



Revista da ASSOCIAÇÃO MÉDICA BRASILEIRA

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Original article

Supplemental care from a bioethical perspective[☆]

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ARTICLE INFO

Article history:

Received 3 May 2013

Accepted 30 June 2013

Keywords:

Supplemental health
Public-private partnerships
Bioethics
Universalization of health

A B S T R A C T

Objective: To describe and analyze, from the perspective of Intervention Bioethics, the legal, institutional and ethical contexts, the conflicts and regulations of supplemental health care in Brazil, since the approval of the regulatory law in 1998 until 2010.

Methods: Qualitative research, using Intervention Bioethics as the theoretical reference. Bibliographical and documental study of the legislation, regulations and assistential framework, as well as interviews with members of the Supplemental Health Board.

Results: There was improvement in the records and rules of action in private health companies, as well as flow of information, contractual and financial guarantees provided to consumers. Conflicts persist regarding access to services and procedures, price increases, policies on autonomy and medical fees. There is a dispute with the public sector regarding the network of health services, with rising costs and no improvement in quality of care.

Discussion: Private participation in health demands comparative assessments and improvement of public-private care regulation, as well as promoting greater balance in the funding and reevaluation of the health care model.

Conclusion: It is necessary to review the regulatory framework considering the supplementary, complementary or duplicate characteristic of assistance, the social actors involved, bioethical and political issues regarding associations between Supplemental Health Care and the National Health System (SUS).

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A saúde suplementar em perspectiva bioética

R E S U M O

Palavras-chave:

Saúde suplementar
Participação público-privada
Bioética
Universalização da saúde

Objetivo: Descrever e analisar, mediante a perspectiva da Bioética de Intervenção, os contextos legal, institucional e ético, os conflitos e a regulamentação da saúde suplementar no Brasil, desde a aprovação da lei em 1998 até 2010.

Métodos: Pesquisa de caráter qualitativo, utilizando a Bioética de Intervenção como referencial teórico. Estudo bibliográfico e documental da legislação, regulamentação e quadro assistencial, além de entrevistas com membros da Câmara de Saúde Suplementar.

[☆] Study carried out at Universidade de Brasília, Brasília, DF, Brazil.

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Resultados: Houve melhora dos registros e regras de atuação das empresas, do fluxo de informação e das garantias contratuais e financeiras aos consumidores. Persistem conflitos no acesso aos serviços e procedimentos, reajustes de mensalidades, políticas sobre autonomia e honorários médicos. Há disputa com o setor público pela rede de serviços de saúde, com aumento dos custos e não melhoria na qualidade da assistência.

Discussão: A participação privada na saúde demanda avaliações comparativas e aperfeiçoamento da regulação público-privada na assistência, assim como promoção de maior equilíbrio no financiamento e reavaliação do modelo de atenção à saúde.

Conclusão: Necessidade de revisão do marco regulatório considerando o caráter suplementar, complementar ou duplicativo da assistência, os atores sociais envolvidos, as questões bioéticas e políticas nas relações entre Saúde Suplementar e Sistema Único de Saúde.

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Introduction

The health care plans and private health insurance, called Supplemental Health Care in Brazil, have been regulated for over 10 years with the goal of solving conflicts, exposed in the justification of the project that gave rise to Law N. 9656 of June 3, 1998¹ and N. 9961 of January 28, 2000,² which created the National Supplemental Health Agency (ANS).

The main conflicts were related to restrictions of coverage of procedures, exclusion of age groups from the products, abusive increase of fees, no guarantees to consumers regarding corporate insolvency and lack of regulation and control by the Executive branch, since the Constitution in Brazil, in 1988, defined health as an attribution of the federal government.³

Several studies in the field of supplemental health have assessed the health needs of the assisted population, the prevalence of diseases, economic conditions, the configuration of the regulations, legalizations and health financing,⁴⁻⁷ but there have been few studies that considered the conflicts related to the ethical aspects involved in policy development in supplemental health. In this sense, the aim of this study is to describe and analyze - through the epistemological perspective of Intervention Bioethics (IB) - the legal, institutional and ethical contexts, as well as conflicts and regulations related to supplemental health care in Brazil, since Law N. 9656/98 was approved until 2010.

Methods

The study adopted the qualitative method of health research, using IB⁸⁻¹¹ as the theoretical reference, which, among other things, is dedicated to the equity issue by incorporating the supplemental health to the persistent or daily bioethical macroproblems faced by most of the population of the so-called peripheral countries.¹²

The research was carried out in two stages. The initial stage dealt with the literature review of conceptual, legal and institutional frameworks of health, bioethics, health care assistance and private health insurance issues in Brazil and in the international scenario. In the approach, in addition to

the concepts, we also researched the conditions, the Brazilian institutional regulation and regulatory process of supplemental health in the country.

The institutional literature was searched primarily at ANS, based on national and international data on health care, the standards, guidelines and public consultations conducted by the agency, as well as in the publications of representative bodies and institutions that comprise the Board of Supplemental Health¹³ (CSS).

The second stage consisted of interviews with representatives of institutions that comprise the CSS, aiming to increase the representativeness of the study and analyses of the conflicts considering the expectations of different segments that have more interaction in everyday supplemental assistance. A convenience sample was created, consisting of 12 representatives from CSS institutions,¹³ representing, respectively, beneficiaries, health care and insurance companies, service providers as well as public and supplemental sector managers.

The project was approved by the Ethics Committee of the School of Health Sciences at Universidade de Brasília (UNB) and is part of the doctoral thesis entitled "Supplemental Health in Brazil from a Bioethical Perspective," presented at the Post-Graduation Program in Bioethics of UNB.

Results

Regulatory framework

The Federal Constitution³ established health as being a citizen's right and attribute of the State, creating the Unified Health System¹⁴ (SUS) It also allowed free private health care, establishing conditions so that individuals could have access to differentiated programs and services in health, especially by allowing tax deduction of the costs spent on private care.¹⁵

Before 1988 there were two levels of private sector participation in health care: the direct provision of services and private health plans and insurance. Under this conception, supplemental health was regulated, with the approval of Law N. 9656/98¹ and N. 9961/2000² creating ANS under the Ministry of Health, with assignments aiming at registration, regulation

Table 1 – Proportion per type of Normative Resolution – NR, ANS, 2002 to 2010.

NR/ANS	%
Administrative/operational/financial ANS	66.70%
Health Assistance	24.30%
Consumers	6.60%
	2.50%

ANS, National Supplemental Health Agency.
Source: ANS data available at: <http://www.ans.gov.br>.
Access on: 06/20/2011.

and control of operating companies that provided private health plans and insurance.

This regulatory framework carries important conflicts and challenges, as the assistance provided by health care plans is called supplemental, but in practice, it is provided in duplicate in relation to SUS for certain strata of the Brazilian population, which also have guaranteed access to public services and have the benefit of tax relief on the part of private expenditure on health.¹⁵

Normative questions

ANS, from 2002 to 2010, published 243 Regulatory Norms¹³ (RN), which were grouped according to their content in Table 1, as the norms frequently deal with more than one aspect, such as the administrative-financial and assistential-operative, among others .

It can be verified through the content analysis, that the regulatory organ regulates the registration of companies, contractual and financial guarantees, and health care coverage to consumers in relation to existing conflicts, especially those listed for approval under Law N. 9656 / 98.

Regarding health care, it predominated what was established by the Law,¹ such as the Reference Plan (minimum), together with some normative resolutions,⁹ which expanded the list of coverage and procedures. The RN 139,¹⁶ in 2006, introduced a performance evaluation of health plans based on an analysis of indicators of morbimortality and on programs for health promotion, prevention and control of diseases, maintaining the segmental option for plans with outpatient / hospital, outpatient or hospital coverage with prenatal care.

As for consumers, were standardized the confidentiality of health data of the beneficiary, the issue of bonds in health services and the lack of portability of grace periods, as well as the process of verification of pre-existing illnesses or lesions and the institution of the Preliminary Investigation Notification (NIP) procedure¹⁷ following a complaint by the beneficiary.

Administrative-operational issues

The analysis of distribution of physicians,¹⁸ the network of services¹⁹ and companies¹³ was another point discussed by

Table 2 – Proportion of the number of Physicians, Services and Agencies, per geographical region; Brazil, 2011.

Geographical region	Physicians ^a (%)	Services ^b (%)	Agencies ^c (%)
North	4.20	4.50	2.90
Northeast	16.80	20.60	14.20
Midwest	7.50	8.80	6.70
Southeast	56.50	45.20	61.20
South	14.90	20.80	15.30

^aSource: CFM. Available at: <http://www.portalmédico.org.br> [accessed 15 Feb 2012].

^bSource: CNES. Available at: http://cnes.datasus.gov.br/Mod_Ind_Natureza.asp [accessed 27 Mar 2012].

^cSource: ANS. Available at: http://www.ans.gov.br/anstabnet/deftohtm.exe?anstabnet/dados/TABNET_03A.DEF [accessed 27 Mar 2012].

the study, encouraged by the number of complaints from beneficiaries and shown in Table 2.

The data show that there is a close association between the percentage of the number of physicians, service facilities and health plan companies that comprise the health care network, shared by SUS and the supplemental care, concentrated in the southeast region, which has greater purchasing power in the country.

The issue of national coverage of the supplemental sector, as well as public assistance, involves a structural issue that affects access to services, due to the heterogeneous distribution of the health care network in the country. The ranking of complaints from consumer protection agencies, such as the PROCON Foundation²⁰ in the State of São Paulo, reflects this reality in the rates of complaints, which happens even in states that have higher level of service provision.

The increase in complaints on access to supplemental health is also a reflection of the country's economic development, which reflects an increase in the number of beneficiaries of private health plans and insurance, which according to the ANS,²¹ increased from 18% in December 2003 to 25% in December 2011, with more than 70% of this universe in the form of collective plans.

Economic and financial issues

There was improvement in the economic and financial control, although the criteria used by the ANS for adjustments per age range and mean adjustments based on those of the corporate group plans are questioned, as the values pushed the index above the general inflation in the country, which according to IBGE²² was 102.85%, whereas for health care it was 133% in the period 2000-2011.

Research published by the National Union of Institutions of Self-Management in Health²³ (UNIDAS) showed the increase in costs of examinations, consultations and hospital admissions between the years 2008 to 2010: consultations experienced an average increase of 15.8%, while the average spending on hospitalizations increased 17.5%.

Conflicts with the medical profession in relation to the adjustment of fees, continued to occur throughout the study period. Even with the enactment of the Brazilian Classification of Medical Procedures and Fees-CBHPM,²⁴ in 2003, which identifies the values of clinical work and the aggregate value of the use of technologies in procedures, there was no improvement, according to medical entities, regarding the adjustment policy practiced by health plan operators.

Manifestation of members of the Supplemental Health Board

The content analysis of 12 interviews with representatives of CSS institutions shows that these consider health a fundamental right in Brazil. Most attributed the growth of private participation to the fact that the State does not ensure universal access to comprehensive care.

Part of the actors felt that progress has been made in the regulations regarding market sanitation, which now has more structured companies, increasing the financial and contractual guarantees for beneficiaries and standardizing the rules of operation for the market operators.

The most critical ones were the representatives of the National Health Council (CNS), medical entities and cooperatives, but with different orientations: the representative of the CNS considered the influence of the market on ANS; doctors mentioned the inadequacy of the law in relation to service providers; and medical cooperatives criticized the regulatory excess by the State.

The representative of consumers' rights pointed out conflicts regarding policies of readjustment of prices and access to services, while medical organizations spoke about the issue of professional autonomy and the readjustment of medical fees. The Unions, in turn, indicated as a primary concern the extension of coverage to retirees.

The business sector of service providers assessed that the main conflicts were at the greater level of demand by the population, which has been changing social class and increasing its demand for a health care network. On the other hand, the plan operators said that the problems were related to the management, in reconciling the individual with the collective attention, because aging and accelerated incorporation of new technologies in health compromise financial support in the area.

The model of care focused on the logic of procedures, the persistence of conflicts in the relationship with the service providers and SUS were the problems pointed out by the representative of the ANS, while the representative of the CNS indicated that the main conflict is not to prioritize the public sector in the face of the country's economic growth.

As for the expectations regarding the regulation of supplemental assistance, both representatives of consumers' and workers' rights and those from the medical area have reservations about the future, pointing out the need to decrease the influence of companies on the regulatory agency, greater expansion qualitative regulation of the public sector in assistance care and increased regulation in relation to service providers.

The ANS interviewee specifically pointed out "the need to fill out the legal vacuum in the relationship between SUS

and supplemental health, as well as with service providers," while the representative of CNS assessed that, according to his understanding, it depends on the political project, namely, "... *whether the government decides that the country's economic growth will be reflected on policies that will serve to promote greater equity in health care assistance or just to further enrich the private health sector.*"

Many interviewees also mentioned that the dynamics established by the ANS in the House of Representatives does not favor conflict management, as the instance is advisory and the forum ends up being a mere space for dissemination of opinions on the subject being discussed.

Discussion

Bioethics is a discipline that professes ethics applied to the analysis of phenomena and living conditions of all beings, including the environment we inhabit, having as its goal the responsibility towards present and future generations. It deals with the ethical and moral values that must be aggregated to the economic development of peoples, together with human and social dimensions.²⁵

In health care there are a variety of factors that influence the results of the care given to users, all being equally important and that are subject to feedback, such as the ethical issues that will guide the policies, which in turn will establish rights in legislation based on technical-scientific knowledge in the area. Thus, when evaluating policies and healthcare segments, it is necessary to consider whether there is a coherent combination of the abovementioned elements and whether the results are acceptable.

In Brazil and with the ideas being expanded to Latin America, Garrafa et al.²⁶ since the 1990s, have pointed out equity as a fundamental principle in discussions of social policies and the mediation of conflicts that occur in health care.

A peculiar characteristic of Brazilian bioethics is the fact that it was constructed in the context of health reform, stemming from constitutional changes observed in health in the last decade of the last century.⁹ It was in this scenario, following the international process of globalization, in which IB emerged, a conceptual territory and applied to the knowledge of ethics that have equity and protection of the weakest and most vulnerable citizens as the central themes in the analysis of policies to reduce inequalities created by economic systems.²⁷

IB is delineated from the understanding of health and quality of life as a universal human right. In this sense, it recognizes the social context as a legitimate field of study and intervention, from the proposed politicization of moral issues in its agenda, in an expanded perspective to situations of exclusion found mainly in the southern hemisphere, and especially in the Latin American context.^{8,10}

The theme of equity, however, has been applied to different understandings, as it is a polysemic concept, which, as Almeida points out,²⁸ reflects values and choices of a given society at a given historical moment.

A study by Fortes,²⁹ in 2010, interviewing Brazilian scholars on Bioethics, pointed out five central ideas about equity. The most significant finding of the study, also supported by IB,

was that of the differentiated treatment in the face of unequal conditions and needs that arise for individuals with the aim of achieving a more egalitarian situation, aimed at health.

Supplemental health could be a measure of equity, from the economic point of view. But scholars such as Carvalho³⁰ refute this suggestion by pointing out the benefit of tax exemption allowed by the Brazilian State in private health care,¹⁵ which would result in a lower amount of tax payments by individuals and businesses that use and sponsor private health care. The State, in this case, would receive a lower amount of taxes, reducing the power of public sector investments, i.e., for the ones that need it the most.

One of the applications of the principle of equity would be on tax contribution, as in addition to promoting greater fiscal and social justice in the distribution of resources, it would allow the State to support the public patrimony through the expansion of the health service network. This possibility, however, does not occur in the indirect financing and / or the purchase of private services, and increases the difficulty of the State in regulating the market, especially when the public entity is not the largest funder³¹ or the largest direct provider of health services.³²

A significant number of countries³³⁻³⁵ currently have public-private partnerships in health care. However, some of them have sought to harmonize its regulatory framework so that private participation contributes to the expansion of population coverage and services, either regarding the expansion of outpatient and pharmaceutical care, or regarding the issue of hospital comfort or even in those cases in which the population has to choose between public or private assistance.

Among other issues raised in the interviews performed during the research and which deserve to be critically discussed in the context of IB – here taken as epistemological reference – is the maintenance of conflicts regarding access to services and procedures, the rising costs of health care plans, questionable policies related to recipients' and professionals' autonomy, among them the grace periods in the presence of pre-existing conditions and the problems pointed out by consumer representatives, of heterogeneous distribution of health care network in the country.

Regarding the problems listed above, IB, among other proposals, considers fundamental the discussion of the so-called four "P's" for the exercise of a sanitary, ethical and responsible practice, especially in situations of vulnerability and related to public management: prevention, protection, precaution and prudence.¹¹ The theme of prevention is used in matters involving possible damage and iatrogenic injuries (by act or omission); precaution is evoked in situations where risks are not adequately addressed, as often happens in decisions regarding access of users to health plans; prudence is remembered with respect to the care necessary against the indiscriminate use of certain technological advances, while protection aims to include in the debate the topic of vulnerability related to the indispensable protection to those who need it most, being vital to differentiate the concept of vulnerability in relation to risk.¹²

Another aspect that deserves discussion is related to the high concentration of health care networks, professionals¹⁸ and services¹⁹ in state capitals and in more developed regions.

Thus, it is important to discuss how supplemental assistance can contribute to the geographical expansion of services and not just how to reach population strata undergoing social mobility, which are also largely concentrated in the more developed regions of the country.

IB interpretation is that these issues contain a number of interests, conflicts and differences, which should be explained and discussed, as well as the potential proposals and agreements, because they are inherent to human life. Therefore, it is not acceptable to expose society to higher expenses, pain and suffering, due to the lack of access to services,³⁶ because there are two forms of health care in the country, which do not meet the practical needs of the overall considered population.

Conclusion

The regulatory framework that allowed the approval of Law N. 9656/1998 on supplemental health reflected part of the demand of sectors of society that have mobilized toward the regulation. However, even when the state took control of policies and supervision of private health insurance plans, there were no further actions at the time regarding a better participation model for the supplemental sector, in relation to SUS.

The regulations in the period 2000-2010, showed advances in relation to registration, operation and supervision rules of health care companies in the market, as well as the establishment of contractual, financial and assistance coverage guarantees to beneficiaries. The same occurred with the data flow of beneficiaries, between companies and the government regulation organ, improving the level of information, both quantitative and qualitative, between the service provider network and society.

The sector has advanced little regarding the assistance model referenced in the list of diseases and procedures, as well as the quality of care. However, it started in 2006 a program of company evaluation performance, introducing new care with the goal of increasing health care management measures and quality of care of the beneficiaries, whose results are in the initial phase.

The assistance provided by health care plans and private insurance during this period of regulation did not favor a better distribution of the network of services and professionals in the country, as most companies are concentrated in the most industrialized and developed regions of the country. It has not helped in reducing the costs of health care, considering the price readjustments over general inflation rates in the country.

During more than 10 years of the law's existence, supplemental health deserves to be re-examined as to the logic of participation in the health system, because the form of duplicate assistance available for certain strata of the population has led to a competitive relationship with the public sector, vying network services, raising prices and making it difficult to hire human resources in SUS, a fact that has contributed to the increase of inequities in the area of collective health care.

It is worth emphasizing that the SUS difficulties originate in the fact that currently, the state is not the largest funder, nor

the largest direct provider of health services in the country, which brings challenges, including the regulation of the supplemental sector. These difficulties in the public area have contributed to increased adherence of the population to private health care insurance and plans, which has led to difficulties in assistance also in private network services, requiring the regulatory agency, private companies and service providers to adopt new managerial and operational measures to increase the efficiency and effectiveness of the sector.

Such measures are necessary, but not enough, to analyze the international situation, as well as that of the Brazilian population, which has increased its power of consumption and needs in the area of social welfare in different geographic regions, as well as aging and increasing demand for health services. It is true that the transfer of a portion of the population to private assistance has relieved the state of part of health costs, despite the lack of data and studies on tax relief in this area. So, it should also be accounted for, in addition to costs, what the public sector did not collect, for further analysis on the effectiveness of the measure.

The analyzed data point to the need for evaluation and reformulation of the model of care, including the intrinsic association and interdependence that occurs with the sharing of the network of services and professionals working in health care, despite the false divorce that occurs in assistance operationalization. In this sense, it is essential to review the regulatory framework of supplemental assistance in Brazil, taking as a guideline the assessment of whether the participation of this segment in health care in relation to SUS must occur in a complementary, supplemental or duplicate manner in order to expand access and quality of health care for the population.

These actions should be promoted together with the review of fiscal policies in the sector, contributing to the reduction of inequities, such as paying out of one's pocket and lack of access to services, especially for the low-income population.

The analysis of the conflicts and challenges of supplemental assistance in Brazil, from the perspective of bioethics, particularly for IB, is linked to ethical and constitutional obligations of health as a fundamental citizen's right, which must be achieved by the whole of Brazilian society, for thus requiring changes in public-private regulations, having as the goal the universal coverage of health care in the country.

Conflicts of interest

The authors declare no conflicts of interest.

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