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**MANAGED PREPAID HEALTH CARE
IN LATIN AMERICA AND THE CARIBBEAN:
A CRITICAL ASSESSMENT**

**Submitted By
THE GROUP HEALTH ASSOCIATION OF AMERICA, INC.
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The purpose of this study was to provide the Agency for International Development with an assessment of prepaid health care activity in Latin America and the Caribbean in tripartite form: A status report, identifying the principal health care financing and delivery mechanisms in various countries, a report on the legal and regulatory issues to be considered when undertaking the establishment of such a delivery system, and a manual for assessing the feasibility of a prepaid managed health care organization in a developing country. The objective was to study some, but not all of the countries in the region. With constraints in this effort, the project concentrated on the following countries: Mexico, the Dominican Republic, Guatemala, El Salvador, Honduras, Nicaragua, Costa Rica, Panama, Argentina, Brazil, Bolivia, Chile, Colombia, Ecuador, Paraguay, Peru, Uruguay and Venezuela.

Alfredo Solari, M.D., Director of a W.K. Kellogg Foundation sponsored project in the Uruguayan Ministry of Health to improve the managerial efficiency of HMOs in Uruguay, was engaged to provide the descriptive account of prepaid health care systems in South America. Mr. John Doherty, a retired Foreign Service Officer with extensive experience in Latin America and the Caribbean, has provided the description of health care systems in Mexico, Central America and the Dominican Republic. Mr. Doherty also undertook the legal investigation of the study.

Erling Hansen, Esq., General Counsel of the Group Health Association of America, Inc. contributed the legal and regulatory overview. Paul Zukin, M.D., of Health Management Associates, developed, under contract to GHAA, the feasibility study manual for prepaid delivery systems. George B. Strumpf, MPA, Associate Director of Group Health Association of America, Inc. was Project Director. Gail-Marie Crowley, MHSA, managed the overall project, developed the preface and integrated the various authors' sections into a coherent report.

Executive Summary

The following report was undertaken to provide the Agency for International Development with an overview of the extent of managed prepaid health care activities in Latin America and the Caribbean. A protocol manual with guidelines for determining the feasibility of a U.S. model health maintenance organization (HMO) in developing countries was also produced and translated into Spanish (Volumes II and III).

A significant number of prepaid health care organizations were found in South America. (See chart "Number of Managed Prepaid Organizations Identified" on page "x".) Some difficulty was encountered in the classification of these entities. A wide diversity in organizational structure exists as well as a plethora of financing mechanisms, patterns of reimbursement and contractual arrangements. Most important were the varying degrees of employer contribution and government involvement.

The health "product" delivered by these organizations also ran the gamut, from few and limited primary care services (examples of which were found in Peru) to comprehensive benefit packages providing preventive and rehabilitative care complementing conventional curative care services (as in Uruguay). Therefore, current and conventional labels extant in

the U.S, such as health maintenance organization, preferred provider organization, independent practitioners association, etc., were not always useful in the Latin American setting and have been avoided whenever possible in favor of the more generic phrase "managed prepaid health care systems."

The development of managed prepaid health care in the region has been chiefly influenced by two factors: the level of economic and social development and European immigration. Brazil leads the region in number of HMOs (156 were found in this survey) serving eight percent of the population. Uruguay follows closely with some 50 Instituciones de Asistencia Medica Colectiva (IAMC) providing care to a very large portion of the population, nearly 45 percent. In Paraguay, 25 HMOs are presently in operation, but they primarily serve the middle and upper-middle classes. Ten HMO-model Mutualistas were found in the Argentine private sector. Current enrollment is falling, however, due to the increasing importance of government sponsored social security institutes known as Obras Sociales. The social security institutes in Argentina cover 75 percent of the population, most in the manner of preferred provider organizations (PPOs).

In the remaining countries of Latin America surveyed, fewer managed prepaid organizations were found. Although three commercial HMOs exist in Colombia, a greater number of social security-type institutions, operating in the HMO fashion, were

reported. Bolivia has only two HMOs, but 11 cooperatives offer health care services (mostly primary health care) either as a side benefit, or as the principal mission of the organization. Only one PPO entity was located in Ecuador, and in Venezuela the strong orientation to independent solo practice has permitted only one hospital-based prepaid arrangement with a government corporation to evolve. In Peru, one HMO and several mixed HMO-PPO organizations were found in Lima. In Central America, where the consultant was bereft of the opportunity of site visits, one recently established managed prepaid system was located in Guatemala. Considerable interest and consideration of the prepaid concept is also known to exist in Panama.

Chile and Uruguay were the only two countries in which a legal review of health care legislation revealed specific enabling legislation for the development of managed prepaid health care organizations. Recent legislation (1981) in Chile permits individuals to channel their social security payments towards the cost of care purchased from the 15 managed prepaid health care organizations known as Institutos de Salud Previsional (ISAPRES). In Uruguay, extensive legislation on standards and obligations of Institutos de Asistencia Medica Colectiva regulate this element of the health sector and the IAMC's delivery of care. Considerable legislation exists facilitating the operation of HMOs in Brazil.

Possible legal obstacles to the development of prepaid health care organizations could arise, as they did in the U.S.,

with the establishment and proliferation of these organizations. Legal encumbrances, not readily evident, may exist as barriers to their development, or may evolve, requiring protective government measures in order to permit the industry to grow.

In addition to the socio-economic and legal aspects mentioned above, various factors have been determined by Alfredo Solari, M.D., as integral in the development of managed prepaid health care organizations. Contributing factors are:

- 1 - The presence of social structures that are community-based, that are in themselves (or at least have the potential to become) highly organized and have a sufficient income base to sustain the costs of organization and delivery of health services on a prepaid basis. Historically, in South America, countries with "community structures" such as large groups of immigrants, industrial labor groups (either through unions or large employers), and production cooperatives (less so consumer and savings and loan cooperatives) have been the most active in prepaid health services.
- 2 - The oversupply of physicians has played an important role in the growth of prepaid health care organizations. The excess supply lowers the medical profession's resistance to the practice of medicine in settings that are not private practice or government services. Unemployment and underemployment become an

important wedge, and community organizations find it easier to employ or contract the services of physicians. Furthermore, the oversupply of physicians coupled with the development of prepaid organizations fosters the growth of physician cooperatives, further drawing patients away from private practice and into the prepaid net.

3 - A third major factor is the perceived inadequacy of services delivered directly by government and social security agencies. The emerging blue and white collar workers often find the ineffectiveness and inefficiencies of these services difficult to accept. Hospitalization in general wards, ambulatory care provided in unattractive out-dated settings, long waiting lists, the unavailability of drugs and little modern technology are causing them to seek alternative health care delivery systems. Two examples of this were found:

a) In Brazil dissatisfaction with the services provided or financed by INAMPS (the social security agency) has led workers in major industries and companies to push for additional coverage with an HMO at the employers' expense.

b) In Uruguay the social security administration revised a decision to develop its own delivery organization in favor of contracting, on a prepaid basis, with HMO-like organizations to provide health services to its beneficiaries.

Four factors were identified by Dr. Solari as inhibiting the development of managed prepaid systems in the region:

- 1 - The ignorance of political and community leaders about the concept of managed prepaid care as an efficient and socially acceptable means of meeting the health needs of the population. The advantages and disadvantages of the system are not well known and, therefore, it is seldom considered as a serious alternative to the traditional two tiered system: private practice and government services. This is frequently due to the dominance exerted by the medical profession in the formulation of public policy health matters and their influence in the ministries of health, social insurance institutes and government services.
- 2 - The medical profession has traditionally opposed the development of the prepayment concept in general and managed prepaid organizations in particular. The best example exists in Venezuela, where the medical association has policies prohibiting its members from practicing in these settings and sanctioning, by the suspension of their licenses, those that disobey this policy. More subtle resistance was found in almost all the other countries. A change in this trend of opposition is, however, beginning to emerge as unemployment of physicians rises and prepaid health care organizations emerge.

- 3 - A third inhibiting factor is the perception that these private sector initiatives are primarily directed towards the needs of the emerging middle classes, thus inhibiting a policy of equal access to care. The active promotion of a government-run national health care service organization is a clear example of this ideological barrier. However, in some countries, the basis for the promotion of government services is not only ideological, but more pragmatically related to the exercise of power and patronage.
- 4 - Finally, the lack of capital resources and technical know-how for the initial development of managed prepaid health care systems has been a major obstacle to development. Resources are generally invested in modern medical technology. None of the countries surveyed had loan or grant policies for the promotion and development of a managed prepaid organization, even when large capital investments were being made in other segments of the health care delivery system.

Several recommendations can be made based on the conclusions of this project:

- 1 - Further on-site case study examination of selected managed prepaid organizations in both urban and rural settings is strongly advised. More detailed information on the financing, utilization, populations served, services provided, and the management of these organizations could then be obtained, in order to

assess the extent of the need for management training in each of the countries. Management expertise was frequently found to be inadequate in the development and expansion of managed prepaid organizations in the U.S. experience. In response to this need, GHAA initiated in 1982 the National HMO Management Fellowship Program, which served to train approximately 200 managers over a period of three years with positive results in the industry. Similar programs could be established for foreign health care managers.

- 2 - A technical assistance pool of experts could also be created to assist in pre-feasibility assessments. The pool would draw on both U.S. sources and expertise identified in the field, as in Brazil and Uruguay. Such a technical assistance team was recently dispatched to the Philippines and resulted in a very favorable response in the Filipino health care community, including requests for follow-up activities. A substantial number of U.S. HMO specialists could be made available for promulgation and development of the managed prepaid health care system in both the public and private sectors in Latin America and the Caribbean.

3 - Last, and perhaps most important, the widespread distribution of Dr. Paul Zukin's feasibility protocol would be a great contribution to the dissemination and effective promotion of the concept of prepaid health care systems and their operation. This manual is, in our opinion, the most comprehensive guide for assessment of HMO development potential presently available. The utility of this document cannot be overemphasized.

Number of Managed Prepaid Organizations Identified

COUNTRY	MODEL	PPO	IPA	HMO	MIXED HMO-PPO	HEALTH CARE COOP	COOPERATIVES	OTHERS
Argentina		2		10	1			
Bolivia				2		7	4	
Brazil			76	156				
Chile					15			
Colombia		14		3	36		*	
Ecuador		1					*	133 company sponsored medical services
Paraguay				25				
Peru (Lima)		2		1	4		*	*company sponsored medical services
Uruguay				50				
Venezuela				1				
Guatemala				1				
TOTALS		19	76	249	56	7	4	

*Indicates activity in the category, but no hard data was available.

Definitions of Terms

- PPO:** Preferred Provider Organization - A fee-for-service arrangement of reimbursement for hospital/medical/dental services on an agreed-upon discounted fixed price charged by the participating providers.
- HMO:** Health Maintenance Organization - An organization that through an organized system of health care, provides and assures the delivery of an agreed upon set of comprehensive health maintenance and treatment services for an enrolled group of persons under a prepaid fixed sum.
- IPA:** Individual Practice Association - An HMO that contracts with an association of physicians from various settings (a mixture of solo and group practices) to provide health services.
- Mixed HMO**
PPO: Combination of HMO and PPO elements.
- Health Care**
Cooperative: Cooperative established for the express purpose of providing directly or indirectly health services to members.
- Cooperative:** Provides health care services to its members as one of various benefits of the Organization.

CONCEPTS AND PRINCIPLES

Most Latin American and Caribbean nations demonstrate a common set of problems afflicting their health care sectors. Principal among these, and of which numerous others are a consequence, is the insufficient financing of the health care system. Political apathy in matters of health care and the consequent lack of sufficient funding in the public health sector has resulted in few and inadequate facilities and health care manpower resources serving the largest segments of the population: the social security beneficiaries and the recipients of public health services. Health care services in many of these nations range from poor quality primary care attention to highly sophisticated comprehensive tertiary care services. Lamentably, the latter are, for the most part, financially inaccessible for many of the lower income population groups.

The rising cost of medical technology and supplies, (most of which are imported), the growing demand for improved health care services from an ever expanding population, compounded by the difficulties which accompany economic stagnation and inflationary conditions, have exacerbated the dilemma to serious proportions. An inordinate amount of the burden has fallen on the national governments who, though committed to the provision of delivery of health care services to the general population, have come to realize the strain of this commitment on the national coffers.

Finally, the loose, unstructured and poorly coordinated components of the health delivery system, both public and private, in many of these nations are typically plagued by managerial inefficiencies, uncontrolled cost and utilization, and duplication of services.

As the problems escalate, pressure has mounted for change in the health care sector. Alternative financing measures are being sought as a possible means of alleviating the health care burden of the governments. Private sector involvement is growing. Methods of encouraging health service users to undertake partial financial responsibility, with or without the involvement of employers or government subsidization, and in accordance with the ability to pay, are being explored. It is quite well known that lower income groups are willing to spend for health services, either of the traditional western or non-traditional curandero medicine. As incomes grow, Brazilian studies have shown that a disproportionately larger amount of income is expended in the purchase of health care services.[1]

In addition to altering the traditional method of financing health services, means of modifying the incentives of fee-for-service medicine, the managerial deficiencies in the sector and the high utilization patterns, are under consideration. In sum, alternative delivery systems are being examined for their contributions in economic efficiencies and control of resources.

It is in the wake of emerging interest in the developing world in these health care delivery alternatives that the following reports were undertaken.

I. Introduction

The U.S. alternative to traditional fee-for-service and public health care services emerged in the last century in the form of prepaid "contract" medicine among plantation owners in the south as they sought medical care for farmworkers. The early railroad companies also took this prepaid route by deducting from rail workers' salaries a sufficient amount to cover the expenses of salaried physicians and railroad hospitals. These early initiatives spread to the mining and lumbering industries, most notable of which was the Kaiser company's contracted medical services that grew during the 1930's to provide care to the burgeoning company's diversified construction industry.[2] It has become a provider of care that presently serves almost one third of the U.S. population enrolled in health maintenance organizations.

In the U.S. charges of the practice of "socialized medicine" were launched against the prepaid health care delivery sector by fee-for-service physicians to whom the concept of organized care was anathema.[3] Considerable opposition to this form of health care can be found among physicians in Latin America and the Caribbean also, as physicians maintain their preference for solo practice. However, with the increased supply of physicians in many of these countries, gradual acceptance of the system is bound to emerge as it did in the U.S.

II. Historical Background

The modern health maintenance organization (HMO) concept developed in the United States as a competitive alternative to indemnity forms of health insurance and Blue Cross-Blue Shield. Both of these types of health insurance were based on the concepts of cost reimbursement to hospitals and fee-for-service to physicians. Shortcomings in the fee-for-services sector included: emphasis on curative care coverage, over-utilization of hospitals, disincentives to practice on a cost efficient basis, and a multiplicity of entry points into the system which confused the consumer.[4]

The HMO structure proposes to remedy these problems by organizing the various elements of health care into a single system. The resulting organizational entity has the responsibility of providing comprehensive health care services to a defined population for a predetermined fee, in effect, taking responsibility for both the financial and delivery aspects of health care. It uses primary care physicians as gatekeepers to the system and guides to the consumer. Referrals to outside specialists are closely monitored. It emphasizes ambulatory care treatment where appropriate, early access to medical care and preventive medicine, thereby reducing unnecessary and costly hospitalization. The centralized management of shared services has the added benefit of reducing overall operational costs.

The combination of the health care delivery and financing functions enables the organization to provide comprehensive health care services to its enrollees on a fixed fee basis. The

physicians, in whatever manner they are affiliated with the HMO, either on salary, capitation or negotiated fee-for-service basis, are at risk financially for the care they provide to the enrollees. Physicians' practice profiles are modified, and cost savings ensue. [5,6]

These structural and health care delivery features are increasingly attractive in the U.S. to purchasers of health care (employers, unions and government) and to the individual consumer. In the early 1970s, there were less than 30 HMOs in the U.S., serving approximately 3 million enrollees. Participation by the elderly, financed by Medicare, and the poor, financed by Medicaid, was very low due to the absence of acceptable reimbursement provisions. By 1985, there were over 370 HMOs with nearly 17 million members. The rate of membership growth for 1984 was 22.4% and 40 new HMOs began operation during that period. These types of health plans are now located in 43 states, the District of Columbia and Guam. Medicare and Medicaid enrollment increased more rapidly than overall HMO membership; there was a 36% increase in members over 65 years old (June 1983-1984) and a 35% increase in the Medicaid category. In January 1985, federal regulations were issued defining reimbursement of HMOs for the over 65 population and signaling a suspected major increase of elderly persons enrolling in HMOs during the next few years. Similarly, state governments have increased Medicaid-HMO contracts, particularly for the welfare category of aid to families with dependent children, because of the demonstrated cost savings while

maintaining a high standard of medical care.7] The employers, who contribute most of the financing for medical insurance for the U.S., were surveyed recently regarding their experience with and attitudes toward HMOs.[8] These findings indicate a high enrollment in HMOs by their employees.

III. Prepaid Managed Health Care Models

In the U.S., the term "Health Maintenance Organization" encompasses a broad spectrum of prepaid organized delivery systems structures. Classic models include:

Staff model- The HMO employs salaried physicians to provide care. The HMO may own the hospital(s) or contract with existing community hospitals.

Group model- The HMO contracts with a multi-specialty physician group on a capitation basis to provide health care services. The HMO may own the hospital(s) or contract with community hospitals.

Network model- The HMO contracts with multiple group practices who may also maintain a fee-for-service practice.

Individual Practice Association model (IPA)- The HMO finances and arranges the delivery of care to its enrollees via independent physicians practicing out of their own offices. Reimbursement to doctors is by negotiated fees or capitation. This model maintains fee-for-service, or traditional medical practice. The HMO contracts with community hospitals for critical care.

These four basic prepaid group models can be further modified by an assemblage of reimbursement policy options and contractual arrangements. HMOs generally take form in the manner which best suits the needs of the sponsors, employers and providers.

IV. Principal Components

The variety of operational structures in existence do, however, share several common elements:

Employed groups, including union members, as principal subscribers to the HMO's health care services - Large employed groups from all sectors of the economy, including dependents, are integral to the formation of a subscriber base. An HMO cannot consider non-group or individual enrollment as a principal source of membership. The expenses involved in marketing to individuals cancel the economies gained from this form of prepaid managed health care.[9]

Administrative services for the management, marketing, actuarial, financial, planning and other organizational activities- The centralized administrative functions of a prepaid managed health delivery system approximate the activities of a business enterprise emphasizing planning, cost control and the undertaking of risk. The development and maintenance of an enrolled membership is the administrative body's task, as is the responsibility of collection and analysis of utilization data and the development of physician practice pattern norms to which the providers will adhere.[10]

Prospective payment - A fixed, prepaid monthly payment is received from the employee. Additional premium payments are required in some instances from the subscriber, in order to cover the estimated cost of health care for all the enrollees and their dependents, regardless of individual utilization of

services. Community based rates are actuarially determined on the number of enrollees and fixed for the period of one year. An increase in enrollment increases the organization's funds, and an increase in the use of services, depletes the organization's expected pool of revenue.[11]

A comprehensive set of health care services - Medical services are provided either directly, by the HMO, or through contractual arrangements with providers. Accessibility and availability of services is guaranteed to the members. A network, usually consisting of several health centers, secondary community health facilities and access to tertiary hospital care, provides a wide range of services available 24 hours a day. The strong emphasis on preventive care, health education, prenatal care, maternal and child wellness programs and avoidance of financial barriers to seeking health services early, or when disease is suspected, maintains health status and diminishes the utilization of expensive acute care resources.

Medical services are provided by HMO affiliated physicians - Providers render services in HMO affiliated centers and hospitals. Physicians are compensated in a manner unrelated to the number of services actually provided, eliminating the traditional incentives characteristic of fee-for-service practice.

Physician extenders and assistant health providers are utilized - Physician assistants, nurse practitioners and other physician extenders are frequently involved in the screening and educational activities of the HMO.

Auxiliary services are integrated into the system -

Physical therapy facilities, medical social services and home health services are often integrated into the system in order to ensure continuity of care. HMOs frequently manage their own pharmacies, dispensaries, laboratories and other health support services, thereby significantly reducing the cost of these services and their products to the HMO and the enrollees.

Voluntary enrollment - Free choice of health coverage is made available by the employer in order to provide the employees with the alternative of traditional insurance to the HMO. This choice is usually for a one year period.

V. Advantages and Disadvantages of the HMO System

The advantages resulting from prepaid health delivery systems are principally due to the organization of the service structure and to the element of prepayment of services. In addition, by altering the incentive mechanism by which physicians' income is directly related to the number of procedures performed, cost savings result from lower utilization and the more efficient use of resources in the health system.

Advantages to Administration:

---The administrative structure of this form of care permits the management to retain an efficient control on the delivery of services, with careful allocation and shared use of resources. Duplication is avoided by coordination of services, appropriate utilization is monitored, and administrative duties are centralized, freeing providers of care from administrative tasks.

---A pooled source of income based on a geographically determined enrolled population permits management to budget for anticipated costs of health care services. Cash flow is more uniform in a prepaid system, enabling management to plan financially for the organization.^{12]}

---A change in physician practice patterns will occur as incentives for remuneration by service or procedure, are eliminated. Encouraging the use of ambulatory services in lieu of hospitalization, where appropriate, is an economical result of providers considering costs and alternatives. Only necessary tests and procedures are ordered.

---The primary care physician becomes the gatekeeper to the medical care system, determining the appropriate utilization of services and coordinating the entry of enrollees into the medical system.

---The HMO will establish formal relations with non-HMO referral physicians as gatekeeper physicians become responsible for referrals to outside specialists. (Maintaining, of course, careful monitoring of the member's outside treatment plan in order not to foresake the cost advantage acquired in the HMO setting.) [13]

---The resultant improved net cash flow generated by the subscribers' payments can result in financial benefits to the organization as it avails itself of the opportunities of short term capital investments. [14]

Advantages to Physicians:

---Physicians are relieved of the financial and administrative tasks inherent in serving private patients. They can enjoy predictable income or stabilized cash flow, regular schedules and time for continuing education. More professional freedom results. [15]

---A referral and consultation structure will evolve from the availability of pooled physician talent.

---Physicians will find, however, that they owe greater responsibility to their associates as a result of their participation in group medicine. Quality assurance and peer review issues will most likely be brought to the fore as

physicians come to realize their dependency on their colleagues' performances.[16]

Advantages to Consumers:

---The prepayment mechanism ensures the consumer of predictable health care costs and does not penalize the individual for appropriate utilization of services.

---Quality of care is enhanced by the continuity of care provided by the organization.[17]

---Greater accessibility to health care results as financial barriers to utilization are removed. First dollar coverage is provided and the use of copayments, generally used to prevent trivial use of services, is nominal.

---The emphasis on preventive health and early detection of disease in ambulatory settings will reduce hospitalization and related costs.

Advantages to Employers:

---The introduction of a competitive health care provider usually will lower the cost of health care benefits for employers.

---A healthier work force with increased productivity and reduced absenteeism can result.

---Employer costs are predictable due to community rating, as there is no adjustment to the premiums for actual experience, i.e. specific costs for the group.

A number of disadvantages of the system have prompted criticism of this form of prepaid health care. Some consumers will lament the limited choice of physician and health care

facilities in an HMO. The lack of choice, however, is a product of the cost-saving technique. Members who insist on seeking care outside the HMO without authorization, cannot expect reimbursement for costs incurred. In addition, consumers have frequently found that longer waiting periods for appointments deemed not urgent will occur. As the members' perceived demand for health care is generally greater than the resources available in an organized delivery system, a system of rationing according to medical need is generally instituted. In the fee-for-service sector, on the other hand, the ability to pay rations medical services.

There is a theory that contracted or capitation reimbursed HMO physicians might regard HMO plan enrollees as "captive" and provide them with inferior services, thereby creating the danger of a dual class system of care within their own practices. This can be particularly troublesome in a situation in which dual choice is not available, usually to a large segment of the low income population. In addition, the possibility of incurring cost savings at the expense of the well-being of the enrollee is a frequent criticism. However, the principal countervailing force to these possible developments is the fact that it behooves the physicians to keep their patients healthy so that they do not become more sick and incur greater amounts of expensive treatment at the cost of the physician.[18]

From the administrative perspective, various financial and managerial considerations must be carefully weighed before embarking on a prepaid managed health care scheme. The delicate

balance, and often conflicting objectives, of the various elements of the organization, require skilled management personnel for the effective operation of a prepaid system. Frequently, this pool of talent is difficult to obtain. Secondly, many HMO models have significant start-up costs, and there is the difficulty of deferring recovery costs of capital to subsequent years of operation. Lastly, financial policies must be made concerning cross-subsidization among classes of policy holders, who to undercharge and who (if anyone) to overcharge. Fiscal solvency must be maintained without succumbing to the unethical practice of selective enrollment in order to skim the population for the healthiest and most financially attractive enrollees.[19]

VI. Environmental Conditions:

In order for a prepaid health care system to become successfully established, certain hospitable environmental conditions must exist:

Political and legal factors- A willingness to accept and promote the prepaid managed health care concept through public policy. There must be an absence of regulation against the incorporation of medical providers and certain strictures on their practice. National laws and local jurisdictional laws regulating practice and participation in the delivery of public health services must be examined, as well as the medical ethics objections to advertising of medical services, and compensatory arrangements. Opposition from medical associations and their extra-legal punitive measures, if they exist, would also serve

as serious barriers to the establishment of a prepaid managed health care system.

Socio-political factors - There must exist a large enough catchment group of employers and employees to whom the concept of a prospectively paid health care service can be marketed. Sufficient income must be earned by the employees to support payroll deductions, over and above employer payments, or government subsidies would be necessary, in order to finance such a health care service.

In the U.S., the public payor participation has been limited, due principally to a lack of expertise in the administration of prepaid medical contracts, coupled with a tendency to avoid being identified as a poor person's clinic. Marketing the concept to a predominantly uneducated, welfare supported group also poses problems, as a sense of identity with the organization must be developed in order to prompt utilization [20]. Medicaid-HMO contracting started to expand in the U.S. during the past 5 years as states became more sophisticated with the contracting process.[21]

Health care industry supply factors - An adequate pool of health care providers must exist in order for a prepaid operation to exist. In most Latin American countries, for example, an oversupply of physicians and a competitive market would make the prospect of affiliating with an HMO type organization more attractive to physicians. However, the lack of physician extenders, nurses and other health workers in many countries may present staffing problems for incipient HMOs.

Providing a rich benefit package in a rural or medically underserved area is, for the most part, unrealistic due to the lack of provider resources generally available in these areas and the lack of significant employer groups.[22] Initial first year costs are generally high, due to the higher rate of serious illnesses in these regions.[23] The prepaid health care system is not a panacea for the problems of health care delivery in underserved areas, and will not attract physicians and resources to these regions without significant government or industry assistance and subsidization.

Health care financing considerations - A health care financing mechanism which will permit the entry of HMO providers in the existing system is necessary. Investors in HMOs from both the public and private sectors must be able to finance the venture by means of equity, common stock, public bonds, government sponsorship, donations, etc. [24] If a dominant Social Security mechanism or public health system exists, consideration should be given to innovative public/private cooperation in the financing and delivery of services.[25]

Sponsorship and managerial factors - An interested and committed sponsoring agent- a physician group, hospital, major employer or the national government must be present as the agent under whose aegis the prepaid health care delivery experiment can be undertaken.

In the U.S. experience, the most significant cause of failed HMOs was insufficient commitment from the sponsoring

group as a result of inadequate capital investment and a lack of clearly delineated organizational objectives. The second most frequent factor leading to failure was a lack of adequate management. Motivation, management and physician involvement are as integral to the success of an HMO venture as are community acceptability, a hospitable legal environment and the availability of capital.[26]

In conjunction with the factors listed above, some countries exhibit indicators of "receptivity" which would make them more disposed to accept the conceptual ramifications of an HMO-type organization, and therefore provide fertile ground for the development of a prepaid system. The actual existence of some form of prepaid health care would, of course, signify acceptance and, hopefully, viability of the model. The existence of prepaid insurance is also considered significant as a measure of the population's willingness to pay prospectively for care from the private sector. Cooperative efforts, whether agricultural, industrial, community or ethnically based organizations offering health care benefits, would also indicate a propensity to accept the concept of prepaid managed health care.

VII. Parallels in U.S. and Latin American Development of Prepaid Health Care Organizations.

The pattern of development of prepaid health care organizations in Latin America closely resembles the evolution of the HMO industry in the United States. Conceptually, the prepaid model in both regions developed as an alternative to

private fee-for-service care and the public delivery systems. A burgeoning middle class in the U.S. demanding affordable quality care led to the growth of prepaid organized care. Rising expectations among members of the lower and middle income groups for improved medical care services and a desire to reduce dependancy on the public and social security services led to the establishment of prepaid health care activities in Latin American countries. Salaried staff model prepaid systems have progressed to contractual group models as they did in the U.S. Variations of the network system, with multiple service delivery sites, are presently evolving in both regions. Lastly, medical association opposition to these arrangements has spurred the development of Preferred Provider Organizations in these countries, quite similar to the development of the PPOs in the United States.

The sequence of obstacles to development of the industry has also proven to be similar. A general lack of capital and adequate financing has plagued prepaid health care in both the U.S. and in the region. In the U.S. the HMO Act of 1973 provided venture capital to HMOs meeting federal qualifications and standards in order to remedy this situation. This short term financial mechanism was quite successful in giving the HMO industry its needed economic impetus.

Hand in hand with financial assistance for nascent HMOs in the U.S. came enabling legislation. The federal law superceded some state and local legislation and regulations inhibiting the establishment of corporate medicine and restrictive reserve requirements, as well as other inhibiting barriers. Though

specific legislation prohibiting the corporate practice of medicine was not found to exist in Latin America as it had in the U.S., it is anticipated that medical association opposition will be a significant obstacle for the establishment of prepaid health care in some Latin American countries.

VIII. Conclusion

Some elements of the U.S. model are not easily transferred to a developing country's setting. For instance, the tenets of dual choice and voluntary enrollment may be a moot issue for selected population groups which may not have the luxury of a choice of alternative. In addition, options for HMO models in developing nations will vary according to the degree of public and private participation sought. If the intent is to provide an alternative to existing health care options in the private sector, a private investment initiative would be most appropriate. Other elements are transferable and have been found to operate successfully for consumers, employers and public payors; prepayment for a defined set of primary services plus hospital care is feasible in many developing countries as has been identified by this effort.

If, at the other end of the spectrum, the objective is to provide care to the indigent, a government-sponsored parastatal entity could be created. It would operate on the model of an HMO (prospective payment and cost containment) but would necessarily need to be financed by the state. [27] Various intermediate combinations of public and private funds would also be possible.

As with any other form of technology, the adaptation of prepaid managed delivery models will require imagination and creativity. The challenge lies in the ability to transfer the appropriate elements of the prepaid model in order to serve the needs of the health delivery infrastructure while accommodating for cultural, socio-economic and political considerations. Some successful examples are cited in the following chapters.

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ORGANIZED PREPAID HEALTH CARE
IN SOUTH AMERICA

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CHAPTER I

INTRODUCTION

1.1 Background

This report was undertaken under the Cooperative Agreement No. LAC-0000-A-00-4049-00 between the Agency for International Development and the Group Health Association of America. The main purpose was to develop a critical assessment of Health Maintenance Organization (HMO) development in Latin America.

Two of the objectives of this project were:

- "to identify and describe prepaid and/or HMO-type activity in the Latin American region";
- "to identify and examine the factors that have contributed to the growth of the activities in the Latin American region".

The report on this subject was to include:

- a) Characteristics of each activity: name, sponsorship, etc.
- b) An assessment of advantages and disadvantages of the "HMO" system.

In order to accomplish parts of this project in South American countries, an agreement was reached between GHAA and this consultant. Sections (b) and (c) of the "Services to be Provided" stated the terms of reference for this report as follows:

"Using a standard format, identify and report on HMO and/or prepaid health care activity in designated South American countries"; as well as "review the social, economic, legal and political factors bearing on the establishment and development of HMO-type systems in each country and assess the feasibility of initial or further development of HMO-type systems in each country reviewed".

There is an accepted definition in the United States of what an HMO is as stated in the HMO Act of 1973, PL93-222 (as amended). The strict application of the U.S. model to the types of prepaid activities existing in South American countries would have excluded practically all of them from the study. In recognition of this limitation, the terms of reference utilized an expanded concept by referring to "HMO and/or prepaid activity". Thus, we identified and described the kinds of prepaid health care organizations existing in each South American country we reviewed.

Each class or type of prepaid activity was then compared to three main prepayment models: indemnity insurance, indirect provision of prepaid services (Preferred Provider Organizations or PPOs) and direct provision of prepaid services by Health Maintenance Organizations, or HMOs. As a result, we were able to select in each country those activities that, although different in some respects from the American HMO concept, were similar enough as to permit inclusion in the study. For those prepaid activities which were identified, an effort was made to describe and list all, or at least the most important, organizations that fit the characteristics of the group in the country concerned.

Direct provision of prepaid health care services by HMO-type institutions was found to be most developed, with the longest tradition and providing the widest coverage to the population, in Argentina and Uruguay, somewhat less developed but growing in Brazil, Chile and Paraguay, and almost nonexistent in Bolivia, Peru, Ecuador, Colombia and Venezuela. Although in each of these countries the presence or absence of HMO-type organizations relates to a series of national social, economic, legal and political factors, there is an overall relationship between the level and pace of socio-economic development and the appearance of this type of health care organization.

The next two sections of this Introduction contain a general reference to the socio-economic development of South American countries and the main features of the health care delivery systems in these countries. They serve as a general point of reference for the presentation of each country reviewed. Toward the end of this chapter there is also a section that analyzes in more detail the characteristics of the three types of private prepaid health care delivery organizations.

Finally, in order to learn about the overall organization and financing characteristics of the health care systems, including the identification of existing types of prepaid activities, and to relate both to the appropriate social, legal, economic and political factors in each of the South American nations, site visits were made to ten countries. Much was learned from these short visits. However, the task of identifying, listing and describing the components of those prepaid organizations most similar to HMOs was arranged in most countries with

a local correspondent. Their efforts have resulted in the lists of prepaid activities that appear at the end of the chapters corresponding to each country.

1.2 Socio-Economic Development of South America

The delivery of personal health care services and its various organizational forms is highly dependent upon the level of social and economic development existing in a country. Universality of access and the establishment and operation of complex financing and delivery systems appear in very advanced stages of development. Therefore, it seems necessary to present an overview of South America's ethnic, cultural, economic and social evolution as background information for a description of the health care delivery systems that have developed in these countries.

1.2.1 Human Resources

Four main ethnic components have contributed to the present population of South America:

- Amerindians: They inhabited this continent before its discovery and conquest by the Europeans. Indian societies at that time (early 16th century) existed at three different cultural levels, a fact that to a large extent determined the composition of the population during the colonial period and afterwards, even to the present day.

Along the highlands of the Pacific coast, with its focal center in Peru, existed the Andean society. It enjoyed a relatively high level of political and military organization, and advanced social,

cultural and economic structures. Its architecture - palaces and elaborate multiroom buildings - its agricultural techniques - terracing and irrigation - and its urbanization with the emergence of inhabited cities, are evidence of its advanced development. The Amazon Basin and the mid-Atlantic coast were occupied by intermediate level Indian societies or tribes that practiced hunting, but also some agriculture. The temperate and southern zone was inhabited by nomadic hunting tribes with a lower level of social development.

- Iberians: During the colonial period, from the 16th to the early 20th centuries, only Spanish and Portuguese were admitted to the South American colonies. Composed mostly of military, religious and self made entrepreneurs, the Iberians that came to this continent were few in comparison to existing Indians (approximately 150,000 Spaniards and a similar number of illegal immigrants compared to about 6,800,000 Amerindians of which a little less than half belonged to the Inca Empire or were under Inca influence).
- Africans: An important demographic contribution was the large scale importation of slaves from Africa, estimated to be as many as 4,000,000 for Brazil and 3,000,000 for all Spanish America, of which only a minority went to the Andean region and an even smaller number went to the southern cone, consisting of present day Argentina, Uruguay and Chile.
- Post-independence immigrants: Late in the second half of the 19th century and continuing until 1930, South America received mass immigrations from Europe - Italy, Spain and some central

and eastern European countries. Some 11,000,000 to 12,000,000 people arrived. The great majority of these went to Argentina, Uruguay, southern Brazil and central Chile. The demographic and socio-cultural impact of this mass immigration, particularly in Argentina and Uruguay was very important.

These four main components blended among themselves to various degrees and, as a result, new socio-cultural groups evolved. Three regions of ecological distribution can be identified for these ethnic groups. These regions showed a different rate of social and economic development not only because of their differences in their populations but also because of climate, location, natural resources, political stability, etc. From the population view-point, they can be recognized as:

- Indo-America: It consists of the highlands from north to south on the western side of the continent. It corresponds roughly to the territories of Venezuela, Colombia, Ecuador, Peru and Bolivia where Mestizo and Indian groups are predominant. At the time of the conquest by Spain, this area was the site of the highest civilization in South America and was the most densely settled. The social and economic organization of the Spanish Empire was sustained upon the relatively advanced institutions of the Indians and on Indian labor which was easily exploited.
- Mulatto America: In the lowlands of Venezuela and Colombia (in the Amazon Basin), and much more so in Brazil, the few and relatively dispersed Indian tribes were eventually decimated

by disease and warfare and replaced by imported Africans, mostly for the purpose of cultivating plantation crops. Their racial and cultural influence became very significant.

- Euro-America: In the temperate zone, the indigenous tribes, already scarce, were destroyed and the mestizo population was surpassed in size and therefore overwhelmed by the avalanche of European immigration around the turn of the 19th century.

1.2.2 Political and Cultural Evolution

The nature of the European domination and its lasting impact on post-colonial South America was determined on the one hand by the economic, political, cultural and ideological forces orienting the Spanish and Portuguese empires and on the other by the level of civilization characterizing the indigenous population. As a result of this European influence, although the political organization of the independent nations was molded after the French and American models, the political culture, values, attitudes and behavior - particularly during the 19th century were - to a considerable extent - the reflection of Iberian politics.

Together with the political and cultural heritage the new nations showed a strong continuity with their colonial status as far as their economic roles were concerned. Colonial South America was a market for European (mostly Spanish) manufacturers and a producer of raw materials - precious metals and tropical crops that were exported to Spain. After independence this economic framework continued to exist in the form of the primary export economy that was predominant in the region until the 1930s and that still remains an essential part of it today.

Social organization and stratification were closely related, both during the colonial period and afterwards, to the system of land tenure and to the pattern of labor relations. The great landed estate, the hacienda, was one of the cornerstones of colonial society and became an autonomous, self-sufficient institution not only in economic terms, but also politically and socially, with the landowner exercising absolute authority over all groups living on the hacienda.

This feudal social structure inherited from the colonial powers resulted in a failure to create a viable modern political system in the new nations, while the central economic role played by the export of raw materials not only reinforced the landed estate system, but increased economic dependence and vulnerability. It provided an obstacle to industrialization and determined the forms of social relationships that in turn tended to perpetuate the archaic social structure.

1.2.3 20th Century Social Change

The old colonial heritage that dominated the South American scene during the 19th century, precluding industrialization and social change, started to crumble in the first half of the 20th century.

The increasing demand for primary exports, the growing centralizing and coordinating role of the state and the creation of new services required as a result of economic expansion, all helped to transform South American urban society. Particularly in the larger cities, a new urban middle class, with an urban proletariat, emerged. These new social forces were reflected in the political system, leading to wider participation, as well as modifying the cultural and social scenes.

The breakdown in international trade created by the world wars and the Great Depression generated conditions favoring industrialization. At the same time urban concentration increased enormously. The growth of the mass media and of transportation networks broke down the isolation of the large rural areas that usually formed the greater part of the countries' national territory.

The timing, speed and character of these transformations has varied among the different nations. In general, Euro-American countries initiated their transformation first, around the turn of the century, with the mass immigration of Europeans. The largest nations of Mulatto America followed, mainly Brazil and Venezuela in the 30's, 40's and 50's. Social change also occurred in some of the Indo-American states. Stagnation and regression did occur, but mass mobilization and social change are the main characteristics of contemporary South America.

1.3 Health Care Delivery Systems in South America

The organization of health care institutions in South America has historically followed the lines of social stratification. Even today, to a large extent, medical and hospital services are organized in separately to serve different income groups.

During the post colonial period the inequality among different social classes, in terms of income and political power, produced similar inequities in living standards and in the accessibility to medical care. Acute care hospitals were located where the powerful and influential in society lived, since they were created to serve predominantly the needs of those groups. The poor either did not have access at all or were looked after by ill-equipped hospitals and clinics managed and financed by charitable organizations.

During the second half of the 19th century and the first decades of the present one, an important change took place in relation to the role of the state. Slowly, the state replaced these organizations in the financing and later in the management of hospitals and clinics aimed at the care of the poor. Until that time the role of the state was limited mainly to a financial support of charity hospitals, particularly for operating expenditures. In addition, the state delivered several preventive services: immunization campaigns, notification of communicable diseases and epidemiological control.

Toward the end of the 1930's, social security organizations were first developed in South America. Their development was the result of workers' demands expressed through the union movement. Within the social security system (almost exclusively of the private sector) hospital and medical care was provided through the creation of Sickness Insurance Plans. Some of these plans developed their own facilities as will be discussed later.

The country visits, referred to in the Introduction of this chapter, provided a unique opportunity to gain first hand knowledge of the overall organization of the health care delivery systems in these countries. This is valuable not only in itself, but also as a means of understanding existing types of prepaid activity and also of exploring its potential development. Since the presentation on each country will start with a description of its overall health care delivery system, it is worth introducing at this point some of its main features. There are traditionally in every country three major components:

1.3.1 Government Services

The governmental sector administers a whole spectrum of health care facilities mainly through the Ministry of Health (MOH) for the indigent people. The Ministries of Defense and Interior provide care for the security forces and their families, and the Ministry of Education (teaching hospitals and ambulatory clinics) also serve the indigent. These services are financed from general revenue and, with the exception of those services provided to the security forces, are perceived as uncomfortable, low in quality of care and generally ineffective and inefficient.

1.3.2 Social Security

The Social Security sector is organized along two different models. In Brazil, Uruguay, Argentina and Chile the Social Security Administration, for the most part, does not operate its own health facilities. In these countries it consists solely of a financing mechanism with which employer, employee and sometimes government contributions ensure the beneficiaries access to health care services organized by others (either government or private services, or both).

In the other countries, most notably Ecuador, Peru, Venezuela, and to some extent Colombia, the Social Security Administration is not only a financing mechanism, but also an organization that operates its own health facilities, both outpatient and inpatient, to serve its own beneficiaries exclusively.

Health care services, organized and administered by the Sickness Insurance Funds, though enjoying a higher level of resources than those of the Ministries of Health, are perceived as ineffective and

inefficient both by MOH officials and by MOH clients. In countries where the Social Security Administration operates its own services, the population covered by sickness insurance benefits is proportionally small (10% - 15%) since coverage is restricted to those actively employed (dependents are seldom included), in the most modern sectors of the economy (predominantly urban based).

1.3.3 Private Sector

The private sector is comprised of physicians and dentists (working as independent professionals), drugstores, private diagnostic and therapeutic clinics and hospitals. Most of the private sector operates on a fee for service basis, with payments made directly by consumers. As will be seen in this report, there is, however, a significant development, sometimes with a long tradition and sometimes new, of prepayment. Particularly in Argentina, Brazil and Uruguay, there is significant purchasing of "private" or "semi-private" services by third parties: mostly Social Security Funds, voluntary insurance and even some government schemes.

Although services provided by private organizations are perceived as being more effective and efficient in comparison to those of the Ministry of Health and of the Social Security Administration, hard, scientific evidence in this regard is nonexistent and may be difficult to obtain given the substantially different levels of funding of the three components.

Despite the significant variations that exist among countries, which will be described later, there are some general conclusions which can be made for most of the South American countries studied:

- a) An important segment of the population, difficult to estimate in precise terms because of the scarcity of health surveys, but ranging between 10%-15% in the most developed countries and up to 35% - 40% in the poorest ones, does not have regular access to health care services, even primary care. For the most part, these are the rural poor and to some extent also the lowest income groups in the large cities. Studies of health expenditures (MOH in Uruguay, 1984 and Antoine Habis in Ecuador, 1984 among others) do reveal that direct payments for medical care and drugs are substantial, in proportion to their income, for these groups.
- b) Health facilities, both ambulatory and hospital, administered directly by the Ministries of Health and by the Sickness Insurance Institutes are perceived to be of low quality and ill equipped, of poor comfort and inefficient. Larger, more powerful companies, react to this by "opting out" of the official social security services either by organizing their own services or by buying health insurance for their employees, thereby ensuring their access to the private sector.
- c) There is in almost every country an oversupply of physicians as a result of two decades of expansion of medical schools. Underemployment or even unemployment of physicians is quite common and is one of the important concerns of health authorities throughout the region.
- d) Because of the lack of ability to cope with direct payments of increased costs of health services, there has been a surge over the last ten years of several forms of prepayment, aimed at middle and upper middle income groups. For the most part, this

development has taken the form of reimbursement, either through traditional commercial insurance or through arrangements with a list of providers that are similar to the Preferred Provider Organizations (or PPOs) found in the United States.

Before entering into the description of each country, it will be useful to present a classification of prepaid health care organizations so that the types of prepaid activities encountered in each country can then be compared against these "model" types.

1.4 Prepaid Health Care Organizations

There are three main forms of prepaid health care organizations in the private or semi-private sector:

1.4.1 Indemnity Health Insurance

The organization provides health care coverage by reimbursing expenditures incurred by the insured, usually with a ceiling (maximum amount covered) but assumes no responsibility in the organization and the delivery of the services needed by the insured person. Premiums are frequently actuarially based, varying according to risk. Since the insured has freedom of choice among providers of care and since these are free to set the prices for their services, there are usually substantial and variable copayments. Copayments arise from the difference between prices paid and reimbursements received by the insured person. The scope of benefits covered (or risks insured) also varies both between insurers and between plans within a single insurance organization. In South American countries we have found traditional health insurance of the indemnity type provided mainly by financial institutions (linked to banks) and by insurance companies.

1.4.2 Indirect Providers of Prepaid Health Care (PPO-type)

Health insurance with price arrangements with a group of providers (similar to PPOs) represents basically the same economic relationship between the insurer and the insured: reimbursement of a fixed amount or a fixed percentage of costs incurred. However, in the PPO model the insurer negotiates arrangements with a group of providers, both physicians and hospitals, regarding their prices. Insurers may be restricted to these providers "entirely" (no reimbursement for costs incurred with providers not included on the list), or "partially", with the percentage reimbursed higher when services of providers included on the list are used.

The insurance organization does not assume responsibility for organizing and ensuring the access to services. It may or may not operate its own facilities. Providers are independent from the insurance entity and are paid on an indemnity basis. Unlike HMOs, in these organization the providers of the services are not "at financial risk". There are copayments, though these tend to be of a fixed amount for a given service and are often smaller than in traditional health insurance. Because of the financing arrangement, the freedom of the insured to select his provider of care is reduced, sometimes restricted to the "preferred" or "closed" list. The scope of benefits covered varies across organizations and between plans within an organization. In South American countries we have found this type of health insurance organized by commercial companies, by unions and by groups of providers frequently in association with an insurance company.

1.4.3 Direct Providers of Prepaid Health Care (HMO type)

By definition, the HMO assumes the financial risk of the cost of care used by the members. It assumes as well the responsibility for the organization and the delivery of health services to its members when needed, most frequently in facilities operated directly by the HMO (particularly for ambulatory care services). There is usually no reimbursement mechanism. Health services provided to members are delivered directly by the HMO personnel or are paid directly by the organization to those providers whose services have been contracted. These can be paid on a fee- for- service or on a per capita basis. User charges or copayments either do not exist or are very limited. When levied, they are of a fixed amount per service and are not dependent on the provider.

Because of the double responsibility of the HMO - for financial matters and for organizing the delivery of care- there is, necessarily, a greater restriction on the members in selection of providers. In addition, access is assured only to services administered directly or recognized as "usable" by the organization.

The scope of benefits, varying among the different organizations and among the several "plans" offered by HMOs is, in general, quite comprehensive, covering both inpatient and outpatient care, diagnostic and therapeutic procedures and, in some limited instances, drugs and some prosthetic devices.

Nine main characteristics were specified in the standard format definition used to identify HMO-type organizations in this project.

These were:

- a) The organization must be a private or semi-private legal entity.

- b) The organization must assume the financial risk and the responsibility for organizing the delivery and ensuring the access to health care services.
- c) Prepayment must be the sole or the most important source of financing of the organization. Regular premiums (monthly or quarterly fees) must be unrelated to the use of services by members. Copayments, though they may exist, must be small and cannot represent a barrier to access to care.
- d) The organization must provide comprehensive coverage of health benefits.
- e) Health services may be provided by the HMO either:
 - directly through its own facilities
 - through contracted providers
- f) Physician services, except highly specialized ones, may be provided by physicians working as
 - employees of the HMO,
 - as a group or an association of professionals that collectively share the financial risk (for medical care) with the HMO.
- g) Continuity of care must be ensured by the organization.
- h) Members cannot be disenrolled by the HMO because of their health status or their utilization of services.
- i) Membership premiums may be paid by the member or by an organization (business, union, social security, etc). In either case premiums are regular and fixed per person, not related to actual use by the member.

The main findings in each South American country follow. For each country an attempt has been made to cover the following topics:

- the health care delivery system
- the types of prepaid activities which exist with emphasis on those most similar to HMOs.
- a summary and prospects for HMO development.

C H A P T E R II

ARGENTINA

2.1 Socio-Economic Characteristics

The Argentinian health care system reflects its early economic and social development, which resulted from massive post-colonial European migration at the turn of the century and the growing strength of the labor movement. Private social insurance institutions developed with the industrial development of the mid 20th century during the populist regime of General Peron. A strong private sector working side by side with a large network of government hospitals and clinics for the indigent resulted from the socio-economic development of the period. Subsequently, an larged number of Social Insurance Funds organized by or in relation to labor unions evolved as a consequence of further industrial and social advancement.

2.1.1 Political Development

Although Argentina obtained its independence in 1816 it was not until 1852 that the institutional, economic and political bases were established on firm enough ground to constitute an appropriate environment for social and economic growth. The political forces related to the large landed interests dominated the political scene

even after the large influx of Europeans formed the basis for urban and industrial development.

The Depression of 1930 created an environment of economic, social and political instability that has been responsible for the alternating of political power between the military regimes (more or less identified with the agrarian interests) and the populist regimes (which responded to the labor forces). The human rights violations and the loss of the Falkland Islands War, coupled with the inability to establish sustained economic growth has debilitated the power of the military forces and opened the door for the reinstatement of the democratic process.

2.1.2 Geography and Population

Argentina is a large country that occupies the temperate and subantarctic zone of South America. The largest portion of its territory, due to its irregular shape, is located in the temperate zone and dominated by the Pampas region, where the majority of the population lives and where the most important cities and industrial centers are located. Argentina has a population of 28.5 million of which 86.9% is urban. Most of the population is of European descent, due to the elimination of the indigenous population and the influx of European immigrants toward the beginning of the 20th century.

2.1.3 Economic Development

Argentina's economic growth during the last 25 years has been, as in the case of Chile and even more so with Uruguay, very unstable with

a moderate growth rate (4.2% yearly) between 1961 and 1970 and an even slower rate between 1971 and 1980 (2.5% annually).

However, because of its earlier development and its small population growth (1.5% yearly) Argentina enjoys one of the highest per capita GNPs of Latin America. The world recession of 1981 - 82 greatly affected the Argentinian economy, which as a result, experienced a decrease in its GNP of 5.9% and 5.4% respectively. There is no evaluation yet available of the impact of the recession and other domestic factors on the health care sector. However, we can assume that the growth in unemployment will cause a decrease in affiliation to union-sponsored systems of health care, which are extremely important in Argentina.

2.1.4 Labor and Cooperative Organizations

The labor movement has been a strong social force in Argentina, particularly during the populist regime of Peron, from 1946 to 1955 and more recently, during the military and civilian regimes until 1983. The predominant form of organization among the labor unions is by industry. The Social Insurance Institutions that provide sickness insurance are organized along these lines and are managed by unions that encompass entire industries.

At the national level, there is a central organization, the General Confederation of Unions, that combines all the industrial or sectoral unions. It exercises a strong influence on national politics. Collective bargaining was suppressed by the latest military regime but was reestablished by the democratic government in 1983.

2.2 Health Care Delivery System

2.2.1 Government Services

The national, provincial and municipal governments operate a large network of ambulatory and hospital facilities. They account for 68% of the total beds and represent about 20% of the national health expenditure.

Every resident in the country has a legal right of access to these services. Fees can be charged and vary according to the income of the patient. In practice, because of the low level of comfort and perceived low quality of care, use of government services is restricted to the indigent. However, some government hospitals, particularly at the provincial and municipal level, sell services under contract to prepaid organizations for their beneficiaries. The importance of the government network of health services as a provider of care is decreasing; until forty years ago it was the predominant source of hospital care in the country.

2.2.2. Non-Governmental Services

There are four different forms of organization and financing of health care services in Argentina.

2.2.2.1 Obras Sociales (O.S.)/Social Insurance Funds (over 400 organizations)

The Obras Sociales are private, non-profit legal entities, originally sponsored by unions as sickness insurance funds. They are financed through mandatory social security contributions by union members. The O.S. provide comprehensive coverage of health services,

among other social benefits, like recreation, education, etc. Most O.S. function as PPOs, entering into special price arrangements with groups of providers. For many Obras Sociales a provider (physician, hospital, etc.) is "valid" and can be considered for a contractual arrangement only if the provider is duly registered with the national agency in charge of controlling the performance of the O.S. The fewer, larger O.S. have developed their own facilities, and have hired or entered into contractual arrangements with a group of physicians. In these instances, they function more like HMOs, since they assume not only the financial risk but also the responsibility for organizing the services for the beneficiaries.

The population covered by Obras Sociales is very large: about 75% of the national population. Because not all O.S are of the same quality and effectiveness, some beneficiaries, while maintaining their mandatory contribution, buy some additional form of care in the private sector.

Most health care costs in the O.S are covered by the payments of the mandatory social security contributions. However, the O.S are allowed to charge copayments or user fees and these can be significant: up to 30% in some organizations for the cost of a physician visit or up to 50% of cost for the dispensing of drugs.

The total expenditures of the Obras Sociales represent about 50% of Argentina's national health bill.

2.2.2.2 Mutualistas/Mutual Benefit Societies (approximately 10 organizations)

Mutualistas are private, non-profit, legal entities, originally sponsored and organized by ethnic immigrant groups as private, voluntary sickness insurance funds.

Most of these organizations developed their own facilities, hired their own health personnel and organized themselves in the form of HMOs. At present, because of falling membership, they predominantly sell services to the Obras Sociales. They have lost membership and importance in the health care scene for two reasons:

- a) Members were forced to enroll in the government sponsored O.S. system.
- b) They have always experienced difficulties in recruiting doctors in Argentina. As in other South American countries, physicians are reluctant to relinquish their autonomous solo practices.

2.2.2.3 Health Insurance Plans (approximately 75 organizations)

Developed during the past 10 to 20 years, these are private, commercial (for profit), legal entities sponsored by three types of organizations: Insurance Companies, Private Hospitals and Provincial Medical Associations. They provide health coverage to about 3% of the Argentinian population of the upper-middle income levels. Of this 3%, about 20%, are enrolled in some O.S. as well. For the most part they appear to be organized along the basis of traditional indemnity insurance or PPO-type systems. This will be discussed later in this chapter in some detail.

2.2.2.4 Private Care

As previously stated, there has been a proliferation over the last forty years of private, community based and commercial hospitals. They are generally more technologically advanced and of higher comfort than government hospitals. They account for 28% of the total number of beds

in the country. Their relative importance as health care providers is, however, much larger since they are responsible for about 60% of the acute care hospital discharges.

The sector is also composed of private diagnostic and therapeutic centers, and private physicians and dentists predominantly in solo practice. There is no information available for us to determine the number of centers and private practitioners. Therefore, their relative importance cannot be assessed. This sector represents about 30% of the national health expenditure.

2.3 Prepaid Health Care Organizations

2.3.1 Obras Sociales (O.S)/Social Insurance Funds

Most of the Obras Sociales are organized along labor lines and sponsored by their respective unions or trade associations. Therefore, unless the beneficiary changes employment and by so doing enters into a different industry, he cannot switch from one O.S. to another.

The O.S. are financed through mandatory contributions of a 7.5% payroll deduction: 4.5% by the employer and 3% by the employee. They provide social benefits to the employee and his/her dependents. The most important benefit, measured in resources allocated to it, is health services. Others include recreational and housing benefits, consumer goods and income subsidies.

The O.S. were originally administered autonomously from the state under union auspices. In 1971, after charges that the O.S. were inappropriately used to promote union power, 75% of the O.S. lost their autonomy and became regulated and controlled by the Federal Government through the Instituto Nacional de Obras Sociales (INOS). Consequently,

300 (out of over 400) O.S. are presently regulated by INOS. They serve 58% of the national population.

Among those regulated, the most important O.S. (in terms of membership volume and in number of organizations) belong to two categories: "Union Sponsored" and "Mixed Administration". Those "Union Sponsored" are managed by the unions. During the military rule (1976-1983) the government intervened in the operation of some of the O.S. The present democratic government has been slowly returning the responsibility back to the unions. The government does not participate in the governing bodies of these institutions, but exerts control and regulates them through the INOS. "Mixed Administration" signifies that the government participates in the governing bodies together with the beneficiaries and/or the institutions. The latter are in turn controlled and regulated by the INOS. There is a group of O.S. still not regulated by INOS enjoying, therefore, a higher degree of autonomy. Categories of O.S. in this group are: "Provincial and Municipal", "Armed Forces" etc. From among the 300 regulated O.S., INOS collects a percentage of the premiums paid by members, creating thus a Reinsurance Fund to bail out an O.S. at risk of financial insolvency.

Most O.S. operate like PPOs. External providers (registered on an approved list) are reimbursed for their services at a fixed, preferential rate, usually lower than fees charged by the same providers to private patients. Some of the larger O.S. in the "Union Sponsored", "Mixed Administration" and "Provincial and Municipal" categories have arrangements for sharing the financial risk with the providers because they have made contractual arrangements on a per

capita basis with hospitals and medical associations. Of course, they undertake all financial risk when providing services directly. A complete list of Obras Sociales is included in Annex 1.

2.3.2 Health Insurance Plans

These commercial, for profit, private legal entities are of recent appearance in Argentina. Of a total of 75 organizations, 20 are of importance due to their membership volume. Most of them are members in one of two trade associations:

- * CIMARA (Camera de Instituciones Medico Asistenciales de la Republica Argentina / Argentinean Chamber of Medical Assistance Institutions). It includes those prepaid organizations that operate their own health facilities.
- * ADEMP (Asociacion de Entidades de Medicina Prepaga/Prepaid Medical Institutes Association). It represents organizations that have very limited facilities and, thus, contract most of their health services to outside providers either through traditional indemnity insurance or, more frequently, through PPO arrangements.

All of these organizations have stated policies to avoid the enrollment of bad risk. Their benefit package is comprehensive and varies according to the plans selected by the member. Invariably they exclude any pre-existing condition, diseases that were present at time of enrollment. There exist plans which exclude maternity coverage, certain diagnostic and therapeutic techniques, and specialized treatments.

Due to their commercial nature, these organizations are very reluctant to provide specific information about their size, mode of operation, type of organization and sponsorship. Furthermore, the secrecy of their operation is protected by law. Therefore, not enough reliable data was gathered and, as a result, the section in the Listing of Prepaid Health Care Organizations corresponding to "Health Insurance Plans" contains only those plans for which we have been able to collect more complete information. In Annex 2 a complete list of these organizations with the name and address is included.

2.3.3 LISTING OF PREPAID HEALTH CARE ORGANIZATIONS

NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED (US dollars/month)	BENEFICIARIES
Ampri S.A. (Asistencia Medica (Privada)	Azcuenaga 1507 (1185) Capital Federal	Commercial	N.A.	PPO-Indemnity insurance	Partial (ex- cept drugs for ambulatory care and highly spe- cialized tech- niques)	N.A.	N.A.
Centro Medico Buenos Ayres S.A.	Suipacha 1085 (1008) Capital Medical	"	"	"	"	8.-per person 115.-per family (5 or more members)	"
Plan de Salud del Hospital Italiano	Gascon 450 (1181) Capital Federal	Non commercial	Hospital	HMO	Two plans: a) comprehen- sive(ex- cludes drugs for ambulato- ry care) b) partial (ex- cludes drugs for ambulato- ry care and highly special- ized techniques)	a) 14.-per person 49.-per family (6 members) b) 9.-per person 28.-per family (6 members)**	8,106
C.E.M.I.C.	Sanchez de Busta	"	Medical Group	"	Partial (drugs partially cov- ered and highly specialized techniques ex- cluded)	20.-per person (single enroll- ment) 10.-per person (groups)	23,000
F.U.S.A.L. (Fun- dacion para la pro- mocion de la salud)	Uruguay 1136 (1015) Capital Federal	"	Other (Found- ation)	HMO-PRO	Different plans a) comprehensive b) hospital care only c) reimbursement	8.-to10.-	6,000

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NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHANGES (US dollars/month)	BENEFICIARIES
Medicina Integrada-Hospital privado de Comunidad de Mar del Plata (fundacion Medica Mar del Plata)	Cordoba 4545 (7600) Mar del Plata	Non commercial	Other (foundation)	HMO	Partial (drugs only partially included)	N.A.	N.A.
Centro Integral Medico (C.I.M.) Sanatorio Guemes	Santa Fe 3651 (1425) Capital Federal	Commercial	Medical group	*	Partial (drugs partially included and highly specialized techniques excluded)	17.-per person 50.-per family (6 or more members) ***	61,433

* US\$ 1 - \$ Ar. 160

** US\$ 1 - \$ Ar. 250

*** US\$ 1 - \$ Ar. 220

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2.4 Summary and HMO Prospects

- a) Argentina has evolved towards the three classic components of health care found in most Latin American countries in which financing and delivery of care are generally organized along income lines.
- Government services are utilized principally by the indigent.
 - Social security services through the Obras Sociales serve middle income groups. They are organized as insurance funds, mainly as PPOs, some as HMOs. The O.S. that do not operate their own facilities purchase outside care according to the financial ability or income capacity of the fund, either in the government or in the private sector.
 - Private sector medical services for the high income population organize health insurance schemes along one of three categories: traditional indemnity insurance, PPO and HMO models.
- b) Since 1971 there have been efforts to reorganize the O.S. through more regulations and controls. There is a clear resistance by the medical profession to enter into labor agreements with the O.S. as they may make them share in financial risk or will cause them to lose their status as independent professionals. The O.S. will continue, however, to be the predominant form of financing health care in Argentina.
- c) For-profit, health insurance organized by the private sector is restricted to high income groups and its growth will depend on economic development and income distribution. There is resistance from physicians even here, in this sector, against organized, structured HMO/PPOs.

CHAPTER III

BOLIVIA

3.1 Socio-Economic Characteristics

The Bolivian health care system is affected by the country's extremely adverse socio-economic situation and by its geography. Bolivia is one of the poorest countries in South America with a per capita income of \$504.00 (1983) and a large Indian population scattered throughout the Andean highlands in small rural communities. The government's main concern is therefore centered in organizing primary health care systems with wide community participation in order to achieve self-help forms of organized health care.

3.1.1 Political Development

After achieving independence in 1825, Bolivia lost, through several wars with its neighboring countries, 54% of its original territory and, more importantly, became a landlocked state. During the 50 years following independence, very little change occurred in the colonial social and economic structure, except for the fragmentation and weakening of the government and state institutions. From 1880 to 1920 there was a period of economic growth led by mining, transportation, (mainly railways,) small industrial development and progress in education.

The first half of the 20th century was dominated by a political coalition of the major mining companies with the large land owners, leading again to a period of economic and social stagnation. The second half of the 20th century has been dominated by extreme political instability with the state mining company (nationalized by the revolutionary government in 1952), the unions, the military forces, the political parties and a whole spectrum of internal and external interests trying to dominate the political scene and exercise power.

3.1.2 Geography and Population

Situated in the center of South America, Bolivia has a total population of nearly 6 million of which 33% are urban. The large majority of the population is Amerindian (54%) and mestizo (31%). Of the total population 36% speak Spanish and 64% speak some Indian language, mostly Quechua and Aymara. There is an estimated 33% illiteracy rate in the country.

Bolivia is divided geographically into two regions with difficulties in communications both within and across the regions. The population is concentrated heavily in the highlands where 90% of the people live.

- Andean Region - Highlands. It is the most developed, has the largest urban concentrations (La Paz, Potosi, Cochabamba, Sucre) and is populated mostly by Indians and mestizos living in small communities scattered in the mountains and valleys, particularly in the eastern branch of the Andes and around the Titicaca Lake. Principal economic activities include: primitive



agriculture, raising of indigenous livestock for meat and wool, mining of tin, salt, oil and gas exploration (the most important economic activity of the country).

- Plains Region - Lowlands. It is more extensive and less populated, with the lowest level of economic development. It is divided into two subregions:
 - a) Northern Plains: Dominated by tropical rain forests, communications are poor, and it is inhabited by small indigenous groups.
 - b) Southern Plains: It is part of the large Chaco tropical plain that continues to the south in Paraguay and Argentina. The main economic activity is agriculture with the production of tropical crops: sugar cane, corn, cotton and some citrus.

3.1.3 Economic Development

Bolivia is the least developed country in South America despite its natural resources. Social stratification and discrimination, political and therefore economic instability, and geographical barriers to easy communication and transportation have all had a role in inhibiting economic development. Heavy dependence on the international price of tin (constituting 80% of its exports), lack of modern productive technologies in agriculture, livestock raising, industrial production and even mining exploration, are all factors that contribute to the lowest per capita GNP among South American countries.

The recent recession that started in 1981, with a consequent reduction of its GNP by 9.1% during 1982, the lack of raw materials and the political instability and uncertainty during the same year, all contributed to the reduction of productive activities. The conflicting

choice between economic growth and income distribution in most sectors of the economy has been a source of continuous tension, even for a democratic, popularly backed government .

3.1.4 Labor and Cooperative Movement

Unions are allowed to be organized at the firm or company level, though most demands are handled centrally by the powerful "Central Obrera Boliviana". The major union strength is in the mining sector. The Ministry of Labor is relatively weak, administering legal mandates and regulations covering only 20% of the economically active population.

The cooperative movement developed more recently in the last 50 years, mainly around the miners' union movement. During the 60's some savings and loan cooperatives were developed as well as a number of agricultural cooperatives. The penetration of the cooperative movement is, however, somewhat weak reaching only 6.7% of the population.

3.2 Health Care Delivery System

3.2.1 Government Services

The national government owns and operates an extended network of health care facilities principally for the care of the indigent population. This includes a wide range of services, from "puestos sanitarios" (clinical outposts) of which there are 824 in the interior of the country, to general hospitals, of which there are 11.

Theoretically government services provide coverage to two different groups:

- a) the population living in the rural areas (about 66% of the national population).
- b) those workers and their dependents who will be eventually incorporated into the social security scheme, but are not as yet enrolled in the Sickness Insurance Fund. About 20% of the national population, including construction workers, domestic servants, professional sportsmen, drivers, cattle ranch workers and seasonal farm workers are yet to be included in the Sickness Insurance Fund as their wages are too low to cover health care expenditures (as of Sept. 1984).

There is an important drive to promote community participation and primary health care is gradually becoming accessible to a larger portion of the population. Due to the scarcity of health personnel, the Ministry of Health has implemented several programs based upon active community participation, such as immunization campaigns and prenatal care services. Unfortunately, the quality of care is poor and these services are not utilized by the higher income groups. It is hard to determine the actual extent of the coverage, but one can assume that large numbers still go unprotected.

3.2.2. Social Security

Although there is a "Caja Nacional de la Seguridad Social", several labor groups have achieved enough autonomy to operate their own social security schemes within the Bolivian Social Security system: railway workers, highway workers, COMIBOL (miners), teachers, bank workers, etc. These organizations function independently and are not always

subject to the same regulations. Each one operates its own network of health facilities including ambulatory clinics and hospitals.

When fully developed, the national social security system will provide coverage to about 27% of the total population. The social security system is intended to provide coverage to the employee and his/her dependents. However, at present, because of limited facilities and resources it effectively provides services to only 7% of the population. As previously stated, the remainder is being served by government facilities.

Sickness and maternity insurance covered by social security provide medical and dental care, even specialized services, surgical, inpatient care and prescribed drugs. It also covers some preventive activities.

There is no coordination in utilization of health facilities by the social security organizations either among themselves or with those facilities of the Ministry of Health. This results in costly duplication of facilities, underservicing and inefficient results. Due to the current economic recession of the country, these social security organizations are experiencing serious difficulties and deficits.

3.2.3 Private Sector

This sector has traditionally been dominated by solo physicians and private hospitals providing inpatient care on a fee-for-service basis. In recent years there has been a development of private prepaid health care organizations of different types, which will be described in detail in the next section.

In both urban and rural areas there exist a number of cooperatives that provide health care benefits, either as a health plan or as one of

the many benefits of the cooperative. Health care services provided by cooperatives vary in their scope, from more or less comprehensive sickness insurance of cooperative members (such is the case in the more economically prosperous cooperatives) to primary health care in cooperatives specifically devoted to the provision of health services. At least eight of the health plan variety and four of the cooperatives providing health benefits were detected in our study.

3.3 Health Care Prepaid Organizations

3.3.1 Health Insurance of the Indemnity Type

At least three companies sell health insurance. Only one of them functions as a PPO whereas the others reimburse expenses incurred by the insured up to a certain limit. The insured is free to choose the provider he/she prefers.

3.3.2 PPOs

In recent years several groups of physicians have started offering ambulatory care with a prepayment mechanism to groups of higher income workers. These physicians are generally related to clinics, but that is not always so. At least 10 clinics throughout the country offer services by this mechanism to 10 bank workers' unions, the groups that are generally insured by this system. The scope of services included is quite limited, since these are only partial insurance systems. It has not been determined exactly how many groups of physicians are working in this manner.

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3.3.3 HMOs

These organizations are also quite new and still very rare. Only two of them were found in La Paz, but they adhere to our definition of an HMO. They cover mainly middle class workers through their unions or employers. The services are offered as side benefits and there is a percentage-based copayment at the time of using the services that is dependent on the type of contract the workers have. They do provide comprehensive care, and drugs may or may not be included. The two HMOs we visited in La Paz are private for-profit companies, and physicians are hired on a salary basis (staff model).

3.3.4 LISTING OF PREPAID HEALTH CARE ORGANIZATIONS

NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES * CHARGES US\$/month	BENEFICIARIES
<u>LA PAZ</u>							
Altiplano	N.A.	Cooperative	Other (co-operative members)	Cooperative	Comprehensive	N.A.	1,250
American Life	Ed. Arco Iris - 9th.floor	Commercial	Financial Institution	Indemnity insurance	Comprehensive	N.A.	2,500
Boliviana de Seguros	--	Commercial	Financial Institution	Indemnity Insurance	Comprehensive	N.A.	2,000
El Salvador	El Salvador La Paz	Cooperative	Other (co-operative members)	Health care cooperative	Partial (ambulatory care and drugs only)	0.05 per family	370
La Financiera	Ed. Carimi 3rd. floor	Commercial	Financial Institution	Indemnity Insurance	Comprehensive	N.A.	900
Medicentro	Av. 6 de agosto 2399	Commercial	Medical group	H.M.O.	Comprehensive	N.A.	70
San Cristobal	N.A.	Cooperative	Other (co-operative members)	Cooperative	Comprehensive	N.A.	4,250
San Sebastian	San Sebastian La Paz	Cooperative	Other (co-operative members)	Health care cooperative	Partial (ambulatory care and drugs)	0.05 per family	580
Urme	Montevideo 116	Commercial	Individual Physicians	H.M.O.	Partial (excluding psychiatry, rehabilitation, prevention and accidents. Copayments of 50% for laboratory and X-rays)	2 per person	2,300

ob

Bolivia

NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES * CHARGED US\$/month	BENEFICIARIES
<u>COCHABAMBA</u>							
Casemeco	N.A.	Cooperative	Others (co-operative members)	Health care cooperative	Partial (including ambulatory care and drugs only)	N.A.	65
Comedfa	N.A.	Cooperative	Others (co-operative members)	Health care cooperative	Partial (including ambulatory care and drugs)	N.A.	60
<u>POTOSI</u>							
Caposa	N.A.	Cooperative	Others (co-operative members)	Health care cooperative	Partial (including ambulatory care)	N.A.	525
Salud y Progreso	N.A.	Cooperative	Others (co-operative members)	Health care cooperative	Partial (including ambulatory care and drugs)	N.A.	345
<u>SANTA CRUZ</u>							
La Mercad	N.A.	Cooperative	Others (co-operative members)	Cooperative	Comprehensive	N.A.	45,745
San Francisco	N.A.	Cooperative	Others (co-operative members)	Health care cooperative	Partial (including ambulatory care and drugs)	N.A.	90
<u>TARIJA</u>							
Madre y Maestra	N.A.	Cooperative	Others (co-operative members)	Cooperative	Comprehensive	N.A.	345

* 2,000 Bolivian pesos per US dollar - October 1984

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3.4 Summary and HMO Prospects

The Bolivian health care scene is largely dominated by the public sector. It serves the largest segment of the population and attempts to cope with the problems of a population with the shortest life expectancy in South America.

Prepaid health services, except for cooperatives, are seen as attractive to those that benefit from a higher income and to whom public services are unacceptable. This is not a large group, and the probability of growth in this income sector is very limited.

Cooperatives are an interesting solution that should be further considered because they bear several advantages: they respond quickly to people's needs, they increase community participation and they directly control services because of their financial mechanism. Due to the direct participation of users, cooperatives are often well administered and there is an effort at cost-containment. They also offer, in many cases, services of higher quality than those of the Ministry of Health with more or less the same level of resources per capita.

CHAPTER IV

BRAZIL

4.1 Socio-Economic Characteristics

The Brazilian health care system is in a state of rapid change as a result of the socio-economic development that occurred during the last 50 years. The geographic diversity of its regions, and its history of socio-economic change and development are the main reasons behind the evolution of a pluralistic health care system. The sector is characterized by the presence of many different types of providers and health care financing mechanisms. On the health care financing side, it is worth noting the importance of the Social Security Institute, INAMPS, which provides health care coverage to about 90% of the population.

4.1.1 Political Development

Brazil gained its independence from Portugal at the beginning of the 19th century, but remained an Empire ruled by Brazilian emperors until 1889. From 1890 until approximately 1930, Brazil became an agricultural state with large landed estates producing the country's principal exports of coffee and rubber. The world depression of 1930 forced some important changes in the economic and social organization of Brazil. Demand for its traditional agricultural exports decreased

and with it also the ability to import. An import substitution industrial development was begun, promoted by a populist government that sought a social contract between industrial firms and the union movement. Toward 1955-1960 that model of economic development had exhausted itself and social and political turmoil appeared in the country. In 1964 democratic institutions were substituted by a military regime that tried, quite successfully, to promote economic development through political and social stability, and by establishment of light and heavy industries. Although the last 50 years have witnessed an important transformation in the Brazilian economy, social change has been slower and there are still very important regional disparities as well as inequalities among social classes.

4.1.2 Geography and Population

Brazil's population of 125 million (1982) is unevenly distributed with 36% of the land harboring 90% of its population. About 68% of the people live in urban centers and most of these are located along the Atlantic coastal region. Fifty four percent of the population is white, Indians and mestizos make up 1% and 45% of the population is comprised of blacks and mulattos. Wide differences between social classes exist, even in the most developed regions of the east and south, and there is still a 30% illiteracy rate in the country. There are five geographic and economic regions that have obtained widely different degrees of socio-economic development:

- South: the most developed and important region of Brazil, it is a heavily industrialized and agricultural region with a wide diversity of economic activity. It is the most densely

populated region of the country and its population is predominantly white, made up of post-colonial European and Japanese immigrants. Its principal cities are: Sao Paulo, Curitiba, Porto Alegre and Santos.

- East: From the economic point of view, it is almost as important as the south. Both have reached a very advanced stage of industrial development. Intensive agriculture along the coast and mining and industrial complexes in the interior are its main economic activities. Population density is high but its distribution is very irregular and is concentrated in the southern part of the region. Main cities: Rio de Janeiro, Salvador, Belo Horizonte.
- Northeast: This region is predominantly agricultural on the coastal plain, with an interior plateau afflicted by drought, making agricultural activity hazardous. Principal cities are Recife, Fortaleza and Natal.
- North: Formed by the Amazon Basin it constitutes the largest region of Brazil occupying 45% of its territory. Sparsely populated and developed, it has, nevertheless, begun some important agricultural and mining efforts over the last 20 years. Main cities: Manaus and Belem.
- Center-west: Occupies 20% of the Brazilian territory and is also sparsely populated and little developed. The construction of Brasilia, Cuiaba and Goiana has spurred economic development over the last 25 years. The most important economic activities are agriculture and cattle raising.

4.1.3 Economic Development

Industrial development reached an important pace during the last 50 years, first as import substitution and later incorporating the heavy steel and petrochemical industries. Industrial processing of Brazil's agricultural and livestock productions has also been very important.

The world recession during 1981 and 1982 had an important impact on Brazil's economy, slowing to a stop its economic growth and increasing its external debt. However, Brazil is the largest and most populous South American country and is destined to become a world economic power due to its growth potential in the fields of agriculture, livestock, mining and industrial development.

4.1.4 Labor and Cooperative Organizations

The union movement developed quite strongly between 1930 and 1960 under the populist regimes of the time. Since 1964 most labor and union activity had been curtailed or completely banned. This situation was changed very recently. Workers of the same industry or economic activity are represented by single unions at the municipal or state level. Penetration of the labor movement is strong, between 25% and 35%.

The cooperative movement is relatively new in Brazil having begun with savings and loan associations and consumer cooperatives only as recently as the 1960's. An estimated 25% to 35% of workers are unionized.

4.2 Health Care Delivery System

Brazil's health care system is, like Argentina's, heavily dominated by the social security financing mechanism organized under the

"Instituto Nacional de Asistencia Medica y Previdencia Social" (INAMPS), the National Institute for Medical Care and Social Security. In theory, it receives contributions directly from, or on behalf of, 90% of the Brazilian population. Its own health care facilities, however, are very limited, and the percentage of the population having actual access to health services provided by INAMPS is very small. Since the health care facilities run directly by INAMPS are insufficient to serve all their beneficiaries, some private health care organizations sell services to INAMPS beneficiaries who pay a monthly premium to these organizations instead of their mandatory contribution to INAMPS. This arrangement is done through enterprises that choose to receive their health care services from private agencies and enroll all their workers in what is known as a "convenio-empresa". No new "convenio-empresa" have been allowed by INAMPS in the past 3-4 years.

4.2.1 Government Services

4.2.1.1. Ministry of Health: Provides health services to the medically indigent people in underserved areas like the Northeast and the Amazon region. Primary care in nature, they are oriented towards preventive medicine and the control of communicable diseases. These services are financed from general revenue.

4.2.1.2 Institutos de Prevision y Municipales/Municipal and State Social Security Institutes: They provide health services to civil servants and their dependents through a network of ambulatory and inpatient facilities. They are financed through a combination of social security contributions made by the beneficiaries,

general revenues at the state and municipal levels, as well as by user fees.

4.2.1.3 Armed Forces: Active and retired members of the security forces are covered by a complete network of facilities run by the Armed Forces. Dependents protected by this network are provided with specialty services and enjoy additional protection from INAMPS for primary and secondary care. Health facilities of the Armed Forces are financed from general revenues through the Ministry of Defense budget. Copayments are also requested from users.

4.2.1.4 Universities: Teaching hospitals offer their ambulatory services to the entire population, covering the whole spectrum of care from primary to the most highly technological services. They are financed from general revenues by the Ministry of Education budget for government universities. These and private teaching hospitals are also allowed to charge middle or high income level users on a fee-for-service basis. They receive payments from INAMPS for services provided to the INAMPS beneficiaries.

4.2.2. Social Security

INAMPS is by far the major source of social security health care financing in Brazil. It is financed not only from the payroll deductions of its beneficiaries, but also from general revenues from the federal government in order to enable it to provide care to indigent people. INAMPS is the fifth largest public corporation in Brazil. It provides coverage to:

- a) urban workers, active or unemployed and their dependents, ensuring their access to the entire spectrum of medical and hospital care.
- b) rural workers, active or unemployed and their dependents, providing them with primary care, dental care and emergency and hospital services.
- c) civil servants of the federal government, active or retired and their dependents.
- d) indigent populations of some regions, whether they make social security contributions or not.

Most of the services financed by INAMPS are provided by third parties; only 20% of physician visits and less than 2% of hospital discharges were undertaken in their own facilities or by their own physicians. The main providers of health services are private physicians and state and municipal hospital facilities.

PROVIDERS OF INPATIENT AND OUTPATIENT
CARE IN BRAZIL

	<u>Outpatient</u>	<u>Inpatient</u>
INAMPS facilities	20.5%	1.6%
Purchase from private providers	29.9%	69.7%
Contractual agreement with unions	9.0%	0.2%
Contractual agreement with government agencies	14.5%	6.3%
Contractual agreement with firms	10.1%	3.9%
University hospitals	2.3%	1.6%
Other agreements	13.7%	16.7%
	-----	-----
Total	100.0%	100.0%

It is worth noting two aspects of the relationship between INAMPS and outside providers:

1) The purchase of hospital care from private hospitals faces all sorts of financial difficulties and has prompted INAMPS to organize a form of payment and a reimbursement policy similar to that of DRG payments of Medicare in the U.S.

2) The "contractual arrangements with firms" (Convenio-Empresa) were arrangements by which firms could retain their contributions to INAMPS provided that, either through their own services or through a prepayment organization (HMO), the firms remained responsible for providing their workers and dependents with at least the same level of health benefits INAMPS would have provided. The relative failure of this kind of arrangement (no new ones are being allowed by INAMPS and old ones are financially constrained) explains the low profile Brazilian HMOs have in the INAMPS picture.

4.2.3 Private Sector

Brazil has a large network of private care providers both in the professional and in the hospital sector. For the most part they are not organized on a fee-for-service basis.

In the past twenty years, however, there has been a surge of different kinds of prepayment organizations related to or supplementing INAMPS. Hospital and health insurance has also appeared and is purchased by the high income groups, thereby ensuring their access to better medical technology and improved accommodations.

4.3 Health Care Prepayment Organizations

Eight different kinds of organizations or arrangements are presented in following section. All of them involve some form of prepayment. Their main features are summarized in the table on page 53. They are as follows:

- a) Traditional indemnity insurance offered by two types of firms each one with its own characteristics:
 - o Insurance companies
 - o Hospital corporations: Membership enrolled through acquisition of capital stock in the hospital.
- b) Services financed by INAMPS and/or supplementary to those financed by the social security administration can be provided either directly or purchased from third parties through two types of organizations:
 - o Business firms: On behalf of their employees and their dependents, firms may develop their own facilities or enter into an arrangement with a provider, usually an organization of the HMO-type, at times a PPO.
 - o Unions: Their members and their dependents may organize their own services, mainly for ambulatory care, and arrange with third-party providers for more specialized services.
- c) Finally, there are four types of health care organizations that finance their activities through prepayment, by individual, family or group affiliation, (sometimes in the latter case with the participation of INAMPS). Of these four, there is one group that functions with the characteristics of a PPO, while the remaining three are, for all practical purposes, HMOs. They are:

- o Sociedades de Garantia de Saude / Health Assurance Societies
- o Beneficencias / Mutual Benefit Societies (HMO-type)
- o Medicina de Grupo / Group Practice (HMO-type)
- o Cooperativas Medicas / Physician Cooperatives (HMO-type)

The listing of HMO-type organizations in Brazil was produced by AMICO, a subsidiary of HCA of Brazil under contract for GHAA. A copy of it is included as Annex 3 to this report.

TYPE OF INSTITUTION ITEMS	MUTUAL BENEFIT SOCIETIES	ASSURANCE SOCIETIES	INSURANCE COMPANIES	CLINICS	GROUP PRACTICE	PHYSICIAN COOPERATIVES	HOSPITALS COOPERATIVES	HMOs
Beneficiaries	Ethnic and religious groups. Trade unions Middle and high	Any public Middle and high class	Any public High class	Any public Different social classes	Any public Enterprising Different social classes	Any public Different social classes	Any public High class	Any public Middle class
Benefit package	Inpatient Outpatient	Different plans (individual, family, collective) with limitations	Inpatient	Inpatient Outpatient	Inpatient Outpatient (except hospital care for chronic diseases)	Inpatient Outpatient (except hospital care for chronic diseases)	Inpatient Outpatient	Comprehensive (includes inpatient and outpatient care plus prevention, etc.)
Limitations to coverage	Services provided only with the institution's own resources	Varies according to plan	Whenever services are needed	Services provided only with the institution's resources	Whenever services are needed	Whenever services are needed	Services provided only with the institution's resources	Varies according to plan
Payment Schemes	Contributions, tax-exempt or State contributions, premiums	Prepayment	Prepayment	Registration, premium sale of services	Prepayment	Prepayment	Registration, premiums, sale of services	Prepayment
Comfort	Extra payment for private rooms	Private physician's visits. Extra payment for private room	Private physician's visits. Extra payment	Private physician's visits	Extra payment for private room	Extra payment for private room	Varies according to plan	Varies according to plan
Technical resources	Own, credited	Credited	Free Choice	Own, hired	Own, hired	Own	Own	Own, hired
Model of Health care delivery	Organized, curative	Non organized, curative	Non organized, curative	Organized, preventive, curative	Organized, preventive, curative	Non organized, curative	Non organized, curative	Organized, curative (some prevention too)

1/20/59

4.3.1 Sociedades de Garantia de Saude

These are commercial firms that will pay directly to providers services rendered to their members. Some of them will organize, at least partially, health care facilities to provide services to their members. Although membership is open to the general public, these plans are generally affordable only to middle and upper-middle income groups.

Medical and hospital care delivery is not provided through the sociedades-owned facilities. There is, however, a list of providers, from which members can procure services, that have an arrangement (regarding price and access) with the organization. The plans are oriented towards curative medicine and operate on demand for services by members.

Plans offered include individual, family and group types. Initially, these plans offered reimbursement of hospital expenditures with complete freedom of choice of hospital, in the form of a traditional indemnity plan. Thus, they were restricted to high income groups. Later, in order to expand their coverage to other segments of society, these Health Assurance Societies started to offer, as an alternative, coverage of ambulatory and inpatient care from a limited provider list of hospitals and physicians.

In individual and family plans (which provide more comfortable services, with private rooms, etc.), there may be limitations on coverage, exclusions, or a waiting period (from the beginning of membership) with limited benefits. In group plans, the extent and characteristics of the health benefit package depends on the agreement negotiated between the firm and INAMPS on the choice of the Health

Assurance Society as provider of the social security benefits (Convenio-Empresa). Group plans organized under INAMPS coverage cannot have limitations or exclusions of benefits (such as pre-existing conditions) and the delivery of services must be free of charge, without copayments, deductibles or any form of user charges.

In individual or family plans, there is no financial participation with INAMPS. These are typical supplemental insurance policies bought by individuals or families to ensure better access to care. Members enrolled under these plans, if they are also INAMPS beneficiaries, are free to use, on their own and under INAMPS coverage, any facility of their choice including those INAMPS owned facilities. On the other hand, in group plans in which enrollment of the group is financed (at least partially) by INAMPS, members are forbidden to use other providers, including INAMPS' own services, unless the users pay for it directly as a private service.

The largest of the Sociedades de Garantia de Saude is Golden Cross, with at least 36 branches, but there are other smaller companies of a similar kind.

4.3.2 Beneficencias / Mutual Benefit Societies

These are non-profit institutions, organized by ethnic, religious or professional groups to provide health care, usually hospital care, to their members. For the most part they serve the middle and upper-middle income groups.

Health care is organized, providing principally curative medical care. Selection of provider is limited to the facilities and physicians of the organization. For the most part, the Beneficencias operate their own facilities. A few have lists of outside providers, who are paid on a fee for service basis.

Beneficencias are financed through monthly premiums paid by members, subsidies, or income raised on capital or by the sale of health services, usually inpatient care, to third parties. Only two of these were detected in the study carried out by HCA.

4.3.3 Medicina de Grupo / Group Practice HMOs

These are health care delivery organizations, some commercial, some not for profit, that are financed through fixed monthly payments (unrelated to utilization) under contractual arrangements with individuals, families or groups. Enrollment is open to the general public although it is only affordable to middle and upper-middle income groups.

Health services delivery is organized by the group, either in their own facilities or with external providers. Ambulatory care is centralized in a facility operated by the medical group. Selection of providers is limited to the medical team, its own facilities or external providers specifically authorized by the group practice HMO.

Health benefits are comprehensive with the unique exclusion of chronic illnesses. The benefit package and the conditions are similar to those described for the Health Assurance Societies, particularly with regard to the INAMPS and its beneficiaries.

Most medical groups operate their own central ambulatory care facility and satellite clinics. Some operate their own hospitals as well, although the majority enter into contractual arrangements with private hospitals to serve their members.

This is the largest group, with over 140 institutions, some of which, like AMICO, have several branches.

4.3.4 Cooperativas Medicas / Individual Practice Association HMOs

These are teams of physicians that have organized themselves into cooperatives in order to provide health services. They are usually sponsored or related to local medical societies. Membership is open and similar to that of the Health Assurance Societies or to Group Practices. The economic relationship between membership and the organization is similar to that of a Group Practice.

The main difference between this organization and the Group Practice HMO lies in the lack of a centralized ambulatory care facility operated by the group. Physicians in this model work out of their own offices. There are at least 76 Unimed (physician cooperatives) in 19 states in the country.

4.4 Summary and HMO Prospects

The Brazilian health care system is greatly dominated by INAMPS, the social security health insurance system. Since INAMPS does not

offer its own services, the provision of health care remains a problem, and in the most remote areas it is up to the Ministry of Health to make health services accessible to the population. There is a problem of lack of access coupled with low efficiency and often poor quality of care, mainly at the primary care level.

There is a drive towards prepaid health care in the more affluent areas, like Rio de Janeiro, Sao Paulo and Rio Grande do Sul. In these regions there are enormous prospects for the further growth of these organizations. If HMOs were to become an answer to the health problems of the Brazilian population at large, they should offer their services through INAMPS, in the manner of the "convenios-empresa" of the past.

CHAPTER V

CHILE

5.1 Socio-Economic Characteristics

The Chilean health care system evolved in two major stages:

- a) Towards the mid 20th century, reflecting two decades of social and economic expansion, Chile organized an extensive National Health Service, financed by social security contributions (from blue collar workers) and general revenue, that provided real coverage to about 3/4 of the people.
- b) Within the last 5 years, reflecting almost two decades of very small economic growth and increasing social and political tension, but mainly as a result of ideological concerns regarding freedom of choice of provider and efficiency, two major developments took place: 1) the decentralization of the National Health Service and 2) the promotion of private enterprises to handle social security health benefits through private, prepaid health care delivery organizations. It appears that these reforms have had little real impact in changing the overall public-private allocation of resources of the health care sector.

5.1.1 Political Development

Chile obtained its independence in 1818. At the turn of the 19th century a period of increasing industrialization and urbanization evolved with expansion of the middle class and the appearance of a strong miners' union movement. Between 1932 and 1973 Chile was characterized by its politically stable environment until, during the late 60's and early 70's, the government's efforts to introduce social reforms, aimed at altering the distribution of income, created a growing social and political tension that ended with the collapse of the democratic institutions and the establishment of a strong dictatorial regime.

5.1.2 Geography and Population

Chile has a population of approximately 11.5 million of which 83.4% is urban. The population is concentrated in the Central Region. The country can be divided equally into 3 regions:

- North: With a dry climate and mining as the main economic activity.
- Central: It has a temperate climate and agriculture and livestock production as the economic base. Nine of the ten most important cities are located in this region.
- South: With a cold-humid climate where mining, forestry, fishing and livestock production are the most important economic forces.

5.1.3 Economic Development

Chile's economic growth during the last 25 years has been very unstable with a moderate growth rate (4.3% yearly) between 1961 and

1970. An acceleration of economic development achieved during the late 70's came to a halt and a deep recession during the early 80's, with 1982 as the worst year, showed a decrease of 14.3% in its GNP. However, with a per capita GNP of around US\$ 1,700 (1982 values), Chile forms, with Argentina and Uruguay, a group of economies that earlier had enjoyed significant development but that have been relatively stagnant economically in the last two decades.

5.1.4 Labor and Cooperative Organizations

As stated previously, the labor movement is very strong in Chile particularly in the mining sector, despite its temporary curtailment in 1973 when collective bargaining was suspended. It has since been partially reestablished by industrial sectors.

The cooperative movement was started in the 50's and has enjoyed some expansion particularly in the savings and loans associations where 96 organizations have incorporated over 600,000 members.

5.2 Health Care Delivery System

5.2.1 Government Services

The Ministry of Health has its own network of facilities organized in 26 public corporations (called Servicios de Salud) that provide preventive and curative medical and hospital care. Together they operate 220 hospitals, 244 outpatient clinics, 916 rural health posts and 978 medical stations.

The Servicios de Salud are public corporations with a high degree of operational autonomy, supervised and controlled by the Ministry of Health. They are financed through a centralized fund called the Fondo

Nacional de Salud / FONASA (National Health Fund) which is financed by general revenue and from the social security contributions of beneficiaries that have opted to get their benefits (health services and income subsidies) from the services provided by the government.

5.2.2. Social Security

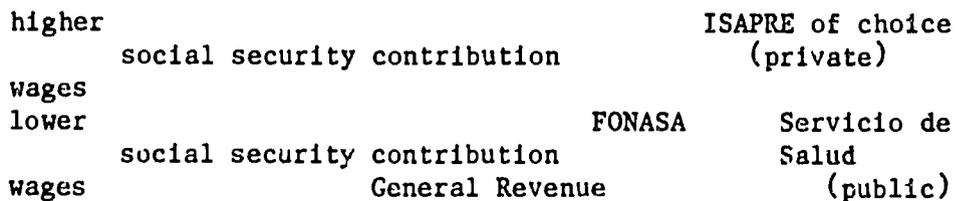
All active employees are subject to mandatory social security contributions of 6% to protect themselves and their dependents. The social security beneficiary has the option of channelling his/her contribution in two fashions:

- a) Through the FONASA, in which case health services must be obtained from one of the 26 FONASA funded Servicios de Salud (the one serving the geographical area where the beneficiary resides).
- b) Through a private, social security company called Instituto de Salud Previsional (ISAPRE).

When a social security member chooses to receive health services, not from a public Servicio de Salud but from an ISAPRE, his social security contribution does not go to FONASA, it goes directly to the ISAPRE he/she has selected. Since contributions are proportional to salaries and wages, and since there is a fixed contribution for a standard minimum benefit package, the ISAPRES have little interest in capturing the lower end of the wage scale of the employed population.

Because of the direct financial link between a social security beneficiary and the ISAPRE, the Social Security System in Chile lacks the concept of solidarity. There is not a central pool where all contributions are collected equalizing the possibilities of accessing

care for all contributors. Graphically it works in the following manner:



The reorganization of the National Health Service into twenty six semi-autonomous, public Servicios de Salud, the organization of the FONASA, and the modification of the social security contributions mechanism allows the contribution to be channelled directly by the contributor to the private health care delivery organization of choice. Both the 26 Servicios de Salud and the 20 or so ISAPREs are the result of a legislative reform which occurred during 1979 and 1980.

In Chile Social Insurance Institutes do not provide their own health services as in other Latin American countries.

5.2.3 Private Sector

As in the case of Colombia with the Family Allowance Organizations, most Chileans consider ISAPREs to belong to the private sector. As legal entities they are private firms, some not-for-profit, some commercial. However, as their beneficiaries are exclusively social security beneficiaries, and as they are partially financed by mandatory payroll contributions, the mandatory nature of the income subsidies make the ISAPREs part of the social security scheme.

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Until the last decade, the private health services sector in Chile had not been strong. Almost all hospital care was previously provided by the hospitals of the then existing National Health Service (decentralized into 26 corporations at the end of the 70's). Private ambulatory care by solo or associated practitioners was more extensive than private hospital care.

Commercial health insurance (indemnity type) has not developed in Chile mostly because its clientele, those in the upper-middle income groups, have for a long time been included in the social security system in a special regime for accessing services that closely resemble private care. Before the reforms of 1979-1980 there were two social security systems: one for blue collar workers which was incorporated in the National Health Service, and another, called SERMENA or Servicio Medico Nacional de Empleados, for white collar workers, the self-employed, university graduates in the professions, etc. The SERMENA system was only an insurance device. It did not have its own services. Contributors to this system had complete freedom to seek care from any private physician or hospital. Therefore, indemnity insurance did not develop because its market was monopolized (affiliation to SERMENA was mandatory for most of these labor groups) by a social security organization. After the reform of 1979-1980 SERMENA was replaced by the arrangement with the ISAPRES already described. It remains to be seen whether this will allow indemnity insurance to develop.

5.3 Prepaid Health Care Organizations

This group is made up of the approximately 20 ISAPREs, of different sizes, serving about 4% of the Chilean population. ISAPREs are regulated by the government with regard to:

- o Minimum benefit package in terms of health services (comprehensive) and income subsidies.
- o The minimum benefit package is linked to the smallest social security contribution allowed, 6%.
- o Minimum length of the contractual arrangement between the ISAPRE and the beneficiary. However, the beneficiary may change over to the government system at any time whenever he/she wishes.
- o Maximum level of copayments for use of health services (20%) for utilization of the basic benefit package.

ISAPREs are, however, free to:

- o Reject potential customers: i.e., those with low wages where 6% does not cover costs, bad risks, etc.
- o Offer supplementary plans for contributions higher and in addition to the basic 6%.
- o Adopt whatever legal status (commercial, not for profit, cooperative, other) best suits the purpose of the organization.

ISAPREs are not forced to run their own health facilities or services, not even for ambulatory care. Therefore, they may be exclusively a financing organization that receives social security contributions and additional income from members in order to pay the health care providers. In fact, most ISAPREs organize themselves as PPOs by entering into contractual arrangements with a list of private

providers for preferential fees. Beneficiaries are either partially reimbursed (according to the kind of plan in which they enroll themselves) for incurred costs, or the services they consumed are paid directly by ISAPRE to the provider and the beneficiary remits the corresponding copayment. Copayments vary according to the plans and may go as high as 40% or even more of the price of the service used.

ISAPREs may operate their own facilities. Some run their ambulatory care centers while one, the largest ISAPRE in the country, operates a complete range of outpatient and hospital facilities. These ISAPREs function more as HMOs despite the fact that they require copayments.

5.3.1 Listing of Prepaid Health Care Organizations

NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED	BENEFICIARIES
Cruz Blanca	Bandera 248 Santiago		Hospital	HMO-PPO	comprehensive coverage: 100%preventive,55%hospitalization 70%ambulatory care,80%medical consult.	UF 1.43	46,158
BanMedica	Huerfanos 886-Piso2 Santiago			HMO-PPO	comprehensive benefit package: 50-100% coverage, drugs and dental optional	UF 1.64	88,207
Promepart	Merced 328 Santiago				comprehensive coverage: preventive care, 85%hospitalization coverage, 50-70% ambulatory care, laboratory procedures and psychiatric care coverage.	N/A	N/A
San Lorenzo	N/A						
El Teniente	N/A						
SudAmerica	Dr. M. Barros Borgoño 61 Santiago	commercial	Insurance company	HMO-PPO	Comprehensive coverage, 100% preventive and curative care 100% Dental	UF 1.21	16,785
Chuquicamata	N/A						
Luis Pasteur	Apoquindo 2942 Santiago				comprehensive coverage: preventive and dental care 60-80% ambulatory care, 80% hospitalization	UF 1.50	16,543
Colmena Golden Cross					comprehensive coverage, 60-70% physician consult, 60-70% hospitalization 60-70% Rehabilitation 100% physical exams and ambulatory care	UF 1.90	23,508

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NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED	BENEFICIARIES
Rio Blanco	N/A						
ISPEN	N/A						
Normedica	N/A						
ConSalud	Alonso Ovalle 1451				comprehensive coverage, medical, Hospitalization, dental available	N/A	19,789
Interclinicas	N/A						

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5.4 Summary and HMO Prospects

- a) Chile has developed a system that offers reasonably good access to almost all its population.
- b) The previous National Health Service and the present 26 Servicios de Salud are reputed to be relatively efficient and effective, although comforts are few. Efficiency may have increased as a result of the decentralization of operations since 1979.
- c) The ISAPREs may be hampered by two basic factors:
 1. They may develop, in fact there is some evidence that this is actually occurring, along "income lines", breaking down the "solidarity" component for the social security system. Workers with low salaries have no real option between FONASA / Servicio de Salud and an ISAPRE.

- ii. The extensive use of copayments and their volume place most ISAPREs far away from the HMO concept or even from the PPO concept, losing in the process the elements of cost containment and increased efficiency.
- d) Prospects for HMO development are linked to the successful growth of the ISAPREs. This may be made difficult by the following factors:
- i. The economic recession that has hit Chile since 1981 and the flaws already described have resulted in a complete halt of ISAPREs' growth since 1982.
 - ii. There is a tradition of a strong national network of government health services which are perceived as being efficient and effective and, most importantly, easily accessible to the population at large.
 - iii. The medical profession has traditionally preferred a strong private practice with limited or no institutional ties, either to ISAPREs or to a National Health Service.

CHAPTER VI

COLOMBIA

6.1 Socio-Economic Characteristics

The Colombian health care system reflects its social stratification and the diversity of socio-economic levels in the five geographical regions of the country. Social security institutions with their own facilities and the services organized and managed by the Ministry of Health are the backbone of a system that attempts to provide coverage to the emerging urban middle class and to the rural population respectively. Rapid economic growth achieved during the last 20 years and political stability have helped to enhance the real coverage provided by the health care system.

6.1.1 Political Development

In 1830 the Republic of Colombia emerged as an independent nation by seceding from Gran Colombia. The first 60 years of independence were characterized by political instability and economic stagnation. Policies adopted in 1886 helped to improve and modernize the economy which brought, in turn, political stability.

As in other Latin American countries the Depression of 1930 brought a new crisis. Social reforms, with the development of social security institutions to look after the needs of the urban working classes, and the development of import substitution industries were the response to this crisis. Real economic growth and social development were not obtained until the mid 50's through a unique political agreement to ensure political stability in the country after a period of widespread social and political violence.

6.1.2 Geography and Population

Colombia has five major natural regions with entirely different climates and socio-economic development.

- Andean region - in which most of the population resides, and which enjoys the highest level of economic development.
- Caribbean region - is the second most densely populated region.
- Pacific region - has some important urban concentrations, but also some of the poorest and most disease prone areas of the country.
- Orinoquian region - the eastern plains.
- Amazonian region - to the south east.

Colombia's population in 1982 reached approximately 28 million, of which 78% were urban. The age distribution of the population is changing substantially through a very rapid decrease of the birth rate, particularly among the urban population. The illiteracy rate has been improved over the last 20 years, however, it is still at a high rate of 21.5%. This rate is substantially higher in the poorest areas like El Choco in the Pacific region.

6.1.3 Economic Development

The Colombian economy has improved substantially over the last 20 years with the significant feature that a wide proportion of the rural and urban population have benefited from this growth. The average per capita GNP almost doubled between 1961 and 1982. As in other South American countries, the world-wide recession during 1981 and 1982 has eroded its ability to sustain growth. The economy remained practically stagnant during 1982 and 1983.

Colombian agriculture is one of the strongest among Latin American countries based on coffee, bananas, tobacco, cotton, corn, sugar cane, etc. Timber of high quality is obtained from forests that cover 68% of the national territory. Mining is also an important economic activity with gold and platinum as its most important products. In terms of industrial development textile industries and food processing are well established, while recently there has been an initial effort made in petrochemical, steel and other heavier industries.

6.1.4 Labor and Cooperative Movement

Union bargaining is restricted for the most part to the level of the firm with few instances in which it is done at the level of an entire industry or economic sector. The government tends to intervene in defense of labor interests.

There is a long historical tradition of cooperative efforts among the Amerindians inhabiting the Andean region of Colombia. The modern cooperative movement began in 1916 with an agricultural cooperative. Legal requirements and protection of cooperatives were established in 1931 and were further expanded in 1981, through the National Board of

Cooperatives. According to the law there are two groups: Leagues or Associations for social, cultural and moral purposes and Federations or Centrals (union of cooperatives grouping a number of the first type), with economic goals. The largest and most influential is the "Instituto de Financiamiento y Desarrollo Cooperativo de Colombia". The cooperative movement in Colombia participates actively with the government in areas like education and social development and, thus, can make an important contribution to the socioeconomic development of the country.

6.2 Health Care Delivery System

In this country, the report will not contain a separate section on health care prepaid organizations since there is very little development of this form of financing. What exists will be described in the section entitled "Private Sector".

As in most Latin American countries the health care delivery system in Colombia is organized into three separate segments: government (several agencies within it), social security and private. Since 1975 there have been legal instruments in existence with which the Ministry of Health coordinates all the different delivery agencies into a coherent national health system. As in other countries, bureaucratic autonomies and other obstacles make this coordination a goal still to be attained.

6.2.1 Government Service

The Ministry of Health operates a national network, the "Sistema Nacional de Servicios de Salud" of ambulatory and inpatient facilities. This is a regionalized system composed of:

- a) 107 regions, of which 97 are headed by a regional hospital.
- b) 470 local health services, some with small inpatient facilities.
- c) 3,000 health centers.

In theory, the Ministry of Health provides services to the indigent population not protected by a social security mechanism which comprises about 70% of the national population. In practice, it is estimated that it provides coverage to only 1/3 of the country's people. In addition to providing health services, the MOH performs other public health duties (epidemiological, nutritional, etc.) through related branches or organizations. In total it expends about 32.7% of the national health budget.

6.2.2 Social Security

There are 2 types of social security organizations:

- a) Cajas de Prevision / Social Security Institutes. These are quasi-public agencies, providing sickness and maternity insurance and income maintenance plans (retirement, old age pension, etc.). There are over 100 of these institutes, although one, the "Instituto de Seguros Sociales" accounts for over 75% of people covered by these organizations.
- b) Cajas de Compensacion Familiar / Family Allowance Organization: These are private legal entities organized like consumer cooperatives. Enrollment is mandatory and made effective through the firm in which the person is employed. Health services are either provided directly or insured, but principally for children (1-18). They also provide a wide range of other benefits: recreation, education, merchandising, etc.

6.2.2.1 Social Security Institutes

There are over 100 of these organizations in Colombia, providing health and income coverage to about 15% of the population. Their total expenditures represents about 58% of the national health budget. The largest is the Instituto de Seguros Sociales. It operates its own national network of hospitals and ambulatory facilities: 37 hospitals with 4,200 beds. In addition, it purchases services from other providers in areas where it does not operate its own facilities. It provides coverage to about 12% of the national population, mainly in the most important urban areas, covering the employees of private firms of the modern sectors of the economy. It is financed by mandatory contributions, as a percentage from payroll, by employers and employees.

Other organizations of this kind are:

- o Caja Nacional de Prevision Social: covers the civil servants of the national government, about 250,000 beneficiaries.
- o There is a social security scheme that protects active personnel as well as dependents of the Armed Forces covering 300,000 people. The Ministry of Defense operates 3 hospitals and 44 clinics scattered throughout the country. Similar protection and services are available for police forces.
- o Caja de Prevision Social de Comunicaciones: which provides income subsidies and health services to employees of the Ministry of Communications and their dependents covering over 100,000 people.

6.2.2.2 Cajas de Compensacion Familiar / Family Allowance

Organizations

These are private legal entities that provide additional social benefits to basically the same segments of the Colombian population as do the Cajas de Prevision. They were organized originally as Family Allowance Funds providing monetary transfers to workers (below a certain income level) with children. Later, these organizations expanded their activities and incorporated as benefits subsidized access to: health, education, recreation, merchandising, loans for home appliances and housing, etc. In effect, they became a cooperative financing institution for their beneficiaries. Some of these organizations developed their own facilities for their expanded role in these additional benefit areas, particularly in merchandising and health services.

The Family Allowance Organization (FAO) provides health services protection to the children of beneficiaries between the ages of 1 and 18. (Infants to age 1 are protected by the Social Security Institutes.) Despite the fact that some operate their own health care facilities (mainly ambulatory care centers, some even have quite sophisticated children's hospitals), most FAOs operate as PPO's reimbursing expenditures incurred by beneficiaries for care provided by a selected, authorized list of physicians, clinics, etc. The enrollment of private firms in these organizations is mandatory by law. Even individual firms must enroll. A firm has the right to choose to which FAO it will enroll.

Family Allowance Organizations are financed through a variety of sources:

- o Payroll contributions from the firms enrolled.

- o Copayments made by beneficiaries when using the services; although sliding scale copayments charged for services are below market levels, copayments requested for health services are considerable: between US\$ 2 to US\$ 4 per physician visit. It is important to note that these copayments vary according to the income level of the beneficiary, the cutting point being around four times the minimum wage. Below that amount, the beneficiaries pay the lowest copayment in the plan.
- o Profits obtained from the commercial operation of owned facilities (supermarkets, hotels, health services, etc.)

6.2.3 Private Sector

Most Colombians will argue that the FAOs just described belong to the private sector and with good reason. As legal entities, they are "not for profit" private firms. However, the nature of the enrollment of private businesses in these organizations, the nature of the payroll contributions by the firms and the transfer payments to beneficiaries per child or family allowance, made mandatory by law, make the Family Allowance Organizations part of the Social Security system.

In Colombia the private sector is a strong provider of services. There are 190 private hospitals with 8,900 beds. It provides an entire range of services to about 15% of the national population.

There are two main types of prepaid health care organizations, with most private providers operating on a fee for service basis:

- a) PPO-type organizations: They are a recent development in Colombia (last 5 years). It is composed of two companies: Colsanitas and Colsisa. Colsalud, a third, failed. They

are private, for profit, insurance organizations that arrange preferential prices and ensure access to care through a group of providers. Their membership is growing, mainly in the middle income segments of the population. Total membership is still small. There are restrictions to enrollment and limitations according to age and pre-existing health conditions.

b) Commercial Indemnity Insurance. Health benefit policies offered by insurance companies.

6.2.4 Listing of Prepaid Health Care Organizations

NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED	BENEFICIARIES
olsubsidio	Calle 67 # 10-67 Bogota	Non Commercial under government supervision	Affiliated public and private firms	HMO	Comprehensive (7) partially	4% payroll of affiliated firms. <u>Copayments</u> (aver- age) -Ambulatory care US\$ 2 -Hospital day US\$ 6 -Emergency care US\$ 3.7	704,930 (only children age 1 to 16, age 0 to 1 in some special categories)
afam	Calle 51 # 15-48 Bogota	Non Commercial under government supervision	Affiliated public and private firms	HMO	Comprehensive ((3) partially subsidized, (7) excluded)	4% payroll of affiliated firms. <u>Copayments</u> (aver- age) -General ambulatory care US\$ 2.3 -Specialities ambulatory care US\$ 3	505,000 (dependents and non-working spouse of affiliated workers, only)
omfama	Carr. 45 #49A-16 Of. 1106 - Medellin	Non Commercial under government supervision	Affiliated public and private firms	PPO	Comprehensive for workers earning less than four mini- mum wages; par- tial only (1) and (9) for workers earning more	4% payroll of affiliated firms. <u>Copayments</u> (aver- age) -Ambulatory care US\$ 3.7 -Emergency US\$ 1.2	463,795 (dependents and non working spouse only)
omfamiliar ndi	Avda. 3 Norte # 51N-56B Cali	Non Commercial under government supervision	Affiliated public and private firms	Mixed (HMO-PPO)	Partial (excludes (2), (3), (6), (7))	4% payroll of affiliated firms. <u>Copayments</u> (avge) -Ambulatory care US\$ 1.5 -Specialities US\$ 3	241,565 (dependents of affiliated workers only)
ompensar	Carr. 7ma. #16-56, P 3 y P 2 - Bogota	Non Commercial under government supervision	Affiliated public and private firms	PPO-HMO	Comprehensive (excludes (2) and (7) partially	4% payroll of affiliated firms. <u>Copayments</u> vary according to income of beneficiaries: -up to 4 minimum wages US\$ 1.2-2 -over 4 minimum wages US\$ 6 - 8	148,676 (workers affi- liated and dependents)

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NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF (see note COVERAGE below)	RATES CHARGED	BENEFICIARIES
Comfenalco	Carr. 4a. #19-85 Bogota	Non-commercial under government supervision	Affiliated public and private firms	HMO-PPO	Comprehensive (excludes (7) partially)	4% payroll of affiliated firms. <u>Copayments</u> (avge.) -Ambulatory US\$ 2.5 -Specialties US\$ 4	90,930 (dependents and spouse only)
Camacol	Calle 49B #63-21 Edif. Camacol P 2 - Medellin	Non-commercial under government supervision	Affiliated public and private firms	HMO-PPO	Comprehensive (excludes (2) and 7, (3) par- tially subsidi- zied)	4% payroll of affiliated firms. <u>Copayments</u> -Ambulatory US\$ 1 -Specialties US\$ 1.5	97,563 (dependents and spouse only)
Comfamiliar Isaralda	Carr. 5a. Calle 22 esq. Pereira	Non-commercial under government supervision	Affiliated public and private firms	HMO-PPO	Comprehensive (excludes (2) and (4))	4% payroll of affiliated firms. <u>Copayments</u> : diff- erent rates according to income, ranging from US\$ 0.45 to US\$ 2.90 in general ambulatory care and US\$ 3 to 7 in spe- cialties.	49,300 (dependents and non-working spouse only)
Asia-Cali	Calle 8a. #6-58 Cali	Non-commercial under government supervision	Affiliated public and private firms	HMO-PPC	Comprehensive (excludes (4))	4% payroll of affiliated firms. <u>Copayments</u> : 2 ca- tegories according to in- come, ambulatory care ranging from US\$ 1.1 to 4 (general) and US\$ 3 to 4.5 (specialties)	58,828 (dependents and non-working spouse)
Comfamiliar	Calle 42 #13-19 P. 5 - Bogota	Non-commercial under government supervision	Affiliated public and private firms	PPO-HMO	Partial (ex- cludes (2), (3), (4) and (7) par- tially included)	4% payroll of affiliated firms. <u>Copayments</u> : -Ambulatory (general) US\$ 2.25 -Specialties US\$ 8	75,338 (dependents and non-working spouse only)

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NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF (see note COVERAGE below)	RATES CHARGED	BENEFICIARIES
Colsanitas S.A.	Calle 79 #15-20 P.2 - Bogota	Commercial	International Financial Institution and medical partners	P.P.O.	Comprehensive	US\$ 30 monthly per person. Decreases with family groups up to US\$ 11.60 per member in a ten person family. Collective arrangements are negotiable. <u>Copayments</u> : US\$ 1 entitles to all ambulatory services	10,000
Colsisa S.A.	Carr. 7a. #24-89 P. 5 Torre Colpatria - Bogota	Commercial	Colombian financial group	P.P.O.	Comprehensive	US\$ 270 yearly per person Family rates decrease, a four person family rate is US\$ 750 yearly and additional members' rate is US\$ 110 yearly	2,500
Cajajan	Bucaramanga	Non-commercial under government supervision	Affiliated public and private firms	P.P.O.	Partial (excludes (3), (5), (7))	N.A.	110,250
Confamiliar del Atlantico	Barranquilla	Non-commercial under government supervision	Affiliated public and private firms	P.P.O.	Partial (includes only (1), (9) and (10))	N.A.	104,860
Confenalco de Antioquia	Medellin	Non-commercial under government supervision	Affiliated public and private firms	P.P.O.	Partial (excludes (2), (3) and (7))	N.A.	67,640
Confamiliar del Cauca	Popayan	Non-commercial under government supervision	Affiliated public and private firms	Mixed HMO-PPO	Partial (includes (1), (9) and (10))	N.A.	66,118
Comfaboy	Tunja	Non-commercial under government supervision	Affiliated public and private firms	Mixed HMO-PPO	Partial (includes (1), (4), (9) and (10))	N.A.	59,500

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NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF (see note below)	RATES CHARGED	BENEFICIARIES
Comfenalco de Santander	Bucaramanga	Non-commercial under government supervision	Affiliated public and private firms	N.A.	N.A.	N.A.	57,728
Comfanorte	Cucuta	Non-commercial under government supervision	Affiliated public and private firms	N.A.	N.A.	N.A.	54,493
Comfamiliar del Huila	Neiva	Non-commercial under government supervision	Affiliated public and private firms	Mixed HMO-PPO	Partial (excludes (2), (3), (6) and (7))	N.A.	47,750
Comfenalco de Cali	Cali	Non-commercial under government supervision	Affiliated public and private firms	Mixed HMO-PPO	Partial (excludes (2), (3), (6), (7) and (8))	N.A.	43,625
Comfenalco de Bolivar	Cartagena	Non-commercial under government supervision	Affiliated public and private firms	P.P.O.	Partial (excludes (2), (3) (6) and (7))	N.A.	42,050
Combarranguilla	Barranguilla	Non-commercial under government supervision	Affiliated public and private firms	N.A.	N.A.	N.A.	41,766
Comfamiliar de Narino	Pasto	Non-commercial under government supervision	Affiliated public and private firms	N.A.	N.A.	N.A.	37,180
Cofrem	Villavicencio	Non-commercial under government supervision	Affiliated public and private firms	Mixed HMO-PPO	Partial (excludes (2), (3), (6) and (7))	N.A.	37,158
Comindustria	Palmira	Non-commercial under government supervision	Affiliated public and private firms	Mixed HMO-PPO	Partial (excludes (3) and (7))	N.A.	36,988

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NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF (see note COVERAGE below)	RATES CHARGED	BENEFICIARIES
Comfamiliar de Caldas	Manizales	Non-commercial under government supervision	Affiliated public and private firms	Mixed HMO-PPO	Partial (excludes (2), (3), (6), (7) and (8))	N.A.	36,228
Cajacom	Manizales	Non-commercial under government supervision	Affiliated public and private firms	P.P.O.	Partial (excludes (3), (7) and (8))	N.A.	32,825
Comfenalco del Quindio	Armenia	Non-commercial under government supervision	Affiliated public and private firms	H.M.O.	Partial (excludes (2), (3) (6) and (7))	N.A.	31,150
Comfenalco del Cesar	Valledupar	Non-commercial under government supervision	Affiliated public and private firms	Mixed HMO-PPO	Partial (excludes (3), (6), (7) and (8))	N.A.	27,315
Comfamiliar de Afidro	Bogota	Non-commercial under government supervision	Affiliated public and private firms	P.P.O	Partial (excludes (2), (3) and (7))	N.A.	25,453
Cajacopi	Barranquilla	Non-commercial under government supervision	Affiliated public and private firms	Mixed HMO-PPO	Partial (includes (1), (4) (9) and (10))	N.A.	23,930
Contraferros	Bogota	Non-commercial under government supervision	Affiliated public and private firms	P.P.O.	Partial (includes only (1) and (10))	N.A.	22,565
Comfacor	Cordoba	Non commercial under government supervision	Affiliated public and private firms	N.A.	Partial (includes (1), (4), (5) and (10))	N.A.	20,370

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NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF (see note below) COVERAGE	RATES CHARGED	BENEFICIARIES
Comfamiliar	Tulua	Non-commercial under government supervision	Affiliated public and private firms	P.P.O.	Partial (includes (10))	N.A.	20,030
Comfenalco del Tolima	Ibague	Non-commercial under government supervision	Affiliated public and private firms	Mixed HMO-PPO	Partial (includes (1), (4) (9) and (10))	N.A.	20,018
Comfamiliar del Ing. Riopaila	Cali	Non-commercial under government supervision	Affiliated public and private firms	N.A.	N.A.	N.A.	19,725
Comfacopi del Tolima	Ibague	Non-commercial	Affiliated public and private firms	P.P.O.	Partial (includes (1), (4), (9) and (10))	4% payroll of affiliated firms. Copayment not available	18,483
Comgirardot	Girardot	Non-commercial	Affiliated public and private firms	P.P.O.	Partial (includes (9))	4% payroll of affiliated firms. Copayment not available	18,383
Comfamiliar de Aseguradores	Bogota	Non-commercial	Affiliated public and private firms	N.A.	N.A.	4% payroll of affiliated firms. Copayment not available	18,205
Comfasucre	Sincelejo	Non-commercial	Affiliated public and private firms	Mixed PPO-HMO	Partial (excludes (2), (3), (7) and (8))	4% payroll of affiliated firms. Copayment not available	17,513
Cafaba	Barrancabermejo	Non-commercial	Affiliated public and private firms	Mixed PPO-HMO	Partial (excludes (2), (3), (6), (7) and (8))	4% payroll of affiliated firms. Copayment not available	14,885
Comfamiliar de la Guajira	Riohacha	Non-commercial	Affiliated public and private firms	Mixed PPO-HMO	Partial (includes (1), (4), (9) and	4% payroll of affiliated firms, copayment not available	14,386

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Colombia -

NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF (see note below)	RATES CHARGED	BENEFICIARIES
Cajamag	Santa Marta	Non-commercial	Affiliated public and private firms	N.A.	N.A.	4% payroll of affiliated firms. Co-payment not available	14,378
Comfamiliar	Cartagena	Non-commercial	Affiliated public and private firms	N.A.	N.A.	4% payroll of affiliated firms. Co-payment not available	13,078
Comfamiliar	Buga	Non-commercial	Affiliated public and private firms	P.P.O.	Partial (excludes (2), (3), and (7))	4% payroll of affiliated firms. Co-payment not available	13,058
Cajacosta	Barranquilla	Non-commercial	Affiliated public and private firms	Mixed HMO-PPO	Partial (includes (1), (9) and (10))	4% payroll of affiliated firms. Co-payment not available	12,103
Cafastia	Ibague	Non-commercial	Affiliated public and private firms	Mixed HMO-PPO	Partial (excludes (3), (7) and (8))	4% payroll of affiliated firms. Co-payment not available	10,315
Confenalco	Buga	Non-commercial	Affiliated public and private firms	N.A.	N.A.	4% payroll of affiliated firms. Co-payment not available	9,800
Confenalco	Palmira	Non-commercial	Affiliated public and private firms	N.A.	Partial (excludes (2), (3), (7) and (8))	4% payroll of affiliated firms. Co-payment not available	9,545
Comfaca	Florencia	Non-commercial	Affiliated public and private firms	N.A.	N.A.	4% payroll of affiliated firms. Co-payment not available	8,963
Comfamiliar Quindio	Armenia	Non-commercial	Affiliated public and private firms	Mixed HMO-PPO	Partial (excludes (2), (3), (6), (7) and (8))	4% payroll of affiliated firms. Co-payment not available	8,823

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Colombia -

NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE (see note COVERAGE (below))	RATES CHARGED	BENEFICIARIES
Comfacartago	Cartago	Non commercial	Affiliated public and private firms	Mixed HMO-PPO	Partial (excludes (2), (3) (6), (7) and (8))	4% payroll of affiliated firms. Co-payment not available	8,483
Cajacopi	Medellin	Non-commercial	Affiliated public and private firms	N.A.	N.A.	4% payroll of affiliated firms. Co-payment not available	7,620
Infava	Cali	Non-commercial	Affiliated public and private firms	Mixed HMO-PPO	Partial (includes (1), (4), (9) and 10))	4% payroll of affiliated firms. Co-payment not available	7,358
Caja abierta de Compensacion de Medellin	Medellin	Non-commercial	Affiliated public and private firms	N.A.	N.A.	4% payroll of affiliated firms. Co-payment not available	6,955
Cajacopi	Cali	Non-commercial	Affiliated public and private firms	N.A.	Partial (includes (1), (4) (9) and (10))	4% payroll of affiliated firms. Co-payment not available	6,385
Comfamiliar	Buenaventura	Non-commercial	Affiliated public and private firms	Mixed HMO-PPO	Partial (includes (1), (9) and (10))	4% payroll of affiliated firms. Co-payment not available	6,300
Comfaro	Armero	Non-commercial	Affiliated public and private firms	Mixed HMO-PPO	Partial (includes (1), (9) and (10))	4% payroll of affiliated firms. Co-payment not available	6,030
Comfamiliar de Putumayo	Puerto Asis	Non-commercial	Affiliated public and private firms	Mixed HMO-PPO	Partial (includes (1), (9) and (10))	4% payroll of affiliated firms. Co-payment not available	5,400

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Colombia -

NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF (see note COVERAGE	RATES CHARGED	BENEFICIARIES
Comfasur	Espinal	Non-commercial	Affiliated public and private firms	Mixed HMO-PPO	Partial (includes (1) and (9))	4% payroll of affiliated firms. Co-payment not available	4,885
Comfachoco	Quibdo	Non-commercial	Affiliated public and private firms	Mixed HMO-PPO	Partial (includes (1), (4), (8), (9) and (10))	4% payroll of affiliated firms. Co-payment not available	4,875
Cajajai	San Andres	Non-commercial	Affiliated public and private firms	N.A.	N.A.	4% payroll of affiliated firms. Co-payment not available	4,628
Comfamiliar	La Dorada	Non-commercial	Affiliated public and private firms	HMO	Partial (includes (1), (4), (8), (9) and (10))	4% payroll of affiliated firms. Co-payment not available	4,625
Comfamiliar	Honja	Non-commercial	Affiliated public and private firms	Mixed HMO-PPO	Partial (includes (1), (4) (9) and (10))	4% payroll of affiliated firms. Co-payment not available	4,160
Comfacopi	Bogota	Non-commercial	Affiliated public and private firms	N.A.	N.A.	4% payroll of affiliated firms. Co-payment not available	3,780
Comfamiliar de Camacol	Cali	Non-commercial	Affiliated public and private firms	Mixed HMO-PPO	Partial (includes (1), (4), (9) and (10))	4% payroll of affiliated firms. Co-payment not available	3,405
Comfamiliar Garzon	Garzon	Non-commercial	Affiliated public and private firms	Mixed HMO-PPO	Partial (excludes (2), (3) (6) and (7))	4% payroll of affiliated firms. Co-payment not available	3,278
Comfan Andercop	Bogota	Non-commercial	Affiliated public and private firms	N.A.	N.A.	4% payroll of affiliated firms. Co-payment not available	3,230

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Colombia

NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF (see note below)	RATES CHARGED	BENEFICIARIES
Asfamilias	Bogota	Non-commercial	Affiliated public and private firms	N.A.	N.A.	4% payroll of affiliated firms. Co-payment not available	2,886
Comfamiliar de Andercop	Cali	Non-commercial	Affiliated public and private firms	N.A.	N.A.	4% payroll of affiliated firms. Co-payment not available	2,700
Comfandercop	Cucuta	Non-commercial	Affiliated public and private firms	Mixed HMO-PPO	Partial (includes (1), (4), (9) and (10))	4% payroll of affiliated firms. Co-payment not available	2,693
Comfepicol	Cali	Non-commercial	Affiliated public and private firms	Mixed HMO-PPO	Partial (includes (1) and (9))	4% payroll of affiliated firms. Co-payment not available	2,665
Comfamiliar	Roldanillo	Non-commercial	Affiliated public and private firms	Mixed HMO-PPO	Partial (includes (1), (4) (5) and (9))	4% payroll of affiliated firms. Co-payment not available	2,248
Comfamiliar de los Andes	Bogota	Non-commercial	Affiliated public and private firms	N.A.	N.A.	4% payroll of affiliated firms. Co-payment not available	1,270
Comfamiliar ATA	Bogota	Non-commercial	Affiliated public and private firms	N.A.	N.A.	4% payroll of affiliated firms. Co-payment not available	1,253

NOTE: TYPE OF COVERAGE:

(1) Ambulatory care	(6) Other diagnostic techniques
(2) Emergency care	(7) Drugs
(3) Hospitalization and surgery	(8) Rehabilitation
(4) Laboratory	(9) Preventive care
(5) X Ray	(10) Dental care

6.3 Summary and HMO Prospects

- a) About 30% of the population does not have access to health services, mainly in rural areas.
- b) Those 33% covered by Ministry of Health services are poorly served: inefficiency, ineffectiveness and low level of resources are the main problems.
- c) There is low level of satisfaction among beneficiaries served by the Social Security Institutes (some 15% of the population).
- d) Out of pocket health expenditures are high and regressive: 25% of income for the lowest income group and 8% for the highest.

In sum, the lack of real access for an important segment of the population, the apparent failure (inefficiency, ineffectiveness) of the government services, the relatively high GNP per capita (US\$ 1,200), and a high percentage of it devoted to health (7%-8%), indicate a fertile ground for exploring the development of new forms of organizing and financing health care services like HMOs.

One important indicator of prepaid services' prospects is the dynamism of Colsanitas and Colsisa in the recent period. Also, the high level of return on commercial prepaid health services points to an important future for institutions that are more cost conscious and efficiency oriented.

CHAPTER VII

ECUADOR

7.1 Socio-Economic Characteristics

Ecuador's health care delivery system reflects the lack of economic development and low income per capita which plagued development in the country until the beginning of the 70's. In effect, its most important characteristic is the high proportion of people that have no real access to health care services.

7.1.1 Political Development

Although Ecuador obtained its independence in 1830, economic and social progress did not occur until the beginning of this century when the construction and operation of the Panama Canal enabled it to develop its export market.

Between 1930 and 1950 the Depression and internal problems with the cacao plantations created an economic crisis that was only overcome during the 50's with the increasing exports of bananas. A period of social and political tension during the 60's was the basis for military intervention. In the late 70's the country returned to democratic rule.

7.1.2 Geography and Population

Ecuador is clearly divided into three regions of which one, the Eastern Amazon Basin region, is almost completely undeveloped and underpopulated, with 3% of the population living there.

The other two regions are:

- The Coast: Situated between the Pacific Ocean and the Andes, the coastal region comprises 25% of the land and holds 40% of the country's people. Agricultural production is low, due to improper soil management, primitive technology, insufficient communications and roads and inadequate land distribution. The majority of its population is mestizo. The region has six of the ten largest cities in the country, including the city of Guayaquil.
- The Highlands: Occupying the center of the country, about 30% of the land. It is, however, the most populated of the three, holding about 57% of the population.

Ecuador is a country with a very large proportion of Indians and mestizos (50% and 37% respectively), the white population is only 8%. Therefore, although the official language is Spanish, Quechua and Araucano are largely used by the indigenous population. The official estimate of the literacy rate is 79%.

7.1.3 Economic Development

Ecuador's economy exhibits the characteristics of underdevelopment: a high proportion of the population in primary activities (agriculture, mining, etc.), use of primitive technologies for production, consequent low productivity and high population growth.

Ecuador's per capita GNP was as low as US\$ 697 (in 1982 dollar value) as recently as 1970. It increased dramatically to US\$ 1,215 in 1982 due to the discovery and exploration of new oil reserves and to the increase in oil prices. As a result, from a moderate rate of economic growth during the 60's (4%), Ecuador went to quite a high rate in the 70's (9.2%). Worldwide recession and a decrease in oil prices in 1981-1982 reversed that situation and the country is facing again economic difficulties and stagnation.

7.1.4. Labor and Cooperative Organizations

The labor movement is relatively weak, and within one company workers may be affiliated with several different unions, some at the firm level, others at the national level. There is no collective bargaining with participation of the state.

Cooperatives started to develop in the early 20's, although they got their real impetus during the 60's with the promotion and support of the state. In 1976 there were about 4,700 cooperatives with 470,000 members and a penetration rate of 4.5% of the population. The strong cooperative tradition in the country, coupled with external aid, may allow Ecuador to increase its cooperative activity.

7.2 Health Care Delivery System

7.2.1 Government Services

Theoretically, the Ministry of Health (MOH) provides coverage to 85% of the nation's population. In reality, it covers somewhere between 30% and 60% of the nation's indigents. At least between 25% to 30%, mostly the rural poor and Indians, do not have any real access to health

services, not even primary health care. The MOH operates its own network of ambulatory and hospital facilities at the national level, covering the entire spectrum from rural health posts to tertiary care hospitals. An important investment effort was made by the MOH during the past ten years (during the oil boom), to construct health care facilities. Most of them are still not functioning because of a lack of operating funds. Health services provided by the MOH are mainly financed by general revenue, although copayments are charged according to the income level of the user.

The Armed Forces provide services within their own facilities to active personnel and their dependents, covering about 3% of the national population. They are financed from general revenue and copayments, which are substantially higher than in the MOH services.

7.2.2. Social Security

The Ecuadorian social security system is formed by a single institution: the Instituto Ecuatoriano de Seguro Social (IESS). It is a public corporation with its authorities drawn from among employers, employees and representatives of the government. It operates its own network of facilities and is financed by social security contributions. Beneficiaries are not charged at the time of use of services. The IESS provides coverage to about 10% of the national population. In areas where it does not have its own facilities, it purchases services from the MOH. Its services are perceived by the beneficiaries as being low in quality and inefficient.

7.2.3. Private Sector

The private sector has several components:

- a) There is a strong private practice, either by physicians working in solo or associated practices, or organized and operating private diagnostic and therapeutic health centers.
- b) Junta de Beneficencia: a private, not for profit legal entity that operates its own hospitals and clinics in the urban centers. It provides services to about 5% to 10% of the population, mainly the indigent/Indian population free of charge. It is financed by subsidies from the national government and it coordinates its program activities with the MOH.
- c) Private firms with health services. One hundred and thirty three firms (industries, commercial enterprises, etc.) operate some form of health service, mainly ambulatory, on plant sites for their employees and, sometimes, for their dependents. This development grew out of dissatisfaction of beneficiaries with the services rendered by IESS. In a few firms these services have been extensively developed, including one company that operates its own hospital. Usually the use of the service does not entail any payment.
- d) Cooperatives with health services: Credit unions, consumer cooperatives, etc. A small percentage of the cooperatives in the country provide health services as a side-benefit to members, mostly for ambulatory care and in their own facilities. The health services of the cooperatives are staffed by young, general practitioners and are, therefore, perceived

as being of lower quality in comparison to the traditional private sector.

- e) Commercial Indemnity Health Insurance: there are six insurance companies offering health insurance policies. This is a development of the last ten years. The number of insured people is small and limited to high income groups. Reimbursement is limited and there is freedom of selection among private providers.
- f) Health Assurance Plan (PPO-type). There is one firm called "Ecuasanitas" that fits in this category. It is a private legal entity, for profit, a branch of Sanitas (Spain) as is Colsanitas in Colombia. It does not operate its own facilities. It has entered into contractual arrangements with a list of physicians and hospitals with whom it has negotiated preferential rates for its members. It began its operations in Ecuador in 1978 and presently has about 20,000 members. Although enrollment is open, it is aimed at middle and upper-middle income groups that cannot be enrolled by the IESS or are dissatisfied with it.

The health benefit package (there are several plans) is comprehensive, covering outpatient and hospital care. It is financed through prepayment by members (individual, family and group enrollment) and substantial copayments at the time of use, particularly for hospital services.

A listing of prepaid health care organizations, as in other chapters, is not included, since there are no organizations of this kind in Ecuador, with the exception mentioned in the text.

7.3 Summary and HMO Prospects

- a) The delivery of health care services to the Ecuadorian indigent has not been appropriately resolved:
1. Between 25% and 35%, at least, do not have real access to care.
 - ii. The services provided by the MOH and the Junta de Beneficencia are insufficiently funded and perceived as ineffective and inefficient.
- b) The dependents of social security beneficiaries do not have adequate protection and existing indemnity and health assurance plans (Ecuasanitas) have failed to attract them. The cost of private care, for both medical and hospital services, is becoming less and less affordable for this group.
- c) There is a consensus that the country has produced more physicians that it can reasonably employ in traditional models of health care delivery.

The combination of these three factors may contribute to creating in Ecuador a fertile ground for the development of alternative health care systems of the HMO type. Furthermore, we have reviewed the work of health economist Mr. Antoine Habis (Private Sector Health Assessment - January 1984) commissioned by the local AID Health Officer and we agree that there are three possibilities for increasing private sector health care delivery services.

- 1) To improve the health care available to the urban middle and low income people by means of the establishment of HMO's. This recommendation is based on the findings:
 - a. That the urban lower and middle income population is faced with the alternatives of high cost private health care, high

cost prepaid health care protection with limited coverage, or deficient public sector health care services only.

b. That there is a very substantial potential market comprised of lower and middle income people who are now organized in cooperatives, and who have the capacity to pay for the type of low cost prepaid comprehensive health care that HMO's can provide.

2) To increase the supply of doctors to the rural areas by establishing a new limited type of license for any medical school graduate to practice rural medicine.

This recommendation is based on the following findings:

- a. That the rural population is underserved by licensed physicians who are willing to practice in rural areas
- b. That there is an untapped pool of trained medical school graduates who are presently unlicensed for general practice, but who might be attracted to this practice given the right incentives.

3) To provide effective health care to the rural population by means of community owned and operated health delivery systems. These should be organized on the basis of pre-packaged models, offering from primary health care to curative care services and hospitalization in a small community clinic. The module would be staffed by a minimum number of medical professionals (one doctor and nurse), several nurses' aides, and a large number of health promoters. This recommendation is based on the following:

- a. That the health needs of the rural areas are underserved by deficient public sector services which are oriented towards curative rather than the preventive care required.
- b. That the passive character of public sector services (with the exception of the very limited and poorly operated Atencion Primaria de Salud program) does not provide the needed linkages to overcome the socio-cultural resistance of the rural population to government provided health care.
- c. That the hierarchical and pyramidal organization of the public sector health care delivery system tends to lose its efficiency at the bottom. This loss occurs precisely at the delivery level in the rural areas where efficiency is most needed.
- d. There is ample evidence that a decentralized, community owned and operated, health care delivery system oriented towards preventive care should be able to correct the aforementioned problems. It could be self-sufficient and economically viable, particularly if low cost direct imports of medication can be obtained.

We feel that more specific recommendations would depend on a feasibility survey performed in the country.

CHAPTER VIII

PARAGUAY

8.1. Socio-Economic Characteristics

Paraguay's health care system reflects the low level of economic development it experienced until the early 70's. In effect, real access to health care services among its rural population, which comprises 64% of the total, is very limited due to the insufficiency of the services of the Ministry of Health and the inability of most of these people to afford the services of the private sector.

8.1.1 Political Development

Although Paraguay obtained its independence in 1814, its history is dominated by internal strife and external territorial wars with its neighbors. In the middle of the 19th century it was defeated in a war against Argentina, Brazil and Uruguay. As a result, a high proportion of its land and half of its people were lost to Brazil. Between 1932 and 1935 it entered into war with Bolivia over control of the Chaco. Political instability and civil war dominated the late 30's and 40's until 1954, when General Stroessner was brought to power.

8.1.2 Geography and Population

Located in the center of South America, landlocked Paraguay is a relatively small country divided into two regions by the Paraguay River:

- Western region or Chaco: Occupies 61% of the land, and is sparsely populated by nomadic Indians.
- Eastern region: Occupies 39% of the land, holds the majority of the population and has the highest level of development.

Paraguay's population of 3.4 million is mostly rural (64%) and of Indian origin. Guaranies (Indians) and mestizos form 95% of the population (65% and 30% respectively).

8.1.3 Economic Development

A high proportion of Paraguay's population is either completely margined from the economy or devoted to primary activities, mainly subsistence agriculture. The country had experienced low economic productivity and a high rate of population growth (2.5% yearly). However, this situation changed significantly during the 70's with a rate of economic growth of 8.6% per year. This turn of events, coupled with a decrease in the growth of the population, enabled the per capita GNP during the period 1970-1982 to go from US\$ 744 to US\$ 1,342 (in constant 1982 dollars).

8.1.4 Labor and Cooperative Organizations

The labor movement has had very little significant impact politically. Cooperative organizations have been developed in the savings and loan and in the agricultural fields.

8.2 Health Care Delivery System

The Paraguayan health care system is of the classic mixed type, with services offered by the public and private sectors as well as by social security. This is a system of services divided by social and economic class, with significant variations regarding quality and comfort of care.

8.2.1 Government Services

Different agencies within the government provide health care services.

8.2.1.1 Ministry of Health: Its responsibility is to regulate and control the performance of all health care services in the country, but it cannot actually fulfill this function due to a lack of resources. It also provides direct health care services to the population. Theoretically, it covers the whole population of the country, but it actually covers only 58.7% of the total population. It is financed from general revenue, and its budget is about 23.5% of all public expenditures in health (that is 23.5% of the 4.9% of the GNP which is devoted to health).

8.2.1.2 Armed Forces: Offers health care services to all the armed forces personnel and their dependents. They also offer services to the population living in remote or isolated areas, such as the Chaco. All in all, it covers around 5% of the total population. It is financed from general revenue, and its annual budget, together with that of the health services of the police and municipalities, amounts to 7.5% of all public expenditures in health.

8.2.1.3 Police: Offers health care services to the police force and their dependents. It also provides first aid in case of accidents. Its total coverage includes only 2% of the population. It is financed from general revenue.

8.2.1.4 University of Asuncion: Provides health care services to approximately 2% of the total population through the Hospital de Clinicas and the Neuropsychiatric Hospital. Only a small part of its budget comes from general revenue, most of it is from other sources.

8.2.1.5 Sewage and water system (Corporacion de Obras Sanitarias): It provides drinking water and sewage services to cities with more than 4,000 inhabitants. Its services reach about 20% of the total population. Its financing comes partially from general revenue, and together with the University of Asuncion, its budget comprises 18.2% of total public expenditures in health.

8.2.2 Social Security

The Social Security System covers approximately 12% of the total population. Beneficiaries include workers, apprentices, teachers, some civil servants, housekeepers, veterans of the Chaco war and some dependents. It covers comprehensive health care services of varying complexity.

8.2.3 Private Sector

It is very difficult to assess the exact extent to which private services are utilized because there have been no surveys in Paraguay

and regulations applying to the private sector are weak in substance and inadequately enforced. With regard to traditional private practice, which is the most common way in which the affluent sectors of society obtain their health care, there is no information available. Though there are regulations pertaining to private health insurance, the information available at the government level is very limited.

8.3 Prepaid Health Care Organizations

There has been a marked growth in recent years in the number of prepaid health care entities in the country. Some have more sophisticated marketing mechanisms than others. There is a lot of competition among the different plans, which in general terms are private, for profit entities offering partial health care coverage.

A list of 25 prepaid health care plans was obtained, of which 11 were studied. All of them are HMOs. Of these, two offer comprehensive coverage and nine partial coverage. There are different varieties of partial coverage, for instance, two of them provide drugs, while seven do not; two offer ambulatory care only, while seven include inpatient care among their benefits, with copayments in one case. Prices range from US\$ 5 to US\$ 20 per person per month, according to the different plans.

9.3.1 Listing of Prepaid Health Care Organizations

NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED* US\$/month	BENEFICIARIES
Centro Medico Santa Clara	Coronel Bogado 868 - Asuncion	Commercial	Medical Group	H.M.O.	Partial (excluding preventive care and drugs)	4.75 per person 11.75 per family	2,523
Corporacion Medica International	Peru 225 Asuncion	Commercial	Medical Group	H.M.O.	Partial (covers ambulatory care completely, the rest has a 50% copayment)	from 7 to 20 per person	800
Cruz Blanca	Oleary 115 Asuncion	Commercial	Medical Group	H.M.O.	Partial (excluding drugs and rehabilitation)	N.A.	2,160
Edificio Medico Carlos Gatti	Estados 181 - Asuncion	Commercial	Medical Group	H.M.O.	Partial (excluding emergency and in-patient care)	from 6 to 10 per person	N.A.
Golden Cross	Victor HaeGo esq. D. Bosco Asuncion	Commercial	Financial	H.M.O.	Comprehensive	20 per family	9,436
Hospital Privado San Lucas	Eusebio Ayala c/Inocencio Lezcano - Asuncion	Commercial	Medical Group	H.M.O.	Partial (excluding drugs)	10 per person Different plans according to paying capacity	N.A.
Sanatorio Adventista de Asuncion	Pettirossi 380 Asuncion	Commercial	Religious Group	H.M.O.	Partial (excluding drugs)	x 6 per person	1,800
Sanatorio Mayo	Coronel Bogado 933 - Asuncion	Commercial	Medical Group	H.M.O.	Partial (excluding drugs highly specialized surgery and deliveries)	from 5.5 to 10 depending on age	3,000

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Paraguay

NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED* US\$/month	BENEFICIARIES
Servicio Medico Familiar	Colon 852 Asuncion	Commercial	Financial Institution	H.M.O.	Partial (excluding drugs)	approximately 6 per person	1,800
Sanatorio Migone Battilana	Eligio Ayala 1293 Asuncion	Commercial	Medical Group	H.M.O.	Partial (excluding drugs, hospital care after 20 days and highly specialized surgery)	22 per family	2,000
Sanatorio Moderno	Brasil 1318 Asuncion	Commercial	Individual Physician	H.M.O.	Comprehensive	7 per person	600

*240 guaranies per US dollar - October 1984.

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8.4 Summary and HMO Prospects

The Paraguayan health care system is a mixture of public and private services with problems of little coverage in some regions of the country and multiple coverage in the more affluent areas, as in Asuncion.

While the poorer sectors of society still lack health services, the rapid economic expansion of the last years created a demand for more comfortable, higher quality services in the still small middle class which cannot afford the completely private services. Still, benefits vary and many services must be paid for directly, even by insured patients, eg.: deliveries, drugs, etc., depending on the policy held. Since the economy seems to have plateaued, it seems unlikely that the demand for this type of service will continue to grow as fast as it did in the past few years but a small, sustained growth can be expected.

HMOs in Paraguay have never tried to be an answer to the health problems of the population at large. They are considered private enterprises and are managed as such. An interesting point to consider is the existence of a strong network of cooperatives, both urban and rural, which presently do not include health care among their benefits but could, in the future, become the basis of a more extended network of primary care services financed and run by their own beneficiaries.

C H A P T E R IX

PERU

9.i Socio-Economic Characteristics

Peru's health care system shows the typical Latin American pattern of services organized along income and social class lines, reflecting its low level of overall economic development. In particular, the differences in the various stages of development reached by its three regions and the ethnic and social groups within each region have had an important impact on the health care delivery system.

9.1.1 Political Development

Peru obtained its independence in 1821. Mining and the export of precious metals and salt was dominated by the Spanish conquerors' colonial descendents and created a very small and privileged ruling social class. The class differences led to a social uprising between 1910 and 1935 and the emergence of a populist political force (APRA). Towards the middle of the 20th century, industrial development in several areas was achieved and a powerful industrial middle class and labor movement emerged. During the 60's social and political tensions rose. Social disparities and economic stagnation lead to military intervention from 1968 to 1979. Recent developments have permitted the return of democratic rule to the country.

9.1.2 Geography and Population

Peru is divided into three regions:

- Coastal Region: Although it occupies only 7% of the land it holds the majority of its people. It is the most dynamic and progressive region, with modern, highly technological agriculture (sugar cane, cotton, rice and fresh fruit plantations), livestock production, fishing, mining (oil, steel, copper and coal) and manufacturing industries (textiles, food, oil, steel and petrochemicals). Lima is the most important city of the region.
- Andean Region: In the center of the country, it occupies 33% of the land, and is densely populated (15 inhabitants per square kilometer) almost exclusively by Amerindians.
- Plains Region: Sparsely populated by Indians practicing subsistence agriculture. This region also has the important oil and gas reserves.

The population of almost 18 million is concentrated in the regions of the Coast and the Andes. There is a large predominance of Indians and mestizos constituting 49% and 37% of the population respectively. A large proportion of the population is rural (35% by official estimates). The official languages are Quechua and Spanish, and a literacy rate of 89% (in either of the two official languages) exists.

9.1.3 Economic Development

Peru is a country with a relatively low (for South American standards) per capita income (US\$ 1,174 in 1982) with moderate to low, although steady, economic growth based on the diversity of economic activities. An important feature of the economy is the technological and productivity differences existing between the coastal and the Andean regions in both agriculture and industry. Modern, efficient and highly productive in the former, primitive, cottage or "artesanal" in the latter.

Similar to other South American countries oriented towards the external markets, Peru has suffered the impact of the recession of 1981-1982, bringing growth to a halt in 1982-1983. High inflation and high government deficits have caused an economic slowdown and have been responsible for the emergence of social and political unrest.

9.1.4 Labor and Cooperative Organizations

Peru has a strong labor movement. Unions are organized at the company level and then grouped into 60 associations and 5 confederations at the national level. Total union membership is estimated between 10-17 % of the population. Collective bargaining and labor pressure through strikes and other measures have increased in the past five years with the return to the democratic institutions. Similarly, the cooperative movement has proven to be relatively strong, with membership reaching about 10% of the population.

9.2 Health Care Delivery System

9.2.1 Government Services

Overall health policy coordination, in terms of investments and programs, is overseen by a National Health Council. It brings together the heads of the governmental and private agencies involved in the delivery of health care and the representatives of professional associations and teaching institutions.

9.2.1.1 Ministry of Health

Theoretically, the Ministry of Health provides coverage to about 65% of the population. In practice, only about 40% have real access to services. Therefore, 25% remain unprotected.

Some 35 to 40 years ago, the MOH was the most important provider of health services. Since then, in the urban areas, it has been supplemented by the appearance of private hospitals and diagnostic and therapeutic centers. It still operates the largest, most complex and extended national network of health care facilities. The MOH services are regionalized (in 16 regions), and each one is divided into "Health Areas" with a hospital base and a network of health centers and rural health posts.

Ministry of Health services are financed mainly through general revenue. There are fees as well that vary according to the income level of the user. The MOH serves mainly the indigent, but also sells services to the Peruvian Social Security in those areas where it does not operate its own facilities. It also sells services to private patients in special sections of the hospital called "pensionados" which are reserved for private pay patients. This serves as an incentive to attract physicians to the MOH facilities.

According to local health experts, the services of the MOH have numerous problems which result in ineffectiveness and inefficiency:

- a) There is insufficient delegation of authority at the operating level.
- b) There is a lack of adequate management in delivery units: inadequate training of health managers and inadequate or nonexistent management techniques.

9.2.1.2 Armed Forces and Police

They provide coverage to active personnel and their dependents representing about 6% of the nation's people. They operate their own network of facilities. Their services are financed from general revenue. In the isolated and forested eastern side of Peru, the Armed Forces provide health services to local populations as part of an overall development effort.

9.2.2 Social Security

It provides health care coverage to about 14% of the national population, mainly through the Instituto Peruano del Seguro Social (IPSS) / Peruvian Institute of Social Security. There are, as well, several smaller Cajas de Prevision (Pension and Health Funds) organized by type of economic activity: miners, fishermen, etc.

The IPSS provides income subsidies and health services to about 10% of the Peruvian population. It protects the employed workers, their children up to one year of age and their dependents for pregnancy and delivery. It is financed through mandatory social security contributions and operates its own network of health care facilities,

mainly in the urban centers. In areas where it lacks its own facilities, the IPSS purchases services from the MOH. The IPSS used to buy, on an experimental basis, services from the private sector under fee-for-service arrangements. These attempts failed and were discontinued because of allegations of abuse, overutilization and overpricing and, because they were perceived to represent a threat to the power base of the bureaucracy running the IPSS services.

IPSS has faced several kinds of difficulties:

- o Financial: Neither the government, nor the private firms regularly contribute to IPSS, because of economic constraints.
- o Efficiency is low due to poor management and bureaucratic rigidity.

As a result, comfort is quite low and the quality of services, as perceived by the beneficiaries, are not satisfactory. This had led many private firms to develop alternative ways of ensuring their employees access to health services, either by developing their own services, or buying supplemental health insurance. These economic and/or financial efforts undermine the firms' contributions to IPSS.

9.2.3 Private Sector

It provides coverage to about 15% of the population, of which around 6% is in some prepaid plan.

9.2.3.1 Private Hospitals

Private hospitals, generally owned by groups of physicians, diagnostic and therapeutic centers, and private practitioners working in solo or associate practice, form the backbone of the private sector in Peru.

Private hospitals finance their activities by:

- o Selling their services on a fee for service basis.
- o Entering into contractual arrangements with firms (for their employees) or with groups (unions, associations, etc.) or with insurance companies. This is generally done on a fee for service basis with negotiated preferential rates. Sometimes prepayment is used as a base in a PPO-type arrangement.
- o Entering into contractual arrangements with individuals, families or groups of people for comprehensive coverage (providing ambulatory care, hospitalization and physician services on a prepaid basis in an HMO-type arrangement).

9.2.3.2 Firms with Health Services or Health Insurance

Firms that are unsatisfied with the IPSS are reacting in two ways:

- a) Those most economically powerful and with larger work forces are developing their own health services at the plant site, financed most frequently through the company's revenues.
- b) The smaller ones, or those with scattered employees, provide additional health coverage to their members by developing a health fund and purchasing health insurance. This can be done directly with a private hospital or, much more frequently, through an insurance company which, in turn, arranges with one or several hospitals and its medical group in a PPO-type arrangement.

9.2.3.3 Cooperatives(agricultural, credit union, consumer, educational, etc.)

Approximately 9% of the Peruvian cooperatives either provide health services directly, or finance ambulatory and hospital care services for their members as a side benefit. A few cooperatives have their own facilities, mostly for ambulatory care, though some have their own hospitals. About 13% of the population benefits from health care services provided by cooperatives. As these services are usually financed through the cooperatives' general revenue, they are free of charge to members. However, some cooperatives utilize a combination of financing mechanisms for their health activities:

- a) exclusive use of user fees;
- b) prepayment plus copayments;
- c) exclusive use of prepayments.

9.2.3.4 Private Voluntary Organizations (PVOs)

Approximately 25% of existing PVOs (270 organizations) operate some form of health facility for their beneficiaries, usually for ambulatory care services and primary care. They tend to serve the indigent in areas where the Ministry of health has difficulties locating or operating its own resources. PVOs provide some limited coverage to about 13% of the national population. Their health services are financed mainly through donations and community financing.

9.3 Prepaid Health Care Organizations

About 6% of the population has some sort of prepaid coverage for health care services. Prepayment is offered by two principal kinds of organizations:

9.3.1 Insurance Companies

They offer two types of pre-paid care:

- a) Indemnity insurance with free selection of providers.
- b) PPO-type arrangements with a limited group of hospitals and physicians.

2. Private Hospitals

They also offer two forms of prepaid care:

- a) PPO-type arrangements with:
 - i. Insurance companies
 - ii. Private firms
 - iii. Groups of members
- b) HMO-type arrangements with individuals or families.

9.3.3 Listing of Prepaid Health Care Organizations (*)

NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED* US\$/month	BENEFICIARIES
Clinica Maison Sante	M. Aljovin 208 Lima	Non-commercial	Mutual Bene- fit Group	H.M.O.	Comprehensive except 9-10	10.- for a family of 4 members	15,000
Clinica Adventista		Non-commercial	Religious Group	PPO-HMO	Comprehensive except 7-9- 10	Not available but the range in simi- lar to Maison Sante	Not available
Clinica San Borja	Avda. Guardia Civil 333 - San Borja - Lima	Commercial	Medical Group	PFO-HMO	Comprehensive except 7-9- 10 with yearly amount limited	13.50 with max US\$ 570 yearly coverage	12,000 (HMO)
Clinica Anglo-Ame- ricana	Alf. Alfredo Zalazar (3a. cuadra) - Lima	Commercial	Medical Group	PPO-HMO	Comprehensive except 7-9-10 with yearly amount limited	The range is simi- lar to Clinica San Borja	7,000 (HMO)
Clinica Ricardo Palma	Avda. Javier Prado - Este- No. 1066 - Lima	Commercial	Medical Group	PPO-HMO	Comprehensive except 7-9- 10 with yearly amount limited	The range is simi- lar to Clinica San Borja	3,000 (HMO)
Clinica Javier Prado	Avda. Javier Prado - Este No. 499 - Lima	Commercial	Medical Group	PPO	Comprehensive except 7-9- 10	Not Applicable	Not Applicable
Clinica San Felipe	G. Escobedo 650 - Lima	Commercial	Medical Group	PPO	Comprehensive except 7-9- 10	Not Applicable	Not Applicable

(*) This information covers only the city of Lima. However, according to our local correspondent, the pattern of organizations, benefits provided and amounts charged by hospital and medical clinics in the cities of Peru (Arequipa, Piura, etc.), are entirely similar to those described herein for Lima.

NOTE: TYPE OF COVERAGE: (1) Ambulatory care (4) Laboratory (7) Drugs
 (2) Emergency care (5) X-Ray (8) Rehabilitation
 (3) Hospitalizations and surgery (6) Other diagnostic techniques (9) Preventive care
 (10) Dental Care

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9.4 Summary and HMO Prospects

- a) 25% of the population has no real access to MOH services. This is compensated for (in part) by the PVOs, the Armed Forces and the cooperatives.
- b) the IPSS suffers from low effectiveness and efficiency. It is perceived as providing low quality care, and has generated several reactions:
 - o firms have developed their own health facilities.
 - o firms have purchased insurance coverage of, among others, the PPO-type
- c) Prepayment involves only 6% of the population. In comparison, the private, fee for service sector serves about 10% of the population. There is a reluctance by physicians to bear the financial risk of providing care. Whether in solo practice or organized in small firms, physicians clearly reject the concepts of capitation and preferential fees. They prefer fee-for-service even when the hospitals have PPO arrangements with some customers.
- d) The best chances for HMO development may come from a profound reorganization of IPSS using the cooperatives and firms with their own services as the basis for expansion.

CHAPTER X

URUGUAY

10.1 Socio-Economic Characteristics

The Uruguayans' health status and health care indicators look favorable when compared with other South American countries, but are unfavorable when compared with its recent history. The stagnation of the Uruguayan economy for the last 30 years explains this apparent contradiction.

Uruguay's health care system, and the absence of a coordinated system, is characterized by the decline of a formerly "universal" access to health services. The social and economic progress achieved during the first half of the 20th century and its lack of evolution thereafter have had a direct impact on the Uruguayan health care delivery system, creating, in effect, unequal access to health care.

10.1.1 Political Development

After obtaining its independence in 1825, Uruguay underwent a century of internal strife between the commercial interests, aligned with the Colorado Party, and the landed state groups supporting the Blanco Party.

With the large migration of Europeans, mostly Italians and Spaniards, and the reaffirmation of central power at the turn of the century, Uruguay had set the base for the social and economic growth

that gave it its stability and progress during the first half of the 20th century. Coparticipation in the governmental structures by representatives of the Colorado and Blanco parties ensured political stability.

As a reaction to the Depression of 1930 an import substitution strategy was initiated, starting an industrial growth that, regreably, was limited by the very reduced size of the internal market. At the time of the Second World War, the Uruguayan economy benefited from increased exports and prices, but at the end of the Korean War both import substitution and traditional exports were not sufficient to sustain economic growth. Social unrest, labor pressure and finally political violence emerged and increased during the 60's and early 70's, ending in a military regime that controlled the country from 1973 to 1984 without being able to solve the basic economic stagnation.

10.1.2 Geography and Population

Uruguay has been characterized as a City-State because of the predominance of its capital, Montevideo, in which about 50% of the population resides.

Ninety percent of the country's population is of European descent, mostly urban (81.9%) with a high literacy rate (official estimate 94.1%). A low birth rate coupled with an emmigration movement are responsible for the lack of population growth (0.5% yearly between 1970-1982).

10.1.3 Economic Development

Uruguay's economy was based on the export of its agricultural production and on small scale industrial development achieved as a

result of the import substitution policies. As stated previously, this model had exhausted its growth capabilities in the mid 50's.

Several attempts to "open up" the economy have been made during the past 30 years, most notably in the late 50's and between 1975-1980, with mixed results. Economic growth was very low between 1950 and 1974 (1.6% yearly) and recovered somewhat, as a result of the promotion of value added exports and a less restrictive economic policy during, the period 1975-1981 (4.3% per year). The recession of 1981-1982 hit the Uruguayan economy severely with a reduction of its GNP by 1.3% and 10% respectively. The prospects for a rapid recovery are dim due to the social costs attached to the needed transformation of the economy.

10.1.4 Labor and Cooperative Organizations

During the military regime, labor organizations were severely restricted in their activities. However, Uruguay has a record of a very strong labor movement with unions organized by industry. Unions were grouped in a strong, centrally controlled, national federation. The Ministry of Labor is in charge of mediating labor-management conflicts and collective bargaining. Union activity resumed this last year.

The cooperative movement has a shorter but very strong tradition in the areas of housing and consumer marketing. There also are some agricultural cooperatives. The strongest cooperative movement and the one with longest tradition is in the area of health care, with cooperatives organized both by consumers (Mutual Aid Societies) and by physicians.

10.2 Health Care Delivery System

Uruguay has a mixed health care delivery system, with public and private services having equal importance in terms of number of people covered, but with important differences where quality of care and comfort are concerned.

The characteristic feature of the Uruguayan system is the long tradition (over 150 years) of the Institutions of Collective Medical Assistance (HMO type). They cover 44% of the total population, providing comprehensive health care services to members.

10.2.1 Government Services

10.2.1.1 Ministry of Health

The Ministry of Health runs its own facilities, ranging from primary care centers to secondary care hospitals. The public tertiary care hospital is run by the University, but all of the MOH's patients have free access to it. Every resident has a right to use the MOH's facilities, though they are free of cost only to the indigent. In reality, they cover only about 30% of the country's population.

Services are financed from general revenue and also from fees charged for services provided. The Ministry of Health receives only 14.6% of all health financial resources, and its participation in both the country's national budget and in overall health expenditure has decreased markedly over the last 10-15 years. Because of this, and for other reasons such as poor management and organization, services provided by the MOH are perceived to be of very poor quality and comfort and are unacceptable to a large percentage of the population.

10.2.1.2 Armed Forces and Police

These organizations operate their own services, providing both ambulatory and inpatient care. Their secondary and tertiary care facilities are located in the capital city, but outside Montevideo, Army Units have their own health posts, while the Police usually contract with local HMOs under a capitation system. These services are financed from general revenue and the social security contributions of the active personnel.

Expenditures in this sector are 7.4% of all health expenditures. They offer services to active and retired personnel and their dependents, who comprise 10.5% of the national population.

These services are considered of good quality but the level of comfort varies depending on the patient's position within the hierarchy.

10.2.1.3 Public Corporations (Hydro, Water Supply Co., National Railways, etc.)

Large public corporations provide health care coverage to their employees, and, less frequently, to their dependents too. The largest among them run their own ambulatory services and contract for inpatient care with private hospitals. Others contract out coverage with existing HMOs or pay their employees' premiums with whichever HMO they have chosen to enroll.

These services cover approximately 1% of the total population. It is difficult to determine the exact portion of expenditures of the national health budget because they are included in the resources of HMOs. Services are generally regarded as being of good quality, but they have the highest per capita cost of the whole system.

10.2.1.4 University

The School of Medicine provides health care to the population in its training hospital, the only tertiary care public hospital, where cases are referred from the entire country. Services are free of charge for indigents and obtainable on a fee-for-service basis for the rest of the population.

10.2.2 Social Security

There are two social security programs related to health care:

10.2.2.1 Family Allowances

It provides subsidies to families with children and provides maternal and child services to working women or workers' wives. The Social Security runs its own maternal and child care clinics, but contracts out for hospital services with HMOs or private hospitals.

10.2.2.2 Sickness Insurance Fund

The Sickness Insurance Fund of the Social Security provides subsidies and health care financing to active workers. It does not run its own services, but contracts on a capitation basis with the HMO that the workers choose.

The main problem with this system is that it does not include all workers (coverage presently is about 10% of the population) and that the benefits expire after six months of unemployment. Presently the unemployed worker has the added burden of having to pay for health care at a time of financial vulnerability.

10.2.3 Private Sector

The private sector has two principal components: traditional private practice and HMOs.

- a) Traditional private practice includes the services offered by hospitals, physicians and dentists.
- b) HMOs (Instituciones de Asistencia Medica Colectiva), are of two types:
 - o Mutual aid societies, organized and directed by their members.
 - o Physician cooperatives, which appeared as a reaction from physicians to the Mutual Aid Societies, and their fear of the loss of control of health services by the medical class.

10.3 Prepaid Health Care Organizations

They provide health care services to 45% of the national population and use approximately 38% of all resources dedicated to health care.

They may be divided into two types:

10.3.1 Limited Benefit Package

10.3.1.1 Hospital Insurance

Private hospitals offer partial insurance, not including physician services. Their membership is very small, serving less than 1% of the national population.

10.3.1.2 Emergency Services

They may include all emergencies or just coronary care, but only emergency care is insured, continuity of care must be provided by other means. This is the reason why there is often double coverage of emergency care, by HMOs and by emergency insurance.

Emergency services are usually organized by groups of physicians and they are growing fast due to the problems of home emergency services of HMOs and of the Ministry of Health. A lack of coordination among the different services, inadequate numbers of ambulances and delays of up to several hours at times in providing home emergency care, have plagued the traditional emergency care service providers.

10.3.1.3 Health Indemnity Insurance

They are organized by commercial firms, generally groups of physicians. These organizations have appeared very recently and their membership is very small. The increase of HMOs' fees has forced many people to leave and seek this new form of health care protection which has lower fees, but offers fewer benefits.

10.3.2 Comprehensive Coverage

There are 50 HMOs that provide health services to about 44% of the national population. They are not for profit organizations that take both the financial risk for the delivery of care needed by their members and the responsibility for organizing the services they might need and making them accessible.

Their financing mechanism is through a monthly premium of about US\$8 (which may be paid directly by the individual or by a union or a

Sickness Fund) and by copayments for the use of some ambulatory services: i.e.: US\$ 0.50 for a prescribed drug, US\$ 1 for a physician visit and US\$ 2.50 for a home emergency visit.

The benefits offered are standardized and legally regulated. They include some preventive services, ambulatory care, inpatient care even for tertiary procedures like renal dialysis, cardiac surgery and hip replacement. Drugs, some dental and rehabilitative services are covered along with limited psychiatric treatment.

All HMOs run their own ambulatory care facilities and about half of them own more sophisticated equipment. The rest must contract for services as needed.

HMOs actually constitute the predominant form of health care delivery and are therefore heavily regulated and closely supervised by government. (See Appendix #4 for additional details.)

10.3.3 Listing of Prepaid Health Care Organizations (HMOs only)

NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	(INDIVIDUAL RATES) RATES CHARGED* US\$/month	BENEFICIARIES
Asociacion Empleados Civiles de la Nacion	Mercedes 1178 Montevideo	Mutual Benefit Society	Non-Medical Union	H.M.O.	Comprehensive	7.6	34,700
Asociacion Espanola la. de Socorros Mutuos	Br. Artigas 1442 Montevideo	Mutual Benefit Society	Ethnic Group	H.M.O.	Comprehensive	7.7	126,000
Asociacion Fraternidad de Asistencia y Pre- vision	San Jose 1226 Montevideo	Mutual Benefit Society	Non-Medical Union	H.M.O.	Comprehensive	8.2	22,300
Asociacion Mutualista del Partido Nacional	Avda. 8 de octubre 2870 - Montevideo	Mutual Benefit Society	Non-Medical Union	H.M.O.	Comprehensive	7.9	11,200
Asociacion Mutualista Evangelica	Br. Jose Batlle y Ordonez 2759 Montevideo	Mutual Benefit Society	Religious Group	H.M.O.	Comprehensive	7.2	22,200
Casa de Galicia	Colonia 1474 Montevideo	Mutual Benefit Society	Ethnic Group	H.M.O.	Comprehensive	7.6	71,400
Central Medica Gremial	Mercedes 1531/33 Montevideo	Non-commercial	Medical Group	H.M.O.	Comprehensive	7.7	16,700
Centro Asistencial	Avda. 8 de octubre Montevideo	Non-commercial	Medical Group	H.M.O.	Comprehensive	5.7	7,900
Centro de Asistencia del Sindicato Medico del Uruguay	Arenal Grande 1539 - Montevideo	Non-commercial	Medical Association	H.M.O.	Comprehensive	7.8	249,600
Centro Integral de Medicina Asistencial	Avda. 8 de octubre 2460 - Montevideo	Non-commercial	Medical Group	H.M.O.	Comprehensive	7.3	14,600
Centro Medico Cooperativo	German Barbato 1466 Montevideo	Non-commercial	Medical Group	H.M.O.	Comprehensive	7.2	20,300

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NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED* US\$/month	BENEFICIARIES
Circulo Catolico de Obreros de Montevideo	Minas 1250 Montevideo	Mutual Benefit Society	Religious Group	H.M.O.	Comprehensive	7.7	46,600
Centro Uruguayo de Asistencia Medica	Dante 2319 Montevideo	Non-commercial	Medical Group	H.M.O.	Comprehensive	7.7	20,800
Espana Mutualista de Asistencia Medica	Avda. Italia 2465 - Montevideo	Mutual Benefit Society	Ethnic Group	H.M.O.	Comprehensive	7.2	22,400
Gremial Medica Centro Asistencial	Colonia 1082 Montevideo	Non-commercial	Medical Group	H.M.O.	Comprehensive	6.6	20,500
Instituto Medico de Prevision, Asistencia y Servicios Afines	Luis A. de Herrera 2275 Montevideo	Non-commercial	Medical Group	H.M.O.	Comprehensive	9.2	31,100
Medica Uruguaya Corporacion de Asistencia Medica	Rio Branco 1268 Montevideo	Non-commercial	Medical Group	H.M.O.	Comprehensive	7.9	33,800
Mutualista Israelita del Uruguay	Garibaldi 2594 Montevideo	Mutual Benefit Society	Ethnic Group	H.M.O.	Comprehensive	7.6	13,700
Organizacion Cooperativa Asistencial	Hocquart 2274 Montevideo	Non-commercial	Medical Group	H.M.O.	Comprehensive	6.7	12,200
Organizacion Medica Asistencial	Millan 2679 Montevideo	Non-commercial	Medical Group	H.M.O.	Comprehensive	6.4	25,600
Servicio Medico Integral	Mercedes 1286/90 Montevideo	Non-commercial	Medical Group	H.M.O.	Comprehensive	7.7	18,100
Societa Italiana di Mutuo Soccorso	Chana 2060 Montevideo	Mutual Benefit Society	Ethnic Group	H.M.O.	Comprehensive	7.7	22,800

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NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED* US\$/month	BENEFICIARIES
Universal Sociedad de Produccion Sanitaria	Millan 3588 Montevideo	Non-commercial	Medical Group	H.M.O.	Comprehensive	6.7	24,100
Uruguay-España	Bulevar Artigas 1483 - Montevideo	Mutual Benefit Society	Ethnic Group	H.M.O.	Comprehensive	7.4	26,300
Gremial Medica de Artigas	Presidente Berretta 668 - Artigas	Non-commercial	Medical Association	H.M.O.	Comprehensive	6.7	9,600
Centro Asistencial de la Asociacion Medica de Pando	25 de mayo 1017 Pando-Canelones	Non-commercial	Medical Group	H.M.O.	Comprehensive	7.5	14,200
A.M.C.C.C.	Avda. Italia Km. 23.300 - Solymar Canelones	Non-commercial	Medical Group	H.M.O.	Comprehensive	4.7	5,000
Cooperative Regional de Asistencia Medica Integral	Pilar Cabrera 617 Las Piedras Canelones	Non-commercial	Medical Group	H.M.O.	Comprehensive	7.9	20,800
Cooperative Medica de Canelones	Luis. A. de Herrera 536 - Canelones	Non-commercial	Medical Group	H.M.O.	Comprehensive	6.0	15,700
Asociacion Medica de Cerro Largo	Jose Pedro Varela 623 - Melo Cerro Largo	Non-commercial	Medical Association	H.M.O.	Comprehensive	6.6	5,500
Organizacion Asistencial Medica de Colonia	Gral. Flores 303 Colonia	Non-commercial	Medical Group	H.M.O.	Comprehensive	6.4	4,600
Asociacion Medica del Este de Colonia	Ituzaingo y Bolivia - Rosario Colonia	Non-commercial	Medical Group	H.M.O.	Comprehensive	5.9	17,300

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NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED* US\$/month	BENEFICIARIES
Centro de Asistencia de la Asociacion Medica del Oeste de Colonia	Calerias Independencia Uruguay 409 Carmelo - Colonia	Non-commercial	Medical Group	H.M.O.	Comprehensive	5.4	8,300
Centro de Asistencia del Sindicato Medico de Durazno	Manuel Oribe 609 Durazno	Non-commercial	Medical Association	H.M.O.	Comprehensive	6.6	8,100
Asociacion Medica Departamental de Flores	Jose Batlle y Ordonez 619 Trinidad - Flores	Non-commercial	Medical Association	H.M.O.	Comprehensive	5.9	4,400
Asociacion Medica Departamental de Florida	A.M. Fernandez 492 Florida	Non-commercial	Medical Group plus Ethnic Group	H.M.O.	Comprehensive	6.0	15,800
Union Medica de Lavalleja	Lavalleja esquina Juan Farina - Minas Lavalleja	Non-commercial	Medical Association	H.M.O.	Comprehensive	5.8	15,000
Asistencial Medica Departamental de Maldonado	Sarandi esq. Montevideo - Maldonado	Non-commercial	Medical Association	H.M.O.	Comprehensive	6.5	26,600
Cooperativa Medica de Paysandu	Colon 1277 Paysandu	Non-commercial	Medical Association	H.M.O.	Comprehensive	6.7	24,500
Asociacion Medica Departamental de Rio Negro	Rivera y 25 de mayo Fray Bentos Rio Negro	Non-commercial	Medical Association	H.M.O.	Comprehensive	6.6	7,500
Asistencial Medica Departamental de Rivera	Faustino Carambulla 1181 Rivera	Non-commercial	Medical Association	H.M.O.	Comprehensive	6.1	10,200

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NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED* US\$/month	BENEFICIARIES
Asociacion Medica de Rocha	Treinta y Tres 45 Rocha	Non-commercial	Medical Association	H.M.O.	Comprehensive	6.6	11,500
Sociedad Medico Quirurgica de Salto	Artigas 917 Salto	Non-commercial	Medical Association	H.M.O.	Comprehensive	5.9	29,900
Asociacion Medica de San Jose	Sarandi 440 San Jose	Non-commercial	Medical Association	H.M.O.	Comprehensive	6.1	8,300
Asociacion Medica de Soriano	Colon 352 Mercedes - Soriano	Non-commercial	Medical Association	H.M.O.	Comprehensive	6.9	17,000
Cooperativa Medica de Tacuarembó	Ituzaingo 314 Tacuarembó	Non-commercial	Medical Association	H.M.O.	Comprehensive	7.2	10,100
Instituto Asistencial Colectivo de Treinta y tres	Santiago Gadea 246 Treinta y Tres	Non-commercial	Medical Association	H.M.O.	Comprehensive	6.6	13,100

* 65 Uruguayan pesos per US dollar - November 1984

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10.4 Summary and HMO Prospects

Whereas until some years ago HMOs grew because of individual affiliations, the increase in health care costs, resulting in higher premiums, coupled with the loss of buying power of the Uruguayan population, has led to gradual disenrollment. There is thus a trend to shift from individual to group enrollment through Social Security.

If this were to occur through a form of national health insurance, HMOs might easily become the most efficient health care delivery organizations in the country.

There is a need to improve management efficiency, particularly with regard to the training of top and mid level managers, and to the provision of clinical guidance for medical staff. There are proposals to strengthen the HMOs but there are also proposals to establish a National Health Service, similar to the British model, which would drastically change the picture. These are political decisions and much will depend on the directives of the new government and the role of the different lobbies.

C H A P T E R XI

VENEZUELA

11.1 Socio-Economic Characteristics

Venezuela's health care delivery system has developed in two stages. Until the oil boom of 1973, the country's three-tiered system of government services, social security organizations and the private sector, was clearly dominated by the first, reflecting a policy of strengthening the public sector based on limited but steady growth derived from oil exploration. The dramatic increase in oil revenues since 1973 has shifted the balance to the private health care sector to attend the increasing demands for technological development and comfort made by the emerging urban middle class.

11.1.1 Political Development

The 19th century and the early 20th century of Venezuela's history was characterized by internal confrontations between the dominant upper commercial class and the landowners of large haciendas. Since 1917 oil production has played the most dominant role in Venezuelan politics. The government's central power was consolidated and increased by the professional transformation of the Armed Forces, the construction of communication networks and the development of public bureaucracy.

In 1967 the nationalization of the oil companies set the stage for the participation of the country in the OPEC oil cartel and the dramatic increases in prices in 1973 and 1979. Oil revenues ensured economic expansion until recently, and a period of relative political stability has existed without interruption since 1958.

11.1.2 Geography and Population

Located in the northern part of South America, Venezuela's territory is divided into three regions:

- Coastal region: Occupying only 18.5% of the land but holding over 80% of the population, it is the most industrially developed sector of the country.
- Plains region: It is a large portion of land covered by savana, sparsely populated and dedicated to extensive cattle raising.
- Guayana region: It is the most extensive and the least populated, but with important, valuable natural resources.

Venezuela's population of 15 million is largely urban (79.4%), located in the coastal region and extremely young as a result of a high rate of population growth. Despite the decline in the growth rate which has occurred during the past 20 years in the urban areas, the country has had an overall growth rate of 2.7% per year during the period between 1970-1982.

Although the literacy rate, according to official estimates, is high (88.1%) this is among children and adolescents. According to CEPAL, Venezuela can be grouped among the countries with low primary school enrollment. In 1970 almost 35% of the population of 15 years of age and over had insufficient education and 23% were illiterate.

11.1.3 Economic Development

Venezuela has enjoyed sustained economic growth during the past 40 years. During the 60's and 70's the yearly rate of growth has been 6.1% and 4.2% respectively. The world wide recession of 1981 and 1982 and the declining prices of oil during recent years have seriously affected the Venezuelan economy. Its rate of growth slowed to 0.4% and 0.6% respectively for both years.

Rich in natural resources and working capital, the Venezuelan economy is, however, limited by some negative factors. They are: insufficient qualified manpower, inefficient management, inappropriate maintenance, lack of adaptation of technology to local conditions and manpower.

In the social area, some important problems persist despite the relatively high income per capita. Among others: a high proportion of families whose income is below the poverty line, illiteracy among the labor force, high drop-out rates in the primary school system and a lack of appropriate health care services among the rural and semi-urban poor.

11.1.4 Labor and Cooperative Organizations

Venezuela is the South American country where collective bargaining has evolved the most on an industry level. Further progress is being made towards negotiating labor contracts at the national level between the Confederations of Unions and FEDECAMARAS, which groups all the firms in the different industrial sectors. In contrast, the cooperative movement is very weak, with an overall penetration of only 0.7% of the population.

11.2 Health Care Delivery System

The Venezuelan health care system is of the traditional mixed type, with a public sector including government and social security services and a private sector, until very recently, almost exclusively dominated by individual private practice. This picture is changing with the rapid appearance of different health insurance plans.

11.2.1 Government Services

11.2.1.1 Ministry of Health

The Ministry operates a large network of facilities, ranging from primary care centers to tertiary care hospitals distributed in the main urban centers. Until about twenty years ago this network was the most important provider of health services in the country, but its relative importance is decreasing in comparison with the private sector. Services are financed from general revenue, but the funding has been relatively stagnant since 1977.

Most indexes point to inefficiency in the services: 2.8 physician visits per hour, and 1.5 physician visits per person protected per year, long hospital stays (8 days) and a low occupancy rate: 58%.

11.2.1.2 Junta de Beneficencia del Distrito Federal

This Board operates the municipal hospitals in the Federal District of Caracas, providing free inpatient care to indigents.

11.2.2 Social Security

There are two main organizations within Social Security:

11.2.2.1 Venezuelan Institute of Social Security (IVSS)

The IVSS provides not only income subsidies but also health services to active workers and their dependents. Its Directory Council is formed by representatives of the state, the employers, the employees and a Commissioner from the Medical Federation of Venezuela. The IVSS operates its own network of ambulatory and hospital facilities throughout the country. It is financed by social security contributions from employers and employees and by funds from general revenue.

11.2.2.2 Social Prevention and Assistance Institute for the Ministry of Education Employees (IPAS-ME)

It provides maternity services, surgery and dental care to Ministry of Education employees and their dependents. Drugs are also sold to beneficiaries at discount prices. The Institute runs its own network of health care facilities in the main urban centers of the country. It is financed by social security contributions from employees and from general revenue on behalf of the Ministry of Education (the employer).

11.2.3 Private Sector

Within the framework of traditional practice of medicine, private hospitals and diagnostic and therapeutic centers have expanded enormously in the past 15 years, changing the balance between government, social security and private facilities. As an example,

the number of private hospitals increased by 80% in the period from 1973 to 1980: from 164 to 266 hospitals.

There has also been a tremendous growth in enrollment in traditional indemnity health insurance. In fact, this growth has been tenfold. Reimbursement to insurers grew by a factor of 12 in the period from 1974 to 1982.

Theoretically, prepayment for health insurance in Venezuela is restricted exclusively to the indemnity type, but in reality some alternative forms seem to have appeared, although disguised, in the last ten years. This situation is a result of the position of the Venezuelan Medical Federation, which firmly defends two principles:

- a) Freedom of choice of providers. The Federation maintains that the prepayment for medical care cannot "lock in" the insurer with a restricted group of providers.
- b) Freedom to set professional fees as a private agreement between the physician and his patient, even when the latter is insured.

However, with the surge of new high technology, high comfort private hospitals organized as commercial enterprises and the emergence of preferential rates between these hospitals and some insurance companies (sometimes commercially linked to a common financial source) there has been the development of what can be termed PPO arrangements.

Our local correspondent has tried to gather data about the names and characteristics of these new organizations, but, due to the great power of the Venezuelan Medical Federation and to the somewhat complex nature of the relationship between insurance companies and hospitals, factual data has been hard to obtain.

11.3 Summary and HMO Prospects

There is an emphasis in Venezuela on curative, high technology medicine, despite the fact that large segments of the population would benefit from more primary care. The public sector organizations: i.e.: MOH, Junta Beneficencia, IVSS, IPAS-ME have large national networks of health care facilities and there is a great deal of duplication of services in spite of an effort to coordinate and integrate the elements. There has been a gradual decline in the productivity, effectiveness and efficiency of government and social security institutions.

The great increase in private services has been fed by the middle and upper-middle class families seeking better care in the new private hospitals, whose costs are so high that they could not be afforded without insurance.

A list of prepaid health care institutions is not available for this country. As mentioned before, the HMO and PPO type of organizations cannot organize openly in Venezuela because of medical union opposition. The local correspondent was not able to gather data which, in most cases, is confidential in nature.

The one form of incipient HMO exists in private hospitals, which organize a closed group plan with a large firm and provide the services to that firm's employees at the same time that they provide services to the public at large. One of those hospitals is the Hospital Coromoto, in Maracaibo, which provides services to the Lagoven Oil Company, one of the nationalized oil companies in Venezuela. It provides comprehensive coverage through prepaid fees related to its

estimated cost per bed times the number of beds contracted with Lagoven. It may include a similar arrangement with other firms, but this could not be confirmed. There also exist price differentials for private inpatients. About 35% of the hospital's patients are from Lagoven.

Another plan, which the correspondent mentioned was a way to avoid resistance from the medical union, is to provide services directly through a private hospital organized as a corporation in which a number of shares are sold on the market. A hospital is built with those funds and with additional sources from medical groups. Once the hospital is completed and ready to begin operation, the institution presents the shareholders with health insurance plans of the open type (because they are not allowed to establish a closed system). The motivation by the shareholders, who are the beneficiaries, to use the institution facilities together with the practitioners working in it, comes from lower copayments, absence of downpayments for hospital care and possibly some form of extended payment for some major expenses. There may also be discounts which cannot be advertised. In theory, the beneficiary-shareholder could demand services from any institution or practitioner in the country, but since he has a direct interest in the institution in which he holds stock, and in which he is offered some additional benefits, it is normally expected that he will demand health services in that institution and only in exceptional cases elsewhere.

The most popular plan, though, is through collective insurance. Using the existing facilities of the private hospitals, the plan enrolls the employees and workers of large firms.

We anticipate a growth in indemnity insurance plans and possibly the establishment of PPOs or HMOs organized by the Venezuelan

Medical Federation, as it faces the growing demand for less costly care and pressure from physicians seeking employment.

In the future, prepayment of medical services of the HMO type will become more widespread in Venezuela. It has a great growth potential mainly because it has not reached the middle class as it has in other countries in South America. It will definitely require a change in the medical union's approach to medical attention in the country, but once this occurs the potential for growth should materialize very rapidly.

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ANNEX 1 : ARGENTINA'S SOCIAL INSURANCE FUNDS / OBRAS SOCIALES

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A) "Union Sponsored" Social Insurance Funds / Obras Sociales

NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED	BENEFICIARIES
Obra social del personal de la Industria aceitera y afines	Lavalle 1759 Pisos 2, 3, 5 (1048) Capital Federal	Private non-profit under government supervision	Non-medical union	P.P.O.	Comprehensive (drugs partially included)	Employer: 4.5% of payroll Employee: 3% of salary (includes family group)	39.200
Obra social de Actores	Alsina 1762 (1088) Capital Federal	"	"	"	"	"	23.085
Obra social de Técnicos de vuelo de Líneas Aéreas	Victor Hugo 369 (1407) Capital Federal	"	"	"	"	"	352
Obra Social del personal superior y Profesional de Empresas Aero-comerciales	Bogotá 3773 (1407) Capital Federal	"	"	"	"	"	3.691
Obra Social del Personal de Aeronavegación de Entes Privados	José Bonifacio 1991 (1406) Capital Federal	"	"	"	"	"	2.088
Obra Social del Personal Aeronáutico	Anchorena 1266 (1425) Capital Federal	"	"	"	"	"	11.970
Obra Social del Personal Técnico Aeronáutico	D'Onofrio 158 (1702) Ciudadela	"	"	"	"	"	6.701
Obra Social de Aeronavagantes	Sarmiento 1967, piso 1o. (1044) Capital Federal	"	"	"	"	"	2.521
Obra Social de Empleados de Agencias de Informes	Lavalle 1537 - Planta baja, Of. "L" (1048) Capital Federal	"	"	"	"	"	554

NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED	BENEFICIARIES
Obra Social del personal de Aguas Gaseosas y Afines	Pasaje Gabriel Lafond 4182 (1419) Capital Federal	Private non-profit under government supervision	Non-medical union	P.P.O.	Comprehensive (drugs partially included)	Employer: 4.5% of payroll Employee: 3% of salary (includes family group)	85.698
Obra Social de Alfajeros, Reposteros, Pizzeros y Heladeros	25 de mayo 1632 (7600) Mar del Plata	"	"	"	"	"	5.000
Obra Social del personal de la Industria de la Alimentación	Solis 1225 (1134) Capital Federal	"	"	"	"	"	256.322
Obra Social del Personal de Artes Gráficas de Santa Fe	Junin 2646 (3000) Santa Fé	"	"	"	"	"	1.206
Obra Social de Artistas de Variedades	Perú 1102 (1068)	"	"	"	"	"	6.523
Obra Social del Personal del Automóvil Club Argentino	Boulogne sur mer 954 (1213) Capital Federal	"	"	"	"	"	12.160
Obra Social del Personal del Azúcar de Calilegua	Sarmiento s/n (4514) Calilegua - Provincia de Jujuy	"	"	"	"	"	2.161
Obra Social del Personal del Azúcar del Ingenio Las Toscas	Calle 13 No. 143 Las Toscas - Pcia. de Santa Fe	"	"	"	"	"	492
Obra Social del Personal del Azúcar del Ingenio Río Grande	Reconquista s/n (4522) La Mendieta - Pcia. de Jujuy	"	"	"	"	"	3.888

NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED	BENEFICIARIES
Obra Social del Personal del Azúcar del Ingenio San Isidro	Salta 150 (4432) Campo Santo - Pcia. de Salta	Private non-profit under government supervision	Non-medical union	P.P.O.	Comprehensive (drugs partially included)	Employer: 4.5% of payroll Employee: 3% of salary (includes family group)	21.658
Obra Social del Personal del Azúcar de Villa Ocampo	Prolongación Mi- tre s/n (3580) Villa Ocampo - Pcia. de Santa Fe	"	"	"	"	"	10.472
Obra Social del Personal del Azúcar del Ingenio Las Banderitas	Azcuénaga 337 (4132) Famaila - Pcia. de Tucumán	"	"	"	"	"	N.A.
Obra Social del Personal de la Actividad Azucarera Tucumana	Congreso y General Paz (4.000) Tucumán	"	"	"	"	"	193.309
Obra Social del Personal de la Industria Azucarera	Congreso 342/48 (4000) Tucumán	"	"	"	"	"	30.861
Obra Social del Personal de Barracas de Lenas, Cueros y Anexos	Florentino Ameghino 1060 (1870) Avellaneda	"	"	"	"	"	4.815
Obra Social del Personal de la Industria Bottonera	San Martin 104 (1650) San Martin	"	"	"	"	"	551
Obra Social del Personal de la Industria del Calzado	Yatay 129 (1184) Capital Federal	"	"	"	"	"	95.000
Obra Social del Personal de la Junta Nacional de Carnes	San Martin 459 (1004) Capital Federal	"	"	"	"	"	2.291

NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED	BENEFICIARIES
Obra Social del Personal de Carga y Descarga	Cochabamba 1635 (1148) Capital Federal	Private nonprofit under government supervision	Non-medical union	P.P.O.	Comprehensive (drugs partially included)	Employer: 4.5% of payroll Employee: 3% of salary (includes family group)	10.272
Obra Social del Personal Auxiliar de Casas Particulares	Charcas 2745 (1425) Capital Federal	"	"	"	"	"	10.770
Obra Social del Personal del Caucho	Valle 1281 (1406) Capital Federal	"	"	"	"	"	5.677
Obra Social del Personal de la Industria del Caucho de Santa Fe	Iturraspe 2458 (3000) Santa Fe	"	"	"	"	"	704
Obra Social del Personal de Cementerios	Federico Lacroze 3908 (1427) Capital Federal	"	"	"	"	"	2.717
Obra Social de Ceramistas	Doblas 629 (1424) Capital Federal	"	"	"	"	"	43.000
Obra Social del Personal de la Cerámica, Sanitarios, Porcelana de Mesa y Afines	Pavón 1255 (1870) Avellaneda	"	"	"	"	"	6.307
Obra Social del Personal de la Actividad Cervecera y Afines	Mumahuaca 4072 (1192) Capital Federal	"	"	"	"	"	5.876
Obra Social del Personal Cinematográfico de Mar del Plata	Neuquén 2655 (7600) Mar del Plata	"	"	"	"	"	362
Obra Social del Personal de la Industria Cinematográfica	Juncal 2029 (1116) Capital Federal	"	"	"	"	"	2.486

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NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED	BENEFICIARIES
Obra Social de Operadores Cinematográficos	Viamonte 2045 (1056) Capital Federal	Private non-profit under government supervision	Non-medical union	P.P.O.	Comprehensive (drugs partially included)	Employer: 4.5% of payroll Employee: 3% of salary (includes family group)	1.750
Obra Social de Colocadores de azulejos, mosaicos, graniteros, lustradores y porcelaneros	Colombres 1419 (1238) Capital Federal	"	"	"	"	"	4.083
Obra Social de Conductores Navales	Finzón 281 (1161) Capital Federal	"	"	"	"	"	7.745
Obra Social del Personal de Consignatarios del Mercado General de Hacienda de Avellaneda	Guemes 743 (1870) Avellaneda	"	"	"	"	"	44
Instituto de Servicios Sociales para el personal de la Industria de la Construcción	Humberto lo. 101 (1103) Capital Federal	"	"	"	"	"	852.182
Obra Social del Personal Administrativo y Técnico de la Construcción y Afines	Pte. Luis Saenz Peña 1142/44 (1110) Capital Federal	"	"	"	"	"	31.013
Obra Social del Personal de la Construcción	Azopardo 954 (1107) Capital Federal	"	"	"	"	"	852.182
Obra Social del Personal de la Industria del Cuero y Afines	Cangallo 3866 (1198) Capital Federal	"	"	"	"	"	77.472
Obra Social del Personal de la Industria del Chacinado y Afines	San Juan 4229 (1233) Capital Federal	"	"	"	"	"	18.126

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NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED	BENEFICIARIES
Obra Social de Chóferes Particulares	Mansilla 4041 (1425) Capital Federal	Private non-profit under government supervision	Non-medical union	P. P.O.	Comprehensive (drugs partially included)	Employer: 4.5% of payroll Employee: 3% of salary (includes family group)	27
Obra Social del Personal de Entidades Departistas y Civiles	General Urquiza 17/21 (1215) Capital Federal	"	"	"	"	"	203.015
Obra Social del Personal de Despachantes de Aduana	Callao 220- 6o. piso (1022) Capital Federal	"	"	"	"	"	3.864
Obra Social de Docentes Particulares	Carlos Calvo 836 (1102) Capital Federal	"	"	"	"	"	27.594
Obra Social del Personal de Edificios de Renta y Horizontal de la R.A.	Bartolomé Mitre 2025 (1039) Capital Federal	"	"	"	"	"	82.087
Obra Social del Personal de Edificios de Renta y Horizontal de Capital Federal y Gran Buenos Aires	Sarmiento 2026 (1044) Capital Federal	"	"	"	"	"	27.096
Obra Social Electricistas Navales	Chacabuco 1553 (1140) Capital Federal	"	"	"	"	"	653
Obra Social de Empacadores de Fruta de Rio Negro y Neuquén	Menguella 130 (8324) Cipolletti - Rio Negro	"	"	"	"	"	7.868
Obra Social del Personal de la Enseñanza Privada	Misiones 262 (1083) Capital Federal	"	"	"	"	"	3.244

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NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED	BENEFICIARIES
Obra Social del Personal de Escribanias de la Provincia de Buenos Aires	Calle 45 No. 509 (1900) La Plata	Private non-profit under government supervision	Non-medical union	P.P.O.	Comprehensive (drugs partially included)	Employer: 4.5% of payroll Employee: 3% of salary (includes family group)	2.139
Obra Social del Personal de Escribanos	Rodriguez Peña 536/38 (1020)Capital Federal	"	"	"	"	"	1.604
Obra Social del Personal del Espectáculo Público	Pasco 148/54 (1081) Capital Federal	"	"	"	"	"	47.873
Obra Social del Personal de Farmacia	Constitución 2066 (1245)Capital Federal	"	"	"	"	"	20.427
Obra Social del Personal de la Feria Infantil	Suipacha 472 - 9o.piso Of. 902 (1008) Capital Federal	"	"	"	"	"	451
Obra Social del Personal Fermolac	Av. Vergara 3131 (1686) Hurlingham	"	"	"	"	"	386
Obra Social del Personal de la Industria del Fibrocemento	Cayo Eliseo Coria 2745 (1706) Haedo	"	"	"	"	"	5.005
Obra Social del Personal de la Industria Forestal de Santiago del Estero	Sarmiento 172 (4200) Santiago del Estero	"	"	"	"	"	15.362
Obra Social del Personal de la Industria del Fósforo	Marconi 652 (1870) Avellaneda	"	"	"	"	"	1.079
Obra Social de Fotografos	Rodriguez Peña 468 (1020) Capital Federal	"	"	"	"	"	927

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NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED	BENEFICIARIES
Obra Social del Personal del Frigorífico Mercado Nacional de Hacienda de Buenos Aires	Timoteo Gordillo 2140 (1408) Capital Federal	Private non-profit under government supervision	Non-medical union	P.P.O.	Comprehensive (drugs partially included)	Employer: 4.5% of payroll Employee: 3% of salary (includes family group)	N.A
Obra Social del Personal de la Actividad Frutícola	Saavedra 121 (3200) Concordia Entre Rios	"	"	"	"	"	9.319
Obra Social del Personal de Manipuleo, Empaque, y Expedición de fruta seca y hortalizas de Cuyo	Montecaseros 1147 (5500) Mendoza	"	"	"	"	"	4.992
Obra Social de Futbolistas	Salta 1144 (1074) Capital Federal	"	"	"	"	"	1.826
Obra Social del Personal de la Actividad Gastronómica	Hipólito Irigoyen 1419. Pisos 2, 3 y 5 (1089) Capital Federal	"	"	"	"	"	158.820
Obra Social del Personal superior de Good-Year Argentina	M. Ocampo esquina Gaboto (1686) Hur-lingham	"	"	"	"	"	1.926
Obra Social del Personal Gráfico	Paseo Colón 731 (1063) Capital Federal	"	"	"	"	"	74.742
Obra Social del Personal Gráfico de Corrientes	Hipólito Irigoyen 1146 (3400) Corrientes	"	"	"	"	"	360
Obra Social de Guincheros	Alvar Núñez 226 (1163) Capital Federal	"	"	"	"	"	2.085

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NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED	BENEFICIARIES
Obra Social del Personal de Consignatarios del Mercado Nacional de Hacienda de Liniers	Av. Tellier 2337/39 (1440) Capital Federal	Private non-profit under government supervision	Non-medical union	P. P.O.	Comprehensive (drugs partially included)	Employer: 4.5% of payroll Employee: 3% of salary (includes family group)	788
Obra Social del Personal de la Industria del Hielo y Mercados Particulares	Colombres 1573 (1238) Capital Federal	"	"	"	"	"	17.126
Obra Social del Personal Mensualizado del Jockey Club de Buenos Aires y los Hipódromos de Palermo y San Isidro	Soler 6063 (1425) Capital Federal	"	"	"	"	"	4.739
Obra Social del Personal de Imprenta	San José 715 (1076) Capital Federal	"	"	"	"	"	16.661
Obra Social del Personal del Ingenio San Pablo	Av. San Martín y Calle 7 (4129) San Pablo - Tucumán	"	"	"	"	"	422
Obra Social del Personal de Jaboneros	Cobo 877 (1424) Capital Federal	"	"	"	"	"	13.129
Obra Social de Jardineros, Parquistas, Vive-ristas y floricultores	Rivadavia 444 (1642) San Isidro	"	"	"	"	"	2.836
Obra Social del Personal del Jockey Club de Rosario	Ovidio Lagos 1587 (2000) Rosario - Santa Fe	"	"	"	"	"	1.113
Obra Social del Personal Ladrillero	Miños 3611 (1702) Ciudadela	"	"	"	"	"	2.178

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NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED	BENEFICIARIES
Obra Social de Capitanes de Ultramar y Oficiales de la Marina Mercante	Bolivar 382 - llo. piso(1066) Capital Federal	Private non-profit under government supervision	Non-medical union	P.P.O.	Comprehensive (drugs partially included)	Employer: 4.5% of payroll Employee: 3% of salary (includes family group)	2.171
Obra Social de Capitanes baqueanos fluviales de la Marina Mercante	Aritobulo del Valle 319 (1161) Capital Federal	"	"	"	"	"	1.482
Obra Social de Encargados Apuntadores Maritimos	Venezuela 1623 (1096) Capital Federal	"	"	"	"	"	4.430
Obra Social del Personal Maritimo	Belgrano 1667/69 (1093) Capital	"	"	"	"	"	28.442
Obra Social de Empleados de la Marina Mercante	San José 83 - 6o. piso (1076) Capital Federal	"	"	"	"	"	11.399
Obra Social de Mecánicos del Transporte Automotor	Belgrano 665 (1092) Capital Federal	"	"	"	"	"	279.061
Obra Social del Personal Superior de Mercedes Benz Argentina	Pasaje Leopoldo Atenzo 637 (1408) Capital Federal	"	"	"	"	"	2.243
Obra Social del Personal de la Industria Metalúrgica	Cangallo 1435 (1037) Capital Federal	"	"	"	"	"	1.140.390
Obra Social de Supervisores de la Industria Metalúrgica	Azcúñaga 1234 (1115) Capital Federal	"	"	"	"	"	74.403

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NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED	BENEFICIARIES
Obra Social del Personal de Micros y Omnibus de Mendoza	San Lorenzo 250 (5500) Mendoza	Private non-profit under government supervision	Non-medical union	P.P.O.	Comprehensive (drugs partially included)	Employer: 4.5% of payroll Employee: 3% of salary (includes family group)	5.492
Obra Social de la Actividad Minera	Rosario 434/36 (1424) Capital Federal	"	"	"	"	"	67.398
Obra Social Modelos Argentinos	Libertad 12 - 2o. piso (1012) Capital Federal	"	"	"	"	"	2.200
Obra Social del Personal de la Industria Molinera	México 2070 (1222) Capital Federal	"	"	"	"	"	36.500
Obra Social del Personal Mosaista	Quirno 89 (1406) Capital Federal	"	"	"	"	"	14.893
Obra Social de Músicos	Paraguay 1162 (1057) Capital Federal	"	"	"	"	"	1.612
Obra Social de Músicos de Cuyo	Rioja 1439 (5500) Mendoza	"	"	"	"	"	N.A.
Obra Social de Músicos de Mar del Plata	España 1486 (7600) Mar del Plata	"	"	"	"	"	45
Obra Social de Jefes y Oficiales Navales de Radiocomunicaciones	24 de noviembre 643 (1224) Capital Federal	"	"	"	"	"	232
Obra Social de Jefes y Oficiales Maquinistas Navales	Libertad 1668 (1016) Capital Federal	"	"	"	"	"	2.097

NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED	BENEFICIARIES
Obra Social del Personal Naval	Mousssey 914 (1162) Capital Federal	Private non-profit under government supervision	Non-medical union	P.P.O.	Comprehensive (drugs partially included)	Employer: 4.5% of payroll Employee: 3% of salary (includes family group)	9.280
Obra Social del Personal de la Industria del Neumático	Jujuy 995 (1229) Capital Federal	"	"	"	"	"	14.879
Obra Social del Personal de la Industria Naval	Av. Cazón 136 (1648) Tigre	"	"	"	"	"	7.358
Obra Social de Comisarios Navales	Estados Unidos 867 (1101)Capital Federal	"	"	"	"	"	35
Obra Social del Personal de Panaderías	Av. Belgrano 3636 (1210)Capital Federal	"	"	"	"	"	74.000
Obra Social de Panaderos, Pasteleros y Fabricadores de Entre Ríos	Velez Sarsfield 447/49 (3200) Concordia Entre Ríos	"	"	"	"	"	1.311
Obra Social del Personal del Papel, Cartón y Químicos	Lima 921 (1073) Capital Federal	"	"	"	"	"	85.550
Obra Social de la Industria de Pastas Alimenticias	Belgrano 4280 (1210) Capital Federal	"	"	"	"	"	5.435
Obra Social de Pasteleros, Confiteros, Pizzeros y Alfajoreros de la República Argentina	Bogado 4551 (1183) Capital Federal	"	"	"	"	"	68,942
Obra Social de Patrones de Cabotaje de Ríos y Puertos	Av. Paseo Colón 1145 (1063) Capital Federal	"	"	"	"	"	4.859

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NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED	BENEFICIARIES
Obra Social de Peleteros	Suipacha 831 4o piso Dto."B" (1008) Capital Federal	Private non-profit under government supervision	Non-medical union	P.P.O.	Comprehensive (drugs partial- ly included)	Employer: 4.5 % of payroll Employee: 3% of salary (Includes family group)	843
Obra Social del Personal de Peluqueria y Peinadores	Ayacucho 960 (1111) Capital Federal	"	"	"	"	"	4.220
Obra Social de Oficiales Peluqueros y Peinadores	Ayacucho 960 (1111) Capital Federal	"	"	"	"	"	4.220
Obra Social de Oficiales Peluqueros y Peinadores de Rosario	Montevideo 1488 (2000) Rosario	"	"	"	"	"	302
Obra Social del Personal de la Actividad Perfumista	Treinta y Tres Orientales 148 (1182)Capital Federal	"	"	"	"	"	14.794
Obra Social del Personal de la Industria del Pescado de Mar del Plata	12 de octubre 4445 (7600) Mar del Plata	"	"	"	"	"	20.808
Obra Social de Petroleros del Estado	Juncal 1461 (1062) Capital Federal	"	"	"	"	"	N.A.
Obra Social de Petroleros	Caseros 715 (1152) Capital Federal	"	"	"	"	"	50.900
Obra Social de Petroleros de Córdoba	Sarmiento 935 (5000) Córdoba	"	"	"	"	"	8.184
Obra Social del Personal de la Industria Petroquímica	San Martin 698 (2200) San Lorenzo - Santa Fe	"	"	"	"	"	3.124

NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED	BENEFICIARIES
Obra Social de Pilotos de Líneas Aéreas Comerciales y Regulares	Lezica 4047 (1202) Capital Federal	Private non-profit under government supervision	Non-medical union	P.P.O.	Comprehensive (drugs partially included)	Employer: 4.5% of payroll Employee: 3% of salary (includes family group)	3.499
Obra Social del Personal de Fábricas de Finturas	Nazca 845 (1406) Capital Federal	"	"	"	"	"	11.005
Obra Social de Profesores de Academias Pitman	Honorio Pueyrredón 81 - Planta Baja "A" (1405) Capital Federal	"	"	"	"	"	578
Obra Social del Personal de la Industria del Plástico	Av. Pavón 4165 (1253) Capital Federal	"	"	"	"	"	48.874
Obra Social de Capataces y Estibadores Portuarios	Carlos Calvo 736 (1102) Capital Federal	"	"	"	"	"	1.401
Obra Social de Portuarios de Bahía Blanca	Siches 4071 (8103) Ing.White - Bahía Blanca	"	"	"	"	"	1.600
Obra Social Portuarios de Rosario	Entre Ríos 1638 (2000) Rosario - Santa Fe	"	"	"	"	"	8.325
Obra Social Portuarios de Puerto San Martín y Bella Vista	Cayetano Nerbutti 248 (2202) Puerto Gral. San Martín - Santa Fe	"	"	"	"	"	290
Obra Social Portuarios Puerto San Nicolás	España 68 (2900)-San Nicolás - Pcia. Buenos Aires	"	"	"	"	"	360
Obra Social Portuarios de San Pedro	Saavedra y Miguel Porta " (2930) San Pedro - Pcia. de Buenos Aires	"	"	"	"	"	206

NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED	BENEFICIARIES
Obra Social Portuarios de Santa Fe	Urquiza 1419 (3000) Santa Fe	Private non-profit under government supervision	Non-Medical union	P.P.O.	Comprehensive (drugs partially included)	Employer: 4.5% of payroll Employee: 3% of salary (includes family group)	711
Obra Social de Portuarios de Villa Constitución	Córdoba 342 (2919) Villa Constitución Santa Fe	"	"	"	"	"	442
Obra Social del Personal de Prensa de Bahía Blanca	San Martín 72 (8000) Bahía Blanca	"	"	"	"	"	524
Obra Social del Personal de Prensa de Córdoba	Obispo Trejo 365 (5000) Córdoba	"	"	"	"	"	807
Obra Social del Personal de Prensa de la Provincia del Chaco	Santa María de Oro 123 (3500) Resistencia - Chaco	"	"	"	"	"	820
Obra Social del Personal de Prensa de Mendoza	Salta 1457 (5500) Mendoza	"	"	"	"	"	969
Obra Social de Empleados de prensa de Córdoba	Obispo Trejo 19 - 4o. piso - so- of. "B"- (5000) Córdoba	"	"	"	"	"	876
Obra Social de Profesionales de la Obra Social del Personal del Papel, Cartón y Químicos	Vera 1587 (1414) Capital Federal	"	"	"	"	"	408
Obra Social de Agentes de Propaganda Médica de la Rep. Argentina	Hipólito Irigoyen 1419 4o. piso (1089) Capital Federal	"	"	"	"	"	30.700

NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED	BENEFICIARIES
Obra Social de Agentes de Propaganda Médica de Córdoba	Ayacucho 27 (5000) Córdoba	Private non-profit under government supervision	Non-medical union	P.P.O.	Comprehensive (drugs partially included)	Employer: 4.5% of payroll Employee: 3% of salary (includes family group)	2.382
Obra Social de Agentes de Propaganda Médica de Rosario	Laprida 1063 (2000) Rosario Santa Fe	"	"	"	"	"	1.919
Obra Social del Personal de la Publicidad	Cangallo 2385 (1040) Capital Federal	"	"	"	"	"	6.172
Obra Social del Personal de Industrias Químicas y Petroquímicas	Brandsen 1486/94 (1287) Capital Federal	"	"	"	"	"	44.851
Obra Social de Recibidores de Granos y Anexos	Av. Juan de Garay 460 (1153) Capital Federal	"	"	"	"	"	4.459
Obra Social del Personal de Recolección y Barrido de Rosario	Buenos Aires 1635 (2000) Rosario - Santa Fe	"	"	"	"	"	5.130
Obra Social del Personal de Refinerías de Maíz	René Simón 910 (2942) Baradero - Pcia. de Buenos Aires	"	"	"	"	"	2.483
Obra Social de la Industria de Materiales Refractarios y Afines	Ntra. Sra. del Buen Viaje 548 (1708) Morón	"	"	"	"	"	2.737
Obra Social de Relojeros y Joyeros	Valentín Gómez 3828 (1191) Capital Federal	"	"	"	"	"	1.412
Obra Social del Personal Rural y Estibadores	Independencia 3058/70 (1226) Capital Federal	"	"	"	"	"	N.A.

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NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED	BENEFICIARIES
Obra Social del Personal de la Industria Salinera	San Martín 72 - 1o.piso- Of, 1 and 2 (8000) Capital Federal	Private non-profit under government supervision	Non-medical union	P.P.O.	Comprehensive (drugs partially included)	Employer: 4.5% of payroll Employee: 3% of salary (includes family group)	2.250
Obra Social del Personal de la Sanidad	Dean Funes 1241 (1244) Capital Federal	"	"	"	"	"	267.804
Obra Social del Personal de Instalaciones Sanitarias	Rincón 1122 (1227) Capital Federal	"	"	"	"	"	6.438
Obra Social del Personal de Seguridad comercial, industrial e investigaciones privadas	Av. Belgrano 1280 1o and 2o. piso (1093) Capital Federal	"	"	"	"	"	40.913
Obra Social del Personal del Seguro	Suipacha 137 (1008) Capital Federal	"	"	"	"	"	N.A.
Obra Social de Serenos de Buques	Macuani 1122 (1071) Capital Federal	"	"	"	"	"	1.168
Obra Social de Técnicos profesionales, empleados y supervisores de Standard Electric Argentina	Laprida 169 (1642) San Isidro	"	"	"	"	"	3.585
Obra Social del Personal de Standard Electric.	Don Bosco 411 (1642) San Isidro	"	"	"	"	"	1.667
Obra Social del Personal de supervisión de la Empresa Subterráneos de Buenos Aires	Emilio Mitre 554 (1424) Capital Federal	"	"	"	"	"	901

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NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED	BENEFICIARIES
Obra Social del Personal de Dirección de la Empresa Subterráneos de Buenos Aires	Bartolomé Mitre 3342 (1201) Capital Federal	Private non-profit under government supervision	Non-medical union	P.P.O.	Comprehensive (drugs partially included)	Employer: 4.5% of payroll Employee: 3% of salary (includes family group)	834
Obra Social del Personal de la Industria del Tabaco	Esteban Bonorino 281 (1406) Capital Federal	"	"	"	"	"	12.256
Obra Social del Personal Telefónico de la República Argentina	J.B. Ambrosetti 134 (1405) Capital Federal	"	"	"	"	"	9.715
Obra Social del Personal de Televisión	Quintino Bocayuva 38/50 (1181) Capital Federal	"	"	"	"	"	7.858
Obra Social de Empleados Textiles y Afines	Montes de Oca 1435/37 (1271) Capital Federal	"	"	"	"	"	65.583
Obra Social de Tintoreros, Sombrereros y Lavaderos	Chile 1571 (1100) Capital Federal	"	"	"	"	"	5.287
Obra Social del Personal de la Industria del Tractor	Juan Orsetti 481 (2152) Granadero Baigorria - Santa Fe	"	"	"	"	"	220
Obra Social de la Industria del Transporte Automotor de Córdoba	Paraná 327 (5000) Córdoba	"	"	"	"	"	7.531
Obra Social de Conductores de Transporte Colectivo de Pasajeros	Moreno 2969 (1205) Capital Federal	"	"	"	"	"	267.475
Obra Social del Personal de la Actividad del Surf	Av. Belgrano 3716 Capital Federal	"	"	"	"	"	3.913

NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED	BENEFICIARIES
Obra Social Conductores de Taxis de Córdoba	San Luis 373 (5000) Córdoba	Private non-profit under government supervision	Non-medical union	P.P.O.	Comprehensive (drugs partially included)	Employer: 4.5% of payroll Employee: 3% of salary (includes family group)	2.650
Obra Social de Vareadores	Av. Centenario 539 (1642) San Isidro	"	"	"	"	"	4.069
Obra Social de Viajantes	Combate de los Pozos 134 (1079) Capital Federal	"	"	"	"	"	N.A.
Obra Social del Personal de la Actividad Vial	San Jerónimo 1641 (3000) Santa Fe	"	"	"	"	"	13.818
Obra Social de Empleados de la Industria del Vidrio	Carabobo 34 (1406) Capital Federal	"	"	"	"	"	9.833
Obra Social del Personal de la Industria del Vidrio	Balbastro 453 (1424) Capital Federal	"	"	"	"	"	45.364
Obra Social del Personal de la Actividad Vitivinícola	Av. Warnes 1892/94(1416)" Capital Federal	"	"	"	"	"	94.884
Obra Social del Personal de Vigilancia y Seguridad comercial, industrial e investigaciones privada de Córdoba	Pringles 21- Barrio Gral. Paz (5000) Córdoba	"	"	"	"	"	1.328
Obra Social del Personal de estaciones de servicio, garages, playas y lavaderos automáticos de la Pcia. de Santa Fe	Riobamba 1075 (2000) Rosario - Santa Fe	"	"	"	"	"	13.980

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NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED	BENEFICIARIES
Obra Social para el personal de estaciones de servicio, garages, playas de estacionamiento, lavaderos automáticos y gomerías de la República Argentina	Luis S. Peña 366 - Piso 1o. (1110) Capital	Private non-profit under government supervision	Non-medical union	P.P.O.	Comprehensive (drugs partially included)	Employer: 4.5% of payroll Employee: 3% of salary (includes family group)	20.443

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B) "State Sponsored" Social Insurance Funds / Obras Sociales

NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED	BENEFICIARIES
Obra Social de la Secretaría de Agricultura y Ganadería	Av. Paseo Colón 922 (1305) Capital Federal	Public	State	P.P.O.	Comprehensive (drugs partially excluded)	Employer: 4.5% of payroll Employee: 3% of salary (includes family group)	35.989
Obra Social Centro Regional de Agua Subterránea	Av. José Ignacio de la Roza 125 (E) (5400) San Juan	"	"	"	"	"	N.A.
D.I.G.J.S. Obra Social de los Ministerios de Comercio e Intereses Marítimos y de Industria y Minería	Av. Julio A. Roca 651- 1er. subsuelo (1067) Capital Federal	"	"	"	"	"	11.853
Obra Social de la Empresa Nacional de Correos y Telégrafos (EN.CO.TEL.)	Maipú 39 (1084) Capital Federal	"	"	"	"	"	145.849
Obra Social del Ministerio de Defensa	Av. Paseo Colón 255- 2o. piso (1063) Capital Federal	"	"	"	"	"	2.574
Obra Social Flota Fluvial del Estado Argentino	Av. Paseo Colón 707 (1063) Capital Federal	"	"	"	"	"	1.207
Obra Social Gas del Estado	Boedo 90 (1206) Capital Federal	"	"	"	"	"	57.523
Dirección General de Obra Social del Ministerio del Interior	Av. de Mayo 760 4o. piso (1084) Capital Federal	"	"	"	"	"	17.522
Servicio de Beneficios Sociales del Ministerio de Justicia	Uruguay 643- 3o. piso (1015) Capital Federal	"	"	"	"	"	3.563

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NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED	BENEFICIARIES
Obra Social Empresa Lineas Maritimas Argentinas	Av. Corrientes 389 (1378) Capital Federal	Public	State	P.R.O.	Comprehensive (drugs partial- ly excluded)	Employer: 4.5% of payroll Employee: 3% of salary (family group included)	17.297
Dirección General de Obra Social del Minis- terio de Relaciones Ex- teriores y Culto	Arenales 884 (1061) Capital Federal	"	"	"	"	"	5.347
Obra Social del Minis- terio de Obras y Ser- vicios Públicos	Edvalla 1790 (1048) Capital Federal	"	"	"	"	"	25.616
Dirección de Obra So- cial de la Empresa Nacional de Telecomu- nicaciones	Cangallo 2740 2740 (1040) Ca- pital Federal	"	"	"	"	"	142.140
Obra Social de la Uni- versidad de Buenos Aires	José E. Uriburu 860 (1114) Capital Fe- deral	"	"	"	"	"	N.A.
Obra Social Dirección Nacional de Vialidad	Av. Comodoro Py 2002 Capital Federal	"	"	"	"	"	39.420
Obra Social Yacimientos Carboníferos Fiscales	Av. Ité. Roque S. Peña 1190 (1035) Capital Federal	"	"	"	"	"	N.A.
Obra Social Yacimientos Petróíferos Fiscales	Sarmiento 778- 8o. piso (1041) Capital Federal	"	"	"	"	"	164.201

C) " Contractual" Social Insurance Funds / Obras Sociales

NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED	BENEFICIARIES
Obra Social Anilsud	Corrientes 222 (1356) Capital Federal	Private non profit under government supervision	Other (agreement enterprises)	P.P.O.	Comprehensive (drugs partially excluded)	Employer: 4.5% of payroll Employee: 3% of salary (family group included)	75
Obra Social de Empresa Privada Celulosa Argentina S.A.	Av. Paseo Colón 635 (1063) Capital Federal	"	"	"	"	"	3.440
Obra Social Corporación Cementera Argentina	Bv. Chacabuco 147 147 - 1o. piso (5000) Córdoba	"	"	"	"	"	14.156
Obra Social del Personal de Cerámica San Lorenzo	Av. San Martín s/n (2200) San Lorenzo Santa Fe	"	"	"	"	"	5.019
Obra Social Ceras Johnson	San Martín 1068 (1004) Capital Federal	"	"	"	"	"	1.217
Obra Social Volkswagen Argentina S.A.	Florencia Varela 1903 (1754) San Justo- Pcia. de Buenos Aires	"	"	"	"	"	4.016
Obra Social Dunlop Argentina Limitada	Av. Ing. Huergo 1433 (1107) Capital Federal	"	"	"	"	"	126
Obra Social Duperial Orbea	Av. Paseo Colón 285 1o. piso (1330) Capital Federal	"	"	"	"	"	5.648
Obra Social Compañía Embotelladora Argentina SAIC	Esigorria 5592 (1408) Capital Federal	"	"	"	"	"	1.192

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NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED	BENEFICIARIES
Obra Social Electro- clor SCA	Capitán Bermúdez Zona Rural (2154) Santa Fe	Private non-profit under government supervision	Other (agreement enterprises)	P.P.O.	Comprehensive (drugs partial- ly excluded)	Employer: 4.5% of payroll Employee: 3% of salary (family group included)	624
Obra Social Mutua- lidad Empleados Fi- restone	Av. Antártida Argentina 2684 (1836) Llavallol	"	"	"	"	"	1.673
Obra Social Ford Mo- tor Argentina S.A.	Rivadavia 611 - 4o. piso (1002) Capital Federal	"	"	"	"	"	9.024
Obra Social Hiram Walker S.A.	Rivadavia 620 (1002) Capital Federal	"	"	"	"	"	326
Obra Social Sociedad Minera Hierro Patagóni- co de Sierra Grande	Locales 8/9 Villa Hipasam (8532) Sierra Grande-Río Negro	"	"	"	"	"	4.338
Obra Social Ingenio Río Grande S.A.	La Mendieta (4522) Jujuy	"	"	"	"	"	N.A.
Obra Social para Direc- tivos, Técnicos y Em- pleados de John Deere Argentina	Juan Orsetti 481 (2152) * Granadero Baigorria- Santa Fe	"	"	"	"	"	366
Obra Social Compañía Minera Aguilar S.A.	Carlos Pellegrini 1069 12o. piso (1009) Capi- tal Federal	"	"	"	"	"	7.706
Obra Social Molinos Río de la Plata	Paseo Colón 746 (1323) Capital Federal	"	"	"	"	"	2.250
Obra Social Pasa Petro- química Argentina S.A.	Suipacha 1111 - 11o. piso (1368) Capital Federal	"	"	"	"	"	3.495

NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED	BENEFICIARIES
Obra Social Cooperativa de Asistencia Mutua y Turismo del Personal de las Sociedades Pirelli Limitada	José Bonifacio 3680 (1407) Capital Federal	Private non-profit under government supervision	Other (agreement enterprises)	P. P. O.	Comprehensive (drugs partially excluded)	Employer: 4.5% of payroll Employee: 3% of salary (family group included)	3.061
Obra Social Compañía Química S.A.	Sarmiento 329 (1347) Capital Federal	Private non-profit under government supervision	"	"	"	"	1.672
Obra Social Refinerías de Maíz SAICF	Pucumán 117 (1341) Capital Federal	"	"	"	"	"	2.800
Obra Social Sulfacid SAIFC	Viamonte 1133 (1053) Capital Federal	"	"	"	"	"	704
Obra Social Superco	Cerrito 1070- 5º piso (1010) Capital Federal	"	"	"	"	"	3.377
Obra Social Empresa Privada Witcel S.A.	Chorrocarin 751 (1427)	"	"	"	"	"	861
Obra Social Cabot Argentina	San Martín 239 (2804) Campana	"	"	"	"	"	491

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D) "Management Personnel" Social Insurance Funds / Obras Sociales

NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED	BENEFICIARIES
Obra Social Asociación del Personal de Dirección de las Empresas de la Alimentación	Bernardo de Irigoyen 546- 2o. piso (1072) Capital Federal	Private non-profit under government supervision	Other (enterprises direction personnel)	R.P.O.	Comprehensive (drugs partially excluded)	Employer: 4.5% of payroll Employee: 3% of salary (family group included)	30.760
Obra Social del Personal de Dirección de la Industria Automotriz Argentina	Piedras 1636/40 (1140) Capital Federal	"	"	"	"	"	4.270
Obra Social Cooperativa Limitada de Asistencia Médica, Farmacéutica, Crédito y Consumo del Personal Superior de la Industria del Caucho	Dr. Emilio Ravignani 2540 (1425) Capital Federal	"	"	"	"	"	9.025
Obra Social del Personal de Dirección de la Industria Cervecera y Maltera	Tucumán 650- 3o. piso (1049) Capital Federal	"	"	"	"	"	3.213
Obra Social Asociación del Personal de Dirección y Jerárquico de la Industria del Cigarrillo	Piedras 1027 (1070) Capital Federal	"	"	"	"	"	3.213
Obra Social del Personal Directivo de la Industria de la Construcción	Av. R. S. Peña 637 8o. piso (1035) Capital Federal	"	"	"	"	"	25.518
Obra Social Cámara de la Industria Curtidora Argentina	Belgrano 3978 (1210) Capital Federal	"	"	"	"	"	1.511
Obra Social Acción Social de Empresarios	Lima 87 - 8o. piso (1073) Capital Federal	"	"	"	"	"	37.029

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NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RAIES CHARGED	BENEFICIARIES
Obra Social de Ejecutivos y del Personal de Dirección de Empresas	Leandro Alem 1067 (1001) Capital Federal	Private non-profit under government supervision	Other (enter- prises direction personnel)	P.P.O.	Comprehensive (drugs partial- ly excluded)	Employer: 4.5% of payroll Employee: 3% of salary (family group included)	308.636
Obra Social del Personal de Dirección de Empresas que actúan en Frutos del País	Av. Paseo Colón 823 - 5o. piso (1063) Capital Federal	"	"	"	"	"	2.309
Obra Social del Personal de Dirección Alfredo Fortabat	Av. Pte. R.S. Peña 636 (1035) Capital Federal	"	"	"	"	"	3.121
Obra Social del Personal de Dirección de la Industria Metalúrgica	Montevideo 373- 4o. piso (1019) Capi- tal Federal	"	"	"	"	"	32.773
Obra Social para el personal de Dirección de la Industria Maderera	Maza 578- 2o piso (1220) Capital Fe- deral	"	"	"	"	"	1.161
Obra Social para el personal de Dirección de la Actividad Minera	Av. Pueyrredón 133 (5000) Córdoba	"	"	"	"	"	1.335
Asociación de Prestaciones Sociales para Empleados y Personal de Dirección de Empresas de la Producción, Industria, Comercio y Servicios	Av. Santa Fe 3567 (1425) Capital Fe- deral	"	"	"	"	"	180.359
Obra Social del Personal de Dirección de la Industria Privada del Petroleo	Lavalle 557- 5o. y 6o. pisos (1047) Capital Federal	"	"	"	"	"	14.308

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NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED	BENEFICIARIES
Obra Social Directivos de Empresas Portuarios y Maritimos	Maipú 521 2o. piso (1006) Capital Federal	Private non-profit under government supervision	Other (enter- prises direction personnel	P.P.O.	Comprehensive (drugs partial- ly excluded)	Employer: 4.5% of payroll Employee: 3% of salary (family group included)	917
Obra Social Asociacion Mutual del Personal de Phillips Argentina	Vedia 3892 (1430) Capital Federal	"	"	"	"	"	2.514
Obra Social del Personal de Direccion de Cerfumeria E.W. Hope	Paraguay 1859 (1121) Capital Federal	"	"	"	"	"	6.699
Obra Social del Personal de Direccion de la Sanidad Luis Pasteurs	Av. Callao 764/66 (1023) Capital Fe- deral	"	"	"	"	"	29.971
Obra Social Asocia- cion del Personal de Direccion de la Indus- tria Siderurgica	Av. Belgrano 367 4o y 5o pisos (1092) Capital Federal	"	"	"	"	"	7.164
Obra Social Mutualidad Industrial Textil Ar- gentina	Av. Leandro Alem 1067 (1001) Capi- tal Federal	"	"	"	"	"	11.515
Obra Social Asocia- cion del Personal Su- perior de la Organi- zacion Techint	Av. Leandro Alem 1002 - 4o. piso (1001) Capital Federal	"	"	"	"	"	7.550
Obra Social del Personal de Direccion de la Industria Vitivinif- cola y afines	Cachimayo 301 (1424) Capital Federal	"	"	"	"	"	6.185

E) "Mixed Administration" Social Insurance Funds / Obras Sociales

NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED	BENEFICIARIES
Instituto de Servicios Sociales Bancarios	Libertad 731 (1012) Capital Federal		Other (union-enterprise-government)	P.P.O.	Comprehensive (drugs partially excluded)	Employer: 4.5% of payroll Employee: 3% of salary (family group included)	492.673
Instituto de Obra Social para el Personal de los Ministerios de Acción Social, Salud Pública y Medio Ambiente y de Trabajo	Viamonte 869 (1053) Capital Federal		"	"	"	"	181.202
Instituto de Servicios Sociales para el Personal de la Industria de la Carne y Afines	Callao 1445 (1024) Capital Federal		"	"	"	"	202.430
Obra Social para Empleados de Comercio y Actividades Civiles	Moreno 648/50 (1091) Capital Federal		"	"	"	"	2.135.017
Obra Social para la Actividad Docente	Tacuari 335/45 (1071) Capital Federal		"	"	"	"	599.042
Instituto de Servicios Sociales para el Personal Ferroviario	Junin 224 (1026) Capital Federal		"	"	"	"	583.298
Instituto de Obra Social de la Secretaría de Estado de Hacienda-Ministerio de Economía	Hipólito Irigoyen 250 3o. piso (1310) Capital Federal		"	"	"	"	71.236
Instituto Nacional de Servicios Sociales para Jubilados y Pensionados	Chacabuco 271- 1o. piso (1069) Capital Federal		"	"	"	"	2.857.467

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NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED	BENEFICIARIES
Obra Social para el Personal de Obras Sanitarias de la Na-	Arcos 1278 (1426) Capital Federal		Other (union-enterprise-government)	P. P. O.	Comprehensive (drugs partially excluded)	Employer: 4.5% of payroll Employee: 3% of salary (family group included)	39.654
Instituto de Servicios Sociales para las Actividades Rurales y afines	Reconquista 630 (1003) Capital Federal		"	"	"	"	1.234.763
Instituto de Servicios Sociales para el Personal de Seguros, Capitalización y Ahorro y Préstamo para la vivienda	Carlos Pellegrini 575 (1009) Capital Federal		"	"	"	"	91.488
Instituto de Servicios Sociales para el Personal de la Industria del Vidrio y Afines	Independencia 1355 (1100) Capital Federal		"	"	"	"	44.066

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F) "Law 21.476" Social Insurance Funds / Obras Sociales

NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED	BENEFICIARIES
Obra Social Atanor SA Mixta	Lavalle 348 3er.piso(1306) Capital Federal	Private non-profit under government supervision	Others	P.P.O.	Comprehensive (drugs partial- ly excluded)	Employer: 4.5% of of payroll Employee: 3% of salary (family group included)	1.577
Obra Social Forja Argentina SAIC	Reconquista 661 6o.piso (1003) Capital Federal	"	"	"	"	"	1.688
Obra Social Papel Misionero SAIFC	Santa Fe 220 (3300) Posadas - Misiones	"	"	"	"	"	2.080
Obra Social Petro- química General Mosconi	Av. Gobernador Verga- ra - Km.2,7 (1925) Ensenada - Pcia. de Buenos Aires	"	"	"	"	"	2.447
Obra Social Sociedad Mixta Siderúrgica Argentina	Av. Belgrano 737 (1092) Capital Federal	"	"	"	"	"	41.019

1.6.2.

G) "Private Firms" Social Insurance Funds / Obras Sociales

NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED	BENEFICIARIES
Obra Social Fiat Concord SAIC	Av. Santa Fe 1780 11o. piso Of.1102 (1060) Capital Federal	Private non-profit under government supervision	Other (enterprise)	P.P.O.	Comprehensive (drugs partial- ly excluded)	Employer: 4.5% of payroll Employee: 3% of salary (family group included)	21.495
Obra Social Olivetti SCA	Suipacha 1119 (1008) Capital Federal	"	"	"	"	"	N.A.

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H) "Provincial and Municipal" Social Insurance / Obras Sociales

NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED	BENEFICIARIES
Instituto de Obra Médico Asistencial	Calle 46 No. 886 La Plata	Public	Other (provincial government)	P.P.O.	Comprehensive (drugs partially excluded)	Employer: 4.5% of payroll Employee: 3% of salary (family group included)	
Obra Social de Empleados Públicos (O.S.E.P.)	Esquiti 215 - 2o. piso (4700) Catamarca	"	"	"	"	"	
Instituto Provincial de Atención Médica (I.P.A.M.)	M.T. de Alvear 758 (5000) Córdoba	"	"	"	"	"	
Instituto de Previsión Social (servicio Obra Social de la Provincia)	Salta 737- 2o. piso (3400) Corrientes	"	"	"	"	"	
Instituto de Previsión Social (I.P.S.)	9 de julio 347 (3500) Resistencia - Chaco	"	"	"	"	"	
Instituto de Seguridad Social y Seguros (S.E.R.O.S.)	Rivadavia 430 (9103) Rawson - Chubut	"	"	"	"	"	
Instituto Obra Social Provincia de Entre Ríos (I.O.S.P.E.R.)	Andrés Pazos 243 (3100) Paraná - Entre Ríos	"	"	"	"	"	
Instituto Asistencia Social Empleados Públicos (I.A.S.E.P.)	Moreno 1170 (3600) Formosa - Chaco	"	"	"	"	"	
Instituto de Seguros de Jujuy (I.S.J.)	Alvear 745 (4600) Jujuy	"	"	"	"	"	
Instituto Provincial de Obra Social (I.P.O.S.)	Felagio B. Luna 345 (5300) La Rioja	"	"	"	"	"	

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NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED	BENEFICIARIES
Instituto de Seguridad Social (Servicio Médico Previsional) Sempre	Fellegrini 245 (6300) Santa Rosa - La Pampa	Public	Other (provincial government)	P.P.O.	Comprehensive (drugs partially excluded)	Employer: 4.5% of payroll Employee: 3% of salary (family group included)	
Obra Social de Empleados Publicos (OSEP)	Eusebio Blanco 450 (5500) Mendoza	"	"	"	"	"	
Instituto de Previsión Social de la Provincia de Misiones (IPSM)	Junín 295 (3300) Posadas - Misiones	"	"	"	"	"	
Instituto de Seguridad Social de Neuquen (ISSN) (Dirección Prestaciones Salud y Asistenciales)	Buenos Aires 353 (8300) Neuquen	"	"	"	"	"	
Instituto Provincial de Seguro de Salud (IFROSS)	Julio A. Roca 250 (8500) Viedma - Rio Negro	"	"	"	"	"	
Instituto Provincial de Salta (I.P.S.)	Balgrano y Mitre (4400) Salta	"	"	"	"	"	
Dirección de Obra Social (D.O.S.)	Mitre 349 (E) (5400) San Juan	"	"	"	"	"	
Dirección de Obra Social del Estado Provincial (DOSEP)	San Martín y Ayacucho (5700) San Luis	"	"	"	"	"	
Caja de Servicios Sociales Provincia de Santa Cruz (IOSS)	Rawson 39 (C.C.330) (9400) Rio Gallegos	"	"	"	"	"	
Instituto Autarquico de Obra Social (IAPOS)	Rivadavia 3452 (3000) Santa Fe	"	"	"	"	"	

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NAME	ADDRESS	LEGAL STATUS	SPONSORSHIP	TYPE OF ORGANIZATION	TYPE OF COVERAGE	RATES CHARGED	BENEFICIAIRES
Instituto Obra Social del Empleado Provincial (IOSEP)	9 de julio 379 (4200) Santiago del Estero	Public	Other (provincial government)	P.P.O.	Comprehensive (drugs partially excluded)	Employer: 4.5% of payroll Employee: 3% of salary (family group included)	
Instituto de Servicios Sociales del Territorio Nacional de Tierra del Fuego, Antártida e Islas del Atlántico Sur (ISSF)	Karukinka 87 (9410) Ushuaia	"	"	"	"	"	
Instituto Previsión y Seguridad Social de Tucumán (IPSS)	Las Piedras 530 (4000) Tucumán	"	"	"	"	"	

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ANNEX 2 : ARGENTINA'S HEALTH INSURANCE PLANS

ANNEX 2: ARGENTINA'S HEALTH INSURANCE PLANS

ASOCIACION MEDICA EMPRESARIA S.R.L.

Santa Fé 1752 -2° piso (1060) CAPITAL FEDERAL

AMPRI S.A.

Azcuénaga 1507 (1115) CAPITAL FEDERAL

AMSA S.A.

Ayacucho 260 (1025) CAPITAL FEDERAL

ATEMA S.A.

Cerrito 1070-6° piso (1010) CAPITAL FEDERAL

CENTRO MEDICO BUENOS AIRES S.A.

Suipacha 1085 (1008) CAPITAL FEDERAL

CENTRO MEDICO DEL PLATA S.A.

Suipacha 1087 -4° piso (1008) CAPITAL FEDERAL

CENTRO MEDICO SANTA FE

Córdoba 1856 (1120) CAPITAL FEDERAL

CEPRIMED S.A.

Laprida 2164 (1425) CAPITAL FEDERAL

CORPLAM S.A.

Viamonte 1181 (1053) CAPITAL FEDERAL

CORPUS S.R.L.

Arenales 1611-2° piso (1061) CAPITAL FEDERAL

DIAGNOS S.A.

Ayacucho 1164 (1111) CAPITAL FEDERAL

DOCTHOS S.A.

Corrientes 569 (1043) CAPITAL FEDERAL

GALENO S.A.

Paraguay 1571 (1061) CAPITAL FEDERAL

GENESIS S.A.

Tucumán 1304 (2000) ROSARIO-SANTA FE

NUBIAL S.A.

Santa Fé 1752 -6°piso (1060) CAPITAL FEDERAL

OMAJA S.A.

Tucumán 950-1°piso (1049) CAPITAL FEDERAL

OPUS S.A.

Talcahuano 736 -2°piso (1391) CAPITAL FEDERAL

PREMINT S.R.L.

Callao 1319 (1023) CAPITAL FEDERAL

PROGRAMA DE SALUD S.A.

Cerrito 1320 -7°piso-Dto.A (1010) CAPITAL FEDERAL

SADAM S.C.A.

Av.Córdoba 679-7°piso-Of.701/703 (1365) CAPITAL FEDERAL

SAMI S.R.L.

Laprida 1857 (1425) CAPITAL FEDERAL

SAN JORGE O.M.

Corrientes 1894 (1045) CAPITAL FEDERAL

SKILL Medicina Laboral S.A.

Ayacucho 1683 (1113) CAPITAL FEDERAL

STAFF MEDICO S.A.

Arenales 1686 (1061) CAPITAL FEDERAL

SUMUN S.A.

Corrientes 1894 (1045) CAPITAL FEDERAL

VESALIO S.A.

Paraguay 1571 (1061) CAPITAL FEDERAL

VITAM S.A.

Viamonte 1167-7° piso-Of.28 (1053) CAPITAL FEDERAL

PLAN DE SALUD DEL HOSPITAL ITALIANO

Gascón 450 (1181) CAPITAL FEDERAL

ORGANIZACION MEDICA ASISTENCIAL TOURING

Esmeralda 605-3° piso (1007) CAPITAL FEDERAL

MEDICINA ASISTENCIAL COMUNITARIA

Rivadavia 4601-1° piso (1424) CAPITAL FEDERAL

COMESA

Rivadavia 576 (5700) SAN LUIS

ASOCIACION MEDICA EMPRESARIA

Cangallo 1685-2° piso-Dto.A (1037) CAPITAL FEDERAL

C.E.M.I.C.

Sanchez de Bustamante 2560 (1425) CAPITAL FEDERAL

CENTRO ARGENTINO MEDICINA INTEGRAL
Santa Fé 3651 (1425) CAPITAL FEDERAL

COMI
Av. San Martín 1639 (1416) CAPITAL FEDERAL

CRUZ AZUL
Uruguay 725-2° piso (1015) CAPITAL FEDERAL

FUSAL
Uruguay 1136 (1016) CAPITAL FEDERAL

INSTITUTO MEDICO LABOR
Rivadavia 6059 (1406) CAPITAL FEDERAL

MEDICUS S.A.
Maipú 1252-12° piso (1084) CAPITAL FEDERAL

MEDICUS -AGENCIA ROSARIO
Urquiza 1441 (2000) ROSARIO-SANTA FE

MINERVA ASISTENCIA MEDICA
M.T. de Alvear 2421 (1122) CAPITAL FEDERAL

O.S.E.
Callao 671-2° piso-Dto. B (1022) CAPITAL FEDERAL

LIFE PROTECCION MEDICA
Santa Fé 1821-2° piso (1123) CAPITAL FEDERAL

LIBRA
Montes de Oca 2390 (1712) CIUDADELA

CRUZ PALERMO
Córdoba 3200 (1120) CAPITAL FEDERAL

CENTRO MEDICO GALILEO

Piedras 83 (1070) CAPITAL FEDERAL

COPEVAL

Lavalle 648 -5° piso-Dto.A (1047) CAPITAL FEDERAL

OSMEBA

Calle 54 N°920 (1900) LA PLATA

SICARVA

Av. Corrientes 1894-1° piso (1045) CAPITAL FEDERAL

M.A.S.S.

Cangallo 1441-2° piso (1037) CAPITAL FEDERAL

MEDICAL'S

Laprida 1365 (1425) CAPITAL FEDERAL

OMINT

Junín 1631-2° piso-Of."D" (1113) CAPITAL FEDERAL

OPTAR

Viamonte 610-1° piso (1059) CAPITAL FEDERAL

ORGANIZACION MEDICA SAN JORGE

Corrientes 1894 -1° piso (1045) CAPITAL FEDERAL

PREMINT

Av. Callao 1315/19 (1023) CAPITAL FEDERAL

PROGRAMAS DE SALUD

Cerrito 1320-7° piso-Dto.A (1010) CAPITAL FEDERAL

SEGURIDAD MEDICA S.A.

Arroyo 844-2° piso (1037) CAPITAL FEDERAL

SEMEPRIN

Verbal 2347 (1406) CAPITAL FEDERAL

TIM S.A.

Arenales 1473-1º piso (1061) CAPITAL FEDERAL

D.A.M.S.U. SAN JUAN

Rivadavia (E) 431 (5400) SAN JUAN

SIMSA S.A.

Arenales 2449 (1124) CAPITAL FEDERAL

CENTRO MEDICO PUEYRREDON

Pueyrredón 1337 (1118) CAPITAL FEDERAL

MEDIN

Lavalle 1759-1º piso (1048) CAPITAL FEDERAL

SERVICIOS DE SALUD

Montevideo 1545 (1018) CAPITAL FEDERAL

UNIDAS

Combate de los Pozos 484 (1084) CAPITAL FEDERAL

COMMUNITAS

Av.Callao 1014-8º piso (1023) CAPITAL FEDERAL

MERLO MEDICO

Lib.Gral.San Martín 281-1º piso (1722) MERLO

KOS ASISTENCIA MEDICA

Alte.Brown 519 (1708) MORON

MEDICINA INTEGRADA

Córdoba 4545-2º piso (7600) MAR DEL PLATA

CAMP

Bu. 14 - 2525 (1125) CAPITAL FEDERAL

PLAN DE SALUD DEL HOSPITAL ALEMAN
Pueyrredón 1640 (1118) CAPITAL FEDERAL

MEDICINA DEL NORTE
Cabildo 1295 (1426) CAPITAL FEDERAL

CENPEC
Gascón 626 (1181) CAPITAL FEDERAL

PROMEFA
Coronel Díaz 1747 (1425) CAPITAL FEDERAL

ASSISTCARD
Viamonte 640 (1053) CAPITAL FEDERAL

COINPAS INTERNATIONAL
Diag.R.S.Peña 615-11° piso (1393) CAPITAL FEDERAL

INTERNATIONAL TRAVELLER'S INSURAN
Corrientes 1922-6° piso (1045) CAPITAL FEDERAL

MEDICAL QARD INTERNATIONAL
Florida 1-11° piso (1005) CAPITAL FEDERAL

CENTRO MEDICO SAN MARCOS
Eduardo Acevedo 297 (1405) CAPITAL FEDERAL

CENTRO MEDICO LURO
Rivadavia 9708 (1407) CAPITAL FEDERAL

DEPARTAMENTO MEDICO EMPRESARIO
Alsina 1609 (1088) CAPITAL FEDERAL

IATROS S.A.
Santa Fé 2534-3° piso-Dto."B" -(1425) CAPITAL FEDERAL

MEDICAL TOURIST ASSISTANCE
Córdoba 469 (1054) CAPITAL FEDERAL

SEGMEDICAL TRAVELLER

Florida 250-3° piso (1005) CAPITAL FEDERAL

SERVIPASS

25 de mayo 749-3° piso (1002) CAPITAL FEDERAL

S.O.S. INTERNATIONAL

Bartolomé Mitre 2025 (1039) CAPITAL FEDERAL

UNIVERSAL ASSISTANCE

Lavalle 652 -6° piso (1047) CAPITAL FEDERAL

CEPRIMI

Pringles 774 (1183) CAPITAL FEDERAL

SUMEDIC

Suipacha 207-2° piso (1008) CAPITAL FEDERAL

CENTRO MEDICO BERNAL

San Martín 572 (1876) BERNAL

A.S.S.I.

Cabildo 3309 (1429) CAPITAL FEDERAL

CEMES

Indpendencia 999 (1099) CAPITAL FEDERAL

CEMECO

Fco. Acuña de Figueroa 829 (1180) CAPITAL FEDERAL

BIO CENTER

Blanco Encalada 2575 (1428) CAPITAL FEDERAL

CENTRO MEDICO MONTE GRANDE

H.Yrigoyen 192 (1842) MONTE GRANDE

MEDINT

Alem 300 (1832) LOMAS DE TAMORA

MEDIVITA

Av.Pte.Quintana 585 (1129) CAPITAL FEDERAL

OSTA

Sarmiento 756-1° piso (1382) CAPITAL FEDERAL

FREEMED

Florida 633-4° piso (1005) CAPITAL FEDERAL

PROMO

Rivadavia 6685 (1406) CAPITAL FEDERAL

OMIPE

Mercedes 214 (1407) CAPITAL FEDERAL

CIRCULO DE SALUD

Mariano Moreno 475-3° piso (5000) CORDOBA

M.A.C.

Santiago del Estero 564 (1075) CAPITAL FEDERAL

CEFRAM

La Rioja 951 (1221) CAPITAL FEDERAL

PARM

Malabia 3234 (1425) CAPITAL FEDERAL

CENTRO MEDICO SANTA CRUZ

San Juan 2483 (1232) CAPITAL FEDERAL

SEMESA

León Gallardo 1796 (1663) SAN MIGUEL

VESALIO S.A.

Riobamba 857 (1116) CAPITAL FEDERAL

SANATORIO SAN LUIS (AMECA S.A.)

ITALMEDIC (HOSPITAL ITALIANO GARIBALDI)
Rodriguez Peña 1736 (1021) CAPITAL FEDERAL

POLICLINICA PRIVADA DE MEDICINA INTEGRAL
Bartolomé Mitre 2553 (1039) CAPITAL FEDERAL

DEMI
Córdoba 1868 (2000) ROSARIO-SANTA FE

CAMI
Av. Caseros 3394 (1263) CAPITAL FEDERAL

C.I.M. (SANATORIO GUEMES)
Santa Fé 3651 (1425) CAPITAL FEDERAL

ACCION MEDICA INTERNACIONAL
Santa Fé 1780-13° piso- (1060) CAPITAL FEDERAL

VIVIR
Maipú 474-4° piso-Of.B (1006) CAPITAL FEDERAL

CENTRO MEDICO SEGUROLA
Vallejos 4496 (1419) CAPITAL FEDERAL

CENTRO MEDICO LEZAMA
Av. Martín García 815 (1269) CAPITAL FEDERAL

MEDICIEN
San Martín 793-5° piso (1004) CAPITAL FEDERAL

CENTRO MEDICO LIBERTADOR
Paraguay 1350 (1057) CAPITAL FEDERAL

SANAS
Estomba 239-1° piso (8000) BAHIA BLANCA

BRINDAR S.A.

BRINDAR S.A. (1000) CAPITAL FEDERAL

(10) 242

MEDICENTER

Guemes 40-7° piso-Dto.E (1704) RAMOS MEJIA

MEDINOR

Av.Santa Fé 2332-2° piso (1123) CAPITAL FEDERAL

P.M.A.

Av.Corrientes 327-6° piso (1043) CAPITAL FEDERAL

MEDYSAN

Avellaneda y Gorena (4146) CONCEPCION-TUCUMAN

PROMOCION IMA

José M.Moreno 40-3° piso (1424) CAPITAL FEDERAL

SERVICIO MEDICO PARA EMPRESAS (S.E.M.P.R.E.)

Av.del Trabajo 5587 (1439) CAPITAL FEDERAL

FLACSO

Federico Laroze 2101 (1426) CAPITAL FEDERAL

ESTUDIO GENESIS

Alfonsina Storni 780 (2500) CAÑADA DE GOMEZ-SANTA FE

DEPARTAMENTO DE ASISTENCIA MEDICA INTEGRAL

Anchorena 1858-1° piso (1425) CAPITAL FEDERAL

PANAMERICAN ASSIS CARD ARGENTINA

Alsina 1214-1° piso (1088) CAPITAL FEDERAL

PRESERFAR S.A.

Vuelta de Obligado 1808-2° piso (1428) CAPITAL FEDERAL

APRES

Andrea Baranda 134 (1878) QUILMES

I.M.S.I.

Rivadavia 239-1° piso (1642) SAN ISIDRO

SERVICIO MEDICO ASISTENCIAL PROMOTORAS
Av.Santa Fé 951-6° piso (1059) CAPITAL FEDERAL

PLUS MEDICO
Lavalle 1759-7° piso-Dto.A (1048) CAPITAL FEDERAL

FAMYL S.A.
Rivadavia 143 (6000) JUNIN

SAN ISIDRO SALUD
Chacabuco 311-1° piso (1642) SAN ISIDRO

SANTA CLARA S.A.
La Tablada 117 (5000) CORDOBA

PREME
Bolivar 55 (5000) CORDOBA

OBICE S.A.
Av.Callao 1014-8° piso (1023) CAPITAL FEDERAL

PLAN CIMA
NACIONES UNIDAS 109-BO.PARQUE VELEZ SARFIELD (5016) CORDOBA

CIPAC
José Marmol 65 (1183) CAPITAL FEDERAL

PAMPA (HOSPITAL BRITANICO)
Perdriel 36 (1280) CAPITAL FEDERAL

PREMEDIN
Venezuela 1296 (1095) CAPITAL FEDERAL

AMID S.A.
Maipú 62-4° piso (1084) CAPITAL FEDERAL

FRE MED

Córdoba 1372 (1120) CAPITAL FEDERAL

CENTRO MEDICO SANTA CRUZ

San Cruz 2483 (1232) CAPITAL FEDERAL

CORPORACION MEDICA DEL SUR

15 de noviembre 1263 (1130) CAPITAL FEDERAL

MEDYSAN

Santiago 1152 (4000) TUCUMAN

ULTRA MEDICINA

Santa Fe 1503 ROSARIO

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ANNEX 3 : BRAZILIAN H.M.O. STUDY

1 OCTOBER 1984

HOSPITAL CORPORATION OF AMERICA

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H.M.O. NAME AND CITIES SERVED	YEARS OF OPERATION	KEY MANAGERS	TYPES OF PLANS	NR. OF EMPLOYEES COVERED (FROM/TO)	COMMERCIAL SECTOR DISTRIBUTION	PROJECTED 1ST SEMESTER OP. CONS./ADMISS.
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BAHIA						
-CLINICA SANTA CECILIA LTDA. AV. SETULIO VARGAS, NR. 663, CENTRO - FEIRA DE SANTANA TELEFONE: 221-5020; 221-1290 FEIRA DE SANTANA, SALVADOR	04	*EVANDRO FERRAZ MELO / DIRETOR MEDICO (MEDICO) *HERCULES CUSTODIO BRAGA / DIR. FINANCEIRO (MEDICO)	STANDARD EXECUTIVE	1000 5000	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	31800 630
-PREVINA CLIN. DIAG. & MED. PREVENTIVA LTDA. RUA BARAO DE LORETO, NR. 21, GRACA - SALVADOR TELEFONE: 237-1122; 245-6197; 235-8263 SALVADOR, ALAGOINHAS, CAMACARI, CANDEIAS, CATU, FEIRA DE SANTANA, ILHEUS, SAO SEBASTIAO DO PASSE, SIMOES FILHO	08	*EDSON DA S. TELES (MEDICO) *GERALDO DE A. SERRA (MEDICO) *ROBERTO DA SILVA VIEIRA (ADMINISTRADOR) *JOSE NEVES FILHO (MEDICO)	P.P.O.	5000 10000	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	12720 252
-PROMEDICA PROT. MEDICA A EMPRESAS LTDA. AV. 7 DE SETEMBRO, NR. 1839, VITORIA - SALVADOR TELEFONE: 247-4611 SALVADOR, CATU, SAO SEBASTIAO DO PASSE, SIMOES FILHO, CANDEIAS, CAMACARI, VITORIA DA CONQUISTA, CRUZ DAS ALMAS	15	*JORGE VALENTE FILHO / SUPERINTENDENTE (MEDICO) *GUILHERME H.S. MARTINS / DIRETOR HOSPITALAR (MEDICO) *ERALDO D.M. COSTA / DIRETOR MEDICO (MEDICO)	STANDARD EXECUTIVE	25000 N.A.	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	349800 6930
-SAMES SERV. ASSIST. MED. DE SALVADOR LTDA. CENTRO EMPRES. IGUATEMI, II-CJ. 101, PITUBA SALVADOR TELEFONE: 244-5177 SALVADOR, CAMACARI	17	*MATERCIO F. DE SOUZA / DIRETOR MEDICO (MEDICO) *MIGUEL J.N. LESSA / DIRETOR ADMINISTRATIVO (MEDICO) *ROBERTO DE O. NASCIMENTO / DIRETOR FINANCEIRO (MEDICO)	STANDARD EXECUTIVE	5000 10000	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	46640 924

CITIES SURVEYED IN THE STATE: 12 (VIDE SAMESF -EST. PE)

RATES CHARGED IN THE STATE: STANDARD - FROM: CR\$ 17000
TO: CR\$ 22000

P.P.O. : N.A.

EXECUTIVE - FROM: CR\$ 75000
TO: CR\$ 82000

11/11

H.M.D. NAME AND CITIES SERVED	YEAR OF OPERATION	KEY MANAGERS	TYPES OF PLANS	NR. OF EMPLOYEES COVERED (FROM/TO)	COMMERCIAL SECTOR DISTRIBUTION	PROJECTED 1ST SE- NISTER OF CONS./ADMISS.
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DISTRITO FEDERAL

-PRO-SAUDE SERV.MED-HOSP. DE BRASILIA S/A. SCRS 513-BL.A-LOJAS 5 & 6,PL.PILOTO- D.F. TELEFONE: 243-8787 BRASILIA, ANAPOLIS (GO)	02	*WALBRON STECKELBERG / SU - PERINTENDENTE (MEDICO) *NERI J.BOTTI/DIRETOR ADMI- NISTRATIVO (MEDICO) *ELITON G. VAZ /DIRETOR FI- NANCEIRO (ADVOGADO) *MARCELO R.DE LUCENA /DIRE- TOR DE MARKETING (PUBLICI- TARIO)	STANDARD EXECUTIVE	10000 25000	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	40280 798
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-COMEPA S/A. SERVICOS MEDICOS S.R.T.S.B. 08 NR. 50 - BLOCO "B" 102/132 - PLANO PILOTO - DISTRITO FEDERAL TELEFONE: 223-5025 BRASILIA, SOBRADINHO	02	*FLAVIO CAUTELLA /DIRETOR PRESIDENTE (MEDICO) *FRANCISCO DE P.CLEFFI /DI- RETOR SUPERINT. (MEDICO) *NELSON V. DE PAULA / DIRE- TOR CLINICO (MEDICO) *ANTONIO J. VOLPI /DIRETOR FINANCEIRO (ECONOMISTA)	STANDARD EXECUTIVE	N.A. N.A.	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	N.A. N.A.
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-AMH ASSISTENCIA MEDICO-HOSPITALAR LTDA. SEP/SUL QUADRA 710/910 -LOTE "B"- DISTRITO FEDERAL TELEFONE: 244-2548 E 244-8884 BRASILIA	06	*VIETE DE FREITAS /DIRETOR GERAL (MEDICO)	STANDARD EXECUTIVE	1000 5000	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	N.A. N.A.
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CITIES SURVEYED IN THE FEDERAL DISTRICT: 02

RATES CHARGED IN THE FEDERAL DISTRICT - STANDARD : FROM - CR\$ 10000
TO - CR\$ 24000

EXECUTIVE: FROM - CR\$ N.A.
TO - CR\$ N.A.

21

H.M.D. NAME AND CITIES SERVED	YEAR OF OPERATION	KEY MANAGERS	TYPES OF PLANS	NR. OF EMPLOYEES COVERED (FROM/TO)	COMMERCIAL SECTOR DISTRIBUTION	PROJECTED 1ST SECTESTER	OP. CONS./ADMISS.
ESPIRITO SANTO							
-GRUMED - GRUPO MEDICO LTDA. AV. DES.SANTOS NEVES, NR 837, P.DO CANTO - VITORIA TELEFONE:227-2908; 227-2044; 227-2686 VITORIA, COLATINA, LINHARES, CACHOEIRO DO ITAPEMIRIM	05	*CELSO ANTONIO /SUPERINTENDENTE (MEDICO) *LUIZ A.B.MUNES /DIRETOR FINANCEIRO (MEDICO) *THAUNAR N.B.ANTONIO /DIRETORA PRESIDENTE (MEDICA)	STANDARD	5000 10000	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	N.A.	N.A.
-SAMES SOC.ASSIST.MED.DO ESP.SANTO AV.LEITAO DA SILVA, NR.181-PRAIA DO SUA VITORIA TELEFONE: 227-1659 VITORIA, COLATINA, CACHOEIRO DO ITAPEMIRIM, LINHARES	N.A.	*HAYLSON L.JUNGER/DIRETOR PRESIDENTE (MEDICO) *TARCISIO J.LAHUD /DIRETOR TECNICO (MEDICO) *CLEIDE M.RILLO /DIRETORA ADMIN.(ADM.HOSPITALAR)	STANDARD EXECUTIVE	1000 5000	PRIMARY: 5.2% SECONDARY: 42.2% TERTIARY: 52.6%	(*)14020 (*)	249
-SEMIC-ES SERV.MED.A IND.E COM. DO E.S.LTDA. R.CARLOS MOREIRA LIMA, NR 275, FERREIRA - VITORIA TELEFONE: 227-7599; 227-0202 VITORIA, COLATINA, LINHARES, CACHOEIRO DO ITAPEMIRIM	06	*SYLVIO R.DE F.COSTA /DIRETOR PRESIDENTE (MEDICO) *ROMUALDO GIANARDOLI /SUPERINTENDENTE (DENTISTA)	STANDARD FREE CHOICE	5000 10000	PRIMARIO: N.A. SECUNDARIO: N.A. TERCIARIO: N.A.	44090	873

(*) ACTUAL DATA SUBMITTED BY H.M.D.

CITIES SURVEYED IN THE STATE: 04

RATES CHARGED IN THE STATE-STANDARD:FROM: CR\$ 11000
TO: CR\$ 15000

EXECUTIVE:FROM:CR\$ N.A.
TO:CR\$ N.A.

FREE CHOICE:FROM: CR\$ N.A.
TO: CR\$ N.A.

107

H.M.O. NAME AND CITIES SERVED	YEAR OF OPERATION	KEY MANAGERS	TYPES OF PLANS	NR. OF EMPLOYEES COVERED (FROM/TO)	COMMERCIAL SECTOR DISTRIBUTION	PROJECTED 1ST SEMESTER OP. CONS./ADMISS.
GOIAS						
-GOIASCLINICAS EMPREEND.SOCIAIS S/C.LTDA. RUA 9-A, NR 80, AEROPORTO -GOIANIA TELEFONE: 223-3573 GOIANIA, ANAPOLIS	11	*ELIANA S.FROTA /DIRETORIA PRESIDENTE (MEDICA) *VALERIA FROTA /DIRETORA SUPERINTENDENTE (MEDICA)	STANDARD EXECUTIVE	5000 10000	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	31800 630
-MATERNIDADE E HOSPITAL S.JUDAS TADEU LTDA. AV.HOMESTINO GUILMARDES, NR. 810 -CAMPINAS GOIANIA TELEFONE: 223-7875 GOIANIA	02	*TEREZINHA DE J.A.ABREU/DIRETORIA PRESIDENTE (MEDICA) *PAULO S.V.M.BRITO /DIRETOR MARKETING (MEDICO)	STANDARD EXECUTIVE	1000 5000	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	16960 336
-SAMED ASSIST.MEDICO HOSPITALAR LTDA. RUA 25-A,NR 336,AEROPORTO -GOIANIA TELEFONE: 224-0522 GOIANIA, ANAPOLIS,	11	*FLEMON DE CASTRO /DIRETOR FINANCEIRO (MEDICO) *LUIZ A.DO E.SANTO /DIRETOR ADMINISTRATIVO (MEDICO) *DOMINGOS B.CORDEIRO FILHO DIRETOR TECNICO (MEDICO) *GETULIO P.DE ARAUJO /DIRETOR (MEDICO)	STANDARD	5000 10000	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	42400 840

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CITIES SURVEYED IN THE STATE: 02

RATES CHARGED IN THE STATE-STANDARD: FROM:CR\$ 12000
TO:CR\$ 16000

EXECUTIVE:FROM:CR\$ 24000
TO:CR\$ 30000

253

H.M.O. NAME AND CITIES SERVED	YEARS OF OPERATION	KEY MANAGERS	TYPES OF PLANS	NR. OF EMPLOYEES COVERED (FROM/TO)	COMMERCIAL SECTOR DISTRIBUTION	PROJECTED 1ST SEMESTER OP. LGNS./ADMISS.
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MATO GROSSO DO SUL

-CENTRO MEDICO LTDA. RUA 15 DE NOVEMBRO, NR. 965 -CAMPO GRANDE TELEFONE: 624-7254 CAMPO GRANDE	06	*LUDE S.CACAO /DIRETOR CLINICO (MEDICO) *JOAO A.A.E SILVA /DIRETOR ADMINISTRATIVO (MEDICO) *FERNANDO J.FERREIRA /DIRETOR FINANCEIRO (MEDICO)	STANDARD	1000 5000	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	21200 420
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CITIES SURVEYED IN THE STATE: 01

RATES CHARGED IN THE STATE-STANDARD :FROM:CR\$ 12000
TO:CR\$ 17000

22/5

H.M.O. NAME AND CITIES SERVED	YEARS OF OPERATION	KEY MANAGERS	TYPES OF PLANS	NR OF EMPLOYEES COVERED (FROM/TO)	COMMERCIAL SECTOR DISTRIBUTION	PROJECTED 1ST SEMESTER OP. COMS./ADMISS.
MINAS GERAIS						
-CLINICA SAO JUDAS TADEU ASSIST. MEDICA HOSPITALAR S/C. LTDA. RUA MAL. FLORIANO, NR. 193-A, PORTO NOVO ALEM PARAIIBA TELEFONE: 462-1211 ALEM PARAIIBA	04	*FERNANDO P. DA ROCHA FILHO /DIR. GERENTE (MEDICO) *HOMERO J. POVOLERI /DIR. TECNICO (MEDICO) *HILTON RESAZIO / DIRETOR COMERCIAL (MEDICO)	STANDARD EXECUTIVE	1000 5000	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	11728 233
-AMH ASSISTENCIA MEDICA HOSPITALAR LTDA. RUA AIACRES, NR. 2125- LOURDES TELEFONE: 337-0237 BELO HORIZONTE	20	*FERNANDO MUEKAY /DIRETOR CLINICO (MEDICO) *JOSE E.C. ALMEIDA /DIRETOR PRESIDENTE (MEDICO) *LIMIRIO DE A. MELO /DIRETOR CLINICO (MEDICO) *EMALDO C.G. DA SILVA /DIR. ADMINISTRATIVO (MEDICO)	STANDARD	N.A. N.A.	PRIMARY: 1.5% SECONDARY: 43.5% TERTIARY: 55.0%	N.A. N.A.
-AMICO ASSISTENCIA MEDICA A INDUSTRIA E COMERCIO LTDA. R. FERNANDES TOURINHO, NR. 503, SAVASSI - BELO HORIZONTE TELEFONE: 225-2211 BELO HORIZONTE, CONTAGEM, SANTA LUZIA, VESPA-SIANO, ITABIRITO, NOVA LIMA	13	*FERDINANDO A.C. ROCHA /DIR. MEDICO REGIONAL (MEDICO) *EULER C. CHAVES /DIR. ADM. REGIONAL (ADM. EMPRESAS)	STANDARD EXECUTIVE P.P.O. FREE CHOICE	25000 50000	PRIMARY: 2.7% SECONDARY: 69.8% TERTIARY: 27.5%	SEE AMICO DATA
-CLIMINAS LTDA. PRONTO SOCORRO AV. D. PEDRO I, NR. 645- FAMPULHA TELEFONE: 441-6709 BELO HORIZONTE	09	*CELESTINO MARRA /DIRETOR CLINICO (MEDICO) *TACITO B. MARRA /ADMINISTRADOR (EXECUTIVO) *CASSIO DE M. MARRA /DIRETOR CLINICO (MEDICO)	STANDARD EXECUTIVE	N.A. N.A.	PRIMARY: 2.0% SECONDARY: 42.5% TERTIARY: 55.5%	N.A. N.A.
-HOSPITAL BELO HORIZONTE AV. ANTONIO CARLOS, NR. 1694 -BELO HORIZONTE TELEFONE: 444-6866 BELO HORIZONTE	02	N.A.	STANDARD EXECUTIVE	5000 10000	PRIMARY: 3.0% SECONDARY: 17.0% TERTIARY: 80.0%	N.A. N.A.
-HOSPITAIS REUNIDOS S/A AV. AFONSO PENA, NR. 2093, SAVASSI-BELO HORIZONTE TELEFONE: 224-9444 BELO HORIZONTE, SARAHENHA	11	*LUCILIO D.O. VIEIRA /DIRETOR PRESIDENTE (MEDICO) *LEYLA M. VIEIRA /ADMINISTRADORA	STANDARD EXECUTIVE	5000 10000	PRIMARY: 2.7% SECONDARY: 69.8% TERTIARY: 27.5%	16960 336
-SAMT SERVICIOS DE ASSISTENCIA MEDICA INTEGRAL LTDA. RUA CUPITIBA, NR. 1045, LOURDES - B. HORIZONTE TELEFONE: 337-059 BELO HORIZONTE, CONTAGEM	13	*JOSE R. CASTILHO /DIR. TEC. (MEDICO) *INEYDA M.C. CASTILHO /DIR. AD. MINISTERIAL. (ADM. EMPRESAS)	STANDARD P.P.O. FREE CHOICE	N.A. N.A.	PRIMARY: -1.8% SECONDARY: 40.6% TERTIARY: 57.6%	N.A. N.A.
-SEMIO SERVICIOS MEDICOS A INDUSTRIA E COMERCIO DE MINAS GERAIS S/C. LTDA. AV. DO BONTORNO, NR. 6213- SAVASSI BELO HORIZONTE	N.A.	*JOSE A.B. CANAAN /DIR. ADMINISTRATIVO (MEDICO) *JOSE F. ROSSI /DIRETOR MEDICO (MEDICO)	STANDARD EXECUTIVE	N.A. N.A.	PRIMARY: 2.7% SECONDARY: 69.8% TERTIARY: 27.5%	N.A. N.A.

157

H.M.O. NAME AND CITIES SERVED	'YEARS OF 'OPERA - 'TION	KEY MANAGERS	'TYPES OF PLANS '=====	'NR. OF EMPLOYEES 'COVERED (FROM/TO)	'COMMERCIAL SECTOR 'DISTRIBUTION	'PROJECTED 1ST SE- 'MESTER 'OP. CONS./ADMISS.
MINAS GERAIS						
-BV CLINICAS ASSIST.MED.ESPECIALIZADA LTDA. RUA TERCILO OTONI, NR. 288,CENTRO -GOVERNA DOR VALADARES TELEFONE:30-0637; 30-0648 GOVERNADOR VALADARES	07	RICARDO A.R.PEREIRA /DIRE- TOR MEDICO (MEDICO) MARCIO J.R.PEREIRA /DIRE- TOR ADMINISTRATIVO (ENGE - NHEIRO)	STANDARD (R)	1000 5000	PRIMARY: 10.0% (R) SECONDARY: 12.0% TERTIARY: 78.0%	155 --
-AME ASSISTENCIA MEDICA A EMPRESAS LTDA. RUA DO SAMPÃO, NR. 376, CENTRO - JUIZ DE FORA TELEFONE:212-5400, 212-5116 E 212-3521 JUIZ DE FORA	N.A.	SALDISIO FELLET /DIRETOR PRESIDENTE (MEDICO)	STANDARD EXECUTIVE	25000 N.A.	PRIMARY: 2.7% SECONDARY: 69.8% TERTIARY: 27.5%	57240 1134
-CEMOBEM CENTRO MED.CODONTOL.BENFICA RUA INES GARCIA, NR.90 , BENFICA -JUIZ DE FORA TELEFONE: JUIZ DE FORA, GOVERNADOR VALADARES	04	LUIZ F.PEDINA /DIRETOR PRE SIDENTE (MEDICO) ROSERIO DE OLIVEIRA /DI- TOR CLINICO (MEDICO) SEBASTIAO AVELAR /DIRETOR TESOUREIRO (MEDICO)	STANDARD	5000 10000	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	14840 294
-SAMEC LTDA. SERV. DE ASSIST.MED. A EMPRESAS RUA CEL. DOMICIANO, NR. 111 - CENTRO MURIAE TELEFONE: 721-2974 MURIAE	04	JOSE S.PEREIRA /DIRETOR PRESIDENTE (MEDICO) WALTER A.SARCA /SECRETAR- IO (MEDICO) JOSE A.GOMES /TESOUREIRO (MEDICO)	STANDARD (R)	1000 5000	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	10600 210
-POLICLINICA UBERLANDIA LTDA. AV. JOAO FIMMEIRO, NR.760, CENTRO -UBERLAN- DIA TELEFONE:235-4465 UBERLANDIA	09	CELSO F.PEDROSA /DIRETOR PRESIDENTE (MEDICO) FALDO R.SALOMAO / DIRETOR FINANCEIRO (MEDICO)	STANDARD (R)	1000 5000	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	16960 --
-PRO-SAUDE PREST.SERV.MED.-LAB. LTDA. AV. JOAO FIMMEIRO, NR. 1068, CENTRO-UBERLAN- DIA TELEFONE: 235-4726 UBERLANDIA, UBERABA	07	JOSE M.O. C.SANTOS /DIRE- TOR (MEDICO)	STANDARD	1000 5000	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	16960 336

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H.M.O. NAME AND CITIES SERVED	YEARS OF OPERATION	KEY MANAGERS	TYPES OF PLANS	NR. OF EMPLOYEES COVERED (FROM/TO)	COMMERCIAL SECTOR DISTRIBUTION	PROJECTED 1ST SEMESTER OP. CONS./ADMISS.
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MINAS GERAIS

-SERVED SERV.MED.UBERLANDIA S/C. LTDA. AV. CESARIO ALVIN, NR.265, CENTRO-UBERLANDIA TELEFONE: 235-4500 UBERLANDIA	06	\$DECIO C.SANTOS /DIRECTOR ADMINISTRATIVO (MEDICO) \$DIVANOR E.BARCELOS /DIRECTOR CLINICO (MEDICO) \$IVONE P.R.SANTOS /DIRETORA	STANDARD (*)	5000 10000	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	16760 -.-
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(*) ONLY OUTPATIENT CARE

(**) ACTUAL DATA SUBMITTED BY H.M.O.

CITIES SURVEYED IN THE STATE: 13

RATES CHARGED IN THE STATE-	STANDARD (*) -	FROM :CR\$	N.A.
		TO :CR\$	N.A.
	STANDARD -	FROM :CR\$	7000
		TO :CR\$	20000
	EXECUTIVE -	FROM :CR\$	16000
		TO :CR\$	45000
	P.P.O. -	FROM :CR\$	25000
		TO :CR\$	50000
	FREE CHOICE -	FROM :CR\$	40000
		TO :CR\$	90000

259

H.M.O. NAME AND CITIES SERVED =====	YEAR OF OPERATION	KEY MANAGERS =====	TYPES OF PLANS =====	NR. OF EMPLOYEES COVERED (FROM/TO)	COMMERCIAL SECTOR DISTRIBUTION	PROJECTED 1ST SE- MESTER OP. CONS./ADMISS.
PARA ----- -CLINISA CLIN.MAT.INFANTIL SANT'ANA LTDA. AV.ALCINDO CADELA, NR. 104,UMARISAL -BELEM TELEPHONE: 223-0006 BELEM	05	*BERNЕСТO DOS S.CARDOZO /DI- TOR CLINICO (MEDICO) *MARIA R.DE A.CARDOZO /DIRE- TORA GERAL (MEDICA) *JOSE V.B.PEREIRA /DIRETOR FINANCEIRO (ADMINISTRADOR)	STANDARD	1000 5000	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	12190 242
-PROTECAO E ASSIST.MEDICA A SAUDE LTDA. AV. GOVERNADOR JOSE MALCHER, NR.1099, NAZA- RE -BELEM TELEPHONE: 224-3882; 224-1572 BELEM	04	*GEORGES ISHAK /DIRETOR ADM COMERCIAL (MEDICO) *NEMER FRAIHA FILHO /DIRE- TOR CLINICO (MEDICO) *ARMINDO J.P.DIAS /DIRETOR FINANCEIRO (MEDICO)	STANDARD	1000 5000	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	31800 630
-SAMES-SERV.DE ASSIST.MEDICA EM GERAL AV.GENERALISSIMO DEODORO, NR.511, UMARIZAL BELEM TELEPHONE: 222-1168 E 222-4692 BELEM	11	*LANDOLPHO MATTOS /DIR.ADM. (ADM.EMPRESAS) *LEONI F.DE MATTOS /DIR.GE- RAL (MEDICO) *LANDOALDO F.DE MATTOS /DIR FINANC. (MEDICO) *LANDRI F. DE MATTOS /DIR. TECNICO (MEDICO) *LAERCIO F.DE MATTOS /DIR. P.SOC. (MEDICO)	STANDARD	1000 5000	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	25001 495

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CITIES SURVEYED IN THE STATE: 01

RATES CHARGED IN THE STATE-STANDARD :FROM:CR\$ 13000
TO:CR\$ 20000

290

H.M.O. NAME AND CITIES SERVED	YEAR OF OPERATION	KEY MANAGERS	TYPES OF PLANS	NR. OF EMPLOYEES COVERED (FROM/TO)	COMMERCIAL SECTOR DISTRIBUTION	PROJECTED 1ST SEMESTER OF CONS./ADMISS.
PARANA						
-HOSPITAL CLIMON LTDA. (HOSP. STA. MONICA) RUA OSORIO RIBAS DE PAULA, NR. 790, CENTRO APUCARANA TELEFONE: 22-2322 APUCARANA	N.A.	#IZIDRO TRIBULATO #JAIR C. TRIBULATO	STANDARD EXECUTIVE	0 1000	PRIMARY: 60% SECONDARY: 20% TERTIARY: 20%	(#) 4630 (#) 778
-ASSIST. MED. AUXILIADORA RUA BARAO DO RIO BRANCO, NR. 63 -14 ANBAR SALA 1411 -CENTRO -CURITIBA TELEFONE: 224-8494 CURITIBA	42	#DR. LUDOVICO RYDYGIER /BIRETOR (MEDICO)	STANDARD	0 1000	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	7632 151
-ORGANIZACAO MEDICA CLIMINHAUER LTDA. S/C. AV. SEATEL, NR. 1102, PATEL -CURITIBA TELEFONE: 222-2008 CURITIBA, SAO JOSE DOS PINHAIS	15	#JOSE C. MURICY /DIRETOR PRE SIDENTE (MEDICO) #CARLOS A. DA V. MERCER /DIR. CLINICO (MEDICO) #JOELSON Z. SAMSONOWSKI /DIR. CIRURGICO (MEDICO) #MARGEN P. CASTRO /DIR. ODONTOLOGIA (DENTISTA)	STANDARD EXECUTIVE	10000 25000	PRIMARY: 30.91% (#) 175130 (#) SECONDARY: 27.69% TERTIARY: 39.40%	352
-PARANA CLINICAS LTDA. AV. 7 DE SETEMBRO, NR. 5293, AGUA VERDE CURITIBA TELEFONE: CURITIBA, SAO JOSE DOS PINHAIS	13	#WALFRIDO M. LEAL /DIRETOR SUPERINTENDENTE (MEDICO) #HAMILTON C. LEAL JR. /DIRETOR FINANCEIRO (ADM. EMPR.) #ANTONIO DA SILVA /GERENTE GERAL (MATEMATICO)	STANDARD EXECUTIVE	10000 25000	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	N.A. N.A.
-UNICLINICAS ASSIST. MED. HOSPITALAR LTDA. R. DR. CARLOS DE CARVALHO, NR. 628, CENTRO CURITIBA TELEFONE: 224-2326 CURITIBA, LONDRINA, MARINGA	10	#IGNACIO HIRATA /DIR. ADM. FINANCEIRO (ADM. EMPRESAS) #NELSON MARCELIANO /DIRETOR CLINICO (MEDICO)	N.A.	1000 5000	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	N.A. N.A.
-CLIMAR CLINICAS S/C. LTDA. RUA NEG. ALVES MARTINS, NR. 3382, CENTRO MARINGA TELEFONE: 24-5932 MARINGA, CASCAVEL, APUCARANA	03	#JOSE HADDAD /DIRETOR (MEDICO) #JOSE ROBERTO RAFTOUM /DIRETOR CLINICO (MEDICO)	STANDARD EXECUTIVE	1000 5000	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	7844 155

(#) ACTUAL DATA SUBMITTED BY H.M.O.

CITIES SURVEYED IN THE STATE: 06

RATES CHARGED IN THE STATE-STANDARD :FROM:CR\$ 15000
TO:CR\$ 19000

EXECUTIVE:FROM:CR\$ 53000
TO:CR\$ 62000

27/1

H.M.D. NAME AND CITIES SERVED	YEAR OF OPERATION	KEY MANAGERS	TYPES OF PLANS	NBR. OF EMPLOYEES COVERED (FROM/TO)	COMMERCIAL SECTOR DISTRIBUTION	PROJECTED 1ST SEMESTER	OF CONS./ADMISS.
PERNAMBUCO							
-SANESE SERV. DE ASSIST. MED. DO S. FRANCISCO RUA TOBIAS BARRETO, NR. 02, CENTRO PETROLINA TELEFONE: 961-1096 PETROLINA, JUAZEIRO (BA),	04	*ELIAS A. DOS SANTOS / DIRETOR PRESIDENTE (MEDICO)	STANDARD (11)		PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	N.A.	N.A.
-CLINICA BRASIL LTDA. RUA DAS FRONTEIRAS, NR. 189- BOA VIAGEM RECIFE TELEFONE: 231-6900 E 231-6005 RECIFE, OLINDA, CABO, PAULISTA	13	*VALTAYER L.T. DE MELO / DIRETOR (MEDICO) *HELIO POLIS D.C.T. MELO / DIRETORA (MEDICA) *MARIA C. DE M. MONTENEGRO / DIRETORA (REL. PUEBLICAS) *LUIZ J.M.P. PINTO / DIRETOR (MEDICO)	STANDARD EXECUTIVE	5000 10000	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	54272	1075
-CLIN. MED. E CIRURG. DO NORDESTE LTDA. - CLINOR AV. OLIVEIRA LIMA, NR. 1029-A, BOA VISTA - RECIFE TELEFONE: 222-4145; 222-4616 RECIFE, OLINDA, PAULISTA, CABO	19	*MARCENIO DE A. QUINTAS / DIRETOR FINANCEIRO (MEDICO) *THEOPAZIO A. DE AZEVEDO / DIRETOR SUPERINTENDENTE (MEDICO) *ELIZER M. DE LIMA / DIRETOR TECNICO (MEDICO)	STANDARD EXECUTIVE	10000 25000	PRIMARY: 1.78Z SECONDARY: 43.75Z TERTIARY: 54.46Z	148400	2940
-CLINICA SANTA HELENA LTDA. RUA DO FAISSANDU, NR. 304, BOA VISTA - RECIFE TELEFONE: 231-2181 RECIFE, CABO, PAULISTA	19	*MANUEL S.F. VIEIRA / DIRETOR PRESIDENTE (MEDICO) *ANTONIO F. VIEIRA / DIR. ADM. FINANCEIRO (ADVOGADO) *FRANCISCO E.F. VIEIRA / DIRETOR ASSISTENTE (MEDICO) *JOSE E.F. VIEIRA / DIRETOR ADJUNTO (AGRICULTOR) *MARIA DA G. TRINDADE / DIRETORA DE EXPANSAO (COMERC.)	STANDARD EXECUTIVE	25000	N.A. PRIMARY: 0.08Z (1) 132293 (1) 3142 SECONDARY: 75,5Z TERTIARY: 24,5Z		
-SEMEFE SERV. MED. DE PERNAMBUCO LTDA. RUA GONCALVES MATA, NR. 95, BOA VISTA RECIFE TELEFONE: 231-6227 RECIFE, OLINDA, CABO, PAULISTA	17	*MOISES E. LOPES / DIRETOR PRESIDENTE (MEDICO) *AMALRY S. SANTIAGO / DIRETOR ADMINISTRATIVO (MEDICO) *BRASIMUNDO F. FURTADO / DIR. TE SOLUREIRO (MEDICO) *FERNANDO C. COSTA / DIRETOR SECRETARIO (MEDICO)	STANDARD	25000	N.A. PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	179352	3553

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H.M.O. NAME AND CITIES SERVED =====	YEARS OF OPERATION	KEY MANAGERS =====	TYPES OF PLANS =====	NR. OF EMPLOYEES (COVERED FROM TO)	COMMERCIAL SECTOR DISTRIBUTION	PROJECTED 1ST SE- MESTER OP. CONS./ADMISS.
RIO DE JANEIRO ===						
-FATIMA ASSISTENCIA MEDICA EMPRESARIAL LTDA. RUA FLORESTA, NR. 113, CENTRO -NOVA IGUAÇU TELEFONE :767-5705 NOVA IGUAÇU, NILOPOLIS	05	*NEWTON P. MONTES /DIRETOR ADMINISTRATIVO (MEDICO) *ORLANDO BOTTARI FILHO /DI- RETOR MEDICO (MEDICO)	STANDARD EXECUTIVE	5000 10000	PRIMARY: 2.6% SECONDARY: 60.4% TERTIARY: 37.0%	12720 252
-AMICO ASSISTENCIA MEDICA A INDUSTRIA E CO- MERCIO LTDA. AV. RIO BRANCO, NR. 45/11ANDAR ,CENTRO - RIO DE JANEIRO TELEFONE:253-6192 RIO DE JANEIRO, NITEROI, SAO JOAO DO MERITI, DUQUE DE CAXIAS, NILOPOLIS, NOVA IGUAÇU, PE- TROPOLIS, SAO GONCALO, ITABUAI	18	*SIDNEY GIAMARUSTI/ DIRETOR ADM.REGIONAL (CONTADOR) *MILTON S. POSENER /DIRETOR MEDICO REGIONAL (MEDICO)	STANDARD EXECUTIVE FREE CHOICE	25000 50000	PRIMARY: 2.6% SECONDARY: 60.4% TERTIARY: 37.0%	SEE AMICO DATA
-EBAM S/A. EMPRESA BRAS. DE ASSIST. MEDICA RUA BONA MARIANA, NR. 220 -RIO DE JANEIRO TELEFONE:296-6102 RIO DE JANEIRO	08	*LUIZ DA M. PAVAN /DIR. MKT. *ROSA E. ALMEIRA /GER. MEDICO (MEDICA)	STANDARD EXECUTIVE FREE CHOICE	25000 50000	PRIMARY: 2.6% SECONDARY: 60.4% TERTIARY: 37.0%	63600 1260
-RIO CLINICAS PREV. MEDICO SOCIAL FRACA SAENS FENA, NR. 55, TIJUCA -R. JANEIRO TELEFONE:209-1242 RIO DE JANEIRO	17	*ANTONIO T. SIMAO/PRESIDENTE (MEDICO) *FLAVIO SAN JUAN/CONSELHEI- RO (MEDICO) *ANTONIO ALEX /CONSELHEIRO (MEDICO) *ELVIRO M. DE S. ROQUE /CON- SELHEIRO (MEDICO)	STANDARD EXECUTIVE FREE CHOICE	50000 N.A.	PRIMARY: 2.6% SECONDARY: 60.4% TERTIARY: 37.0%	127200 2520
-SAMOC S/A SOC. ASSIST. DOS MEDICOS DA ORDEM DO CARMO RUA SILVIO ROMERO, NR. 44 -RIO DE JANEIRO TELEFONE:224-2892 RIO DE JANEIRO	14	*JOAO PINHO FILHO /D. PRES. *CANDIDO DE S. BOTAFOGO /DI- RETOR TECNICO *JOSE R. SCAF /DIR. FINANC.	STANDARD EXECUTIVE	25000 50000	PRIMARY: 2.6% SECONDARY: 60.4% TERTIARY: 37.0%	63600 1260
-SEMES SERVICOS MEDICOS GUANABARA LTDA. RUA ARAUJO FENA, NR. 20 -TIJUCA- R. JANEIRO TELEFONE:264-6792 E 264-0122 RIO DE JANEIRO	16	*FELIX C. ZAIDE /DIRETOR PLA- NEJAMENTO *JOSE CIOCCA /DIRETOR COMER- CIAL *ELIAS COHEN /DIRETOR FINAN- CEIRO *AMADEU N. DOS S. SIMOES/ DI- RETOR ADMINISTRATIVO	STANDARD EXECUTIVE	15000 20000	PRIMARY: 2.6% SECONDARY: 60.4% TERTIARY: 37.0%	N.A. N.A.

2064

H.M.O. NAME AND CITIES SERVED	YEARS OF OFFERATION	KEY MANAGERS	TYPES OF PLANS	NR. OF EMPLOYEES COVERED (FROM/TO)	COMMERCIAL SECTOR DISTRIBUTION	PROJECTED 1ST SEMESTER OP. CONS./ADMISS.
RIO DE JANEIRO -SEMIC SERVICOS MEDICOS A INDUSTRIA E COMERCIO LTDA. RUA CONDE DE IRAJA, NR. 529, BOTAFOGO -R.J. TELEFONE: 266-2246 RIO DE JANEIRO	17	*FLAVIO H.P.FIGUEIREDO /DIRETOR ADM.FIN. (MEDICO) *DIBSENES C.ALVARENGA /DIRETOR MEDICO (MEDICO) *JOSE VALVERDE FILHO /CHEFE MED.ASSISTENCIAL (MEDICO) *JOGENIR LUGON /CHEFE MEDICO HOSPITALAR (MEDICO) *MARIA D.ONENA /CHEFE DEPTO OPERACIONS (TEC.ADM) *JOSE S.V.DE MELO /CHEFE CONTABILIDADE (AUDITOR) *LUIZ M.MAGALHAES /CHEFE RECURSOS HUMANOS (ADM.)	STANDARD EXECUTIVE FREE CHOICE	25000 50000	PRIMARY: 2.6% SECONDARY: 60.4% TERTIARY: 37.0%	84900 1650

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CITIES SURVEYED IN THE STATE: 09

RATES CHARGED IN THE STATE-STANDARD :FROM:CR\$ 10000
TO:CR\$ 26000
EXECUTIVE:FROM:CR\$ 20000
TO:CR\$ 43000
P.P.O :FROM:CR\$ 25000
TO:CR\$ 50000
FREE CHOICE :FROM:CR\$ 35000
TO:CR\$ 85000

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H.M.O. NAME AND CITIES SERVED =====	YEARS OF OPERATION	KEY MANAGERS =====	TYPES OF PLANS =====	NO. OF EMPLOYEES COVERED (FROM/TO)	COMMERCIAL SECTOR DISTRIBUTION	PROJECTED 1ST SE- MESTER OP. CONS./ADMISS.
RIO GRANDE DO SUL						
-SULCLINICA LTDA. RUA GENERAL OSORIO, NR. 454/456, CENTRO - PELOTAS TELEFONE: 25-5855 PELOTAS	12	*DAVID LORENZATO /DIRETOR MEDICO (MEDICO) *CELSOM COSTA /DIRETOR ADMNISTRATIVO (EMPREGARIO)	STANDARD EXECUTIVE	5000 10000	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	N.A. N.A.
-AMIC ASSISTENCIA MEDICA INTEGRADA S/C.LTDA. R.VOLUNTARIOS DA PATRIA, NR. 513 - 301/401 CENTRO - PORTO ALEGRE TELEFONE: 25-4946 PORTO ALEGRE, VIAMAO, ALVORADA, GRAVATAI, CACHOEIRINHA, CANOAS, ESTEIO, SAPUCAIA DO SUL, SAO LEOPOLDO, NOVO HAMBURGO, PELOTAS, CAXIAS DO SUL, CARAZINHO, SANTA MARIA, PASSO FUNDO	03	*EROS C.MAGALHAES /DIRETOR MEDICO (MEDICO) *CARLOS F.QUEIROZ /DIRETOR (MEDICO) *WALTER H.BROCK NETO /DIRETOR (MEDICO) *JOSE C.P.DE SOUZA /DIRETOR (MEDICO) *CIRNE P.TISATTO /DIRETOR ADM. (ADM. DE EMPRESAS)	STANDARD EXECUTIVE	5000 10000	PRIMARY: -. SECONDARY: 24.5% TERTIARY: 75.5%	(R)27660 (R) 43
-POLICLINA CENTRAL LTDA. RUA SANTO ANTONIO, NR. 146 -CENTRO PORTO ALEGRE TELEFONE: 33-3810; 25-0103; 21-7958 PORTO ALEGRE, ALVORADA, CACHOEIRINHA, CANOAS, ESTEIO, GRAVATAI, NOVO HAMBURGO, SAO LEOPOLDO SAPUCAIA DO SUL	21	*MARCIA M.ZADUCHLIVER / DIRETOR GERAL (MEDICO) *JAIINE ZADUCHLIVER /DIRETOR MEDICO (MEDICO)	STANDARD EXECUTIVE FREE CHOICE	25000 50000	PRIMARY: 2.7% SECONDARY: 69.8% TERTIARY: 27.5%	82680 336
-SERVIDED SERV.IE ASSISTENCIA MEDICA LTDA. AV.INDEPENDENCIA, NR. 944,INDEPENDENCIA - PORTO ALEGRE TELEFONE: 27-2866; 24-3400 PORTO ALEGRE, CACHOEIRINHA, CANOAS, ESTEIO, SAO LEOPOLDO, ALVORADA, GRAVATAI, VIAMAO, PELOTAS, SANTA MARIA, PASSO FUNDO, NOVO HAMBURGO, CAXIAS DO SUL	08	*MILTON S.ZUCKERMANN /DIRETOR GERAL (MEDICO) *THIERRY A.S.OLIVEIRA /DIRETOR TECNICO (MEDICO) *CARLOS A.T.P.DIAS /DIR.ADM FINANCEIRO (ODONTOLOGO)	STANDARD EXECUTIVE	1000 5000	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	N.A. N.A.
-SEMES MEDICINA DE GRUPO LTDA. RUA CEL. NIEDERAUER, NR. 1569-CENTRO SANTA MARIA TELEFONE: 221-5272 SANTA MARIA	04	*RAYMUNDO J.D.DE C.LEITAO / DIRETOR (MEDICO) *VALKIRIA BORGES /DIRETORA (MEDICA)	STANDARD (R)	1000 5000	PRIMARY: 1.2% SECONDARY: 40.5% TERTIARY: 58.3%	(R)5290 -.

209

H.M.O. NAME AND CITIES SERVED	YEARS OF OPERATION	KEY MANAGERS	TYPES OF PLANS	NR. OF EMPLOYEES COVERED (FROM/TO)	COMMERCIAL SECTOR DISTRIBUTION	PROJECTED 1ST SEMESTER OP. CONS./ADMISS.
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RIO GRANDE DO SUL

-SALUX SERVICO DE ASSISTENCIA MEDICA LTDA. AV. ALBERTO BINS, NR. 802, CENTRO - P. ALEGRE TELEFONE: 24-3481 PORTO ALEGRE, CAXIAS DO SUL, NOVO HAMBURGO SAC LEOPOLDO, CANDAS, GRAVATAI, PASSO FUNDO, PELOTAS, SANTA MARIA	10	*GILBERTO S. DA SILVA / DIRETOR ADM. FIN. (ADMINISTR.) *MIRIAM M. MENTZ / DIRETORA (ADMINISTRADORA) *NILSON LANZIOTTI / DIRETOR COMERCIAL (ADMINISTRADOR) *RUI B. DOS SANTOS / DIRETOR TECNICO (MEDICO) *LARRY GIACOBBS / DIRETOR TECNICO (MEDICO)	STANDARD EXECUTIVE	25000	N.A. PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	103350 2048
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(**) ONLY OUTPATIENT CARE

(*) ACTUAL DATA SUBMITTED BY H.M.O.

CITIES SURVEYED IN THE STATE: 17

RATES CHARGED IN THE STATE - (*) STANDARD: FROM: CR\$ N.A.
TO: CR\$ N.A.

STANDARD : FROM: CR\$ 11000
TO: CR\$ 16000

EXECUTIVE: FROM: CR\$ 73000
TO: CR\$ 82000

FREE CHOICE: FROM: CR\$ 180000
TO: CR\$ 190000

2185

H.M.O. NAME AND CITIES SERVED =====	YEARS OF OPERATION	KEY MANAGERS =====	TYPES OF PLANS =====	NO. OF EMPLOYEES COVERED (FROM TO)	COMMERCIAL SECTOR DISTRIBUTION	PROTECTED 1ST SE- CTOR OP. CONS. /ADMISS.
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SANTA CATARINA
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-POLICLINICA SANTA CATARINA LTDA.
RUA SANTOS SARAIVA, NR.329, FLORIANOPOLIS
TELEFONE:44-0094
FLORIANOPOLIS

N.A. LUIZ ROBERTO MOREIRA /DI-
RETOR PRESIDENTE (MEDICO)

STANDARD (*)

1000 5000

PRIMARY: N.A. N.A. N.A.
SECONDARY: N.A.
TERTIARY: N.A.

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(*) ONLY OUTPATIENT CARE

CITY SURVEYED IN THE STATE:01

RATES CHARGED IN THE STATE:STANDARD-FROM:CR\$ 8000
TO:CR\$ 10000

270

H.M.O. NAME AND CITIES SERVED	YEAR OF OPERATION	KEY MANAGERS	TYPES OF PLANS	NR. OF EMPLOYEES COVERED (FROM/TO)	COMMERCIAL SECTOR DISTRIBUTION	PROJECTED 1ST SE- MESTER OP. CONS./ADMISS.
SÃO PAULO						
-SAMAM SERV.DE ASS.MED.DE AMERICANA S/C.LTDA RUA 7 DE SETEMBRO, NR. 751,CENTRO-AMERICANA TELEFONE:61-0269; 61-0313 AMERICANA	09	BARLEY GELMINI /DIRETOR PRE SIDENTE (MEDICO) PLINIO ZEBEZ /DIRETOR CLI- NICO (MEDICO) LANCELOT E.CAMARINI /DIRE- TOR ADM.FINANC. (ECONOM.)	STANDARD EXECUTIVE	1000	5000 PRIMARY: N.A. SECONDARY:73.08Z TERTIARY:26,92Z	(1)14880 (1) 78
-ARAMED S/A MEDICINA IND.E COM ASSOCIADA AV. MAUA, NR. 670, CENTRO - ARARAQUARA TELEFONE: 36-1366 ARARAQUARA, MATAO		PAULO H.SCHULTEN /DIR.ADM. (MEDICO) OTAVIO A.PINTO /DIR.CLINI- CO (MEDICO)	STANDARD EXECUTIVE	1000	5000 PRIMARY: N.A SECONDARY: N.A TERTIARY: N.A	21561 427
-CLINICAS BEBEDOURO S/A PRACA VALENCIO DE BARROS, NR. 59, CENTRO - BEBEDOURO TELEFONE: 42-2992 BEBEDOURO	03	ABEL A.F.TOLLER /DIRETOR FINANCEIRO (MEDICO) CARLOS E.P.MIGLIANO /DIRE- TOR CLINICO (MEDICO)	STANDARD EXECUTIVE	1000	5000 PRIMARY: N.A SECONDARY: N.A TERTIARY: N.A	9540 185
-EMED SERV.MEDICOS HOSPITALARES S/C.LTDA. AV.PROF.CARVALHO PINTO, NR. 53-CRESCUMA TELEFONE: 431-3000 CAEIRAS	12	WALTER FERRARESI /DIRETOR ADMINISTRATIVO (MEDICO) JOSE C.B.CARVALHO /DIRETOR CLINICO (MEDICO) DANILO BERNARDIMELLO / SO- CIO PROPRIETARIO (MEDICO) VITOR ATIQUE /SOCIO-PRO - PRIETARIO (MEDICO) IRINEU SPIANDORELLO /SOCIO PROPRIETARIO (MEDICO) CLARISVALDO H.FILHO /SOCIO PROPRIETARIO (MEDICO) SILAS R.SALUM /SOCIO PRO - PRIETARIO (MEDICO)	STANDARD	5000	10000 PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	N.A. N.A.
-CAMFILINICAS S/C.LTDA. RUA COELHO NETO, NR. 50,EUANABARA -CAMPINAS TELEFONE: 31-2255 CAMPINAS,INDAIATUBA, VALINHOS, VINHEDO, SORO- CABA, PAULINIA, LINEIRA, AMERICANA, ITU, PI- RACICABA, SALTO	05	SERGIO L.R.PORCIANO /DIRE- TOR CLINICO (MEDICO) CRESO B.COIMBRA /DIRETOR TECNICO (MEDICO) JOSE R.N. FRAGOSAS /DIR.ADM FINANCEIRO (ADVOGADO) CLAUDIONOR MELLO /DIR.CON- VENTOS/COMMERES (ECONOM)	STANDARD EXECUTIVE	5000	10000 PRIMARY: 1.5Z SECONDARY: 36.2Z TERTIARY: 68.3Z	(1)47636 (1) 15.2
-MEDICAMP S/C.LTDA. RUA CONEGO NERI, NR. 157,EUANABARA-CAMPINAS TELEFONE: 41-5666 CAMPINAS,AMERICANA, MOGI-MIRIM, INDAIATUBA, SALTO, PAULINIA,	08	UBIRANELLE FRAGA /DIRETOR (MEDICO) LUDNO FRASA /DIRETOR ADJUN- TO (MEDICO) WANDA LEPARIZI /DIRETOR ME- DICO (MEDICO)	STANDARD EXECUTIVE	10000	25000 PRIMARY: 2.0Z SECONDARY: 68.0Z TERTIARY: 30.0Z	(1)57716 (1) 2512
-MEDES S/A. RUA CONS.ANTONIO PRADO, NR. 544- CENTRO DESCALVADO TELEFONE: 83-2340 DESCALVADO	07	LUIZ S.F.DA SILVA /PRESI- DENTE (MEDICO) JAIR A.COSTA /DIRETOR CLI- NICO (MEDICO) LUDWENCO F.SABRIELLI /DIRE- TOR ADM.(ADVOGADO)	STANDARD FREE CHOICE	1000	5000 PRIMARY: N.A SECONDARY: N.A TERTIARY: N.A	19980 376

2711

F.M.O. NAME AND CITIES SERVED	NATURE OF SERVICE	KEY MANAGERS	TYPES OF PLANS	NO. OF EMPLOYEES COVERED (FROM/TO)	COMMERCIAL SECTOR DISTRIBUTION	PROJECTED 1st SEMESTER	OP. CONS./ADMISS.	
SAO PAULO								
-ANES ASSIST.MEDICA DE GUARAREMA LTDA. PRACA DR. EOTELMO EGAS, NR. 11 - GUARAREMA TELEFONE: 475-1132 GUARAREMA	N.A.	#GINO FANCOCHIA /DIR.ADM. #VALERIO L.M.S.MARTINS	N.A.	N.A.	PRIMARY: N.A SECONDARY: N.A TERTIARY: N.A	N.A.	N.A.	
-AMEDE ASSIST.MEDICA CENTRAL S/C.LTDA. RUA DR. VILBO PECANHA, NR. 34 - TELEFONE: 269-7777 GUARULHOS	N.A.	#EDUARDO DE S. JUNQUEIRA /DI- RETOR PRESIDENTE (MEDICO)	STANDARD	N.A.	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	N.A.	N.A.	
-HOSPITAL E MATERIDADE FIO XII S/C LTDA. AV. PAFA FIO XII, NR. 707 TELEFONE: 209-9547 GUARULHOS	N.A.	#SEBASTIAO FANCOCHIA /DI- RETOR PRESIDENTE #BING FANCOCHIA /DIR.ADM.	STANDARD EXECUTIVE	5000	10000	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	N.A.	N.A.
-INASA SERV.AMB.HOSPITALAR S/C.LTDA. RUA DR. FANOS DE ABEVEDO, NR. 135 TELEFONE: 208-4398 GUARULHOS	7	#CONDJ M.CARDUZ /DIR.PRES. #PAULO C.SFADA /DIR.CLINI- CO (MEDICO)	STANDARD EXECUTIVE	3000	5000	PRIMARY: 2.7% SECONDARY: 69.8% TERTIARY: 27.5%	6360	127
-GRUPO MEDICAL ASSIET.MEDICA S/C. LTDA. RUA FELICIO MARCONDES, NR. 274- CENTRO TELEFONE: GUARULHOS, SAO PAULO (S.M.PAULISTA)	07	#LUZIMAR S.AMDRIM /DIRETOR CLINICO (MEDICO) #PAULO C.G.AMDRIM /DIRETOR FINANC. (CONTOLGO) #HELIO ANTONIO A.JR. /DIR. ADM. (ECONOMISTA)	STANDARD EXECUTIVE FREE CHOICE	25000	35000	PRIMARY: 2.7% SECONDARY: 69.8% TERTIARY: 27.5%	N.A.	N.A.
-SEISA - SERVICOS INTEGRADOS DE SAUDE LTDA. AV. ESPERANCA, NR. 282, CENTRO - GUARULHOS TELEFONE: 208-2711 GUARULHOS, SAO PAULO, SANTO ANDRE, SAO BERNAR- DO DO CAMPO, SAO CAETANO DO SUL, OSASCO, SUZA NO, MOBI DAS CRUZES, SAO JOSE DOS CAMPOS	11	#ALEXANDRE F.M.LOURENCO /DI- RETOR PRESIDENTE (MEDICO) #SEBASTIAO D.M.MONTANS /DI- RETOR FINANCEIRO (MEDICO) #JOSE N.BALLINI / DIRETOR CLINICO (MEDICO) #EDUARDO YUKISAKI /DIRETOR CONSELHO (MEDICO) #VALENTIM M.FERNANDES /DIRE- TOR COMERCIAL (MEDICO) #ANTONIO GARCIA /DIRETOR CONSELHO (MEDICO)	STANDARD EXECUTIVE FREE CHOICE	7000	10000	PRIMARY: 2.7% SECONDARY: 69.8% TERTIARY: 27.5%	16970	340
-SAMIL SOC.DE ASSIST. MED.DE INDUSTRIA LTDA. AVENIDA PRESIDENTE VAREAS, NR. 1591, VILA INDUSTRIAL -INDAIATUBA TELEFONE: 75-2699 INDAIATUBA, CARPINAS, SALTO, ITU	12	#PEDRO MASCHIETTO /DIRETOR CLINICO (MEDICO) #DORLANDO ANNICCHINO JR./DI- RETOR ADMINISTRATIVO (MEDI- CO)	STANDARD (**) EXECUTIVE (**)	13000	25000	PRIMARY: N.A SECONDARY: N.A TERTIARY: N.A	25440	504
-FARMAS CHIERIGHINI LTDA. (SAMED SERV.DE AS. MED.E CIPURS.) RUA CONVENCO, NR. 503, VILA NOVA -ITU TELEFONE: 482-1050; 482-0071 ITU	11	#HELIO CHIERIGHINI /DIRETOR ADMINISTRATIVO (MEDICO) #EMNIO CHIERIGHINI /DIRETOR CLINICO (MEDICO)	STANDARD EXECUTIVE	1000	5000	PRIMARY: N.A SECONDARY: N.A TERTIARY: N.A	13780	273
-ITUCLINICAS CENTRO DE INV.DIAG.CLIN.CIRURS. DE ITU S/C.LTDA. RUA QUINTINO BOCAIUBA, NR. 47, CENTRO -ITU TELEFONE: 482-4190; 482-0760 ITU, SALTO	02	#ERICO M.VIYOTA /DIRETOR CLINICO (MEDICO) #CARLOS C.M.COSTA /DIRETOR COMERCIAL (MEDICO) #ROBERTO S.ARRUDA /DIRETOR ADMINISTRATIVO (MEDICO)	STANDARD EXECUTIVE	0	1000	PRIMARY: N.A SECONDARY: N.A TERTIARY: N.A	2290	45

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H.M.O. NAME AND CITIES SERVED =====	YEARS OF 'OPERATION'	KEY MANAGERS =====	TYPES OF PLANS =====	'NR. OF EMPLOYEES 'COVERED (FROM/TO)'	'COMMERCIAL SECTOR DISTRIBUTION'	'PROJECTED 1ST SE- MESTER 'OP. CONS./ADMISS. '
SAO PAULO						
-AMICO ASSISTENCIA MEDICA A INDUSTRIA E CO- MERCIO LTDA. AV. EDUARDO SII, NR. 90 - JACAREI TELEFONE: 51-2666 JACAREI	13	*PEDRO A. GUILMARDES /DIR. MEDICO REGIONAL (MEDICO) *LUIZ TORELLO /DIR. ADM. RE- GIONAL (ADVOGADO)	STANDARD EXECUTIVE P.P.O.	5000 10000	PRIMARY: 2.7% SECONDARY: 69.8% TERTIARY: 27.5%	SEE AMICO DATA
-JUNDIAI CLINICAS S/C LTDA. RUA PRUDENTE DE MORAES, NR. 744, CENTRO - JUNDIAI TELEFONE: 434-0466 JUNDIAI, CAMPO LIMPO PAULISTA	15	*ANTONIO M. PEREIRA /PRESI- TE (MEDICO) *JULIO FERREIRA /DIRETOR ADMINISTRATIVO (MEDICO) *DUSAN R. DE OLIVEIRA /DIRE- TOR CLINICO (MEDICO) *MARY FOSSEN /DIRETOR COMER- CIAL (ECONOMISTA)	STANDARD EXECUTIVE	25000 N.A.	PRIMARY: N.A SECONDARY: N.A TERTIARY: N.A	162869 3227
-SOPAN SOC. BENEF. DE ASSIST. MED. LTDA. S/C RUA DAS PITANQUEIRA, NR. 651, VIANEIRO- JUN- DIAI TELEFONE: 437-7244 JUNDIAI, CAMPO LIMPO PAULISTA	14	*ARNALDO M. DOS REIS (MEDI- CO) *LAZARO DE F. NUNES (MEDI- CO) *PAULO A. DE L. PINHEIRO (ME- DICO) *RENATO DE A. FURTADO (MEDI- CO) -TODOS SOCIOS-GERENTES	STANDARD EXECUTIVE	5000 10000	PRIMARY: N.A SECONDARY: N.A TERTIARY: N.A	31122 617
-MEDICAL S/A MEDICINA A INDUSTRIA E COMERCIO ASSOCIADA AV. ANA CAROLINA BARROS, NR. 124 - LIMEIRA TELEFONE: 41-0446 LIMEIRA	12	*JOSE LUIZ BLUMER /DIR. PRESI- DENTE (MEDICO) *ANTONIO SIMONI /DIR. FINANC *ADILSON S. COSTA / DIR. R. PUB *LUIZ ROZAM /DIR. CLINICO (MEDICO)	STANDARD EXECUTIVE	N.A. N.A.	PRIMARY: N.A SECONDARY: N.A TERTIARY: N.A	N.A. N.A.
-ASSIST. MEDICO-HOSPITALAR S. LUCAS S/C LTDA. RUA VOL. VITORIANO BORGES, NR. 319, CENTRO LINS TELEFONE: 22-3176 LINS	0,7	*JAIR C. PARAIZO /SOCIO-GE- RENTE (PROFESSOR) *ROBERTO BENEDITO LEITE / DIRETOR CLINICO (MEDICO)	STANDARD EXECUTIVE	C 1000	PRIMARY: 50.0% (R) 1660 (R) 157 SECONDARY: -.- TERTIARY: 50.0%	
-SAMMAR SERV. DE ASSIST. MED. MARILIA S/C LTDA. AVENIDA RIO BRANCO, NR 515, CENTRO -MARILIA TELEFONE: 33-2163 MARILIA	06	*JOSE J. M. A. DA SILVA /DIRE- TOR CLINICO (MEDICO) *JOSE H. DE MAGALHAES /DIRE- TOR ADMINISTRATIVO (MEDICO) *JAYRO DOMINGUES /DIRETOR COMERCIAL (MEDICO) *EDVALDO T. SAMARCO /VICE-DI- RETOR COMERCIAL (MEDICO)	STANDARD	5000 10000	PRIMARY: 2.7% SECONDARY: 69.8% TERTIARY: 27.5%	7420 147
-MATA CLINICAS S/A. RUA EFASILIA, NR. 626, CENTRO -MATAO TELEFONE: 41-5684 -LIMEIRA-SP-REC.D/ADILSON MATAO	05	*SISUEISSA MASSUDA /PRESI- DENTE (MEDICO) *SIDNEY BERWERT /DIRETOR CLINICO (MEDICO) *TAYASHI INEHARA /DIRETOR ADMINISTRATIVO (MEDICO)	STANDARD EXECUTIVE	5000 10000	PRIMARY: N.A SECONDARY: N.A TERTIARY: N.A	33920 672

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H.M.O. NAME AND CITIES SERVED	YEARS OF OPERATION	KEY MANAGERS	TYPES OF PLANS	NR. OF EMPLOYEES COVERED (FROM/TO)	COMMERCIAL SECTOR DISTRIBUTION	PROJECTED 1ST SE- MESTER TOP. COMS./ADMISS.
SAO PAULO						
-SAMED SERVICO DE ASSISTENCIA MEDICO-HOSPITALAR S/C. LTDA. RUA EUSENIO MOTA, NR. 255- JO.SANTISTA TELEFONE: 449-8136 E 449-8211 MOBI DAS CRUZES, SUZANO, POA, ITAGUAQUECETUBA, ARUJA	12	#OSMAR M. COUHO /PRESIDENTE (MEDICO) #OSWALDO MORI /VICE-PRESIDENTE (MEDICO) #JOSE C. DE TOLEDO /DIRETOR SUPERINTENDENTE (MEDICO) #JOSE M. JORDAO /DIRETOR ADMINISTRATIVO (MEDICO) #OSWALDO PANSARDI /DIRETOR ADJUNTO (MEDICO)	STANDARD EXECUTIVE	7000 10000	PRIMARY: 2.7% SECONDARY: 69.6% TERTIARY: 27.5%	18660 370
-POLICLINICA PIRACICABA S/C. LTDA. RUA SAO JOSE, NR. 407 CENTRO - PIRACICABA TELEFONE: 22-8501 E 22-4644 PIRACICABA	02	#JERONIMO S. BARRICHELLO /SOCIO DIFETOR (MEDICO) #ANTONIO C. NOGUEIRA /SOCIO DIFETOR (MEDICO) #ALFREDO MESANELLI JR. /SOCIO DIFETOR (MEDICO) #ZENILDA M.M. FREITAS /SOCIA DIFETORA (BIOMEDICA)	STANDARD EXECUTIVE	1000 5000	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	5300 105
-PORTO CLINICA S/A. RUA MATIAS CARDESO, NR. 397, CENTRO - PORTO FERREIRA TELEFONE: 81-1367; 81-1894 PORTO FERREIRA	11	#OSART PASSIO /DIRETOR ADMINISTRATIVO (MEDICO) #NEIF JOAO /DIRETOR CLINICO (MEDICO)	STANDARD	1000 5000	PRIMARY: 9.02% (*) 17885 (*) SECONDARY: 84.25% TERTIARY: 6.73%	55
-POLICLINICA RIBEIRAO PRETO LTDA. RUA MARIANA JUNQUEIRA, NR. 473, CENTRO - RIBEIRAO PRETO TELEFONE: 625-5271 RIBEIRAO PRETO, SERTAOZINHO	14	#FAUSTINO JARRUCHE /DIRETOR (MEDICO) #MARIANO A. DE FIGUEIREDO /DIRETOR (MEDICO) #MIGUEL MARAO NETO /DIRETOR (MEDICO)	STANDARD EXECUTIVE	10000 25000	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	84800 1680
-SOCIEDADE SAO FRANCISCO CLINICAS RUA GARIBALDI, NR. 1210, HIEIENOPOLIS - RIBEIRA PRETO TELEFONE: 636-8100; 636-4011 RIBEIRAO PRETO, SERTAOZINHO	05	#JOAO F.M. PESSOA /PRESIDENTE (MEDICO) #JOSE A. BIAGINI /DIRETOR CLINICO (MEDICO) #OMEDIO S. PRADO JR. /DIRETOR ADMINISTRATIVO (ADM. EMP.) #MARCOS V. PAPA /SUPERINTENDENTE (MEDICO) #CARLA F. RUSA /ASSESS. ADM. (ADM. DE EMPRESAS)	STANDARD EXECUTIVE FREE CHOICE	5000 10000	PRIMARY: 18.0% SECONDARY: 10.0% TERTIARY: 72.0%	20500 406
-SAMES SOC. DE ASSIST. MED. SALTO S/C. LTDA. RUA FLORIANO PEITOTO, NR. 1122/52 - SALTO TELEFONE: 483-2374; 483-2050 SALTO, ITU	12	#HAROLDO L. RIBEIRO /DIRETOR GERAL #RUDNO FRAGA /DIRETOR FINANCEIRO #WANDA LIPARIZE /DIRETOR #LEIFANELLE FRAGA /DIRETOR -NAO INFORMARAM AS RESPECTIVAS PROFISSOES-	STANDARD	1000 5000	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	22260 441

H.M.O. NAME AND CITIES SERVED =====	YEARS OF OPERA- TION	KEY MANAGERS =====	TYPES OF PLANS =====	NR. OF EMPLOYEES 'COVERED (FROM/TO)'	COMMERCIAL SECTOR 'DISTRIBUTION'	PROJECTED 1ST SE- 'RVICE' 'OP. CONS./ADMISS.'
SAO PAULO ===						
-GRANDE ABC SERV. ASSIST. A SAUDE S/C LTDA. R. CEL. FERNANDO FRESTES, Nº 52/1 ANDAR - SANTO ANDRE TELEFONE: 449-0252 SANTO ANDRE	02	*MARIO MARTINS FILHO /DIRE- TOR (MEDICO) *JORGE SAYUM /DIRETOR	STANDARD EXECUTIVE FREE CHOICE	15000 20000	PRIMARY: 2.7% SECONDARY: 69.8% TERTIARY: 27.5%	39160 760
I-HOSPITAL ANA COSTA S/A RUA PEDRO AMERICO, NR. 50 -SANTOS TELEFONE: 32-3533 SANTOS, CUBATAO, S. VICENTE, GUARUJA, FRAIA GRANDE	27	*JAIME ROSENBOJM /DIR. PRESI- DENTE (MEDICO) *ALDISIO FERNANDES /DIR. SU- PREFINTELENDE (MEDICO/ADM) *SILDO DA R. BRITO //DIR. TE- SOUZEIRO (MEDICO) *MADREZ M. RODRIGUES /DIRE- TOR CLINICO (MEDICO)	STANDARD EXECUTIVE	25000 50000	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	N.A. N.A.
-AMICO ASSISTENCIA MEDICA A INDUSTRIA E CO- MERCIO LTDA. AV. DR. NELSEN D'AVILLA, NR. 423 -S. J. CAMPOS TELEFONE: 21-9908 SAG JOSE DOS CAMPOS	15	*PEDRO A. GUIMARAES /DIR. ME- DICO REGIONAL (MEDICO) *LUIZ TORELLA /DIR. ADMINIS- TRATIVO (ADVOGADO)	STANDARD EXECUTIVE P.P.O.	5000 10000	PRIMARY: 2.7% SECONDARY: 69.8% TERTIARY: 27.5%	SEE AMICO DATA
-CLINICA SAG JOSE S/C LTDA. PRACA ELZA FERREIRA RAHAL, NR. 83-SJ CAMPOS TELEFONE: 21-4709 SAG JOSE DOS CAMPOS	14	*RICHRO NAKAGAWA *MAGDEU HENRIQUES NETO	N.A.	N.A. N.A.	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	N.A. N.A.
-POLICLIN S/A SERVICOS MED-HOSPITALARES AV. NOVE DE JULHO, NR. 430, V. ADYANNA S. JOSE DOS CAMPOS TELEFONE: 21-353 SAG JOSE DOS CAMPOS, CACAPAVA	12	*NILSON MATIMO /DIR. PRES. (MEDICO) *CYRO A. DE BRITO /DIR. MEDI- CO (MEDICO) *JOSE J. RIBEIRO FILHO /DIR. SUPERINT. (ADMINISTRADOR);	STANDARD EXECUTIVE FREE CHOICE	N.A. N.A.	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	N.A. N.A.
-AMESP ASSISTENCIA MEDICA DE S. PAULO LTDA. RUA TUTOIA, NR. 207 - CAPITAL TELEFONE: 289-5477	24	*IRAVI M. NOVAES *JOSAYNE B. DE BELLO *PEDRO MACHS *NICOLING BARFERIO	STANDARD EXECUTIVE FREE CHOICE	50000 100000	PRIMARY: 2.7% SECONDARY: 69.8% TERTIARY: 27.5%	180200 3570
-AMICO ASSISTENCIA MEDICA A INDUSTRIA E COMER- CIO LTDA RUA AZEVEDO MACEDO, NR. 92, VILA MARIANA -CA- PITAL TELEFONE: 549-6111 SAG PAULO, SANTO ANDRE, SAG BERNARDO DO CAMPO SAG CASTANO DO SUL, DIADEMA, MAUA, OSASCO, GUARULHOS		*RICHARD D. WRIGHT /DIR. PRE- SIDENTE (ADM. HOSP) *MARIO W. J. VIEIRA /DIR. EXEC DESENV. (MEDICO) *RENATO ALLEMAN /DIR. EXEC. AREA MEDICA (MEDICO) *ANTONIO GIORGANO JR. /DIR. EXEC. OPERACOES (CONTADOR) *CLAUDIO M. JOSE /DIR. FINAN- CEIRO (ECONOMISTA)	STANDARD EXECUTIVE P.P.O. FREE CHOICE	200000 250000	PRIMARY: 2.7% SECONDARY: 69.8% TERTIARY: 27.5%	SEE AMICO DATA
-ASSISTENCIA MEDICA IGUATEMI AV. PROF. FRANCISCO MORATO, NR. 719 -CAPITAL TELEFONE: 913-1222	23	*EDSON DE O. GIOVANNETTI /DI- RETOR SUPERINTELENDE *NILTON B. SEBASTIÃO /DIRETOR AD- MINISTRATIVO *JOSAO B. MACHADO /DIR. CLINICO *CARLOS MENDES /DIR. CONV.	STANDARD EXECUTIVE	15000 20000	PRIMARY: 2.7% SECONDARY: 69.8% TERTIARY: 27.5%	36000 714

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F.M.O. NAME AND CITIES SERVED =====	YEARS OF OPERATION	KEY MANAGERS =====	TYPES OF PLANS =====	NR. OF EMPLOYEES 'COVERED' (FROM/TO)	'COMMERCIAL SECTOR' DISTRIBUTION	PROJECTED 1ST SE- MESTER 'OP. CONS./ADMISS.'
SAO PAULO =====						
-BENEFICENCIA LUSO-BRASILEIRA S/C.LTDA. R. COFFEEIA DIAS, NR. 194 - CAPITAL TELEPHONE: 571-4302	N.A.	MARRY ANDRADE / DIR. PRES. MARRY ANDRADE JR. / DIR. CLIN.	STANDARD	1000	5000 PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	5724 115
-BENEFICENCIA MEDICA BRASILEIRA S/A. HOSPITAL SAO LUIZ RUA DR. ALCEU DE C. RODRIGUES, 95 - CAPITAL TELEPHONE: 240-6611	24	HELIO DE A. VASCON / DIRETOR PRESIDENTE (EXECUTIVO) FRUY M. ANTONIO / DIRETOR SUPERINTENDENTE (MEDICO) FRENATO F. BARROSA / DIRETOR CLINICO (MEDICO) RELISA P. GUIMARAES / DIRETO- RA ADMN. (ADM. HOSP.)	STANDARD EXECUTIVE	N.A.	N.A. PRIMARY: 1.51 SECONDARY: 37.52 TERTIARY: 61.02	N.A. N.A.
-CASABLANCA S/A. INSTITUTO DE MEDICINA E CI- RURGIA AV. 9 DE JULHO, NR. 3369, JO. PAULISTA - CAPITAL TELEPHONE: 881-9750	16	MARNEL D. DE M. NETO / DIRE- TOR ADMINIST. (MEDICO) JOSE C. CAMPANARI / DIR. FIN. (MEDICO) NELSON F. MARQUES / DIRE- TOR TECNICO (MEDICO) ROBERTO A. MASTROI / DIRE- TOR COMERCIAL (MEDICO)	STANDARD EXECUTIVE	N.A.	N.A. PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	N.A. N.A.
-CERIMED ASSIST. MEDICA ODONTOLOGICA RUA PEIXOTO GOMIDE, 337, B. VISTA - CAPITAL TELEPHONE: 826-0933		GIUSEPPE CERINO / DIRETOR SUPERINTENDENTE (MEDICO) MARCIZIO CEPINO / DIRETOR TECNICO (MEDICO) MARGARET TUSA / DIRETOR CO- MERCIAL (ADVOCADO)	STANDARD EXECUTIVE	N.A.	N.A. PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	N.A. N.A.
-CLAME-CLINICA DE ASSIST. MED. A INDUSTRIA E COMERCIO S/C. LTDA. RUA DOM PASTOR, NR. 1199 - IPIRANGA TELEPHONE: 273-5959 CAPITAL	15	ROQUELAS MADRUGA / DIR. CLINI- CO (MEDICO) VICENTE IZZO / DIR. ADMINIS- TRATIVO (MEDICO)	STANDARD EXECUTIVE	N.A.	N.A. PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	N.A. N.A.
-CLINIC CLINICAS PARA A INDUSTRIA E COMERCIO S/C. LTD. RUA PROF. SEBASTIAO SOARES FARIA, NR. 57 - 11 ANGAR- BELA VISTA - CAPITAL TELEPHONE: 285-0336 SAO PAULO	11	WALTER YAROSLAVSKY / DIR. MEDICO (MEDICO) GUY A. BONAFE / DIR. ADMINIS- TRATIVO (MEDICO) MISSEM CASTIEL / DIRETOR CO- MERCIAL (ADM. EMPRESAS)	STANDARD EXECUTIVE FREE CHOICE	N.A.	N.A. PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	N.A. N.A.
-CLINICA OSVALDO CRUZ DE S. PAULO LTDA. PRACA S. CRUZ, NR. 47 - PARAISO - CAPITAL TELEPHONE: 284-7100 SAO PAULO, OSASCO	24	CELSON B. FERREIRA / DIRETOR EXECUTIVO (MEDICO) PAULO E. TORRES / DIRETOR EXECUTIVO (MEDICO) DAVID E. JIP / DIRETOR CLI- NICO (MEDICO) CLAUDETTE MARCHETTI / SEREN- TE REL. PUBLICAS (P. PUBLIC) PASQUAL BIANCHI NETO / GER. ADMN. (ECONOMISTA) JOSE P. C. BRAGA / ASSESSOR JULPICO (ADVOCADO) WILSON CRICCI / ASS. ASSIN- TES ECONM. (ECONOMISTA)	STANDARD EXECUTIVE	20000	25000 PRIMARY: 2.72 SECONDARY: 69.82 TERTIARY: 27.52	48800 970

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H.M.O. NAME AND CITIES SERVED =====	'YEARS OF 'OPERATION	KEY MANAGERS =====	'TYPES OF PLANS '=====	'NR. OF EMPLOYEES 'COVERED (FROM/TO)	'COMMERCIAL SECTOR 'DISTRIBUTION	'PROJECTED 1ST SE- 'MESTER 'OP. CONS./ADMISS.
SAO PAULO =====						
-CLINICA SAO BENTO S/C.LTDA. RUA LEAO XIII, NR. 146 ,JO.S.BENTO -CAPITAL TELEFONE:298-9633 SAO PAULO, SANTO ANDRE	09	*KJITI YOSHIMURA /ADMINIS - TRADOR (MEDICO) *FRANS R.H.KOBAYASHI /PLANE JAMENTO (MEDICO) *SEVERINO F.G.MARQUES /MANU TENCAO (MEDICO)	STANDARD	N.A. N.A.	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	N.A. N.A.
-COMESA S/A SERVICOS MEDICOS RUA DR.AFONSO BACCARI, NR.222 - CAPITAL TELEFONE:549-7111	22	*FLAVIO CAUTELLA /DIR.PRESI DENTE *FRANCISCO DE P.CLEFFI /DI- RETOR SUPERINTENDENTE *NELSON V.DE PADUA /DIRETOR MEDICO (MEDICO) *SERALDO RUBO /DIR.COMVENIO *ANTONIO J.A.VOLPI /DIRETOR FINANCEIRO *ELYSIO S.ROMANO /DIRETOR CLINICO (MEDICO)	STANDARD EXECUTIVE FREE CHOICE	40000 50000	PRIMARY: 2.7% SECONDARY: 69.8% TERTIARY: 27.5%	99650 1975
-CONSULT ASSISTENCIA MED.E CIRURG.S/C.LTDA. R.ESTADOS UNIDOS, NR. 136, JO.PAULISTA- CAPITAL TELEFONE:292-9704	10	*ROBERTO HEGG /DIRETOR CLI- NICO (MEDICO) *WILSON SENCALVES FILHO /GERENTE ADMINISTRATIVO	STANDARD EXECUTIVE	5000 10000	PRIMARY: 1.0% SECONDARY: 23.5% TERTIARY: 75.5%	14840 294
-CREMED -LANCAMENTOS E PROMOCOES S/C. LTDA. AV.ERIG.FARIA LIMA, NR. 1306 -CJS. 1813/15 JARDIM PAULISTA TELEFONE: 212-6086 CAPITAL	06	*HILTON DE CASTRO /SOCIO GE RENTE (EXECUTIVO) *AMELIA R.DE CASTRO /SOCIA (SECRETARIA)	STANDARD	N.A. N.A.	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	N.A. N.A.
-EAM EQUIPE DE ASSISTENCIA MEDICA LTDA. RUA CRISTIANO VIANA, NR. 145, CERQUEIRA CESAR - CAPITAL TELEFONE:881-1265 CAPITAL	16	*JAYME B.REGEN/DIR. (MEDICO)	STANDARD EXECUTIVE	1000 3000	PRIMARY: 2.7% SECONDARY: 69.8% TERTIARY: 27.5%	5300 110
-HELP ASSISTENCIA MEDICA S/A AV.EUSEBIO MATOSO, NR. 246,PIMMEIROS-CAPITAL TELEFONE: 853-3986 SAO PAULO, SANTO ANDRE, SAO BERNARDO DO CAM- PO, SAO CAETANO DO SUL, DIADENA	10	*PAULO B.DE C.FONTES /PRESI DENTE (MEDICO) *EDGARD J.AMATO /DIRETOR EXECUTIVO (MEDICO) *EDUARDO BERGER /DIRETOR EXECUTIVO (MEDICO) *MARCUS A.A.RANJOYA /DIRETOR EXECUTIVO (MEDICO) *MARCOS A.V.LOBO /DIRETOR EXECUTIVO (MEDICO)	STANDARD EXECUTIVE FREE CHOICE	15000 20000	PRIMARY: 2.7% SECONDARY: 69.8% TERTIARY: 27.5%	36000 710

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H.M.O. NAME AND CITIES SERVED =====	'YEARS OF 'OF FEA - 'TION	KEY MANAGERS =====	'TYPES OF PLANS '=====	'NO. OF EMPLOYEES 'COVERED (FROM/TO)	'COMMERCIAL SECTOR 'DISTRIBUTION	'PROJECTED 1ST SE- 'MESTER 'OP. CONS./ADMISS.
SAO PAULO =====						
-HEALTH DE SAO PAULO ASSISTENCIA MEDICA LTDA, AV. ERIS LUIZ ANTONIO, 5049, JARDIM PAULISTA CAPITAL TELEFONE: 282-8922	15	#LUIZ F.P. PEREIRINI /DIRETOR #ELACOS EMPRESARIAIS #LUIZ PEREIRINI JR./DIRETOR VICE-PRESIDENTE #JOSE C. NOGUEIRA /DIRETOR CLINICO (MEDICO) #CARLOS A.C. FARIAS /DIRE- TOR TECNICO #ANGELA FRABOSO /DIR. OPERA- CIONAL	STANDARD EXECUTIVE FREE CHOICE	25000 30000	PRIMARY: 2.7% SECONDARY: 69.8% TERTIARY: 27.5%	57240 1150
-HOSPITAL MODERNO LTDA. R. PARAO DO RIO BRANCO, NR. 555 -CAPITAL TELEFONE: 247-9639	11	#PAULO BERCA /DIR. SUPERINT. #AFONSO M. DA S. TEIXEIRA /DI- RETOR CLINICO (MEDICO)	STANDARD EXECUTIVE	N.A. N.A.	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	N.A. N.A.
-HOSPITAL N. SENHORA DO CARMO S/A. R. MARTINIANG DE CARVALHO, NR. 741 -CAPITAL TELEFONE: 289-2907 SAO PAULO, OSASCO, GUARULHOS	13	#ANGELO L. MANCINI NETO /DI- RETOR PRESIDENTE (MEDICO) #EMILIO S. JACOVI NI NETO /DI- RETOR FINANCEIRO (CONTOL.) #NELSON A. FRANCO /DIRETOR MEDICO (MEDICO) #NICOLAU MANCINI FILHO /DI- RETOR ADMINIST. (ADM.) #ROSEMS M. MANCINI /DIRETOR CONVENIOS (OPERADOR RX)	STANDARD EXECUTIVE	1000 3000	PRIMARY: 2.4% SECONDARY: 43.9% TERTIARY: 53.7%	5250 105
-HOSPITAL ZONA SUL RUA SAL. ROBERTO ALVES DE CARVALHO FILHO, NR. 270, SANTO AMARO -CAPITAL TELEFONE: 522-6030	N.A.	#FRANCISCO A. CAVALCANTI /DI- RETOR CLINICO (MEDICO) #WALTERS MARGUES /DIR. ADM.	STANDARD EXECUTIVE	N.A. N.A.	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	N.A. N.A.
-HOSPITAL E MATERNIDADE V. MARIA S/A AV. GUILHERME COTCHING, NR. 940 -V. MARIA CAPITAL TELEFONE: 291-2211	20	#ALDO PERLI /DIRETOR ADMI- NISTRATIVO (MEDICO) #LOURIVAL M. GOZZO /DIR. SU- PERINTENDENTE (MEDICO) #LAERTE SECOLIN /DIRETOR PRESIDENTE (MEDICO) #ANIS GEBARA /DIRETOR COMER- CIAL (MEDICO) #ISAAC MILNER /DIRETOS SE- CRETARIO (MEDICO)	STANDARD EXECUTIVE	N.A. N.A.	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	N.A. N.A.
-HOSPITAL N.S. DA PENHA S/A RUA ARNALDO VALLARDI PORTILLO, NR. 90 - CAPITAL TELEFONE: 295-7444 SAO PAULO		#FRANCISCO ANTONASIO /DIRE- TOR PRESIDENTE (MEDICO) #PAULO ANTONASIO /DIRETOR VICE-PRESIDENTE (MEDICO) #GERALDO CASAGRANDE /DIRE- TOR ADMINISTRATIVO	STANDARD	1000 3000	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	N.A. N.A.

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H.M.O. NAME AND CITIES SERVED	YEARS OF OPERATION	KEY MANAGERS	TYPES OF PLANS	NO. OF EMPLOYEES COVERED (FROM/TO)	COMMERCIAL SECTOR DISTRIBUTION	PROJECTED 1ST SEMESTER OP. CONS./ADMISS.
SAO PAULO						
-INTERCLINICAS - ASSISTENCIA MEDICA E CIRURGICA S/C.LTDA. AV.PAULISTA, NR. 777, BELA VISTA -CAPITAL TELEFONE:268-5333	19	#LUIZ A.DE A.S.DORIA /DIRETOR PRESIDENTE #DOMINGOS ALBANO /DIRETOR VICE-PRESIDENTE #PALMIRO ROCHA #JULIO TIMONER #OSVALDO B.ANDERSON #HELMUTH PROBST #WILLIAM N.KUNRO	STANDARD EXECUTIVE FREE CHOICE	166000 200000	PRIMARY: 3.4% SECONDARY: 41.7% TERTIARY: 54.9%	402800 7980
-INTERMEDICA SAO CAMILO S/C.LTDA. AV.POMPEIA, 1050, POMPEIA -CAPITAL TELEFONE:263-7144	13	#PAULO S.P.BARBANTI /DIRETOR SUPERINTENDENTE #RENATO CORDEIRO /DIRETOR #PE.NIVERSINDO A.CHERUBIN #ROBERTO M.F.NIGRO #WALTER LANFRANCHI #LUIZ O.FERNANDES #JOSE P.MAY #FRANCISCO A.R.CUMHA /GER. RELACOES EXTERNAS	STANDARD EXECUTIVE FREE CHOICE	30000 40000	PRIMARY: 2.7% SECONDARY: 69.8% TERTIARY: 27.5%	69960 1386
-INTERMEDICI MEDICINA CIRURGICA LTDA. AV.ERIG.LUIZ ANTONIO, NR. 3803, JARDIM PAULISTA -CAPITAL TELEFONE: 64-4204	14	#ALEXANDRE F.A.LOURENCO /DIRETOR PRESIDENTE #LUIZ A.DE LOURENCO /DIRETOR CLINICO (MEDICO)	STANDARD EXECUTIVE	5000 10000	PRIMARY: 2.7% SECONDARY: 69.8% TERTIARY: 27.5%	14850 290
-INSTITUTO PAULISTANIA DE MEDICINA E ODONTOLOGIA S/C. LTDA. AV.JURUBATUBA, NR. 481- BROOKLIN TELEFONE: 241-7311 SAO PAULO	16	#WILSON J.NICOLAU /DIRETOR SUPERINTENDENTE (MEDICO) #MASAYUKI ISHI /DIRETOR CLINICO (MEDICO) #LEO V.ALBUGUERQUE /DIRETOR ADMINISTRATIVO (MEDICO) #SEIJO TOMA /DIRETOR DE PATRIMONIO (MEDICO)	STANDARD EXECUTIVE	N.A. N.A.	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	N.A. N.A.
-LAPA ASSISTENCIA MEDICA S/C.LTDA. R.BRIG. GAVIÃO PEIXOTO, NR.159,LAPA -CAPITAL TELEFONE:260-4306 E 260-2387		#FLAVIO J.N.PUGLI /DIR.ADM. #EMIL SAEINO /DIR.FINANC.	STANDARD EXECUTIVE	5000 10000	PRIMARY: 2.7% SECONDARY: 69.8% TERTIARY: 27.5%	21200 420
-MECA LTDA. MEDICINA E CIRURGIA ASSISTENCIAL ALAMEDA SANTOS, NR. 1054-JARDIM PAULISTA TELEFONE: 251-5099 SAO PAULO, GUARULHOS	18	#ELIAS J.RACY /DIRETOR SOCIO (MEDICO) #JOSE WEXLER /DIRETOR SOCIO (MEDICO) #NILSON M.CELSO /DIRETOR SOCIO (MEDICO)	STANDARD EXECUTIVE	10000 13000	PRIMARY: 2.7% SECONDARY: 69.8% TERTIARY: 27.5%	25440 504
-MEDIAL-SAUDE S/A. AV.AGAMI, NR. 333- MOEMA TELEFONE: 570-8639 SAO PAULO	13	#FERNANDO A.P.ROCHA /PRESIDENTE (MEDICO) #SAMIR J.KALIL /DIR.ADM.FINANCIERO (MEDICO) #GERARDO ROCHA MELLO /DIRETOR CLINICO (MEDICO) #ADRIO SCAPPIRA /DIRETOR TECNICO (MEDICO)	STANDARD EXECUTIVE	50000 75000	PRIMARY: 2.7% SECONDARY: 69.8% TERTIARY: 27.5%	127200 2520

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U.N.J. NAME AND CITIES SERVED =====	YEARS OF OPERATION	KEY MANAGERS =====	TYPES OF PLANS =====	NR. OF EMPLOYEES 'COVERED (FROM/TO)'	COMMERCIAL SECTOR DISTRIBUTION	PROJECTED 1ST SE- MESTER 'OP. CONC. /ADMISS.
SAO PAULO === =====						
-MEDIC S/A.MED.ESPEC.IND.E COM. ALAMEDA ITU, NR.215/3 ANDAR,JARDIM PAULISTA CAPITAL TELEFONE:279-4311	23	*JOSE J.PEREGRINO /DIRETOR CLINICO (MEDICO) *SEBASTIÃO JMD /DIP.ADMINIST. *TSUTOMU DYURE /DIR.EXPANS. *ANTONIO E.B.PALLARES /DIR. MANUTENCAO DE CONVENIOS	STANDARD EXECUTIVE FREE CHOICE	20000 25000	PRIMARY: 1.8% SECONDARY: 37.9% TERTIARY: 60.3%	53000 1050
-METROPOLE SAUDE ASSIST.MED.CIRURG. S/A RUA BELA CINTRA, NR. 561 -CAPITAL TELEFONE:256-0739 E 256-6879 SAO PAULO, SANTO ANDRE, SAO BERNARDO DO CAM- PO, SAO CAETANO DO SUL, MAUA, OSASCO, GUARULHOS	20	*JORGE KULASSARIAN/DIRETOR PRESIDENTE (MEDICO) *MARIO ALGRANTI /DIR.FINAN- CEIRO (MEDICO) *ANTONIO A.DIAS /DIR.CLINI- CO (MEDICO) *HELIO ZILMAN /DIRETOR ADMI- NISTRATIVO (ADM.EMPR.)	STANDARD EXECUTIVE	5000 10000	PRIMARY: 2.7% SECONDARY: 69.8% TERTIARY: 27.5%	17596 350
-NACIONAL SAUDE SERV.MED.HOSP.S/C.LTDA. AV.ALVARO RAMOS, NR. 2272, BELENZINHO - CAPITAL TELEFONE:264-5199	11	*ARMANDO M.CORDEIRO JR. /DI- RETOR PRESIDENTE *ALEXANDRE C.KISS /DIRETOR CLINICO (MEDICO)	STANDARD EXECUTIVE	5000 10000	PRIMARY: 2.7% SECONDARY: 69.8% TERTIARY: 27.5%	16960 336
-POLICLINICA SANTA AMALIA S/C. LTDA. R.HERMINIO LEMOS, NR. 385, CAMBUCI -CAPITAL TELEFONE:270-8311 SAO PAULO	16	*WALTER D.RODRIGUES /DIRE- TOR SUPERINT. (MEDICO) *SEBASTIAO S.OLIVEIRA /DI- RETOR CLINICO (MEDICO) *JOSE A.B.MARTINEZ (MEDICO) *REINALDO P.DE BARROS (ME- DICO) *JOSE C.FUSCO (MEDICO) *ANTONIO A.P.FAUPERIO (ME- DICO) *ANTONIO C.VITARI (MEDICO)	STANDARD EXECUTIVE	7000 10000	PRIMARY: 2.7% SECONDARY: 69.8% TERTIARY: 27.5%	18020 357
-POLICLINICA SANTA FE LTDA. AV.ADOLFO PINHEIRO, NR. 1362, SANTO AMARO CAPITAL TELEFONE:247-8599, 246-2250 E 246-3745	20	*JULIO L.CAVALECANTI /DIRE- TOR CLINICO (MEDICO) *MARY DE A.LACERDA /DIRETOR CLINICO (MEDICO) *NICOLAU P.YOMM /DIR.ADM. *FERNANDO P.VAZ /DIR.ADM.	STANDARD EXECUTIVE	N.A. N.A.	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	N.A. N.A.
-PRD SAUDE SOC.LTDA. RUA SUATINO, NR. 400 -CAPITAL TELEFONE: IDEM EAMCIL	20	*RAIFIO COFFEEIA NETO /PRESI- DENTE (MEDICO) *LILIZ F.SILVEIRA /SUPERINT. ADMINISTRATIVO (MEDICO) *ARCHIMEDES MAFIOZZA /SU- PERINT. CLINICO (MEDICO) *JOSE F.D.BEAGA /DIRETOR JU- RIDICO (ADVOGADO) *CARLOS R.BONCHETTI /GEREN- TE DE MARKETING (ADVOGADO) *FALLO R.FIJOCCI /GER.REC.HU- MANOS (ADVOGADO) *RAVILSON FAGANFO /GER.FIN. (ADM.DE EMPRESAS)	STANDARD EXECUTIVE FREE CHOICE	5000 7000	PRIMARY: 2.4% SECONDARY: 39.7% TERTIARY: 57.9%	12720 252

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N.M.C. NAME AND CITIES SERVED =====	YEARS OF OPERATION	KEY MANAGERS =====	TYPES OF PLANS =====	NR. OF EMPLOYEES COVERED (FROM TO)	COMMERCIAL SECTOR DISTRIBUTION	PROJECTED 1ST SE- MESTER OP. CONS./ADMISS.
SAO PAULO ===						
-FRONTO-SOCORRO SANTA PAULA LTDA. AV. SANTO AMARO, NR. 2468, BROOKLYN -CAPITAL TELEPHONE: 77-8695 E 241-5122	26	BYVONE CAPJANO /DIR. PRES. RECIFE SCHAIR /D. SUPERINT. (MEDICO) JOSE F. CIVIDAMES /D. TECNICO (MEDICO) EDGAR A. MASSER /D. CLINICO (MEDICO)	STANDARD EXECUTIVE	N.A. N.A.	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	N.A. N.A.
-SACI SERV. ASSIST. MED. AD COM. E IND. S/C. LTDA. R. RUI BRANCO, NR. 403 -CAPITAL CAPITAL	23	WILSON FRY /DIR. PRESIDENTE CARLORO DOMENEGUETTI /DI- RETOR FINANCEIRO RAFAEL LIBERATORI / DIRE- TOR ADMINISTRATIVO	STANDARD EXECUTIVE	10000 15000	PRIMARY: 2.72 SECONDARY: 69.82 TERTIARY: 27.52	21200 420
-SAO PAULO CLINICAS S/C. LTDA. RUA PERNAMBUCO, NR. 77, HIGIENOPOLIS -CAPITAL TELEPHONE: 826-8499	10	MESSIAS A. FEOLA /DIRETOR CLINICO (MEDICO) BELIANA M.V. SANTANA /DIRETO RA ADMINISTRATIVA	STANDARD EXECUTIVE	5000 7000	PRIMARY: 2.72 SECONDARY: 69.82 TERTIARY: 27.52	12700 253
-SEMIC SERV. MED. A IND. E COM. S. PAULO S/C. LTDA. R. SAO VICENTE PAULA, NR. 102 -CAPITAL TELEPHONE: 825-4428 E 825-4479	18	JURANDYR A. BALTHAZAR /DIRE TOR PRESIDENTE DECIO CATANI /DIRETOR CLI- NICO (MEDICO)	STANDARD EXECUTIVE	15000 25000	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	N.A. N.A.
-SERMA SERV. MED. ASSIST. LTDA. AV. PACAEMBU, NR. 1687, PACAEMBU -CAPITAL TELEPHONE: 872-4835	20	MARCOS H. VIGONTI SEVERIANO ATOMES NETO FRANCISCO C. LUCCHESE	STANDARD EXECUTIVE	N.A. N.A.	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	N.A. N.A.
-SAMCIL S/A SERV. DE ASSIST. MED. AD COM. E IND. RUA EVEZU, NR. 119 -A. PINHEIROS TELEPHONE: 211-4811 CAPITAL, S. ANDRE, S.S. DO CARPO, DIADEMA, MAUA OSASCO, GUARULHOS, S.J. DOS CARPOS, CAMPINAS	24	MILIPIO CORREIA NETO /PRESI DENTE (MEDICO) LUIZ R. SILVEIRA /SUPERINT. ADMINISTRATIVO (MEDICO) ARCHIREDES WARDOLZA /SU- PERINT. CLINICO (MEDICO) JOSE P.C. BRAGA /DIRETOR JU RIDICO (ADVOGADO) CARLOS R. BURENATI /GEREN- TE DE MARKETING (ADVOGADO) PAULO R. RICCI /GER. REC. HU- MANOS (ADVOGADO) RAVILSON F. GOMES /GER. FIN. (ADM. DE EMPRESAS)	STANDARD EXECUTIVE FREE CHOICE	40000 80000	PRIMARY: 2.72 SECONDARY: 69.82 TERTIARY: 27.52	N.A. N.A.
-SIM SERVICO IBIRAPUERA DE MEDICINA S/C. AV. ADOLFO PINHEIRO, NR. 339- SANTO AMARO TELEPHONE: 246-7044 CAPITAL, SANTOS, S. ANDRE, S.C. DO SUL, S.P. DO CARPO, MAUA	N.A.	LUIZ E. DA S. FREIRE /DIR. SU PERINT. (MEDICO) ANTONIO C. DE TOLEDO /DIR. ADM. (MEDICO) DIALMA F. DA SILVA /DIR. CLI NICO (MEDICO) CASSIO P. MOURA /ASSESSOR DA DIRETORIA (CONTADOR)	STANDARD EXECUTIVE	N.A. N.A.	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	N.A. N.A.

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H.M.O. NAME AND CITIES SERVED =====	YEARS OF 'OPERATION'	KEY MANAGERS =====	TYPES OF PLANS =====	'NR. OF EMPLOYEES 'COVERED (FROM/TO)'	'COMMERCIAL SECTOR DISTRIBUTION'	'PROJECTED 1ST SE- MESTER 'OP. COMS./ADMISS.'
SAO PAULO =====						
-SUTRAMEDI MEDICINA EMPRESARIAL S/C.LTDA. VIA ANCHIETA, NR.1838, IFIRANGA - TELEFONE:61-0929 E 274-7000 SAO PAULO, SANTO ANDRE, SAC BERNARDO DO CAMPO SAO CAETANO DO SUL	09	FRUI DE A.SANTOS /DIRETOR PRESIDENTE (MEDICO) ISUELENA M.TRENCH /DIRETORA ADMINISTRATIVA (CIR.DENT.) PAULO V.ARAUJO / DIRETOR CLINICO (MEDICO) ESTEFANO BRUNO /DIRETOR FI- NANCEIRO (CONTADOR)	STANDARD EXECUTIVE	N.A.	N.A. PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	N.A. N.A.
-UNICLIN ASSIST.MEDICA INTERNACIONAL S/C.LTDA RUA ESTADOS UNIDOS, 2174, JARDIM AMERICA CAPITAL TELEFONE:250-8211	09	MARY ELWING /DIRETOR CLINI- CO (MEDICO) DAVID ELWING /DIR.ADMINIS- TRATIVO (ADM.EMPR.) MICHEL D.P.PEREYRI /DIR. FINANCEIRO (ECONOMISTA)	STANDARD EXECUTIVE	N.A.	N.A. PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	N.A. N.A.
-SAO CARILO ASSIST. MEDICA S/A. RUA ARMANDO SALLES OLIVEIRA, NR. 120-CENTRO SAO BERNARDO DO CAMPO TELEFONE: 448-9334 SAO BERNARDO DO CAMPO, DIADENA	29	ABELARDO ZINI /DIRETOR (MEDICO) CARLINDO DE ALMEIDA /DIR. (MEDICO) CLOVIS F. LERRO /DIRETOR (MEDICO) WASHER B.DE CASTRO /DIR. (ECONOMISTA)	STANDARD EXECUTIVE	7000 10000	PRIMARY: 2.7% SECONDARY: 69.8% TERTIARY: 27.5%	14840 295
-HOSPITAL NOSSA SENHORA DA POMPEIA RUA BARALDI, NR. 670 - S.C.DO SUL TELEFONE:453-5544 E 441-7877 SAO CAETANO DO SUL	20	DANTE A.MONTAGNANA (MEDICO) AVITOR DE RUSSI NETO ALBERTO B.ADAS	STANDARD EXECUTIVE	5000 10000	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	N.A. N.A.
-SERMED S/A. RUA EPITACIO PESSOA, NR. 1625, CENTRO -SER- TADZINHO TELEFONE: 642-3733 SERTADZINHO, RIBEIRAO PRETO	09	YUSSIF ALI MERE /SUPERIN- TENDENTE (MEDICO) RAUL CLEMENTE /DIRETOR CLI- NICO (MEDICO)	STANDARD EXECUTIVE	10000 25000	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	65720 1302
-SAMHO SERV.DE ASSIST.MED.HOSP. LTDA. RUA 7 DE SETEMBRO, NR. 26-2/A, CENTRO - SOROCABA TELEFONE: 31-5889 E 31-4943 SOROCABA, ITU, SALTO, TATUI	12	ANTONIO VIAL /DIR.COM. (ME- DICO) RICAO ROSAS BARRIOS /DIRE- TOR OPERACIONAL RIVO V.MARTIN /DIR.CLINICO (MEDICO) REDESAY M.SILVA /DIR.ADM. FINANCEIRO	STANDARD	10000 25000	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	7420

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H.M.O. NAME AND CITIES SERVED	YEARS OF 'CPEFA' - 'TION	KEY MANAGERS	TYPES OF PLANS	'NR. OF EMPLOYEES COVERED (FROM/TO)	'COMMERCIAL SECTOR DISTRIBUTION	PROJECTED 1ST SEMESTER	'OP. CONS./ADMISS.
SÃO PAULO							
-SIAM SERV. A IND. DE ASSIST. MEDICA S/C. LTDA. RUA DA PENHA, NR. 914, CENTRO - SOROCABA TELEFONE: 33-9333 SOROCABA, TATUI, VOTUPORANGA, SALTO	09	#BENEDITO J. PINTO / DIRETOR (CLINICO) (MEDICO) #NELSON P. BRESSAN FILHO / RE- LACCES MEDICAS (MEDICO) #IMAO DOY / DIR. ADMINISTRATI- VO #ADENIR H. WATANABE / DIRETOR (MEDICO) #EZIO OKUMURA / DIRETOR (MEDICO) #EDUARDO M. HISATSUGU / DIRE- TOR (MEDICO) #JOVANI FURLANI / DIRETOR (COMERCIANTE)	STANDARD EXECUTIVE	5000 10000	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	33920	672
-HOSPITAL E MATERIDADE CAMPOS SALLES AV. ANTONIO MARQUES FIGUEIRA, NR. 200 - SUZANO TELEFONE: 477-1177 SUZANO, ITAQUASECUTUBA, MOGI DAS CRUZES, SÃO PAULO	12	#MARIO EGASHIRA / SOCIO-PRO- PRIETARIO (MEDICO) #CARLOS T. WATANABE / SOCIO- PROPRIETARIO (MEDICO) #PAULO AKAKAKI / SOCIO-PRO- PRIETARIO (MEDICO)	STANDARD EXECUTIVE	N.A. N.A.	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	N.A.	N.A.
-CEMED CENTRO MEDICO POLICLINICO S/C LTDA. R. CAP. LISBOA, NR. 695, CENTRO - TATUI TELEFONE: 51-3131 E 51-2946 TATUI	09	#ALCEU NACHADO FILHO / DIRE- TOR GERAL (MEDICO)	STANDARD	1000 5000	PRIMARY: N.A. SECONDARY: N.A. TERTIARY: N.A.	11448	227
-VIO-MED SOCIEDADE VINHEDENSE DE MEDICINA LTDA. S/C. RUA DR. ANESIO AUGUSTO DO AMARAL, NR. 250 CENTRO - VINHEDO TELEFONE: 74-1710 VINHEDO, CAMPINAS, JUNDIAI, INDAIATUBA, SALTO, ITU	10	#JOSE O.M. DOS SANTOS / SO- CIO (MEDICO) #MANOEL MATEUS NETTO / SO- CIO (MEDICO) #OSVALDO BEANI / SOCIO (ME- DICO) #PAULO ANNES / SOCIO (ME- DICO)	STANDARD	1000 5000	PRIMARY: 1.0% SECONDARY: 90.0% TERTIARY: 9.0%	(8)14670 (8)	11

(*) ONLY OUTPATIENT CARE

(*) ACTUAL DATA SUBMITTED BY H.M.O.

CITIES SURVEYED IN THE STATE: 48

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SAO PAULO
 === =====

BECAUSE OF THE LARGE NUMBER OF H.M.O. ENROLLMENT IN THE STATE OF SAO PAULO, H.M.O. PRODUCT CHARGES (PER CAPITA/PER MONTH) ARE CLASSIFIED AS FOLLOWS:

A) CITY OF SAO PAULO (CAPITAL)

STANDARD -FROM:CR\$ 11000
 TO:CR\$ 20000

EXECUTIVE-FROM:CR\$ 20000
 TO:CR\$45000

P.P.O. -FROM:CR\$ 25000
 TO:CR\$ 50000

F. CHOICE-FROM:CR\$ 45000
 TO:CR\$ 90000

B) CITIES AROUND SAO PAULO (SANTO ANDRE, SAO BERNARDO DO CAMPO,
 SAO CAETANO DO SUL, DIADENA, MAUA,
 OSASCO AND GUARULHOS)

STANDARD -FROM:CR\$ 9000
 TO:CR\$ 16000

EXECUTIVE-FROM:CR\$ 17000
 TO:CR\$ 40000

P.P.O. -FROM:CR\$ 25000
 TO:CR\$ 50000

F. CHOICE -FROM:CR\$ 30000
 TO:CR\$ 65000

C) CITIES IN THE INTERIOR OF STATE OF SAO PAULO, NOT INCLUDED IN
 ITEMS "A" AND "B" ABOVE:

STANDARD -FROM:CR\$ 12000
 TO:CR\$ 20000

EXECUTIVE-FROM:CR\$ 30000
 TO:CR\$ 60000

P.P.O. -FROM:CR\$ 45000
 TO:CR\$ 80000

F. CHOICE -FROM:CR\$ 50000
 TO:CR\$ 100000

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STATE	CITIES SURVEYED	SURVEYED H.W.G. OPERATING IN THE STATE
ALAGDAS	1	-
AMAZONAS	1	4
BAHIA	12	4
CEARA	1	2
DISTRITO FEDERAL	2	3
ESPIRITO SANTO	4	3
GOIAS	2	3
MARANHAO	1	1
MATO GROSSO	1	1
MATO GROSSO DO SUL	1	1
MINAS GERAIS	13	15
PARA	1	3
PARANA	6	6
PERNAMBUCO	6	6
RIO DE JANEIRO	9	7
RIO GRANDE DO NORTE	1	1
RIO GRANDE DO SUL	17	6
RONDONIA	1	1
SANTA CATARINA	1	1
SAO PAULO	48	86
SERGIPE	1	1
TOTALS :	170	152

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ANNEX #4:
ORGANIZATION OF HMOS IN URUGUAY

ORGANIZATION OF HMOS IN URUGUAY

Enrollment in HMOs

The enrollment with an HMO can be done in three different fashions:

- a) Individual enrollment: The person pays a monthly premium directly. The HMO has a special place for collection or it sends collectors to the houses of its members.

In contrast to the following systems, this one represents a higher collection cost to the HMO as well as possible delays in payments. In 1984 the individual enrollment represented 67% of total HMO population.

- b) Enrollment through the Sickness Insurance Fund (DISSE): this fund is part of the Social Security Administration under the control of the Ministry of Labor and Social Security and is the intermediary agent between the HMOs and the beneficiaries. It is financed by employers' contributions (4% of total salaries paid to the workers) and workers' contributions (3% of salary) made to the Sickness Insurance Fund. The Fund, in turn, contracts with HMOs for health care services. Social Security beneficiaries, (workers included in the Sickness Insurance Fund) have the right to select the HMO

from which he/she will receive the services. The Fund pays his/her premium directly to the HMO on his/her behalf. Labor groups comprised within this regime and for which enrollment is mandatory are: construction, land and ocean transport, wood, paper, textile, graphic, clothes, leather, metallurgy, electronics, jewelry, plastics, food and meat packing, chemical products and pharmaceuticals. Recently retail store employees, as well as rural workers and housekeepers, have been incorporated into the Fund. Prior to these incorporations, this type of enrollment amounted to 23% of the total HMO population. It is estimated that this percentage will increase with the concomitant decrease in individual enrollment.

- c) corporate enrollment: made through an agreement reached between a company or union and an HMO. This type of enrollment generally covers activities excluded from the Sickness Insurance Fund regime and serves about 10% of the total population.

Health service coverage provided by HMOs

Health service coverage to which beneficiaries are entitled through the payment of a monthly premium is standardized and legally regulated. It includes some preventive services (immunization and periodical clinical and paraclinical controls), ambulatory care in all specialties, inpatient care (either common or in intensive care units), dental care, diagnostic techniques, drugs, surgery, Xrays, rehabilitative services and limited psychiatric treatment.

The following services are excluded from the health service coverage:

- actions and/or procedures with an aesthetic objective whenever the maintenance or recovery of a function is not involved.
- orthotic and prosthetic devices.
- psychoanalysis and other psychiatric therapy techniques.
- rehabilitation techniques not providing real benefit to the patient in chronic physical diseases or with definite sequelae.
- diagnostic and therapeutic techniques and procedures which are: of high unit cost and rate application, of unproven efficiency and on an experimental basis, or not incorporated in the common medical practice within the country.

The members have the right to receive care within the limits of the department (political division) where the HMO has its main facility, except in cases of emergency, which is covered by the HMO throughout the country.

Besides this benefit package, HMO members, regardless of their kind of enrollment, pay a mandatory additional amount of US\$40 per month as a contribution to a Catastrophic National Health Insurance Fund. This Insurance Fund collects contributions from all HMOs as well as from other agencies, mainly from the Ministry of Health which pays on behalf of the population that receives basic health care services from Ministry of Health facilities. In turn, the Catastrophic National Health Insurance Fund contracts, on behalf of the entire population of the country, the delivery of highly specialized services (cardiac surgery, chronic renal dialysis, kidney transplant and a few others) with private and autonomous health care organizations that may or may not be part of the HMO.

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In summary, health benefit coverage of HMO members is quite comprehensive, not only because of the services that the organizations provide at their own cost, but also because of the highly specialized and costly services that are provided through the Insurance Fund.

Prepayment experience in the rural areas

SAYSS (Servicios de Asistencia y Sociales Salto) is a new occurrence in health care under way in the rural areas of the County of Salto. Representatives of the community and of public institutions actively participate in the organization whose main objective is to provide health care services within the mentioned area. It also undertakes social works.

Governing Bodies - It is directed by authorities working at two levels: a) at the central level in the city of Salto; b) at the local level through the Support Commissions.

The Central Committee and the Local Support Commissions are integrated through the appointment of members representing the public sector, and by community elections for the remaining members. The government representatives, come from the public institutions connected to SAYSS, which are: the Ministry of Health participating through the Salto Health Center, the City Government, the Board of Primary Education, (through the School Inspectors), and the Police.

Structure - It operates through 27 clinics, most of them function within primary schools in the rural Salto area. These clinics are managed -except in technical matters- by a Local Support Commission with a President, Secretary, Treasurer and members.

Services provided - Twenty of the 27 clinics have permanent staff. There are six physicians living in the area and three physicians living

in the capital of the department who travel to the rural area. The non-medical personnel are specialized in primary and emergency care.

Services provided: primary care, general medicine, pediatrics, gynecology. Twenty five of the clinics provide dental care as well. The patients' clinical records are kept in the clinics at the local level so that the rotation of physicians does not harm the continuity of care. In addition, radio-transmitters are being set up in order to facilitate communication.

On the average, there are about 2000 ambulatory visits per month. Physicians provide care at the local clinics at different frequencies, varying according to the distance and the density of the population from two visits a week to one visit a week or one visit every fortnight.

Financing - It is mainly financed with the contributions of the beneficiaries through a monthly prepayment which depends on the number of people covered and on the kind of services provided, but it never exceeds US\$0.42 per family. Furthermore, they receive grants and government support in goods and services (such as transport) and personnel.

Drugs - They are mainly provided by the Ministry of Health and also purchased by SAYSS. There are some donations as well.

Central Facility: Centro de Salud de Salto (Salto Health Center) - Uruguay 364, Telephone 2929; person in charge: Mr. Revello.

Printed material (booklets, etc.)

In Uruguay there is little information issued by the HMOs with the aim of letting the public know their activities, their coverage, their

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members' rights, etc. This situation is mainly due to the fact that HMOs, and more specifically Mutual Benefit Societies, have existed in Uruguay for over one century, therefore they are well known with regards to their scope and the percentage of the population covered by the system is quite large.

We were able to gather brochures from only three HMOs in Montevideo. This reflects a very low level of marketing. However, lately through radio and T.V. commercials some HMOs have begun to try to expand their membership, aiming at workers newly incorporated in the Sickness Insurance Fund.

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PROSPECTS FOR THE DEVELOPMENT
OF HMO-LIKE HEALTH
CARE DELIVERY SCHEMES
IN MEXICO, CENTRAL AMERICA,
PANAMA AND THE CARIBBEAN

BY: JOHN DOHERTY

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I. SUMMARY

This study was undertaken under Cooperative Agreement No. LAC-0000-A-00-4049 between the Agency for International Development (AID) and the Group Health Association of America, Inc. (GHAA) for the purposes of identifying and describing prepaid and/or HMO-type activity in Latin America and the Caribbean. This portion of the study concentrates on public and private sector health care services in the northern region of Latin America and the Caribbean.

The study is concerned principally with the growth and development of HMO and HMO-like schemes of health care delivery in the northern region of Latin America, namely Mexico, Central America, Panama and the Caribbean and with the health laws and legislation which regulate these schemes. It also examines the health delivery systems in several countries with the aim of facilitating consideration of the feasibility and transferability of generic elements of the U.S. prepaid health systems experience or modification of that experience in search of alternative approaches to financing and delivering health care generally.

Findings

As a result of extensive research and discussions with Latin American and Caribbean health experts, a basic conclusion of this study is that there are few, if any, formal legal constraints to the

development of prepaid medical care schemes in the region and that specific enabling legislation exists only in Brazil, Chile and Uruguay. This conclusion however, derives primarily from review of the laws of each country studied and does not reflect practice, tradition or internal regulation of governmental agencies, knowledge of which would require on-site observation. Another conclusion based on information available in Washington, DC and from local contacts, is that the only truly sizeable presence of HMO or HMO-like activities in the region is largely concentrated in the Southern Cone.

Other distinctions bearing on HMO development in the southern and northern regions are differences in demographics and per capita income which indirectly relate to marketing and financing aspects of HMO feasibility. Mexico with approximately 73,000,000 people is the only populous country in the North. The next largest is Guatemala with 7,477,000. Following in descending order are: the Dominican Republic, 6,418,000; Haiti, 5,800,000; El Salvador, 4,671,000; Honduras, 3,818,000; Costa Rica, 2,340,000; Panama, 1,900,000; and Belize, 149,000. [1] The combined populations of all the countries of the English speaking Caribbean including Belize and Guyana is less than 7,000,000 persons with Jamaica and Trinidad and Tobago accounting for 3,558,000 of that total.

In terms of GNP per capita income per annum, Mexico is highest with U.S. \$1,800. [2] Panama, Costa Rica, Guatemala and

the Dominican Republic are the only other countries with GNP per capita income over U.S. \$1,000 per year. Honduras, Haiti, Belize, El Salvador and Nicaragua are considered lower or low income countries.

Innovative approaches to health care services and health care generally are more advanced in the three countries with the highest incomes--Mexico, Costa Rica and Panama. There are signs however, of some experimentation with and potential for alternative approaches to medical care delivery in Guatemala and in the Dominican Republic. In Guatemala there are provisions of law which enable socially insured persons to avail themselves of private care. In the Dominican Republic an archaic provision in the basic social insurance laws continues to force large numbers of wage earners prematurely out of the social insurance system when their earnings surpass 303 pesos (U.S. \$30.) per month. These people must seek private alternatives to medical care under social insurance which has contributed to the proliferation of activities among physicians and institutions in the private health sector.

Another recommendation of this study is that on-site HMO feasibility studies be undertaken in Panama where there has been movement in group practice in cooperation with the Hospital Corporation of America, and in Guatemala and the Dominican Republic where there appear to be prospects for the development of publicly and/or privately funded prepayment schemes.

Mexico should also be made the subject of an in-depth study. Growing numbers of employers in Mexico are meeting demands for private medical care by providing Group Medical Expense Benefit plans, contributions to which are tax deductible.[3] This and emerging privately insured medical care schemes should be examined and contrasted with similar schemes in other countries of the region.

An in-depth study of Costa Rica is not recommended as it has an integrated single medical care delivery system under its Social Insurance Fund. The integration took place in 1961 with the goal of providing health services to the entire population. Today, almost 90 percent of the population of Costa Rica is medically insured, though the accomplishment has not been without cost as the system is in a critical state financially. Ninety-five percent of the country's doctors are on the Social Insurance payroll. Social, economic and political uncertainties in the country and the region are having a seriously adverse effect on the health care delivery system in Costa Rica and in all other countries of the region.

The low or lower income countries should not be precluded from further study despite the lack of meaningful private sector initiative potential. While the American HMO experience may not be transferable directly, some of the basic concepts will apply and prospects for modified approaches to alternative medical care schemes in cooperation with Health Ministries and social insurance funds should be examined.

In his Guide to the Assessment of HMO Feasibility, Dr. Paul Zukin raised the question of public-private cooperation in the region where a hospital based HMO might serve clients paid for by the Ministry of Health or social security system. "This can achieve cost savings in the public sector by obviating the need to construct facilities where suitable public institutions do not exist, and it can benefit a private hospital by assuring a given level of occupancy. This system may be presently seen in Panama." [4] This would seem to be an option for a group of doctors in La Ceiba, Honduras who, according to an OAS Secretariat official, are hoping to assume direction of a hospital formerly owned by the United Fruit Company and to introduce some kind of HMO scheme. The need for consideration of a public/private mix in the health care sector in these countries is evident as David de Ferranti has stressed in the World Bank's Paying for Health Services in Developing Countries. [5] Incipient alternative financing schemes seem to slowly be taking shape in the region.

This study is also intended to assist in identifying countries in which the potential for developing such services seems most feasible. In the Caribbean basin region, for example, Panama, the Dominican Republic and Guatemala are countries which would seem most suited for developing alternative mechanisms and approaches to health care and perhaps

should be targeted for full feasibility studies. This and the role of the private sector in Mexico's health care system are discussed in greater detail later in this report.

One of the primary findings of this study, although not a stated objective, is that there is an extraordinarily large body of information available in Washington, DC, relating to health care systems in Latin America and the Caribbean including the laws and legislation which regulates them. The Hispanic Law Division of the Library of Congress has compiled a collation of laws on a country-by-country basis. The Pan American Health Organization utilizes the Library on a frequent basis in the tracking of health legislation for PAHO reports and conferences. In 1981, the Library of Congress instituted a computer access system which was utilized in this study to extract and review, on a selective basis, health laws and legislation in Mexico, Guatemala, Costa Rica and the Dominican Republic.

II. INTRODUCTION

2.1 Overview of Health Delivery and Social Insurance Systems in Mexico, Central America, Panama and the Dominican Republic

This overview covers the eight Spanish-speaking countries in the northern region of Latin America minus Cuba. Belize, although geographically located in Central America, is for purposes of this report considered part of the English-speaking Caribbean. In all but one of these countries, Nicaragua, where the Sandinistas have unified health delivery services in a single system under the Ministry of Health, social insurance is an established vehicle for financing and providing health care. However, coverage under social insurance varies widely and is not entirely unrelated to GNP per capita income with the higher income countries, Mexico, Costa Rica and Panama having more advanced delivery systems and reaching greater portions of their populations. In the lower income countries the Ministries of Health are the primary providers of health services.

In Mexico several government agencies with separate social insurance funds provide medical services, e.g., the Ministry of Health and Welfare; The Mexican Institute of Social Security; the State Employees Institute of Social Security and Services; the National Defense and the Navy plus government enterprises such as the Mexican National Railways, Mexican Petroleum and the Federal District Department. These provide approximately 75 percent of medical services in Mexico.[6] Most services under social insurance are conducted in government

owned facilities although services can be contracted out to private health providers. In 1974 the Government of Mexico introduced a new National Health Plan. The plan proposes to extend coverage with emphasis on the rural population, to provide national coordination of medical care services and to establish a national hospital system. Mexico has pursued an ambitious program for serving the indigent population through an integrated development program called COPLAMAR which reaches about 10,000,000 or 1/3 of the rural population.[7]

Costa Rica is unique in the region as its medical care delivery services have been intergrated in a single system under social security. It is also unique in that the Social Insurance Institute provides coverage to nearly 90 percent of the population, the most extensive in the region. The Institute, in addition to running its own hospitals, is also responsible for management of all public hospitals and health care facilities. The Ministry of Health retains responsibility for providing medical care to the indigent population.

Like Costa Rica, Panama has also been integrating medical care services albeit with less success. The process began in 1972 when the Government adopted a proposal to harmonize the Ministry of Health and Social Insurance Fund (CSS) programs in an effort to decentralize and expand services. While half the population of the country today is still under the Ministry of Health and the other half under CSS, there is no doubt that integration has enabled CSS to extend the scope of social insurance to a greater percentage of people while utilizing Ministry of Health facilities.

The lower income countries in the region, Guatemala, Honduras, El Salvador and the Dominican Republic have single social insurance funds but relatively low percentages of their population are provided medical care services by the Funds. The bulk of medical care is provided by the Ministries of Health which have almost exclusive responsibility for primary health care in urban as well as rural areas. These countries have much in common not only in terms of their relative stages of underdevelopment and staggering economic problems, but also in regard to their health systems which are hamstrung by lack of coordination, rising costs, wasteful duplication and all the other ills which translate into low quality health care for a majority of their people. The margin for private sector participation in upgrading health care is generally smaller in these countries, but there are developments in Guatemala and the Dominican Republic in this regard which are discussed elsewhere in this report, that indicate potential for increased private sector participation.

In each of these countries, to varying degrees, private medical services are provided on an ability to pay or direct payment basis and in most of the countries in combination with social or private insurance. There are also provisions in some to treat indigents in private facilities when public facilities are non-existent or inaccessible. Increasingly, people with the ability to pay, including working class people, are opting for private medical care. For most it is a matter of sacrificing for higher quality care. For some it is a matter of class attitude which attaches a stigma to use of public or government sponsored facilities. This explains, in part, the high percentage of privately owned hospitals in six of these countries: Dominican Republic 64.6, Honduras 53.6, El Salvador 37.3, Guatemala 32.8 and Mexico 30.1. In Costa Rica and Panama the percentages are 8.1 and 17.9 respectively. In general, medical facilities in the private sector are smaller than in the public sector with the percentage of total beds being much lower. With the exception of Dominican Republic 23.3, Honduras 22.8 and Mexico 14.1, beds in private facilities in the region are less than 10 percent of the total.[9]

2.2 Overview of Health Delivery and Social Insurance Systems in the English-Speaking Caribbean

As mentioned previously, the total population of the English speaking Caribbean is under 7 million or roughly equivalent to that of the Dominican Republic. The countries of the Caribbean regions are mostly small island states with small populations. It would be difficult to establish HMO or HMO-like schemes in most of these tiny countries. The lack of a market, low prepayment income potential and prohibitive administrative costs would render such endeavors impractical. However, Trinidad and Tobago, with over a million inhabitants enjoying the highest per capital income in the region (U.S. \$4,000) has potential for the development of alternative prepaid health care schemes.[10] Jamaica is already experimenting with alternative health care financing approaches.

Health care services in the English speaking Caribbean are generally disorganized and poorly integrated. The bulk of these services are provided through the Ministries of Health. The principal medical care facilities in most countries of the region are owned by the governments and the fees are usually reasonable and sometimes free or scaled to income.[11] Public hospitals are generally overcrowded and people with the means utilize private hospital facilities. Often even primary health care services are based on the ability to pay rather than need. Only Antigua and Bermuda provide medical care through national health insurance programs on a cash reimbursement basis.

Beryl Frank, in his Problems and Trends of Social Security in the English-Speaking Caribbean, suggested that some of the governments of the region, in their desire to reduce expenditures and to seek new sources of financing for health services, are considering including in their social security programs measures whereby insured persons and their employers will contribute a percentage of earnings in order to reimburse private and public providers of health care.[12] Schemes of this type are found in Antigua, Barbados and Bermuda. Frank also suggests that the Latin American pattern of establishing a separate and frequently uncoordinated competing network of medical care installations is not an appropriate solution in the Caribbean.

2.3 Regional Perspective of Health Laws and Legislation

Extensive research at the Hispanic and Eastern Caribbean Law Division at the Library of Congress, the National Library of Medicine and the Libraries of PAHO, OAS and the Department of State, and detailed examination of the files of the International Policy Staff office of the Social Security Administration as well as materials supplied by the General Counsel of PAHO have revealed that there is no singularly comprehensive collection or body of health laws and legislation for any of the countries of Latin America available in Washington, DC.

The Pan American Health Organization is just now beginning to focus on the need to develop a comparative health law compilation for the region. This is undoubtedly due in part to heightened interest in most countries of the Hemisphere in the development of alternative health care approaches as a means of making current systems more efficient and extending primary health care to their expanding populations. However, despite the determination of PAHO Secretariat officials to move ahead in this area, it is not likely that significant progress in this regard will be made in the foreseeable future. PAHO sponsored a conference on legislation last fall in Washington, DC which confirmed the need for pooled information, but this is only a beginning and there are budget constraints affecting the process. The International Digest of Health Legislation, a quarterly published by the World Health Organization which usually contains some references to specific aspects of health

legislation in one or two Latin American countries, is available in the PAHO library, but is of very limited value for the purpose of gaining an overall legislative prospective in the region. WHO conference proceedings and other WHO publications are available in the PAHO and the Department of State libraries but these do not contribute significantly to a more comprehensive understanding of the legislation.

In general, the objective of legislative research in this study was to determine the existence of either enabling or restrictive health laws and legislation which would affect the development of prepaid HMO or HMO-like schemes and group and corporate practices of medicine. It was also to examine the extent of laws pertaining to advertising, the legal processes for licensing and the roles of doctors and other medical professionals and laws pertaining to employment of non-national professionals and insurance laws.

The first and most important conclusion of this research is that on-site visits to the countries themselves are absolutely essential to identify accurately the legal and regulatory requirements of an HMO feasibility survey. Review of laws and legislation available at the Hispanic Law Division, indicates there are few, if any, enabling laws or laws of a generally restrictive nature governing the development and functions of HMO or HMO-like organizations in the region. Conversations with Latin American health experts tend to confirm this along with suggestions that legislation will emerge only as these alternative schemes proliferate and command regulation.

Basic statutes dealing with the licensing, education and conduct of medical professionals are available at the Law Library but are not framed in the context of group or corporate practice nor do they go beyond basic requirements and processes.

Advertising of medical services, which is outside the Latin American experience generally and would be frowned upon in most countries in the region, is accorded scant attention in the health legislation of most countries except in the regulation of drugs and medical equipment. Health laws of most countries are very rigid in the regulation of advertising as it relates to the marketing of pharmaceuticals, and medical equipment, but do not specifically refer to advertising by hospitals and medical facilities.

The labor laws of most countries are primarily concerned with setting the requirements for work permits for non-nationals. In some countries, there is a ceiling or set percentage of non-nationals (10 percent in Mexico) who can be employed in an enterprise, whether foreign or domestic. Some specify professional or industrial sectors in which the numbers of non-nationals are regulated.[13] Information regarding this aspect of labor law is available at the U.S. Department of Labor Library.

Private medical insurance is relatively new in many countries and, in the case of Mexico, is evolving rapidly. Laws and regulations governing medical insurance schemes were not available at the Library of Congress, but private sector information services deal with the subject.[14] Employers in

Mexico are increasingly providing private medical insurance for salaried employees. The International Benefits Information Service advises clients "... most multinationals have implemented hospital and medical coverage for salaried employees. There are two types of coverage: one with a limit on the amount paid for room and board, surgical fees, ambulance, and nursing care; the other, is 50 percent more expensive but has no limits. Most plans have coinsurance varying from 10 percent to 25 percent with a deductible of 1 percent to 3 percent of the sum insured. Usually both apply per event rather than on an annual basis."

2.4 General Assessment of Political Environment and Market Place Conditions Relating to Health Services in Cental America and the Caribbean Basin Region

As the political leaders and economists in the United States, Japan and Western European nations talk in terms of extended economic recovery and refer to the economic recession in the past tense, the economies of most countries of Latin America and the Caribbean are still suffering the continued effects of the recession and are beleaguered by the unabated escalation of inflation and high rates of unemployment and underemployment. Resolution of the economic crisis, particularly in the countries of the northern tier of Latin America, is seriously complicated by high birth rates which have defied efforts by the governments of many of these countries to implement family planning and population control measures. This has been among the factors contributing to general economic and political instability in the region and is also a factor in health care planning as well as in the provision of primary health care. It is not without effect on the ability and the will of governments, particularly in the low income countries to make needed changes in their health care delivery systems. Some experts assert that the recession and continuing economic crisis have actually generated the intensifying search for alternative and integrated health delivery systems. In other words, it is economic necessity as well as the demand for expanded coverage to meet the needs of growing populations which make the prospect of developing alternative approaches, including the promise of

more efficient and cost effective schemes generated by private sector involvement, a matter of high priority.

In regard to health care, Mexico is clearly the most advanced country in the subregion, but is beset with serious problems; it has double the combined population of the rest of the countries in the subregion. When unveiling the National Health Plan in August, 1984 the Government of Mexico released a study which showed 14.8 million citizens with no health services whatsoever. More than 100,000 children die every year before the age of five because of malnutrition and 20 million suffer from serious lack of nourishment.[18]

Costa Rica, the oldest standing democracy in Latin America, brings health care to a larger percentage of the population than any other country. Nevertheless, its single system integrated approach is experiencing serious difficulty due to rapidly escalating costs of the system and general deterioration of the economy. For the first time in nearly 10 years the "model democracy" is also experiencing serious political instability due to both internal and external factors.

The region as a whole is experiencing serious economic problems and, except for more politically stable Mexico and Panama, most countries of the region are suffering politically as a consequence of deteriorating economic and social conditions which are being exploited by the Marxist governments of Cuba and Nicaragua and internal revolutionary forces seeking power through destabilization. This has exacerbated conditions

generally. It has also contributed to disturbingly heavy emigration and immigration as well as economic and social displacement.

It is against this background that governments of the region struggle to provide more and improved health care to their peoples. In that struggle the search for innovative alternative health care delivery schemes including the employment of publicly and privately funded prepayment schemes and greater involvement of the private sector is assured.

III. ORGANIZATION OF HEALTH SERVICES - MEXICO

3.1 Health Delivery and Social Insurance System

According to 1984 Mexican Government statistics, its social security institutions provide medical services to 34.3 million people or about 46 percent of the population made up of workers and their families. About 5 million agricultural workers and their dependents are included in this number.

The Mexican Social Security Institute (IMSS) is the largest of the government social security programs. Others are listed in 2.1 above. An additional 5 million plus rural inhabitants received medical care under COPLAMAR, an integrated non-contributory development program which is administered by IMSS but state financed. As in most countries of Latin America the Ministry of Health has responsibility for primary health care. Through increasingly integrated efforts (see new National Health Plan, Sec.3.2 below) Mexico has made more progress than most of her sister republics in extending health care to the indigent population.

Medical care in Mexico is largely "direct", but with the intensification of efforts to extend medical care to the entire population and to maximize integration between public and private sectors. Innovations are being encouraged, including the use of private facilities by insured persons.

Multinational companies doing business in Mexico are meeting the demands of their salaried employees for private medical care by providing Group Medical Insurance Benefit plans for these employees. This is highly recommended as a useful

method for attracting and retaining desirable employees.[16] As an incentive, tax deductions are granted. There is a growing trend in the direction of private care utilization in Mexico despite the comprehensive and generally satisfactory care under social insurance.

3.2 New National Health Plan

In August of 1984 the President of Mexico announced a National Health Plan (complete text in General Annex) aimed at responding to these basic objectives: to expand coverage of health services; to increase the basic quality of medical attention; to prevent disease through preventive medicine and timely detection; to improve sanitary conditions and the environment; to bring down population growth rates; and to extend and improve social assistance.

The basic thrust of the program is aimed at meeting the needs of the large segment of the population not now covered by medical care. The plan proposes to extend coverage to the entire population, regionalizing the medical assistance services and creating a national system through coordination of efforts with the support of regional and local commissions. Establishing a national hospital system and providing primary medical care to the rural population are specific targets within the first three years.[17] The plan's population control thrust aims at getting 7.6 million women to use modern contraceptives by the end of the century in addition to 600,000 using traditional methods of birth control.[18]

3.3 Political Environment and Market Place Conditions Relating to HMO Prospects

Ever since 1929 when the Mexican Revolution became solidified under the single party rule of the PRI (Party of the Institutional Revolution), the country has been blessed with political stability. Many observers of the Mexican scene through the years have predicted the ungluing of the Party and the country as a whole due to economic crisis, various student uprisings or feared rebellions in the "campo" by an impatient rural population. None of these has ever occurred in any uncontrollable fashion and is not likely to in the foreseeable future.

Nevertheless, the current economic crisis is perhaps the most severe thus far and is affecting a rapidly growing (2.9 birth rate) population which is expected to reach 100 million by the end of the century. Just as there are intense pressures on the economy to produce jobs and to deal with both emigration and immigration problems, there are also intense pressures on the Government of Mexico to project providing medical care for millions more people when the current system cannot serve the existing population. The austerity program which has imposed belt-tightening measures on an already burdened people and the rescheduling of external debt are viewed as positive steps toward strengthening the economy.

The future will much depend on the Government of Mexico's ability to provide for low income groups and to prevail on unions and employers to maintain agreements on wages and prices

until austerity measures take effect. Immigration from Mexico to the U.S. has long provided a safety valve of sorts, but unless economic growth occurs in an accelerated fashion, internal social pressures are certain to reduce its value.

Meanwhile the Mexican Government seems very committed to both improving and extending coverage of health care delivery services. Developing innovative approaches and greater utilization of the private sector seems to be an integral part of the planning process.

Accordingly, even without precise information of the actual numbers of HMO or HMO-like schemes already in existence in Mexico, it is likely that the development of publicly financed care in the private health sector will increase and that some kind of public/private mix in funding and cross-utilization of facilities will continue to evolve. There would be considerable indirect benefit to an exchange of information in the field of health care, particularly regarding experiences in prepaid approaches. There would also be value in having the ability to contrast health care developments in Mexico with lesser developed countries in the region. For these reasons it is recommended that an in-depth study of the Mexican health delivery system in the context of alternative systems development be undertaken.

IV. ORGANIZATION OF HEALTH SERVICES - CENTRAL AMERICA

4.1 Guatemala Health Delivery System

Health Laws and Legislation. Prospects for HMO Development.

Unlike Mexico and many countries of South America, Guatemala maintains rigid separation of the medical delivery networks of the Ministry of Public Health and Social Assistance (MSP) and the Guatemala Institute of Social Insurance (IGSS). There is no co-utilization of facilities or transfer of social insurance funds to support MSP as an integrated system. The IGSS expends as much as MSP each year but only 14.5 percent of the population is covered by social insurance.[19] The MSP therefore is responsible for attending the rest of the country with roughly the same amount of money.

In reality, the number of people actually covered by social insurance for general medical care is much smaller. A unique provision of the social security law limits medical care services outside the capital to accidents both work related and non-work related. This means that most IGSS facilities in the rural areas are confined to treating trauma and in the process, medical care is denied to 70 percent of agricultural workers covered under social insurance.[20] Even in the capital city region, entitlements under IGSS are limited. They include maternity care for the wives of insured workers and medical care for children only up to two years of age. In terms of general medical care, therefore, a very small percentage of the population and also of the labor force is covered by social insurance.

The MSP is the principal provider of medical care outside the capital and yet 58 percent of its hospital beds are located in the capital city area where only 25 percent of Guatemalans reside.[21] The MSP maintains a network of health centers and health posts throughout the country. Dr. Milton Roemer's draft paper Health Service Coordination in Guatemala (USAID/Guatemala, June, 1975) listed a total of 87 health centers and 376 health posts with the former generally staffed by one of two doctors plus auxiliary personnel and the latter by allied health personnel, usually an auxiliary nurse who has had only a few months of training following elementary school.

Generally, as in other low or lower income countries of Latin America, medical facilities under social insurance in Guatemala are smaller, fewer in number, and better staffed and equipped. They are also more costly to maintain with doctors paid considerably more and administration costs accounting for a significant portion of overall costs. In Guatemala doctors are strongly unionized and relatively well paid.

As a consequence of this fragmented approach to medical care, a large part of the population is either poorly served or not served at all by the system. There are voluntary non-profit agencies at work in the health field in Guatemala, most of them church related, which are engaged in running small clinics primarily in rural villages. There is also a private medical sector which is small and largely concentrated in the capital city area but is expanding and could be an important element in

Guatemala's search for an improved, coordinated and updated medical care delivery system. According to Dr. Roemer, there were about 38 privately owned hospitals with 1200 beds, but those figures have undoubtedly increased since 1973 although not all changes which have occurred would alter statistics very significantly. For example, Dr. Roemer reported an infant mortality rate of 81 per thousand as compared with 79 per 1000 in 1985. Dr. Roemer also reported 1,270 active doctors or a ratio of about 1 to 4,300 people. More than 75 percent of these doctors are in the capital area and while very few are exclusively in private practice almost all devote some part of their time to private practice.

In terms of prospects for the development of HMO or HMO-like health delivery schemes, they are not promising in Guatemala although there is at least one organization now in operation which could conceivably serve as a model. This is Medica Guatemalteca which has 10,600 members, two small facilities in downtown Guatemala City and its own staff of doctors and auxiliary personnel. In arrangement with the IGSS, members of Medica Guatemalteca covered by social insurance will be reimbursed for part of the costs of private care. In its brochure, which appeals to employers as well as individuals, Medica Guatemalteca offers its services to family members not covered by IGSS including children over two, home visits and emergency service on a 24 hour basis. To employers it offers medical service for their employees at the work place and claims

that participating employers have more contented work forces and better labor relations. (This brochure is included in the General Annex of this report.) According to the AID Health Officer in Guatemala, there may be plans for creating a similar plan at one of the better hospitals in Guatemala City.

There is also new legislation being considered which will make it mandatory for either IGSS or MSP to contract for services of the other when facilities of either are inadequate or nonexistent. This will open up the possibility for more innovative delivery approaches. This plus the fact that the Guatemala social insurance system already provides for reimbursement to insured persons for private care would seem to warrant a more in-depth study of HMO-like development feasibility in Guatemala.

The determination to proceed with a feasibility study should be considered within the context of current social and economic conditions, the political climate, and demographic projection. Guatemala, with 7,500,000 people has a population growth rate of 3.1 percent. More than 50 percent of the labor force of 2 1/2 million is in agriculture with a small percentage of that paying into social insurance or receiving medical care under social insurance. The bulk of medical care provided is financed from general revenue.[22]

The private sector dominates the Guatemalan economy and is backed by government policies promoting trade and investment. Since 1979 the economy has suffered from recession, low work prices for agricultural exports, and the effects of

balance of payment difficulties among Guatemala's neighbors, which has reduced their capacity to buy Guatemalan products. Deteriorating economic conditions are exacerbated by the political strife which is afflicting the region. Guatemala suffers from the additional burden of guerrilla insurgency which has severely restrained tourism and private investment.

Under such conditions, it is difficult to project any significant changes in the struggling health delivery system of Guatemala. Nevertheless, as the population increases and the demands for health care escalate, the need for alternative and innovative delivery schemes also increases. While the role of the private health sector in Guatemala is not presently substantial, there is potential for growth and more involvement in the system. A study of the means for bringing that about and for sharing U.S. private sector experience may be useful.

4.2 El Salvador. Health Delivery and Social Insurance System
Health Laws and Legislation. Prospects for HMO Development.

El Salvador is no exception among sister Central American republics seeking to extend health care to the entire population. A national health plan aimed at bringing health services to all but the 15 percent of the population covered by the private health care sector, has been evolving. The plan envisages integration of all public health sources especially the two traditional providers, the Ministry of Health (MOH) and the Salvadoran Social Insurance Institute (ISSS). However, since the ISSS only covers 5.7 percent of the population, the lowest percentage of any social insurance fund in Latin America, the advantages which system integration have brought to other countries is largely lost, both in terms of bringing in any substantial additional revenue from social insurance as well as in the area of opening up social insurance facilities to public and primary health care. The ISSS has only 11 percent of the nation's total hospital beds in 18 hospitals.[23]

The private health care sector which provides services primarily to persons with the ability to pay, owns 25 or 37.3 percent of the hospitals, but those facilities only account for 9.3 percent of the total hospital beds in El Salvador. This is an important statistic in what it says about the overburdened MOH hospitals which number only 24 but contain 6,111 or 80 percent of the nation's hospital beds

Government of El Salvador efforts to overhaul the system are complicated by both the enormity of the task and an acute shortage of required financial resources. Laws introduced in recent years extending social insurance coverage to the public sector and attempting to adjust and update the regulation of health care generally have not produced profound changes in the system.

The inability of the Government of El Salvador (GOES) to move ahead on the health care front is directly related to the continuing guerrilla war and the political and economic uncertainties it engenders. Thanks to significant external assistance, primarily from the U.S., short term economic prospects are somewhat brighter than in recent years.[24] However, the economy continues to be the economy of a country at war, with large scale capital flight, reduced public and private investment, declining trade and diminished production and exports. The GOES is making progress in controlling the guerrilla war, and the development of democracy and democratic institutions continues. However, the cost of these efforts in both human and financial terms is phenomenal, and maintaining public and social services continues to contribute to a growing and increasingly onerous debt burden.

The prospects for developing meaningful alternative approaches to the health care system are not in the short term promising. Nevertheless, this should not preclude, as mentioned in the summary of this report, the examination of innovative

approaches aimed at encouraging the further development of the private health care sector and its participation in the search for solutions.

4.3 Honduras. Health Delivery and Social Insurance System.

Health Laws and Legislation. Prospects for HMO Development.

In the region only Haiti and Bolivia are considered poorer countries than Honduras. With a population of about 4 million and a labor force of 1 million the per capita income in 1982 was \$690 per year. The infant mortality rate is 117 of 1000 and life expectancy is 53 years.[26] The economic situation is similar to that of neighboring states. Primarily an agricultural country, Honduras depends heavily on the production of bananas, coffee, timber, beef and sugar for export trade. Light manufacturing in agriculture is also important. The same economic woes besetting other countries of Central America have also had an adverse effect on economic growth in Honduras, i.e. capital flight, falling commodity prices and rising petroleum prices. Little improvement is expected in the near future. Real growth of the Gross Domestic Product was negative for the second year in a row in 1984 and with a population growth rate of 3.5 percent this translates into a significant decline in the standard of living.[27]

The health care system of Honduras has been amply described in Primary Health Care in Honduras, a study prepared for AID by James Austin of the Harvard School of Business, and by Antonio Ugalde, of the University of Texas at Austin, in The Integration of Health Care Programs into a National Health System in Latin America.

These studies in addition to analyzing the health system of Honduras also focus on efforts by the Government of Honduras to establish an integrated health system. These efforts aim at reducing inefficiencies in the medical delivery services of both the Ministry of Health (MOH) and the Honduran Institute of Social Insurance (IHSS), at bettering integration of scarce resources, and at expanding primary health care to the rural areas of the country. Statistics alone pinpoint the need for this expansion program with 75 percent of the population living in the rural areas while 72 percent of the hospital beds are located in the two urban areas, Tegucigalpa and San Pedro Sula. IHSS services are strictly for urban populations and reach only 300,000 of the population. The IHSS has strongly resisted efforts to create a national health system as have physicians. Their resistance and its effect on the future of the Honduran health care delivery system is assessed by Ugalde.

USAID has been actively encouraging and working with Honduran health care authorities in their efforts to develop a more comprehensive and cost effective system which would facilitate the expansion of primary health care to the rural population. USAID is also considering the feasibility of the participation of the private health care sector in this process. The private sector owns 25 of the nation's 44 hospitals which serve only 9 percent of the population, mostly higher income people. The participation of the private sector in alternative medical care schemes may well depend on practice and custom rather than law or regulation. Here again the

transferability of the U.S experience with HMO's in any direct sense does not seem feasible, but conceptually there is a margin of applicability of at least some aspects of that experience, especially regarding U.S. private sector approaches to organization, management and administration. Any prepayment approach would be conditioned by the extremely small base of insured workers paying into the system and of non-insured persons with the ability to pay.

4.4 Nicaragua. Sandinista Innovations in the Health Care System.

On March 1, 1982, the Sandinista Government promulgated Decree Law No.974 which established a single National System of Health with the aim of providing medical care to the entire population. The medical care components of the Nicaraguan Social Insurance Institute (INSS) were thus transferred to the Ministry of Health (MOH). Prior to this date the medical care system of Nicaragua was already unique in that there was legislation that mandated consolidation of medical services for both insured and non-insured persons. Despite this 1955 law, however, INSS continued to operate independently from the INAPS (The Public Assistance Institute) with the scope of INSS coverage extremely limited. Under the Sandinista system, workers and employers continue to pay social insurance, part of which is transferred to the Health Ministry and retained in part by INSS for sickness and maternity cash benefits for which INSS continues to have responsibility.

In 1983 another reform amalgamated INSS with the Ministry of Welfare in the Institute of Social Security and Social Welfare (INSSBI). Unlike the case of Cuba, Nicaraguan employers and employees affiliated to INSSBI contribute through payroll taxes toward financing the health care of the nation as a whole.

There are conflicting claims as to the degree of success or failure of the Sandinista Government's efforts to forge a single health delivery system under the Ministry of Health and other innovative approaches to the development of a more

equitable social delivery system in general. When the Sandinistas came to power they earmarked education and health as the two principal priorities of the new government. It is not unreasonable to expect, therefore, that progress in stamping-out illiteracy and in bringing health to all the people should have been made since 1979. According to Beryl Frank the INSS protected 20 percent of the labor force by the end of 1981. With the unification of all medical services this coverage percentage has undoubtedly increased.[28] The Government of Nicaragua (GON) claims that under Somoza infant mortality was the highest in Central America, 121 of 100 live births, which dropped to 89 of 1000 in 1983. The GON also alleges that prior to 1979 only 28 percent of the population had access to medical facilities and 90 percent of all medical care went to 10 percent of the population. Today they boast that 70 percent of the population has access to medical care and that more than 200 new health clinics have been built in rural areas. The GON also claims that previously 40 percent of all health complaints were due to malaria, but that after anti-malaria medication was administered to 75 percent of the population the number of cases dropped from 70,000 per year to 4000.[29]

It is difficult to perceive of such tremendous strides in the medical field in a span of just 4 years even with generous aid and technical assistance from Cuba and other countries. This is particularly so when considering the economic realities of Nicaragua today. The country is facing an extended period of zero economic growth or less. The foreign exchange situation

is bleak with shortages in basic consumer goods as well as gasoline and spare parts. Inflation is estimated between 60 to 80 percent.[30] Private investment continues to decline as the economic structure of the country is increasingly nationalized. Trained labor and capital resources continue to flow out of the country. Prospects for making further improvements in the health care delivery system under these conditions or even sustaining gains already made are not promising.

4.5 Costa Rica. Health Care System. Social Security as a Primary Provider of Medical Care.

Legislation has played a major role in the development of an integrated health delivery system in Costa Rica which has successfully merged public sector health services with those of social security. The integration process began in 1973 with Law No. 5349 which directed the Ministry of Health and all other agencies with health delivery functions to transfer their health facilities and services to the Costa Rica Social Insurance Fund (CCSS). However, once the integration process was initiated, it was found that CCSS did not have the necessary infrastructure nor the means to deal effectively on a national basis with planning and implementation issues and with serious managerial and financial problems. This brought about an inter-agency cooperative effort to produce relevant regulations aimed at facilitating integration.

Under the integrated system the CCSS has full responsibility for the integrated network of hospitals. The CCSS also took over all medical care to individuals insured and non-insured, including preventive measures such as immunizations and well child care. Over 90 percent of the country's health personnel is employed by CCSS and almost all hospital beds fall under its jurisdiction. [31]

The MOH retained basic responsibility for primary health care given under community and rural health programs. The Ministry also has responsibility for sanitary programs, such as insect control, malaria, food and drug control, environmental

programs and child nutrition. Demographically, Costa Rica's population growth rate of 2.3 percent is the lowest in Central America.[32] It has the second lowest infant mortality rate (37.6/1000) and longest life expectancy (men 67.5, women 71.9). Having a homogeneous population base (98 percent white) has also been a favorable factor in the advanced development of Costa Rica. All these elements have contributed to the development of the most advanced integrated health care system in the region. The fact that Costa Rica has consistently committed a larger share of its national budget to health care delivery also contributed to the evolution of a system that reaches more people (about 90 percent) with a more equitable distribution of available services. The system does, however, face formidable financial problems. While the Government of Costa Rica has made progress in efforts to deal with the economic crisis through austerity measures aimed at stabilization of the economy, public sector expenditures have been slashed.[33] The health sector, like all others relying on public funding, has experienced considerable budgetary constraint. While the economic outlook for Costa Rica is more promising than in neighboring states, much will depend on the Government's ability to attract investment, increase trade and to continue to hold public expenditures in check.

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V. ORGANIZATION OF HEALTH SERVICES - PANAMA

5.1 Status of Integrated Health Services

Panama is one of three countries in the northern tier of Latin America providing a high percentage of medical care services under social insurance (53.5 percent). The others are Costa Rica (approximately 90 percent) and Mexico (55.4 percent).[34] This largely results from constitutional provisions in 1972 mandating integration of medical care services provided by all public agencies including the Social Insurance Fund (CSS). The principal effect of integration was to harmonize functions of the Ministry of Health and the CSS and to unify their administrative and financial operations with an aim to bringing health care to everyone.

This coordinated approach to an integrated or national health delivery system, which differs somewhat from Costa Rica's single agency system, has been implemented in all provinces of Panama, but excludes the capital district. Nevertheless, the CSS has been able to increase medical services significantly using hospitals and health centers of the Ministry of Health. The state of health of the overall population has improved measurably. In effect, the CSS has been able to retain and enhance its operational capacity while at the same time supporting the health budget of the state through employer and employee contributions.[35] While not enjoying the same degree of success as the integration process in Costa Rica, health experts generally agree that Panama is well on its way to achieving the "health for all" objective.

Notes from the Department of Commerce Foreign Economic Trends of August, 1984, add to confirmation that the Government of Panama is moving ahead in the health field. Trends reports that the CSS is constructing a 20 million dollar 100 bed hospital in the densely populated suburban city of San Miguelito and that emergency and outpatient facilities are being constructed at Santo Tomas Hospital in Panama City. Trends also reports that Panamanian demand for U.S. health equipment and products continues to be strong.

5.2 Health Legislation

Another basic health law in Panama, in addition to the 1972 constitutional provision cited above, is act No. 23 of 1941 which established the Social Insurance Fund. This act implements Article 105 and 106 of the National constitution which designated the beneficiaries of social insurance benefits and health care protection provided to the labor force. Act No. 15 of March, 1975, eventually expanded coverage to "all workers, their families, spouses or companions, their children under 18 and their dependent parents. Benefits include medical and surgical treatment, pharmaceutical and dental benefits, hospitalization and x-rays."

The United Nations Economic and Social Council report of March 5, 1981, describes sickness, maternity and accident benefits as well as information pertaining to the promotion of healthy children, environmental health programs and disease control programs in Panama. (A copy of the document was submitted to AID with the original of this report.)

5.3 Political Environment and Market Place Conditions
Relating to Health Care. HMO Prospects.

Panama has made relatively more progress in recovering from the recession than most other countries in the region but is still confronted with problems of high unemployment (14 percent includes visible underemployment), declines of canal transits due to the diversion of crude oil through the new pipeline and generally reduced world trade. The prospects for 1984 reported by the U.S. Department of Commerce were for only slight economic growth. On the positive side, there were improvements in the balance of payments, increased production in agriculture and the external debt growth rate dropped. [36] Income from the pipeline and the canal are among factors putting Panama in a relatively more favorable economic condition than the countries of Central America.

Panama also enjoys a greater degree of political stability than her neighbors to the north although economic and social conditions outside the capital district generally contrast sharply with those of Panama City where 1/3 of the population resides. Unemployment in Colon, for example, exceeds 20 percent. While not affected by guerrilla warfare afflicting other nations of Central America, there is communist agitation among unions in the agricultural sector. In addition to having the second lowest population growth rate in the region (2.4 percent), Panama has a growing middle class which is rapidly turning to the private health care sector. There have been developments in the private sector including the aforementioned

Hospital Corporation of America which would indicate that some development of HMO-like schemes in Panama is under consideration. This point has been reinforced by Dr. Paul Zukin in Guide to the Assessment of HMO Feasibility. In discussing opportunities for public-private cooperation, he stated there may be opportunities for a hospital-based HMO to serve clients paid for by a minority of health or social security systems. "This can achieve cost savings in the public sector by obviating the need to construct facilities where suitable public institutions do not exist, and it can benefit a private hospital by assuring a given level of occupancy. This system presently may be seen in Panama."

VI. ORGANIZATION OF HEALTH SERVICES - THE DOMINICAN REPUBLIC

6.1 Dominican Health Care System.

In the Dominican Republic, health care services are not integrated. Like so many other countries in Latin America, the Dominican Republic has a basically two-pronged approach, with the Dominican Social Insurance Institute IDSS attending insured workers and the Ministry of Public Health responsible for the rest of the population. In the Dominican Republic only 4 percent of the population is covered by social insurance (the Government of the Dominican Republic claims 15 percent). [37] Statistics pertaining to the extent and quality of health care provided by the Ministry of Public Health are unavailable. The Ministry is reportedly underfinanced, overstuffed and generally inefficient. Public health services are considered woefully inadequate. Coverage by IDSS is also quite limited, particularly in regard to dependents. There are maternity benefits, but pediatric care is limited to the first eight months of a dependent child's life.

The private health sector in the Dominican Republic owns more than 50 percent of the national hospitals. An archaic provision of the basic social security law which removes workers from IDSS roles and eligibility for medical benefits when their salaries exceed 303 pesos per month (U.S. \$94). This has the effect of forcing a significant portion of the labor force to seek private sector medical care.

Some industries and firms in the Dominican Republic provide health insurance for their employees. The health plan and schedule of payments of one of the insurance companies contracted for this purpose (Compania Seguros Dominicanos De Salud C. por A.) is quite comprehensive.

6.2 Health Legislation.

The above cited revision excluding higher paid workers was extended by Law No. 906 of August 8, 1979 described in an IDSS communique. Among provisions of law cited in the communique is one granting to insured workers freedom to opt for medical services in private sector facilities in accordance with regulations and rates set by the IDSS. This provision is contained in Article 76 of Law No. 1896. The IDSS Social Insurance Development Plan 1974-78 details the use of private medical facilities and services by insured persons and provides a general description of the system. A 1983 perspective on projected legislation which would revamp and update the social insurance system of the Dominican Republic is also available in the annex of documents submitted with the original text to AID.

6.3 Prospects for Prepaid Health Care and HMO-like Organizations.

The Dominican Republic is experiencing extremely difficult financial conditions marked by continued low international prices for its commodity exports, high import demand, severe liquidity problems and slow economic growth. This in a country with a per capita income of \$1,260, and 30 percent of its labor force unemployed and with underemployment nearly as high.[38] About 40 percent of the labor force is in agriculture.

Social insurance legislation tends to favor the development of private sector health care, but this covers only a small portion of the population. There may be prospects for development of publicly financed HMO-like schemes, but these would likely be very limited. Given the generally poorly organized and financed condition of the health care delivery system in the Dominican Republic, perhaps the most meaningful contribution U.S. private care sector including HMO's could make would be to provide technical assistance in the basic organization, administration and financing areas which might provide much needed central focus.

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Potential sources of health care information outside the U.S. noted during the course of researching this study are: Intstituto del Seguro Social and Interamerican Studies Center in Mexico City; ILO's International Social Security Association in Geneva; Biblioteca Regional de Medicina in Sao Paulo;

Fundacion Para el Avance de las Ciencias Biomedicas in Bogota; and Centro Nacional de Informacion y Documentacion en Salud, in Mexico City. Some measure of the utility of these sources is provided by the Instituto del Seguro Social publication Seguridad Social. The January-April 1984 issue contains a comprehensive report on the Role of Human Resources in the Social Insurance Integration process in Costa Rica, and reports on coordination in Brazil, Mexico, Colombia, Venezuela and Panama between medical schools, public health and Social Security in medical education.

The Library of the U.S. Department of State is a valuable resource in the compilation of legislature profiles. The Library maintains complete and generally up-to-date collections of official daily bulletins or gazettes of every country in the region. The Diario Oficiales or Gacetas record all newly promulgated laws as well as revisions to existing laws. These daily journals are filed in bound volumes except for those of recent vintage (1983-84) which are either stacked in unbound form or have been committed to microfilm.

At the present time the Library maintains files of unbound recent editions for the following countries: Argentina, Brazil, Chile, Cuba, El Salvador, Ecuador, Mexico, Paraguay, Peru and Venezuela. The countries for which recent editions have been microfilmed and the file numbers of those files are as follows: Colombia M.S.130; Costa Rica, M.S. 32; Dominican Republic M.S. 133; Guatemala M.S.107 and Nicaragua M.S. 135. Uruguay is the only country in the region for which the Library does not have an up to date collection of the Diario Oficiales.

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JOHN DOHERTY

7.3 End Notes

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LEGAL AND REGULATORY
CONSIDERATIONS FOR
HMO DEVELOPMENT

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As part of the overall assessment and evaluation of the factors which may foster or inhibit the development of HMOs or HMO-like health care delivery schemes in the Latin American region, it is necessary to be aware of and become familiar with relevant laws, regulations, decrees and other government proclamations. In addition, the rules and practices of quasi-governmental organizations, such as medical societies, must be considered. These laws and rules establish the legal climate for HMO formation and must be assessed to develop an organizational structure that will comply with all legal requirements and permit the achievement of marketing objectives. Such an assessment must take place on site in conjunction with determining the feasibility of a particular project or proposal.

In the United States it has been the policy of the federal government and many states to encourage HMO development. This has resulted in and from the enactment of a federal HMO law and state HMO laws. These laws govern the establishment, organization and operation of HMOs. Few countries apart from the United States have HMO-specific enabling laws.

This latter observation is true of the Latin American region where there does not appear to be enabling legislation for HMOs. This is not a surprise. In the United States the term HMO achieved recognition in federal law only in 1972, although HMO prototypes had been in existence since 1929. In 1972 only three states had enabling legislation which specifically authorized HMOs and five more states permitted formation of HMO-like organizations. All other states had laws which to a lesser or greater degree would restrict the operation of HMOs. By 1985 the situation had changed quite dramatically. Now 41 out of 50 states have enacted HMO enabling legislation.

It is also relevant to this report to note briefly the recognition of HMOs in federal legislation. These health care organizations were first recognized in 1959 with the enactment of the Federal Employees Health Benefits Act. This Act authorized the federal government to contract with "comprehensive medical plans" of two types: individual practice prepayment plans and group practice prepayment plans. These were the generic names in 1959 for what we now know as HMOs. When the FEHB Program began in 1960 there were 10 comprehensive plans involved; in 1985 the number had grown to 191.

HMOs were recognized again in 1965 when the Congress amended the Social Security Act to create the Medicare program for older Americans. The Medicare Act authorized payments to HMOs by

referring to "an organization which provides medical and other health services (or arranges for their availability) on a pre-payment basis..." HMOs could provide physician services only to Medicare beneficiaries until 1972. In that year the Medicare Act was amended to include "health maintenance organization" as a defined Medicare provider form with authority to provide both physician and hospital services. Curiously, HMOs have not participated extensively in the Medicare program because of an inadequate payment formula. This formula was substantially amended in 1982 to further encourage HMO participation in this program.

In the interim between 1972 and 1982, the Congress enacted the federal HMO Act which provided grants and loans for HMO development. This caused the number of HMO like organizations in the United States to grow from approximately 30 in 1972 to nearly 300 by 1982. The enactment of state HMO laws, described above, was a concomitant development. In 1985 the number of HMOs in the United States exceeds 350.

There is a rough parallelism between these developments in the United States and what is already happening and can be expected to happen in the Latin America and the Caribbean. The summaries of health care activity in selected countries show most Latin countries trying to deliver health care through a central government financing mechanism and, less often, through government owned and operated clinics and hospitals. In many

countries the government contracts with private organizations to arrange, pay for and/or deliver health care services. It is important, therefore, to know what types of organizations may do business with the government. Where employers and employees are required to participate in a national social insurance program it may be critical for an HMO-like organization to be able to participate in the program in order to be viable.

We have observed from the U.S. experience that there is no single, official definition of "health maintenance organization." The definition varies according to which piece of pertinent legislation or regulation is being considered. The most important sources for HMO definitions are HMO enabling laws, social security and social welfare legislation and statutes authorizing government worker health benefits programs.

In order to assess the operational impact of the definition of an HMO under a particular statutory framework, it is first important to understand the purpose of the statutory context in which the term "health maintenance organization" is used. In this regard, two major purposes of HMO legislation can be summarized as follows:

- . To license and/or certify HMOs. Relevant statutes are concerned with the overall organization of the HMO entity and authorize the establishment of the HMO as well as its continued regulation.
- . To authorize government agencies to purchase prepaid health

services. Relevant statutes are designed to authorize a governmental agency to expend funds to obtain prepaid health services for certain designated populations.

With regard to the first category, the primary example is state licensure laws governing the establishment and generation of HMOs. These requirements may include a minimum benefits package under the definition of basic health services and very specific provisions on HMO organization and operations, covering governing board, fiscal and managerial requirements. As we noted earlier there do not appear to be laws of this type in the Latin America and the Caribbean. However, such laws might become desirable or necessary in the future, as they did in the U.S.

In the second category, government purchasers of prepaid health services may have their own definitions and unique requirements for HMOs. However, programs may rely, to some extent, upon the definitions and requirements established for HMOs under a separate HMO enabling law. Any assessment of the potential HMO marketplace must consider not only private employer groups, but also the number of potential enrollees who are covered by social insurance, social welfare or special government worker benefits programs. The significance of obtaining approval to secure contracts with government purchasers is quite evident in Latin America, where significant amounts of health care are provided through government sponsored and funded programs.

Laws governing the licensure of HMOs generally have four major purposes:

- . To ensure that the HMO has adequate working capital
- . To establish reserves or other financial guarantees in the event of HMO insolvency
- . To examine and approve rates charged by HMOs
- . To require that subscriber contracts and marketing materials are consistent with regulatory disclosure requirements

Classification of HMO laws governing HMO licensure can generally be accomplished by assignment to one of two categories.

- o Specific HMO Enabling Statutes.
These statutes are laws specifically designed to authorize the establishment and regulation of prepaid health plans. These laws are generally concerned with issues such as the HMO's contracts, marketing materials, and financial viability with attention also given to the acceptability of facilities, medical recordkeeping procedures, and peer review and quality assurance mechanisms.
- o Medical Service and Hospital Service Corporation Laws.
These statutes may be used to establish HMOs where specific HMO enabling legislation is lacking.

Generally, the existence of specific HMO enabling legislation creates a favorable legal climate for organizing and operating an HMO. These statutes usually recognize the service nature of HMOs (as opposed to the HMO's indemnity characteristics) and often attempt to limit the impact of indemnity insurance laws on HMO operations. Moreover, specific HMO enabling statutes often establish requirements for financial reserves, marketing activities, relationships between the HMO and physicians, and relationships of other laws to the HMO's operations. It should be emphasized, however, that although the existence of specific HMO enabling legislation generally enhances the legal climate for establishing and operating an HMO, enabling legislation can contain or be interpreted to impose certain burdensome requirements. For example, HMO enabling laws may be vague on the issue of financial reserve requirements, allowing the regulatory body broad discretion in establishing the amount of money or other security that needs to be posted as a reserve. In view of the general nature of many specific HMO enabling law requirements, an analysis of the associated rules and regulations promulgated by an agency, coupled with discussions with regulators, must also be considered in any assessment of the legal climate.

It may be feasible, in those countries that lack specific HMO enabling legislation, to utilize medical and hospital service corporation laws (or their equivalent) for establishing an HMO, particularly when there is administrative precedent to

do so. The service corporation laws also vary and statutory requirements governing reserves and board composition must be analyzed closely. Although service corporation laws are directed at corporations engaged in indemnification rather than in the provision of health services, HMOs can be effectively established under these statutes.

Finally, where the service corporation laws have limited or no utility, other legal means must be identified. In such cases, judicial, administrative, and operational precedents must be examined. In this regard, the value of specific HMO enabling legislation is that it often limits the general applicability of the insurance laws to HMO operations, many of which can be extremely burdensome. Thus, when other legal means are utilized, it is important to work with regulatory officials in order to ensure that the HMO entity is treated in a manner separate and distinct from an insurance company. In such cases, it may be necessary to seek a letter from the regulatory body affirming that no action will be taken against the HMO for operating as an insurance company.

Several other areas of law may impact the development and operation of an HMO and should be reviewed in assessing the overall legal climate for the HMO. These areas include the following:

- o Advertising Limitations
- o Corporate Practice of Medical Restrictions

o Restrictions on the Use of Allied Health Professionals

Advertising

Traditionally, the advertisement of medical services or prices has been severely restricted by statutes governing the licensure and conduct of physicians by rules established by medical practice boards, and by codes of ethics adopted by medical societies. These statutes generally prohibit "unprofessional conduct", leaving it to the medical practice board to define the criteria for such conduct. Of primary concern to participating HMO physicians is whether advertising HMO services and fees and soliciting enrollment by the HMO could expose the participating physicians to sanctions under existing professional conduct restrictions. Determination of the limitations on HMO advertising will assist the HMO in developing its marketing strategy as well as insulating contracting physicians from charges of unprofessional conduct.

Corporate Practice of Medicine

In the past, the common law prohibition against the corporate practice of medicine, as well as medical practice acts, restricted the employment of physicians by nonphysician-controlled corporations. The key to understanding this prohibition lies in the employment relationship between a physician and a nonphysician-controlled corporation. The

purpose of this rule is to avoid the corporation's interference with the physician-patient relationship and to assure that the physician's primary duty is to the patient and not the corporate employer.

Today, however, the prohibition may not be a serious concern for HMO development. The significance of the corporate practice of medicine limitation on HMO activities depends, to a great extent, on the statute utilized to establish the HMO as well as on the organizational structure adopted by the HMO. As for organizational structure, the corporate practice of medicine prohibition takes on more significance when the HMO employs physicians, as is the case with staff model HMOs. HMO enabling statutes can resolve the issue by specifically authorizing HMOs to employ or contract with physicians. Further, HMO enabling statutes can provide that a licensed HMO is not to be deemed engaged in the corporate practice of medicine. If the statute is not clear on this issue, or if a service corporation law or other legal mechanism is to be used and a physician employment relationship is anticipated, then the corporate practice of medicine prohibition must be carefully analyzed.

Allied Health Professionals

An HMO may intend to utilize allied health professionals such as physician assistants, nurse practitioners, and others in

the delivery of health services to HMO members. If such professionals are utilized, it is important to identify the statutory and regulatory requirements governing these health professionals. For example, laws regulating physician assistants will often define the medical services that a physician's assistant can perform as well as the necessary degree of physician supervision. Identification of these legal requirements will aid the HMO in developing appropriate staffing patterns while assuring that health services will be available and accessible to HMO members.

There may be other statutes, as well as judicial or administrative determinations, which will affect the HMOs that are outside the general categories described above. For example, a law may require the HMO to maintain a certain amount of liability insurance for personal injury lawsuits. Another example is the area of subrogation which may or may not be permitted. Subrogation permits the HMO to proceed against third parties on behalf of an HMO enrollee in negligence suits where the HMO has incurred costs in providing health services to the injured enrollee. Also, judicial developments, such as demands by nonphysician health professionals to participate as providers in the HMO program contrary to the staffing plans of the HMO, may have to be considered.

Once the HMO entity is established, a number of operational concerns should be anticipated and planned for as part of the

HMO's development. These include but are not limited to: subscriber contracts; liability stemming from the professional negligence of the HMO physicians; financial deficits generated from unanticipated utilization, costs, or insufficient enrollment; and potential anti-trust concerns relating to HMO operations. A brief description of these areas is set forth below, followed by the types of available protections that the HMO may wish to secure prior to becoming operational.

One of the most important legal documents for the HMO is the subscriber contract, that is, the contract between the HMO and a contracted employer group. Since this document has the widest exposure of any HMO legal contract and potentially carries with it the most liability, careful drafting of this document is essential. The subscriber contract should cover at a minimum such areas as prospective enrollee eligibility, effective dates of coverage, causes for termination, and coordination of benefits provisions. However, of critical importance is a clear description of services to be provided as well as the procedures through which such services will be secured.

An area of concern for HMOs is legal action brought by subscriber contract, that is, the contract between the HMO and a contracted employer group. Since this document has the widest exposure of any HMO legal contract and potentially carries with it the most liability, careful drafting of this document is essential. The subscriber contract should cover at a minimum

such areas as prospective enrollee eligibility, effective dates of coverage, causes for termination, and coordination of benefits provisions. However, of critical importance is a clear description of services to be provided as well as the procedures through which such services will be secured.

Another area of concern for HMOs is legal action brought by subscribers for breach of the HMO-subscriber contractual relationship. Often this issue arises when the HMO denies coverage for a benefit to which members believe they are entitled. This problem usually occurs when members seek health services outside the HMO health care system. Under these circumstances, the HMO may deny coverage if the situation was not a true emergency and the member could have obtained the services within the HMO system. Unless the subscriber contracts (and supporting enrollment literature) are clear on how enrollees use the system, particularly in emergencies, the HMO may find itself unable to limit abuses of certain services, such as unauthorized visits to a hospital's emergency room. It is important to note that ambiguous or vague terms or conditions in the subscriber contract are generally construed against the drafter of the document (the HMO) rather than the consumer of the services. Most HMO laws require HMOs to make full and fair disclosure of benefits, exclusions, and limitations.

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In this regard, not only should the subscriber agreement be clear and legally sufficient, but also all marketing materials should be developed to be consistent with the subscriber contract requirements. Finally, the marketing staff of the HMO must also be familiar with the contents of the subscriber contracts and be instructed on the legal problems connected with "overselling" the HMO program.

Closely related to the issue of the HMO's financial viability is the ability of the HMO to maximize third party reimbursement. The opportunity for third party reimbursement generally arises when a member to whom the HMO has provided services is covered under another insurance program for the same risk or under governmental programs. There are two mechanisms which HMOs utilize to maximize third party reimbursement: subrogation and coordination of benefits, both of which should appear in the subscriber contract.

A subrogation clause most often appears in insurance contracts or policies. The purpose of the clause is to permit the insurer to recover any monies received by an insured party from other sources for which the original insurer has been liable under the terms of the insured's policy. With regard to the delivery of health care services provided or arranged by an HMO, a subrogation clause appearing in a subscriber contract should give the HMO the right to recover its costs for the medical services rendered to the member. Subrogation should take care of instances in which the member has received

reimbursement under a nonhealth insurance policy issued in his or her name or as a result of a settlement or verdict obtained by the insured that includes damages, a part of which are allocable to medical expenses. This working definition is to be distinguished from a coordination of benefits (COB) provision setting out rules, in accordance with legal requirements, of apportionment for medical expenses when more than one group health insurance or HMO program is involved.

The ability of the HMO to engage in subrogation will, to a great extent, be determined by the relevant insurance laws. Finally, the overall effectiveness of the subrogation program will depend upon the ability of the HMO to identify accidents or injuries that are suitable for subrogation.

The purpose of coordination of benefits is to minimize the possibility of double payment for services when a person is covered under more than one group health insurance policy or HMO membership agreement. Today, double coverage is a growing phenomenon, since both husbands and wives are often engaged in active employment, with health coverage being offered by both of their employers.

In developing the subscriber/employer contract, it is necessary to establish in that contract the procedure for coordination of benefits. Moreover, coordination of benefits can be a factor in determining the extent of capitation payments to be made to the medical group, particularly in the area of physician services.

A most significant area for an HMO and, to a great extent, the providers contracting with the HMO is the concern over the HMO's financial stability. Financial instability in HMOs may be due to a variety of factors, such as adverse selection, excessive utilization, poor management, and inadequate marketing. Nevertheless, agencies that regulate HMOs will be concerned with whether the HMO has adequate working capital to meet the HMO's obligations as they become due, and sufficient reserves or other provisions to pay claims in the event of HMO insolvency. Therefore, in developing an HMO it is necessary to have an appropriate financial plan that provides for adequate capitalization and reinsurance for certain costs that may be beyond the HMO's financial capability.

Finally, some insurance companies who write reinsurance for HMOs also offer insolvency insurance coverage. Generally, such coverage will pay for health services rendered to the members in the event of HMO insolvency for the period for which premiums have been paid. However, of particular concern is how the policy defines "insolvency" and whether the insurance coverage is available at such time that the HMO can no longer pay its bills.

The primary emphasis of this section has been to examine those legal issues associated with the establishment and operation of a prepaid health plan. Providers must understand the terms of the risk payment mechanisms utilized by HMOs as well as the basic assumptions behind these terms. Moreover, financial viability of the HMO will also be a concern to

providers. This concern is particularly important with respect to the HMO's protection against insolvency and the providers' continuing responsibilities, if any, in the event of insolvency.

It is clear that the establishment and operation of an HMO require considerable planning to assure that the objectives of the HMO are achieved. In this regard, it is critical that the legal climate regarding the development of the HMO be assessed not in a vacuum but in coordination with the financial plan, the marketing strategy, and the structuring of the health delivery system. Therefore, continuous interaction between the HMO sponsor and counsel, as well as between counsel and other consultants, is desirable during the HMO's planning, development, and operation phases.

Whether the legal environment in a particular country will be favorable to HMOs or HMO-like organizations will be difficult to determine. The statutes and other legal materials frequently provide only partial clues to the true circumstances. In some countries there may appear to be substantial legal barriers while at the same time there is considerable HMO activity; in other countries seemingly less restrictive laws or the absence of laws altogether may pose major difficulties. In addition, conclusions about the legal climate in a country cannot be based on the experience of organizations whose sponsorship or political desirability have facilitated problems with barriers which may remain as serious obstacles for subsequent applicants.

HEALTH CARE LAWS
IN BRAZIL, CHILE AND URUGUAY
AFFECTING HMO DEVELOPMENT

BRAZIL
Summary of Significant Laws That
Pertain to Prepaid Health Care
(Provided by the Hospital Corporation of America)

MTPS ("Ministerio do Trabalho e da Previdencia Social" - Ministry of Labor and Social Security) Ordinance of April 10, 1969.

Legal Grounds:

Articles 140 and 133 - General Regulations on Social Security - approved by Decree 60601, of March 14, 1967,

Article 31 of Regulations on Occupational Accident Insurance - approved by Decree No. 61784, of November 28, 1967.

Defines scope of INAMPS/Company Agreement:

- Processing and payment of beneficiaries;
- Performance of medical expert examination for the granting of paid sick leave;
- Providing out-patient medical care, as well as supplementary or diagnostic and therapeutical services, to the insured and his/her dependents;
- Processing and payment of sick leave owed for occupational accidents;
- Providing of overall medical care to those suffering occupational accidents, as set forth in art. 29 of the Regulations approved by Decree No. 61478/67.

Exclusion:

- Retirement and pension-plan beneficiaries;
- Professional rehabilitation;
- Patients after 180 days (consecutive or not) of hospitalization per year, who are unable to return to work or to continue treatment at an out-patient clinic or ward.
- . INAMPS participation per employee - 5% of minimum wages;
- . Sets forth other more specific provisions
 - System for avoiding duplication of care (simultaneously by the HMO and the INAMPS);
 - Termination of agreement if verified that there have been dismissals intended for cutting down the company's medical/hospital care costs;

- Provides for the INPS' checking on such agreements entered into by the Company and on its own resources or on the resources of those responsible for providing the services;
- Other exclusive aspects for Companies under medical/hospital care agreements.

MPAS Ordinance No. 39, of September 5, 1974.

Established the PPA (Prompt Action Plan) -- designed for making health services immediately more accessible to social security beneficiaries.

Execution Through:

- Destination of the Social Security System's own hospitals for highly specialized hospital care and for research and development;
- Agreements with Companies;
By means of the INPS' financial participation and supervision, including the fostering of such agreements;
- Accreditation of doctors established in suburbs and peripheral urban area;
- Disciplining the relationship with:
 - . Companies under medical/hospital care agreement;
 - . Establishments and cooperatives providing medical care under the prepayment system, giving preference to those ensuring free choice of clinics, professionals and hospitals;
- Agreements with City Governments;
- Conditions for installation of new services;
- Option for special facilities (surcharge on facilities and supplementation of man-hours for the beneficiary);
- Decentralization of services aimed at optimizing care provided to the public primarily for the following tasks:
 - a) Annotation of working papers ("Carteira de Trabalho");
 - b) Enrollment of dependents;
 - c) Objective indication of the services available to beneficiaries;
 - d) Supply of explanatory pamphlets concerning beneficiaries' rights and procedures to follow;
 - e) Receiving of complaints and suggestions on official forms.

Ordinance 78, of October 10, 1974 - MPAS ("Ministerio da Previdencia e Assistencia Social" - Ministry of Welfare and Social Security)

Provides for the accreditation of institutions rendering medical care services.

Legal Grounds -- Duties as set forth in the PPA ("Plano de Pronta Acao" - Prompt Action Plan).

Scope of Accreditation - Institutions:

- I - Health Insurance (art. 129 of Decree-Law 73, of November 21, 1966);
- II - Own Prepayment Systems (art 135 of Decree-Law 73/66);
- III - Ruling on Cooperatives (Law. No 5764, of December 16, 1971);
- IV - Any authorized institution under the provisions of Law No. 5768, of December 20, 1971, regulated by Decree No. 70951, of August 9, 1972 - articles 57/61;
- V - Guarantee arising from affiliation to or association with any care institution regularly incorporated and having its own personality, equity and structure for such purpose;
- VI - Other prepayment systems, such as those of financial-institution guarantee, by means of credit cards or guaranteed checks, with a limited deductible and a given value per event, for a given period, whenever approved by the Central Bank of Brazil.

Requirements to be met by the Institutions in order to obtain a Certificate of Accreditation:

- Legal proof of operation permit, issues by the proper Government Agency;
- Act approving the plan or program to be developed, as the case may be;

- Care plan and technical notes;
- Descriptive memorandum, curriculum or medical staff and organization of technical services;
- Covered risks funding plan;
- Intended participation in social security;
- Indication of beneficiaries covered and manner of opting for the proposed plan;
- Indication of medical/hospital care agreements previously entered into;
- Showing capability of providing medical/hospital care to beneficiaries under such an agreement;
- Certificate of Regular Status before the INPS;
- Indication of the regions and areas where the domiciles for care of beneficiaries and the domiciles for insurance of the insured in activity are located.
- "Curriculum" of the professionals responsible for the technical coordination of services;
- Designation of the professionals who will represent the institution at meetings scheduled by the Institute of Social Security.

Other Provisions

- Permanent verification and control by the social security;
- Such an agreement may encompass all (or part of) the services, excluding certain events;
- Social Security participation in funding the insured care services;
- Supply of the "Proper Care-Domicile Care" -- a Card issued by the service company;
- Employer's annotation in the employee's Working Papers ("Carteira Profissional").

MPAS Ordinance No. 79, of October 10, 1974.

Legal Grounds: duties as set forth in the PPA.

Provides for rules concerning INAMPS (National Institute of Medical Care and Social Security)/Company agreement, those most noteworthy for this report being:

I - Scope:

1. Performance of medical expert investigation and supplementary examinations for evaluating working capacity;
2. Providing complete medical care;
3. Providing overall medical care in cases of occupational accidents (art. 2 of Decree No. 61784/67);

II - Execution:

1. In the facilities of the companies providing medical/hospital care;
2. In the facilities of contracted third parties (those duly accredited only) - MPAS Ordinance No. 78, of October 10, 1974.

II - Beneficiaries:

1. The insured;
2. The insured and his/her dependents.

IV - Official Funding:

Payment of a per-capita amount (insured/month); other less significant modes, e.g., financing and/or assignment of equipment, facilities and personnel.

V - Verification/Control:

1. Adequacy of demand to resources for providing such care and to time schedules;
2. Individualized treatment of the beneficiary;
3. Sanitary conditions and upkeep of facilities used;
4. Permanent checking on the technical standards of the care services and on the rules laid down by the social security authorities;
 - 4.1 - professional qualification;
 - 4.2 - participation in meetings and seminars;
 - 4.3 - promoting courses for qualified personnel training;
 - 4.4 - supply of informative material.

SAM ("Secretario de Asistencia" - Secretary of Medical Care of the National Institute of Social Security - INPS) Service Guideline No. 390.57, of February 18, 1975.

Regulates the execution of medical/hospital care agreements with companies for providing Medical Care.

Responsibilities/Scope

Providing medical care comprised by clinical, surgical and dental services, at out-patient clinics and/or hospitals.

- areas more lacking in such services - doctors and hospitals providing at least general-practice, pediatric, surgical and obstetric care.
- medical examinations justifying absence from work will be up to the company's contracted or own service.
- the service company is to keep a Personal History File on the beneficiary, whether on the job or on paid sick leave.
- the beneficiary's care domicile.

Funding

- Employee's reimbursement against presentation of proper invoices and payment forms.
- Partial sharing in the reimbursement for an event which is -- due to its financial amount -- characterized as excessively high, provided that:
 - . it is included among the services normally provided by the area's INPS facilities;
 - . it is a valid therapeutical conduct.

Settlement of Differences

On Process	On Publication
On Scope	On Termination of Agreement
On Signature	On Control and Verification (see item V of Comments on Ordinance 79/74/INPS)

On (undetermined) Emergency

General Provisions

- Excluded the INPS' obligation of providing medical care to beneficiaries. Any given care services may be charged to a medical/hospital care company.
- An agreement entered into with a company is not extendable to another, even if both of them belong to the same group.
- An identical principle applies to a company established in different locations (including within the same State).

INPS Resolution No. 900.11, of April 4, 1975.

SAM Service Guideline No. 399.02, of April 29, 1975.

Specific rules for the accreditation of medical institutions as regards medical/hospital care agreements.

Availability of own resources (out-patient and/or hospital facilities) for immediate and adequate care of beneficiaries under the system.

Other less significant provisions of an administrative nature.

* * *

Definition of (Medical/Hospital Care) Agreement

A covenant executed between the Institute (INPS) and a Medical Group, Institution or Company, either directly or through a contractor affiliated to the Institute, whereunder the liability for providing medical and hospital care to a defined group of beneficiaries is transferred to said group, institution or company, without a direct or subsequent intermediation of the Institute in the referral of beneficiaries and rendering of service.

Chile
Summary of Significant Laws that Pertain to ISAPREs
(Instituciones de Salud Previsional)

Ministerio de Salud Publica - Ministry of Public Health DFL 27
of April, 1981.

Establishes the Instituciones de Salud Previsional (ISAPRES) which will substitute the Health Services and National Health Fund in the delivery of health care. The institutions are to be overseen by the National Health Fund.

- Separation of the ISAPRES and the Health Service. ISAPRES must apply for registration permitting operation, meet minimum capital requirements (2,000 U.F. invested) and provide the National Health Fund with the cash equivalent of one month's collected premiums in order to guarantee that it will complete its financial obligations.
- The National Health Fund will make use of the guarantee in the event of an ISAPRE's default on payment for the use of services of the national Curative Medical System and the services provided by the Commission for Preventive and Invalid Medicine or for payment of fines.
- Workers wishing to participate in an ISAPRE must contact the ISAPRE of choice who in turn must inform the Fund of the new subscriber. Employers must make the appropriate deduction from workers' salaries for the ISAPRE payments.
- In the event that the ISAPRE's services are inadequate or insufficient a worker may seek care from the National Health System. The ISAPRE must then reimburse the Fund for services rendered to its enrollee.
- Medical certifications and the legal benefits resulting from them are distributed by the ISAPRES and countersigned by the Health Service.
- Contracts must be for one year and cannot be unilaterally terminated by the ISAPRE except for Breach of Contract by the enrollee. The enrollee, however, can terminate the contract with 30 days notice and revert to the National Health Fund. All contracts must offer dependents coverage for those who seek such coverage.
- The National Health Fund may sell the services of the Curative Medicine System to enrollees for those wishing to use its services.

- The Commission for Preventive and Invalid Medicine is responsible for resolving all claims brought against ISAPRES by enrollees.
- ISAPRES must submit monthly financial and statistical updates to the Fund.
- The Fund may cancel an ISAPRE's registration for any of the following reasons:
 - a) Capital diminishes below legal limits
 - b) guarantee obligations are not fulfilled
 - c) bankruptcy
 - d) noncompliance with obligations of services
 - e) legal or regulatory violations
 - f) violations of obligations as stated in this law
- Upon cancellation of the registration the ISAPRE's guarantee will be used by the Fund to liquidate debts outstanding. The ISAPRE will be liable for any remaining balance due. If the liquidation results in a balance in favor of the ISAPRE, that portion of the remaining guarantee is to be returned to the ISAPRE.
- In the event of cancellation of the registration of the ISAPRE, all enrolled members revert to the care of the National Health Fund until such time as they chose to affiliate with another ISAPRE.

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Ministerio de Salud Publica-Ministry of Public Health Decree
4 of January, 1984.

Regulates the distribution of medical leave authorizations and their corresponding benefits by the Health Service and the Instituciones de Salud Previsional (ISAPRES).

- Describes the interested parties and the official form of the medical leave authorizations to be used by the Health Service and ISAPRES.
- Details the procedures for processing and payment procedures for compensatory medical leave.
- Indicates sanctions for violations of medical leave privileges.

Exclusions:

Work accidents and illnesses of workers affiliated with the Employers Mutual Associations.

Uruguay
Summary of Significant Laws Pertaining to IAMCs
(Instituciones de Asistencia Medica Colectiva)

Ministerio de Salud Publica (MSP) - Ministry of Public Health
Law No. 9.202 of January 12, 1934

Public Health Law

- Established the commitments of the Ministry of Public Health placing in its charge the organization and direction of the services of Assistance and Hygiene as well as jurisdiction over the Sanitary Police, Medical and related professions, Foods, Prostitution and Social Vices. Creates an Honorary Commission for Public Health which is to monitor and curb the violations committed by physicians and other health workers.

Ministry of Public Health, Ministry of Finance and Ministry of Education and Culture.

Decree No. 271/981 of June 21, 1981

- Establishes uniformity of administration and financial reporting of Collective Medical Assistance Institutions (IAMC).

Ministry of Public Health

Law No. 15.181 of August 21, 1981

Determines the standards for private and collective medical assistance, repealing previous regulatory standards established in Decree-Law No. 10.384 of February 13, 1943 and Law No. 14.164 of March 7, 1974.

Scope:

The Ministry of Public Health is charged with monitoring the delivery of medical assistance to all the inhabitants and assuring that only qualified physicians, odontologists and obstetricians provide medical services. Services may be public or private, in which case it may be provided on a collective or individual basis.

- Three categories of IAMCs are established: a) Assistance Associations b) Professional Cooperatives c) Assistance Services created and financed by private companies or of "mixed economy" status. The MSP is responsible for establishing standards of care, minimum enrollment and medical resources, equipment and hospital capacity.
- All administrative functions of the IAMCS, such as registration and authorization for operation, accounting procedures, etc. and inspection, monitoring of technical and fiscal matters are under the purview of the MSP.

- Grants the IAMCs a tax free status, both national and municipal.
- Established the determinants of basic coverage to be offered by the medical assistance groups.
- Delineates the groups with which IAMCs are prohibited from associating, namely with labor unions, and political groups or others which might affect the mission of the IAMC or be used as a lucrative means of obtaining new enrollees.

Decree No. 86/983 March 22, 1983
Ordinance 8/983

Establishes guidelines for medical care coverage to be delivered by IAMCs, emphasizing preventive and rehabilitative health care. Regulates diagnostic and therapeutic procedures to be included or excluded from coverage.

Decree No. 87/983 March 22, 1983
Ordinance 10/983

- Minimum requirements for IAMCs - minimum number of enrollees, number of physicians and other infrastructure requirements.
- Determines procedures for non-compliance.

Decree No. 88/983 March 22, 1983
Ordinance No. 11/983

Regulates planning and investment in both IAMCs and private practice delivery.

Decree No. 89/983 March 22, 1983
Ordinance No. 16/983

Regulates the development of infrastructure, equipment and hospitalization capacity of IAMCS.

Decree No. 90/983 March 22, 1983
Ordinance No. 15/983

Regulates the rights to medical attention of enrollees in IAMCS. Guarantees enrollment for specific population groups as a form of social security for families, pregnant women and newborns.

Decree No. 91/983 March 22, 1983
Ordinance No. 14/983

Regulates matters dealing with the coordination of Special Care Services of the IAMCS.

Decree No. 92/983 March 22, 1983
Ordinance No. 13/983

Established norms for the consolidation of debts of the IAMCS under the general direction of the social security.

Decree No. 93/983 March 22, 1983
Ordinance No. 12/983

Regulates the control of all technical accounting aspects of IAMCS and mandates the submission of all statistics to the National Information System (SINADI)

Decree No. 94/983 March 22, 1983
Ordinance No. 9/983

Establishes the schedule of fixed prices for services rendered by the IAMCS.

Ordinance No. 22/983 May 2, 1983

Authorizes IAMCS to offer private inpatient care to its members under certain conditions, and to charge for such services.

Ordinance No. 21/983 May 5, 1983

Identifies techniques and procedures for diagnosis and therapy.

Ordinance No. 18/983 May 6, 1983

Odontological services to be guaranteed by the monthly payment.

Ordinance No. 19/983 May 6, 1983

Excludes coverage of prosthetic and orthotic devices provided by IAMCS.

Ordinance No. 20/983 May 6, 1983

Establishes Ministry of Public Health control of IAMC assemblies.

Decree No. 161/983 May 24, 1983

Ordinance No. 23/983 modifying article 8b of Decree No. 86/983 to include coverage for sports injuries.

Executive Resolution (May 26, 1983) taken at the Counsel of Ministers No. 221/983 Ordinance No. 28/983. Deligates to the Ministry of Public Health various Executive powers.

Ordinance No. 26/983 June 6, 1983

Obligations of IAMCS in urgent and emergency care situations.

Ordinance No. 27/983 June 6, 1983

Determines the criteria for maintenance and operation of facilities and the procedures for billing of services.

Ordinance No. 25/983 June 6, 1983

Responsibilities of IAMCS in providing prenatal care.

Ordinance No. 30/983 June 8, 1983

Standards for planning and controls for patients receiving pacemakers.

Ordinance No. 24/983 June 10, 1983

Regulates the procedures for absorption and mergers between IAMCS. Health Department Creditors are to supervise the liquidation of IAMCS.

Decree No. 24/983 June 10, 1983

Ordinance No. 32/983

Rates charged by the Ministry of Public Health for services rendered.

Decree No. 198/983 June 17, 1983

Ordinance No. 31/983/

Establishes standards for medical attention provided by mobil units.

Ordinance No. 34/983 June 21, 1983

Sets up a workplan for consideration of preventive and rehabilitative health services that should be provided by IAMCS to its members.

Ordinance No. 33/983 July 6, 1983

Designating the Directors of Auditing Departments to supervise liquidation of IAMCS.

Decree No. 287/983 August 18, 1983

Ordinance No. 37/983

Utilization of services of the Ministry of Public Health by the IAMCS authorized to operate in the interior of the country.

Decree No. 288/983

Ordinance No. 38/983

Requirements that IAMC provide funerary services for their members.

Ordinance No. 39/983 August 31, 1983

Establishing secondary delivery sites in various Departments of the country in order to guarantee IAMC enrollees access to ambulatory care.

Ordinance No. 40/983 September 1, 1983

Extension for consideration of psychiatric, preventive and dental care services of IAMCS.

Ordinance No. 42/983 September 19, 1983

Establishes prices for services rendered by IAMCS.

Di.Na.Co. Prin Instructor Resolution No. 440/983

September 22, 1983

Sets standard for a system to raise premiums.

Decree No. 439/983 November 23, 1983

Substitutes article 4 of Decree No. 90/983. Refers to solicitations for incorporation.