

The false private health insurance by association: a real case analysis of how actors influence the policy-making in health systems (is there any winner?)

| Alessandra Beatriz M L de Abreu

National Agency for Private Health and Plans in Brazil, Rio de Janeiro, Brazil

Background After the edition of Law 9.656, 1998 many regulatory dilemmas have been brought to debate in Brazilian Supplementary Health, often triggered in a centrifugal way, from society to governmental organizations.

Methods This paper aims to investigate a Brazilian case study related to collective health plans by association consumers and specific contractual rescissions. Following an evidence-based policy question the author seeks to understand how the decision-making of normative process for the construction of a health system and its regulatory framework can be complex and intricate by several variants. This article uses the rational of different authors and perspectives as an initial parameter of analysis to uncover the extent to which stakeholders influence decision in policy-making regarding Health Systems and challenges of regulating a public-private structure. Using a concrete case study, the author constructs a rhetorical article allowing the reader to see herself/himself as part of the context of building a health system. The reader can immerse in the reality of the people and actors involved in the implementation of a country's regulatory process, permeated by diverse social interests. The public servant role and the debate of the difficult task of balancing the access to public and private service in a health system. Using an interpretivist inductive approach initiated by the debate of an evidence-based policy article, the idea is to demonstrate how power, culture and politics are factors, many times ephemeral but essential in the definition of science and the practical world of society and its systems.

Results The author uses a qualitative method of research analyzing the phenomenon of false collectives through this case study and a historical context of facts. No specific quantitative data were collected, and the case was analyzed according to author's knowledge of years of public service exercised in health regulatory field. This methodology seeks to draw a parallel between the interpretivist technique and the need to integrate social problems as well as the reader into the studied question.

Conclusions The epistemology of public service versus the society it serves and the role of each actor, as well as their dilemmas, traces the problematic investigated in this article. How the interpretivist technique can help unravel complex social problems and trace a philosophical route of learning and community participation to build a fairer and more balanced health system.

Cite as: de Abreu ABML. The false private health insurance by association: A real case analysis of how actors influence the policy-making in health systems (is there any winner?). *J Glob Health Rep* 2018; 2: e2018004.

CORRESPONDENCE TO:

Alessandra Abreu | 49 Holland Road Flat 3 | London W14 8HL | UNITED KINGDOM
alessandra.abreu.79@gmail.com

On 3 June 1998, the Brazilian legislator edited the law 9,656 that regulated the already existing supplementary private health market. The prediction of a health insurance that could be negotiated between associations, trade unions, and the health insurance companies gave the Brazilian society a different way of contracting a health insurance. However, in the mid-2008, the emergence of the so-called “false private health insurance by association” or widely known as “false collectives”, completely changed the regulation perceptions.

This article aims at understanding, through sociological studies and evidence-based policy arguments, as the Brazilian private health system suffered influences and changes due to the emergence of actors during the regulation process which were unknown for Brazilian Private Health officials. To accomplish this analysis of a specific case in the Brazilian regulation which was denominated the “false collectives health insurance”. I will use the *inductive process of interpretivist research*.

It also aims to address the political role of the Brazilian regulatory Agency and observe in a critically perspective the impact of society and researchers in the construction of public policies for the private area of health in Brazil comparing all those issues with Gilson’s perspective.

METHODS

Understanding the historical process of law 9.656/98

During the end of the 90s, Brazil was in a process of stabilizing its currency - the real, created in 1994 - decreasing inflation and expansion of the middle class. Aggregated to this, some changes following international guidelines of new public management were orienting a more neoliberal role in economic terms, with privatization of some important areas and opening them for external investments. Within this scenario, the regulatory agencies emerged and the regulation of the private health market in Brazil.

Nevertheless, that private health market already existed for more than 10 years before the regulatory market. The regulation at that time was coordinated by the National Council of Insurances and was not properly a private health regulation but a regulation regarding insurance, asset, and price policies.

Specificity of the Brazilian legislation – how to construct a policy perspective

The analysis of any legislation, especially in Brazil is a complex task because the political arena is permeated by dozens of parties, with different ideological perspectives influencing the process of creating a norm all the time. Because of historical roots- whose reasons escape the scope of this article- one of the most important motivations present in Brazilian norms and to which is part of the puzzle to understand this article refers to the workers’ right.

Having this perspective, we must analyse what the article 16 of Law 9.656/98 says:

“Article 16. The contracts, regulations or general conditions of the products treated in item I and § 1 of art. (1) of this Law shall bear policies indicating clearly:

VII- the regime, or type of contract:

- A) individual or family;*
- B) employed-based health insurance; or*
- C) Private health insurance by association”.*

It is important to understand the context. In 1998, the private health insurance by association (article 16 1, b) was formulated to empower associations and trade unions to represent workers in the process of negotiation of a private insurance. The fact that those associations would be responsible for a large community (the associated members) and with it a potential large amount of money, would give them strength to negotiate in equal standards with the insurance companies.

However, in mid-year 2008, the rising alarming number of denounces – especially involving elderly consumers excluded from certain health contracts-, lit the alert for a problem so unexpected: the emergence of false associations that congregated users of private health insurance just to after practice the predatory behaviour known as *cherry-picking*.

The context in which the Regulatory Agency took its decision concerning this problem is the crucial key to understanding how Gilson's statement (1) can be applied to this case.

As explained by Dobrow et al. (2) "*The two fundamental components of an evidence-based decision are evidence and context.*"

The philosophical and practical aspects of evidence support two distinct orientations to what constitutes evidence, reflecting fundamentally different relationships between evidence and context. The first is a philosophical-normative orientation, while the second is a practical-operational orientation".

RESULTS

The influence of external factors in the creation of the context for the policy of associative private health insurance

The first analyses of denounces conducted by the regulatory agency's officials demonstrated that consumers - more properly elderly and carriers of chronicle diseases- were being excluded in an abusive manner from collective health plans by associations, especially when they needed some important and high costly procedure. Time after, the public servants understood that the mechanism used for this exclusion was basically the creation of associations that mediated the insurance negotiation and attracted those people offering them high-quality health insurances for a low-cost.

However, it is important to notice that there was not exactly a binding association (or an *animus for association*) between the consumer and the representative institution, meaning, there was not a real connection of interest between the association and the consumers.

To understand how Gilson's statement (1) can be identified in this particular case is important to understand how external factors were influencing the change of the regulatory environment, despite any authorized governmental act for that. Moreover, We have to acknowledge that in general policies are immersed in very complex human contexts and to understand that We have to use a "big perspective", as Thomas Mann (3) defined: "*To see things or people small, one choose to see from a detached point of view, to watch behaviors from the perspective of a system, to be concerned with trends and tendencies rather than intentionality and concreteness of everyday life. To see things or people big, one must resist viewing other human being as mere objects or chess pieces and view them in their integrity and particularity instead. One most see from the point of view of the participant in the midst of what is happening if one is to be privy to the plans people make, the initiatives they take, the uncertainties they face*".

The standards and the actors of policy

Defining standards for policy-making is always a difficult task, especially because according to Brownson et al. (4) "*public policies must be not only technically sound, but also politically and administratively feasible. Therefore, even when quantitatively (epidemiologically) a particular policy has shown to be more appropriate, often the political and administrative context can frontward the decision, even if in the long-term unfavorable to society*".

Sometimes a specific actor can vitally command the entire regulatory political agenda, determining movements based on the knowledge of market asymmetries. Gilson et al. (1) are consistent when affirming that "health policies and systems are themselves political and social constructions". However, more important than acknowledging is discovering how this reality can positively or negatively influence the process of elaboration and implementation of a health system policy. It is also important to develop ideas that can tackle issues as, for

instance, information asymmetries before they polarize the policy agenda in an irreversible manner.

In the specific case of Brazilian health policy here analysed, another factor should be taken into consideration in policymaking context. In general, the councils of higher decisions of all public agencies have multiparty representations appointing the board of Directors, which generates a high instability not only over the decision process but after, when the policy is implemented. Very frequently, the interference of external actors is not clearly defined, nor in what extent their specific interests have importance to a certain decision; also, the implementation process can undergo influences which epicenters are not recognized.

In the public sector the policymaking agenda has strict rules (5): “(...) in the public sector, these processes benefit knowledgeable players: senior politicians whose constituency and personal interests have led them to specialize in a specific set of policy issues, professional interest group leaders, veteran issue journalists and career bureaucrats. (...) Multiparty parliamentary regimes are characterized by having more partisan veto players than presidential regimes or parliamentary systems modeled after the Westminster two-party system model (Tsebelis 2002). This increases the complexity of the bargaining environments in these systems, and thereby increases political instability within them”.

Thus, in a scenario of political instability, often what market actors need to do is to identify a regulatory failure forcing the policymakers to decide rapidly, in order to eliminate steps related to setting the policy agenda outside the stage. And that seems to be exactly what happened in the case in analysis.

Obviously, some other factors are paramount for this type of action to flourish. Following a synthesis of some of them.

Lack of scientific social researches and population participation

An idea to change the market and a health policy alone do not have fruition without a suitable environment. When Gilson et al. (1) affirm that “it is important to acknowledge the particular value of social science perspectives in the field”, we have to acknowledge different perspectives. The one I will adopt here is related to education in a macro point of view or how lack of education can profoundly influence a process of policymaking.

Academic production related to supplementary health regulation is still limited in Brazil in relation to the speed with which this market moves and requires decisions. This factor can be considered a great barrier to the production of an appropriate health policy to the population. In this respect, a robust and well-founded academic production can provide elements to trace the political agenda, being of fundamental importance in countries whose education level of an important parcel of the population does not allow a more active participation, even when legal instruments are foreseen for this.

The statement of Freudenberg et al. (6) goes in the same direction: “Effective action to promote policies that improve population health requires a deeper understanding of the roles of scientific evidence and political power in bringing about policy change; the appropriate scales for policy change, from community to global; and the participatory processes that best acknowledge the interplay between power and evidence”.

In the case under study, after the analysis of several consumer denounces, three assertions remained clear: the first, that the lack of policies aimed at the elderly population or low-income people without access to public health increased the asymmetry of information regarding prices of products in private health, stimulating people to associate themselves with false institutions in order to comply with legal requirements to contract collective plans – which tend to be cheaper than individuals. Second, this aspect clearly demonstrated that the lack of policy for individual health insurances, specifically to improve and facilitate the access of the elderly and chronic patients, especially those in low-income strata of the society, probably was a vector of great impact allowing some actor to manipulate the society behavior. Fi-

nally, we can affirm that all those aspects correlated, not alone, caused a great asymmetry of information in part of the private health market, driven by the absence of solid studies that could impact on the political agenda at a time prior to the adherence of these people to false institutions. Stimulate research concerning private health market would have been a great resolution to avoid this kind of situation, particularly focusing on studies of population behavior and health market consumer's behavior.

It is also important to acknowledge that part of the regulation problem was generated by, on one side, the needs of part of population – elder and consumers excluded from collective market – to have access to health treatments, private or public. On the other side, the lack of participation of the same consumers in private health policymaking decision. Finding manners to break old patterns that have contributed for social inequalities in policies is very important, as said for Lancaster et al. (7) *“It is our concern to explore how the dynamics of power operate in health policy making processes and to consider new ways of disrupting and challenging marginalisation where it is found to occur. In this context, we suggest that the ‘evidence-based policy’ paradigm and ‘consumer participation’ agenda ought to be considered together, given their potentially co-constitutive power-effects”.*

This case only illustrates how obvious is the necessity to find ways to increase social participation in the policy decisions of regulatory agencies, although how to do this, is not yet clear.

We must also contemplate within this problematic that the consumer has a non-technical knowledge that expresses the routine of a societal market behavior in a very real perspective. However, this knowledge needs a bridge between the public servants and the policymakers to exist.

In a process of policymaking, such knowledge is in general ignored and this also creates the tendency that a norm somehow does not become effective when implemented or even does not integrate the asymmetries of information that occur in the market. The great challenge presented – not only in this specific case but many others within the regulation of private health market is to join in this *subjugated knowledge* (Foucault (8), as Lancaster et al (7) affirm: *“Subjugated knowledges’ are local knowledges which have been “kept in the margins,” that is, “a whole series of knowledges that have been disqualified as non-conceptual knowledges, as insufficiently elaborated knowledges: naïve knowledges, hierarchically inferior knowledges, knowledges that are below the required level of erudition or scientificity”.*

CONCLUSIONS

In this article I have tried to demonstrate how health systems can be influenced by societal and political forces and how social science or the lack of science can define in a large sense the policymaking stage in a country, comparing a specific Brazilian case to Gilson et al's. (1) affirmative.

According to Savigny et al. (9) *“[Governments and liberal democracies] extensively anticipate corporate demands and preferences, building a concern for business profitability into policy-making at the most basic level, and consequently considerably reducing the need for corporations to engage in overt lobbying or observable political conflict”.*

Several are the actors who seek to influence health systems. Public servants often have the arduous task of choosing what at a given historical moment appears to be the best policy for society, knowing that very often, the construction of this framework has already been influenced by political and market interests even before its beginning.

Whatever interests are at stake in any political arena, one assertion seems to reflect the truth: independently of political factors, social scientists and consumers must always join in the process of defining health system aiming at its equilibrium. Still, how to do it is an arduous mission for the public servants and the social science as well.

A practical and functional health system highly depends on active social participation, as the political set is the normal part of this process. While the voices of these citizens are, as Fou-

cault said, subjugated, they will be *outsiders* of the political framework and as consequence will not recognize it as an effective norm.

Although some actors in regulation process seem more interested in the deepening of this exclusion state, contributing to the enlargement of information asymmetry and the gap among social and political stages, the reality appears to be that this situation in a long run tends to point to the breakdown of the health system in a broader view, worsening the social breach and the dissatisfaction among that subjugated voices.

In the end, all we have to ask is: is there any winner?

Acknowledgements: This article would not have been possible without the daily love and committed support of my parents, when two years ago I decided to accomplish my goal of attending a master's degree in the United Kingdom after 12 years of acting in the Brazilian public service. To them I owe my resolute faith in ethical principles, social justice and the strong belief that each and every human being has an important value to life. With them I have learnt to have courage to recommence whenever I need to. To them my eternal gratitude and profound respect. To my brother for his generosity. To some colleagues of the National Health Agency who believe in the greatness and the real meaning of serving the public, particularly those who believed in my potential as a public servant and an empowered woman. This work is especially dedicated to the Brazilian people, for the moving resilience and incredible perseverance in believing in a more just and dignified future and to whom I have devoted my professional life.

Disclaimer: The views and opinions expressed in this article are those of the author and do not necessarily reflect the official policy or position of any agency of the Brazilian government. Assumptions made within the analysis are not reflective of the position of any Brazilian government entity or the Ministry of Health.

Funding: None.

Authorship contribution: AA is the sole author.

Competing interests: The author has completed the Unified Competing Interest form at www.icmje.org/coi_disclosure.pdf (available on request from the corresponding author), and declares no conflict of interest.

REFERENCES

- 1 Gilson L, Hanson K, Sheikh K, Agyepong IA, Ssengooba F, Bennett S. Building the field of health policy and systems research: Social Science matters. *PLoS Med*. 2011;8:e1001079. PubMed <https://doi.org/10.1371/journal.pmed.1001079>
- 2 Dobrow MJ, Goel V, Upshur REG. Evidence-based health policy: context and utilisation. *Soc Sci Med*. 2004;58:207–17. PubMed [https://doi.org/10.1016/S0277-9536\(03\)00166-7](https://doi.org/10.1016/S0277-9536(03)00166-7)
- 3 Soğancı İÖ. Unfolding Meanings: Some Considerations for Qualitative Interview Studies. *Eğitimde Nitel Araştırmalar Dergisi*. 2013;1:88–101.
- 4 Brownson RC, Chiqui JF, Stamatakis KA. Understanding evidence-based public health policy. *Am J Public Health*. 2009;99:1576–83. PubMed <https://doi.org/10.2105/AJPH.2008.156224>
- 5 Rosenthal M. Agenda control in an unstable multiparty parliamentary democracy: evidence from the Israeli public sector. *Const Polit Econ*. 2011;23:22–44. <https://doi.org/10.1007/s10602-011-9113-0>
- 6 Freudenberg N, Tsui E. Evidence, power, and policy change in community-based participatory research. *Am J Public Health*. 2014;104:11–4. PubMed <https://doi.org/10.2105/AJPH.2013.301471>
- 7 Lancaster K, Seear K, Treloar C, Ritter A. The productive techniques and constitutive effects of 'evidence-based policy' and 'consumer participation' discourses in health policy processes. *Soc Sci Med*. 2017;176:60–8. PubMed <https://doi.org/10.1016/j.socscimed.2017.01.031>
- 8 Foucault M. *Society must be defended: Lectures at the Collège de France 1975–76*. London: Picador; 2003.
- 9 Savigny H, Marsden L. *Doing political science and international relations: theories in action*. New York: Palgrave Macmillan; 2011. United States. June 2014. Available: <https://www.cdc.gov/std/program/final-std-statutesall-states-5june-2014.pdf>. Accessed: 12 February 2018.