Health promotion in the health insurance: relationships and tensions between private plan providers, beneficiaries and state regulatory agency[1]

Promoção da saúde no âmbito da saúde suplementar: relações e tensões entre operadoras, beneficiários e agência reguladora estatal

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Abstract

The relations between private plan providers, beneficiaries and the state agency in the provision, use and regulation of health promotion programs will be analyzed. Multiple case studies will be investigated, cases whose data were obtained from interviews with 40 participants (managers, professionals and beneficiaries) of 6 health operators in Belo Horizonte/MG, besides participant's observation developed in the programs. The analysis revealed tensions between the logics that guide the actions of the regulatory agency, the provision of programs and the interests of the beneficiaries. Providers aim to reduce costs and attract customers. Beneficiaries seek comprehensive care, but face restrictions on access. The regulatory agency encourages further rapprochement between the industry and public health guidelines, but the means have reduced transformation potential. There is logic of capital accumulation that determines and tensions health promotion in health insurance.

Keywords: Supplemental Health; Health Promotion; Private Sector.

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Resumo

Analisam-se as relações entre operadoras, beneficiários e agência estatal na oferta, utilização e regulação de programas de promoção da saúde. Estudam-se casos múltiplos, cujos dados foram obtidos de entrevistas com 40 participantes (gestores, profissionais e beneficiários) de seis operadoras de planos de saúde em Belo Horizonte/MG, além de observação de ações desenvolvidas nos programas. A análise revelou tensões entre as lógicas que orientam a atuação da agência reguladora, a oferta de programas pelas operadoras e os interesses dos beneficiários. As operadoras objetivam reduzir custos e atrair clientes. Os beneficiários buscam cuidados integrais, mas enfrentam restrições ao acesso. A agência reguladora incentiva aproximação entre o setor suplementar e as diretrizes públicas de saúde, contudo os meios utilizados têm potencial reduzido de transformação. Há uma lógica de acumulação de capital que determina e tensiona a promoção da saúde na saúde suplementar.

Palavras-chave: Saúde Suplementar; Promoção da Saúde; Setor Privado.

Introduction

This article presents and discusses part of the results of a research that addressed the relation between the health promotion programs and the insurance model practiced in the private health insurance and plans. The analysis of these programs produced results that point to the relevance of expanding the discussion of conflicts of interest between health care operators, beneficiaries and the National Regulatory Agency for Private Health Insurance and Plan (Agência Nacional de Saúde Suplementar or ANS, in Portuguese). The private health insurance and plans sector is based on the activities and health services provided by the private sector. In Brazil, private plans were made viable in the 70's, due to the medical model crisis and the strong presence of the company-provider relation (Menicucci, 2011). Since then, there has been a considerable increase of the number of people that sign up for private care (Noronha; Santos; Pereira, 2011).

According to the Federal Constitution, the private sector has the right to provide health care to complement the Unified Health System (Sistema Único de Saúde or SUS, in Portuguese), provided they follow the guidelines and principles of the public system (Brazil, 1988). When defining health activities and services as a public relevance, the Federal Constitution transfers its regulations, inspection and control to the State, even though its execution isn't directly executed by the public power, but by contractors or insured companies, individuals or legal private entities (Brazil, 1988).

The regulatory framework of the private health insurance happened in 1998, with the no. 9656 Federal Law, that regulated private operators in Brazil. In 2000, no. 9961 Federal Law was published, marking the creation of the ANS, an authority linked to the Ministry of Health, which aims to develop national strategies to regulate private operators (Andrade et al., 2009; Ceccim et al., 2009).

ANS came as a new element to regulate a complex sector, supported by and made of an economic logic, composed by actions with opposing interests (Pó, 2011). Thus, the structuring of an institution inside the Ministry of Health to regulate the private sector resulted in challenges related to the difference in

the capitalist interest of the private sector and the social protections goals of SUS (Noronha; Santos/ Pereira, 2011).

Facing the challenge of aligning the model practiced by the private sector – characterized as biologycist and doctor-centered (Jorge; Coelho; Reis, 2007) – to the public politics ideals, the ANS created, in 2004, a change induction process on the insurance logic, through incentives to the creation of health promotion programs (Brazil, 2008).

In that context, the effort to impact the quality of attention provided by the private sector can be translated by the Private Health Insurance and Plans Qualification Program. In this program, the operator's performance evaluation is through the Private Health Insurance and Plans Performance Index (Índice de Desempenho da Saúde Suplementar or IDSS, in Portuguese), calculated based on indicators defined by the ANS, among which the registration and monitoring of projects of health promotion and sickness prevention, together with the agency, are included (Brazil, 2010). But the main focus of the regulatory attention is directly connected with the list of mandatory procedures, such as the insurance price control and waiting time for meeting medical demands (Silva et al., 2013).

Health promotion, as a way to make the insurance model reorientation viable, consists of a comprehensive and complex field of knowledge and practices, whose definition cannot be limited to a concept, which brings to different approaches about the theme (Silva; Sena, 2010).

In this context, the most modern approach and with the highest transformation potential of the insurance model starts with the understanding of health promotion as a useful and political and ideological area to analyze and act upon the determinants and constraints of the health-sickness process. Such determinants and constraints are related to the circumstances provided by physical, social, economic and cultural aspects in which the individual or the collective are inserted (Moysés; Moysés; Krempel, 2004; Pedrosa, 2004). Given this concept, a collective of practices that gives privilege to the subject's involvement on the decision making processes in participative, constructive and directed areas to promote autonomy and main role of individuals and communities is highlighted (Pedrosa, 2004). Considering the private sector's economic interests, the health promotion is here questioned. It is assumed that there is a predominance of a logic of cost shrinking that permeates the provision of the program, because of the emancipatory practices based on the principles of health promotion. Therefore, it seems that a tension prevails between financial rationality and the beneficiary interests, in the presence of induction of health promotion programs by the ANS. Thus, this article has the objective to analyze the interests of different agents involved in provision, usage and regulation of health promotion programs on the private sector.

Methodology

It is a qualitative research, related to the theoretical and methodological framework of the hermeneutic-dialectic. Regarding the interaction between hermeneutic and dialectic, both refer to the praxis structured by tradition, language, power and work. However, as hermeneutic emphasizes the unit of sense and consensus, dialectic is oriented to search the dark and contradictory cores to sustain a critic (Minayo et al., 2005; Habermas, 1987).

The methodological process of this study was structured in three steps: exploratory, field work and understanding of data.

In the exploratory step, the identification and recognition of the operators that work with health promotion programs in Belo Horizonte and/or the metropolitan area was started, through a search on the ANS data base. In this search, 79 operators were identified, among which the 39 that had more than 5,000 beneficiaries were selected.

Among these 39 operators, we tried to identify those who offered health promotion programs. This movement showed itself very challenging, once the information about the programs are not disclosed and not all of the developed programs are registered at the ANS.

Among the 23 operators that confirmed, through phone contact, the development of health promotion programs, 4 operators of the self-managed genre (operators 1, 4, 5 and 6) and two managed care operators (2 and 3) accepted our invitation to participate

on the research and were included on the second step of the study.

A multiple case study was done. The analysis cases were of the six private health operators that offered health promotion programs and accepted our invitation to be part of the study. In each of the cases, distinct units of analysis consisting of health promotion program that, included on the study, characterize the genre of incorporated multiple cases were identified, according to the typology described by Yin (2005).

The field work was done in two phases. On the first, interviews were conducted with partly structured script with management representatives from operators and/or health promotion programs coordinators, aiming to identify general information about the organization of the provided services and the programs themselves, their coverage, the clients profile, access and beneficiaries' addition to the programs and the relations between operators and the ANS.

The second phase of the field work consists of profound analysis of the interviews with professionals and beneficiaries, aiming to maximize the knowledge about the study cases and the participants' observation of the activities of the investigated programs, as well as documents related to these formers.

To guarantee anonymity of institutions and study agents, corporate and people's names were omitted. Thus, the characterization of operators was organized in a random number sequence (1 to 6) e the interviewed agents were given codes, as follows: manager OP1 and physiotherapist OP1 correspond, respectively, to the interviews with manager and physiotherapist from operator 1 .

The analysed programs focused on the elderly and offered: physical activity (OP 6), physical conditioning (OP 1), memory workshop (OP1), dance (OP 1) body awareness (OP 1) and yoga (OP 6). We also identified programs focused on obesity control and treatment (OP 2 and 4), nutrition reeducation (OP 2), nutrition (OP 5), worker's health education (OP 5) and teenage groups (OP1).

The interviews with professionals focused on the work process and their relations with each other and with the users. On interviews with beneficiaries, we searched to clear the access ways, as well as their motivations, expectations and evaluations about the programs.

On the building of research protocol, the usage of multiple sources and the contexture of evidence on the presentation and interpretation of the results as elements to enlarge and favor the legitimacy of the case study constructed were proposed. Given this, the observation was one the strategies used to pick up values, concepts and technologies that aren't necessarily seen in an interview, when the "should be" is said, and not what it really is, or how every single one interprets the same case, without necessarily expressing a conflict (Feuerwerker; Merhy, 2008).

The empirical corpus of study, consisting of four interview with managers from operators OP 2, OP 3, OP 4 and OP 6, five interview with the health promotion programs coordinators from OP 1, OP 2, OP 3, OP 4 and OP 5, an interview with the manager from as outsourced provider from OP 1, fourteen interview with professionals from OP 1, OP 2, OP 4, OP 5 and OP 6 and sixteen interviews with users from OP 1, OP 2, OP 4, OP 5 and OP 6 adding up to a grand total of 1,013 minutes of recorded audio. The corpus was also composed of 33 pages of daily records referring to observations of the studied practices.

The interpretation of all six studied cases was made from the cross case synthesis, proposed by Yin (2005). The technique deals with every individual case as a separate study and aims to investigate if the different cases share relevant similarities or singularities that may reflect on the theme categories.

In this process, the data the interviews and observations were compared and triangulated to elaborate an analytical description of each operator's case. This type of description presents, also, the ideas that are underlying the subject's discourses on the research.

Sequentially, a cross-reading of the cases was carried out, through which themes related to the problem and the research objectives were identified. The ones found is this study were: health promotion approach revealed in the programs; attention model practiced by the operators: where does health promotion stand?; tension to promote health in the private sector: crossings of the capital. In this article we will deal with the third category.

The theme categories identified through the synthesis of crossed cases were discussed from the data articulation and the related scientific production, consisting the movement, at the same time, understanding and critical supported by the hermeneutic-dialectic referential. Is this process, the empirical data are compared and confronted with the discussion from other studies, to sustain or contradict the findings and resultant analysis of the interpretation.

All the steps of this study respected research ethical commandments involving human beings, having been approved by the Ethics in Research Committee of the Federal University of Minas Gerais, under the number of 0581.0.203.000-11. Data collection was preceded by the signing of free and informed consent from all study subjects.

Results and discussion

The data analysis highlighted that the health promotion programs on the private sector find themselves on a dispute territory. There are tensions between the logics that guide the political induction by the ANS, the programs offered by the operators and the beneficiary interests.

The cross-analysis of the cases conducted to the understanding of a dominant logic of capital accumulation, in the private sector, mediated by health promotion programs, setting up a process of literal replication (Yin, 2005) both on the self-managed and the managed care operators. Similar results were seen on the multiple cases, confirming the existence of a singular phenomenon in these cases: the capital as a determiner on the investment on health promotion.

Hence, the distinct conceptual and juridical way to operate private plans, with lucrative commercial characteristics (as of managed care operators) or not (as of self-managed operators), were not expressed in differences of interest from the operators regarding health promotion programs .

Marketing and the new products offer, like health promotion programs, represent, for operators, the possibility to attract and increase loyalty in customers. Thus, discourses are emblematic to reveal the logic of capital accumulation tied to strategies to prevent risks and injuries, through which it becomes possible do reduce the high cost services consumption.

> [...] Operator's goal is to reduce incidents. [...] We act today where we've already spent; if there's a cost, we intervene (OP 2 Manager).

> When we talk about health promotion, we always think about the cost. It is impossible to say that we deal with health only because it is cool, it is not (OP 5 Coordinator).

> The patient gains health, the operator gets cost reduction and commercial area has marketing (OP 2 Manager).

The participants' discourses reveal the health care operators' interests. In health promotion plans, they see the possibility to overcome a crisis in the private sector, due to market competition and high operational costs regarding medical assistance.

> For those who promote health plans and cannot have ANS approval, but still invest, I believe that it is first because of the tendency, second because the private sector is mid-crisis and if most competitors say "do this that it will work", everybody will follow. It is not because of something very deep, it is crisis (OP 2 Manager).

Regarding costs rising, data depicted that the elderly population increase and the people getting sick with preventable diseases are important factors that influence on the creation and maintenance of health promotion programs.

> We need to get these active people and prepare them to age well, with quality, healthily. [...] Aging less sick, that would reduce the number of incidents. So that is the logic of prevention and promotion programs (OP 6 Manager).

> We are trying to make our own health become sustainable. If he (the user) loses weight or doesn't get overweight, he will consume less medicine and then not only will I improve his treatment, but also improve my costs. We will never balance our accounts in the future if we don't act based on prevention, avoiding getting sick (OP 5 Manager).

Some authors also discuss the need of investments on health promotion activities, life quality improvement and health conditions management for

the population in general (Malta et al. 2011; Freitas et al., 2011) and, specially, the elderly (Veras, 2012).

The programs offer is highlighted as a quality patient care differential for the beneficiaries. This is one of the marketing strategies used by operators and transmitted through reports and ads.

> I believe health promotion is a differential for the operator for not every health company has the program (OP 2 Manager).

> Because we have to work with marketing, disclosure. [...] Therefore, we produce folders to be handed, create marketing e-mails for disclosure, aiming to charm people, through attractive and different things (OP 3 Coordinator).

> Therefore, the disclosure for the programs is done through direct mail, text message to cell phones, marketing e-mails, information on the website, social network and the operator's own magazine (OP 1 Coordinator).

The creation of strategies with the potential do reduce costs and contribute with the institution's financial sustainability cannot and should not be neglected. However, there seems to be some tensions, marked by capital contradiction, that limits health promotion intervention to an approach about individual health determiners, with little reach if compared with the goal that can change the private sector, requiring investment in autonomy, empowering and community participation.

Such elements were not revealed on interviews and observations of analysed practices setting up a challenge to make the social justice model prevail over the logic of capital accumulation.

Also worth mentioning that the interest to "improve health" of the beneficiaries, with prevention activities and also ones focused on improving life quality, is also present on the discourses and it seems legit, but does not prevail over the market logic that dominates the area, revealing a huge contradiction on the health promotion programs offer.

> We keep on repeating all the time to try to convince the mother to change her habits so the child can have a healthy life, focusing, also, on lowering costs (OP 5 Coordinator).

> So, we have a lot of activities focusing on getting through people's minds the idea of a healthy life. [...] Aging healthily, that would lower the number of incidents. [...] Of course there's the humane issue, the person actually having a better life, but it is not only that, there's a whole cost context involved (OP 6 Manager).

Previous reports transmit the ideology of healthy life style and habits. In general, this type of intervention encourages a new consuming scale that stimulates the market of other products, goods and services, such as sporting goods, balanced diets, among others (Jouval Jr., 2011). It is about an approach proposed by the Lalonde report, in the 70's, that emphasizes the interventions about individual behavior facing coping with high costs with medical assistance (Buss, 2000). Even though, along these lines there are few strategies that alter the macro determinants of the health-sickness process. From the perspective of those who offer health promotion programs, the dominant logic is that of capital accumulation, focusing on reducing assistance costs, attracting customers and making them loyal and transferring them the responsibility. But this process is tensioned by the opposing interests of the subjects involved.

Along these lines, the beneficiaries seem to seek programs (or they are taken to them) aiming for other ways to deal with their own health and there they end up finding social and bonding opportunities. As so, the programs get new meanings in these people life styles, finding there a space for friendship and new relationships in a context marked by the lack of care.

> The diabetics group became a little group of friends and that is not a prevention program. Thus, we want to refocus, increase the number of people and the approach model (OP 4 Manager).

> Here, everything is beneficial for health, even taking the bus, leaving home, meeting people we can relate to and also those with whom we cannot. (Beneficiary 4 OP 6).

> The motivation is health, is it not? And, also, meeting with friends, because there is always the gang. I have some friends that are in this group and some

> bonding to join it. They are friends that I got to know over time. There is always a friend you can find. (Beneficiary 1 OP 1).

> It is almost a family, either with the group or the professional helping. She has been with us for seven years (Beneficiary 5 OP 1).

The results indicate that the health promotion programs start to represent new caring spaces for the beneficiaries in a society where the search for attention is a cultural value to be restored. This discussion is enlarged by Freitas et al. (2011) when they reveal that such programs represent a socializing, bonding and suffering-confronting possibility space for the beneficiaries of the private sector. This logic, in a way, prevails over the traditional method to organize the service on the private sector and contribute to a change in the model the practice on this sector: biologicist, doctor-centered and not producing any care (Pimenta et al., 2012). Luz (2005) contributes to this debate by analyzing the health and medical crisis on the contemporary culture. She states that less caring medical practices, marked by neutral and objective relations between therapist and patient, has left lots of gaps related to individual subjectivity. Technical "coldness" between both social agents does not satisfy the care needed for the patients and that results in searches for other practices that enable complex social relations in which symbolic and subjective elements are present.

However, the beneficiaries' access to these programs on the private sector is frequently limited to certain groups that present certain criteria such as risk of getting sick and also to those who have availability to participate on the activities on time and place determined by the operators. This access limitation depicts that the promotional activities are not set up to be a right for the beneficiary, but meet, mostly, the operator's interest. This is partly due to the lack of regulations on programs of the private sector, which demonstrates that this aspect is a problematic one in the field (Silva et al., 2013).

Besides, when focusing on risk groups, a biopolitical mechanism control of the "vulnerable" are established. On Foucault perspective, biopolitics works as a life regulation device, dictating rules on how to live, according to what is set based on certain rationality (Foucault, 1985). In this sense, other studies have also shown that health promotion programs from the private sector operate based on a biopolicy, through establishing acts that determine the lifestyle that are considered healthy by the majority (Ribeiro et al., 2011; Reis; Puschel, 2009; Freitas et al., 2011). In the triangle of dispute of interest (operators, beneficiaries and the ANS), the latter, as the government responsible for regulating the private health sector, keeps a discourse that idealizes bringing together the private sector to the public policies, which focus is the integrality of the assistance with all its implications.

Also, the regulatory agency exposes, as its objective, the reorientation of the insurance model that predominates on the private sector, through incentives to create and improve preventive and promotional programs. However, the means to encourage change were revealed, on the interviews with the participants, conflicting due to the dimness of the normative resolutions that contained the guidelines to organization and development of the programs, apart from the structural requirements that, according to the interviewed managers, will hardly be coped with.

In that context, the understanding from the managers has emerged that the enrollment on the already existing programs and new proposals, together with the ANS, are impracticable due to the amount of requirements and goals regarding, essentially, the production. Thus, contradictorily, the Private Health Insurance and Plans Performance

Evaluation Program, regarding health promotion, seems to confirm the quality investment reduction to meet the quantitative requirements.

> One of our problems with the ANS is this, the operator focused on quality. So , our morbidly obese group has a six-month duration and the ANS doesn't have that reading. Their reading is quantity, I can meet the obese once, but I have to meet ten percent of all of them (OP 2 Manager).

The interviewed managers and coordinators revealed that, to recognize and approve the programs, consequently, increase the score that qualifies the operators on the health care market, the regulatory agency imposes standards according

to what they understand as a priority. The priorities considered by the ANS are bases on national epidemiologic studies, that point to the need of investments on areas such as children, teenage, adult and the elderly care, women's health and mental health, focusing on the stimulus to physical activity, healthy nutrition, preventing and combating smoking, among others (Brazil, 2011). But the inflexibility of such standards, linked with the limitation or lack of an open space for discussion about the developed programs, result in conflicts and resistances, revealed on the critics from interviewed managers and also due to the fact that some programs kept being offered, regardless of not being recognized by the ANS, for not meeting its requirements.

> You don't finish seeing one law, and the ANS releases another. You get lost trying to follow what the ANS wants (OP 1 Coordinator).

> The way the ANS itself is obliged to regulate makes things difficult. It's just standard after standard; one cancelling the previous one and we get lost. Then, registering the program at the ANS, the way they put it, gets practically impossible. First because you've got to have a he number of beneficiaries on the programs and it is not always that you will have so many people because it is not everyone that wants and you cannot make them do it. [...] The way we have to register our programs is super complex, super confusing (OP 6 Manager).

The formulation of technical manuals and the seminar to guide about organization and plan the programs was one the strategies created by the ANS to try, through technical and theoretical support, instruct about the main issues found in programs evaluated by regulatory agency, such as: low comprehension and coverage, low technical consistency of the programs, lack of monitoring and evaluation, lack of measures to guarantee sustainability. (Brazil, 2008). But the big diversity of themes and the complexity of health regulation disclose that knowledge and technical expertise should not spare the dialogue between the ones involved, including social participation, given the regulation must meet society's objectives (Pó, 2011).

Also relevant considering the importance of structure, fundaments and institutionalization of the programs of the private sector so the strategies are not limited to small groups, without defined objectives and results and with punctual activities, without reaching representativeness. However, the establishment of coverage goals, quantitative financial investments and areas of strong acting, without taking into consideration the specifications of programs and other arguments that may sustain them, does not contribute to the expansion and improvement of the propositions, neither does it collaborate with the programs accompanying, having in mind the protection and guarantee of the beneficiaries rights on the usage.

Before the above, it is possible to infer that the incentives from the ANS are not enough to determine the investments on the field, given the analysed operators continue to keep the programs that were not registered or approved by the ANS, because they represent the possibility of satisfying their market conveniences or complement insurance strategies for the operator. The findings in the study allow such claim once, in all analysed operators, from 13 health promotion programs being offered, only five were registered in the ANS. It is worth mentioning that the register was only identified in two operators, those with bigger amount of beneficiaries.

Besides, the diversity of programs and the organization, that extrapolate the care line encouraged by the ANS, also point to a standard influence related to the agency and discloses distinct ideals from the acting parts in dispute.

This conflict map, formed by the divergence between the interests disclosed by the ANS, beneficiaries and operators, refers to a discussion about the challenges of registering in a dual health system, with opposing ideals.

Thus, considering the primordial market objectives of the private health sector, the challenge of regulating health practices based on the principles and standards from SUS is disclosed, which include health promotion as a proposal to face social determiners of the health-sickness process, having comprehensiveness as premise.

This structural and historical challenge has its origins on the opening for private health services ex-

istence and it was consolidated with the creation of a specific agency (ANS) to partly regulate the sector, with great independence from the Ministry of Health (Noronha; Santos; Pereira, 2011). This contradiction is seen in the fact of the ANS being constituted as a public policy that acts together with groups that seek their own rights prevalence.

This discussion refers to the questionings of Cohn (2011) about the possibility of existence of a regulatory body for the whole Brazilian health system treating the precepts from SUS and the market interest indifferently. The same author also puts that as the ANS is linked to the Ministry of Health as a regulatory body, it hasn't advanced much beyond the actions from organizations dedicated to the consumer's defense, thus restraining their role.

What can be said, from the results of this study, is that regulatory actions developed by the ANS, regarding health promotion programs, disclose some gaps that point to the need of actions with bigger potential to promote adequate conditions for the offered services, through quality control of the health practices and the users' education regarding their rights. The clarity on the regulatory processes has also been highlighted as an aspect that needs improvement by the regulatory agency. In health promotion, it is highly important to increase space for dialogue between regulatory agency and operators, in order to improve the understanding about health promotion ideas and about possible strategies to breed practices linked to guiding principles related to the holistic conception, equity, intersectoriality, social participation and sustainability. In this sense, the public regulation should be strengthened regarding the development of actions capable of guaranteeing public interest, which is oriented through the centralization of health needs and not by the capital logic.

It is also worth mentioning the Federal Constitution provides space for private health care offer, given they follow the premises from SUS. So, besides care actions, the private sector has the duty to integrate preventive and health promotion practices, not as a plus, but essentially as part of the service package provided.

If so, it is believed the relations between operator and their beneficiaries may occur in a more fair way, through the guarantee of the right to health as a whole.

Final Considerations

The collection of analysed data highlighted that the health promotion programs are linked to a logic of capital accumulation expressed on sustainability or profit by the operators.

In this perspective, operators see programs as possibilities to beat the market competition and care high cost. Even though, this market logic doesn't consider social health indicators and doesn't embody the premises from SUS. Thus, the objective of qualifying the care and promoting health to the beneficiaries was revealed as secondary, after commercial interest from private initiative.

The beneficiaries, on the other hand, see the programs as a possibility to satisfy some psychoemotional needs, through socializing and the bond created with their peers and the professionals involved. But the focus of the programs in some groups, defined according to the operators' convenience, depicts that health promotion in this studied context is not set up as a right.

In this case, the ANS, as a state representative responsible for regulating the private health sector, encourages the approach between the private sector and the standard from the public health policies, which are focused on the integrality of care with all its implications. However, the means used by the regulatory agency seems to have shrunk changing potential, given there is a maintenance of the hierarchical and fragmented production logic, information dimness, apart from strategies that keep their focus on actions restricted to primary prevention.

The results point to incoherence between the health promotion premise and the capitalist convenience that determine the organization of the private sector services. The creation or strengthening of clearer and dialogical regulatory policies is urgent, with potential to adjust, minimally, the two subsectors of health (public and private) in a way that both are organized to offer great services to promote people's health.

More articulation on private health is expected with the fields of action of health promotion through the breaking of the sector's barriers, creating strong partnerships to increase the investments in public policies and a healthy environment. In this context, it is highly necessary to re-guide the insurance model practiced by the private sector, through elaboration of strategies that stimulate empowering and autonomy on subjects, rather than the dominant focus on cure and prevention.

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