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Electronic version
URL: https://journals.openedition.org/ei/7512
DOI: 10.4000/ei.7512
ISSN: 2553-1891

Publisher
Association Économie et Institutions

Electronic reference
Mariana Jansen Ferreira, “Health financialization in Brazil: some evidence in the hospital sector”, Économie et institutions [Online], 30-31 | 2022, Online since 01 September 2022, connection on 05 November 2022. URL: http://journals.openedition.org/ei/7512 ; DOI: https://doi.org/10.4000/ei.7512

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Introduction

1 The reflection on capitalism and health interaction acquired a new dimension in 2020, with the diverse and profound effects caused by the Covid-19 pandemic. Different reflections on this interaction, especially within the capitalist mode of production, have existed for a long time.

2 Throughout the 1970s and 1980s, several countries began to identify expenditures associated with social protection systems, in a context of economic crisis, as responsible (at least in part) for the increase in the public deficit and debt. In this context, health economics was expanded in mapping efficiency measures in public resources allocation. In this process, principles of private health management from the United States began to increasingly influence the field of health economics all over the world and the reflections on the interaction between capitalism and health, contributing to the incorporation of “new public management” mechanisms for the public health sector.

3 In the early 1990s, institutions such as the OECD (in 1992) and the World Bank (in 1993) published works with similarities regarding the assessment of reforms and the importance of expanding the space of the private sector in the systems, as well as the convergence of reforms that tended towards a model of “organized competition,” in which there would be an association between market mechanisms and the public regulation of systems. At the end of the same decade, it was WHO’s turn to change the tone of its reports: instead of defending universal public health systems, as it did before, the defence of universal coverage and the centrality of the debate was shifted to the adoption of mechanisms market (in order to generate greater competition and, therefore, efficiency in health systems) and the expansion of private participation in
the provision of health services - even though ensuring access and equity remained central to the institution (WHO, 1998, 2000).

Throughout this process, both the field of research and health management practices began to be influenced by new paradigms of efficiency, with principles from the private sector being increasingly incorporated into the public sector. This entire process boosted a trend towards the (re)commodification of health.

Articles such as Maarse (2006), André, Hermann (2009), Batifoulier (2015), André, Batifoulier, and Jansen-Ferreira (2016) systematized how and which market mechanisms are incorporated in health systems, inducing both the incorporation of private sector principles (such as efficiency) and greater private participation within public health systems, either in terms of their financing or services provision.

In parallel, several agents within the health system (with emphasis on health plans and insurance; hospitals; diagnostic laboratories; pharmacies and pharmaceutical chains), many of them with greater participation of the private sector, expanded their movements of capital accumulation, with important capital concentration, mainly through mergers and acquisitions, characterized by growing participation of foreign capital (mainly from the United States) and financial (with emphasis on investment funds, such as hedge funds).

Financialization in health can be analyzed in two dimensions: in the public sector and in the private sector.

In Brazil, the public health sector is primarily affected by how financialization impacts the public budget. In view of the relevant portion of resources for payments of public debt services, public policies become restrictive and fight each other for resources. If in the 1980s and 1990s, this would occur due to low economic growth and tax revenue, in the 2000s, the government had greater tax collection, but high-interest rates constrained the social budget. Pressured by social security spending obligations on the one hand and by income transfer programs on the other, the Brazilian public health system, the Sistema Único de Saúde - SUS, became underfunded and below its constitutional scope. Concerning the private sector, financialization is visible in financial gain as a parameter for accumulation and in the growing direct presence of the financial sector in various health segments: hospitals, insurance companies, etc.

In this article, our focus is on understanding the specificities of the health financialization movement in Brazil, and its effects on the greater capital concentration, especially through mergers and acquisitions with foreign and financialized participation, with an emphasis on the private hospital sector. To this end, this article is organized into four parts. The item I is a brief presentation of the characteristics of the Brazilian health system; item II is a contextualization of the trend towards financialization in health, focusing on the country’s specificities. In item III, we present evidence of this financialization in the health system in Brazil, with a focus on the private health sector and on the effects of opening the sector to foreign capital. In item IV, we detail the analysis of the trend in the hospital sector.
I. Brief presentation of the Brazilian (public and private) health system

Between the 1930s and 1980s, Brazil had a three-part health system: 1. a stricto sensu private system, in which people paid directly or had private plans for consultations, exams, and treatments; 2. a health care system linked to the narrow retirement and pension system then existing, only accessible to workers in the formal labour market, which do not reach 40% of Brazilian workers; 3. a public system, which was limited primarily to regulation and preventive actions, concentrated on endemic diseases and vaccination campaigns (Viacava et al., 2018; Marques, Jansen-Ferreira, Hutz, 2021). This highly fragmented system expanded in the 1960s and 1970s, associated with strong economic growth driven by the industrial sector and a period of military dictatorship. It meant that social demands had little space to support a broader public system, and economic growth benefited large industries, with the expansion of the health system associated with social security and private health insurance as a benefit to the company. In this process, the private health system has grown significantly in terms of private insurance and health provision, especially hospital services (Menicucci, 2007).

The “Movimento Sanitarista,” inspired by the British NHS and by a movement of similar demand in Italy, contributed to the growing unification of the health system financed through social security and, after the country’s re-democratization in 1985, to a much more profound change (Escovel, 1999): the creation of the “Sistema Único de Saúde” – SUS, created in the 1988 Constitution and regulated in 1990. SUS emerged as a universal public health system without direct service payment, financed through collectively paid taxes. It should provide comprehensive care, with all health needs being met by the system. At the same time, it predicted that the private initiative could occur in the health sector and be complementary to the SUS.

During the last decades, as shown in figure 1, there has been a significant increase in the provision of health services, with a large boost in the number of health facilities and doctors.

Figure 1: Number of establishments and personnel in the health services provision – 1981-2017.

<table>
<thead>
<tr>
<th>Health service provision</th>
<th>1981</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of establishments</td>
<td>21,532</td>
<td>129,544</td>
</tr>
<tr>
<td>Number of hospitals</td>
<td>5,660</td>
<td>6,794</td>
</tr>
<tr>
<td>Number of doctors</td>
<td>111,000</td>
<td>447,000</td>
</tr>
<tr>
<td>Number of doctors per 1,000 population</td>
<td>0.94</td>
<td>2.15</td>
</tr>
<tr>
<td>Number of nurses</td>
<td>90,000</td>
<td>230,000</td>
</tr>
<tr>
<td>Number of dentists</td>
<td>78,000</td>
<td>127,000</td>
</tr>
</tbody>
</table>

However, although the data coincide with the period that encompasses the creation and implementation of the SUS, this strong growth is not only linked to the public system. In fact, over the more than 35 years since its creation, SUS has become a systematically underfunded system (Mendes, Marques, 2009). Contrary to what the Constitution foresees, there are no resources specifically intended for the SUS, which ends up “disputing” with other social policies in the public budget. Even when the minimum resources allocated in the system by the federal, state, and municipal levels of government were defined (Brazil, 2012), this did not significantly change the resources allocated in the system. Thus, in 2017, around 59% of health resources were private, and only 41% were public. This puts Brazil in a unique position compared to other countries with universal public health systems in which public participation is predominant. Thus, although we have only 41% of the current public expenditure on health in Brazil, around 75% of the population uses the public health system exclusively, SUS (IBGE, 2019).

This inequality is reflected in the public and private availability of health service provision. As shown in figure 2, the private sector concentrates most hospitals’ specialized and diagnostic services in the country. In turn, SUS basically has the entire primary care network.

Figure 2: Health establishments by type and broken down by % type of establishment (public/private) of total care network – 2017.

<table>
<thead>
<tr>
<th>Health establishments</th>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family health support centers</td>
<td>100.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Health centers/primary care centers</td>
<td>99.2%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Hospitals</td>
<td>35.8%</td>
<td>64.2%</td>
</tr>
<tr>
<td>Specialized clinics / specialized outpatient clinics, polyclinics</td>
<td>13.2%</td>
<td>86.8%</td>
</tr>
<tr>
<td>Diagnosis and therapy support service units</td>
<td>6.3%</td>
<td>93.7%</td>
</tr>
</tbody>
</table>


In this sense, the SUS generated important access to primary health care, essential in a country where thousands of people were still dying from basic diseases, but it generated a much smaller increase in terms of access to more complex exams and care. And in the case of more complex care provided by the system, such as for the treatment of cancer and organ transplants, there is also a demand from the beneficiaries of private health plans, significantly expanding the waiting lists.

In recent years, the trend towards financialization has challenged this already insufficient system structure. On the one hand, financialization has increasingly hampered the allocation of more public resources to the SUS and aggravated its structural problems, making the system even more underfinanced in the face of current demands. On the other hand, as discussed further in this article, financialization also affects the provision of the private health sector. It is important
first to investigate the specifics of financialization in the Brazilian health sector to understand these characteristics.

II. Health financialization as part of a broader movement

It is first essential to analyze the specificities of the trend in the country to understand the Brazilian health system's financialization. This specification is important, considering that financialization has both general features that allow it to be analyzed as a broad phenomenon with the potential to characterize a specific capitalist accumulation regime, but also has specificities, considering the historical insertion of each country and the sector analyzed in question.

The financialization, or dominance of financial capital in capitalist accumulation, has been the object of reflection by several authors in the last decades, with emphasis on the Marxist reflections of Chesnais (1996, 1998), some authors of the Theory of Regulation (Aglietta, 1998; Boyer, 2000; Gutman, 2008), as well as many other contributions (Arrighi, 1994; Lavoie, 1995; Epstein, 2005; Roberts et al., 2006; Duménil, Levy, 2014; Philippon, 2015). Without any intention of exhausting the debate, it is possible to summarize some of the characteristics that this group of authors associates with financialization: the increase in the size and diversity of instruments existing in the financial sector; focus on the company’s share value, affecting the entire structure of the company’s investment decisions; the detachment of the links between profits (used for mergers and acquisitions, distribution and acquisition of financial assets) and investments (resulting in reduced growth rates) and a process of income redistribution with an increasing weight of capital income over work, including interest, dividends and commissions; the relationship between the State-economy, with greater pressure on public debt and greater empowerment of Central Banks, subjected to scrutiny by the international financial market and risk assessment agencies with regard to monetary and exchange rate policies, attached with the greater empowerment of financial elites and rentier class.

In summary, we can adapt the definition proposed by Epstein (2005: 1), who refers to the process as “the increasing importance of financial markets, financial motives, financial institutions, and financial elites in the operation of the economy and its governing institutions, both at the national and international level.”

The Brazilian economy has already shown signs of financialization, in the sense of the primacy of financial gain, since the 1970s (Bruno et al., 2011; Lavinas, Araujo, Bruno, 2019). When analyzing the productive investment rate growth, profit, and financialization rate, the three variables were positively related between the mid-1960s and 1993, growing until 1977 and declining together until 1993. However, from then on, while the rate of productive investment remained very low until 2004, the rate of profit grew, and the rate of financialization expanded even more rapidly. Since 2004, when the country had a faster pace of economic growth, boosting productive investment, the profit growth rate has remained much higher, and the rate of financialization even more. That means that, in Brazil, financialization would mark one “finance-dominated accumulation regime” without necessarily generating a “finance-led growth regime,”
which means not generating relevant effects in terms of productive expansion and aggregate demand.

21 In the same period, starting in the 1990s, when financialization expanded in Brazil, the country created its previously presented universal health system, the SUS. This concomitance results from an ambiguity in the country’s historical moment and an economic imperative. In the second half of the 1980s and early 1990s, the Brazilian state was under pressure from contradictory trends. The economic crisis, with a reduction in the pace of economic growth, a sharp increase in the inflation rate and public debt (Cruz, 1995), and the worldwide rise of neoliberalism (Dardot, Laval, 2009), pushed for economic liberalization (commercial and financial) and the reduction of public spending. However, the redemocratization (in 1985) and the approval of the 1988 Constitution demanded an increase in public resources. The contradiction quickly became apparent and affected the SUS from the beginning, with important funding restrictions and the ambivalent permanence of the private sector as part of the health system (Mendes, Marques, 2009).

22 Thus, public health resources were expanded since the 1990s, but most Brazilian health remained private in terms of funding. As a result, the implementation of the universal public system has never been complete, allowing the participation of the private sector, which on the one hand, has a convenient “partner” in SUS (which bears the most expensive health care, such as cancer treatment, hemodialysis, transplants), while the private hospital and health insurance sectors preserve their profitability by focusing on the most profitable healthcare.

23 In this process, the principles of efficiency and expected profitability inherent to financialization and under the influence of international experiences began to influence the (public and private) health system.

24 Healthcare system reforms since the 1970s have changed the systems by inserting market mechanisms into the public systems (increased competition, payment mechanisms to hospitals and doctors for results) and expanding the direct participation of the private sector (in financing and, in smaller dimensions, in service provision) (Maarse, 2006; André, Hermann, 2009). Co-payment mechanisms, which already existed in the health systems of several European countries, have been enhanced, both on the premise of increasing efficiency and as an accountability instrument, increasing the “responsibility” of patients.

25 The United States’ hegemonic influence, visible in the financialization of different economies, is also inscribed regarding health systems. It was made explicit in the pressures to open up to the competition in order to facilitate the insertion of US corporations (hospitals, insurance companies, and even financial institutions) into the health systems, as evidenced by the pressures under the General Agreement on Trade and Services (GATS) and by the mergers and acquisitions in the sector. In addition to the incorporation of precepts developed in the US health system regarding the implementation of mechanisms to increase efficiencies, such as the “new public management” logic, payment for DRG in hospitals, and payment for the performance of doctors, among others (Jansen-Ferreira, Mendes, 2018).

26 In terms of mergers and acquisitions in the healthcare sector, this movement is related to several factors. First, it is important to locate as part of a broader capital concentration movement, which has grown in different sectors at an unprecedented pace from the 1980s onwards in the United States (between 1980 and 1988, there were
26,000 transactions, totalling more than US$ one trillion), and in the rest of the developed countries in the following decade, and in the 2000s in emerging markets (Cano, 2002). This movement of capital concentration was subordinated to the objectives of strengthening companies and consolidating internationally. However, more than in previous decades, it was fostered by a highly speculative purchase of companies with the objective of valuation in the stock market. That is, by a financialized logic of capital appreciation (Chesnais, 1996; 1998).

In Brazil, the process accelerated in the 1990s, first in the industrial sector and then in the services sector, such as energy and telecommunications, mainly in acquisitions (Correa, Aguiar, 2002). The number of mergers and acquisitions grew 134% in the country this decade, driven by the trade opening process, privatizations, and inflationary stability after the Real Plan. During this period, 61% of the merger and acquisition operations involved foreign resources (KPMG, 2001). Between 2000 and 2014, the total number of mergers and acquisitions in the Brazilian economy increased even more, from 353 to 818 per year. In almost all years of the series (except for 2002, affected by the electoral period, and 2008, affected by the initial impacts of the US sub-prime crisis.), foreign capital was present in more than 50% of concentration operations (Galvão, 2021).

Regarding health, in the private portions of the health systems, countries as different as Germany, the Netherlands, the United States, and Brazil registered an increase in mergers and acquisitions in the 2000s, in a movement driven by the search for economies of scope and scale (Andrietta, 2019). The interests of the private sector, both those already involved in the healthcare sector (such as US healthcare corporations) and those without experience in the field (such as large investment funds, mainly private equities), influenced the changes in the sector. The expansion of the mergers and acquisitions process took place through privatizations between private institutions and between public institutions.

In Europe, for example, between 1990 and 2009, there were 1,606 mergers and acquisitions in the healthcare sector involving general and surgical hospitals (31%), skilled nursing care facilities (27%), and home care services (16%). Among internal acquisitions, 60% were made by other health institutions and 27% by financial institutions. However, 27% of all mergers and acquisitions were carried out by foreign institutions (among those, 52% were financial corporations, and only 28% were health institutions). It is important to clarify that “privatizations through mergers and acquisitions led by financial institutions - encouraged or not by regulatory changes or by the action of the States - by definition alter the public-private mix of health systems” (Angeli, Maarse, 2012: 271). It means not only a change in ownership but an increase in the market principles incorporation within the management of healthcare organizations, accentuating the adoption of “new public management” mechanisms.

III. Evidence of health sector financialization in Brazil

A relevant set of authors analyses Brazil’s relationship between financialized capitalism and health. Among the different analyses, it is important to highlight those that show the growth of the private health sector segments in the last three decades, even after the creation of SUS in 1988 (Costa, 2017).
Brazil’s changes in the 2000s are illustrative of this trend. During the Worker’s Party (Partido dos Trabalhadores – PT) governments (Lula da Silva, between 2003 and 2010, and Dilma Rousseff, between 2011 and 2016), there was a simultaneous expansion between SUS and the private health market, in a context of increasing financialization of the entire economy.

Between 2003 and 2014, a period of strong economic growth, economic expansion contributed to the unemployment rate falling from 12.6% to 4.8%, and the part of formal jobs in the total employment increased from 45.2% to 57.7%. Since private health plans are directly associated with the formal labour market’s benefits, private health plans coverage went from 18.9% to 26% of the population (Marques, Ximenes, Ugino, 2018). As the government maintained the possibility of discounting private health spending in the Income Tax (principle provided in the Constitution), the share of public resources with tax exemption in health increased. Tax exemptions (subsidies) provided to the private sector increased from 0.16% to 0.42% of GDP between 2003 and 2015, from R$ 4.4 billion to R$ 26.2 billion (in real terms), as the only federal health expenditure that grew - except for exemptions, the allocation of resources remained stable at 1.6% of GDP. Most of this growth is due to a discount in the Income Tax expense on private health spending (from R$ 2.7 to R$ 11.9 billion) and medicines (from R$ 1.8 to R$ 4.6 billion in the same period) (National Treasure, 2016).

The greater number of affiliates allowed the sector’s earnings to expand, which, moreover, went through an important concentration process in the period, with a reduction of 415 institutions between 2000 and 2014 (an average of 29.6 fewer operators per year) and 153 between 2014 and 2018 (less 38.25 operators, on average, per year). Picture of the concentration of Health Plans is completed when comparing the number of operators with that of beneficiaries. While in 2011, 331 health operators concentrated 90% of the beneficiaries of the plans, in 2014, there were already 293, and in 2018 only 252 operators concentrated 90% of the beneficiaries (Marques, Jansen-Ferreira, Hutz, 2021). In this process, “the market value of healthcare companies and private insurers came to R$40.4 billion in 2015, as opposed to R$12.2 billion in 2002 – having tripled in just 13 years” (Lavinas, Araújo, Bruno, 2019: 10).

In parallel, the governments fostered two trends in the private health sector: greater investment in the national pharmaceutical industry expansion (Gadelha, Maldonado, 2008) and expansion of the scope for participation of foreign capital in the health sector.

In January 2015, the health sector was opened to foreign capital. After the creation of SUS, foreign capital could operate in the pharmaceutical, health insurance, and insurance sectors but not in direct sectors of outpatient and hospital care. At the beginning of the second term of the Dilma Rousseff government, in 2015, the almost complete release of foreign capital in the health sector was approved by Law nº 13,097 (Brazil, 2015), which created new and broad exceptions to the constitutional prohibition on the direct or indirect participation of foreign companies or capital in health care activities, including philanthropic hospitals (Lavinas, 2017; Bahia, Scheffer, 2018).

According to United Nations Conference on Trade and Development (Unctad, 2016), the foreign direct investment (FDI) in the Brazilian health sector grew from US$ 16 million in 2014 to US$ 1.3 billion in 2015, which represented an increase from 0.02% to 2.00% of the total FDI in the country. These investments would generate more than 70 mergers
and acquisitions in the sector, involving hospitals (such as the North American UnitedHealth) and financial conglomerates (Apex Brasil, 2017).

This last trend points to the fact that not only the private sector has increased its participation, but more specifically, within a financialized logic. Bahia et al. (2016) and Sestelo (2018) show how companies outside the health sector, such as hedge funds, have increased their participation. In its turn, Andreazzi and Kornis (2008) present how Brazil is part of a worldwide movement (more advanced in the United States although present in several countries) of the medical-industrial-financial complex Constitution, in which the process of concentration and financialization permeates the entire sector, with the largest companies in the health segment being integrated with the major international financial oligopolies.

Thus, the last fifteen years point to a trend towards the financialization of the Brazilian health sector. In empirical research, Bahia et al. (2016) point out some significant trends in the sector, such as the expansion of critical financial results from non-financial operating bases; increased share of global investment funds in equity holdings, mainly from health insurers and hospitals; expansion of the “initial public offerings” (IPO) on stock exchanges; growing ideological influence of its corporate think tanks financed by corporate resources. With the growing participation of effective financial institutions acquiring portions of health institutions, mainly in the form of private equity funds, not only the corporate composition changes but also the strength and reach of the corporate strategies of groups operating in a relevant sector such as health care services. The consolidation of large leading companies went hand in hand with the entry of financial institutions into their shareholding control and the adoption of professional corporate management practices, which corroborates the trend towards financialization as a systemic standard (Andrietta, 2019: 212).

In the ten years between the beginning of 2011 and 2020, the total market value of healthcare companies (health plans, pharmacies, and pharmaceutical chains) on the stock exchange went from R$ 25.7 billion to R$ 147 billion, with the relative weight of these companies on the stock exchange going from less than 1% to 5.28% (Panorama Farmacêutico, 2020).

Andrietta (2019) explores how the conditions of capital accumulation have changed in health in Brazil, analyzing companies from different segments and deepening the discussion around 31 companies from three subsectors (health plans and insurance; hospitals; and diagnostic laboratories). The data shows how, in the 2000s, profits increased in all segments, even with some losses in specific years, mainly associated with the recession in the Brazilian economy in 2015 and 2016. Profits were higher mainly in the Health Plans and the Pharmaceutical Industry (those sectors register a net profit of around R$ 300 millions per year), compared to the sectors of Diagnostic Medicine, Hospitals, and Pharmacies (whose profits remained below R$ 100 million, with few exceptions).

Considering that the hospitals and diagnostic centres sector has undergone the biggest change in recent years, we chose to look at a more detailed way of this health segment.
IV. Specific evidence of financialization in the hospital sector

The hospital sector is characterized by the complexity of the services provided and the high amount of capital required for its operation. It is characterized in Brazil as a fragmented sector, given the high number of existing hospitals, but with very concentrated property in a few institutions. According to Andrietta (2019), the hospital sector had a strong expansion between 2006 and 2011 (average revenue growth of 62%), followed by a retraction because of the 2015 and 2016 recession. Such retraction, added to the opening of the sector to foreign capital in 2015, made it possible to expand mergers and acquisitions since companies with a greater capacity to resist the crisis are interested in incorporating smaller institutions.

Thus, as shown in Figure 3, while there were, on average, eight mergers and acquisitions in the hospital and diagnostic centres sectors between 2000 and 2015, there were 31 in 2016, around 50 per year in 2018 and 2019, and 87 mergers and acquisitions in the sector in the year 2019. In 2020, 55 operations of this nature were carried out in the Brazilian hospital sector, mainly from large groups or new investors that took advantage of the fragility of assets, given that the health sector was also impacted by Covid-19.

Figure 3: Accrued total of merge and acquisitions transactions in Hospitals and Clinical Analysis Labs sector, Brazil – 2001 to 2020

Source: Own elaboration from KPMG (2021).

Thus, the sector that until 2015 represented less than 2% of total mergers and acquisitions in the country (except for 2008, when it was 3.1%) reached more than 7% of mergers and acquisitions in the Brazilian market.

Since its release in 2015, the sector has stood out for the significant participation of foreign capital. In 2017, while 45.5% of the total mergers and acquisitions operations in Brazil were cross-border operations (with foreign control company acquiring a Brazilian control company based in Brazil), this proportion was 82% in the hospital sector.
sector (41 out of 50 operations). In 2019 and 2020, cross-border operations accounted for around 75% of mergers and acquisitions in the sector, remaining above the average across sectors (KPMG, 2018; 2019; 2021).

In turn, Oliveira et al. (2021) analyze all merger and acquisition processes that took place in the hospital sector and health insurance providers between 2009 and 2017 with specificity: the focus is on the processes that required CADE (Administrative Council for Economic Defense) approval, the body responsible for the defence of competition in Brazil and that investigates all processes of concentration of capital with anti-competitive potential. During this period, CADE assessed 93 processes of capital concentration involving 211 companies and three individuals. In this period, nine institutions concentrated 66% of operations, with the strongest concentration around three health institutions: Rede D’Or São Luiz (responsible for 22% of operations), Amil International Medical Assistance, and Qualicorp.

It was found that these groups concentrated investments in the country’s most populous regions, with higher income and greater coverage of health insurance, 72% of mergers and acquisitions took place in the Southeast region. As explained by Oliveira et al. (2021: 13), “through network analysis, it is clear that these companies have expanded and diversified their performance in the market, which can increase their influence and, specifically, their power, the latter stressed even by CADE (2018)”.

In addition to finding horizontal operations of hospitals and health insurance providers, vertical operations between hospitals and/or health insurance providers with companies in other healthcare services were identified: “These acts of concentration evidenced the formation of a robust network composed of three economic groups with predominantly foreign corporate control and a latent need to establish policies to analyze the risks and benefits of this new reality to the Brazilian health market” (Oliveira et al., 2021: 1).

As in the case of the analysis performed by Angeli and Maarse (2012) regarding Europe, the data presented by Oliveira et al. (2021) also indicate conglomerate formation associated with agents from non-health related markets and, in terms of foreign capital, with a predominance of cross-border operations carried out by companies from the United States.

As for foreign capital participation, it is observed that the main groups in the network receive foreign investment and that practically the entire network presents a direct or indirect influence of foreign capital, with the participation of 12 foreign companies with a predominant origin from the United States of America.

In 2012, the Canadian VSAP (investment capital) and UnitedHealth Group, from the United States (gigantic acquisition operation of Amil Assistência Médica, which did not need CADE’s authorization); in 2013, the Swiss Re Direct Investments Company, from Switzerland, which acquired a shareholding in SulAmérica; in 2014, Bain Capital Partners, a US global private investment company that manages several capital investments, that acquired shareholdings in Intermédica Sistema de Saúde (Oliveira et al., 2021).

In 2015, after the change in legislation that allowed broader participation of foreign capital in the health sector, opening up the hospital sector, there was a greater volume of foreign capital inflow in the sector, including four major operations involving institutions from around the world: Broad Street Principal Investments, a Goldman...
Sachs Group’s company, acquired a shareholding in Grupo Oncoclínicas do Brasil Serviços Médicos; AXA Group’s AXA Corporate Solutions Brasil e América Latina Resseguros, from France, acquired a shareholding in Grupo SulAmérica; Pacific RDSL Participações, from Singapore, managed by GIC Ventures Group, acquired a shareholding in Rede D’Or São Luiz; Carlyle Group’s investment funds, from the United States, acquired a shareholding in Tempo Participações, which belonged to Grupo Tempo.

Considering the entire process of capital concentration previously mentioned, it is worth highlighting the largest hospital conglomerate, Rede D’Or, which has more than 30 units, including hospitals and auxiliary structures, such as diagnostics, and has about 20% of the entire sector revenue. The group expanding strategy is marked by some characteristics. First, due to the wide acquisition of already existing institutions: between 2008 and 2011, the chain acquired 15 hospitals in São Paulo, Rio de Janeiro, and Pernambuco. Second, by financing this process through strong borrowing from financial institutions (around R$1 billion between 2007 and 2015) and issuance of debentures totalling an additional R$ 3 billion between 2011 and 2016. Third, great equity change, with the expansion of financial institutions and large international funds. In 2010, the group sold ¼ of its property to a bank (BTG Pactual). In 2015, after allowing foreign capital to enter the sector, 8% of the company was acquired by the North American private equity fund Carlyle and 12% by the Singapore sovereign fund (Rede D’Or, 2015; Andrietta, 2019).

In October 2020, in an award for the most relevant company in the last ten years for all economic sectors, given by the most important weekly publication on economics in Brazil (the newspaper Valor Econômico), the Rede D’Or was chosen (Valor Econômico, 2020a). The data presented in figure 4 summarizes the growth rate of net revenue and the profit margin of Brazil’s main hospitals and diagnostic centres. As already noted, Rede D’Or increased its accumulated revenue by almost 190% in seven years and its net profit margin by 67%. With that, in the same period, it went from 177th to 62nd largest company in the country, considering all sectors and the largest company in the health sector.

Figure 4: Selected economic data from the main hospitals and diagnostic medicine center in Brazil, 2012-2019.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Capital origin</th>
<th>Accumulated growth rate between 2012 and 2019 (in %)</th>
<th>Net margins of activity (net profit on net revenue)</th>
<th>Position among the 1000 largest companies in the country (all sectors)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rede D’Or São Luiz</td>
<td>BR</td>
<td>188,9%</td>
<td>67,1%</td>
<td>177</td>
</tr>
<tr>
<td>Hospital São Paulo</td>
<td>BR</td>
<td>63,5%</td>
<td>-3,8%</td>
<td>171</td>
</tr>
<tr>
<td>Dasa</td>
<td>BR</td>
<td>30,5%</td>
<td>27,7%</td>
<td>186</td>
</tr>
<tr>
<td>Esho</td>
<td>US</td>
<td>122,6%</td>
<td>16,8%</td>
<td>-</td>
</tr>
<tr>
<td>Hospital Albert Einstein</td>
<td>BR</td>
<td>40,2%</td>
<td>77,9%</td>
<td>270</td>
</tr>
<tr>
<td>Fleury Medicina e Saúde</td>
<td>BR</td>
<td>31,0%</td>
<td>69,1%</td>
<td>320</td>
</tr>
</tbody>
</table>

Source: Own elaboration, from Valor Econômico (2020a).

As a result, although the hospital sector has shown lower profitability in recent years than other health sectors, Rede D’Or has shown a high expansion. In the analysis of
Andrietta (2019: 185), the recent evolution of the hospital sector, we would highlight especially the Rede D'Or illustrates the trend of financialization of these institutions, see “the pace and value of acquisitions, the need for complex financing strategies for asset expansion and, interconnectedly, the penetration of large institutional investors, banks and, recently, international funds.”

56 The capital in health was concentrated in the early 2000s in the sectors of diagnostic medicine and health plans. The movement was slower in the hospital sector (Hiratuka, Rocha, Sarti, 2016). However, from the 2010s onwards, the movement grew among hospitals, with significant participation of investment funds, and from the legal change in 2015, with foreign capital participation.

57 Although the available data do not allow us to state that this financialization of health, with a focus on the hospital sector, hinders access to health care, it is worth pointing out some observations. Bahia and Scheffer (2018) point out that the increase in foreign investment and the enhancement of the private health sector promotes unfair competition with the public sector, deepening the public-private segmentation historically established in Brazil but with the potential to further expand the trend. Oliveira et al. (2021), when analyzing the mergers and acquisitions between 2009 and 2017, point to an intense concentration of capital with the formation of three large groups and, under the effect of legal changes, with the growing participation of foreign capital. As pointed out in figure 3, this trend accelerated further between 2017 and 2019 due to legal changes in the sector.

Conclusion

58 The Covid-19 pandemic in 2020 indeed increased and will still expand the possible reflections on the relationship between health and capitalism.

59 In this article, we seek to analyze a specific perspective of analysis on health capitalism regarding the financialized health capitalism in Brazil. Health financialization has essential and specific effects. In Brazil, the trend has limited resources for public health, contributing to the difficulties of full implementation of SUS.

60 In our analysis, the private sector continues to expand its participation in the different health branches and make significant profits, even in unfavourable economic contexts such as the Brazilian recession of 2015-2016. In addition, using the hospital sector as an example, it is evident that financialization in private health is made explicit by strong capital concentration and expansion of (foreign) financial institutions’ participation in the ownership of health institutions.

61 The development and profitability of the business are subordinated to the financial logic of “appreciation” to guarantee a high price in future business sales. Several movements registered in the health sector are subordinated to this logic: consolidation of market niches with the creation of localized oligopolies, buying smaller businesses, especially within the same geographic area of influence, horizontal and vertical business concentration movements, going public on the stock exchange (IPO). All these characteristics are associated with the expansion of capital accumulation and, in financialization, the predominance of financial instruments, objectives, and targets. If such characteristics can distort the objectives of productive companies, the issue is even more complex concerning the effects on social services, such as health.
At this moment, it is impossible to point out a tendency to increase the share of financial gains (non-operational) over operational gains in health. Unlike other economic sectors, in which the reallocation of resources for non-operational gain may occur more widely, in health, due to the dynamics of the service provided, this trend seems rare.

Even so, it is quite relevant that the company’s most significant success case in the last ten years in Brazil is in the health sector. Moreover, this success is associated with a substantial revenue and net profit increase in the last decade. On December 8, 2020, the Hospital Rede D’Or went public on the Stock Exchange, making the third largest IPO in the history of the Brazilian stock market, and valued at a market value of more than R$100 billion (Valor Econômico, 2020b). It seems to us a very symbolic fact of financialized health capitalism.

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Financialization, understood as the trend towards the supremacy of the financial market, institutions, profitability, and the financial elite, has been an essential feature of capitalism in recent decades. Its effects on sectors such as healthcare require extensive investigation to understand how healthcare systems (in their public and private aspects) have changed. In this article, we chose to focus the study on the sphere of financialization regarding how it changes the private health sector in Brazil, especially in terms of greater capital concentration with the participation of financial and foreign capital, with a special focus on changes in the hospital system.

La financiarisation, comprise comme la tendance à la suprématie du marché financier, des institutions, de la rentabilité et de l’élite financière, a été une caractéristique essentielle du capitalisme au cours des dernières décennies. Ses effets sur des secteurs tels que les soins de santé nécessitent une enquête approfondie pour comprendre dans quelle mesure les systèmes de soins (dans leurs aspects publics et privés) ont changé. Dans cet article, nous avons choisi de concentrer l’étude sur la sphère de la financiarisation en ce qui concerne la façon dont elle modifie le secteur privé de la santé au Brésil, notamment en termes de plus grande concentration du capital avec la participation de capitaux financiers et étrangers, avec un accent particulier sur les changements dans le système hospitalier.
INDEX

Keywords: health financialization in Brazil, mergers and acquisitions in the hospital sector, health capitalism

Mots-clés: financiarisation de la santé, Brésil, fusions et acquisitions, secteur hospitalier, capitalisme sanitaire


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