

# Bioethics perspective model supplemental assistance in Brazil

Regina R.P. Carvalho<sup>1</sup>, Paulo A.C. Fortes<sup>2</sup>, Volnei Garrafa<sup>3</sup>

## Resumo

Este artigo apresenta os resultados de estudo voltado aos planos e seguros privados de saúde, denominado de assistência suplementar, regulamentados no Brasil há mais de uma década para solucionar conflitos na prestação de serviços. A partir de metodologia qualitativa descreveu-se e analisou-se o modelo de assistência, as questões resolvidas, as que permanecem e as que emergiram nesse período. Resultados mostram que o setor suplementar pouco avançou do modelo baseado na lista de doenças e procedimentos, aprovado como plano referência, aumentando os conflitos relativos à incorporação de tecnologias e ao incremento da demanda e dos custos, diante do envelhecimento populacional. Consolidaram-se políticas na regulamentação que ferem princípios bioéticos do Sistema Único de Saúde, na assistência aos mais vulneráveis, às gestantes e idosos. Falta regulação, por parte do Estado, na adequação da área suplementar com outras políticas públicas, no sentido de aperfeiçoar a qualidade da atenção e ampliar equitativamente a cobertura assistencial.

**Palavras-chave:** Brasil. Saúde suplementar. Bioética. Modelo de assistência. Serviços de saúde. Sistemas pré-pagos de saúde. Assistência à saúde.

## Resumen

### Perspectiva bioética del modelo de asistencia suplementaria en Brasil

Este artículo presenta los resultados de estudio dirigido a los planes y seguros privados de salud, denominado de asistencia suplementaria regulado en Brasil hace más de una década para resolver conflictos en la prestación de servicios. Desde una metodología cualitativa, se describió y se analizó el modelo de asistencia, las cuestiones resueltas, las que permanecen y las que emergieron en ese periodo. Los resultados muestran que el sector suplementario poco avanzó desde el modelo basado en la lista de enfermedades y procedimientos, aprobado como plan referencia, aumentando los conflictos relativos a la incorporación de tecnologías y al incremento de la demanda y de los costes ante el envejecimiento poblacional. Se consolidaron políticas en la reglamentación que hieren principios bioéticos contenidos en el Sistema Único de Salud, en la asistencia a los más vulnerables, a las gestantes y a los ancianos. Falta regulación, por parte del Estado, en la adecuación del área suplementaria con otras políticas públicas, en el sentido de perfeccionar la calidad de la atención y ampliar equitativamente la cobertura asistencial.

**Palabras-clave:** Brasil. Salud suplementaria. Bioética. Modelo de asistencia. Servicios de salud. Sistemas prepagos de salud. Prestación de atención de salud.

## Abstract

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This paper presents the results of a study about the private health plans and insurance, called supplementary health, which were regulated in Brazil more than a decade ago in order to solve conflicts in the provision of services. The model of care, the issues resolved, those that remain and the ones that emerged during this period were described and analyzed, using a qualitative methodology. The results show that the supplementary sector made little progress from the model based on the list of diseases and procedures, approved as a reference plan, increasing conflicts regarding the incorporation of technologies and the increase of the demand and costs, due to the aging of the population. Regulatory policies that hurt the bioethical principles contained in the National Health System were consolidated, mainly regarding the assistance to the most vulnerable, pregnant women and the elderly. Regulation is lacking, by the State, in the adequacy of the supplementary area with other public policies, in the sense of perfecting the quality of care and expanding healthcare coverage equitably.

**Key words:** Brazil. Supplemental health. Bioethics. Model of care. Health services. Health maintenance organizations. Delivery of health care.

## Aprovação CEP FS/UnB n.º 041/11

1. **Doctor** pariziregina@gmail.com – Instituto de Assistência Médica ao Servidor Público Estadual, São Paulo/SP, Brazil. 2. **Lecturer** pacfusp@usp.br – Departamento de Prática de Saúde Pública da Universidade de São Paulo, São Paulo/SP, Brazil. 3. **Post-doctor** garrafavolnei@gmail.com – Cátedra Unesco e Programa de pós-graduação em Bioética da Universidade de Brasília, Brasília/DF, Brazil.

## Correspondence

Regina Ribeiro Parizi Carvalho – Rua Coronel Lisboa, 515, Vila Mariana CEP 04020-040. São Paulo/SP, Brazil.

They declare that they do not have conflict of interest.

In 1998, Brazil regulated private insurance plans and health care, which became known as supplementary health insurance, in order to deal with conflicts in providing services to the target population, the economic policy adjustments and the establishment of rules for companies that operate in this market. The regulatory process occurred in the ballast of Health Reform, the implementation of the Unified Health System (SUS) <sup>2</sup> and the expansion of the Brazilian bioethical debates, since that various social actors who campaigned in the reform process were the same who introduced bioethics in Brazil <sup>3</sup>.

The period, since the adoption of the regulation of the supplementary sector, was characterized by the expansion of economic globalization, the increase of private participation in health care in many countries <sup>4,5</sup>, for the advancement of science and the incorporation of biotechnologies in medicine, which were followed up in Brazil, of economic changes and demographic transition, with the increasing aging of the population <sup>6</sup>.

It is in this context that the regulation which occurred in the Brazilian supplementary health care model was described and analyzed, from 1998 to 2010. This work, without the pretense of exhausting the subject, sought to broaden the debate on the model for assistance and private insurance plans, by using as justification the bioethics of intervention (BI) <sup>7</sup>, which calls for the application of ethical references, especially the equity, as a guiding principle for policies and programs, whether in the public or private sectors, with the perspective of achieving a more egalitarian horizon in the health status of the population.

## Method

The work was developed in two stages. The first one was data review, study of the literature and documentary research, substantiating the theoretical and methodological framework and research strategy <sup>8</sup> of the following categories of analysis on the regulation of the supplementary sector: regulatory framework, legal, assistance, administrative/operational and economic/financial issues, opinion of the social actors, international scene and bioethical issues.

The second stage was characterized by exploratory and field research, aiming to deepen and broaden the representativeness of the issues discussed, by electing the Supplementary Health Chamber (CSS), from the National Supplementary Health

Agency (ANS) <sup>9</sup>, as a privileged space for participation in the regulatory process. By respecting the criteria for membership of the Chamber, we selected a convenience sample, with twelve representatives of entities, from medical area, consumer protection, the health plan operators, service providers, the unions, the regulator and the social control of SUS. Issues contained in the categories of analysis mentioned before were presented to respondents, as subjects of the interview, allowing their free expression.

The theoretical set of data and field research were analyzed, by taking into account the methodological foundations which recognize the challenges of such pathways to knowledge, the link between the subject and object of research and the need for overcoming the dichotomous debate between qualitative and quantitative research <sup>8</sup>. In this sense, the ideas of Habermas were taken as reference <sup>10</sup>, which analyzes language as the central core of knowledge, emphasizing the need to study the context and observation of praxis, because given the lack of transparency, it is necessary to admit the truth as provisional. Such measure is necessary, since the actors involved in the process – the observer and the observed – have interests, which change according to the dialectical transformation of reality.

Regarding the bioethics of intervention <sup>7</sup> the importance of systemic thinking and the analysis of the complexity of phenomena in health field were considered, as well as the need to the establish ethical references – equity, protection and justice – for the analysis of information collected in the elaboration of policies and programs which prioritize the most needy and vulnerable people, aiming to promote a greater balance in health, in before the unequal living conditions of them.

It should be noted, however, that this work is part of a larger study. For reason of space, we will only present a part of the results obtained in relation to assistance issues, the views of social actors and bioethical issues.

## Result and discussion

The assistance model of care plans and private health insurance is provided by Law 9,656/98 1, with reference to the list of diseases of the International Statistical Classification of Diseases and Health Problems (ICD) of the World Health Organization (WHO), <sup>11</sup> as well as the list of procedures for obligatory coverage <sup>12</sup>, which became known as the Reference Plan of Healthcare, set out in article 10,

of the mentioned law, whose provision became a obligatory minimum condition for registration and operation of operators in the health insurance market in Brazil.

### *The regulation of the assistance model*

In the period from 2002 to 2010, new coverings were added to the initial list, according to the scientific and technological upgrades in biomedicine. These increases were related to both the new procedures incorporated into the routine care as a result of technological advances, and the demand of society – the case of procedures dealing with family planning<sup>12</sup>.

The debate, according to interviews with representatives of consumer protection and the National Health Council (CNS), which participated in the CSS, as well as pressure for new coverings, particularly in the areas of new surgical techniques, with the inclusion of orthoses, prostheses and medications, and with frequency, they are coming to the courts in the search of a decision for such conflicting issues. This movement has been called “legalization of the right to health”, in relation to which Scheffer analyzed<sup>13</sup> negatives to the access to the coverage by operators, revealing that, in addition to the issues described, there are also demands for the procedures which have not yet consolidated in the clinical scientific protocols or authorized by the National Health Surveillance Agency (Anvisa).

A research carried out by Oliveira<sup>14</sup> examined legal demands for assistance coverage in a case study of a self-management operator, from 1998 to 2009, checking the increase of 23.8% of the legal demands in such period. The predominant reasons were conducting gastropasty (obesity surgery), payments of spas, deployment of orthotics and prosthetics, medicines of high complexity, among others.

The list<sup>12</sup> of obligatory coverage of the plans, therefore, remains an important instrument both for the population and for the regulation of ANS, because it eases the monitoring of scientific updates, supervision of coverage restrictions and possible deviations of demand whose issues were central to the process which caused the regulation of insurance plans, but they still remain in the list of complaints about the sector in the country. In contrast, it is also true that it promotes a model of care based on the consumption of services, notably in a specialized and fragmented way, without a line of orientation and care, which makes the costs in health care increase, and it is not always associated with

the consequent improvement in the health status of beneficiaries.

This model of health care has gradually been discussed in regulation, according to the manifestation of ANS representative, because which is established as a basic and minimum plan that an operator should ensure in the product offered in the market, and this is which predominates in the Law 9.656/98, in addition to segmenting option of plans with ambulatory/hospital coverage or only hospital with only antenatal service.

However, Normative Resolution (RN) 139/06, approved by the ANS in 2006, changed part of the logic of this model when it established the Program of Qualification of Health Insurance, introducing the performance evaluation of operators of the plans and health insurance. Part of the program is based on the evaluation of morbidity and mortality indicators of care provided to beneficiaries and the development of programs for health promotion and disease prevention<sup>15</sup>.

The program was introduced in stages, by composing a set of indicators that measure the quality of care provided to beneficiaries/clients of the company and they are transformed into performance grades for each operator, which are reported annually to communication bodies. The debate on the model of care was stimulated before the absence of programs for health promotion and disease prevention in the supplementary sector, as well as problems related to late diagnosis of neoplasias, after-effects of chronic diseases and questionable clinical behavior, such as the high percentage of surgical childbirths (cesarean sections), among other issues. Regarding the necessary measures, these involve aspects of compatibility with SUS guidelines, regulation of operators, of the professional practice and the ability of the assistance network in the country.

According to the respondents, another issue related to the assistance quality was the establishment of the agreement with ANS and the national medical organizations, entitled Guidelines Project<sup>16</sup>, whose goal was to update information and recommendations on the prevention, diagnosis, treatment and control of diseases listed in the CID, based in evidences published in scientific medical literature. Data analysis showed that until June 2011 were offered 82 guidelines for treating diseases, disorders and grievances prevalent in the population. Although in a greatly reduced number before the list of diseases which are part of CID, the instrument has also integrated a set of measures which aimed a higher quality in the provision of care within the supplementary sector.

A case study of a health plan operator, performed by Kanamura <sup>17</sup> has shown the magnitude of expenditures on medical and hospital assistance, particularly when they are associated with procedures involving high technology, chronic disease and people who are over 70 years old. The higher expenses in 2002 were analyzed, in relation to which the author found that 36.2% of the funds were spent only 1% of the target population of the plan.

Questions about this model of care to health were also pointed out in the thesis of Hernandez <sup>18</sup> in a longitudinal study carried out from 2000 to 2006 with 2,143 elderly people aged 60 and over, with and without health insurance in São Paulo. The author concluded that the associations found with the dependent variable above is more related to social and demographic issues, and access to services rather than differences in health conditions of individuals who used the public or private assistance. In the results, she also discusses that the most diagnosed or associated illness amongst the holders of private and plans insurance, with respect to the ones who only used SUS was osteoporosis.

Thus, although these issues have a direct cost in the expenditures of the plans and indirect cost related to the volume of cases which are being processed in the judiciary, it was not verified in the period studied other initiatives of the regulator body, in conjunction with the operators in order to perform investments in the area of cost-benefit assessing of incorporating these new biotechnologies, as pointed out in some interviews with operators of health plans.

ANS approved RN 264/11 <sup>19</sup> and RN 265/11 <sup>20</sup> in order to increase the adherence of the beneficiaries to the initiatives of health promotion and prevention of diseases, by creating mechanisms of pecuniary incentives for the participants of the programs. However, there are missing joint public policies that encourage more integrated programs, for example, in the area of Occupational Health with the Ministry of Labour or the Active Aging with SUS/MS, among others.

The reflection considers that integration and adequacy of these programs would be advisable, since over 70% of the beneficiaries are from group plans, in which workers, in their majority, count on different services and programs in the assistance areas and health of the worker, as well as there are no specific policies to prepare for retirement and the importance of active aging for good health conditions and quality of life – which are priority issues in the agenda of trade union interviewed.

### *Ethical issues of the assistance model*

This fragmented model based on the consumption of services, without the establishment of a line of care with the patient, which was observed in the model of supplementary assistance, shows relationship with the health model called by Sfez <sup>21</sup> as *perfect health*. This, according to the author, was the result of a critical study developed to investigate “new utopias” and it was carried out with the upper classes of the United States, France and Japan in 1997.

The survey revealed that, for this population group, the representations of health and disease were linked to the body and the ecosystem, and subject to correction by the credit given to the new knowledge in the field of biotechnological science. Thus, the genome project started to represent the guarantee, in the future, of preventive correction of “imperfect bodies”, while the fourth generation medicines could ensure the health recovery with minimal side effects.

In this model, the individual would become responsible for the maintenance and improvement of his body in relation to the diets, the physical exercises, and to skin care, besides abandoning lifestyle considered harmful to health. Therefore, people would start to count on, in order to maintain a youthful and healthy appearance, a medical arsenal and clinical services such as aesthetic and reconstructive clinics, gymnastics and slimming gyms.

The interest in this project, according Sfez <sup>21</sup>, was not related only to the population but also to the biotechnology industry in the areas of drugs, orthotics, prosthetics and other materials that are part of the health industrial complex, as well as plans and private insurance, which are interested to reduce costs and increase profits, and governments – in order to reduce their budget costs with health.

Lehoux <sup>22</sup>, in 2002, when he was evaluating the difficulty to determine the meaning of medical practices only in the clinical plan, stressed that the biggest challenge is to analyze the tensions between the market value of technologies in health; which is what the producers report, once they are introduced to the market, the clinical value, i.e., which they provide from the knowledge and practice of health professionals and social value, the positive and negative changes resulting from its use.

These aspects have been also deepened the bioethical discussion, especially on the policies of incorporation of new biotechnoscientific knowledge, which have increased the ability of intervention “in being born, living and dying” <sup>22</sup>. At the same time in

which the debate emerges from about new health technologies, Latin American authors<sup>23</sup> developed a critical current – which is called as bioethics of intervention –, which is geared mainly to analyze health in countries of low and middle income, pointing to of the need to expand the look even more, both for emerging issues in the light of new scientific knowledge, as to persistent issues aggravated by the inequalities generated in the expansion of the economic process of globalization. Accordingly, Garrafa and Porto<sup>24</sup> warn that is necessary to aggregate, in the social value of these technologies, the condition of accessibility to people, so that they do not become another factor of inequality in health conditions, and widening existing inequities.

All these issues are being increasingly more determinant in the assistance policies and rules, which in the private sector are also aligned to the financial stability and profit margin, which can generate further inequalities, conflicts and differences in health care. This statement corroborates the interviews with representatives of organizations, members of the CSS. According to the participants, such distortions occur in the policies of the supplementary assistance in relation to the needs for health plans use by pregnant women, as well as the increase of needs for pre-existing diseases and worsening of the value of the plans for seniors or interference in the autonomy of professionals, creating situations which are not always compatible with the ethical and moral values that society designs in health.

In these interviews, in parallel, operators complained of increasing difficulty in making individual interests for the use of services with the financial sustainability of collective care plan compatible, on the degree of incorporation of technology in medicine and increased demand due to aging, leading to decreased and concentration of plans and insurance market. In this sense, Habermas<sup>10</sup> brings a central discussion about conflict situations apparently irreconcilable, claiming that all the actors have interests and these should be made explicit in the arenas of debate. It is argued that truths are provisional before the scenarios in constant transformation and, consequently, the change of interests. Thus, it is important that the spaces of dialogue allow explaining these interests, the greatest possible transparency of the information and the dynamics of interim and liable to new assessment agreements, since the truths and interests are also provisional.

Applying Habermas' argument in light of BI, it can be said that, in these spaces, it is essential that the Ministry of Health (MS) takes its regulato-

ry role, by explaining the differences of interests, providing reliable information, and promoting the possible agreements. Moreover, and above all, its institutional role should be to harmonize the activities of the private supplementary sector, coordinating institutionally through ANS, with the ethical guidelines of the SUS. The principles and guidelines of the System are achievements of the citizens, approved by the population, in line with the agenda of multilateral organizations. These assumptions are discussed in the BI<sup>7,24,25</sup>, and pointing to the need for effective policies to protect the most vulnerable population.

It is worth noting that BI is focused on the most vulnerable parcels of collectivity, featuring these sectors of the population not only in arising from the lower purchasing power, but also as a result of exposure to more fragility – as occurs with children, pregnant women, elderly people, people with disabilities, among others. Thus, for this current of bioethics, the social adverse conditions cannot be traded, in relation to factors that may increase the condition of fragility. Under this perspective, BI is consistent with the constitutional principles which ensure that health is a right of the citizen and a duty of the State, which has a population assistance funded by population through their contributions of tax payment to the government or to the private sector, both for reduce their risks of health problems as to contribute to the dignity of human life.

Finally, it is important to bring to the conceptual discussion a key criterion, advocated in under the principles of SUS regarding BI: fairness. The world, with so many differences and inequalities between individuals and peoples, requires application of the principles that make possible covering diversity. Equity, which is a conceptual tool that allows to equate inequality without eliminating the differences, is one of the few criteria that takes this capability. As revealed by Almeida<sup>26</sup>, the notion of fairness has been applied with different understandings, because it is polysemic concept that reflects the values and choices of a society at a historical moment.

The central importance of fairness concept in bioethics, as well as their different interpretations, was reaffirmed in a study carried out by Fortes<sup>27</sup>, in 2010. By interviewing Brazilian scholars, he pointed out five central ideas about fairness, and the most expressive one was found in the study and also supported by BI was the different treatment before unequal conditions and needs which are presented to people, in order to achieve a more egalitarian horizon, aimed at health.

However, the implementation of equity in health policies and programs requires constant monitoring, evaluation and a dialectic discussion of the results found, since that its application occurs in certain scenarios for permanent transformation. Such scenarios and actors, in turn, will pass by other changes to the implementation of equity measures, which may result in distortions, such as increasing inequality, which should, then, be evaluated and corrected *pari passu* in the course of the trajectory.

### Position of the organizations

The equity, which is a concept employed by BI and it more significant in the studies of Fortes, has expanded geographically in the health field, such as in SUS, and this principle have been approved among all member countries of Unesco<sup>28</sup>, in 2005, in the *Universal Declaration on Bioethics and Human Rights*, which in point (i), paragraph b of Article 14 on Social Responsibility and Health, in an equally the issue of assistance as the *access to quality health care and essential medicines*.

Before international bodies, Brazil has reiterated its commitment to health as a fundamental and equitable, which is feasible due to public and private policies which promote better living conditions and social inclusion. Recognizing the need to access health care quality and essential medicines equitably to the most vulnerable groups of the population (women and children), which translate into themselves the essential nature of life.

Thus, the regulatory rules of supplementary assistance, for example, shortages and worsening of financial values for services of pregnant women and children, should be submitted, by ANS, to the compatibility with the principles and guidelines of SUS because the fact that it is a type of private service does not give autonomy in relation to the precepts approved for health in the Brazilian Constitution.

In the specific case of the regulation of the supplementary assistance, it is also necessary that there is room in the regulatory agenda for points that encourage discussion of conflicts and bioethical issues that interface with the assistance issues. Because, as evidenced in interviews with members of the CSS in this study, the approach and resolutions restricted to the technical and administrative sphere have not contributed to reduce conflicts, promote a better assistance and improve the law.

SUS and ANS can and should deepen the debate regarding the care model, seeking to qualify the public-private partnership between the SUS and

the supplementary assistance sector. Before the worsening of the problems, these instances of implementation of health policy must define and enforce clear rules regarding all private services, and not limited to occasional and fragmented interventions. The best governance of these sectors, however, requires guidance and goal, which, in Brazil, must compete primarily toward the universal access to health care.

WHO<sup>29</sup>, in 2012, dealt with the financing and universal coverage of health issues as priority themes. Their analysis shows that, annually, approximately 150 million people worldwide depend on the payment of their own, in order to guarantee their assistance. From these ones, 100 million are pushed below the poverty line exactly as a result of these expenditures.

This scenario has indicated a large number of unassisted people, which is a framework that probably will be exacerbated in the economic crisis of the European countries. The economic problems in that continent have set co-payments to people at time of service, even in the public sector. The gravity of the situation is revealed by the significant number of bankrupt families due to private expenditures on health care.

WHO has pointed out that the form of pre-payment, either to the public sector through taxes, whether for private, through tuition, is still the best form of health financing, because besides allowing a better condition compatible with family budgets, it prevents the submission of people to additional suffering at the time of service. According to the organization, this type of payment tends to decrease the vulnerability of the patient at the time of treatment or hospitalization, since the services have been funded forehand, even before the onset of illness.

Health costs have also been subject of discussions regarding public budgets. WHO estimates that the waste of resources would be between 20% to 40% of the total employed. The great incorporation of technology, aging of the population and the care model based on excessive consumption of more complex diagnostic and therapeutic services have led to the unprecedented rise of costs of the assistance.

Bioethics, as well as BI, has been shown as an essential tool in discussions of health systems, because when dealing with specific issues, it has the ability to extend the analysis to more general topics, while maintaining consistency with ethical principles and at the same time allowing discussion of the adversary, which, as Habermas<sup>10</sup> says, is nothing

more than the flip side of the same reason. The universalization of access to assistance, from the perspective of BI, is a non-negotiable principle, since it is essential to life. Therefore, interests, conflicts and disagreements should be exposed and discussed, as well as propositions, and renegotiating agreements made, because they are inherent to human life, which, in turn, depends on the health condition.

In parallel, as stressed before, the issues discussed here are part of a study that examined the regulation of supplementary assistance in Brazil, in the last decade. In this, we analyzed other categories that affect the assistance model, as the regulatory framework which termed the supplementary health sector, but in practice it is assistance and it is not “supplementary”, whether in the way of funding, because it allows tax breaks, whether in the development of assistance actions, because it doubles the access to certain strata of the population, if it is compared to the assistance provided by SUS.

Other issues discussed, such as economic and financial, administrative and operational issues, and the international scene also interfere in this relationship. Because having health as a business condition, with predictability of earnings (commodification) and concentration of network services in the private sector and in the more developed states, as well as the internationalization of finance capital in healthcare companies certainly will aggravate conflicts of different orders, especially the assistance model that – in this context – will be increasingly standardized according to business logic and profit, regardless of cultural issues and own health demands of the country.

### Final considerations

The additional assistance in Brazil was regulated for more than a decade, with the approval of Law 9.656/98, which gave the state the power to registration, regulation and supervision of plans and private health insurance in the country. This allowed for the period from 1998 to 2010, advances in establishing rules for operation of these operators, “making the market healthy”, increasing the financial and contractual guarantees to consumers, information flow and operational control over the companies.

The sector, however, had a little progress of the assistance model referenced in the list of diseases and procedures than the one which is not provided by law or demand of society itself. Studies have pointed out the high cost and lack of signifi-

cant differences, of the model, in the impact of the health conditions of the people who use the public or private sector, although this last one relies on increased funding and better access to services and new technologies.

This form of assistance, although eases the monitoring and supervision of the coverage of the services offered by operators plans and private health insurance also has stimulated the implementation of assistance model based on the consumption of complex and fragmented services, stimulating the process of “legalization” of assistance to health, before the negative or the lack of predictability of coverage.

ANS has instituted programs of supplementary health qualification, by introducing new care in the assistance plan, but still with incipient results. In a general way, it appears that lack of policies which can assess and incorporate biotechnologies and a greater integration with other public policies, such as those ones related to the labor world and the aging process.

In the bioethical field, especially of BI, the understanding is that MS must take its role as the greatest health regulator instance, including regarding ANS, aligning the model of supplementary assistance with the principles and guidelines of SUS. This process would promote a greater adaptation to the policies and programs of SUS, especially regarding the protection of the most vulnerable people, such as children, pregnant women, and the elderly people, among others. This would run even to reaffirm their commitments to the international level, with multilateral organizations.

The model of health care is critical to BI, because it brings consequences in health financing, organization of service providing, in public-private partnerships of assistance and in incorporating biotechnologies. Each and every one of these aspects should be discussed from the principle of equity, with the goal of making the access to health care universal, which is a greater expectation of society.

Finally, with the worsening crisis in assistance to health in many countries, due to the economic downturn, population issues, the lack of technological resources, in addition to the persistent problems in low and medium development countries, it is essential that Brazil and its organizations discuss this scenario, the model of care and the form of funding, as well as how participation should occur and the regulation of the relationship between the public and private sectors in the SUS.

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**Participation of the authors**

Regina R.P. Carvalho carried out, in her condition of doctoral student, the research which originated the article, which she wrote and revised. Paulo AC Fortes participated of the critical review of the work, contributing in the adequacies to the final formulation. Volnei Garrafa participated of the conception, designing and critical review in his condition of guide of the thesis and the article.

Received:: 21. 7.2012

Reviewed: 29. 3.2013

Approved 22. 6.2013