

Healthcare



Perspectives on
healthcare in
Latin America

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Foreword

The Healthcare landscape in Latin America is changing quickly. Demand is growing as populations age and chronic diseases become commonplace. Increasing wealth in some demographic segments drives a desire for higher quality services. Governments are increasing spending, and local and multinational private sector players are investing heavily to expand their footprint in the region. Globally, McKinsey believes healthcare to be a strategic industry over the long term, and locally we have invested in recent years to build a vibrant Latin American Practice.

The objective of this Compendium is to identify some of the factors driving change and shed some light on emerging opportunities. We hope it is useful in initiating a thoughtful discussion.

We welcome your feedback, and ideas for future articles and reports.

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From quantity to quality: The health of the Brazilian healthcare system

In the last 20 years, Brazil has implemented one of the largest universal healthcare systems in the world with dramatic results:

- Infant and maternal mortality have dropped more than 50%.
- Diseases like AIDS and TB no longer pose major threats to society. “No developing country has had more success in tackling AIDS than Brazil,” *The Economist*.
- Access to care even for people in the poorest, most remote areas of the country has been dramatically improved through initiatives such as the Family Health Program (PSF) without blowing the budget.
- Innovations, such as outsourcing of hospital management to non-profit organizations in prominent states such as São Paulo, have had positive impact both in terms of outcomes and efficiency.

At the same time, Brazil’s aspiration as a country has grown. Relative macroeconomic stability and stable growth mean that some argue that Brazil has “emerged”. For the health system to keep up, Brazil needs to shift focus from delivering quantity to delivering quality. This means ensuring that:

- Wait times are reduced so that people get the right treatment quickly; and
- Out-of-pocket spending is reduced for poorer population segments.

Getting the right treatment quickly

Reasonable wait times are critical to a quality healthcare system, both from patient and system point-of-views. Without them, patients are either deterred from seeking care or, when they do, they suffer increased pain, disease complications and incapacitation. Furthermore, in the scenario of long wait time, patients also often suffer increased cost as they resort to out-of-pocket spending in order to obtain basic treatment. For the system overall long wait times are a burden; total treatment costs are ultimately higher as patients are in a more serious state once they are finally treated.

With few exceptions across the country, people report long wait times at every stage of care within the public system—to schedule appointments, routine and complex exams and surgeries and to get approval for and fulfill prescriptions. The experience of a 10-year-old girl living in Santa Cruz (Rio de Janeiro State) is typical.

The patient's mother comments, "Sometimes we spend the whole day waiting to see a doctor without success."

What is the source of the problem? Capacity does not seem to be the issue. Both infrastructure (number of hospital beds) and people (number of physicians) compare favorably with countries like the UK, the US and Argentina.

The issue seems to be productivity and management.

- The system does not enforce appropriate direction of patients among its facilities and as a result it is normal for non-emergency patients to clog the emergency room, as hospitals admit them without referrals.
- The system mis-manages staff in terms of monetary, professional and work condition incentives creating issues with motivation and performance.
- The system's management of processes and funds is weak. As one public hospital administrator admits, "Often, patients wait for surgery due to lack of beds or funds in one area to acquire material necessary to perform the operation, while in other parts of the same hospital beds go empty and material is in excess."

In turn, efforts in other parts of the world to cut wait times by increasing productivity have produced positive results. Application of techniques from different fields, such as lean service operations, have helped countries like Turkey and Egypt realize improvements. For instance, since 2003, Turkey has managed to reduce wait time in the emergency room by 20%, increase the number of exams per care center by 98% and boost outpatient contacts per person by 150% through implementation of:

- Hospital efficiency programs and facility rationalization
- Facility use streamlining through patient access regulation
- Management competence building

- Enforced use of alternative primary care options (eg, family medicine program and mobile vans)

In addition, innovations from other countries also suggest effective ways to treat patients yet reduce demand on the physical system. MediCall Home in Mexico has been able to solve ~60% of primary care demands from its patients over the telephone using Cleveland Clinic protocols and a call center staffed with physicians.

Such successes not only increase the quality of care. They also lower healthcare costs.

Without blowing the budget

Medicine is integral to quality care and for poorer people the most important driver of high levels of out-of-pocket spending. For a middle income country, and particularly one with a universal system, Brazil has high levels of out-of-pocket spending. For the lowest 40% of the population, almost three quarters of that cost is medicine.

Recent government efforts to reduce this burden, through initiatives such as availability of generic drugs and the creation of *Farmacia Popular*, have begun to make difference. For example, inclusion of medicines for treating blood pressure is an important advance. Nonetheless, out-of-pocket spend remains high. There appear to be three primary causes: incompleteness of the list of medicines approved for distribution through the public system; resource misallocation; and the burdensome process required to obtain medicine.

Of these, list incompleteness is an important culprit, even despite broadening in recent years. An increase in breadth and depth of drugs approved by the public system for dispersal is a clear, quick way to decrease out-of-pocket spend in lower income populations, as there are examples of relatively basic drugs that are not sufficiently represented. For instance, not all types of antibiotic drugs and products such as nebulizers used to treat child bronchitis are included on the list, resulting in out-of-pocket spending by many low income parents. In this respect, a review and expansion of the list is necessary. However, simple expansion of this list will not be sufficient to resolve out-of-pocket spend.

Misallocation of medicine resources is a large problem that exists in all regions of the country, regardless of ease of distribution. Mismanagement of distribution results in undersupply in some facilities and oversupply in others. Aware of this problem, many doctors advise their patients not to waste treatment time searching for certain medicines, such as those to treat asthma, in the *Farmacia Popular*.

Finally, the process necessary to obtain government subsidized medicine is long and burdensome, both with regard to supply and purchase. On the one hand, formal procedures regarding public service purchasing make periods to stock medicine unnecessarily long. On the other, the procedures necessary for patients to obtain medicine make quick treatment with subsidized medicine often impossible. If a patient wants to begin treatment immediately, often out-of-pocket purchase of the drug is the only choice.

Again, healthcare reforms in other countries suggest potential remedies for Brazil. The Turkish government invested and reallocated funds to cover drugs, expanded the breadth and depth of medicine available through the government and set price limits. There out-of-pocket spending on drugs, as a percentage of total healthcare spend, has dropped 40%. In Mexico, the government has successfully tackled the problem of high out-of-pocket spend by redistribution of funding to concentrate on units that serve the poor more and revision of its medicine list to ensure funding for and availability of drugs that have higher frequency of use and/ or are more expensive.

Spending adequately to fund the system

As the population ages, Brazil faces the likelihood that public healthcare spending will outpace the growth of tax funds needed to cover the government's 50% share—a share which is low compared with countries like Germany (77%) and the UK (87%). Meanwhile, many experts predict that total healthcare expenditures will rise rapidly and at a greater pace than GDP, going from 7% of GDP in 2006 to 13% in 2030, in part due to an aging population and longer expected life-spans. Given the country's already high tax burden, government funding of this increase would be disastrous.

This mismatch creates an opportunity for the private sector. The tertiary education sector in Brazil provides an example of an area that has boomed as private companies have stepped into the void created by demand that outstripped the government's ability to supply universities.

The government will also have to respond. Possibilities include:

- Creation of systems and processes that reduce duplication in services and promote incentives that reduce unnecessary demand, particularly for expensive services
- Increase in the diversity of providers and care settings through deregulation and incentives (e.g. private versus public, clinics versus hospitals).
- Implementation of outcome-based incentives to reward the best and most efficient providers.

The bottom line: the system will have to do more with less, and making that happen will require strong political will.



Brazil has made tremendous progress in terms of quantity, creating a universal access system for almost 200 million. Now it's time to ensure that the system offers quality as well.

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Tracking shifts in Mexico's healthcare system and spotting pharmaceutical opportunities

Healthcare in Mexico is at an inflection point. Recent advances in public policy have helped bring noticeable improvements in health indicators, but the system is under pressure. In this paper, we will look at recent developments in healthcare in Mexico, focusing on shifts that are particularly significant to the pharmaceutical industry. Next, we look at the pressure points it faces including capacity constraints, increasing costs and growing disparities, and some of the policy options available. And finally, we consider the implications of these changes for pharmaceutical companies operating in Mexico.

Recent developments

Mexico is one of the richest countries in Latin America, with GDP per capita in 2011 estimated by the World Bank at just over \$15,000 and an economy that is expected to grow by 4.6 percent in 2011. The country's healthcare priorities match those typical of fast-growing, developing economies.

In general, the nation's health has improved noticeably over recent years, thanks to national preventive medicine and a variety of public sector programs including the creation in 2003 of Seguro Popular, a national low-cost health insurance program. Furthermore, separate initiatives have focused on improving the quality and availability of drugs.

The country has also become more sophisticated at controlling healthcare costs. For example, centralized price negotiation and reverse auctions have made public drug spending more effective.

The challenges ahead

But while public policies have succeeded in improving health in Mexico, new pressures have arisen that alter the challenges the system faces.

Capacity constraints

Demographic changes and other factors are putting increasing pressure on the Mexican healthcare system. Mexico lacks the resources and capabilities to address these shifts.

The Mexican population is aging rapidly and witnessing an increase in ailments more common in developed countries. For example, increased obesity is leading diabetes to expand at three times the rate of population growth (Federacion Mexicana de Diabetes, INEGI). Cancer and cardiovascular diseases are also on the rise.

Mexico in addition has 2-3 times fewer specialists compared with its OECD peers (OECD). Gustavo Nigenda with the National Institute of Public Health noted Mexico trains “too few specialists for its epidemiological profile” (Reforma, 2010). In addition, primary care practitioners interviewed said they would like more continuing education opportunities related to new diseases that are becoming prevalent. Mexico also only has 16 hospital beds per 10,000 people compared with 41 for Argentina and 24 for Brazil (WHO).

Increasing the number of specialists and hospital beds is expensive and would require at least 5 to 10 years. While long-term approaches will be required, there are several immediate, low-cost options that could offer quick relief:

- Define protocols to manage common diseases for non-specialists who do not have access to international guidelines (e.g., due to limited resources and language barriers). Institutions like the Instituto Nacional de Salud Publica could publish such domestic guidelines annually.
- Promote more continuing education opportunities for primary care physicians.
- Assess regularly health access and quality across cities, systems and providers (e.g., % of Type II diabetes patients on metformin).
- Train a cadre of non-physician health practitioners – similar to nurse practitioners in the US—in specific disease areas which could quickly address the epidemiological need for more specialized care.
- Expand preventative efforts, such as patient education on obesity and diabetes, through programs such as PrevenIMSS.

Physicians may initially resist such efforts, believing they represent increased oversight or take away their autonomy. To help prevent this, the government should frame the goal as to provide physicians with better resources and help them improve the care that they offer their patients.

Cost pressures

While Mexico has been effective at keeping the public cost of drugs down, the increased prevalence of diseases common to developed countries has placed enormous pressure on the national healthcare budget. Today, more than half the public healthcare funds are spent on non-communicable diseases, with about 20 percent focused just on diabetes. In addition, national finances are worsening due to an aging population and increased unemployment. In 2009 alone, the Mexican national social security system (IMSS) ran \$2.9 billion in the red. The Ministry of Health has warned that, unless obesity rates slow, public health costs will double by 2017 (Milenio, 2010). Such a situation would lead to greater rationing of care and ultimately to a deteriorated population health.

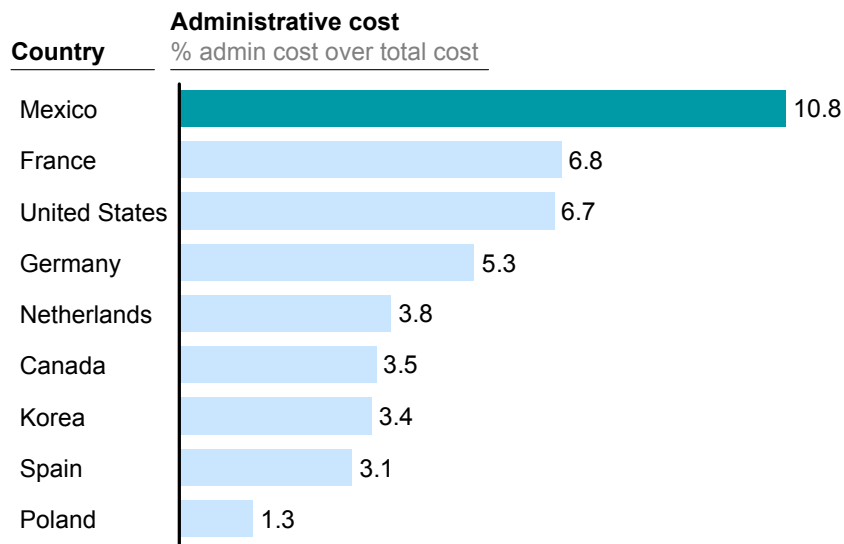
The presence of multiple healthcare systems separately serving state, private sector, military and oil sector employees contributes to marked inefficiencies. As a result, healthcare administrative costs, as share of total health expenditures, are three times higher than Canada, Spain and South Korea (Exhibit 1). Mexico has begun the process by establishing task forces to look at ways to consolidate these systems. But while integration would bring more effective oversight and reduce costs, it has been slow to implement.

There are several intermediate options that could produce immediate benefits and set the stage for future integration. Most importantly, each system could separate the payor and provider functions, retaining their current ownership structures. The payors could then, similar to their counterparts in the US and Europe, institutionalize processes to lower their provider costs. Payors, for instance, could fix payments for individual conditions providing incentives for providers to reduce their inherent costs. The various systems could also utilize demand management mechanisms, such as tiering of medications (e.g., generics and branded products have lowest and highest co-pays respectively) and rating physicians by cost efficiency (e.g., physicians with lowest costs per patient managed get most referrals), to reduce unnecessary use of healthcare services.

The government can start setting the stage for integration including developing a compelling case and creating the political momentum. It should also create a financial oversight authority to mediate payments between payors and providers—whether within a single system or across systems—helping to encourage separation of payors and providers. The government should work with systems to create a uniform, cost-reducing approach to setting the payments for individual diseases (e.g., such as how it convenes the various systems today into a national council to evaluate drugs for approval).

Exhibit 1: Healthcare system's administrative cost by country

2009

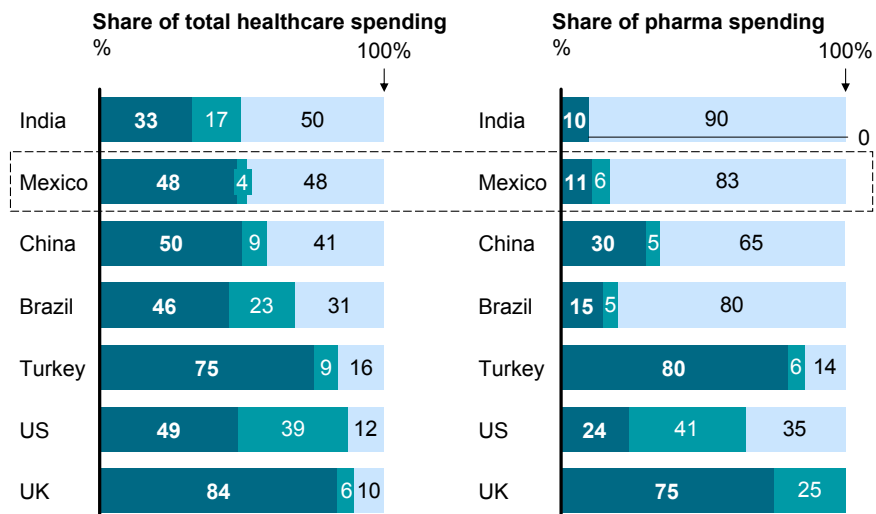


SOURCE: OECD Health Data 2011

Exhibit 2: Share of spending by country

2008

Out of pocket, %
Other private, %
Public funding, %



Source: World Bank, OECD Health Data, 2011; WHO National Health Accounts, 2009

Disparities

The Mexican healthcare system is also challenged by disparities that have developed. Low-income groups are penalized because of the relatively high proportion of medical expenses that is paid by individuals in Mexico. For example, out-of-pocket expenses in Mexico accounts for a little more than 50 percent of total expenditures compared to 12 percent in the United States. Out-of-pocket expenses on drugs account for 83 percent of total drug expenditures in Mexico compared with 65 percent in China and 35 percent in the United States (Exhibit 2).

Different systems also provide significantly different levels of care with some systems, such as Pemex, spending almost 9 times as much per capita as the Seguro Popular. Rich states such as the Federal District ~6 times more specialists and 3 times more hospital beds than poorer states such as Chiapas (Mexican Ministry of Health 2010).

To address these disparities, the government must develop specific initiatives designed for various geographic settings. In urban areas, integration among health systems could bring faster efficiency improvements because of the higher density of services. In low-density rural areas, the focus should be on programs that can be launched quickly and that have a proven track record such as mobile health platforms. The government can also offer targeted incentives to support patients in low-density areas such as higher public payments for these patients and subsidized transportation services for patients requiring hospital care. Furthermore, private health insurance could be stimulated, especially for urban middle-income segments, thus alleviating out-of-pocket expenditures.

Public health programs could reduce the need for trained physicians by appointing specific days per month for entire villages to receive specific disease coverage (e.g, diabetes testing) which is provided by non-physician healthcare workers. Broad-based rural education should address prevalent diseases, particularly those affecting children, youth and the elderly.

Implications for pharmaceutical companies

The top-performing companies will begin by getting the basics right. They will implement capability and organizational improvements throughout their organization as they prepare to launch programs linked more directly to the shifts we have identified. They will assure that relationships with all levels of government and key private and public accounts are not neglected.

Successful companies will also sharpen their core functions to respond to increased use of generics, provider consolidation and cost pressures. They will aspire to bring their local capabilities to global standards, rather than trudge forward with practices that are “good enough” for a developing market. This includes understanding the nuances and likely evolution of specific channels—for example, public programs or mass retail. These companies will make use of the global and regional expertise of their parent organizations, but will have sufficient local authority to adapt the model for Mexico, updating their plans every quarter if necessary to follow the changes.

Beneath these broad strategies, we've identified several of specific efforts that will help pharmaceutical companies keep pace with the shifting environment:

- **Public reforms:** Bolster local R&D efforts, such as drug co-development with the government and enhanced use of local clinical trials. This will help establish solid relationships with regulators and other authorities and familiarize physicians with a company's products. Companies must work with the government to understand the likely evolution of reforms and seek opportunities to work with the government to drive change.
- **Capacity constraints:** Expand marketing and sales strategies to address the growing importance of non-specialists, such as primary care physicians and non-physician healthcare practitioners. Working with the government to develop disease guidelines, continuing medical education programs or other outreach efforts should be considered.
- **Cost pressures:** Aspire to best-in-class stakeholder management in Mexico including well-defined approaches to pharmacoeconomy, price negotiations and reverse auctions.
- **Disparities:** Pursue growth opportunities associated with programs to narrow the healthcare gaps among geographies, income levels and care programs. For example, a company should ensure that they participate in any expansion of drugs and diseases covered by Seguro Popular.

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Making a mark in Brazil's branded generics market

Many multinational pharmaceutical companies are intensifying their participation in Brazil's pharmaceutical market – with good reason as Brazil enjoys the largest share of the ~\$50bn Latin American pharmaceutical market. In addition, the market is growing, especially in the private market, which accounts for almost 65% of sales. The private market is primarily out of pocket, self medication is common and there is minimal reimbursement outside the hospital setting. Operating conditions in Brazil are attractive, with a stable political and economic environment and few regulatory or pricing constraints.

Many new players, particularly multinational pharmacos, are looking to increase their presence, particularly in the Branded Generics market. With ~60% of sales, branded generics account for the majority of the Brazilian pharmaceutical market. These products are forecasted to capture more of the profit pool than innovative and true generic products combined by 2015. Local players like Ache and Eurofarma are already reaping the rewards of concentrating on branded generics and account for more than two thirds of the branded generics sales. Thanks to increasing sales of these products, they are experiencing strong topline growth.

But new participants looking to enter the fray must make critical decisions on how to compete. Those issues focus the following discussion.

How to compete: go-to-market success factors

As discussed above, the branded generics market is an out of pocket market where the patient has to chose among branded generics and generics. The patient is influenced by two key stakeholders: the physicians that prescribed the branded generic and the Balconista (pharmacy clerk) that has clear incentives to switch to a generic alternative. In light of these dynamics, winning with branded generics in Brazil requires getting six things right.

1. Large physician sales force. Brazil has more than 200,000 physicians, ~80% of them specialists. Leaders employ very large sales forces to call on doctors regularly, sometimes more than three times a month. Several leading local sales forces range between 1,200 and 1,600 FTEs. They pay short visits (5-15 minutes) to more than 15 physicians a day, distributing lots of samples (often 4-6/call).

These sales reps play an important role in reinforcing the reputation of a lab. As one doctor said, “I don’t trust government inspection, so I prefer to use the brands I have been working with for a long time. I can trust the lab, the drug quality, and its efficacy.”

2. Deep portfolio of products. Most successful players have an extensive portfolio—on average, some 120 products. Many market duplicates—the same active molecule (usually a lucrative molecule) sold under different product names with different price points for different economic segments.

Leaders also manage their portfolio actively to achieve the highest returns. They launch several new products every year and retire poorly performing products quickly which requires having a very strong regulatory team. Leading local players each launched 10-30 products and retired 5-20 products between 2005 and 2009.

3. Strong pharmacy presence. The Brazilian pharmacy market remains very fragmented, but the top five drugstore chains account more than 25% of the sales (two largest players currently merging). Switching at the pharmacy is common in Brazil and in most cases the pharmacy has an incentive to switch to cheaper generic alternatives. Therefore, building relationships with pharmacy clerks, especially in small and independent drugstores where switching is especially common, is critical. Some local market leaders employ a trade sales force of some 100 FTEs to maintain their pharmacy presence and discourage switching.

4. Competitive pricing. Physicians in Brazil often prescribe multiple medications to the patient. They are often willing to pay a premium for a valued brand, but in general prices must be competitive.

5. Brand awareness. Reputation counts, with physicians and patients, when they choose drugs. Leaders employ various strategies to build brand awareness:

- Specialized or niche play—promoting the company as a specialist in a particular disease area
- Favorable margins—wooing pharmacists with frequent discounts
- Strong quality control—enforcing rigorous compliance standards to enhance the company’s reputation among physicians.

6. Low-cost manufacturing. The operating margins for branded generics are much lower than those for innovative products (40% vs. 60-70%) so even small manufacturing improvements can have significant impact on economics. These improvements can also help the company with other key success factors—reducing the cost of the samples needed for physician visits and keeping prices competitive. Local manufacturing and sourcing are especially valuable here.

How to compete: challenges for new entrants

New entrants looking to establish a branded generics presence in Brazil face a formidable challenge: how to enter the in the face of strong local competition.

Local broad-base players have expanded their branded generics business both through organic growth and acquisitions. For example, Eurofarma built the largest branded generics sales force in Brazil by growing it from 150 in 2001 to more than 1,900 in 2009. Ache made acquisitions to help achieve its market-leading position in generics – acquiring Asta Médica in 2003 to become the largest Brazilian lab and Biosintética in 2005 to become the third largest true generics player in Brazil.

New entrants into BGx have taken different approaches to establish a presence. These are some examples of the strategies followed by different players:

- Acquisition, such as Sanofi-Aventis' purchase of Medley, a leading local branded generics company
- Roll-up of several mid-size players by Hypermarcas (i.e, Neoquimica, Farmasa, and Mantecorp) to establish a strong presence in the branded generics space
- Pfizer's minority stake acquisition of Teuto to leverage capabilities to build out the business
- Small-scale internal build, such as announced by AstraZeneca to start building a branded generics platform by focusing initially on a select number of products.

Once established in the Brazilian market, new players in branded generics face growth challenges, especially as they compete with local players. Some of these local players are strong and getting stronger – starting to explore R&D and opportunities to build on their Brazilian market success elsewhere in Latin America.



Bottom line, new players may well find the branded generics market in Brazil attractive, but they will not find making their mark there easy. However, the practices that are spelling success for local players and other multinational pharmacos can point the way.

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Rx

CENTRO MÉDICO

Area for medical notes with a repeating 'Rx' watermark pattern.

MD

MD

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Winning in Brazil's retail pharmacy market

The retail pharmacy industry in Brazil faces a rosy future. The industry looks likely to sustain its strong growth, which has averaged 14% a year and outpaced other retail formats, such as hypermarkets (5%) and supermarkets (10%).

But large retail chains have outperformed the industry, concentrating on one or two strategic levers, such as expanding operations from regional to multi-regional, sharpening operational efficiency, or improving the customer experience and relationship. As competition intensifies, winners will have to achieve excellence along these multiple dimensions.

The following discussion explores why and how industry players should rethink their strategies to capture their share of this promising market.

The retail pharmacy landscape in Brazil

Consumer, healthcare, regulatory, and competitive trends are shaping a retail pharmacy landscape with significant growth opportunities mainly for large chains, but also increasingly strong competition.

Growth opportunities. The Brazilian middle class is expanding rapidly and enjoying an explosion in disposable income. These consumers also want the health and beauty products that pharmacies can offer, and they like the retail pharmacy shopping experience.

As Brazil's population grows and ages, the universal healthcare system struggles to meet the soaring demand for drugs. The retail pharmacy industry stands to gain, as ~80% of all prescription spending has been out-of-pocket, which means higher prices. This trend seems likely to continue, to the benefit of industry economics.

Large chains. Large chains, which have been growing 25% a year, are well positioned to keep capturing a disproportionate share of the growth opportunity. Middle-class consumers increasingly value their store experience and expect the differentiated assortment that larger players can provide, often at better prices, thanks to greater negotiation leverage with suppliers and economies of scale.

Government/regulatory changes intended to reduce market informality or to regulate medicine sales also favor large players. For example:

- Tax substitution rules (*Substituição Tributária*) prevent small players from evading taxes, which effectively decreases their competitiveness.
- Electronic invoice regulations (*Nota fiscal eletrônica*) require retailers wishing to participate in government programs (*i.e., Farmácia Popular*) to have a structured IT system in place, which excludes independent players from the program.
- Recent regulatory changes requiring “behind-the-counter” sales of OTC drugs benefit large players that have the bargaining power needed to partner with OTC suppliers on product displays. In turn, many smaller players have lost OTC sales.

Mounting competition. As players cross regional borders in pursuit of growth and scale, they have to fight head-to-head with incumbent players more than ever before. Aggressive investments and more professional management will lead to a fiercer battlefield.

- Players are making significant capital investments, often by wooing foreign capital and private equity investments. For example, BTG Pactual has followed an aggressive strategy of M&A and organic expansion to build BR Farma into Brazil’s largest pharmacy chain in only three years (from 430 stores to 744 including franchise operations), going public in 2011 in a successful IPO.
- Top players are also professionalizing management capabilities, especially upgrading operations, merchandising capabilities and logistics skills, to get ahead of the competition. For example, many are investing in IT systems to improve product management and reduce stock-outs and in CRM systems to increase share of wallet.

Critical factors in retail pharmacy success

Over the next 10 years, winning strategies in the Brazilian retail pharmacy market will involve the pulling of multiple levers, not just one or two.

1. Multi-regional strategies. Many players have grown rapidly by expanding into other regions. For example, Droga Raia has 350 stores in five regions that represent ~67% of the total Brazilian market. Pague Menos has stores in all states (if often only one store), and BR Farma expanded beyond the south, southeast, and federal district into the northeast.

Currently, all but one player remain regional; it is clear that all will have to turn multi-regional at least in order to capture a clear share of market growth. Doing so will bring important benefits,

including dilution of investments to enhance the consumer experience, new avenues of growth, greater attractiveness to top talent and stronger purchasing power and supplier collaboration (e.g., exclusivity deals, tailored displays of consumer goods).

Of course, realizing the gains will involve some pain. New entrants have brand and logistics disadvantages versus incumbents. Tax substitution rules in some states give players with a local distribution center a financial advantage.

Ensuring that the benefits of expansion outweigh the costs requires answering key strategic questions up front, such as:

- Should we focus expansion on the underserved, fast-growing retail market in the northeast or on the interior of the more developed south/southeast?
- Should we tap M&A or grow organically?
- Should we concentrate on our own stores or explore franchise models?

2. Sophisticated retailer skills. Retail pharmacy chains in Brazil have enhanced their skills in the last few years, putting most a step ahead of many large grocery chains. But the market requires more, with more scientific, fact-based, and client-focused execution of such capabilities as:

- Merchandising and operations. Drogarias Araújo, for example, has invested in IT systems to strengthen product management, cutting stock-outs significantly below the high industry average, and to improve distribution efficiency, adjusting service levels to store location and sales performance. This investment has contributed to Araújo's EBITDA of ~8,0%.
- Client relationship management. Some pharmacy chains in Brazil have embraced client relationship management, mining rich databases of consumer behavior information to offer personalized deals. Droga Raia, for example, built a sophisticated CRM system that supports tailoring specials to clients by time, location, and purchasing pattern (card holders account for >70% of sales), for greater share of wallet and product launch success.
- Supplier relationship management. Drogasil, for example, has implemented more professional purchasing practices, with a key account structure for collaborative, win-win negotiations with suppliers, especially consumer goods companies. Sharing their understanding of the channel, they develop joint strategies to maximize sales, e.g., tailored displays and personalized product launch offers.

3. Local execution. Successful retailers find the right balance between a consistent value proposition across stores and specific local differentiation. Retail pharmacy chains in Brazil tend to be dispersed, operating in locations with very different consumers and shopping occasions (e.g., quick gas station stop versus planned purchase).

In addition, the relatively small sales space of Brazilian retail pharmacies requires making choices by store cluster, adjusting category emphasis, with different assortments and investment levels. Droga Raia, for example, has four store formats, with varying mix (e.g., more

impulse-driven products in gas station stores) and category emphasis (e.g., more focus on upscale personal care in wealthier regions).

4. Internet presence (and other growth avenues). Many retail pharmacy chains in Brazil have an internet presence, but a very limited one, with little investment or service (e.g., very high stock-outs). This lack of focus reflects the impact of regulatory and logistical issues, the continued existence of rapid delivery service and the need for a national presence to make a mark on the internet.

But the internet represents a significant opportunity for retail pharmacies in Brazil, especially for a first mover. Brazilian e-commerce has grown an average 40% annually for the past few years. Today, Brazil has 70 million internet users, with 35% penetration among middle-class consumers, resulting from the quadruple of broadband penetration in the past five years. In turn, for an example of potential, Brazil retail pharmacies might consider proliferation of Drugstore.com in the US, which realized 2010 revenues of \$456 million from OTC and personal care products.

In addition to the internet, other areas of diversification exist in product and service expansion. While Brazilian regulatory restrictions limit diversification into products and services like food and photo development, concepts like special health foods and basic diagnostic self-service may soon offer other avenues to growth. Retail pharmacies have already become preferred payor processors in some states (north and northeast), especially where banking is limited.

5. Organizational capabilities. Moving on multiple strategic fronts while managing double-digit growth requires strong organizational capabilities. Companies that have weathered or are contemplating an IPO are generally ahead, with more professional management capabilities and governance and a distinct culture, supported by strong talent and a clear succession plan.

Talent looms especially large, given its scarcity in Brazil. While a national presence and more sophisticated operations may help, retail pharmacies will still need to develop programs that attract talent and performance cultures that retain it.



In summary, a convergence of trends makes this a great moment for retail pharmacy chains in Brazil to act, and actions already taken by industry leaders point the way to capture a disproportionate share of growth and play a major role in shaping the market.

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Growth in Brazil's branded generics market: Perspectives from Maurizio Billi, President of Eurofarma

Founded in 1972, Eurofarma has secured a position among the most admired Brazilian pharmaceutical companies, thanks largely to its success with branded generics. Accounting for 62% of the sales in Brazil's large and growing pharma market, branded generics face a rosy future. In a rare interview, Eurofarma President Maurizio Billi shares with McKinsey some thoughts on that future, for his company and the rest of the industry in Latin America.

Foundation for growth

Billi believes that Eurofarma has built a strong platform for growth. He highlights three specific actions: "We consolidated our presence with doctors, getting them to prescribe our products more. We created a good research department for new products. We specialized in the art of copying a product, which is difficult. We showed all our employees what we need – to be more agile, more questioning, and have more drive to do things faster because we are very small compared to the large multinationals."

Of course, Billi recognizes that Eurofarma faces challenges to growth: "We often don't have the internal knowledge of how to make the company grow. We know what we want, but don't know too well how to get there."

Aspirations for growth

Billi pins his aspirations on regional internationalization—expansion beyond Brazil into other Latin American countries. Eurofarma launched this strategy in 2009 by acquiring a local company in Argentina, and Billi plans to stay this course because, he says: “I believe there are still many opportunities for consolidation, perhaps not so many in Brazil, but many in Latin America. There are many family businesses, many companies without succession perspectives.”

Getting more tactical, Billi says: “We do not need to make very significant acquisitions. What we really need is a base. We don’t have to buy the market leaders—just a company with a median position to serve as a base for us to build our culture and our products.”

The Eurofarma growth strategy set in 2005 originally called for acquiring five companies in five countries, but as the Latin American market evolves so does the strategy. “Our original concept was to cover 90% of the Latin American market,” Billi volunteers, “but Venezuela now represents 15%, so if it stays out, we will never have 90%. Peru was not on our radar, but now it is.” He continues, “I believe we will end up buying a bit more than originally planned.”

To date Eurofarma has made four acquisitions outside Brazil and has taken a consistent approach to their integration: “We are keeping their management because it makes sense to do so. They understand more about those markets than we do.”

Financing growth

Of course, executing a growth strategy predicated on acquisitions can be expensive. But Billi outlines a clear financing strategy: “Our route is, use our own cash and bank indebtedness. There are some lines one can access at a reasonable cost. Then do an IPO. That we are going to do an IPO is certain. We just don’t know when. Our current position is, we will do it when all the alternative financing possibilities have run out.” He excludes private equity from the mix, saying: “If we have to go for private equity, it’s best to do an IPO directly.”

Competing for growth

Billi expresses strong respect, even admiration, for the major multinational pharmaceutical companies: “They are extremely efficient. I would give God knows how many years of my life to have access to the research into new molecules to be able to do the work like Pfizer, like Astra Zeneca. I greatly admire the work these companies do in R&D.”

But Billi often cites the need to know a market in order to succeed there. This belief leads him to dismiss multinational pharma companies as an immediate competitive threat in Brazil for branded generics: “The multinationals don’t have our heads. Until they understand how the market works, they are going to take a long time and leave space for us. I’m not worried about this type of competition. I’m worried about the competition from the Brazilian companies. This group of five or six Brazilian companies, they are very good.”

Billi takes these competitors very seriously, admitting: “They have the same problems we have —they need to win space. They have access to the same technology in product development and in marketing. They know where the good physicians are. We are determined to do things the right way, but the others also are.”

For Eurofarma doing things the right way means:

- Remembering that “the major business of a company like ours is to develop products that are losing patent and be one of the first to arrive in the market. A good example is Sildenafil, the generic of Viagra. Since it lost its patent, consumption of this pill in Brazil has multiplied by five. This is a sexual revolution. Our strength lies with this emerging Brazilian class that is getting access to medication.”
- “Launching new products faster and faster; investing very strongly in marketing.”
- “Getting closer to some multinationals and even being an arm of them in these markets.”
- Creating a culture of agility, “without much bureaucracy, without exchanging too many e-mails, without too many Powerpoint presentations.”

Success also requires motivated leadership. What motivates Maurizio Billi? “To work and be able to work. Be able to face challenges, risks, and problems and have happy outcomes. One doesn't get motivated by financial values. Motivation comes from what we conquer, and having very good competition is even more motivating.”

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Connecting rural Latin Americans to better health

Increased use of telemedicine in Central and South America can lead to improved health and longer lives in the hard-to-reach rural regions. A program in Brazil shows that advances in technology, medicine and communication have made expanded deployment possible. Now governments must work with the private sector to make it a reality.

Latin America has witnessed gradual improvements in its health indicators. In just four years, between 2006 and 2010, infant mortality rates have dropped from 20 per 1,000 live births to just under 18. During the same period, life expectancy at birth has edged from 73 years to almost 74. Yet, amid these improvements disparities remain, with health outcomes in rural areas lagging those in urban areas.

The challenge behind closing this healthcare gap is unique. In least-developed regions, like Sub-Saharan Africa, poor health is directly linked to a scarcity of clean water, simple medicines and other basic resources. There, infrastructure and distribution optimization can bring improvements. But suboptimal health outcomes in rural Latin America are tied to limited availability of medical knowledge in these areas, which manifests itself as less well-trained primary care physicians and the relative absence of specialists. To help find ways to bring better healthcare to rural Latin Americans, we looked at a telemedicine project in Brazil that posted some initial successes, but has yet to achieve its full potential. As part of the study, we interviewed health experts on the region, including officials at the Pan American Health Organization, healthcare professionals working in rural areas of Brazil and officials working with Brazil's public telemedicine program. These discussions, coupled with in-house expertise, showed some of the reasons for the disparities and pointed to measures that could bring near-term relief.

Drawing from the Brazilian example, primary care physicians in the rural regions often lack opportunities for continuing education and there are no performance-based incentive systems

to encourage self improvement. In addition, clinics in rural regions are often staffed by less-qualified doctors, those who cannot find jobs in the cities, or by inexperienced, young doctors waiting to be accepted into urban residency programs. The relative absence of specialty care physicians in rural areas is related to insufficient local demand, generally unattractive living conditions and a lack of opportunities for advancement.

Taken together, these factors lead to limited access to healthcare, as shown by long waiting lists for referrals; low quality care, for example incorrect diagnoses; and higher costs than necessary, such as unnecessary referrals and transportation expenses. We estimate that more than 120 million people are affected across Latin America, about a fifth of the region's population.

Telemedicine, the practice of using telecommunications technology to augment local clinical care, can be a significant part of the solution to improving rural health. At its core is a central hub, staffed by experienced nurses, family medicine experts and other specialists. By telephone, Internet and data transfers, these skilled professionals could link with general practitioners at rural outposts. For example, the local doctors would see patients, take their medical histories and perform physical examinations, identifying anything suspicious. The data would be sent to the central hub and analyzed. Then specialists at the hub could make initial diagnoses, request further tests or specific examinations, suggest therapies or recommend transfers to better-equipped facilities.

Put in practice, telemedicine can improve access to healthcare for patients in rural areas, improve the quality of care and reduce costs. In the Brazilian state of Minas Gerais, front-line physicians working with a telemedicine program there report higher quality care was offered to more patients, while an initial analysis of available data suggested annual costs were reduced by an average of 10,000 reais at each outpost.

From a practical standpoint, the three barriers that have blocked rapid expansion of telemedicine services have been largely overcome:

- **Medical knowledge** has advanced significantly, and, for most conditions, diagnosis and treatment are straightforward for competent practitioners or specialists. This is especially true for ailments common in rural areas.
- **Remote evaluations** are easier to conduct with technological advances bringing a plethora of low-cost medical devices to the market. These instruments, for instance, can transmit electrocardiograms to a central hub for immediate evaluation.
- **Communication** is no longer a limiting factor in many rural areas as mobile telephones and Internet access has become widespread.

The more intransigent obstacle centers on local skills. Our discussions and analysis show that limited availability of managerial skills is the most significant factor preventing governments from deploying telemedicine more aggressively.

For example, Brazil initiated a telemedicine program for rural areas in early 2000. The state of Minas Gerais and other areas posted early successes, but overall the program failed to reach

its full potential. Our analysis uncovered several key problems that could have been corrected with improved managerial skills.

The program did not focus sufficiently on the “customer,” that is the physicians stationed locally. For example, many were poor typists and it was an unnecessary burden for them to input on a keyboard patient histories and examination findings. This alone—which might have been corrected by using a telephone voice recording system to collect the data—discouraged many from adopting the program.

In addition, the incentives for the health professionals were not tied to outcomes of the telemedicine system. In many cases, health outcomes, cost savings or even participation in the system were not measured.

And finally, rather than creating a nationwide solution, each participating state built its own central hub. The system missed the opportunity to reap economies of scale, which were vital to its general success. Regional hubs did not have sufficient demand to justify appropriate staffing levels, and well-staffed hubs were needed to generate demand from the local practitioners. Such quandaries prevented these regional systems from gaining sufficient traction.

Countries that have successfully created a telemedicine system have addressed the need for managerial skills by building partnerships with private-sector players. MedicallHome, a Mexican for-profit joint venture with telecommunications company TelMex, provides 24-hour medical services to a million families. Unlike the telemedicine model in Brazil, MedicallHome works directly with patients, who are encouraged to contact the central hub with their concerns. Patients are assisted according to evidence-based protocols developed by the Cleveland Clinic. MedicallHome operates on a flat \$5-a-month subscription model. Further examples around the globe include HealthLine Bangladesh, a partnership between for-profit organizations that created a health hotline targeted at the rural poor, and EMRI India, a public-private partnership that provides emergency services independent of social class and location.

Analyzing the successes in these countries and the lessons learned in Brazil, we see three core responsibilities that governments should assume to boost telemedicine. These measures focus on bringing in private-sector partners who can add managerial discipline and creativity to the system.

First, governments must provide a supportive ecosystem, allowing remote treatment decisions while ensuring quality standards. The government should, for instance, write policies that allow diagnoses to be made over the phone, medication to be prescribed by e-mail or patients to be referred to a specialist using text messaging. At the same time, governments must ensure quality, for example by establishing minimum levels for a set of key performance indicators and penalizing companies that fall below these levels. Financial penalties, such as the seizure of performance guarantee bonds, and cancelation of contracts could be used to enforce these standards.

Next, governments must map out clearly their priorities for telemedicine. This would entail identifying regions that are poorly served under the current model and categories of care that hold the greatest potential impact, such as maternal health or infectious diseases.

Cross referencing these two categories and creating a “heat map” would pinpoint areas for immediate focus.

And lastly, governments should seek private-sector suppliers able to address these priorities effectively. In one method, the government sets a maximum price per resident in the targeted area, for instance the amount it would cost the government to serve that area, then invites bidders to offer the services at a lower price. The winning company is reimbursed by the government based on its bid and is responsible for providing quality service as detailed in the tender. (Similar auctions for toll road construction in Brazil led to bids of up to 65 percent less than the government’s maximum and a road system that is praised by drivers.)

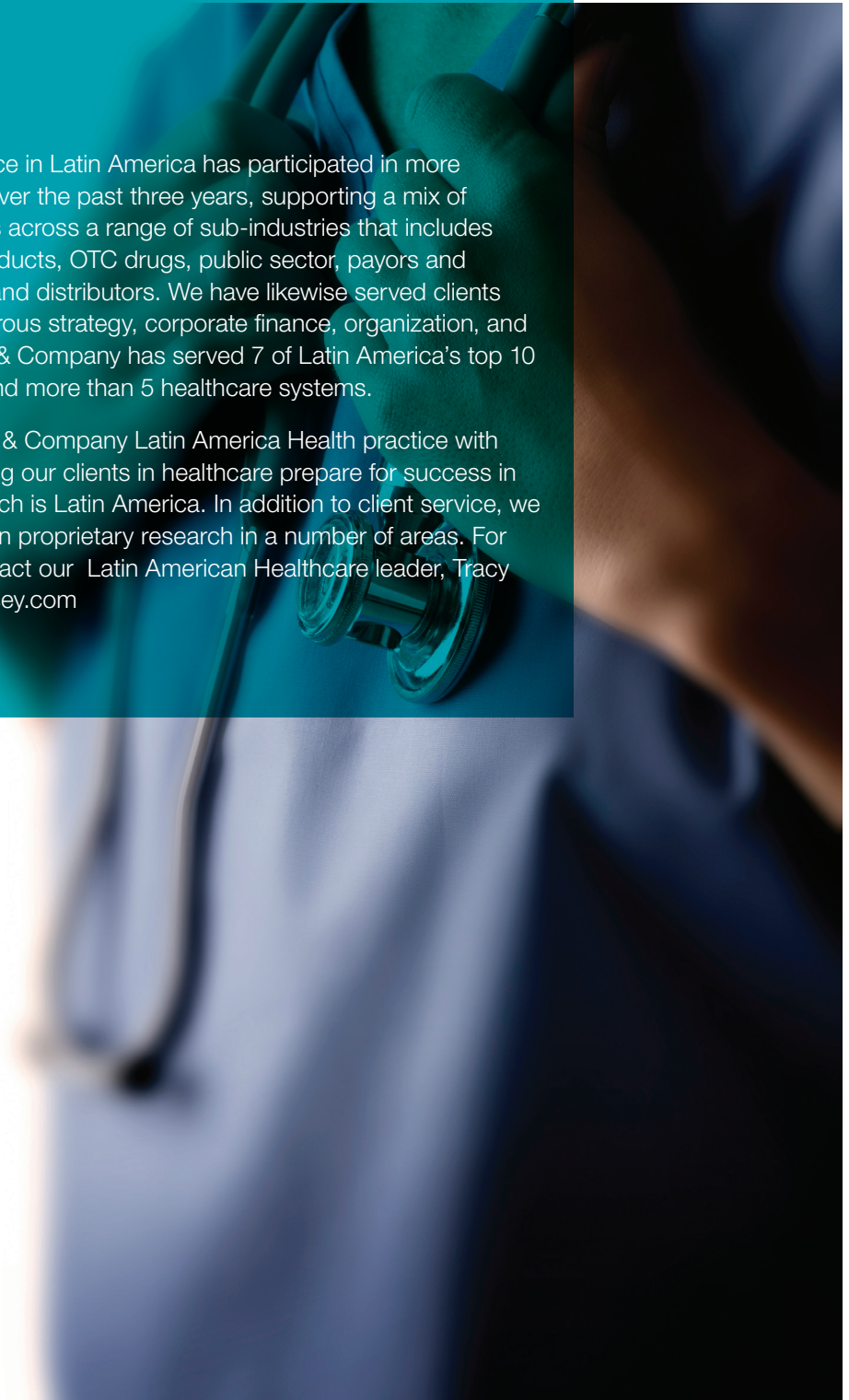
Improving healthcare in rural Latin America requires bringing medical knowledge and expertise to hard-to-reach areas. Telemedicine can achieve this goal. Medical practices, technology and communications have advanced far enough that they are no longer substantial obstacles to deploying telemedicine systems. The final hurdle is gathering appropriate managerial skills around the efforts. By partnering with private-sector providers, governments can harness their skills and reach the full potential of telemedicine.

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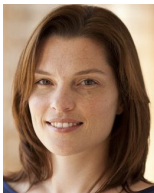
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