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Multinational Corporations and Health Care in the United States and Latin America: Strategies, Actions, and Effects*

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Abstract

In this article we analyze the corporate dominance of health care in the United States and the dynamics that have motivated the international expansion of multinational health care corporations, especially to Latin America. We identify the strategies, actions, and effects of multinational corporations in health care delivery and public health policies. Our methods have included systematic bibliographical research and in-depth interviews in the United States, Mexico, and Brazil. Influenced by public policy makers in the United States, such organizations as the World Bank, International Monetary Fund, and World Trade Organization have advocated policies that encourage reduction and privatization of health care and public health services previously provided in the public sector. Multinational managed care organizations have entered managed care markets in several Latin American countries at the same time as they were withdrawing from managed care activities in Medicaid and Medicare within the United States. Corporate strategies have culminated in a marked expansion of corporations' access to social security and related public sector funds for the support of privatized health services. International financial institutions and multinational corporations have influenced reforms that, while favorable to corporate interests, have worsened access to needed services and have strained the remaining public sector institutions. A theoretical approach to these problems emphasizes the falling rate of profit as an economic motivation of corporate actions, silent reform, and the subordination of polity to economy. Praxis to address these problems involves opposition to policies that enhance corporate interests while reducing public sector services, as well as alternative models that emphasize a strengthened public sector.

The process of globalization raises several problems regarding health care and public health. Influenced by public policy makers in the United States, such organizations as the World Bank, International Monetary Fund (IMF), and World Trade Organization (WTO) have advocated policies that encourage reduction and privatization of health care and public health services previously provided in the public sector (Stocker et al. 1999; Iriart et al. 2001; Rao 1999; Turshen 1999; World Health Report 2000). These policies in turn have affected policies of the World Health Organization (WHO), the Pan American Health Organization, and the U.S. National Institutes of Health (NIH). The latter organizations have accepted funding from the World Bank and have initiated programs influenced by the Bank's policies (NIH Fogarty International Center 2002; McMichael and Beaglehole 2000).

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In addition to these non-commercial organizations, multinational corporations based in the United States have expanded worldwide. Managed care organizations, health care consulting firms, and pharmaceutical and medical equipment companies have entered foreign markets. U.S. industrial corporations also have operated in foreign countries; the participation of workers and the promotion of products in those countries have raised concerns about the impacts on local economies, environmental health, and occupational health (Kim et al. 2000). The "flight" of multinational corporations to foreign sites with less costly labor and environmental regulations has led to unemployment and loss of health insurance benefits for U.S. workers (Stocker et al. 1999; Kim et al. 2000). As MCOs have faced declining rates of profit in U.S. markets, they have entered foreign markets, usually seeking access to public social security funds designated for health care and retirement benefits (Iriart et al. 2001). When MCOs shift their focus to foreign public trust funds as a source of new capital, they tend to withdraw from U.S. Medicare and Medicaid markets, with consequent disruption of services for patients.

OBJECTIVES AND CONTENT OF THE PAPER

In this paper, we aim to achieve the following objectives:

1. To identify the strategies that multinational corporations, based in the United States, have developed to penetrate the Latin American health care market (although we focus on Latin America, the same corporations also expanded into Africa and Asia);
2. To examine the actions of multinational corporations that affect health care delivery and public health policies in Latin America; and
3. To evaluate the effects of multinational corporations on health care delivery and public health policies in Latin America.

The paper examines the process by which multinational corporations have penetrated the Latin American market. We show how reforms imposed by the IMF and the World Bank have supported the efforts of U.S. and European corporations by facilitating the penetration of private capital. Subsequently, we trace the evolution of the health care system in the United States to investigate whether a less profitable market has played a role in the movement of corporations abroad. We try to clarify the strategies and actions that corporations have used to influence governments and to change their domestic laws and regulations regarding health issues. In addition, we investigate how practices of corporations' health insurance plans have contributed to: (1) inequality in health care access; (2) quality of health services; (3) changes in the work of health care professionals; (4) stress in the public sector by corporate selection of low risk patients; and (5) changes in domestic laws and regulations regarding health issues.

This paper has emerged from a long-term, larger study of the impact of economic globalization on public health and health policies in the United States and Latin America. In addition to our group working in the United States, Mexico, and Brazil, we have coordinated our efforts with colleagues based in Argentina, Brazil, Chile, and Ecuador. We have reported other components and findings of the investigation in other articles (Waitzkin 1998; Stocker et al. 1999; Iriart et al. 2001; Waitzkin 2001; Waitzkin et al. 2001a; Waitzkin et al. 2001b; Waitzkin 2003; Davidson et al. 2002; Waitzkin et al. 2003; Buchanan et al. 2003). Our earlier work described the initial movement of multinational managed care corporations first to Western Europe and later to less developed countries, especially in Latin America (Stocker et al. 1999; Waitzkin and Iriart 2000).

METHODS

Data Collection

Bibliographic research—We reviewed the research and archival literature, published and unpublished, with the purpose of tracing the actions and strategies of multinational corporations in the United States and in the Latin American health care market. The search included professional journals, business journals, newspapers and magazines, and corporate records in the public domain. Databases in medicine and health policy, business, government, and the social sciences were searched to locate pertinent articles from 1990 through the present. The Internet web sites of multinational corporations as well as their filings with the U.S. Security and Exchange Commission were assessed. Keywords to search databases and indexes included: health care, health policy, public health, international, globalization, privatization, managed care, Medicare, Medicaid, Latin America, Mexico, Brazil, and the names of specific companies.

Our investigation focused primarily on multinational corporations such as Aetna and CIGNA. However, we also investigated documents and reports that could shed light on the role of multinational financial institutions such as the IMF and the World Bank, as well as international health organizations such as WHO and the Pan American Health Organization, in facilitating the penetration of Latin American markets by multinational corporations. Thus, part of the research strategy was to seek access to country-specific documents by the World Bank and the IMF pertaining to Mexico and Brazil, and to examine the language used in letters of intent, agreements, loans, and reports. The bibliographic research included pertinent libraries, offices, and archives in Mexico City and Guadalajara, Mexico, and Brasilia, Brazil.

Interviews—We conducted interviews with respondents in Mexico City and Guadalajara, Mexico, and in Brasilia, Brazil. The purpose of the interviews was to investigate specific practices in the corporations' health care delivery, such as health programs they offered and how these programs compared to those offered by the public sector. For respondents, we selected individuals representing each targeted type of organization: government agencies; international financial institutions and trade organizations; international and national health organizations; multinational corporations; organized groups of consumers, professionals, non-professional workers, and environmentalists; and spokespersons for international trade agreements. We also interviewed citizens covered by public or private health insurance. The purpose of these interviews was to investigate the perceptions of health services from the point of view of consumers. As recommended by methodological guidelines for qualitative research, we continued to recruit respondents for in-depth interviews until the responses became redundant and additional information or viewpoints were not elicited (Schensul, Schensul, and LeCompte 1999). By this criterion, we conducted 42 interviews. If permitted by respondents, the interviews were recorded, and pertinent passages were transcribed. Human subjects provisions were approved in advance by the University of New Mexico's Institutional Review Board (IRB 02–211).

For these interviews, we used a standardized protocol of closed-ended and open-ended items. In addition to inquiring about the respondent's demographic characteristics and personal background, the interview protocol included items such as the following examples:

1. What are your organization's views about public health and health services?
2. How has your organization tried to affect health policies? Please give specific examples of legislation, regulatory changes, or other goals.
3. How has your organization succeeded in affecting health policies? Please give specific examples of legislation, regulatory changes, or other achievements.

4. What conditions enhance your organization's probability of success in obtaining its goals? What conditions impede your organization's success in obtaining its goals?
5. What are your organization's views about the impact of international trade agreements on public health? Health services? Health outcomes?
6. How would you define globalization?
7. What are the advantages and disadvantages of globalization?

While the semi-structured format allowed probing after initial responses, the protocol of planned items enhanced quality and consistency across interviews.

Data Analysis

We used established analytic techniques for qualitative research (Strauss and Corbin 1998), as implemented in our own previous research. In brief, the process of data analysis involved a series of steps, by which the bibliographic database, field notes, and transcripts, when available, were categorized according to thematic emphases. First, "open coding" involved an unrestricted, line-by-line analysis of the field notes, to produce provisional concepts and categories. In a later step, "axial coding" organized these provisional categories into broader conceptual dimensions of categories and subcategories. "Core categories" were then identified. Variation of perspectives, especially sources of debate and controversy, also were clarified. Preliminary brief memos summarizing the observations, coding categories, and conclusions were prepared frequently during each phase of coding and analysis.

Presentation

In the following sections we present some of our main findings. After considering the health care market in the United States, we examine the movement of multinational corporations into international markets; we focus especially on Aetna and CIGNA, which initially emerged as the most prominent corporate actors in the process of international expansion. We then analyze the roles of multinational corporations and international financial institutions in health reform. In conclusion, we discuss the implications of these findings for theory and praxis.

FINDINGS

The Changing Characteristics of the Health Care Market in the United States

The chronic crisis of U.S. health care—Navarro (1994) points out some key issues in the U.S. health care industry and in health reforms enacted between 1980 and 1994. The massive involvement of for-profit hospital chains in the delivery of health services during the 1980s created a considerable growth of the for-profit sector (see also Caronna 2004). This involvement was facilitated by federal policies and programs such as Medicare, which provided about one-third of the revenue for these chains. The government paid for but did not control the delivery of health services and provided subsidies representing a large proportion of overall health expenditures. These conditions contributed to the crisis of health services in the 1980s. The medical-industrial complex acquired influence by financing members of Congress sitting in powerful committees that draft health legislation. From 1981 to the first half of 1991, for example, insurance political action committees (PACs) contributed about $60 million to congressional campaigns. The medical professional, pharmaceutical and hospita1 PACs contributed, respectively; $28 million, $9 million, and $6 million.

Many issues raised by Navarro remain pertinent. The managed care and insurance companies, for example, have made contributions to PACs totaling more than $48.9 million since 1989. Beneficiaries from these contributions have continued to champion the interests of the health care industry over the interests of the public at large. Legislators receiving such campaign funds

have voted to weaken patients' ability to hold their managed care organizations accountable for their actions and also have promoted the interests of physicians seeking higher fees (Public Campaign 2003, 2002).

By November 1992, according to Navarro (1994), the situation in the health care sector of the United States had deteriorated to an unprecedented degree, and further deterioration has occurred subsequently. In 1992, the proportion of uninsured population had increased by 22 percent, and the funds going into administration had quadrupled. The deterioration of the health care sector that Navarro reported in the early 1990s is reflected in current data showing that the situation has worsened. One key finding of a 2000 Consumers Union report was that the percentage of family income spent on premiums and out-of-pocket expenses ranged from a high of 17 percent for families with income under $10,000, to 6 percent for families with incomes of $45,000, to 3 percent for families with incomes $100,000 and over (Shearer 2000:i). The following 2001 data, which show consumer units' annual incomes and variation in percentage spent on health care according to income, indicate similar conditions of higher proportional expenditures in lower income groups (see Table 1).

Other key findings of the 2000 Consumers Union report (Shearer 2000) include the following: (1) the sickest 10 percent of the population spent six to seven times more than the average person's expenditures on health care, and this population accounted for 68 percent of health expenditures; (2) one in six households headed by a person under age 65 spent 10 percent or more of its income in out-of pocket costs in addition to directly paid premiums, a burden that increased with age (p. i); and (3) the number of uninsured increased to over 44 million people (p. 3). As Adiga (2000) puts it, America's privately managed health care system has created a heavy financial burden for millions of seriously ill patients and middle-and lower-income families.

The rise and fall of managed care organization profitability—Despite the penetration of managed care in the United States MCOs in the United States have faced a declining rate of profit. The MCOs reaped major earnings initially by paying hospitals a fixed capitation for each patient at a low negotiated rate (Freudenheim and Krauss 1999). However, the rate of profit fell as the market became increasingly saturated (Stocker et al. 1999). By 1996 private health insurance premiums were rising at a much lower rate than MCO costs. Reasons for higher costs included rapidly increasing prices of medications, greater bargaining power for doctors and hospitals as they have consolidated, and a sicker population available for recruitment by MCOs after healthier populations initially were recruited (Winslow 1997).

By 1997 the managed care industry was struggling with higher medical costs, insufficient premiums, heavier than expected Medicare costs, and an increasingly competitive market (Bennett 2001; Pulliam and Winslow, 1997; Scism 1997a, 1997b; Winslow 1997; Anders and Winslow 1997). CIGNA and Prudential in particular were experiencing financial problems (Anders and Winslow 1997). By 1998 managed care premiums continued to rise at a slower pace than inflation in the health sector; this situation pushed managed care operating profits down to only 1.2 percent, compared to 8 percent four years earlier (Vranjes 1998). For these reasons, managed care in the United States matured into a slow growth field with slim profits, as the huge revenues of the past became harder to achieve (Pulliam and Winslow 1997; Freudenheim and Krauss 1999).

Under these circumstances, mergers of MCOs aimed to enhance their bargaining positions. The merger of Wellpoint Health Networks and Health Systems International, for example, led to control of about one-sixth of California's 12 million MCO enrollees, "a size that could drive hard bargains with doctors and hospitals in the hotly competitive California market" (Freudenheim 1995:1). When Prudential HealthCare put its health unit up for sale, its

4.7 million members made it "an attractive acquisition candidate if anything to keep it out of the hands of someone else" (Scism 1997a:B11). Aetna's 1998 acquisition of Prudential made Aetna, according to its own press release, the country's largest provider in health benefits, with approximately 22.4 million members overall and 18.4 million members in managed care (Aetna Inc. 1998c).

Yet the managed care industry's problems persisted. Anders and Winslow (1997) wrote that the problems vexing the MCOs included an inability to bridge the tensions between cost control and patient choice—a major problem that contributed to the failure of President Bill Clinton's proposed national health plan in 1994. Private-sector advocates argued that they could do a better job than a government-dominated plan; they vowed to hold down costs by steering patients to cost-effective doctors and hospitals, thereby improving medical quality and curbing wasteful expenditures. However, by 1998 health plans began to raise premiums several points above the 2.5 percent inflation rate, citing an inability to control medical costs as much as predicted. This increase proved dramatic when compared to the premium increases of 1 percent or less offered in the mid 1990s (Anders and Winslow 1997; see also Casalino 2004 for recent cost increases affecting the U.S. managed care market).

Medicare and Medicaid proved less amenable to managed care than industry officials had anticipated. MCOs had rushed to enroll Medicare patients, but the geriatric market proved much less lucrative than expected. The initial profits had been large because federal payments for Medicare MCO members had risen as much as 10.5 percent a year. During the summer of 1997, however, when Congress enacted limits that would raise premiums just 2 percent annually in future years, concern grew about MCOs' ability to manage costs within these stipulated premium increases. In the Medicaid market, many states ratcheted down their payments to MCOs (Anders and Winslow 1997).

Changes in the value of stocks reflected the financial difficulties of the managed care industry. From 1990 to 1995, MCO stocks surged an average of 33 percent a year, far ahead of the overall market, but by 1997 worsening stock market values disappointed analysts and investors (Anders and Winslow 1997). All large MCOs were facing financial trouble: Shares of Aetna tumbled more than 10 percent, Oxford Health Plans lost more than 75 percent of its stock market value, and PacifiCare Health Systems' stock fell by 20 percent of its value in less than a month. This weaker position in the stock market has persisted subsequently.

MCOs' exit from U.S. markets—In light of declining revenues in the U.S. market, MCOs began to pull away from U.S. markets. For example, Aetna's rapid expansion into foreign markets, especially Latin America, occurred during the period 1996–1999, when those countries began to liberalize their social security funds. During 1999, while already exiting from some international markets, Aetna initiated operations in Argentina and Colombia. These actions occurred only a year before Aetna's decision to sell its international businesses. In 1997 CIGNA expanded into Brazil, a market that other U.S. companies such as American International Group, Inc., and Liberty Mutual Fund Group had just entered. As previously mentioned, MCOs also expanded domestically, although this expansion did not necessarily improve their financial conditions. Aetna's rapid expansion in fact worsened its overall financial situation, partly due to an inability of computer systems to support such fast growth (Anders & Winslow 1997).

Both Aetna and CIGNA experienced expansion in their Medicare and Medicaid membership from the mid-1990s until 1999 (Tables 2 and 3), and they also experienced a shift from traditional fee-for-service programs to managed care. In a press release on July 25, 1996, for instance, Aetna announced its decision to leave Medicare Part A and part B fee-for-service programs to focus on the expansion of Medicare managed care.

According to its 2000 Securities and Exchange Commission report (Aetna 2000:6), Aetna exited certain unprofitable Medicare markets during 1999, yet the membership by the end of the year grew larger than the previous year's. This increase indicated that, while the company dropped members in unprofitable markets, it acquired new members in more profitable areas. Aetna's 2001 and 2002 SEC reports continued to document the company's exit from unprofitable Medicare as well as commercial markets, a fact reflected in declining membership for those years. CIGNA also experienced a sharp decline in its combined Medicare-Medicaid membership during 1999–2003. Managed care organizations' commercial membership followed the same pattern of growth during the 1990s and a sharp decline afterwards. It should be noted that MCOs' expansion during the mid- and late-1990s generally took place despite a falling rate of profit overall. It therefore is not surprising that eventually the MCOs began to leave these markets.

MCOs have exited from managed care programs in multiple geographical areas. Regarding Medicare, data gathered by the Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration, HCFA) on MCO withdrawals showed that by December 2000 Aetna withdrew from Medicare managed care markets in 11 states: New York, California, Pennsylvania, Connecticut, Florida, Georgia, Illinois, Kentucky, Louisiana, Ohio, and Washington (Lankarge 2001). CIGNA withdrew from Medicare markets in 13 states: Arizona, California, Colorado, Delaware, Florida, Georgia, Maryland, New Jersey, New York, Ohio, Pennsylvania, Texas, and Virginia. The American Association of Health Plans (AAHP) estimated that at least 711,000 Medicare beneficiaries would be affected starting January 1, 2001, based on announcements made by MCOs to withdraw from Medicare markets and a survey of the 43 MCOs with the largest number of Medicare enrollees. According to these estimates, Aetna's pullout affected 355,000 members in 11 states, while CIGNA's pullout left 104,000 members in 13 states without managed care coverage under Medicare (Fisher 2000; McGinley and Winslow 2000). By the end of 2001, Aetna was exiting Medicare markets in numerous counties of New Jersey, Pennsylvania, Arizona, and California, affecting an additional 105,000 members—a number equivalent to 38 percent of its Medicare membership. Several other companies, including PacifiCare Health Systems and Health Net, Inc. also were exiting selected Medicare plans across the country, leading to a total of approximately 500,000 subscribers who had to seek new medical coverage (Rundle 2001). According to Lankarge (2001), the total number of beneficiaries who lost their plans during 1999–2001 rose to more than 1.7 million.

MCO withdrawals from Medicaid markets also have occurred in multiple states, including both urban and rural areas. The number of exits throughout 1997–1999 remained high and widespread across states; MCOs dropped about 1.2 million enrollees during this period. Dropped subscribers frequently experienced the burden of selecting a new health plan and discontinuity of care if required to change providers. Exits abated to some extent in 2000, but at the same time entries by MCOs into new markets dropped to nearly zero, and share of enrollment in commercial plans has continued to decline (Felt-Lisk et al. 2001:ii, 5, 7, 17).

According to the Health Care Financing Administration, private-sector Medicare MCOs received more than enough federal payments to provide the basic Medicare benefits. The payment formula set by law, however, did not always pay enough to cover the extra benefits offered by the MCOs to produce profits. MCOs have also complained that the Balanced Budget Act of 1997 capped Medicare reimbursement increases at a pace that has not kept up with rising medical costs (Bennett and McGinley 2000).

Managed care has remained a troubled industry. During 2000, commercial MCOs reported costs increasing at a rate of approximately 10–12 percent annually. In a July 18, 2000 press release, Aetna announced higher than anticipated costs in its commercial and Medicare

managed care areas (Aetna Inc. 2000a). Managed care organizations such as Aetna have tried to address their high costs by increasing premiums when renewing contracts and by evaluating markets and products with the goal of exiting when financial or strategic purposes were not met. In December 2000, Aetna completed the sale of its financial and international services, an action aimed at enhancing stockholders' confidence and stock values (Aetna Inc. 2000b).

In summary, during the 1990s managed care in the United States evolved with an initial cycle of tremendous expansion and then a notable contraction. After attaining substantial rates of profit in the early stages, MCOs have reduced benefits and have raised premiums due to increasing costs. Managed care organizations have abandoned markets in the United States, especially those that involve patients with Medicare and Medicaid. We have focused on Aetna and CIGNA because they are major MCOs in the United States and also because they have maintained a large presence in markets abroad. The following section examines the expansion of the managed care industry in international markets.

Corporations and International Health Care Markets

Corporate expansion into international markets—As the domestic market became more contentious and less attractive, a transition from national to multinational managed care emerged. U.S. and European multinational corporations, including pharmaceutical companies, long-term care corporations, and MCOs, turned to the international service sector as an alternative source of profits (Price et al. 1999). Other factors drove this transition as well. One of them was the triumph of marketplace ideology. From Eastern Europe to Latin America this ideological change led to governments setting aside welfare state ideologies and initiating privatization policies (Vranjes 1998). Some governments' moves to control costs and to privatize what were perceived as wasteful health care delivery systems increased the demand for US. managed care organizations around the world (Kertesz 1997).

In Latin America, the health care market presented very lucrative opportunities during the second half of the 1990s (Swafford 1996; Cisneros 1997; Financial Times 1997). The health care sector, still untouched by the privatization wave that had swept the region in the previous years, underwent reforms that opened the door to private capital (Swafford 1996). After implementation of reforms, favorable economic conditions created advantages for investors. By 1999, Latin America had become ripe for US. companies' investments and operations (Freudenheim and Krauss 1999).

Corporate strategies in international expansion—One strategy followed by corporations to export managed care has involved investment in joint ventures with local companies. Joint ventures provide an already established clientele and help corporations circumvent national laws that restrict foreign ownership. These arrangements include some degree of financing from social security funds and the private management or ownership of previously public programs (Stocker et al. 1999; Iriart et al. 2000). Between 1996 and 2000, Aetna entered into joint ventures with domestic companies in Mexico, Brazil, Venezuela, Argentina, and Colombia. Aetna's press releases highlighted these ventures as important steps in the company's strategy to expand into emergent markets (Aetna Inc. 1996; 1997; 1998a; 1999a; 1999b; 1999d). The strategy encompassed not only expansion but also exiting from certain international markets—such as Canada and some European countries—that had become inconsistent with the company's focus on the high growth potential of the world's emerging markets (Aetna Inc. 1998b; 1999c).

The timing of Aetna's international ventures coincided with ongoing or imminent reforms to privatize health services and pensions in the targeted countries. Securities and Exchange Commission reports often referred to the company's intentions to invest in emerging and other selected markets outside the United States that showed the potential for favorable long-term

returns. These selected markets included not only Latin America but also emergent markets in Asia such as China and Hong Kong—countries made increasingly attractive by the initiation of pension fund privatization. International markets proved profitable, as shown by Table 4.

Although Aetna's strategy during the late 1990s emphasized expansion in emerging markets with high growth potential (Aetna Inc. US. SEC 1999:16), in early 2000 Aetna realigned its business in Global Health—which included Aetna U.S. Health Care and Aetna International—and Global Financial Services. In December 2000 Aetna completed the sale of Aetna International and Global Financial Services, to focus solely on U.S. Health Care and related business. A press release on December 18, 2000 announced initiatives to strengthen profitability and to increase competitiveness (Aetna 2000c). Although Aetna's international operations remained profitable, Aetna's officers emphasized that the sale of some foreign operations aimed to focus and consolidate the corporation's activities in the U.S. market, which had become relatively inefficient and unprofitable. Substantial additional assets derived from the sale of Aetna's foreign subsidiaries (Aetna 2000c), but the question of whether these emerging markets did not prove as profitable as expected remains to be explored.

CIGNA's main international operations have focused on Japan, although from the late 1990s it began expanding operations in Latin America and other Asian countries. In 1997 and 1998, CIGNA invested in health care operations in Brazil, which included the acquisition of a staff model MCO serving approximately 337,000 members. This MCO, with both individual and group contracts, maintained a network of 16 clinics, four hospitals, and one laboratory. CIGNA also entered into a management contract for one of the largest health care operations in that country, serving approximately 968,000 members. The contract contained an option for CIGNA to acquire a two-thirds ownership interest in the MCO. The Brazilian health care firms marketed their services to both employer groups and individuals through their agents and provided care on a fee-for-service basis through contracted practitioners, hospitals, and laboratories. CIGNA also made several acquisitions in the health care markets of Chile and Mexico and established offices for representation in selected emerging markets, such as China and India. In addition, CIGNA International began its own operations or entered into joint ventures to participate in the growing pension segment of foreign markets (CIGNA Corp. U.S. SEC 1998:16–18).

In 2000 CIGNA's international markets included Brazil and Chile. During 1999, CIGNA completed a review of its Brazilian operations, which consisted primarily of a traditional health care operation and a managed care business. After completing this review, CIGNA withdrew from the health care operation but continued the managed care business (CIGNA Corp. U.S. SEC 1999:18). However, CIGNA's growth potential in Brazil's private health care and pension markets did not meet its long-term business goals. In January 2003 the company sold its Brazilian health care and pension operations (CIGNA Corp. U.S. SEC 2003:24), after extracting substantial revenues from prepaid capitation fees.

Business apparently went better in Mexico. According to a press release on May 22, 2002, CIGNA Seguros—a component of CIGNA International—gave policy holders global access to hospitals in Mexico and the United States. A new major medical coverage offered services at any hospital in Mexico. These hospitals included top rated facilities such as those belonging to the Grupo Angeles (Hospital Angeles de Interlomas and Hospital Angeles del Pedregal), as well as Hospital ABC and Hospital Médica Sur (CIGNA 2002)

A second corporate strategy, in addition to joint ventures, has involved a trade show approach, through which corporations organize conventions or presentations at professional meetings to build interest in managed care principles (Stocker et al. 1999). Attendees at such meetings have included Latin American health care leaders who have received financial assistance from

corporations, the World Bank, or both. The trade show approach also has provided justification for the World Bank's and IMF's requirements for structural adjustment programs, such as reforms favoring the privatization of health services in developing countries that have benefited U.S. and European corporations (McMichael and Beaglehole 2000; Armada et al. 2001; Sen and Koivusalo 1998; Iriart et al. 2000, 2001; Stocker et al. 1999; Freudenheim and Krauss 1999). International organizations such as PAHO and WHO also favored these reforms and designated representatives to participate in the trade shows on managed care (Armada et al. 2001).

A third and newer strategy for corporations to expand in international markets involves the use of their own governments to influence international trade organizations such as the World Trade Organization. Governments exert this influence by setting agendas at meetings of trade organizations and ensuring commitments from other countries that benefit corporations, usually based in the United States and Europe. Influenced by multinational corporations, the U.S. and European governments exert power to achieve disproportionate effects on WTO policies and to take advantage of WTO's regulations and provisions to advance their own economic agendas: "When the U.S. and the EC [European Community] can agree on which direction global regulatory change should take, that is usually the direction it does take" (Pollock and Price 2000: 1997). Smaller or less developed countries do not exert similar influence, which means that their preferences generally do not reach the forefront of negotiations.

This scenario appeared at the WTO negotiations in January 2000 concerning the General Agreement on Trade in Services (GATS) (Zarrilli 2002:73–74). GATS specifies four modes of services for which countries can negotiate commitments: cross-border provision of services (Mode 1—delivery of services based in one country to consumers based in another country); consumption of health services abroad (Mode 2—delivery of services to foreign consumers within the provider's country); commercial presence (Mode 3—investment in the services of another country); and presence of natural persons (Mode 4—temporary migration by workers to provide services in another country) (Hilary 2001). World Trade Organization members can make commitments on any of these modes of delivery. Developed countries hold a strong interest in Mode 3, under which a supplier may establish a branch or subsidiary in the consumer's territory. Mode 4 provides some advantages for developing countries, because the ability of health personnel to provide services abroad improves the possibility of earning hard currency (Zarrilli 2002:73–74).

Most commitments negotiated at the January 2000 meeting dealt with Mode 3, and very few focused on Mode 4. Developing countries had wished to restore a balance between the commitments in Modes 3 and 4 regarding supply and had planned to gain more liberalization for their own professionals to circulate in other countries. These developing countries had hoped to ensure that the export of services would be included in the liberalization process and to enforce the principle that they would open their own domestic markets according to their national policy priorities and development needs (Zarrilli 2002:73–74). Such hopes of developing countries, however, did not reach fulfillment in the GATS negotiations.

Even if countries choose not to liberalize trade in health services, other sectors covered under GATS negotiations—such as financial services, which include health insurance—directly impact on health care (Lipson 2001). The United States and European Union have proposed that country members of the WTO grant greater market access in financial services, by eliminating or lowering restrictions on investments by foreign companies—commercial presence, or Mode 3. These proposals run counter to national legislation needed to prevent, for example, "cherry-picking," which involves corporate decisions to provide services to young, healthy, and financially advantaged segments of the population while excluding older people,

sick people, and the poor. Another example permitted under GATS involves selling life insurance but not health insurance abroad because the former is more lucrative than the latter (Zarrilli 2002). Aetna's selling part of its joint venture in health care insurance with Grupo Financiero Bancomer in Mexico, while keeping its operations in pension and annuity markets (which, according to a press release of December 6, 1999, showed growth and return characteristics that better aligned with the company's strategy), provides another example of similar practices.

Summary—As MCOs have faced declining profitability in U.S. markets, they have expanded into international markets, especially in Latin America. Corporations have used several strategies in penetrating international health care markets. One strategy has involved the formation of joint ventures with local companies. A second strategy has employed trade shows, by which corporations host leaders who can influence government and professional policies within their respective countries. Third, corporations have directed their governments to take favorable positions in the World Trade Organization to affect negotiations about GATS and related international trade agreements. These strategies have culminated in a marked expansion of corporations' access to social security and other public sector funds for the support of privatized health services.

The Role of International Financial Institutions in Health Reform

International financial institutions intervene in social policy making by requiring major health care and social security reforms (Armada et al. 2001). Loan conditions and renegotiation of external debt payments have comprised the major tools of political leverage used by international financial institutions. "Letters of intent" that debtor countries have submitted to the IMF provide evidence of how health and pension reforms become embedded in major economic policies.

Reform in Mexico—The following excerpts from a letter of intent dated June 15, 1999 from the government of Mexico to the IMF describe the health care and social security policies that Mexico intended to implement in the context of its request for financial support from the IMF (IMF 1999a):

> The Government intends to continue with the process of structural reforms, particularly in the areas of the banking system and social security. . . . The Government is studying various options to strengthen further the recent reforms to the social security and health care systems. The Government plans to relax investment restrictions by: (i) allowing the private pension funds to invest more in private sector instruments; and (ii) allowing private pension fund managers to offer to participants more than one fund (with varying degrees of risk). . . . With regard to health care, the most immediate objective is to ensure the efficient operation of the public health care reform implemented in 1997–98 (para. 19, 27)

An IMF press release dated July 7, 1999 announced the approval of the loan: "The IMF today approved a 17-month Stand-By credit for Mexico equivalent to SDR 3,103 million (about US $4.123 billion) to support the government's 1999–2000 economic program. . . ." (IMF 1999c: para. 1.

The Mexican health care reform of 1997–1998, mentioned in the letter of intent, has led to important changes. Some background on the Mexican social security system clarifies the significance of these changes. First, it is important to note that the country's health care system is divided into two subsystems, the Social Security System and the Ministry of Health, each serving a different population.

Social security in Mexico is mandatory for workers in the formal labor sector, both rural and urban. The principles of "integrity, solidarity, redistribution, and public administration" guide social security; that is, participants are to pay according to income but to receive services according to need (Laurell 2001a:298, 303). Covering workers and their families, social security consists of the Mexican Institute of Social Security (IMSS) for workers in the private sector and the Institute of Security and Social Services for Workers of the State (ISSSTE) for workers in the public sector. Social security increased coverage steadily during the 1980s and early 1990s and incorporated previously unprotected groups such as university students and taxi drivers (Laurell 2001a, p. 298).

The Ministry of Health, in theory, is responsible for the health care of the "uninsurable" or "open" population. Although the Ministry traditionally has provided a variety of services, comprehensive health care has not reached the entire eligible population. During recent years, about 10 million Mexicans have lacked access to any type of health care.

In June 1995, the Mexican government presented the basic characteristics of the reform to the World Bank before presenting it to the Mexican Congress. The 1995 World Bank document where this information appears, *Mexico: Country Strategy and Implementation Review Meetings* (World Bank 1995), mentions three proposals for possible reforms in the operation of Mexico's social security system: (1) to change from progressive, mandatory, employee-employer contribution rates to flat rates; (2) to allow employers to opt out of the Social Security system, provided that the employers provide access to MCOs for their employees; and (3) to permit uninsured people with regular incomes to buy into Social Security (Laurell 2001b). The document also lists several government strategies as part of the health care reform, which include: (1) to guarantee of a basic package of preventive and primary care services; (2) to decentralize responsibilities and budgetary authority for services; and (3) to reorient the role of the central Ministry of Health to a more normative one, emphasizing stewardship of the system rather than direct service delivery. The final goal of the reform was "to have the public Social Security institutions finance but not provide services" (World Bank 1995:6). This same document refers to the reform as "complex and risky," with potential "dramatic financial consequences on a system that already requires budgetary transfers" (World Bank 1995:7).

The Mexican Congress approved the reform in 1995, despite protests, criticisms, mobilizations, and alternative proposals, and the reform went into effect in July 1997. The new social security law made the transition from financing and providing public services to private administration. Private MCOs could then compete for IMSS-insured clients, receive funds from the Social Security Health Fund, and purchase services from IMSS specialty hospitals or the public National Health Institutes (Laurell 2001a).

Interviews with Mexican respondents (selected according to the criteria specified under the plan for interviews in the methods section above) suggested that the new social security law has opened doors to private investment. Most respondents expressed a perception that the reform moves public resources into the private sector, which can happen in several ways: (1) by allowing unequal competition between the private and the public sectors, where the former can select healthy and younger patients while the latter continues to be responsible for chronically ill, more expensive patients; (2) by allowing private companies to access social security funds; and (3) by requiring that the IMSS return contributions made by employees when they choose to receive health care elsewhere. Respondents also perceived a marginalization of doctors in the public sector, in terms of salaries and prestige, as compared to doctors in the private sector. A loss of solidarity within the profession, respondents noted, has resulted from privatization. Interviewees also suggested a view that the private sector possessed insufficient capacity to provide care for large numbers of people.

Reform in Brazil—In Brazil, pressure from international financial institutions and particularly the IMF forced the government to reduce social spending substantially. A broad package of controversial measures, for instance, reduced the 1999 health budget by $854 million (Hensley 1999). In letters of intent to the IMF, the government committed itself to seek alternatives that permitted multinational corporations to gain access to public social security funds (IMF 1999b).

To provide some context, the Brazilian health system has functioned as a mixed public-private system. The public system operates in two ways: (1) services are both financed by and provided in the public system, using public resources and facilities; and (2) services are provided in the private sector—where no public services and/or facilities are available—and financed by the public sector. In other words, the latter part of the Brazilian public system provides public reimbursement for services delivered by private entities (this type of reimbursement differs substantially from the financial arrangements in the Mexican system). The private system is called a supplementary system, with services financed and provided in the private sector (Médici 1997). About 24.5 percent of the Brazilian population hold private health insurance, while 75.5 percent of Brazilians receive care—or could potentially obtain it— in the public system.

Private entities that work under contract with the government provide a large proportion of the services in the public system, under the public reimbursement system described above. For example, private hospitals provide most in-patient services with public reimbursement, since about 80 percent of hospitals that deliver such services to the public system are private entities. In contrast, public establishments provide about 75 percent of out-patient care (PAHO 2001). Because health is a constitutional right—guaranteed by the State—for all Brazilians (Brazil 1988: Article 196), about 43 percent of the privately insured population also have utilized the public system, particularly for more complex and costly procedures (Hensley 1999). Despite the large proportion of the population that has obtained services from the public system, this sector gradually has become more fragmented and underfunded (Almeida et al. 2000).

The 1988 Federal Constitution enacted in Brazil sought to implement the Unified Health System (*Sistema Único de Saúde*, SUS). Throughout the country, the Public Health Movement (*Movimento Sanitario*) promoted the SUS, partly as a criticism of the prior model that financed the private sector with public resources while undermining the public sector (Campos 1997). Under the 1988 Constitution private enterprises could participate in the SUS, but only in a supplementary manner and by means of public contracts and agreements. Such enterprises were to provide services free of charge to the population when such services were financed by the SUS. Allocation of public funds to aid or to subsidize profit-oriented private institutions was forbidden (Brazil 1988: Article 199, paragraphs 1 and 2).

The SUS's basic principles were universality, equity of care, and integrity of actions, which means that the entire public system should provide the same comprehensive services to the entire population without restrictions, according to individual needs. Financing was to come from the social welfare budget of the federal government, the states, the federal district, the municipalities, and other sources (Médici 1997). Measures to establish the mechanisms of funding allocation and to define the managerial model for the SUS emerged during the 1990s through ministerial regulations such as the Basic Operational Norms (*Normas Operacionais Bázsicas* (NOB) 91, 93, 96). The NOB 96 (*Normas Operacionais Bázsicas* 96) redefined the roles and responsibilities of the states, the federal district, and the federal government in the health sector.

Specifically, the NOB 96 proposed implementation of the Family Health Program as a condition to transfer financial resources from the federal government to municipalities. This

program was regulated by the Ministry of Health, and municipalities gave little input in its implementation. The program was compatible with the basic health services packet for the poor—instead of the comprehensive care mandated by the 1988 Brazilian Constitution—which the World Bank had actively promoted in developing countries (World Bank 1993; Merhy and Bueno 1998). NOB 96 also allowed for management of large public hospitals as Social Organizations (*Organizações Sociais*), a model which dissociated public institutions from municipal governments and facilitated implementation of managed care in the public sector (Brazil 1996). However, introduction of competitive managed care to capture financial resources in the Brazilian public sector conflicted with the principles of universality and integrity enacted through the 1988 Constitution (Merhy and Bueno 1998).

During the late 1990s the Brazilian federal government implemented a series of changes that contradicted principles of the 1988 Constitution. The *Lei de Regulamentacão do Setor*, or *Lei* 9,656—commonly referred to as the Health Plans Law—was introduced in 1998 to provide regulation of private health plans and the private insurance sector. At the same time, however, the law introduced language that facilitated the expansion of private capital—both domestic and foreign—in the operation of private health plans and insurance. This measure contradicted constitutional principles (Article 199, paragraph 3) forbidding direct or indirect participation of foreign companies in health care except in cases allowed by the Law 8,080 (*Lei Orgânica da Saúde)* (Brazil 1990; 1998)). By 1999 Aetna, CIGNA, and other large U.S. insurance companies had made sizable investments in Brazil (Hensley 1999).

In summary, international financial institutions such as the World Bank and IMF have taken active roles in promoting policies that favor the penetration of international health care markets by multinational corporations based largely in the United States and Europe. In particular, the international financial institutions have advocated reforms that have privatized public sector services and have opened them to corporate ownership and/or administration. Policies of the international financial institutions have fostered reform decisions in Mexico and Brazil that have supported an expanded role for multinational corporations in those countries' social security systems.

Important problems existed in the health care sector prior to the reforms. For instance, lack of resources affected personnel, maintenance of equipment and installations, and supply of medications, leading to deterioration in working conditions and delivery of services. A decrease in resources, however, derived in large part from structural adjustment policies undertaken in the 1980s. These policies caused health care budgets to shrink, as well as massive unemployment and low wages, which further reduced contributions to the social security system (Laurell 2001a). Corruption and inefficiency have existed in Latin American public and private systems. Yet, according to recent research, both corruption and inefficiency have increased under privatization (Schuld 2003).

Effects of Multinational Corporations' Penetration in Latin America

Corporate managed care has exerted several important effects on health care and public health programs in Latin American countries. These effects include restricted access for vulnerable groups of patients and reduced spending for clinical services as a result of higher spending on administration and return to investors. Because copayments required under managed care plans have created barriers to access, they have led to increasing use of and strain on public hospitals and clinics (Iriart et al. 2001; Stocker et al. 1999; Waitzkin and Iriart 2001).

Effects of reform in Mexico—As noted previously, international financial institutions play crucial roles in the reforms that take place in debtor countries, where multinational corporations often benefit from these reforms. In Mexico, the World Bank supported reforms of both the health care and the pension components of the social security system, with loans of $700 million

and $25 million for the former and two loans of $400 million for the latter (Armada et al. 2001). The reforms clearly facilitated the penetration of private capital into the social security system. In health reform, this penetration occurred by allowing patients to "opt out" of coverage by the social security system and into coverage by managed care organizations. The World Bank itself pointed out the reform's potential to weaken the social security system's financial underpinnings due to adverse selection and "cream skimming." These tendencies involve moving "good risks" from the social security system to MCOs, while leaving the social security system with the relatively "bad risks," who contribute less to the system but make more use of it (World Bank 1998). In spite of these concerns, one of the World Bank's conditions for Mexico to access the loan was that some MCOs would be operating by the year 2000 (aLaurel 2001a:307).

The Mexican health reform included a package for the "uninsurable" population in rural or poor urban areas. Proponents portrayed the measure as an "essential health package" that would provide "universal coverage." The package contains selected public health interventions and cost efficient (measured in disability adjusted life-years) ambulatory clinical services. Components of the package include basic sanitation at the household level; family planning; pap smear screening for cervical cancer; prenatal, delivery, and post-delivery care; child nutrition and growth surveillance; immunizations; ambulatory care for people with diarrhea; family anti-parasite treatment; ambulatory treatment of acute respiratory disease; prevention and ambulatory care of hypertension and diabetes; accident prevention and first aid; and community training for self-care (Laurell 2001a:321). This essential health package closely resembles the previously described basic packages promoted by the World Bank in developing countries.

Although the government provides it free of charge, the essential package contains fewer services than those traditionally provided to the poor by the Ministry of Health. For example, although the essential health package includes preventive screening by pap smears for cervical cancer and ambulatory care for hypertension and diabetes, it does not cover treatment of cervical cancer detected by pap screening or inpatient treatment for the complications of hypertension and diabetes such as heart disease, kidney disease, and stroke. In concrete terms, this gap in coverage means that all services not included in the package will be charged directly to the patient or financed by state governments with limited capacity to make independent decisions and to collect taxes. Services not included in the package must be contracted through public or private insurance (Laurell 2001a, 2001b). Predictably, patients who develop such problems either will not receive adequate services or will receive limited services at public sector health institutions that have experienced cutbacks of funding due to the reform. Prior to the reform, even though the combination of social security and the Ministry of Health remained far from providing comprehensive coverage for the whole population, the social security system had offered comprehensive coverage to all members, while the Ministry of Health had offered a large variety of services to the uninsured population.

Private health insurance plans vary, and a comparison of them is beyond the scope of this paper. As described by our interviewees, several features of private plans deserve mention: (1) co-payment for physician appointments can reach as high as 65 percent of appointment cost; (2) for tertiary care, the deductible can amount to about 30 percent of total coverage, plus 10 percent of what the insurance company pays; (3) costs incurred in cases of illness that do not lead to tertiary care are not covered; and (4) coverage excludes prescriptions. Private employers may offer such a plan without employee premiums; therefore, it is promoted as a "free" plan as part of the benefits package. Although employees are not required to make contributions to premiums, substantial copayments often prove necessary, and employees cannot choose between social security and other types of private insurance. Employees often must purchase

additional coverage. Also, when the employer provides “free” premiums, the corporation can claim a tax deductible expense.

Effects of reform in Brazil—Private companies in Brazil have implemented several classic features of managed care. For instance, they have employed mechanisms to restrict utilization, such as denial of care, refusal to reimburse physicians for certain procedures, arbitrary termination of contracts with physicians, and preferred private provider networks. Private health insurance plans have been increasing, as has the number of patients’, complaints due to service denials (Silva 2001). Although the 1998 Health Plans Law (*Lei* 9,656) was introduced to protect consumers from the arbitrary practices of insurance companies, which in the absence of regulation could fragment plans and raise premiums at their convenience, the companies have found ways to circumvent the law. Complaints about rising premiums, restrictions on physician visits and hospitalizations, and contracts that do not conform to the legislation have continued after the enactment of the law. New contracts frequently have not covered the minimum services required by legislation. At the same time, insurance companies have reported high profits.

By late 2000 a special commission appointed by the Mexican Congress initiated financial investigations concerning the practices of these companies (Prates 2000; Miranda 2000). Legislation eventually caught up, forcing companies to comply with insurance laws and curtailing “cream-skimming” and “cherry-picking” practices. These actions increased costs for companies, which raised premiums to maintain profits. A decrease in the number of privately insured people from 41 million in 1998 to 35.1 million in 2003 reflected the inability of many clients to afford the higher premiums (IBGE 1998IBGE 2002; ANS 2003). It also highlighted the public system’s financial difficulty in absorbing those who moved from the private to the public system.

Disinvestment in the public sector has led to reduced provision of services. A reduction of 2.5 percent of the funds allocated to the public health sector took place in the 1999–2000 budget (CNS 2000), and in general the budget has not kept pace with population growth. Paradoxically, specialized and expensive medical procedures still have taken place largely in the public sector, and those covered by private insurance have utilized public facilities when they have needed such services (Almeida et al. 2000). Some professionals have argued that, to provide health care to private patients without affecting services to SUS’s patients, public hospitals will need to increase their numbers of beds. This change already has occurred at the University of Rio de Janeiro’s hospital, which has expanded with resources of the National Bank of Economic and Social Development to provide care to privately insured patients (Estadao 2001). The increasing mix of private-public financing in public hospitals, according to respondents, may lead to reduced access for those who depend only on the public sector.

In summary, privatization and the opening of public sector services to corporate participation have exerted major effects. Especially in Latin America, the international financial institutions and multinational corporations have influenced reforms that, while favorable to corporate interests, have worsened access to needed services and have strained the few remaining public sector institutions. Reform decisions have continued despite research verifying predictions that the policies would worsen access and health care outcomes among the most vulnerable populations. Reforms supported by the World Bank and other international financial institutions have threatened the social security system while providing “packages” of basic services that leave many needs unmet.

CONCLUSION: THE BEGINNINGS OF A THEORY AND PRAXIS

Economic Motivations for Globalization Policies

Since Adam Smith, economists have recognized that, over the long term, firms face a falling rate of profit as the market for a good or service becomes increasingly saturated. Our own research group and others have observed that one motivation for exporting managed care involves the falling rate of profit in U.S. markets. As noted earlier, some for–profit managed care organizations abandoned specific Medicare and/or Medicaid markets in the United States, as they entered new markets in Latin America and other regions. In health care, the falling rate of profit resembles that experienced in most other goods and services over time (Moseley 1991; Marx 1998).

When the rate of profit falls, corporations may develop several strategies, which include: increasing the productivity of labor, diversification into new product lines, and searching for new markets abroad. The managed care industry, for instance: has used all these strategies but has emphasized the search for foreign markets. Thus, in a largely correct prediction during 1996, the president of the Academy for International Health Studies noted the relationship between market saturation and exportation for managed care organizations: “By the year 2000, it is estimated [that] 80% of the total U.S. population will be insured by some sort of MCO. Since 70% of all American MCOs are for-profit enterprises, new markets are needed to sustain growth and return on investment” (Lewis 1996). The dynamics of globalization facilitate the movement of insurance companies and managed care organizations from U.S. to foreign markets, and globalization also affects services within the United States.

Globalization, “Silent Reform,” and “Common Sense”

In our research, we have found that crucial decisions about privatization and the entry of multinational corporations into the public sector generally occur in the executive branch of government. In the United States, the pertinent agencies of the executive branch include the Office of the U.S. Trade Representatives and the Department of Health and Human Services. For instance, in late 2001, the U.S. Congress approved “fast-track” authority for the executive branch to enact international agreements in trade for health care and other services, with only a yes or no vote permitted by Congress, rather than legislative consideration of a trade agreement’s details. In Latin America, the pertinent agencies of the executive branch usually comprise the Ministry of Health and/or the Ministry of the Economy.

After consultation with international financial institutions such as the World Bank or International Monetary Fund, policy decisions reach implementation usually through executive decrees or changes in regulations, rather than through new laws debated in the legislative branch. These policy changes receive little attention among lawmakers, the public media, or professional associations and consumer groups. The political process that accompanies such reforms therefore is usually a silent one, restricted to the executive branch of government. Although it could be argued that Mexico’s health care reform was not silent—since it was subjected to approval by the legislature—a single party (*Partido Revolucionario Institucional*, PRI) dominated both the executive and legislative branches, which guaranteed the approval of proposals from the executive branch.

Why do citizens in many cases consent to privatization schemes? The concept of “common sense” refers to the acceptance of new ideological discourses that challenge the role of the welfare state and transform the expectations of citizens in the face of growing crises. “Experts” in health care construct this common sense, according to several “fundamentals”: the causes of the health care crisis are financial; administrative rationality is indispensable to solving the crisis; financing and delivery must be separated to increase efficiency; demand rather than

supply should be subsidized; private administration is more efficient and less corrupt than public administration; the market is the best regulator of quality and costs; and deregulation of social security allows the user freedom of choice (Iriart et al. 2001:1250).

The legitimacy of such policy changes often contributes to the dismantling of the public sector. In Mexico, for example, "a gestation period of almost a decade," during which public institutions were slowly undermined and discredited, was necessary to legitimize the reform (Laurell 2001a:299). Yet the worsening of the crisis in the public system—such as shortages of medications—could be traced to political decisions and appointments made by the same actors who became advocates of privatization. These examples show how governments can create artificial crises and then use them to build their cases for privatization (Schuld 2003:43–44).

Subordination of Polity to Economy, and the Role of the State

Pierre Bourdieu, as well as other theorists of the state, has critiqued market principles as the main basis for policy change. Bourdieu presented an early theoretical interpretation of "social capital" (1984), now a widely used concept in health policy and public health. More recently Bourdieu focused on globalization and the subordination of democratic political processes to the marketplace (1998, 1999, 2003). Through "economism," Bourdieu argued, policy makers choose reforms based on technocratic assumptions that market processes—the "confidence of the markets"—achieve the broadest good across social classes in both economically developed and less developed countries. From this view, technical experts in international financial institutions and corporations call upon political leaders to take their advice, rather than relying on democratic, consensus-building processes to evaluate policy reforms.

In policies that subordinate the polity to the economy, the role of the state—which includes not only government agencies but also organizations supported largely by public-sector financing—becomes crucial. After World War n, the United States (though to a lesser degree than other economically developed countries) adopted policies that fostered "safety net institutions," which have provided health care and other needed services to people who could not provide adequately for themselves. According to Bourdieu (1998) and other theorists (Miliband 1991; Poulantzas 2001), while the state historically has acted to foster private economic activities, the economism that accompanies globalization has led to increasing acceptance that—to the extent that it interferes with trade both within and across national boundaries—the state must be dismantled. This dismantling involves cutbacks of public sector services and reversals of laws and regulations that restrict trade in health services within the private marketplace.

Praxis

Action informed by theory, or praxis, has focused on the detrimental effects of economic globalization on health and health care, as well as alternative projects that aim toward improvements in health conditions (cf. Waitzkin 2000, 2001). Opposition to policies which generate adverse effects on health and health services has increased worldwide. Specific examples of organized resistance have shown that such policies can be blocked or reversed. For instance, a campaign to eliminate users' fees in public-sector health services and education led to a major change in the World Bank's policies of enhancing privatization and corporate trade in services. Through a series of protests, a coalition of health professionals, non-professional health workers, and patients who use public hospitals in El Salvador have blocked, at least temporarily, the privatization of those institutions.

Alternative projects favoring international collaboration have countered some effects of globalization on health and health services. For instance, the Brazilian Workers Party, which

won the presidency in late 2002, has emphasized the expansion of public hospitals and clinics at the municipal level. Adopting the principle of community participation in municipal budgets, the new government has encouraged the strengthening of municipal public services and has tried to limit the participation of multinational corporations in health (Merhy et al., 2003). Such efforts have occurred in the context of a global network of advocacy organizations, political parties, labor unions, and organizations of professional and non-professional workers. This network aims to develop alternative models of service delivery that emphasize a strengthened public sector, and to counter the corporate dominance in health care that globalization encourages.

Linkages between economic globalization and health deserve' more critical attention. A growing network of professionals and advocates has drawn attention to the new policies affecting health and health services that derive from the new conditions of global trade. Such profound changes arise as part of broader processes of economic globalization that lead to widespread unrest. Those concerned with health and security worldwide no longer can afford to ignore these changes.

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TABLE 1

Percentage of Annual Income Spent on Health Care, by Income Group of Consumer Unit

Income before taxes ($)	Percentage of income spent on health care (%)
5,000 to 9,999	16.6
10,000 to 14,999	14.5
15,000 to 19,999	12.4
20,000 to 29,999	8.5
30,000 to 39,999	6.4
40,000 to 49,999	5.0
50,000 to 69,999	4.3
70,000 and over	2.6

Source: U.S. Department of Labor, Bureau of Labor Statistics. *Consumer Expenditures in 2001,* April 2003, Table 2. Consumer unit was defined as members of a household related by blood, marriage, adoption, or other legal arrangement Financially independent individuals living alone or sharing a household and students living in university-sponsored housing were considered as separate units.

TABLE 2

Aetna's risk, Medicare, and Medicaid Membership in Managed Care (Thousands)

	1995	1996	1997	1998	1999	2000	2001	2002	2003
Risk	3,742	5,394	5,335	7,303	11,117	9,883	8,276	5,025	4,458
Medicare	700	300	400	500	700	500	257	100	100
Medicaid	100	100	100	100	200	200	200	100	100

Note: "Risk" refers to insurance products including managed care and traditional indemnity products. Managed care and traditional Medicare membership are combined in this table. Disaggregated data are not available in Aetna's SEC reports.

Source: Aetna Inc. U.S. SEC 1996, p. 7, 10; 1997, p. 10; 1999, p. 5–6, 8; 2000, p. 8; 2001, p. 5–6, 8; 2002, p. 5, 7; 2003, p. 7.

TABLE 3

CIGNA's Commercial, Medicare and Medicaid Managed Care Membership (in Thousands)

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Commercial	1,046	1,137	1,130	2,140	2,123	1,993	1,921	2,016	1752	1,332
Medicare	44	56	69	96	147	188	N/A	N/A	N/A	N/A
Medicaid	149	150	52	49.	63	74				
Medicare +Medicaid	193	206	121	145	210	262	138	84	113	42

Note: For the years 1999–2002 membership for Medicare and Medicaid was not broken down but aggregated in one group. For comparison purposes we report these categories both aggregated and separately for the years 1994–1998.

Source: CIGNA Corp. U.S. SEC 1997, p. 6; 1998, p. 7; 1999, p. 7; 2001, p. 10; 2002, p. 10; 2003, p. 10.

TABLE 4

Aetna International's Operating Earnings ($ Millions), 1994–1999

Region	1994	1995	1996	1997	1998	1999
Asia Pacific	31.3	46.0	53.8	55.7	65.2	67.5
% change	—	47.0	17.0	3.5	17.0	3.5
Americas	46.3	59.1	66.0	83.0	112.9	147.5
% change	—	27.6	11.7	25.7	36.0	30.6

Note: Asia Pacific includes China, Hong Kong, Indonesia, Malaysia, New Zealand, Philippines, Taiwan, and Thailand. Americas include Argentina, Brazil, Canada (through September 30, 1999), Chile, Mexico, Peru, and Venezuela. Year 1999 includes Colombia as well. The term "operating earnings" refers to revenues minus operating expenses.

Source: Aetna Inc. U.S. SEC 1996, p. 20; 1997, p. 20; 1999, p. 18; 2000, p. 17. The lack of financial information after 1999 derives from the fact that Aetna sold Aetna International in late 2000.