

## Health promotion in supplementary health care: outsourcing, microregulation and implications for care

*Promoção da saúde no setor suplementar: terceirização, microrregulação e implicações no cuidado*

*Promoción de la salud en la salud suplementaria: la externalización, microregulación y las implicaciones para la atención*

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### How to cite this article:

Silva KL, Sena RR, Rodrigues AT, Araújo FL, Belga SMMF, Duarte ED.

Health promotion in supplementary health care: outsourcing, microregulation and implications for care.  
Rev Bras Enferm. 2015;68(3):423-9. DOI: <http://dx.doi.org/10.1590/0034-7167.2015680315i>

Submitted: 02-09-2015 Approved: 04-11-2015

### ABSTRACT

**Objective:** to analyze health promotion programs in the supplementary health care. **Methods:** This was a multiple case study with a qualitative approach whose data were obtained from interviews with coordinators of providers contracted by the corporations of health insurance plans in Belo Horizonte, Minas Gerais. The data were submitted to Critical Discourse Analysis. **Results:** Home care has been described as the main action in the field of health promotion transferred to the providers, followed by management of patients and cases, and the health education groups. The existence of health promotion principles is questionable in all programs. Outsourcing is marked by a process with a division between cost and care management. Implications of this process occur within admission and interventions on the needs of the beneficiaries. **Conclusions:** Statements revealed rationalization of cost, restructuring of work, and reproduction of the dominant logic of capital accumulation by the health insurance companies.

**Key words:** Outsourced Services; Supplemental Health; Health Promotion.

### RESUMO

**Objetivo:** analisar programas de promoção da saúde no setor suplementar. **Método:** estudo de caso múltiplo de abordagem qualitativa, cujos dados foram obtidos em entrevistas com coordenadores de prestadoras contratadas pelas operadoras de planos de saúde de Belo Horizonte, submetidos à Análise Crítica do Discurso. **Resultados:** a atenção domiciliar foi apresentada como a principal ação no campo da promoção da saúde transferida para as prestadoras, seguida de gerenciamento de doentes e de casos e dos grupos de educação em saúde. Em todos os programas é questionável a existência dos princípios da promoção da saúde. A terceirização é marcada por um processo micro-regulatório restritivo, com cisão entre a gestão dos custos e a gestão do cuidado. Há implicações desse processo na captação e intervenção sobre as necessidades dos beneficiários. **Conclusão:** os discursos foram reveladores da racionalização de custos, reestruturação do trabalho e reprodução da lógica de acumulação do capital dominante na saúde suplementar.

**Descritores:** Serviços Terceirizados; Saúde Suplementar; Promoção da Saúde.

### RESUMEN

**Objetivo:** analizar programas de promoción de la salud en los sistemas privados. **Método:** estudio de caso múltiplos con un enfoque cualitativo, cuyos datos fueron obtenidos de entrevistas con los coordinadores de los proveedores contratados por los operadores de los planes de salud de Belo Horizonte. Los datos fueron presentados al Análisis Crítico del Discurso. **Resultados:** atención domiciliar se ha descrito como la principal acción de la promoción de la salud transferido a los proveedores, seguido de la gestión de los pacientes y los grupos de casos y educación para la salud. En todos los programas es dudosa la existencia de los principios de promoción. La externalización es marcada por un proceso de fractura entre la gestión de costos y gestión de la atención. Hay implicaciones de este proceso en la captación e intervención en las necesidades de los beneficiarios.

**Conclusiones:** los discursos fueron reveladores de racionalización de costos, la reestructuración del trabajo y la reproducción de la lógica dominante de la acumulación de capital.

**Palabras clave:** Servicios Externos; Salud Complementaria; Promoción de la Salud.

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## INTRODUCTION

The Supplementary Health Care sector is composed of the actions and health services provided by the complementary private sector to the public Unified Health System in Brazil. It is characterized as a sustainable organization that is permeated by an economic logic and composed of actors with antagonistic interests. It can be stated that the care model practiced is medical-hegemonic and procedure-centered, with few actions of health promotion and disease and risk prevention, leading to an uncritical consumer of technologies<sup>(1)</sup>.

In recent years, through incentives of the National Health Agency – (Agência Nacional de Saúde – ANS), the corporations have tried to review the paradigms and build a quality care model with investment in health promotion<sup>(2)</sup>. The health promoting actions can be considered as a very important heterogeneous set of strategies for the consolidation of policies for people's health, and must be used in the implementation of health care models based on the production of comprehensive and autonomized care<sup>(3-4)</sup>.

In this sense, different strategies and health promotion programs were incorporated by companies and appear to respond to the demand for modernization and cost savings by implementing a new health care logic that operates with other professionals and other care strategies<sup>(4)</sup>. The proposal of incentives for promotion programs also meets the expectations of the beneficiary, for the possibility of preventing disease and improving quality of life as well as by obtaining discounts and rewards offered by the company<sup>(4)</sup>.

It recognizes the interests at stake in promoting health in supplementary care and displays, as well, a component in imbricated restructuring programs that is revealed in the outsourcing of supply and action management. Thus, it is considered that the health promotion investment in supplementary health can be a device that includes new working relationships, changes in hiring methods and services, and substitutability in health practices.

Outsourcing and other forms of organizational transformations in the working world make up the complex scenario of corporate restructuring. In health, both in the public and the private system, outsourcing is a trend, especially in hospitals, which is manifested by two movements: one aimed directly toward professionals, by hiring worker cooperatives, and another by allocation and provision of services in support activities<sup>(5)</sup>.

In public service, outsourcing has been used with the justification of maintaining quality, quantity and price of goods and services provided by individuals with government regulation<sup>(6)</sup>. This regulation, however, seems to be the subject of disputes in supplementary health care, where user assistance is established from the corporation-provider-user relationship,

but dictated by an external regulation determined by ANS<sup>(2)</sup>.

The stresses in the field of supplementary health care are not new, and are characterized by a profound process of rationalization, with the submission of health institutions to an economic logic, outsourcing of services, increasing automation of diagnostic processes, dismemberment of the global medical act on multiple diagnostic and therapeutic acts performed by various professionals, whether or not they are physicians<sup>(7)</sup>.

Considering that the ANS has the corporation's ability to remain in the market, the rights of users, and the products, values and coverage of the programs as targets of the regulation<sup>(2)</sup>, it is understood that there are aspects of the programs of health promotion offered that cross the relationship between corporation-provider-user, and which are on the margins of the macro-regulatory process. Thus, the question is how this offer is processed and the relationships are established in the outsourcing, as well as the implications in the delivery of care, understanding that this is a microregulation field.

Microregulation is a group of induction and control mechanisms exercised by an economic agent over another. In the relationship between corporations and providers, these mechanisms are manifested in the form of contracts, payment and non-financial instruments of regulation, such as the existence and availability of professionals, restrictions on the use and access to certain intermediary services, in the adoption of prior authorizations, in auditing procedures, among other mechanisms<sup>(8)</sup>.

Microregulation also focuses on the relationship between providers and users with devices that influence the "choices" and the utilization of users about the professional and health facilities; as well as in the care delivery space with the relationships that are established in the encounter between workers and beneficiaries<sup>(7)</sup>.

The implications of this relationship that is established between providers and users is marked by the interests in dispute of the actors in the outsourcing of supplementary care, and are not always explicit. Thus, the aim of the study was to analyze health promotion programs in the supplementary health sector, revealing discourse on the delivery of care, focusing on outsourcing and microregulation practiced within the industry.

## METHOD

This was a qualitative approach, using multiple case study. Six contractors who provided health promotion services to 19 private insurance providers in the city of Belo Horizonte, Minas Gerais provided the setting for the study. The contact with the providers was obtained by corporation indication or key informants in the field of health insurance.

Data collection was conducted from July of 2012 to July of 2013. Interviews were conducted using a semi-structured guide with coordinators of health promotion programs of

six providers that maintained a relationship of service provision for the studied corporations. At this stage of the study, it was decided to analyze the outsourcing processes in Supplementary Health Care by capturing the perspective of service providers, although it is acknowledged that such an option is limited to one of the actors disputing the provision of health promotion programs. In another phase of the study, the perceptions of corporations and beneficiaries were analyzed.

The interviews were recorded and then transcribed, followed by the analysis of empirical data, which was based on Critical Discourse Analysis. From this perspective, it is understood that the statement reflects entities and social relationships and also construct or develop them as key entities of different ways of positioning people in different ways as social subjects<sup>(9)</sup>.

The three-dimensional model of discourse analysis<sup>(9)</sup> distinguishes three dimensions in statement - text, discursive and social practice - according to analytical purposes, bringing together three analytical traditions essential to discourse analysis.

In an approximation of the categories for discourse analysis<sup>(9)</sup>, these dimensions are used in this paper: intertextuality, interdiscursivity and representation of events/social actors. Intertextuality refers to the voices present in statement; interdiscursivity points to the articulated statements in the text, usually evidenced by use of metaphors. The third dimension demonstrates the position of the subjects that emit the statement (active, passive, impersonal, collective) and the represented processes.

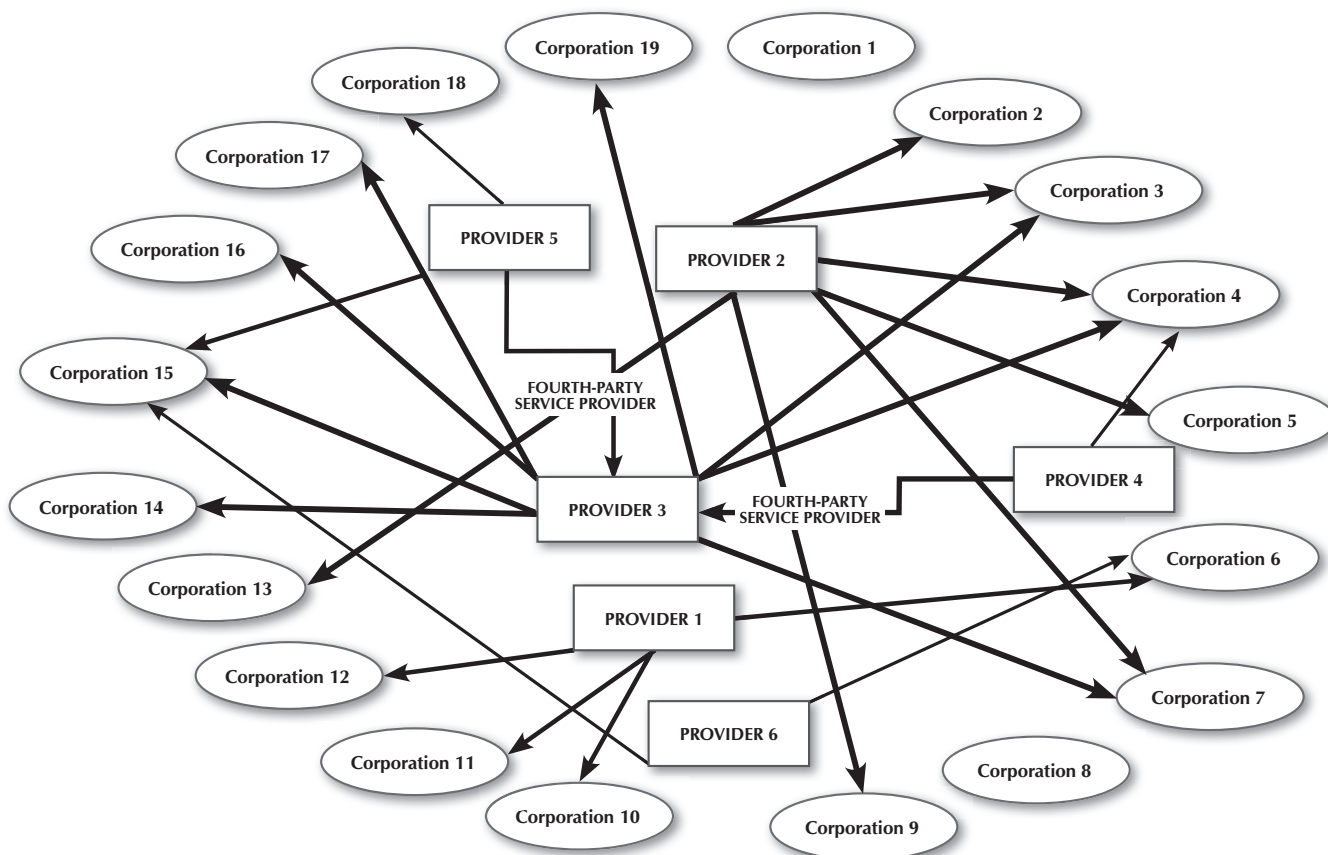
In accordance with ethical principles, the research was approved by the Ethics Committee of the Minas Gerais Federal University, Number CAAE 0581.0.203.000-11. Participants were informed about the purpose of the study and signed the Terms of Free and Informed Consent.

**RESULTS**

The results indicate that outsourcing of health promotion programs in supplementary care is a complex reality, marked by disputing actors.

Figure 1 illustrates the scheme of relationships between corporations and providers. Six companies that provide services to corporations in the city were investigated. There were two health plans corporations in the city that provided assistance to beneficiaries exclusively using their own services. The remaining 17 corporations employ services of other providers. Some providers offer services to more than one corporation, including those that compete with each other. In the reverse flow (of the relationship of corporations with the providers), the inverse is also true, with purchase of services by corporations of different outsourced companies, competitors in the market.

The investigated providers began their activities in the healthcare market in the period between 1996 to 2010, and the findings indicate that health promotion outsourcing arises by demand from corporations. In this sense, those being interviewed explained that investing in outsourced companies by



**Figure 1** - Relationships between providers and corporations studied

professionals who had experience in health plans or private services helps to meet the demands of a growing market.

The employment of professionals with public health experience is revealed as the opportunity to bring health promotion to supplementary care. In this context, there is evidence of the growth of providers, with allusion to the expansion of actions and programs and the expansion of a customer portfolio demonstrated by the metaphors “stepping down” and “gaining ground”.

*Provider 3 has ten years, is a company that began with a group from Hospital 1, with the intention of discharging the patients of Hospital 1. In this context, they received greater care, which was from Corporation 15, which is currently the biggest client of Provider of 3. (Coordinator, Provider 3)*

*For it [starting the health promotion program], we invested in a larger proposal, then it was a full team from physician to occupational therapist, so that the corporation hired according to CLT (Consolidation of Brazilian Labour Laws), at that time was also complicated, it was heavy. So, at that time we already had a reasonable experience, so we proposed, “Then I will open the company to care initially for you,” this is a good opportunity because Provider 2 was born, already having a first client and a loyal customer with a significant demand for us to manage. The management of chronic cases is only one of the fronts because we are stepping down. And Provider 2 was born, so we were initially serving Provider 9, and later we were gaining ground in the market. (Coordinator, Provider 2)*

*Then the companies, when we talk about any corporation that has several enterprises in its portfolio, such group-operative work, we welcome demand, the company pokes the corporation that knows this is available by competition and requests. (Coordinator, Provider 2)*

The transfer of the benefit, by the use of the metaphor “it was heavy”, is revealed to be a cost-saving alternative sustaining a discourse of economic rationality and the purpose of outsourcing.

Home care was indicated by the participants as the main activity included by corporations in the health promotion role, and its implementation was transferred to the outsourced providers. The six providers analyzed provide home care services either through a home care modality (Corporation 6), specific intervention (Provider 5), or home care (Providers 1, 2, 3, 4 and 5). They even offer chronic case management programs for corporations (Corporation 2 and 6); managing complex cases (Corporation 3); health education groups aimed at groups with chronic conditions, pregnant women and adolescents (Providers 2 and 3); vaccination campaigns (Provider 2); courses and events (Providers 4 and 5); ambulance services and patient transport (Providers 1 and 4).

The statements of participants in the study are permeated by the representation of home care as a form of hospital care transfer - materialized in its technologies and practices - for the home.

*Our differential is that we do what we do in hospital, the procedures, I will not say all of that, but most of what is possible. We do the same at home. So we avoid hospitalization, we reduce the number of consultations. ... And*

*sometimes it depends on the situation, until the exams are completed. Why have the doctor at home, then the patient sometimes does not need to have so many tests, unless necessary. (Coordinator, Provider 1)*

In the previous report, the Coordinator of Provider 1 emphasizes that activities which have been made in the hospital are performed in home care, in a statement indicating the reproduction of processes and relationships at home, but with simplification of care.

Others interviewed expressed that home care is a locus of building new relationships and requiring from professionals the expression of new skills, since it begins to deal with other demands, not only those that are specific to those traditional performed by health institutions at the home locus.

*The everyday life with families is quite overwhelming, so sometimes the contacts are very close. You're very close there, inside the house. [...] The families become close, they take freedoms, then they call all the time, they request all the time. [...] This, I think is a big challenge, mediating families is a major challenge of home care. You do not have a companion, you have a family. [...] It is an intelligent hospital that states that only one companion is allowed at a time. (Coordinator, Provider 3)*

The statement of the Coordinator of Provider 3 reports a major contradiction of care in home care that is revealed in the frequency and intensity of contacts and experiences at home. The use of adverbs and the repetition of the expressions that emphasize the challenges for care in home care (“quite crushing”, “big challenge”) are confronted with the proximity of established relationships declared as “very close” and “all of the time”.

The intertextuality present in the statements are emblematic and reveal the centrality of assistance in professional and technical conduct, often ignoring the subjectivity that permeates and crosses care relationships at home:

*Because, in addition to people assuming these attitudes and behaviors, we also have the question of the technique; inside technique we work a lot with SOPs (standard operating procedures). [...] It is not the guy throwing the keys there, not [referring to the professional who comes in the home and drops the key on the table], there is hand washing, the polite and ethical posture of introducing yourself. It is the profile that I am presenting to you; of SOPs, ethics, posture, support. You place yourself in a position like, “I am a qualified professional, I am here to take care of your father. Even if your father has any complications here and dies, the only one who can help you here at the moment is me, I cannot leave his side now. (Coordinator, Provider 4)*

*[...] Then, we work with the patient that we approach, “Look, you have this ...” You say what the diagnosis is, explain what it is, and why he takes that medicine. ... You explain to him what that medicine is. Because otherwise, the patient does not take it, he is resistant to the treatment. So, our goal is to educate him to follow the treatment. So, we can work on this issue of promotion and prevention. (Coordinator, Provider 1)*



The position assumed by professionals in determining the plan of care contradicts the assumptions of autonomy, empowerment and accountability, the assumptions of health promotion. Even in an educative function, there is a transfer of knowledge, supported by authoritarianism and, in the prescription of correct ways of acting, it is indicated by verbs in the imperative function. Outsourcing adds crossings in the provision of care, with implications for capture and intervention of needs and user demands.

*Some health insurance agrees with our assessment [the determination of frequency of home visits]. So, we go there and evaluate and think that that patient must receive visits throughout the month. So, they [coordinators of the corporations] authorize or do not authorize. Some health insurance determines: "look at this patient; I want this and this and this." Then, for example, "I want nurses during the entire month, physician for the entire month, physical therapy three times a week." (Coordinator, Provider 1)*

*When the health insurance approves, we do everything [full and necessary support for home care]. (Coordinator, Corporation 6)*

*Another thing that makes it difficult is when the corporations release the care plan to the patients; sometimes certain patients need equipment, but it is not authorized by the health insurance [...]. (Coordinator, Corporation 6)*

The outsourcing of home care tends to be used for users whose care has higher cost or for those who are more dependent on care, revealing the understanding that there is a lack of accountability by the corporation for this care.

*So, for example, Corporation 11; it evaluates according to the degree of need of the patient. So depending on the patient dependency, itshe sends for us. If it is an easier patient, it provides care with its own team. (Coordinator, Provider 1).*

Understanding the supply of home care and other programs in supplementary care, the cost reduction logic was revealed as the primary motivation for investment and growth of the actions that corporations refer to as health promotion. The intertextualities, metaphors and emphatic intonations of the words "awesome" and "without a doubt" present in the following reports confirm the explicit interest in capital accumulation for the provision of health promotion programs:

*For real? The health insurance companies invest in chronic case management to decrease their cost. For the beneficiary; we do not open it; so we put it as, "we want to give you a better quality of life; we want to teach you to live with your disease that is incurable, and progressive in some cases, in the best way possible," but the goal of the company is to reduce the use of resources. [...] The initiative, we did not see this in any of the Corporations 15, 9 or 2, the initiative to offer services to you because I am worried about your future. [...] We do not think like that: "let's work now on Smoking Cessation to prevent lung cancer, emphysema" ... No! It happened; they had cancer, emphysema; it is a high*

*cost patient; let's take him home or "let's work on obesity because it predisposes people to chronic diseases; there is a marriage of things," no, that's morbidity, let's act on the morbidity. (Coordinator, Provider 2)*

*[...] After I came here [to the provider], I had another view. When I worked in the corporation, I had a little bit of utopia about it. I really believed it was best for the patient, the quality ... this is unquestionable, we realize that it is much better, families are more satisfied, the home care condition is very resolving. But what happens is that the cost reduction is AWESOME. [...] This happened as a matter of cost; WITHOUT A DOUBT! (Coordinator, Provider 3)*

Other respondents recognize that the cost rationalization is the determinant of the supply of health promotion programs and home care; but they do so with a critical discourse that recognizes the need for cost containment; but they do not deny that there are other interests – the family; the hospital corporation, the beneficiary - that comprise this relationship.

*[...] The health insurance company wins because the hospital's cost is too high; this outsourced company gains even hiring a physician, a nurse; the family wins because it has a greater comfort in the home, of being there with that patient, to be able to sleep at his side; the whole situation of being within your living space [...] the issue of caring is focused on humanization because this client of that company we have gained; one minute sitting, listening and talking to that patient, listening to his complaints [...]. (Coordinator, Provider 4)*

Based on these findings, we can say that outsourcing of health promotion in supplementary care acts as a device that responds at the same time to the corporation's interests, the provider, the beneficiaries. "Everybody wins" is the discourse which portrays this understanding; although in many aspects it demonstrates the supremacy of the rational logic of costs that meets the interests of capital accumulated in the health sector.

However, it should be considered that the new health care modalities employed as health promotion by corporations, while not addressing all dimensions and principles in this field, are important strategies that also respond to the interests of beneficiaries and families in a logic of the production of freedom in the care practices - whether at home or in other spaces - that capture the health demands and needs, although in the form of prevention, clinical management and biopolitical intervention.

## DISCUSSION

Corporations and providers indicate home care actions, chronic case management, vaccination campaigns as health promotion. The inadequacy of the denomination and use of health promotion is understood, considering that in most of the actions, interventions for diseases and vulnerabilities established especially for recovery, rehabilitation or even clinical management were observed. In general, the empirical evidence did not permit the demonstration of the potential of these actions for the changes in behavior and transformation of social determinants, the object of health promotion intervention.

Deregulation of a set of actions in the list of procedures of the regulatory agency in supplementary health induces the allocation of those actions not traditionally offered by the sector as health promotion. The fact of health promotion being considered a field characterized as heterogeneous in concepts and methods is associated with this understanding<sup>(10)</sup>.

Furthermore, it should be considered that the more used initiatives can reveal a movement for change in the health insurance that formerly proved to be an incipient field of intervention or one that was almost absent from health insurance providers as managers of clinical care management systems, risk prevention, disease and disorder, rehabilitation and recovery.

The elements identified in the study do not allow us to characterize home care as health promotion, but the fact that this care modality occupies a special place in supplementary health, defined as a alternative care that exceeds the dominant mode, centered on consultations and medical care<sup>(10-12)</sup>, represents an important fissure that can compete in the overcoming of the current health care model.

Furthermore, from the perspective of social practices, other studies show that home care has mainly been used as an alternative to rationing and cost transfer<sup>(10-12)</sup>.

This finding reveals a contradiction in the provision of the so called health promotion programs in supplementary health that present themselves as devices of cost rationalization in contraposition to the prospect of a change in the care model in the industry.

A change in the care model requires new forms of care production operating in the amplification of autonomy and the possibility of live work in action by the teams, in order to rescue cooperation, complementarity and solidarity in professional practice<sup>(12-13)</sup>. This singularity reinforces the importance of light technologies to overcome the challenges facing the delivery of care.

However, the findings of the study indicate that even in programs that are supported by educational activities, there is little possibility for the user and family to debate their decisions and choices about the offer and performance of care, thus assuming the representation of a passive person facing the impositions placed upon them by the team/professional. In particular, in home care, the care is permeated by a relationship of dispute between the technical and scientific knowledge of health professionals, and the know-how of the family about the user's care, producing stress that interferes directly in the plan of care, since in most cases, family care is not legitimated by the hegemonic medical and professional-centered model represented by the home care team<sup>(14-15)</sup>.

We see an exercise of disciplinary power whose passivity of the user/family is based upon strategies of "awareness" to follow the plan of care. In this case, the prescription of care and the distribution of guidance often confronts a dispute that is established between the power of professional/staff and the users/family. In this process, the user and family compete for power and cannot accept some regulation of professionals. If he does not want to, he does not follow the prescribed diet, does not do some physical therapy, does not follow the recommended treatment plan<sup>(4)</sup>, and is characterized as an undisciplined or rebel user/family.

It should be considered that the statement of humanization is also present in the interviews as a consequence of the

transfer of care to the home. However, it turned out to be a contradictory relationship that is not accompanied by negotiation and agreement of the plans of care which remain focused on the corporation and providers' decisions.

Thus, the determination of the "needs" of beneficiaries is performed externally to the patient and family, and does not provide spaces for discussion of the rules imposed for care.

In respect to the relationship between corporations and providers, outsourcing has proved to be a device that passes through the delivery of care with implications for capture and responses to the health needs of the users. Even outside this direct benefit, the corporation is the definer actor of care production, using payment procedures as a regulatory instrument. This relationship of outsourcing is marked by the scission between the management of costs (which remains in the corporation) and care management, which is transferred to the providers. The interviewees revealed no space to dialogue about the meeting of the logic that governs costs and care management.

Another study<sup>(7)</sup> showed that rationalizing measures, such as non-authorization for hospitalization or special and high cost procedures, adopted by corporations, have a direct impact on assisting beneficiaries and, in general, are transformed into problems between the provider and the user, as the corporation "removes responsibility" of the care transferred to the providers. Thus, it is noted that the outsourcing process implies a delay and loss of quality of service provided from the perspective of capturing, interpreting and serving the needs of beneficiaries.

In this arena of conflict of interest, spaces for debate between the logic that guides corporations, providers and beneficiaries were not presented. So it seems mechanisms prevail to restrict the access by the corporation to restrict the delivery of care in its expanded form. The regulation in this case is centered on the restrictive process, with countless steps existing and authorizations for access to care, and the definition of which technologies and procedures are to be offered for each patient, regardless of their needs. In general, this definition is supported by the lack of access to specific technologies such as prostheses and high complexity and high cost procedures.

It is pertinent to mention that Health Insurance, as part of the healthcare market, is influenced by an economic dimension that has repercussions in an interest for cost reduction and reorganization of the model of care delivery<sup>(11,16)</sup>.

It is highlighted that microregulation is a fairly autonomous territory or immune in relationship to regulatory measures and regulation by the ANS and, on that basis, it operates with its own logic, dictated on the one side by the protagonism of multiple actors, with their interests, and on the other, by the existence of certain regulations or rules external to the field<sup>(7,17)</sup>.

## FINAL CONSIDERATIONS

The findings of this study showed that care delivery in health promotion of supplementary care has the characteristic of fragmentation of care, due to the restrictive aspects of microregulation and the irresponsibility of corporations which operate with a logic centered on the demand and supply of what was contracted, and not on health care delivery logic.

Overall, the actions, programs or activities are inappropriately referred to as health promotion, as they do not reveal the principles of care delivery centered on autonomy, continuity and integrality. Even with this conceptual mistake, the importance of this set of actions that have the potential to improve the quality of life of beneficiaries is recognized.

However, as disclosed in the findings, health promotion is used as a component of corporate restructuring that responds much more to the cost rationalization than properly to a

potential to develop a new model of care.

Macroeconomic factors that influence the appreciation of profit and cost reduction determine supply and outsourcing of health promotion programs offered by the corporations. Thus, we conclude that outsourcing the actions denominated by corporations as health promotion in the supplementary sector is permeated by discourses that reveal cost rationalization, restructuring of work, and the logical reproduction of capital accumulation with implications for care delivery.

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