. As is common in the English-language literature on satisfaction, existing measures of satisfaction may contain problems of validity that lead to underestimation of dissatisfaction. On the other hand, the existing literature does not provide systematic evidence of the widespread dissatisfaction with public-sector services that has entered policy discourses concerning the advantages of privatization.