



Private health plans with limited coverage: the updated privatizing agenda in the context of Brazil's political and economic crisis

Planos privados de saúde com coberturas restritas: atualização da agenda privatizante no contexto de crise política e econômica no Brasil

Planes privados de salud con coberturas restringidas: actualización de la agenda privatizadora en el contexto de crisis política y económica en Brasil

Ligia Bahia ¹
Mario Scheffer ²
Mario Dal Poz ³
Claudia Travassos ⁴

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¹ Faculdade de Medicina, Universidade Federal do Rio de Janeiro, Rio de Janeiro, Brasil.

² Faculdade de Medicina, Universidade de São Paulo, São Paulo, Brasil.

³ Instituto de Medicina Social, Universidade do Estado do Rio de Janeiro, Rio de Janeiro, Brasil.

⁴ Instituto de Comunicação e Informação Científica e Tecnológica em Saúde, Fundação Oswaldo Cruz, Rio de Janeiro, Brasil.

Correspondence

L. Bahia
Departamento de Medicina Preventiva, Faculdade de Medicina, Universidade Federal do Rio de Janeiro, Praça Jorge Machado Moreira, Rio de Janeiro, RJ 21941-590, Brasil.
ligiabahia@terra.com.br

The proposed expansion of “accessible”, “popular” or “cheap” health plans presented by the Health Minister, Ricardo Barros, has the same, social-rights-reducing character expressed in other measures put forward by the current government, such as PEC 241 (<http://www.camara.gov.br/proposicoesWeb/fichadetramitacao?idProposicao=2088351>), the *Constitutional Amendment Proposition* which, if approved, will reduce per capita health spending ¹ and contribute to deepening inequities in health access in Brazil.

In the absence of efforts to identify the problems and determinants of the current national political and economic juncture, the expression “crisis”, uncritically extended to the health system, is directly extracted from sectoral business agendas. The expansion of the private plans and insurance market, through the commercialization of contracts with reduced coverage or co-payment schemes which inhibit service use, is presented as the only solution to the crisis.

This formulation is autochthonous, though it maintains a connection with prescriptions from multilateral agencies which recommend austerity with the radicalization of fiscal adjustments and the reduction of national States’ social responsibilities.

The initiative to stimulate cheap plans fits with international recommendations, such as those issued by the World Bank, to implement universal health coverage in low- and middle-income countries through demand-side policies,

which include subsidies for acquiring private plans, in substitution of national systems, based on public supply ^{2,3}.

However, the association of the national cheap plan proposal with multilateral agencies’ canons is restricted to generic statements on promoting greater private expenses, by individuals and families, stimulating pre- or co-payments.

The formula which was initially presented consists on deregulating coverage rules, especially those related to the possibility of reducing the number of health units, restricting supply of medical specialties and smaller territorial coverage of health insurance plans. Another formulation under consideration intends to make the “double door” official, which consists of caring for patients, and receiving payments, from both the Brazilian Unified National Health System (SUS, in Portuguese) and private insurances in the same public health units.

In order to formulate an “accessible health insurance project”, a working group ⁴ was brought together by the Health Minister, with the participation of the Brazilian National Agency for Supplementary Health (ANS, in Portuguese) and the National Confederation of General Insurance, Private Pensions and Life, Supplementary Health and Capitalization (CNSeg, in Portuguese). Simultaneously, a report by the State’s Attorney’s Office (Consultoria Jurídica junto ao Ministério da Saúde. Memorando nº 219, de 8 de agosto de 2016. Ressarcimento ao SUS) admitted the pos-



sibility of establishing individualized contracts “between public service provider units and health insurance companies”, in addition to forgiving unpaid health insurance company debts regarding SUS reimbursements.

The key point for the viability of cheap insurance plans seems to consist, on the demand side, on increasing direct individual and family expenses on service use and, on the side of the sector's companies, on the official integration of part of the SUS public network with health-insurance-accredited services, as a strategy for reducing care-related costs and, consequently, offering products with lower prices.

Health insurance companies would therefore include public establishments in their network of accredited health providers. The reduction in coverage would be mitigated, in its turn, by the use of public units and by the exclusion and limitation, in the cheap plans' contracts, of care for health conditions, their aggravations and other situations. That is to say, SUS's universality and integrality would be guarantors of the reduction of private health insurance prices.

Other national plans to elevate cheap plans to the status of government program had a less extravagant design.

The first took place during Fernando Henrique Cardoso's second term in office, through a Provisional Measure ⁵ soon after a sectoral law (*Law 9,656/1998*) that regulated health insurance coverage and price hikes was approved. At that time, insurance companies sought to dehydrate legal contents and advance the idea of even more restrictive plans, such as those subsegmented by geographical areas, which would only offer the care available in services located in those areas.

A new attempt was made at the end of Dilma Rousseff's first term, within the context of changes to the income pyramid structure, the basis of which was pushed upwards due to increases in formal jobs and wage growth. Owners of large economic groups connected to health insurance, through side negotiations, such as meetings with high-ranking public officials and contracting consultants among political personalities with direct access to executive government groups, sought to obtain public subsidies to expand the offer of “basic” plans to millions of Brazilians ⁶.

The favorable momentum also stimulated then-representative Eduardo Cunha to put forward the PEC 451 (<http://www.camara.gov.br/proposicoesWeb/fichadetramitacao?idProposicao=861000>), which, if approved, would make it mandatory for employers to offer private health insurance. SUS, in this scheme, would be destined for informal workers.

We should point out that the Brazilian Legislative is permeable to health insurance companies' interests. According to the Superior Electoral Court's records, insurance companies and executives donated R\$ 54.9 million to electoral campaigns in 2014 ⁷, contributing to the election of three senators and 30 federal representatives, among them the former representative Eduardo Cunha and the current Health Minister, Ricardo Barros.

The Brazilian “cheap plans” schemes contains excessive pragmatism. Always in the present or the short term, its proponents evoke the economic juncture and “no-win” scenarios, but, deep down, they scarcely care about positive or negative signs of economic growth.

The use and mix of common sense ingredients, such as the idea that it is impossible for SUS to provide care for everyone, or statements by administrators that the constitutional SUS must be revised ⁸, echoed by sectors with undeniable social strength, led to the development of a “magical” solution, one that has an extremely high ideological content but is packaged as a technical defense of the common good ⁹. However, there are nuances to the “accessible” plan proposals which, if made explicit, subsidize reflection and political action.

Under the assumption that public systems in low- and middle-income countries are incapable of effectively providing universal coverage, proponents of transitioning from systems based on supply and on public providers to systems directed by demand and by pre-payment contracts allow for different solutions: for rich countries, they recommend the classic universal model, whether through a national health service or through social insurance, while all other countries would be left with the proposal of universal coverage ³.

Several conditions and circumstances have been used as pretexts for naturalizing social asymmetries and, especially, for acquiescing to different patterns of a right to health. Among them, the difficulty in raising social contributions and taxes, since a significant part of the population works in the informal sector; the underfunding and social dissatisfaction with the low quality of care in public health services; the large numbers of bureaucratic and institutional agents and barriers (veto players and veto points) which impede radical reforms and redistributive policies; in addition to the limited availability of information on citizens' opinions and experiences regarding health service access and use, which pushes political decisions away from the population's priorities ³. Add to this the private sector's prominence in developing countries' health sys-

tems and the existence of public systems organized around vertical programs¹⁰.

This echoed in academic spaces. As a result, recommendations of universal coverage have been questioned^{11,12} and the strengthening of systemic government regulation and expansions of public budgets have been emphasized¹³. These are essential measures for broadening access to health, although there is no parity and isonomy among countries that opted for horizontal processes of universal systems, such as SUS.

The metrics for determining the dimension of the private sector in low- and middle-income countries do not fit a country like Brazil, which took vigorous steps toward an effectively universal system. In the universal coverage proposal, the proportions of the following situations are considered for the identification of subsystems within the health systems of developing countries: (a) the participation of private sources in health spending; (b) charges for using services in the public sector; (c) the private sector's participation in primary and secondary care activities; (d) the presence of large international economic groups in the private insurance market¹⁴.

Under these delimitations, Brazil, despite an elevated proportion of private health spending (55% in 2014), has a public system responsible for 59.9% of all care¹⁵ and 14.9% of expenditures related to direct payments for using health services, a lower proportion than that of several developing countries.

These numbers show undeniable advancements in SUS. We therefore see a pattern of public/private relations that is different from what is observed in high-income countries, with a strong, parallel dynamism of the private health sector in Brazil. In the United Kingdom, it is the public sector that is predominant: private insurance coverage increased from 0.2% of the population in 2000 to 3.4% in 2014¹⁶. In 1998, 24.5% of Brazilians had private insurance, a proportion which rose to 27.9% in 2013¹⁷. Health insurance's participation in total health expenditures is lower than 5% in 42 countries, out of 53 researched European Union nations¹⁶. In Brazil, in 2013, private health expenses, excluding medication purchases, were 33.7%¹⁸.

In our country, the tension between the two models (one based on supply and the other on demand) is expressed both in the government coalitions which won recent presidential elections and the coalition that took power in 2016 following the impeachment, in the disagreement with a truly universal SUS and the intensified pressures for increasing the commercialization of private insurance.

Representatives from health insurance companies, the multinational pharmaceutical industry, social health organization and the medical elite, promptly and conveniently invited by the current government to formulate health policy proposals, launched the "Health Coalition"¹⁹ movement, which states this is "*a unique opportunity for uniting the entire productive chain in order to reflect on the Brazilian health system*" and the "*moment to strengthen free market mechanisms so the sector can reach financial balance in a sustainable manner*". The term sustainable, in the case of "accessible" plans, is evoked in the sense of lower prices seeking new market niches.

Health insurance prices are formed as a result of costs and frequency of service and medical procedure use. Under the current Brazilian rules, prices vary according to age group, type of coverage, quantity and quality of the accredited network of doctors, hospitals and laboratories, room service comfort, geographic scope and moderating percentage or factor value (co-payment or deductibles)²⁰.

The reaction against the expansion of restricted coverage plans brings together negative experiences from doctors and health insurance clients regarding payment values, waiting times and medical attention guarantees. There is also a natural rejection of the pricing model based on personalized risk assessment, which generates high entry prices or pecuniary exclusion when renovating insurance contracts. The realization that health problems are unpredictable and that preventive, diagnostic and therapeutic procedures are indivisible and that, therefore, health needs are incompatible with promotional plans is already a part of the day-to-day repertoire.

There are also many problems with the lower price plans that have been so far brought to market. Ambulatory plans that only cover appointments and exams, without hospital admittance, and which are established in the legislation, are used by only 4% of the population who have health insurance. The so-called "false collective" plans, allowed by the ANS, in which two or more people buy insurance as a legally registered company, or through dissimulated adherence, by joining an association or entity indicated by brokers, also have lower prices, but collect complaints because they increase prices and revoke contracts at their whim or because they offer few options and low resolutiveness in their accredited network.

One of the adverse effects of already-existing "accessible" plans is the judicialization. The amount of lawsuits against health insurance companies grew at a much higher rate than the increase in the number of their clients. Current-

ly, the most contested items are the restrictions in coverage, especially the most expensive and complex treatments. Courts find in favor of patients in over 90% of these cases ²¹. This foreseeability may be verified by court decisions which, after repeatedly judging abuses committed by health insurance companies, registered majority, uncontested interpretations in favor of protecting users ²².

Therefore, the outlines of the cheap plans proposal are not wholly new, nor are its consequences unpredictable. The originality is due to a loan in authorship. The private health insurance companies now have the Health Minister as their representative.

Contributors

All the authors participated in all stages of producing this text.

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