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Health Insurance Check-up in Latin America

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Recorder: Edmund Santiago

Summary: *This session discusses how universal access, quality of care, and controlling health care costs are being addressed in Latin American countries.*

Mr. Edmund Santiago: First, we have Ines Torres, managing director for Sur Seguros Insurance Company in Buenos Aires, Argentina. She is a member of the Instituto Actuarial Argentino.

We also have Rafael Trava, who is the director of Buck Consultants in Mexico City, and he is a member of the Asociación Mejicana de Actuarios in Mexico. He is an actuarial consultant and is our representative for Latin America and operates out of Mexico City.

Ines will begin with a presentation on health care in Argentina followed by Rafael, who will talk about health care in Mexico. Then I will finish up with a general overview of health care in Latin America.

Ms. Ines Torres: In Argentina, some very important things are happening. Because the services were not good in relation to health services, the government decided to

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change many things. I want to show you some important data on health care pertaining to our country. In order to have a good overview, Table 1 shows

information for not only Argentina but also Brazil, Paraguay, and Uruguay. As you can see, Brazil is a very big country, and its population is almost five times our population.

TABLE 1
POPULATION DATA FOR ARGENTINA, BRAZIL, PARAGUAY, AND URUGUAY

	Argentina	Brazil	Paraguay	Uruguay
Area (thousand km2)	2,767	8,512	407	177
Population (million)	32.7	151.4	4.4	3.1
Urban Population (%)	87	76	48	86
Average Annual Population Growth 1991–2000	1.0	1.4	2.6	0.6
Population over 63 years of age (%) 1991	8.4	3.0	3.0	11.3
Population over 63 years of age (%) 2025	13.1	8.4	6.7	16.0
Adult Illiteracy (%)	5	19	10	4
GDP per person	2,790	2,940	1,270	2,840

In Table 2 we see health information. The health expenses as a percentage of gross domestic product (GDP) are 7%. The average expense is $418 per year per person. If divided by sectors, you can see that the public sector is at 22%, the social security sector is at 37%, and the private sector is at 41%. We really have plenty of resources. The point is, how are they used? We have a good quantity of hospitals, 140,000 beds, 90,000 doctors, so the relationship between inhabitants and doctors is 338, which is definitely a very good ratio.

If we analyze the same information regarding other countries (see Table 3), you can see that these other countries have different figures, especially in mortality. The figures for Brazil are something to be concerned about. Brazil has some figures that must be analyzed carefully. For instance, look at the comparison between Paraguay and Brazil with relation to the doctors and inhabitants.

TABLE 2
HEALTH DATA FOR ARGENTINA

Mortality		
Infant mortality (per thousand live births)		26
Maternity mortality (per 100,000 live births)		75
General mortality (per thousand inhabitants)	8.6	
Life expectancy from birth (in years)		71
Total Health Expense As GDP Percentage		
Year		1994
Percentage		7.14
Total Health Expense Per Person		
Year		1991
U.S. Dollars		$418
Total Health Expense By Sector		
Public Sector		22%
Social Security Sector		37
Private Sector	41	
Total		100%
Health Resources		
Total Beds		140,000
Hospitals		3,066
Public Beds		92,000
Private Beds		48.000
Beds Per Thousand Inhabitants		4.8
Total Human Resources		400,000
Doctors		90,000
Inhabitants/Doctors		338

TABLE 3
HEALTH DATA: ARGENTINA, BRAZIL, PARAGUAY, AND URUGUAY

	Argentina	Brazil	Paraguay	Uruguay
Infant Mortality (per thousand live births)	26	63	40	20
Maternal mortality (per thousand live births)	75	230	200	25
General mortality (per thousand live Inhabitants)	8.6	8	6.6	9.7
Life expectation (in years)	71	66	67	72
Total Health Expense in Percentage of GDP				
Year	1994	1989	1995	1991
Percentage	7.14	4.12	3.1	8.2
Total Health Expense Per Person				
Year	1991	1989	1987	1991
U.S. Dollars	418	113	72	255
Total Health Expense by Sectors				
Public sector	22%	75%	22%	26%
Social security sector	37		17	43
Private sector	41	25	61	31
Total	100%	100%	100%	100%
Health Resources				
Total beds	140,000	520,000	5,437	13,275
Hospitals	3,066	3,783	626	264
Public beds	92,000	116,000	3,875	9,467
Private beds	48,000	404,000	102	3,808
Beds per thousand inhabitants	4.8	3.6	1.3	4.2
Total human resources	400,000	2,000,000	11,287	14,185
Doctors	90,000	506,000	3,073	2,890
Inhabitants/Doctors	338	708	1,481	357

The cost of health care in Argentina, $18 billion per year, is very high. The distribution is as follows: 41% are in the private sector, and the annual cost per person in that area is $612; 22% is in the public sector, and the annual cost per person in that area is $333. There is still another sector to be considered: 37% through the social security entities: 15% through Administración Nacional del Seguro de Salud (ANSSAL), which is in charge of distribution of money between different entities; 22% through Plan de atencion Medica Integral (PAMI), the

government office that takes care of retirees and all the others that are written there. The annual cost per person on social security is $304.

Some important changes are taking place, especially in the public sector and social security. You can ask yourselves why these types of entities concentrate on so many clients if they are not giving good service. The answer is that the regulations do not allow people to choose the entity they want. There are specific regulations stating where you must be a member. If you work for an insurance company, you must be a member of the health insurance entity and no other. Of course, if you want to participate in a health entity, you must pay an additional amount on top of the initial mandatory payment.

The funding of these union-sponsored entities is 3% from the employees and 5% from the employers. All these percentages are obtained from the workers' salaries, so in total it is 8%. If you are not included in a labor union contract, which in general corresponds only to the management level, you can opt for a management personnel medical entity, of which there are about 24 today. Of the 24 entities, I should say that only about 3 of them are very important. The funding is 3% from the part of the employees and 5% from the part of the employers, also calculated on salaries. If you are a self-employed person, you have some more options. You can go to a prepaid private health entity that's an HMO, to a nonprofit mutual society, to a management personnel nonunionized medical entity, or to a private service. In general, in this type of entity, the monthly cost is from 180 pesos up to 800 per family per month. As you can see, these entities are very costly; however, they provide very good care.

If you are a retiree, you are entitled to go to PAMI, a state-managed organization. The funding is 3% from the active employee's salary; 2% from the employer's. The funding is 5% of declared income for self-employed people and, finally, 3% on the retiree's income. As you see, they have different sources of funding. PAMI is a very big entity and the services are very bad these days.

At last, you have the inhabitants without resources. For these persons, we have free hospitals where they can ask for care. The most important thing is that no population group has protection from the insurance companies. It's perhaps because they are not under this regulation. Up to the present time, there has been no market for them.

Something that is good to know is how the beneficiaries are divided, considering the type of entity. The union-sponsored entities are very important and they have great power. We have 230 entities with almost five million recipients.

TABLE 4
BENEFICIARIES OF SOCIAL SERVICES: 1994
ARGENTINA

By Type of Entity	Number of Entities	Percentage	Number of Recipients	Percentage
Union-Sponsored	230	62.7%	4,656,274	39.0%
State Run	17	4.6	86,327	0.7
By Contract	35	9.5	49,694	0.4
Management Personnel Plan	24	6.5	576,869	4.8
Mixed Administration	13	3.5	2,462,102	20.7
Association of Social Services	31	8.5	95,968	0.8
Other	16	4.4	56,442	0.4
Subtotal	366	99.7	11,927,049	66.9
PAMI	1	0.3	3,943,373	33.1
Total	367	100.0%	1,926,949	100.0%
Uninsured			507,234	
Total			12,434,283	

The other entity that is very important is PAMI. It is only one entity with almost four million people. Table 4 shows a total of 12 million beneficiaries, but, in fact, many people are out of this health care program and out of this coverage.

Because of our population of 32 million people, you can imagine the power of the union-sponsored entities. For instance, there are insurance employees who pay their mandatory payment to the obligatory plan, but then they pay additionally to this type of entity. In order to obtain better care, sometimes they have their own clinics, and sometimes they contract this type of service with some other clinics or doctors.

In general, the care they render is very good. Most of them are only finance entities and do not provide coverage. They contract for services with other medical associations or groups. Considering that some new regulations will take place in Argentina, some groups began to buy some of these prepay private services. For instance, Tim, Galeno, and Life were bought by Exxel, a very important group in Argentina. Qualitas was bought by Principal.

No doubt, in Argentina very important modifications are necessary. Two million

people are not covered. There is a low proportion of people paying. There is a substantial inequality in payments because payments are calculated as a percentage of salary, so people with higher salaries are paying much more than they would for private care. There is financial deficit in all types of medical entities (remember that in Argentina we used to have very high inflation). These types of entities were very rich at that time because they provided the service and they paid the provider one or two months later. This meant a very important financial profit at that time. Now they do not have that and they do not even know how to calculate their costs. So they find themselves with this type of financial deficit. They do not know how to manage properly.

There is a lack of information about existing resources. We have resources, but we do not know where they are in order to make better use of them. The costs are increasing. There is increasing dissatisfaction about care received. People are more and more willing to obtain good care from doctors and entities. The government is reducing the financing from salaries, especially from employers. From February 1994 onward, there has been a cap on salaries of about $5,000 per month. Before that date, the percentage applied to total salaries; from February of 1994, the percentage applies up to that maximum. In some cases, this is reducing the financing for the entity. Public hospitals began to charge for the services thus rendered to social services beneficiaries. For instance, say I am an insurance employee and I am in a hurry to get care, so I go to the public hospital. In the past this care was free, but now I must tell them in which social service I participate, and the hospital charges the cost of this care to my social service. There is no more free coverage from the state for participants in social services.

The key question is, how important will the modifications be? When are they going to take place? In Argentina, the union-sponsored entities are powerful and have very huge interests. Some changes have taken place already. For instance, the public hospitals are charging the social service entities for the services that they give to their affiliates.

Since January 1996, each employee must opt for only one social service if they have more than one job. Since early 1996, spouses must opt for only one social service. In this way, they are entitled to receive better service. There's a free choice between PAMI and another social service. If you are a retiree at this moment and you belong to PAMI but you participate in the insurance social service actively and you consider the previous coverage better, you can change back again. This option was taken by very few people, 20,000 people up to now (less than half of 1% of the total family members). However, in the future, it is expected that more people will choose this option.

Other changes are taking place. For example, the determination of a minimum service to be rendered is called Obligatory Medical Program (PMO). The social service can offer different levels of assistance, depending on the affiliate's payments. They have only the obligation to render the PMO care, and that's why it is important to add those payments in the case of a couple or in the case of a person having two employers. Social services that cannot render the PMO service, because they do not have enough income, must close down, merge with others, or find another avenue. They cannot go on giving services below the minimum.

PMO service for active personnel costs 17 pesos per month. PMO services are supposed to cost about 35 pesos per month per person. Some other changes are expected to take place in the future. For example, employees can change from one social service to another. Another possibility is that members of management personnel social service can opt for any available social service. Self-employed and unemployed people can opt for a social service paying the minimum. If you have someone in your program, such as a parent, or some dependent people who are not your own family members, you may include them for an additional charge. In the past it was 1.5% of your salary; now it is only the normal monthly payment depending on their age ($17 or $35), and social services can receive additional voluntary payments. If people want better care and want to pay more for it, they can do it. To help in this deregulation process, a loan from World Bank was approved initially of $150 million.

Unions have their own interest. So they do not want World Bank to be the only financing entity for this conversion. They obtained approval for ANSSAL to participate with an equivalent amount in order that they can serve their own interests. The unions' objective is that the deregulation takes place not only between their own entities but with all the others. The leading case is the Bank Personnel Social Service, which is bankrupt. It is in the process of resolving its current situation with the assistance of Coopers & Lybrand.

In the meantime, the obligatory medical program was established. The primary and secondary care and the prices of each item are 17 pesos per person per month. The entities have 180 days to adapt to this new resolution. Services can be provided by their own facilities or through a contract with providers. It introduces the concept of a family doctor who is the one who refers to specialists when necessary. Additional medical services are going to be paid by the participant paying 2-10 pesos per visit. For retired people, the obligatory plan costs 75 pesos per month per person. So you can see that we have opportunities to participate in our country in this activity. I should say that we have opportunities through private prepay entities or through insurance companies.

Today it is more convenient to participate through pre-pay private health entities because there are no restrictions on this type of company. There is no specific controlling entity. The rates can be changed during the lifetime of the client. There is a favorable tax treatment and the investments are not controlled. On the contrary, considering an insurance company, we have restrictions today on creating new insurance companies. We have an insurance law and a superintendency controls the entities. The plans must be approved. The tax treatment is not so favorable and the investments are regulated.

Insurance companies must work together in order to obtain better conditions to offer to health care plans, for instance: require no value-added tax or no payment of other type of taxes; improve their images; incorporate know-how; and offer complimentary products. Some companies began to do this. The most important thing to remember is that health care is always a consumer priority. To participate in the health market must be an objective for every company that has something valuable to offer.

Mr. Santiago: Next we'll have Rafael Trava with his presentation on health care in Mexico.

Mr. Rafael Trava: I will make a presentation about the health care situation in Mexico. I will try to focus this presentation in a different way. The key issue is what is happening right now in our country. We will try to show what the reality is. We have real problems in many senses, and I will try to give you an idea of how to bring the actuaries to the stage. If you want to design a product for the Mexican health care market, you have to keep in mind the following issues.

We say that health care business in Mexico is looking for a future because we really have no idea of what is going to happen. We have some ideas right now; however, I will try to explain what is going on. We are going to talk about today's environment and what the health care structure is in Mexico. These are the key issues that we have to cope with for each sector. We are trying to figure out which market is looking towards the future. In today's environment, we have a lot of problems that lead us to change. Mexico should not continue running in the same direction. We must have a new mentality and a new attitude.

We have to focus on efficiency in order to solve our social, economic, and political crises. In that sense, it will bring us to change the structure of the legal frame. A new social security law will start on January 1, 1997.

From a social approach, one must keep in mind that our demographic growth has been reduced. We are now growing at the rate of 2–2.5%, while in the past, we

were growing at a rate of 4.5%. This is a big problem. Everyone is looking for a better quality of life. In the past, everyone did not know of a high quality of life, especially the low-income people. Now everyone wants it. We started to change the poverty index by improving education opportunities. We found this to be the biggest problem. The people must be educated. Generally speaking, we must resolve what has happened. We must solve problems for those who own less. In addition, we need to increase the coverage of the new system.

From our economic view, I would say that the size of the economy shows a decrease from last year. It is because of this that we have really faced a more critical economic situation in Mexico, after a lot of political turmoil. In December 1984, we went through a huge devaluation of our currency, and obviously, this cooled off the confidence that we had instilled in this system. We are currently living in an economic recession because the banks have extremely large balances due. No credits are offered from anybody. We have to finance the deficit for the banks and they have to collect money or they cannot move the money. The government is supporting the financial system to avoid bigger problems. We hope that in the near future this recession will be over. Figures show that we had a slow economic recovery within the last year. We have no choice but to do more with less. Everyone, including the government, is trying to reduce costs. However, in general terms, we must act and not react as has been the case in the past.

The reason our economy is weak is because of political facts. The country is large, and the political system is in crisis. No one believes in the system. As such, the political system is weak. There is a lack of political leadership. We have no idea what is going to happen within the next year, which is an election year. However, we are sure that everything is going to change. The government is currently taking some steps to eliminate the power because the people have lost faith in the government and don't trust it. Even the states are hearing rumors that the president will be gone in December. Our country cannot tolerate rumors as they just provoke a lack of trust among the people. Democracy is the key issue. Right now, we almost have a balance, as a representative house and a one-party system is gone. Legal structures for these political issues have to change, and some are already changing.

Now we will discuss the health care benefits in Mexico. Generally speaking, I would say that the social security health care benefits are focused mainly on the needy population. Because these services are financed mainly by the federal budget, they function with a low quality of service, and this is a key issue to be solved. Quite honestly, they are working hard, but I really don't know how they are going to do it. In addition, we have the social medicine that is mandatory within the social security law. The service of this system in the first level of attention is

crowded. It is almost impossible to get in. If your condition requires surgery, and if it is not an emergency, it is scheduled it for two months later. On the second level of attention, once you are in the hospital of the social security system, the service is reasonable. There is high quality of services on the third level of medical attention. This level has high specialization and high-tech equipment, and is quite nice. Everyone, including a lot of private people choose to use this level of attention.

The social medicine has problems in managing unionized social security employees' relationships. The social security system in Mexico has 360,000 employees. Can you imagine what it would be like to handle this union? There is a social problem. With these people and dealing with them is always a problem. They are trying to do something about this, however, the system has a lack of capacity to cover the demand. The demand has increased as a result of the economic situation and because private medicine has become very expensive for everyone. People who normally did not use the social security system are now using it because of the crisis. Private medicine is just too expensive.

The total cost according to the law is now 12.5% of the payroll. This amount is covered 75% by the employer, 20% by the employee, and 5% by the government. With the new law, they changed the structure of this contribution in order to review the amounts for those with lower incomes. On the average, the income for the social security will be the same as expected. Social security covers 50% of the total population. The total population in Mexico is about 90 million. Basically, the services provided by social security are sickness and maternity. For sicknesses, social security provides: doctor visits, medicines, and hospitalization. Maternity coverage includes check-ups for the babies. Health care for workers' compensation is also covered in this area.

The Social medicine is facing new challenges and rules in the future. As of January 1, 1997, the new rules will allow employees to opt out of social security health care systems. This means that they will be able to look for other options either in price or in quality. This was not possible in the past. They say that they are going to compete with private medicine. They say that they are expecting to show everyone that the people want to stay in the social security system. They will need to balance the budget because it seems that they will not get too much money. They first need to find out how to balance the budget. They have to improve the quality, reduce bureaucracy, and increase coverage. The only way to get more money is to reduce bureaucracy and to do more with less.

Now I am going to try to cover some strategic issues that you have to keep in mind if you want to consider going into the health care business in Mexico. This is why I

bring to the table more information concerning social and technical approaches. The government has to finance the social security deficit because if the social security system does not provide good services, problems will arise. The government has no choice but to come up with the money. By the end of the day, if money is missing, the government must replenish it. The government has to provide a medical service infrastructure. It has to increase preventive medicine programs which have been reduced due to the crisis. Maybe they will end up paying too much in the future if they do not keep these kinds of programs. If they want to serve the increasing demand of medical services, they have to implement a new legal frame for health care.

Social security has to operate with a balanced budget, must reduce its bureaucracy and handle union relations very carefully. In order to compete with the private sector, they are going to implement health care family services. This is related to what Ines explained earlier about Argentina. If you are self-employed, you can go to social security, and for $25 a month, you can have family coverage; they still say that they will be able to balance the budget. How can they? They are almost giving the service away for free. They are quite afraid of what the private sector is going to do. They want to create attention so that more people will enter the system in order to create these family services, which are supposed to be for the needy population. However, this is not really true. They will have to implement a lot of cost controls and look for the modernization of the medical infrastructure.

Insurance companies need to offer competitive products, so maybe capitation will be the key. We have to create the infrastructure to cope with a new potential market. They must provide value-added services. They need to outsource or obtain technical support and must create databases for experience control. We don't have a lot of experience in order to really underwrite well.

Obviously, due to this situation, there are new players. Some very important new players are HMOs, PPOs, and TPAs. Many of the HMOs from America are looking for a market in Mexico. They invest in hospitals, and they are looking for the pre-pay medicine concept, something similar to Argentina's scheme. I would say that some of the things that happened in Mexico are a mixture of concepts from other countries. These new players are looking for strategic alliances with current providers. They already have some kinds of health care services related to the insurance business. They are offering cost containment for large organizations, due to the fact that you will be able to opt out of our social security. One of the things these HMOs are offering is, "We will control and contain your claims". They must deal with commercial issues. They are going to make a market through insurance agents and through banks to which they will pay commissions. In Mexico the insurance side of the business is well regulated. This means that the government

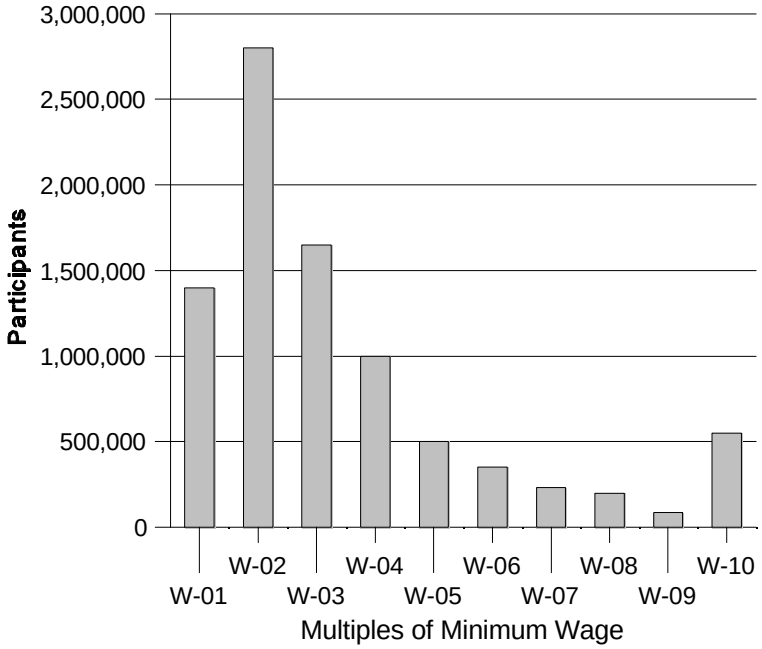
may ask for many things but, you can act by yourself at once. Service and product differentiation will be another important issue for this new place.

There's a potential market of more than 600,000 employers. There are 9 million participants, and 45 million individuals in the family structure. Insurance companies today cover about 2.5% of this market. In general, most of the cases overlap because, in the same manner that services are bought through the social security, people also purchase additional insurance coverage in some other place. As you already know, the market is huge. But if you look closely, out of 600,000 employers, 450,000 are small operations with one-to-five employees. There are only about 200 companies that employ more than 2,000 employees, 400 companies that employ between 1,000 and 2,000 employees, and 375 companies that employ between 100 to 750 employees. In truth, the market is 1% of the total population. These companies make 80% of the social security contributions. The big problem is really to provide services to that population.

Chart 1 shows minimum wages and salary structures. The minimum wage in Mexico right now is about US $100.00 per month. If you see the distribution of these people, most of these people are just making minimum wage. Just look how many of these participants are making just minimum wage per month. Obviously, there's a big problem in financing because the contribution to the social security is based on the payroll. One of the problems they are going to face is that social security expected that most of the people in this area will opt out and that means that they will want to keep the budget balanced for the low-income people. They will raise the contributions, however, this type of decision must be made within the next six months, since the new law is due to come into effect on January 1, 1997.

I would like to make some final comments. The health care system in Mexico is going through an adjustment process. The potential market is high, and we expect a big increase in the near future. The changes in the social security legal framework will bring new business opportunities. We have to establish products, services and prices, which will become the key of success in this emerging market. We must create these correctly in order to balance between what services we offer, what price we charge, and how we wrap the product. The key question is, how do we market this product to really make people aware of the fact that something is truly different?

CHART 1
HEALTHCARE BENEFITS IN MEXICO
DISTRIBUTION OF PARTICIPANTS AS A MULTIPLE OF MINIMUM WAGES



It would be very important and necessary to search for a niche in this potential market. Even so, when you break down companies by sector, I believe that the characteristics are that for each population it will be necessary to define different approaches. In order to sell products and services, it would be necessary to have a technical support for all new players to really create a good growth for the business. In order to develop the market, the service will play a very important role, as well as, keep track of the information. Keeping track of the experience will also be important in order to rate properly in the future. I feel that the key issue for the insurance health care in Mexico is to offer something different. I believe we need a new approach, as we cannot approach the market in the same old-fashioned manner. This is the reason why doctors and hospitals are working together to develop new products in order to truly compete with insurance companies.

There is a large HMO in Mexico and it is said that this company is run by doctors. I do not know if they will succeed, however, they are trying to present things a little differently. I have the impression that this is the direction that Mexico will take in this conversion.

Mr. Santiago: I work for International Reinsurance Managers (IRM). As I said before, I'm going to try to give you a general overview of health care in Latin America.

We're going to talk about universal access to medical care, the quality of health care in Latin America, controlling health care costs, current limitations on the health care systems, opportunities for supplemental markets, short- and long-term outlooks and finally we're going to wrap up with some key health care statistics in Latin America.

Universal access to medical care and access to health care coverage could be very difficult to obtain by a significant segment of the population in some countries of Latin America. Their medical facilities might be limited in some parts of the country and might require long hours of travel to access the closest facility. In the early days, access to health care coverage was, for the most part, limited to the country of origin. Only those who could afford to pay their own way for better coverage out of their own country would do it. Today, access to health care coverage in Latin America has been enhanced significantly.

There are a number of factors that have influenced the move from more limited health care access to, perhaps, worldwide access. Some of these are new medical insurance plans offering a wider geographical scope of coverage. Some plans might offer a local coverage, as well as coverage outside of their country, mainly in the United States. You may wonder about the availability and affordability of these plans. Some of these international plans might be sold by local companies, as well as, foreign companies not registered in the given countries. Another factor, is the economic and political situation in each of the different countries. Yet another consideration is access to hospital and physician networks inside and outside of the country. Nowadays, we are seeing, in some countries, the development of some hospital networks, HMOs, TPAs, and so forth.

Another factor is assistance companies that provide medical assistant services worldwide. The main purpose of these assistant companies is to provide the patients access to hospitals outside of their countries and to maintain the financial strength of the insurance companies offering these types of products and the availability of reinsurance support to insurance companies selling these products. Typical reinsurance agreements that you might see may either be quota share arrangements, or a specific or aggregate excess of loss.

There are existing medical facilities with advanced technology in the country versus outside of the country, and new market segments which purchase these products offer these coverages. Now, these new types of products have different limits and benefit structures which might be affordable to different classes of people. In the coming years we should expect to see a continuous increase in the level of access to health care in Latin America.

Now let's talk about the quality of health care. The quality level of health care in Latin America has been evolving over the past few years with the emergence of health care reforms in many countries. Medical care and facilities, in general, have been and still are in need of significant improvements. In most countries, the health care was to a great extent administered by the local governments. Only those who could afford it could benefit from the better quality of services offered by the private health care plans. The quality of health care found in Latin America varies from country to country. Today, some countries have more advanced medical facilities and technology. These countries include Argentina, Brazil, Chile, Mexico and Panama, among others.

There are a number of factors that influence the quality of health care in Latin America. As I mentioned before, there have been health care reforms. For example, the Law 100 in Colombia and the new law in Mexico, along with the economic growth and political stability of the different countries has provided more access to better educated medical personnel, improved medical facilities, and more advanced medical technology. These are all examples of actions taken to improve the quality of health care in Latin America.

Another factor is the financial strength of insurance companies offering this product. There are numerous insurance products and product features now available in Latin America. Some of these products might include comprehensive major medical products offering local coverage, as well as international coverage. Travel assistance programs provide medical services in a case of emergency or sickness. "Hospitalization only" products are prime examples of hospitalization programs for care in the United States. Here in the United States, it is typical to access hospital networks.

There are catastrophic programs offering coverage for organ transplants, cancer, and cardiovascular diseases with the low deductibles. There is a new type of product we are promoting. This product is the stop-loss for self-funded. This type of coverage is becoming very common in places like Brazil, Mexico, and Venezuela. Some of the product features that we might encounter in these types of products include maximum benefit amounts of up to $2 million dollars, copayment levels of 10% to 20%, and copayment penalties for care outside of a hospital network of 30% to 50%. Deductible levels may vary depending on the geographical scopes. There could be a deductible level of $1,000 for care in the United States and $250 if you obtain care in the country of origin. There are also stop-loss limits and air ambulance coverage.

One key factor is the pricing of some of these products, especially from a U.S. standpoint. There are things like the location of the country and the utilization of

services in the country versus outside of the country. All of those points need to be taken into consideration when pricing these products. The quality of health care accessible to residents in Latin America today have definitely been enhanced by these products, which provide access to health care in the U.S., as well as in other parts of the world.

Let us now discuss the control of health care costs. It is very important to control both the level and volatility of health care costs in Latin America. The economic and political environment of the country usually has a direct impact on the level of medical inflation. In some countries, companies that provide medical services are starting to implement managed care and cost containment features such as utilization review, certification requirements, second opinions and medical audits to control health care costs. Medical insurance product features such as deductibles, copayments and stop-loss levels are tools being used to control health care costs of medical insurance plans. There may be times where some product features may be offered which provide an incentive to stay in the country of origin as opposed to seeking care outside of the local country.

Other things that assist medical insurance providers in their product design, pricing, and reserving medical products is the availability of electronic data processing capabilities, better human resources, and the availability of more sophisticated information to analyze and evaluate medical costs.

Next, we will go over some of the current limitations on health care systems in Latin America. Over the past few years, a good number of health care systems throughout Latin America have been going through a process of fairly rapid evolution. This process needs to continue since there are still many limitations found in this health care system. Medical facilities and technology need to continue to improve in order to be able to provide top quality medical services. Privatization of health care systems is a key factor in promoting the development of new products that enhance the access to quality and health care in Latin America.
Managed care and containment features need to continue to be implemented to control the cost of medical care in Latin America. Statistical information is still limited, and in many cases, not compatible with that found in the United States. For example, I believe that hospital and physician networks should continue to be developed across countries in Latin America. As I said before, these are starting to be developed in some countries to a much lesser extent than what we find in the United States, and in some other countries, it is nonexistent. We should expect to see these limitations decrease as these health care systems continue to evolve at such rapid levels.

Let us look at some of the opportunities for supplemental markets. The need for better access in quality health care for the people of Latin America has created a number of opportunities for supplemental markets for companies offering medical services and medical insurance. These could provide products such as international medical plans offering worldwide coverage that could be marketed through brokers, credit card programs, banks, etc. Insurance plans for catastrophic diseases offer in-country and out-of-country coverage, for example: organ transplants, cardio-vascular problems and neurological diseases. Companies are offering specialized services, such as home health care and rehabilitation programs for the workers' compensation program in Argentina. They are also offering travel programs that offer worldwide accident and emergency coverage, for example, travel assistance companies, travel agencies, hotels and credit cards.

Let's look at the short- and long-term outlook. Over the next few years, we should expect to continue to see a higher level of access and quality of health care available in Latin America, since health care reforms should continue to be a key factor in enhancing the level of health care. Numerous insurance products and product features should emerge from changes in the health care systems. Increased implementation of managed care and cost containment features should be a key factor in controlling health care costs. We should expect more changes and regulations that will possibly affect the development of health care systems. A prime example of a place in need of some of these changes would be Argentina. It is expected that Argentina will be going through those changes fairly soon. We should also see an increased level of medical technology being available. Finally, we should see some increased competition leading to higher quality products and services.

Let me show you some key health care statistics for some of the countries in Latin America (Table 5). First, we have the rate of nurses, pharmacists, dentists, and physicians per 10,000 people. We see that the level of nurses in French Guiana is at a very high level of 99 per 10,000. As for pharmacists, we also see that in Costa Rica and French Guiana, the level is 3 per 10,000 people. When we look at the dentists, we see that Uruguay has the highest level at 8 per 10,000 as opposed to. Argentina which has the highest level of physicians with 27 per 10,000.

TABLE 5
KEY HEALTH CARE STATISTICS
LATIN AMERICAN COUNTRIES
(PER 10,000 PEOPLE)

	Nurses	Pharmacists	Dentists	Physicians
Argentina	5	0	2	27
Belize	17	1		3
Bolivia	2		1	7
Brazil	2	0	1	9
Chile	3		3	8
Columbia	4	3	4	8
Costa Rica	5	3	3	10
Ecuador	3		5	12
El Salvador	3	1	1	3
French Guiana	99	3	3	
Guatemala	3	1	1	5
Guyana	4	0	0	2
Honduras	3		1	7
Mexico	5		0	
Nicaragua	4		1	7
Panama	10		2	10
Paraguay	2		1	7
Peru	8	2	2	10
Surinam	27		1	9
Uruguay	5		8	19
Venezuela	5		3	14

Birth rates for the top five countries in Latin America show Guatemala having the highest rate at 38.6 per 1,000; however, the fertility rate (number of children per woman) is the highest in Honduras at 5.6 when compared to the United States, where the level is two children per woman. As you can see, there is a significant difference.

I will now move on to show you some AIDS statistics as of 1992 for each of the different countries (Table 6). In each country, cases were reported at a rate per 100,000 people. We see that Brazil has the highest amount of cases reported at 7,640. Guyana has the highest rate of AIDS cases, at 14.9 per 100,000 people.

TABLE 6
AIDS IN 1992 IN LATIN AMERICAN COUNTRIES

	Cases Reported	Per 100,000
Argentina	605	1.8
Belize	12	6.8
Bolivia	22	0.1
Brazil	7,640	4.8
Chile	162	1.1
Columbia	434	1.3
Costa Rica	117	3.7
Ecuador	57	0.5
El Salvador	114	2.0
Guatemala	94	9.0
Guyana	160	14.9
Honduras	709	13.0
Mexico	3,219	3.4
Nicaragua	6	0.1
Panama	99	3.9
Paraguay	18	0.4
Peru	73	0.3
Surinam	29	6.9
Uruguay	90	2.8
Venezuela	328	1.5

Let's discuss the level of infant mortality. The highest amount of reported cases is in Bolivia with 89 deaths per thousand. Next, we have the maternal mortality and Paraguay is highest with 379.5 deaths per 1,000. For the countries with the highest access to health care, we have Suriname at a 100%. Costa Rica and Chile at a very high level of about 95%, and then there is a significant drop for Guatemala at 59%.

In the demand for hospital beds, Paraguay has the highest population at 1,087 people per bed. For the percentage of children under the age of one year old with measles immunizations, Panama has the highest rate at 99%. The percentage of children under the age of one year with DPT immunizations is 99% in Chile and it's 95% in Costa Rica. Finally, the death rate per thousand is led by Uruguay and Bolivia at a fairly high rate of 9.9 and 9.5%, respectively.

Mr. Joshua David Bank: I'm from Deloitte & Touche. Ms. Torres, what is being done about those who are not employed? Didn't you say it is more than half of the country? It is not in any of the formal systems. I'm asking in terms of the reform.

Is anything being done to change those systems or is reform concentrated on the employer types of centers?

Ms. Torres: Thirty-two million is the total population, and twelve million are active. Out of that population we have about 20% unemployed. People without any type of coverage can go to the hospital and get free care. They do not have any problem. The issue is the quality of service is soetimes not as good as is necessary. For initial care they have everything available there.

From the Floor: Does the World Bank project involve these services as well?

Ms. Torres: No. The loan is only to reconvert the system. Initially, it was to finance a group study that established the PMO and to reconvert the different social services, which are broken. Most of the money is expected to be used to pay dismissals, so there is a high amount of bureaucracy there. They have more employees than are needed.

From the Floor: Is that now under way? Is that project started?

Ms. Torres: Yes, but these changes are taking place very slowly.

From the Floor: Mr. Trava, does the new 1997 law include worker's compensation? Is that going to also be an opt out or privatized like in Argentina?

Mr. Trava: Yes. There is a big change in the workers' compensation. Each company is able to rate the cost. They will pay 0.25–1% as a minimal contribution, and depending on the experience of the company, they will pay the difference. You may switch from one level to another. If you have a difference of 1%, this means that you are able to insure like a stop loss or something like that in order to avoid the switch from one company to another, which could cost much more money. I believe that this is the first step in privatizing workers' compensation, and I believe they have a lot of pressure to put it all together at once. I am sure in the near future they will. The first change will come in workers' compensation, however, at the moment, there is an opportunity for private businesses.

Mr. Andres E. Montes: I work with CHUBB in the regional office for Latin America in Miami. I have a couple of comments and then I'd like to ask some questions of our panelists. First, we found that the Latin America health care market is attractive, in general, despite the many social and economic problems that currently exist. It's interesting to contrast the United States and Latin America in a couple of key areas, for example, the demography. Ms. Torres talked about how in Argentina you see more of an aging population. But in Latin America in general, if you look at the

population pyramids, you'll find that the vast majority, maybe 50%, are under the age of 30. This is kind of in contrast to the United States where we have an aging population. So there's a striking contrast there, which implies tremendous future health care needs.

The second contrast is the health care regulatory environment in the U.S. versus Latin America. Currently, as everybody knows, there are the small-group reforms. There's community rating in the U.S. and there are mandated benefits which are squeezing out the insurance companies (New York or Florida); however, in Latin America we are seeing the opposite situation. We see privatization. We talked about the Law 100 in Colombia and the social security reform in Mexico. In Argentina there's privatization and social security systems that try to encourage private capital to be invested.

Next, I have something that I would like Mr. Trava to confirm. It is my understanding with regards to the Mexican social security reform and the social security health care system, that there are no mandated benefits when employers opt out of this system.

Mr. Trava: I think that's correct. That's my understanding. This is another contrast from what was proposed a couple of years ago in the United States.

Traditionally, foreign companies in Latin America have targeted the upper 5%–10% of the social economic class of the country that can afford private health care. My question for the panel is, what can foreign firms do to address the health care needs of the masses of Latin America? What can be done to improve the quality and maintain profitability for the insurance companies?

Mr. Santiago: I'll try to answer from a general point of view, and maybe Rafael or Inés can go into more detail with respect to Argentina and Mexico. But that's a good question. We're seeing that there are more products with a limited benefit structure, there's still access outside of the country or access to good facilities in their respective countries. So there is a trend to access the lower-income-level market segments.

Mr. Trava: I would like to clarify this opt out to social security. Throughout the social security, there will be some special rules because you cannot allow a company with two people to opt out to the social security. There will be some rules about which companies can opt out to social security.

We talked about the companies bigger than 200 people, and they say that maybe this type of company would opt out. Another alternative would be, for instance, to

combine health care services with worker's compensation. Let's assume that within worker's compensation they have a piece of health care, and you include it in your insurance policy so you can show to a social security official that you can offer the same service. Maybe they will accept that situation.

But, I would like to point out point that at this stage, they are only rumors. We are expecting to have the real rules no later than August 1996. There are some people with a lot of influence with the House of Representatives, people with unions. It's a tough issue that they have to deal with very carefully because of the political environment. It is not a good time to try these kinds of things now.

I also believe that insurance companies are succeeding in Mexico, in the mass marketing, in the mass population, and we must find a way to approach this market because the key is the service. If you go directly to the insurance company, it makes a big difference. Unfortunately, as far as I know, people are not aware of what they can get from insurance companies. The insurance companies' coverage is very small. Basically, you get insurance coverage with a good company. As you know, most of the companies pay the social security, and even this does not give the employees the culture of the insurance. In some cases, the insurance company has not properly run business in Mexico.