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DISCUSSION PAPER

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Carlos Octávio Ocké-Reis[2]

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DISCUSSION PAPER

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SINOPSE

A idéia que defende uma regulação dos planos de saúde em favor dos grandes *players* e do *"managed care"* é incompatível com as diretrizes do Sistema Único de Saúde (SUS), por isso, defendemos a adoção de um tipo de ação regulatória em direção ao fortalecimento da esfera pública. Em particular, apontamos como essa alternativa poderia capacitar a Agência Nacional de Saúde Suplementar (ANS) no enfrentamento da crise econômica do mercado de planos, desfazendo a ficção de que o mercado, uma vez fortalecido, vai cooperar com o SUS, ao invés de contaminá-lo.

ABSTRACT

The idea of regulating private health plans so as to favor major players and the *"managed care"* is incompatible with the guidelines of the National Health System [*Sistema Único de Saúde* (SUS)] and for this reason we defend instead a regulatory action aiming to strengthen the public sphere. In particular, we discuss how this alternative could improve the regulatory capacity of the National Supplementary Health Agency [*Agência Nacional de Saúde Suplementar* (ANS)] to face the economic crisis in the health plan marketplace, dispelling the mistaken notion that the market, once strengthened, will cooperate with the SUS rather than contaminate it.

> "The truth is that, in the last 200 years, we have thought little about the institutional outline of democracy. Since the great explosion of institutional thought, when the democratic institutions were invented—and yes, they were in fact invented—institutional creativity was practically seen no more" [Przeworski (1998)].

1 INTRODUCTION

We have parallel public and private systems, a type of *two-tier* system where people, who have private health plans, can go to public services since our constitutional philosophy defines that health care should be allocated on the basis of need rather than ability to pay. So many people pay for some type of plan, which intermediates the financing of health care, and regardless of the indirect public subsidies given to the individuals, health expenditures became a burden to the Brazilian household budget in the 90's.

Generally speaking, the structuring of these health plans has been necessary because of the increasing costs of medical services provoked by the growth of medical technology [Vianna (1987)]. The household expenditures were partially or totally sponsored by employers through fringe benefit payments, and the public employees working for state-owned institutions were also able to take advantage of this type of arrangement, as shown by Bahia (2001).

In many cases, these employment-based health plans represent simply a *sum of individuals* not organized, without any bargaining capacity over the contracts carried out by its sponsor. Since the health plans are responsible for 90% of the total expenditures with fringe benefits from the employer, it seems the latter are demanding that the employee's financing should rise. Thus, it is rare to see an individual choice as declared by the liberal approach: the employers advance themselves onto consumers' preferences—in theory effectuated freely—arbitrating a consumption basket, which sometimes has little relation with the workers' health need in Brazil [Bahia (1999)].

It is worth mentioning that the expansion of this market was promoted by a set of government incentives. Such incentives limited public expenditures that otherwise could have been channeled towards improving access and quality of the National Health System [*Sistema Único de Saúde* (SUS)] in Brazil [Ocké-Reis (2000)].

As we are talking about the financing of medical services for those workers who are located under the dynamic pole of the Brazilian economy, due to political and social reasons, the State felt the necessity to establish the regulation of the private health plans. In other words, being sensitive to the potential for protest of *those who have voice and vote*, the federal government found itself forced to represent the interests of the consumers of individual health plans, defending them against poor quality of services, fraud, and price increases (for rates that rise by more than the average of inflation).

In some way, the health insurance companies could also have supported the creation of the regulatory Law. Even so they claimed that the Superintendence of Private Insurance [*Superintendência de Seguros Privados* (Susep)], a bureau of the

federal Treasury, was responsible for carrying out this regulatory policy. It seems that price freezing in the Brazilian economy—implemented during the second half of the 80's—had a negative effect. When their prices were strictly controlled, medicine groups and medical cooperatives found juridical means to circumvent such control. Years later, given the fragility of the consensus around the regulation of health plans, the equalization of the competitors regarding the regulation of prices may have been one of the paths identified by the insurance companies to obtain a more favorable position inside the market competition pattern [see Ocké-Reis (1997)]. Although, this sector did not delay in realizing that the construction of National Agency of Supplemental Health [*Agência Nacional de Saúde Suplementar* (ANS)] and the prohibition to segmenting the health plans design brought trouble to the insurance companies' aspirations to gain a major participation in the market share.

In that picture, in spite of a favorable correlation of forces for market de-regulation, a new process came about in the field of social policies: the inception of Law 9.656 of national coverage, which started to regulate the private health plans in 1998, as well as the formation of ANS by means of Law 9.961two years later.

Evidently the privatization process and the growth of the regulatory state are like Siamese twins in the arena of the European welfare state crisis of legitimacy. However, the Brazilian health system had never been a natural monopoly of the State, and for this *raison d'être* there never was a global proposition to privatize the sector. That does not mean that there have not been attempts to expand the market through the State's facilities (i.e., the beds of the public university hospitals). What is basically important to emphasize is that the health plan marketplace has grown substantially, independent of any regulatory action. This scenario only changed, and gradually, after the regulatory Law in 1998.

At last but not at least, Wasem, Greb and Okma (2002) do suggest that the arrangement regarding the mix of public and private funding can affect *the role of the social health insurance* across the countries. Following this finding, we would like to discuss the possible ways in which the ANS can cope with the economic crisis faced by the health plan marketplace, and dispel the mistaken notion that the market, once strengthened, will cooperate with the SUS rather than contaminate their public facilities with the effect of aggravating the chronic social inequality in Brazil.

This paper considers that the regulatory actions do work as an instrument to correct the failures of the health plan market. Unlike Agency's rules in defense of both the competition and the consumers, such actions can bring about, paradoxically, a larger concentration of market, if the power of the oligopolies can't be faced. To criticize this sort of management, we first talk about the political context in which the ANS has arisen, and describe the nature of the market economic crisis. Considering these issues, we suggest an alternative proposal indicating the key role of the Agency to overcome this crisis, especially how this could promote both public health principles and the price reduction of the health plans. We end up arguing as one market's institutional reform could restore the meaning of those Agency's rules by protecting the ANS from being captured by the oligopolies.

2 A BRIEF DESCRIPTION OF THE MARKET

According to ANS, we can point out that the private health plans correspond to roughly 30 millions users, two thirds of which are younger than 40 years old. As the probability of getting sick differs among the age groups, the Agency assigned seven price levels for individual plans. In the following table, we can see the number of users in accordance with the age (Table 1).

TABLE 1
BRAZIL: USERS OF HEALTH PLANS ACCORDING AGE —2001

Age	Users	%
0 - 17	8.258.273	27,5
18 - 29	6.593.935	21,9
30 - 39	5.488.293	18,2
40 - 49	4.341.314	14,4
50 - 59	2.565.747	8,5
60 - 69	1.540.645	5,1
70 - +	1.317.428	4,4
Total	30.105.635	100,0

Source: ANS, November 2001.

In general, the market is composed of the following prepaid medical organizations (see Tables 2 and 3):

a) The health insurance companies are linked to the financial capital and they cannot lawfully deliver services. They are similar to *indemnity plans*, although they must count on physicians and hospital nets. In the case of free choice, the health insurance reimburses the consultations, and the exams and the hospitalizations respect specific limitations and franchises.

b) The medicine groups (prepaid group practice) are predominant in the market. They can manage health plans and deliver medical services. Moreover, the leading enterprises, whose owners are frequently physicians, have their own hospitals.

c) The medical cooperatives are organized throughout the national territory working as partners as well as providers. Some of them have their own hospitals. The Doctors of Brazil Union (Unimed) are constituted by 90 thousand autonomous doctors, and represent 364 cooperatives as well as develop health insurance's activities.

d) The *companies' health plans* are in general a non-profit organization and do not trade their plans. Having their own provider relationships, the employers manage health programs through their human resources department or through their employee associations. They also have preventive programs and outpatient clinics for treating small risks. However, they are being obligated to privatize this kind of service, losing space to health insurance corporations concerning their increasing costs and their partial lack of economies of scale (low number of users).

TABLE 2
BRAZIL: PERCENTAGE OF HEALTH PLANS USERS, ACCORDING PREPAID MEDICAL ORGANIZATIONS —1999

Organizations	%
Health insurance	12,0
Medicine group	37,0
Medical cooperative	23,0
Companies' health plans	28,0
Total	100,0

Source: Abramge (1999) *apud* ANS, September 2000.

TABLE 3
BRAZIL: NUMBER OF HEALTH PLANS ACCORDING PREPAID MEDICAL ORGANIZATIONS—1999

Organizations	Number	%
Health insurance	28	2,0
Medicine group	840	53,0
Medical cooperatives	364	23,0
Companies' health plans	355	22,0
Total	1.587	100,0

Sources: Abramge, Unimed and Ciefas (1999) and Fenaseg (1998) *apud* ANS, September 2000.

We identify a broad diversity of private health plans, depending on economical and institutional characteristics:

a) The patrimonial and financial structure of the employer, sponsor of the health care financing.

b) The patrimonial and financial structure of the private health plans as well as its insertion in the economy (commercial or financial).

c) The qualification and the occupational position of the employees.

d) The vertical line of the health insurance plans (simultaneous presence of the financing and delivering activities).

e) The quality, the supply capacity, the location and the technology available by accredited doctors and hospitals.

f) The monopoly of providers (the case of the physicians, who are taken captive by Unimed in some regions of Brazil).

g) The amount of users.

h) Other important issues:

i) The socialization of the risks among employers, health plans, consumers (employees) and providers.

j) The type of payment (pre or post).[1]

k) The type of employer financing (partial or integral).

l) The refunds (partial or integral).

m) The periods of lack of some medical procedures.

n) The levels of coverage exclusion: medicines and risk selection (elders, chronics diseases etc.).

o) The physician reimbursement methods.

p) The type of provider relationships (own, accredited or free choice).

In 1999, these prepaid medical organizations earned around US$ 7.5 billion (Table 4). This volume came up to 2,5% of the Brazilian Gross Domestic Product (GDP). The health insurance companies were very lucrative, profiting around US$ 1.6 billion, although they accounted for approximately 2% of the market. It is worth emphasizing that the federal government is to some extent responsible for such income, when allowing employers and employees to reduce part of their tax expenditures.

TABLE 4
BRAZIL: PROFIT ACCORDING PREPAID MEDICAL ORGANIZATIONS—1999
[US$ billions][a]

Organizations	Profit	%
Health insurance	1.6	21,5
Medicine group	1.7	22,8
Medical cooperative	1.3	17,5
Companies' health plans	2.9	38,2
Total	7.5	100,0

Source: Abramge (1999) *apud* ANS, September 2000.

[a] Amounts in *Reais* (R$) converted to US$ by the exchange rate of September 2003.

According the *World Health Report* 2000, the consumption of health plans is quite significant within the private health sector financing in Brazil (Table 5), although its result is considered controversial [see Navarro (2000)].

TABLE 5
BRAZIL: COMPOSITION OF THE HEALTH SECTOR FINANCING—1997

Financing	%
Public[a]	48,7
Private	51,3
Total	100,0

Source: World Health Organization (2000).

[a] It was not computed the amount of public subsidies under the health public financing.

1. In a first glance, despite of being a minority, the alternative of prospective payment is increasingly being offered by employers with the intention of avoiding unemployed and retired fringe benefit's eligibility — regarding the mandatory coverage assured for these groups in the regulatory legislation.

As it refers to the price formation process, the demand for health plans is a consequence of the increasing costs related to the production of medical services in the context of currency depreciation. Moreover, the high inflation of this sector is caused by several factors: the asymmetrical information, the market imperfections (uncertainty and externalities) and the existence of a demand potentially inelastic to price [Nogueira and Siqueira (1998), and Phelps (1997)]. It sounds as if there are other economic factors provoking this high inflation linked to opportunity costs associated with the remuneration of the interest tax, and the costs associated with the partial lack of the process of *creative destruction*.[2]

In particular, the transaction costs related to verifying quality (the reputation and the costs of brokerage) is significant for those who want to move out from his health plan to another one. What is important for the patient is the confidence he has in the solution of his health-related problems by medical and hospital services [Berstein and Gauthier (1999), and Pauly (1998)]. This frequently results in markets without competition, additional financial expenditures, more levels of coverage exclusion, and could lead to a loss in the quality of health care.

Besides, there is a common sense, which advocates that the presence of advanced medical technology guarantees the quality of care, involving inappropriate incentives to demand high cost services. This perception reflects the medicalization of society that makes the population more willing to consume new technologies, especially high-tech ones. Such cultural phenomena is fed in the context of the market standard of competition: on one side, the health plans try to reach new users, emphasizing in the mass media the importance of technological factors to resolve health problems, hiring expensive providers. Because of the publicity's effect, this induces consumers to generate losses, choosing more care and consequently pressing the costs. On the other side, health plans are forced to impose managerial techniques, rationalizing risks and lowering costs to counter-balance that pressure. In our opinion, it is important to make clear that this contradictory market strategy is one of the most important cause of moral hazard in Brazil, and somehow it is an interesting critique of the mainstream approach—where both consumers (moral hazard) and providers (principal-agent problems) are uniquely responsible by demanding more care and by overspending expenditures [see Andrade and Lisboa (2001), and Cutler and Zeckhauser (2000)].

Therefore, it is unsurprising that in Latin America's largest city, São Paulo, the health plans premiums have increased by 4.4 times the average rate of inflation and 1.7 times the rate of health inflation from 1996 to 2002 (Table 6). These results help explain why prepaid medical organizations have acquired high profits, and consequently why private expenditures played a significant role in the financing of the health care sector.

2. By Schumpeter, the new consume goods, the new production methods, the new markets and the news forms of labor organization observed in the capitalism history "(...) illustrate a mutant industrial process (...) that incessantly revolutionizes the economic structure from inside, incessantly destroying the old one, and incessantly creating others. This process of creative destruction is the essential fact about the capitalism and (…) it is upon that the capitalist corporations must live" [Schumpeter (1984)].

TABLE 6
BRAZIL, SÃO PAULO: ACCUMULATED RATE OF INFLATION: GENERAL, HEALTH AND HEALTH PLANS PREMIUMS'—JULY/1996 TO APRIL/2002

Cost of living	Rates	Index (a)	Index (b)
General	44,5	1,0	-
Health	117,1	2,6	1,0
Premiums	196,8	4,4	1,7

Source: Dieese/ICV. Done by: IPEA/DIMAC.

After all, as the collective contract is negotiated firm by firm (see its composition in Table 7), it may observe a wide multiplicity of plans. In each case, they are the result of the tension among the extent of employers' benefits; the aims of the health plans concerning prices, coverage conditions and health care quality; and the collective bargaining of the employees. In the extreme case, one can observe the following standards of supply: *community rating* (mutual health plans), which present mixed financing and cross subsidies regarding low-income users and high cost procedures. In general, this occurs when there is no mark-up to target and no advertising costs to invest, especially in the *companies' health plans* that count with it a huge number of young users. And *experience rating plans* where there is a radical selection of the worker's risks, according to their income, occupational and demographic characteristics.

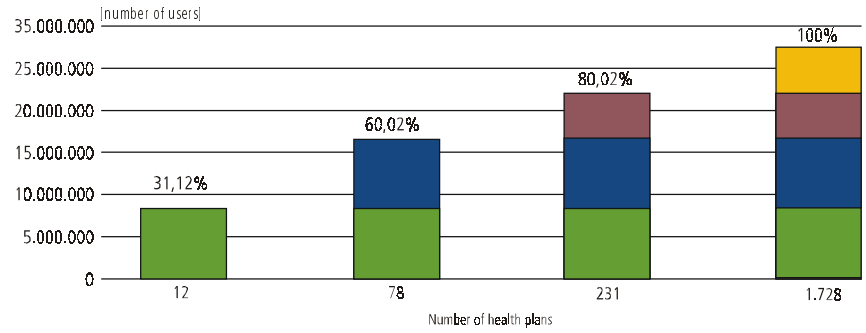
TABLE 7
BRAZIL: COMPOSITION OF THE HEALTH PLAN MARKETPLACE—1998

Health plans	%
Employment-based	65,0
Individual	35,0
Total	100,0

Source: IBGE/PNAD. Done by: IPEA/DIMAC.

Looking at the market standard of competition, there is a relative concentration of a few health plans struggling for the majority of the consumers (see graph). Following Labini's tradition, Andreazzi (1998) argues that there exists a differed oligopoly ranked by heterogeneous products, which allows few opportunities for price competition, and she believes that the major health plan companies try to find comparative advantages to achieve lower costs and financial funding.

BRAZIL: CONCENTRATION OF USERS ACCORDING THE NUMBER OF HEALTH PLANS—2001



Source: ANS, 2001. Done by: IPEA/DIMAC.

There are many differences among the plans with reference to their patrimonial and financial structure, their installed capability of services, and their insertion in the productive structure. This, however, does not deprive the market of its character, since all types of health plans and health insurances are somehow near substitutes for each other [see Robinson (1953)], taking into consideration a certain profile of demand (levels of income, occupation and health-related risks). For those which are looking for *extraordinary profits*, there is no doubt that their innovations are prepared to get the consumers belonging to another employment-based health plan in the context of low salaries and hard competition.

The market goes on operating with two bands within the regulatory policy, namely, the new health plans will be regulated by ANS, and the old ones will continue to be protected both by ordinary legislation and by Consumer Protection Code, being almost out of ANS control (see Table 8).

TABLE 8
BRAZIL: NUMBER OF USERS OF HEALTH PLANS ACCORDING TO THE CONTRACT SITUATION—2001

Law 9.656/1998	Users	%
Number of plans prior to the law	22.417.153	74,5
Number of plans posterior to the law	7.688.482	25,5
Total	30.105.635	100,0

Source: ANS, November 2001.

Passed on 24 August 2001, a federal government bill n. 2.177-43 tried exactly to correct this administrative irregularity, which inhibits ANS to move itself toward these two bands. However, the old plans' passage to the new regulatory regime through the *Special Plan of Adhesion to Adapted Contract* would punish doctors and consumers, and so the federal government annulled it, recognizing the pressure of the organized civil society.

It is worth saying that ANS signed, through the Ministry of Health, a management contract with the central government. Among the performance indicators to be evaluated in this contract is the achievement of a yearly migration percentage from the old plans to the news of 25% for 2002 and 10% for 2003. We deduce, thus, a gradual strategy is being adopted to overcome this impediment

brought about by the contractual ambiguity of the market. Recently, the federal government is trying to approve another bill to allow definitely this emigration in 2004.

This brief description over the marketplace allows us to discuss how to improve the ANS's capacity to face the economic crisis, although it is clear that there is a high level of profitability in this market, which demonstrates the power of the oligopolies. Regarding the imperfections of this market, there exists a differed oligopoly ranked by heterogeneous goods, which allows few opportunities for price competition. For this reason, what we criticize—for the sake of the public sphere's affirmation—is the hypostasis that *only* major players and the *"managed care"* application would lead this market to a stable level of prices.

3 THE KEY ROLE OF THE ANS TO FACING THE CRISIS

3.1 THE CRISIS ANNOUNCEMENT

There is no opportunity to show in detail the magnitude of the economic crisis. It is difficult to see the extent of its impact on each segment, pointing out the winners and losers in a market so diverse economically and institutionally.[3]

I do not want to deny either that this crisis is being looked at like a pretext for conglomerates to pass it on to consumers without shouldering the risks inherent to this economic activity. Some requests for financial adjustments or incentives are unnecessary and make part of the strong lobby practiced by them. Yet even recognizing the difference between such lobbies and those arising from real problems, they did not invalidate the hypothesis of the crisis; on the contrary, they are an expression of it.

We are watching a sub consumption crisis in a conventional sense, whose characteristics could be seen in Sweezy (1986): "Marx holds the belief that an interruption in production may result in the impossibility of capitalists selling goods according to their value. The problem is limited to a restricted volume of demand for consumption—restricted by low wages regarding the capitalists' tendency to accumulate".

But we say conventional because it has no similarity whatsoever to the economic (industrial) environment and much less to the Marxist teleology about the capitalist crisis that constitutes the hard core of this proposition. However, there are some elements that allow us to pass beyond the equation inscribed in *The Capital*. Despite the disproportionate increase in premiums in relation to the average inflation rate, capitalists find difficulties in selling health plans by their respective *value*, considering a restricted demand due to the presence of low wages (Table 9).

3. As we do not have any data to analyze this subject, we found out these information described below through ANS's website (http://www.ans.gov.br/portal/site/home/index.asp) and through some newspapers.

TABLE 9
BRAZIL: REAL AVERAGE INCOME OF EMPLOYED PEOPLE—1997-2001
[base: July 1994 = 100]

Year	Index (average)
1997	129,27
1998	128,69
1999	121,62
2000	120,86
2001	116,13
2002	100,6

Source: IBGE/PME. Done by: IPEA/DIMAC.

In this context, the tendency of rising costs and the adoption of regulatory norms pressurize the premiums' increase. Given the absence of efficient managerial mechanisms or ambulatory nets, a rise in prices makes especially small health plans less competitive, as they must reduce the number of users, lowering their profitability. If the small plans put a minor rise in prices, disproportionate to the increase in costs, this could guarantee them some competitiveness, but it might be impracticable to gain something economically rewarding to cover their expenditures. Actually, this pressure on costs conducts the plans toward economic constraints mainly the small ones, and causes two consequences on the supply side: the health plan companies' bankruptcy and their attempt both to enlarge the level of utilization review and to reduce the comprehensiveness of health plan coverage.

This portrait becomes more complicated with the commercialization of the new individual plans, which are under ANS's control, and so are risky for the corporations' business. For awhile, there is a rigid rule here trying to avoid risk selection, what prevents us to repeat the United States' experience: over there, health plan companies evaluate, case by case, the insurability capacity of the consumers. A medical report is not the only thing requested: medical check-ups are frequently demanded with blood and urine tests as well as saliva samples to make sure the economic viability of the plan [Gabel *et al.* (2002)].

For this reason, some health plan companies are reducing their offering of individual ones. According to these corporations, they aggravate their deficits, because the federal government controls the prices, the legislature enforces bills enhancing the plan coverage without suitable technical advice, and the judiciary legitimates orders forcing them to bear the costs of covering what is not included in the old plans. Therefore, their prices are below the costs, contracts are not respected, and there is no limit to the insured's expenses.

Since health plan companies go on informing ANS about their economic and financial situation, if the rising costs trajectory and the restrictions to segmentation of the health plans design are maintained, an increasing number of corporations will be broke. In the management of this sub consumption crisis, especially small health plans will be facing difficulties as they have economic disadvantages and often present managerial inefficiencies.

3.2 THE ANS's PERFORMANCE

The ANS has already applied the *fiscal administration regime* to a large number of health plans, similarly to a *defensive bankruptcy petition*. It seems clear the systematic application of this instrument reveals the nature of this crisis, whose utilization is becoming itself more and more necessary.

How does it work out? During the period of one year, the corporations' accounting department is verified by a director chosen by ANS, who will integrate himself into the company with the purpose of investigating its financial and economic situation, the conditions of users' assistance, and any debts related to the Agency (*supplementary health tax*). Later, the board of directors will determine the adoption of technical measures, intended to normalize the company's situation. The health plan companies may either pay heavy penalties or undergo judicial interventions. The same coverage and prices prior to the intervention shall be maintained and consumers shall have their contractual rights fully granted.

From that moment a recovery arrangement shall be proffered. Those that are not able to improve while the fiscal administration is in force, because of their incapacity to pay debts at the appointed time, have their consumers passed on to another health plan. Thus, the *fiscal administration regime* can be described according to:

a) If the health plan companies manage to normalize both its economic and financial situation, it is allowed to come back to the marketplace without ANS's interference. Two of these corporations, for instance, have already returned after this intervention period.

b) If the company undergoes an intervention and is not able to show its capacity for balance, it will be liquidated by ANS. *Extra judicial liquidation* results in the users' transference belonging to the bankrupted health plan. In this case, the corporation' owners remain with their property inalienable for a twelve-month period. This property is supposed to pay debts to any services rendered, be these debts with doctors, hospitals or laboratories. Some health plans have already been closed.

The proposal put forward by Abramge to overcome this situation was disapproved in 2003, because it sought to create flexible individual plans, which are under ANS's control, so as to expand the market. As we know, although they subsist, *regarding the new regulatory Law* it is not allowed to supply ambulatory plans with an extremely low coverage, which could be offered to the low-income consumers by lower prices. In the same line, it is not allowed to supply plans *purely* based on *experience rating*, which radicalize the difference among individuals according to nosological and demographic characteristics, avoiding high expenses of chronic diseases treatment (preexistent or not) and of the elderly's health care.

On the whole, Abramge's proposal stated that consumers had only the right to determine a few medical consultations, laboratory tests and inpatient procedures. In reality, this claim has come in order to escape from the strictness of the regulatory norms and the precarious labor relationships, the latter evident by wage reductions

and the lack of *labor cards*. This circumstance is preventing the offering of individual plans to low-income consumers.

But how prejudicial could this decision be? Some health services become both ineffective and discontinuous, if the contract does not cover a disease or even an exam, which might be necessary to the patient healing. There is almost a consensus between sanitarians and physicians, and so the regulatory Law still keeps its opposition to the radical segmentation, to be precise the extension of the level of utilization review and the reduction of the comprehensiveness of private health plans coverage.

Using a *misleading* Darwinist argument, what intrigues us is to note a silence in respect to the belief that the concentration of the health plan marketplace by means of major players would offer a solution to overcome that crisis: only those corporations more capable—through oligopolist competition—could lead to the reduction of the prices. But we contest the idea of regulating health plans so as to favor major corporations and the *"managed care"*, arguing that it is incompatible with the political guidelines expressed by the SUS. Instead, we defend regulatory actions aiming to strengthen the public sphere, which should have "(…) as its background motivation social pressures, operating to submit the State and bring it, from its position as a structure 'above society', to an inversion that do not make society a property of the State but something able to civilize the State, submitting its movement to the permanent attention of the civil society" [Genro (1995)].

3.3 THE KEY ROLE OF THE ANS

This picture above reflects a latent economic crisis concentrated on some health plan companies. Its complexity requests a meticulous research, although the lack of data prevents identifying the extent as well as the depth of the crisis.

Notwithstanding other factors, this lack of data would be enough to demonstrate that defining the ANS's role from a technical, a non-political standpoint, rejecting the objectives of the State in relation to the health system, becomes a limitation to design its activities. Generally speaking, regulatory actions do work out as corrective instruments of the imperfections of the health plan marketplace, nevertheless such actions can inconsistently bring about a larger concentration in the market—in a direction contrary to the Agency's normative aims—if the economic power of oligopolies is not shortened. Those regulatory actions can even determine the competition standard and the level of profits, and this is a strong reason for ANS to indicate the path to a solution, taking into account the oligopolies' power.

The specialization of ANS's human resources is fundamental to supervise the health plan marketplace, and it is an essential prerogative within the regulatory policy. An incompetent financial management by health plans, besides the non-fulfillment of both the ANS's regulation and the consumers' contractual rights might cause serious consequences to patients. Thus, it is important to enhance ANS's supervisory activities, overcoming some operational dilemmas that express dichotomies concerning its organizational mission: *to regulate or not employment-based health plans; to renovate or not old contracts*; *to enlarge or not the eligibility of retirees,*

unemployed and elderly consumers; *to enlarge or not the mobility of consumers among the health plans*; *to regulate or not delivering services*; *to regulate or not the health plan companies together with the health plans; to implant or not quality indicators regarding private services delivered*; and, finally, *whether regulate access and quality or regulate only economic and financial aspects*.

It would be a mistake to ignore this essential role of the Agency, especially because of the managerial irresponsibility of some health plans. Yet this supervision to adjust the market could provoke a likely side-effect, which tends to increase in parallel the crisis: the strengthening of major economic groups, when the Agency normalizes the operating rules, supervises the economic and financial irregularities or even purges fraudulent health plan companies. As a consequence, the ANS's normative aims would be abandoned to overwhelm the crisis, reinforcing a technocratic view in dealing with the private health plan regulation.

According to Offe (1984) an organization is supposed to articulate three distinct levels of administrative rationality: bureaucratic (adequacy to the text), teleological (contingent), and that which operates its political consensus both internally and externally. In our perspective, we would say that the ANS's supervision activity (adequacy to the text) should explicitly materialize the aims of the State defining a *modus operandi* in advocacy of both a consumer's right and competition (contingent) on the marketplace.

At a first glance, it could be possible to make an agreement round these former rationalities. But it is tremendously complex to fabricate a consensus on the subject of how to overcome the economic crisis resisting the tendency to market concentration and how to design a regulatory policy in favor of a *regulatory social contract*, namely, an institutional reform in the marketplace, which would represent a singular path to constructing a public sphere inside the marketplace to restore the SUS's unicity.

4 THE REGULATORY DISJUNCTIVE

One can have the feeling that ANS's performance based on learning by doing is rather satisfactory in this initial stage. This alone, nonetheless, is not enough to face the economic crisis in the health plan marketplace without disregarding the perspective of reducing the oligopolies' power.

From a normative point of view, the main goal of the ANS is to promote competition and consumer protection, seeking to restructure the market to reduce oligopolistic practices and the elimination of economic abuses. As it is a relevant matter of public policy, this Agency should look after the consumers' social welfare. It should also provide the necessary information about companies hired and health plans coverage, as it is already done by the *consumers' protection associations* and by the non-profit organizations (*bearer of pathologies' entities*). More to the point, the health plans regulation should be compatible with the aims of the SUS, according to Constitution and Laws 8.080 and 8.142 of 1990.

However, according to the civil society entities, the ANS's objectives are not being fulfilled. On the contrary, they are being increasingly transformed more and

more in a figure of rhetoric. The health plans, on their side, declare that the costs are not being covered by the premium adjustments sanctioned by the federal government, especially after the adoption of the regulatory rules. The physicians claim a bigger payment as well as criticize the interference of health plan companies in their jobs. Finally, the ANS's managers believe they are doing a good job by keeping an efficient function of the marketplace.

We just want to highlight that the marketplace does not accept the health plans regulation. Actually, beyond restraining the magnitude of the premiums, it can determine the market standard of competition. For this reason, I have many doubts related to the judgment that "the efficiency agenda setting accepts (…) solutions of positive sum, when all of the groups affected by this policy earn, permitting unanimous solutions" as presented into the typology pointed out by Costa *et al.* (2001).

In this context, among the alternatives to find out a solution to overcome the mentioned economic crisis, there is the delineation of the following regulatory disjunctive.

On one side, even though there is ideological rhetoric in favor of both competition and a consumer's right, it is recommended pragmatically that the Agency should sponsor the consolidation of major players and the institutionalization of *"managed care"*—guided by a kind of social Darwinism. So accepting passively this movement concentration that lays itself inside the capitalist system, this idea conjectures that *only* the oligopoly competition shall favor the reduction of premiums. In addition, one could propose the adoption of risk-sharing measures to rationalize both the level of utilization and the costs of medical care. Presuming these microregulation dimensions, there wouldn't be more problems to arise efficient contracts by avoiding itself *agency problems* such as moral hazard and adverse selection, although "(…) no easy solution (…) exists, and all systems of insurance—whether private and public—confront it" [Hacker (2002)].

Mendes (2001), for instance, evaluates that "(...) the existence of State regulation with the establishment of minimum rules for the game (...) is going to determine huge quantitative and qualitative modifications, for the well or for the evil, among them, (...) the concentration of the private health plans with the elimination of the inefficient and the small ones (...) (and) the appeal of new players, specially, the foreign corporations".

However, we refute this scheme based on four interrelated arguments. As Navarro (1993) has already pointed out upon the American case "(…) the capitalist class (and its different components) has an enormous influence on the way in which health care is financed and delivered. The insurance companies and the large corporate employers are the major forces that shape this financing. Their economic and political influence is enormous, limiting considerably the government's ability to respond to popular demands". In particular, if the Agency develops into a technocratic management, regulatory actions could work out as corrective instruments of the imperfections of the health plan marketplace, nevertheless, such actions can inconsistently bring about a larger concentration in the market, conversely to the Agency's normative aims. So it is plausible to think over the

hypothesis that its *efficiencism*[4] might deepen the hegemony of capital in the health care system [see Bayer and Leys (1986)]. Furthermore, there are many proposals to apply instruments to rationalize the level of utilization and to reduce health care costs in Brazil, but they were not institutionalized entirely until now by the ANS's health plans regulation. As a few policy makers comprehend, this could be done putting forward some specific rules lying on managerial control of clinical decision-making, limits on patient choice of both medical professional and hospitals, and risk-sharing among patients, and providers. Regarding this topic, it is worth saying that Hacker and Marmor (1999) criticize precisely this concept of *"managed care"* for the reason that "in fact, the clearest and most unmistakable trend has been in the direction of straightforward price-discounting, as plans have used their market clout to selectively contract with physicians willing to accept negotiated rates". At last, an integral adhesion to the microeconomic regulatory agenda looks short-ranged. According to Kahn (1998)— who makes use of the neoclassical economic theory with institutional considerations—this approach cannot say accurately at all about "how to achieve" the internalization of the supposed acquisitions in efficiency, namely, how to make the regulated economic agents actually yield competitive prices.

Actually, as if it were a strategy to reduce the scope of the public financing under the SUS, this pragmatist proposal hides its aspiration to ensure access to a range of health care for some workers on the basis of the ability to pay and not based on need.

On the other side, considering it was established the universal access on medical care in the Brazilian Constitution (article 196) to guarantee a comprehensive coverage to Brazilian people—we judge that ANS can help to refund the health plans market. However, given the limits of the public financing concerning fiscal restrictions, we are aware of challenges on the private health plans regulation to constructing a public sphere inside the marketplace to restore the SUS's unicity, which is a particular type of two-tier system.

Flood, Stabile and Tuohy (2002) has already mentioned the controversies about the appropriate roles of public and private financing in health care, where "(…) there are significant limitations on the extent to which (the government funding to pay) is applied and variations across countries with regard to these limitations".

Supposing an increase of public health financing and a progressive allocation of the public subsidies to private consumption, we believe that the Agency is able to guide an institutional reform to face the economic crisis on a basis favorable to SUS 's public principles, reaching indeed lower prices in the marketplace. Connecting the improvement of ANS's supervisory activities with the State's aims related to a consumer's right and market competition, the indispensable would be the publicization of the marketplace. This arrangement could resist the concentration of

4. *Efficiencism* is not efficiency. Following Marinho e Façanha (2001) — who present a rigorous, sophisticated, and comprehensive scheme of concepts, proceedings and applications that work as instruments to delimit the evaluation of the effectiveness, efficiency, and efficacy of organizations, management models, and social programmes — we believe that the efficiency evaluation is the numerical result of the comparison between possible excellent results and effective results. The most efficient is that which achieves the best relative performance, that is, the best practice. It is noteworthy, however, that the authors emphasize a central aspect: the efficiency evaluation must not be confused with or used as a basis for the reduction of financial or organizational resources. Instead, the adoption of economic rationality criteria is proposed — which may recommend the expansion of expenditures. Such criteria, therefore, are conceived as they entail the maximization of results in face of the resources used to obtain them.

the major health plans forestalling the typical fault of a regulation based on delegation as the ANS's capture by the conglomerates [see Majone (1996)].

But how to design this publicization derived from a *regulatory social contract*? We have some general ideas to present below. Some of them have already been in practice, yet the key characteristics of this new regulatory policy rely on a historical bloc capable of resisting those who hold the social power, constituting a public sphere in the marketplace induced by ANS in favor of the participation of the civil society, and rely on a creation of a social health insurance to civil servants establishing an oligopsony power under the marketplace.

a) The strengthening of institutional mechanisms to publicize the private health plans regulation:

i) coordinating and democratizing the decision-making process from both ANS's board and Supplementary Health Council linked to the Health Ministry in consonance with the resolutions taken by both Health National Council and organized civil society institutions, specially *consumers' protection associations*; *ii*) generating incentives for those health plans, whose aims try to reach the same clinic and epidemiological targets defined by the Health Ministry; *iii*) diffusing information related to facilities and the quality of public health system.

b) Disciplining the economic and financial contracts between consumers and health plans:

i) discriminating the regulatory action *vis-à-vis* the type of prepaid medical organization; *ii*) expanding the regulation (the emigration) toward the whole health plans market without harming consumers; *iii*) applying a separately and effective regulatory action to employment-based and to individual health plans; *iv*) forbidding the radical segmentation (the extension of the level of utilization review and the reduction of the comprehensiveness of health plans coverage); *v*) applying legal and administrative sanctions against health plans that practice irregular actions, inclusively, property rights.

c) Control of prices and the quality of health plans:

i) lighting a *beacon* for the private health plans regulation by way of the *companies' health plans*, specially via state-owned ones, creating a social health insurance to civil servants as an attempt to make an oligopsony power under the marketplace; *ii*) adoption of price control by means of the introduction of incentives and penalties; *iii*) promoting consortiums and/or cooperatives of small health plans; *iv*) promoting consumers' cooperatives giving them greater bargaining power; *v*) creating *accrediting* instruments and quality indexes to evaluate both the health plans and the medical services delivered; *vi*) creating an efficient information system based on the health plans accounting balance; *vii*) checking costs spread sheets to subsidize the strategic planning in relation to price adjustments and to health public system's indemnity—whenever an user of the private system goes to the public one.

d) To value ANS's specialized bureaucracy with a view to reducing the harassment by economic lobbies:

i) to grant good working conditions; *ii*) promoting public exams; *iii*) improving the communication and coordination among their departments ; *iv*) to coordinate its action together with the Ministry of Justice (the Consumer's Protection Bureau and the Administrative Council of Economic Law), with the Treasury (the Economic Monitoring Bureau), the Federal and State Public Ministry, and with the Supreme Tribunal of Justice.

The configuration of such political and institutional changes would allow to promote, or rather, to refund the health plan marketplace in favor of the public sphere strengthening—in which democratic planning rules over the market relationships: the State and the organized civil society need to reinvent social reproduction measures in the field of medical care, protecting themselves against the "Satanic mill" that Polanyi talks about [Polanyi (1980)].

5 FINAL CONSIDERATIONS

We must recognize even so we have before us a big deal: given the present-day limits of health public financing, could there be a possible alternative to lessening the crisis, whose solution would not follow the idea of the consolidation of major health plans corporations and the institutionalization of *"managed care"*?

Knowing the obstacles that prevent reaching the economic optimization, this route means abdicating the strategy to refund the marketplace, which is a differentiated oligopoly, operating in a context of imperfect competition. It means indeed to reduce the ANS's capability to face the rent-seekers practices, since the economic agents could become less susceptible to price administration and to the objectives of the State in the area of both regulation and financing.

If the application of *fiscal administration regime* and *extra judicial liquidation* works out as a corrective instrument, such actions can inconsistently bring about a larger concentration in the market—in a direction contrary to ANS's normative prescriptions—if the oligopolies' power can´t be faced

. This pathway could even affect the role of the health policies subscribed to in the Brazilian Constitution, setting them too far from its responsibility as a social right, aggravating thus the chronic social inequality in Brazil.

We are aware of challenges on the private health plans regulation. But ANS holds a *conditio sine qua non*: the power to arbitrate the health plans economic spaces, which allows it to escape from the technocratic logic by creating a marketplace subordinated to a *regulatory social contract*, and accordingly helping to build a public sphere inside the marketplace to restore the SUS's unicity.

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