PAPER TO CONCLUSION OF THE MINERVA PROGRAM ACTIVITIES

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HEALTH MARKET REGULATION

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Introduction

Regulation of Market is a very recent concept inside the health sector in Brazil. This issue started to grow from the promulgation of Law 9,656 of 03/06/1998 that it makes use on the plans and private insurances of health assistance. The National Agency of Supplemental Health itself, was only created in 2000, through Law 9,961 of 28/01/2000. In this way, the quarrel about the subject still needs to be deepened and to be extended.

The concepts brought of the Economy for the nucleus of the issue - not concluded yet - about the performance of the State in the health sector, well are not consolidated in the institutions of the sector, regardless if they are public or private. It can be, frequently, seem in quarrels about access to the services offered by the SUS – National Health System, the expression regulamentation to be used in regulation place and vice-versa and to be placed in an eddy of concepts that includes auditorship, control, monitoring, evaluation and others.

Economic concepts such as demand, supply, marginal cost, imperfection of market or efficiency, are not well known, or are used in accordance with the common sense by actors of the health sector in the State of the Bahia, focus of this work.

Some conceptual severity seems to be necessary. The appropriation of knowledge brought of the Economy to the health sector, will be able to bring greater consistency to the issue about market regulation as a form of state intervention in the private market of health, and in the same time, it could conclude the semantic and conceptual mistakes as the use of the expression regulamentation in regulation place, or regulation meaning management of hospitals beds or management of other available services of SUS.

Perhaps in the efforts for organizing the emergency services through the work of the Brazilian Emergency Net together to Health Ministry, it has initiated, in a more common way, the use of the expression **regulation in health** meaning rational allocation of resources (scarce) in the scope of the public system of health. In the truth, one was arguing a more rational model of **management of resources** and not regulation of the health market - concept ampler than that one.

This work intends, then:

1. to rescue the regulation concept, leading it toward its economic direction, and put it again, in the interior of the quarrel on the intervention of the State in the health sector,

2. to debate the contribution of the PLANSERV - Assistance to Health of the Public Servers of Bahia - as the biggest operator of health plan, main purchaser of services and products from the private market of health in Bahia, for the process of regulation of such market.

To reach such an intention, the work is divided in following sections.

A - Understanding the Market of Health: showing some necessary economic concepts to understand the regulatory process and the peculiarities of the health market;

B - Understanding the Regulation of the Health Market: showing the main concepts in regulation, in order to contribute for the issue on the participation of the State in the health market;

C - The American and Brazilian Experience: showing, only as illustration, some aspects of the model of regulation practiced in the United States and also presenting the Brazilian experience, under the logic of its agency of regulation, the ANS - National Agency of Supplemental Health;

D - PLANSERV a Proposal of Regulation for the Bahian Market: presenting the PLANSERV, public agency of the Government of the State of Bahia and arguing its regulatory capacity inside Bahia's market.

E - Conclusions

A – UNDERSTANDING THE HEALTH MARKET

GENERAL CONCEPTS

The necessary and sufficient economic concepts for the introduction of the issue of the health market regulation are under discussion here are: market, monopoly, oligopoly, monopolistic competition, good-public and others, so that the final issue about the function of PLANSERV as regulatory agency, can be better understood.

Market

Market is the relation between all the potential buyers and sellers of one commodity or service in particular. To depend on the number of participant sellers and the relation between them, the markets can vary from monopolies to perfectly competitive ones.

Structures of Market

The monopolies are markets characterized by the existence of only one producer of a certainty good. This situation represents the biggest possible concentration in a market. In this case, the price can be determined by only one of the participants: the producer. The monopolies constitute an failure of market, because it can separately influence the price, concentrating the economic power in its hands.

It has, however, some situations where the monopoly is the desirable form to structuralize a market, showing itself as the most efficient solution from the economic point of view. In such a cases promoting the competition, would impose great costs to the society. In some industries, the existence of significant economy of scale can create a situation of natural monopoly, where the average cost of production of a good falls for beyond an excellent extension of demand for that good. In these cases the monopolies are desirable, because one only big producer will be able to produce the good at a lower price than the reached ones in a competitive market. Monopolies, however, tend to be allocatively inefficient, because to maximize profits, they diminish the production to a level below of that one considered socially excellent and practice prices higher than those of a competitive market, even so are producing to a lower cost than these markets, as seen before.

In the health market the conditions are not propitious to the existence of monopolies, because the potential social exclusion that this type of concentration of power can cause. The regulation can, in this case, stimulate the competition and, in this way, reduce the prices and promote greater equity in the access. Moreover, it cannot speak in monopoly or another structure of market for the health market as a whole, since it is formed by

some segments with different behaviors. For instance, examinations and procedures of high complexity as those that need image of high definition, can need bigger concentration of market, in order to have scale. In general this segment needs high initial investment and has relatively small demand when compared with the demand for medical consultations for example. In these cases the creation of barriers could function as a regulation tool, whose objective would be to stimulate the economy of scale and the consequent reduction of the production cost.

The perfectly competitive markets reflect a structure of market without the necessity of imposition of barriers, completely free and has functioning sufficiently clearly. They are characterized for great atomicity because they have infinite sellers and buyers of such way that none of them, separately, can intervene with the market price; its products are homogeneous, since any change made for a seller, immediately will be adopted by its competitors, in order not to lose purchasers; they take care of to the Principle of the Rationality, through the which sellers and purchasers want to maximize its profits, its satisfaction, through rational actions; it does not have information asymmetry; it has great mobility of good, or either, it does not have transport costs; it does not present externalities - influences of external factors in the costs of the firms or the satisfaction of the customers and also use factors of production in perfect competition.

The health market also does not behave as perfectly competitive for not presenting homogeneous products and presenting some barriers to the entrance of new firms. The products and services of the health market differentiate itselves for the close relation that keep between its production and the knowledge of who produces them. To be taken care by a doctor "X" can imply such a great difference, as live or die, given the biggest knowledge that such doctor can accumulate in its day-by-day. Thus, the ability, attitude and knowledge of who produce can make all the difference, becoming the product, or service, differentiated. The necessary knowledge to the market and the cost for its attainment, beyond the necessity of association, reserves of patents and tradition are relevant aspects in the health market consisting in barriers to the entrance of new competitors.

These two extremities are presented here as an ideal, they are not realistic, It is just to show the differences most important between them and to propitiate the understanding about how health market structure itself inside the spectrum that goes from a extremity to the other. Between them, there are hybrid structures, some look more similar to monopolies, others to perfect competition. Picture 1, summarizes the characteristics of each structure.

The health market seems to behave more as monopolistic competition, if looked from the point of view of the services renders. This structure if characterizes for unrestricted entry and exit, in spite of some existing barriers as above discussed, and a large number of independent sellers producing differentiated products. In this case, it is not important if the product differentiation is real or not. What it matters here is the perception of the consumer, because it is this perception of the differentiation existence or not, that it will intervene with its decision of purchase. In the market of health that is easily perceived as discussed above. Two different doctors take care of the same patient of different forms and the patient will perceive the difference between them. More than this, the patients will be able to see significant differences between doctors of the same level of knowledge, to depend on the form as it treats them, the environment where it takes care of them, or of other aspects that involve them in that moment where the attendance was done.

Oligopolies are markets, whose structure is characterized by the presence of few firms producing all or the majority of the output of some good that may or may not be differentiated. The number of competitors is characteristic remarkable of this structure. In the perfect competition and the monopolistic competition there are a great number of firms, while in the pure monopoly, there is only one. The oligopoly is placed between these two extremities. The presence of a small number of participants, determines one strong relation of interdependence in taking decision inside the market. Each action of each firm will be observed and will intervene with the behavior or the decisions of the others that immediately will react.

Picture 1 - Synthesis of the market structures

Structure	Objective of the company	Number of firms	Type of product	Access of new companies to the market	Profits in the long run	Examples (approached)
Perfect Competition	Profit maximized (1)	Infinite	Homogeneous	Do not exist barriers	Normal profits	Hortifrutigranjeiros
Monopoly	Profit maximized (1)	One	Only	Barriers (4)	Extraordinary profits	Steel straws (Bombril)
Monopolistic Competition	Profit maximized (1)	Many	Differentiated (3)	Do not exist barriers	Normal profits	Physicians and dentists
Oligopoly - Classic Model - *Mark-up* Model	Profit maximized (1) Mark-up maximized (2)	Concentrated oligopoly : Few firms Competitive oligopoly: few firms dominate the sector	Homogeneous or differentiated (3)	Barriers (4)	Extraordinary profits	Homogeneous: Aluminum (CBA, ALCAN, Alcoa) Differentiated: automobiles

1- Maximized profit: prescription delinquent = marginal cost
2- Mark-up = sell revenue – handle rights
3- Differentiation due:
- characteristic physics (power, chemical composition)
- promotion of sale (advertisement, attendance, free gifts)
- packing
- maintenance
4- Barriers to entry:
- monopoly/ oligopoly pure or natural, which had the great scale of production
- reserve of patents
-control of basic raw material
- tradition

Source: Vasconcelos 2002

HEALTH MARKET

When it is about health market, what is it speaking of? The Brazilian Constitution of 1988, says that health is a right of all and a duty of the State. Is the health, in fact, a good that must be provided by the State?

The State intervention in market is not well succeeded in promoting economic efficiency, especially if we look the question from the liberal point of view.

There are, however, at least two situations in which such intervention is desirable, because in those cases the market would not function in an efficient way: public goods and externalities.

Health and Public Goods

Public goods are those that benefit all consumers, such as national defense. A public good will be undersupplied by a market when consumers cannot be excluded from sharing in its benefits and thus have no incentive to pay for its production (Browning-Zupan 2004). This expression is used for economists not to refer to goods provided by the government, but to assign goods that present definitive characteristics, from which the most important are: to present consumption not-rival and to be not-excluding.

To be not-rival means that, given a certain level of production, the consumption of the good for personal one do not diminish the amount of the good that could be consumed by another one. In other words, the consumption of a not-rival can occur in a simultaneous way for many people. Once produced, the good will be available for all the consumers without affecting the level of individual consumption.

Not-excluding is the characteristic that a good can not be consumed in an exclusive way for none consumer, or to demand a very high cost so that it could be consumed. By this characteristic, once produced, it is not possible confine, or store the good, or its benefits in such a way that it could be offered to an only consumer. A classic example of this kind of good is the public illumination. Once offered, it is not possible to capture its benefits for only one consumer.

Although these two characteristics almost always appear together, they are distinct and they can appear, also, separately.

Externalities

Externalities occurs when, in the process of production or the consumption of a good, it produces beneficial or harmful effect to individuals not directly involved in the market exchanges. When such effects are beneficial are called positive externalities or external benefits, and when they are harmful, negative externalities or external costs.

The expression externalities are used to indicate that these effects are external to the directly involved parts in its production. The pollution caused for the paper plants is an example of negative externalities. The individuals that suffer with such pollution, are not directly involved with its production. The pollination of orchards for bees of a neighboring apiary is an example of positive externalidade and its benefits for the producer of fruits had not been gotten by its direct action, as well as beer cans consumed in the Carnival of Bahia for the people that collect empty cans for recycling. The directly involved ones are the ones that produce and the ones that drink beer, but additional benefits are received by people that collect the cans, who in turn produce more positive externalities, since they clean the streets.

In the health market the vaccination, for example, produces benefits for all the society and not only for that who was vaccinated, since it diminishes the risk of all the individuals to contract a certain illness, against which the vaccination is being effected. In the other hand the indiscriminate use of antibiotic with ample spectrum that shows a benefit for a group of patients, can select the communitarian flora microbial, in such way that it reduces its effectiveness in treat others patients who will be contaminated by selected communitarian species and resistant to those antibiotics.

These are few examples, but if we think that a healthier population or, at least, without illnesses, increases the productive capacity of the work force, can itself glimpsed all the benefits for the society in general, that the relations of purchase and sell inside the health market can reach.

Relevance of Health Market

In an only example can be perceived the relevance of the health sector for the society. If a patient with Meningitis Meningococcal - infect-contagious illness of high virulence and high lethality - was left without attendance, what could happen to the society? The answer is simple and obvious. The patient would die, but before dying, he would contaminate many people, over all children, and these would contaminate other people. At the end, an epidemic would be occur. This example means that people cannot without assistance, either for

humanitarian reasons, or for social reasons as to avoid an epidemic, or for economic reasons as the high cost to stop an epidemic or the high cost of lost days of work, what reduce the production of goods.

The extension of the health market

Health market involves the purchase and sellers of products and services that are not public good and that are oriented to the maintenance or reestablishment of health, considered here as illness absence.

Another concept of health, however, must be discussed, in order to extend a little more, the quarrel about the characteristics of this market. The World Health Organization - OMS adopts the health concept as "full state of welfare, physic, psychic and social".

Considering the concept brought for the OMS, the limits between illness and health become more inexact, in such way that between being with totally healthy and being totally sick, exists a wide spectrum of possibilities involving each one of the aspects of the life above considered by the concept. The health can be seen, thus, as one of the extremities of a complex process that extends from the full health until the full illness. The health market would have to be, then, prepared to take care of all the necessities generated for this spectrum. In fact, the extension of the health market in Brazil is not this. Nor it seems to be in the rest of the world.

It is common between professionals of the health sector, be public or private, hear the expression: "we are working with illness and not with health". Rigorously, the health market would have to offer products and services, whose objective was the extreme health of the process health-illness and not the extreme illness as it seems to be its focus.

It is unanimously accepted by sector that a market, whose focus was the health, would have other aspects and would involve products and services very different from those that are commercialized today. Basic sanitation, infrastructure, education, leisure, housing, environment pollution free, would be the products of the front of that market. But secondarily, it would be necessary to commercialize hospital medicines, materials and medical services.

This macroscopic vision of the necessities in health extends for other sectors of the economy, the capacity for supply them. Health is, then, a multidiscipline and ample question. So ample, that it is not possible to be taken care by an only market.

In the impossibility to take care of all the health sector necessities, the specialization of the health market was happening, then, in the direction most tangible, concrete and possible to be apprehended by an only market: the extreme illness! E this market started to turn around medical knowledge, knowledge capable to finish with the illnesses and to be sold under the form of products and services.

As seen before, the amplest health concept brings in itself a load of subjectivity, impossible to be captured in a simple form and easy to be consumed for the market: physical, psychic, social welfare, how to measure, to pack and to sell such things? The face most concrete of the health is the illness, then deal with the illness, can be shown as the easier form for sell health. At least, the form most mercantile of the question.

It can be said, finally, that the health market characterizes for a **specialization in treat illness** and not in preserving or promoting the health. Such specialization leaves many other necessities in health for being supplied for other markets, or simply without being supplied.

When individual perceive itself as sick, or next to the extreme illness, they search their immediate return to the extreme health. The health necessity, in this case, will be translated by search of services and products, inside and out side market, whose acts on the illness, so that it can return to the health state. The same does not happen when they are healthful, or if they perceive themselves thus.

The individuals perceive its necessities in health better, when they are sick and not when healthful. And perceives health as illness absence, searching, thus, avoid the illnesses in order to come back to perceive themselves as healthful. This strengthens the idea that the illness is more mercantile than the health properly said.

The extension of the health market is, then, restricted to the necessary products and services to combat illnesses. In this way, medical consultations, hospital, medicines, materials and services are what it is commercialized in the health market and do not present characteristics of not-rivalry and not-exclusion. Therefore such products and services cannot be considered good-public. For they, are valid the market rules, what restricts the necessity of State intervention to its regulating paper.

Characteristics of Health Market

Let us consider, in detail, this aspect of the individual behavior that influences the market: the perception of its proper state of health. Different individuals have different perceptions on one same state of health. For one same body temperature, for example, an individual can decide to buy antithermal and another to wait more

time, or consider unnecessary the use of a medicine. In this aspect, the health market is similar to others markets, since its purchasers can decide for the purchase or not from the perception or valuation that makes about its necessity, using the available information. It means that the health market is characterized by high degree of uncertainty. As because never one knows to certain when an illness will occur, as because when it really occur, no one knows, in what moment the individual will perceive itself as sufficient sick to begin to consume products and services of that market.

It is certain, however, that from determined point of the process health-illness, the purchase of services and or products will not be defined by the individuals. The consumption, in the biggest part of the cases, will pass to be defined by the proper market. Since knowing of the purchaser about itself depleted and its decision of consumption starts to depend on the health professionals.

The exact moment when the decision leaves the hands of the individual, is when it makes its first purchase: one consults with a health professional. Such loss of power of decision becomes clearer, if the professional is a physician, as because the signification that this professional has in the imaginary of the individuals, as for the knowledge, that in fact, accumulates.
The individual delegates the power of decision to the physicians, mainly, but could be to another health professional, who will have the power to choice what must be consumed, for recognizing and believing that it has more and better information on the process health-illness. This means that the health market involves an abysmal asymmetry of information. Who sell knows much more then that who purchase. And it is the perception of the individuals. In this way, the health professional starts to define what the purchaser will consume, and will do this purely interested in well-being of its patient, or in raising its proper income.

It is not surprising, that the health market is structuralized around medical knowledge, as said above. Few professionals hold such knowledge, what becomes it a rare good in a market, where many desire or need to buy it.

This knowledge of few, determines the information asymmetry, that in turn, guarantees survival to the market increasing the distance between purchaser and sellers. This asymmetry becomes so bigger, how much bigger either the specialization and knowledge of the professionals about the services and products that commercialize.
The physician, inside of the health sector, is whom that biggest specialization reaches, given the amount of knowledge and information that it accumulates during its formation. In this way, he increases the asymmetry of

information in the relation with its patient (consumer) and accumulates, also, greater power of decision about the purchase and sell process in the health market.

The asymmetry of information added to the fragility for the absence of health and the perspective of death that the sickness backwards, places the purchaser, definitively, in the hands of the sellers. Moreover, in the health market, **the product or service commercialized cannot be tested previously**, what becomes the relation of purchase and sell, a confidence relation, beyond commercial one. Hardly, it will have plea about the basket of products offered for the consumption. In the health market, therefore, **supply has the power to increase its proper demand.**

The instabilities provoked for the uncertainties and the asymmetry of information present in the health market, beyond the structure of remuneration used for the system, in which the consumer does not have to pay for the total cost of the products and services, can determine a standard of over usage of the services and products, that will imply in the rise of the system costs. This risk (**moral hazard**) is characteristic of the health market. The individuals pay its insurances and feel free to use them, either if exceeding the use, to be felt safe, either if placing in risk situation, because they are safe of the certainty of the attendance.

Another relevant characteristic of the health market is the interdependence of its segments. The industry of the sector health comprehends a complex net that involves the health care equipment industry, the pharmaceutical industry, the public and private rendering of services (hospitals, clinics, laboratories and professionals of health), public and private intermediate, centers of research and technological development, deliverers and the consumers. A decision taken in one of these segments will determine consequences in all the others, also in the state of health of the individuals. Thus, it can be perceived a close relation between its functionings, but it can not be said there is coordination. The acting form of each segment, always strongly centered in proper interests, compromises the efficiency of the market as a whole.

From the point of view of its structure, the health market if characterizes by the presence of barriers to the entry of new rendering as high cost of the medical education of the health professionals, the association necessity to intermediate institutions, high cost of material investment and equipment, among others. The existence of barriers can imply in some degree of immobility of the production factors, what takes away the health industry from the purely competitive markets.
There is no consensus between economists about which facts consist in barriers to the entry of new firms in the market.

A pioneering definition and reason to intense debate is Joe Bain's. He understands barriers as "the extent you which, in the long run, established firms can elevating to their selling prices above minimal average cost of production and distribution... without inducing potential entrants you enter the industry".

This definition does not involve other aspects as economy of scale, the capital cost requirements of entry, government restrictions like tariffs, patents and absolute cost advantages of existing firms, and learning curve.

Picture 2 - Summary of the Health Market Characteristic

Caracteristics	Description
Specialization in the heal of illnesses with few products focusing its promotion and prevention	The health market if specialized in products and services focusing the heal of illnesses, therefore of easy sale and that supply necessities easily identified as analgesic for who feels pain.
High degree of uncertainty	It is not known when an illness will occur and when the consumer will feel the necessity to buy it, since this decision depends on it perception of its states of health
Asimmetry of information	the salesmen know much more on the products and services than the purchasers and use these information to intervene on the demand.
The products and services cannot be tested previously	It is not possile to try a surgery before it had been cared through. The same ocurrs with others services and products what increases the level of depence between purchaser and salesman
The supply create demand	Given the reliable relation and dependence between physicians and patients (salesman and purchasers), the salesman can stimulate the demand, even if in improper or fraudulent way or fraudulent.
Moral Hazard	the purchasers use the health services excessively believing that they are pleased, actually they raise the costs of the system.
Interdependence among the segments	As the market of health specialized in healing illnesses, a relationship net was established among the segments: industry of material and medicine, hospitals and other establishments of health and consumers. An increase in the price of medicines an affects the cost of the other segments.

Presence of barriers to the entry of other rendering	Necessity of association, high cost for formation of professionals and others, diminishing the mobility of the production factors.

Failures of the Health Market

Failures of market are situations when the market is not the more efficient option of the economic point of view. The most rational justification for the presence of the State in the economy is the existence of market failures. Its presence, in these situations, is given by the imperious necessity to guarantee greater efficiency to a market, in order to guarantee equity in the access and the security in the provisions and consumption of goods and services, besides guaranteeing the rights of future generations – like the protection of the environment.

The natural monopolies, public goods, externalities, information asymmetry, transaction costs are examples of market imperfections.

In the health market, the failures most important are related to the relation among its main actors: the insurances companies, the rendering and the consumers (users). Such relation does not happen in a cooperative form, in contrary, it has been always tense, in way that the behavior of each one intervenes negatively with the behavior of the others, compromising the functioning of the market.

Failures relative to the relation between insurances companies and users:

1. Adverse Selection: the definition of the market made by the insurance companies excludes carriers of a great number of illnesses like all the chronic-degenerative ones. The potential consumers, excluded by the insurance companies, tend to lie on its state of health, in order to be incorporated. In this way the insurances companies incorporate users with high risk of illness and death, while the less risky ones do not feel attracted by the services offered from those companies, because they do not perceive themselves like sick people. As seem, the question of perception of each individual about its state of health, intervenes on its decision of purchase from the health market. The insurance companies in reply, charge higher prizes to compensate the increase the average risk that raises its costs. Greater prizes, then, implies in a feedback process that strengthens the decision of not participating of the less risky population.

2. Risk Selection: in consequence to the adverse selection, the insurance companies answer with the risk selection. They search to incorporate individuals with less risk of illness by creating barriers to the entry of certain groups of patients and adopting prizes differentiated by the risk, with consequent exclusion of potential buyers.

3. Moral Risk (moral hazard): when incorporated, the users tend to feel more confident on the provisions of health assistance and consequently they place themselves in risky situation or using the services excessively. Another aspect that increases the moral risk is the necessity of the users to establish with the health team, over all with the physician, a reliable relation. So, they will use the services until they find professionals who they can trust. This behavior leads them to repeat consultation and or exams, raising the total cost of the system. Perhaps such behavior finds justification in the fact that the prices practiced by the insurance companies, as remuneration for medical services, does not attract good professionals, what increases the unreliability of the users, and, at last the moral risk.

Failures between users and renders:

1. Moral Risk: as well as in the relation between insurance companies and consumers, the moral risk occurs between the users and the renders, but in this in case , the renders are the ones who stimulates the demand, increasing the costs of the system. The great asymmetry of information, characteristic of the health market, makes the user to lose its power of decision when purchasing, leaving in the hands of the renders the definition of the products and services to be consumed. The renders can, thus, induce strongly the demand.

2. Asymmetry of information: in the competitive markets, sellers and buyers have knowledge about the products and services of the market they participate, because it is assumed that they must make rational decisions to reach their proper interests. It is difficult of being carried through if one does not have complete information on products and services. This asymmetry is more evident, when the products or services can not be tested before have been bought. Although this failure is more perceivable in this relation, it is the cause of all the other failures.

Failures in the relation between insurance companies and renders:

1. Induced Demand: as stated, the asymmetry of information between users and renders, makes possible that the latter stimulate the demand, what concurs for the rise of the costs of the insurance companies. In reply they establish mechanisms of intervention in the medical act, in order to hinder or to discourage the induction of the demand. The contracts firmed with the renders reflect this concern of the insurance companies and tend to restrict the capacity of induction of the demand as much as they can.

Picture 3 – Failures of market in the relati on between insurance companies and users

Type of Failure	**Definition**	**Consequences**
Adverse Selection	Trend of the system of insurances to incorporate customers of greater risk, in result of the behavior of the insured to hide information on its real conditions of health	- Low level of socialization of the risks - Few insured - High prices - Low performance of the market
Risk Selection	Strategy used by the insurance companies with the objective to prevent the potentially high combination of low prizes and potentially high costs, by creating barriers to the entry in the system for insured with profile of high risk	- restriction of access to the system for determined groups (deficient, aged and carrying of chronic illnesses) - differentiation of prices according to risk
Moral Risk	Change of behavior of the insured in function of not having to support the total cost of the attendance, what leads them to use excessively the offered services ("since I am paying, I will use them")	- extreme use of the services - increase of costs

Source: Almeida (1998).

B - UNDERSTANDING THE HEALTH MARKET REGULATION

Concept

Regulation is a variety of public policies drawn to lead the economic activity and its consequences in level of a segment of the economy, of the firms or of an individual unit of activity. This definition restricts the regulatory function to microeconomic level. Another wide concept is the Kenneth J. Meier's (1985) by whom regulation is any attempt by the government to control behavior of the citizens, corporations or sub governments. From this concept and taking public policies as an intentional set of actions create and monitored by the government, in order to solve a problem or subject of public concern, all public policies, could be considered regulation.

The first definition seems more appropriate for the understanding of the regulation actions of the health sector that will be discuss ahead in this work.

Types of Regulation

1. In accordance with the participation of the State in the market.

By delegation: in this case the decision power is delegated to independent institutions (regulatory agencies) to control the market of products and services of public utility or other activities of public relevance. This type of state intervention has reached its greatest expression in the United States of America.

According to Montone (2000), the regulatory agencies must have three basic characteristics:

- regulatory power issued by law that guarantees to them capacity to regulate, to control, to audit and to punish;
- administrative independence through the term of its board of directors and with flexibility of the management instruments like organizational, structure human resources, system of purchases and others;
- financial autonomy obtained through the collection and execution of resources proceeding from specific taxes.

These characteristics are necessary to protect the agencies from interferences caused by political games, guaranteeing them true autonomy. Otherwise, the agencies would become easy target to phenomenon of

capture by regulated agents or by the State itself, which can place them in a dependent situation, impeding them to play their role.

By participation of the State in the market: this was the most common way of market regulation exerted by the State in centuries XIX and XX, mainly in sectors as energy, water, transport and communication. This type of regulation is based in the premise that the presence of the State in the market facilitates its regulation and control and protects the public interest, but the coexistence under the State of the functions of regulation and production - intrinsic to this model, diminishes its capacity to supply efficiently the necessities of the consumers and compromises the confidence of the market in the regulatory capacity of State, since it would be creating administrative and legal environment for the regulation of its proper competitors.

After years and with the mature of experiences like the American, this type of regulation has been abandoned. The governments have begin to observe that is possible to regulate by the regulatory agencies without their direct participation which almost always has high social cost, since the use of resources in the provisions of services and products, efficiently produced by the market, could be used for implementation of social policies with more significant results for the society. The creation of the regulatory agencies in the United States has involved many sectors: the financial system, the stock market, medicines, foods, transports, communication, environment, electric energy and others and has shown that it is possible regulate the market been out of it.

2. In accordance with the relation between regulated regulators and:

By summons (or deterrence): in this type of relation, the regulator believes that the regulated agents are not ethical, therefore there is a need of harder and coercitive action, in order to ensure that they assume the expected behavior.

By complaisance (or compliance): in opposition to the regulation by summons, this type of regulation is characterized by a relation of cooperation and understanding based on the premise that the regulated agents desire to act in a proper way and will do it as much as possible.

What actually happens is that the behavior of the regulated agents vary from market to market or from firm to firm. And, "even though the regulators adopted a differentiated or combined approach that takes in consideration such variations, they are frequently are compel by the legislation, political pressures or other types of pressure, to use a particular, independent regulatory in spite of its adequacy." (Walshe, 2002).

3. In accordance with the focus:

Economic: regulation oriented toward the economic control of the market, through the control of the entry and exit of firms in a determined market, through the competitive practices, the size of the economic units and the prices that the firms can charge. This type of regulation, in general, is focused in one only sector of the economy, as well as its agencies. It can be said that economic regulation is regulation in *strito senso*.

Social regulation: regulation directed toward the control of the social repercussions of the actions of the market, either during the productive process, either during the consumption of products and services. As it is worried about very wide questions like environmental pollution, health and security of the workers, the social regulation has transversal action and effect to the segments of the economy. Its action is wider than the economic regulation and tries to lead the corporations to assume great responsibilities for security and health of workers and consumers. The social regulation impose costs to the great firms and consequently suffer great opposition from them. This type of regulation became more notable since the growth demands for better quality of life in the 1960s. It can be said that social regulation is regulation in *lato senso*.

Justifications to regulate

The regulation is a form of state intervention that is justified in all the situations where the market is not capable, by itself, to find the optimum level of satisfaction of the social necessities and economic efficiency. It is what happens in the market failures and in the cases of products and services of great social relevance as health, education and environment.

The health market has significant failures of market as great asymmetry of information that hinders the consumers to make rational choices concerning to what they will consume and hinders the insurance companies to have complete information about the real costs of the diagnostic and therapeutical procedures that they are paying to their insured. Beyond the information asymmetry that is the market failure that is in the background of all the others market failures like the adverse selection, the risk selection and the moral risk, the health market also presents important externalidades. The biological waste is an example of negative externality, that imposes a cost to the society to be degraded.

Finally, it must be dig up the great social relevance of the issue health. As discussed before, the health market deals with the human life and there is no greater social appeal then the preservation of life. Moreover, the losses in worked days and years of life represent very high social cost, so it is a role of the State to guarantee that the health market acts in order to extend its covering, reducing the exclusion level.

Opportunities to Regulate

The health market is the result of the interaction among, at least, three participants: the consumer, the insurance companies and the renders of services. This interaction has two opportunities of regulation. The relation between insurance companies and consumers and between the renders and the consumers. The regulation actions are strongly focused in the insurance companies and strong emphasis in prices control. While the renders suffer less pressure in its price structure, they are more pressured for quality and security of the products and services that they offer. The following chapter will present the American and Brazilian experience in regulation and in both of them it can be seem the oriented focus to the relation between insurance companies and users.

Deregulation

What would happen if the health market was deregulated, let to its proper laws and rules. For this analysis it is necessary to have in mind the characteristics of the health market that had been already presented in the first chapter, as well as the justifications for its regulation that had been seem before. The health market presents significant failures, important externalidades and has social relevance.

In result of the great asymmetry of information, the market would become more excluding by the action that would intensify its risk selection, excluding as much as possible the risky groups. With lower number of insured, the cost per capita would be higher, what would force the prizes up, what leads to the increasing the exclusion. Only the ones who had enough income, would be able to pay to be incorporated.

The market would more and more specialize in provide expensive procedures that has lower costs of production without any concern about epidemiologic indications of which pathologies are more relevant to the society.

The population of higher risk of illness would be excluded from the covering of the insurance companies, what would rise the morbimortality by illnesses of difficult treatment and higher cost, and at last would be absorved by the State through social programs like the Medicare and Medicaid in U.S.A.

The excluded individuals would pressure the public services raising its demand and exclusion of the ones that really need those services. The population excluded from the insurance companies has greater vocalization power and would obtain, certainly, better assistance then the ones that really depend on the public service.

Finally, the State would have to absorb the new demand, retaking its role of supplier with consequent rise of its expenses in the health sector, diminishing the investments in others.

C – THE AMERICAN AND BRAZILIAN EXPERIENCES IN HEALTH MARKET REGULATION

THE AMERICAN EXPERIENCE

Structure of the American health market – brief historical

The sprouting of enterprise organizations in the scope of the health care assistance in the United States occurred since the end of century XIX, through the organization of the renders of services.

- End of century XIX, beginning of century XX - the professional corporations of health under the form of groups of renders as hospitals and doctors began to appear. These groups offer its products to great groups of consumers, mainly industries and commercial companies of bigger size.
- The first plans of Medicine of Group appear, but did not consolidate themselves until the 1930s until the Great Depression.
- The Blue Cross appeared – institutions that agregated the hospitals in order to avoid the restrictions imposed by legislation.
- The insatisfaction of the medical class with the remuneration practised by the Blue Cross, leaded the American Medical Association to creat in 1940 the Blue Shield., that aggregate groups of physicians.
- In 1963 the Medicare and the Medicaid were approved by the American Congress. The former with format of social insurance, oriented toward the aged population, and the latter with format of public policy oriented toward the poor population. They begin to work in 1965.
- 1973 with the approval of the Health Maintenance Organization Act appears the Managed Care, model of management of health services with the objective to reduce costs and to increase the efficiency of the system.
- Three types of companies begin to function in the model of Managed Care: insurance companies, wich manage health organizations; suppliers organizations and renders of services.
- The organizations of suppliers are known today as Integrated Delivery Systems - IDS and are formed by associations of professionals of health and/or hospitals.
- The management organizations organized themselves under the forms showed below
  a. HMOs – Health Maintenance Organization
  b. PPOs – Preferred Provided Organization
  c. POSs – Point of Service.

Picture 4 – Types of Health Manager Organizations in USA

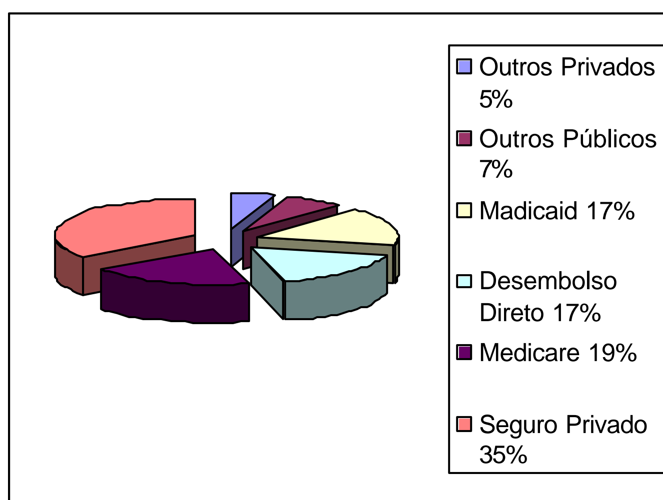
Tipo	Características
HMO: Health Maintenance	- Organization that provide health services through contracting of a net of associated suppliers.

Organization	- Suppliers can be contracted individually or through suppliers organizations - There are five main types of HMOs, that differentiate by the type of contract established with the suppliers. -
PPO: Prefered Provided Organization	- Insurance company that intermediate the supply of services between an employer and a group of services suppliers; - They are different from the HMOs because they allow the use of services outside the associated net.
POS: Point of Service	- It is a hybrid plan, that contemplates characteristics of the HMOs and the PPOs - the insured can use services of renders that are outside associated net; - Concentration in supply of specialized services

Source: Silva (2003)

In 2000, the United States had its expenses distributed as showed below in graph 1. It can be seen that "the health system of the United States is characterized by the strong presence of the private initiative in the production and supply of health services for the economic active population, while the State, through specific programs, guarantees the access to the services only for the more vulnerable social groups, as aged and low income population. Despite this, about 15% of the population does not have access to any kind of services, either because they do not have enough income to acquire any type of plans or insurances offered in the private market, either because they are outside of the criteria of eligibility of the public programs." Silva (2003).

Graph 1 - Distribution of the American market for type of covering



Fonte: Silva (2003)

The expenses with health in U.S.A. show robust numbers and are growing in reason of the increase in the private sector, and in the public sector increasing from US$ 27 billion in 1960 to US$ 1,3 trillions in 2000, which represents 13,2% of the American GDP.

In terms of expenses per capita, they grow, in same period, from US$ 476 to US$ 4,637 representing a rise of 870%.

Between 1960 and 1980, the total expenses per capita in health had increased 168% (constant values), from what the private expenses increased 108%, while the public expenses increased 358% in the same period. This increase of the public expenses occurred due to the creation of the Medicare and Medicaid. During 1980s, however, the growth of the private expenses (68%) was greater than the public expenses (55%), what stimulated the adoption of mechanisms of control and costs reduction. Silva (2003).

Some fragilities of the American health market according to Kirkman-Liff.

- Remuneration of suppliers under the logic of it fee-for-service.
- High level of medical specialization.
- Fast incorporation of high technology.
- Focus on hospital and healing. Programs of basic attention suffer the diffidence from the population.
- Complex market with rules and regulations that differ from insurance company to insurance company and from region to region.
- Practice of adverse selection by the insurance companies.

Model of regulation

The American model is centered in the regulation for delegation, but it does not have a responsible federal agency for regulating the whole American market. The regulation in the United States is strongly based on state agencies that define the rules for the market in accordance with the peculiarities of each state. The result is that exist a variety of rules that differs from state to state and increases the complexity of the regulatory process. Even inside of one state, more than one agency exists and act on insurance companies and the renders of services. It can happen, for example, that one organization of managed attention is regulated by a regulatory insurance agency for financial control and by another regulatory agency for the control of quality of the assistance, the standards of use and ability to offer services of adequate form.

The regulations of the states, not necessarily, keep coherence among themselves. The performance of the National Association of Insurance Comissioners – federal agency responsible for the business of the insurance

companies - from 1996 have done some similarity to the regulations of the different American states, as well as the HIPAA - Health Insurance Portability and Accountability Act, that defined a minimum standard of accessibility and covering to be fulfilled by the insurance companies.

The self management companies are regulated by the Department of Work in the federal level.

Picture 4 – Main items submitted to the state regulation in U.S.A

ITEM	DESCRIPTION
Authorization for functioning	The HMOs gets authorization for functioning by a request a state authorization license (Certificate of Authority - COA) and the solicitation is generally processed by the state departments of insurance.
Information for the beneficiaries	The HMO Model Act requires certain level of communication with the users of the HMOs. The individual user or the responsible for the group contract has the right to receive a copy from its contracts and the regulators demand that they are filed and approved for the responsible regulatories instances for the revision of contracts. The users also receive a document as prove of covering, information about how the services can be gotten, a list of health plan renders and a notification about the disconnection of the beneficiaries' physician from the plan. The PPA Model Act demands similar spreading for the users of the plans of the PPOs.
Access to the medical services	The HMOs need to assure the access and the availability of the users to the medical services. Equally, the PPA Model Act demands that the plans that offer PPO option assure a certain level of access for the covered services.
Issues involving the renders	The HMO Model Act determines that the organizations of managed attention request license of professional performance to the state and supply to the regulators copies of the contract signed with the renders, as well as the names and addresses of all the contracted renders. Also determines that the contracts include a clause that protects the users against claims of the renders in the case of insolvency of the plan. The Managed Care Plan Network Adequacy Model Act (NAIC) also includes a series of steps in the contract with the renders.
Reports and archives	The HMOs must keep a filed document, including the annual reports, tables with the indices of prizes and updates of the information contained in the license of original functioning.
Quality guarantee and examination of the use	There are a serie of laws that prescribe the procedures of the HMOs about the quality assurance and examination of the use. Among them there are the determination that HMO has archives of the description of its program of quality control, has an internal system capable to identify chances of improvement for the services, measures the performance of the renders, assures a level of production of the renders, colet and analyze data of overutilization and subutilization of the services and keeps policies and procedures written for association of all the health professionals.

Procedures of the users complaints	Law NAIC requires that the HMOs have written procedures drawn to effectively deal with the complaints of the users. These procedures must be approved by appropriate the state agency.
Standards of solvency and guarantees	The HMO Model Act establishes requirement of specific capital, reserves and deposits that all the HMOs must fulfill. This is to prevent insolvencies of the HMOs and to protect the consumers and other parts of the insolvency effect.
Financial situation and visits of inspection	The regulators have power to conduct inspections in order to examine the finances of the HMOs, activities of market and programs of quality control. The inspection process can involve visits *in loco*.
Implementation of the HIPAA	The Health Insurance Portability and Accountability Act (HIPAA) establish minimum requirements for standards of health services. Many petitions of the states exceed those established by the HIPAA.
Operations in many localities	Organizations of managed attention that operate in two or more states must be submited to the existing regulations in each jurisdiction.

Source: Kongsvedt (2001).

Beyond insurance companies, the renders of services and the pharmaceutical industry are strongly regulated, over all in respect of prices, amounts, supply and quality as Phelps (1997) resume in the picture below.

Picture 5 - Instruments used for regulation of the health sector in U.S.A

Aspects of the Regulation	**Used Instruments**	
	Inputs	**Outputs**
Price	▶ Control of wages ▶ Antitrust legislation	▶ Rules of the Economic Stabilization Program (ESP) ▶ Regulations of the states ▶ Rules of price of the Medicare ▶ Antitrust legislation
Entry / Supply	▶ Licenses ▶ Certificate of Need Act	▶ Rules of the Food and Drug Administration (FDA)
Quality	▶ Licenses ▶ Certifications	▶ Rules of the Health Department ▶ Rules of the Food and Drug Administration (FDA) ▶ Systems of quality control of attendance

		(PSRO/PRO)

Sources: Phelps (1997)

As seen, the health market in the United States is rigorously under the look of the State, even though It is more market oriented than in the other countries.

Brief description of the health market in Brazil

The private market of health in Brazil covers more than 30 million Brazilians and the rest of the 152 million are covered by the National System of Health - SUS. Its distribution by age of users is seen below in the picture 7. There is a relevant concentration of users - more than 67% - in the bands until 40 years. See picture 6 and 7 below.

Picture 6 – **BRAZIL: COMPOSITION OF THE HEALTH SECTOR FINANCING—1997**

Financing	%
Public*	48,7
Private	51,3
Total	100,0

Source: World Health Organization (2000).
*It was not computed the amount of public subsidies under the health public financing.

Picture 7 – **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 accordance with the type of participant organization it can be seen a greater participation in number of users in the Medicine of Group companies, in which also concentrates the biggest number of companies, 840 corresponding 53% of the market. See pictures 8 and 9 below.

Picture 8 – **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.

Quadro 9 – **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.

In 1999, these prepaid medical organizations earned around US$ 7.5 billion. 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. Ocké-Reis (2004).The picture below shows the main caracteristics of each type of company which participate in the private health market in Brazil.

Picture 10 – **TYPES AND CARACTERISTICS OF PARTICIPANTS COMPANIES IN THE HEALTH MARKET IN BRAZIL**

Types of Companies	Caracteristics
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 limitati ons and franchises.
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.
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.
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).

Source:Ocké-Reis 2004

Regulation

The actions of regulation of certain market, are not necessarily systemized and organized in the interior of one only institution. Laws, norms and rules dictated by different institutions still can have regulatory character, even if it was not its initial intention. In this way, Brazil, even before creating its agencies, in some extend, exerted on the health market some level of regulation. Requirements of license issued by the Sanitary Vigilance guaranteeing the conditions of minimum hygiene and health, or the necessity of authorization of the Regional Council of Medicine so that a health establishment functions, is State actions State that exist since many years even before the creation of regulation agency.

With the creation of the National Agency of Supplemental Health - ANS by Law 9,961 in 28th of January of 2000, these actions had been grouped inside of the target of one only institution responsible for the policies of regulation in health market. The existence of the ANS, does not except this market of other types of regulation. The regulation of the quality of the rendering services is under the responsibility of one another agency, the ANVISA - National Agency of Sanitary Vigilance, while the rules of commerce and finance of the insurance companies, for example, can be given by institutions that regulate the commerce or the insurance activity.

The ANS and ANVISA are federal institutions, created under the logic of independent agencies and they express a model strongly centered in the regulatory power of the federal level. The Brazilian federalist system does not allow the states the same freedom to create its mechanisms of regulation that the American allows theirs. In this way, the states have had small participation in the regulatory process in the health market in Brazil.

The model of independent agencies - regulation for delegation - under the Federal Government has been formally adopted by Brazil and there is an effort to consolidate it, even though the great participation of the Brazilian State in the health market, issue that will be discussed ahead.

The National Agency of Supplemental Health - ANS

The institutional structure was given with the creation of the ANS, what unified the activities of regulation in one only agency. It has structure of autarchy in special regimen, in order to guarantee independence to decide and financial independence. ANS belongs to Health Ministry as established in the first article of its Internal Statute:

Art. 1º. The National Agency of Supplemental Health - ANS, created by the Law 9,961, of 28 of January of 2000, it is autarchy under special regimen, linked to the Health Ministry with headquarters and forum in the city of Rio De Janeiro - RJ, with indeterminate period of duration and authority in all the domestic territory. It is characterized by administrative, financial, patrimonial, management of human resources autonomy and in its technical decisions. It has fix term of its director board.

Its main activities respect to the control of assistance coverings and conditions of access; entry, operation and exit of the operators; readjustment of prices; audit of the activities of operation and commercialization of the plans; monitoring of contracts; and compensation to the SUS.

It has for purpose promote the defense of the public interest in the supplemental assistance to the health, regulating the sectorial operators, including its relations with renders and consumers, contributing for the development of the actions of health in the country.

In the almost four years of its existence the ANS has advanced in its function of leading the private market of health in the direction of the public interest. Some fragilities, however, can be seen in the process of regulation of the market, and can compromise the capacity of the agency in reaching its objectives. "Such fragilities are related, among others things with the following aspects: inadequate projects of risk management practiced by the operating companies; fragility of the legal mark of the regulation, target of constant legal appeals and absence of adjust regulation in the relations between public and private subsystems, evidencing the necessity of revision of the adopted model of regulation." Silva (2003).

Contradictions of the Brazilian model

The existence of independent agency of regulation approaches the Brazilian model to the model of regulation by delegation, even though the real independence of the ANS could be questioned. In this model, the State does not participate of the health market, its actuation is carried through the agencies. Brazil, however, by its Constitution, understands health as a duty of the State and, in such way, had created, had implanted and is implementing the SUS - National System of Health that operates through a proper net of hospitals and other services.

It seems contradictory that when assuming the model of regulation by delegation, the Brazilian State, has not, at the same time, initiated a discussion about the role of the SUS, through which it heavily participates of the health market, covering more than 100 million Brazilians.

Considering experiences like the American, in which the health assistance was left under the market logic and presented, in consequence, the necessity of a posterior intervention of the State with the creation of the Medicare and Medicaid and still thus possess around 15% of its population without any type of covering, it is not expected that the Brazilian State leaves the health market. The question is not this. The question is: the reason why SUS has not been used as a tool of regulation in the health market.

The power of regulating through the SUS seems sufficiently significant to be rejected. This system possesses a national net of hospitals, laboratories, therapeutical and diagnosis centers and other services of health sufficient to compete in an important form with the private services.

Such competition could represent a mechanism of coordination of the market, in such way that the insurance companies and the renders were lead by the market forces to assume a responsible socially behavior, reducing costs and increasing the access.

It is certain, however, that at least, two changes would be necessary so that the SUS assumed such role. The first one, in the direction of the ANS to fortify its function of coordination between the public and the private starting to understand the SUS as a participant, in fact, of the health market - one firm! And the second, in the scope of the SUS, in the direction to implement a more enterprising, less bureaucratic management, oriented toward the search of the economic efficiency of its net, without damage for the maintenance of its constitutional principles.

A key element for such change is the introduction of the competition in the scope of the SUS. Units with different performances cannot be, for example, contemplated with equal budget. They could, thus, compete for better budgets to each year searching fulfilling goals agreed for each period. The professionals of these units, equally, would have to be stimulated with prizes for performance, model, by the way, already practiced in the public sphere as the example of the Secretariat of Finance of the State of Bahia.

Moreover, public units would have to be stimulated to compete with private units of the same area for the attendance of the population. The compensation chambers would be instrument of devolution to the SUS for the attendance of patients covered by insurance or another modality of private covering. E this relation could be regulated by the ANS.

The contradiction, that seems more evident, is this. The Brazilian State participates of the health market through the SUS, but does not use this powerful tool of regulation of the private market to reach its objectives of protecting public interest.

A failure in the Brazilian regulation model

An important failure in the Brazilian model is that only one segment of the chain of health assistance has being focused by the ANS, which is the relation between insurance companies and consumers'. A regulation chance is being lost, when the renders are left completely free to act in a market, where there is strong interdependence among its agents. This segment of the health market acting without better control, with structures of prices that vary from state to state, from city to city, and even from health unit to health unit.

The practice of abusive prices of this segment has implications for the whole health system and the role of the ANS is not sufficiently clearly over the renders and industry of materials and medicines.

D- PLANSERV, A PROPOSAL OF REGULATION FOR THE HEALTH MARKET IN BAHIA

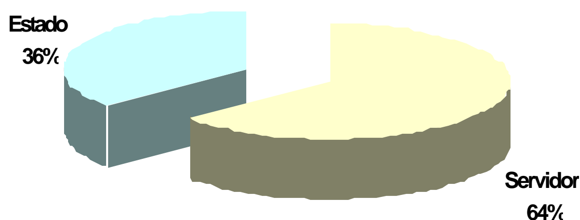
THE PLANSERV

PLANSERV - Assistance to the Health of the State Public Servants is an agency of the Government of the State of Bahia under the Secretariat of the Administration.

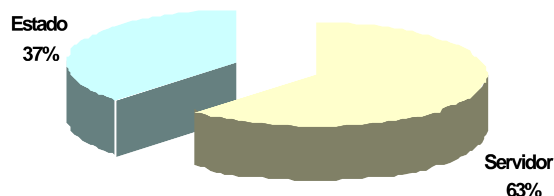
It is responsible for the management of health assistance of the state public servants, who voluntarily associate to it. PLANSERV is supported by a fund, FUNSERV - Fund of Expenditure of the State Public Server, for which contribute, servers and government.

Inherent to the structure of the PLANSERV, the fund functions under the continuous and direct monitoring of the PLANSERV's General Coordination. The State, legally, must contribute monthly with until 5% of the total value of the servant's payroll. The monthly value to be expended is defined in accordance with the financial availability and is coordinated, directly, by the Secretariat of Finance and the Secretariat of Planning. The contribution of the servants varies from 7.4 to 10.4% of the growth wage, proportional to their wage band.

Graph 2– Percentage of economical-financial resources for the assistance to the health according to contributions of the government and the servers - Bahia - 2003



Graph 3– Percentage of economic-financial resources for the assistance to the health according to contributions of the government and the servers - Bahia - jan ago/2004



Fonte: Portarias financeiras do PLANSERV publicadas no DOE

The PLANSERV has 455 thousands of beneficiaries, of which 197 thousand are titulars and 258 thousand are dependents. This population is distributed between capital 42% and rural area 58%. In accordance with the age band it has 34% of the beneficiaries with age up of 19 years; 40% between 20 and 49 years and 26% above of 50 years. It is a group that tends to age, since that the State has not contracted new servants in a significant amount.

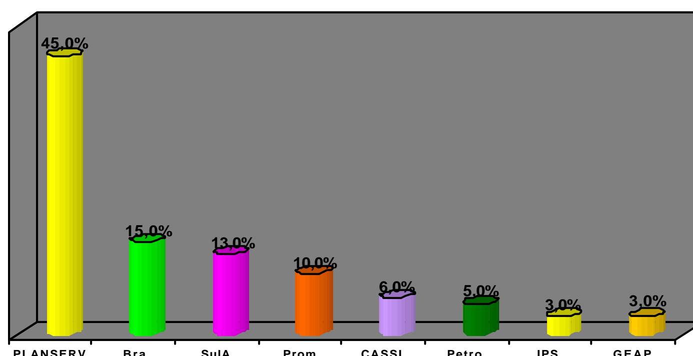
Health Market in Bahia

According to the Association of Hospitals and Services of Health of the State of Bahia, there are approximately exist 1.800.000 lives that have some type of supplemental health assistance in the State of Bahia. This market corresponds about 14% of the population of the State and the PLANSERV participates approximately with 25% of this total, significant portion of the market, considering the number of operators of supplemental health in the State. Comparing, however, the position of the PLANSERV with the eight biggest operators of Bahia, in number of attended lives, one verifies that its participation corresponds to 45%, as picture and graph bellow.

Picture 11 - Number of lives attended by the main operators of supplemental health in the State - Bahia - 2004

Plano	Nº vidas
PLANSERV	449778
Bradesco	150000
SulAmérica	125867
Promedica	110000
CASSI	65000
Petrobrás	58000
Unimed	40000
IPS	37000
GEAP	30200

Graph 4 - Percentage distribution of the number of lives attended by the main operators of supplemental health in the State - Bahia - 2004



Fonte: Diagnostic and Operational Report of PLANSERV 2004.

The picture 11 and graph 4 show the distribution of Bahia's market among the nine biggest participant companies. The PLANSERV appears as the greater of them in number of covered individuals.

The PLANSERV does not has proper net, thus it purchase services of the private net of renders. These renders are the same ones that serve to insurance companies and to private plans. The roll of medical procedures covered by the PLANSERV is the broadest of the State contemplating all procedures regulated by the ANS and more those ones that along the years had been necessary to the beneficiary servants.

Responsible for more than 25% of the market of health and manager of a group that tends to age and to present pathologies in the more advanced stages, therefore of more difficult and costly treatment, the PLANSERV had became the biggest customer of Bahia's market of renders. Among the 10 biggest hospitals of

Bahia, only 01 does not carry through any type of rendering of services to the PLANSERV. Of the others 09, eight presented rate of occupation for PLANSERV's patients, superiors to 50 % until the end of 2003, what was object of concern for these units in meeting of accompaniment of the net. The two biggest hospitals already had arrived to present PLANSERV rate of occupation superior to 60%.

The accompaniment of the occupation rates illustrates the position of the PLANSERV in relation to its net.

Regulating action of the PLANSERV on the Bahia's market

For presenting biggest group of costumers and one of more costly, because its epidemiologic profile, the PLANSERV has been seen and respected by the greatest and best renders as their more important customer. Even though they argue that the PLANSERV's prices do not cover their costs of production. The structure of remuneration used by the PLANSERV is the one defined by the Brazilian Medical Association - AMB in 1992 (AMB 92). The table recommended at that time, is not adequate to current reality as in value as the procedure composition. Frequently the institution discusses this issue with the renders, in order to decide what considers its biggest challenge, the low remuneration of the medical act itself.

When analyzing the structure of the accounts of the PLANSERV it can be seen that the physicians are the ones who earn less. The greatest responsible for the cost of a hospital procedure are, usually, material and medicine. This composition is not characteristic of the PLANSERV, it is the same for the biggest operators of Bahia's market.

Considering that in the assistencial process the physicians is the determinative factor of the consumption and that the costs verified in the system are closely related to their technical and ethical behavior, the PLANSERV has searched to narrow relation with these professionals, through systematic meetings, either technical or commercial.

The intention is to discuss a way of remuneration capable to privilege more the professional instead of the material and medicine. The quarrels have been carried through by procedure or group of procedures and culminate with the publication of an administrative act - legal instrument - that officializes the decision taken with the renders.

Inside of the Bahia's context, this kind of experiences has been showing the power of market of the PLANSERV, what suggests the possibility of a systematic actuation of the institution in the direction of

regulating the health market of Bahia, acting on the gap left by the ANS: the regulation of the segment of renders.

The change for a coherent organizational model with the regulating function, participating in the market as public operator, can become costlyand with difficult transit in the politic sphere, but even though, the actuation of the PLANSERV could be in accordance with market rules, creating the technical and institutional conditions for the practice of lower prices for the segment of renders. The prices defined by the PLANSERV could be a signalizer to the market as a whole, what, at last is market regulation.

Assuming the position of regulating structure, the PLANSERV will be regulating the market, not only, on the economic point of view, increasing its efficiency, but, also, defining a standard of sociallyresponsible behavior, either by the practice of prices that makes possible the magnifying of the covering, either by the determination and audit of the standards of quality to be reached by its renders.

The PLANSERV can carry through economic and social regulation, and will do it more, as the more efficiently conducts the market through transparent negotiation, through definition of clear social and economic objectives and through the creation of the necessary and sufficient mechanisms and legal instruments to the regulating function.

E – CONCLUSIONS

- ✍ The health is a "product", whose supply is not possible to be provided by only one market, since it depends on products and services that are offered by different markets as infrastructure and environment. The segment, where the market more grew is that of goods directed toward the cure of illnesses.

- ✍ Such goods cannot be considered public good, since they are rival and /or excludent. Thus, the state intervention in the health market should be restricted to its regulation.

- ✍ Health is a market, whose structure approaches to a structure of monopolistic competition with some specific imperfections that comes from the great asymmetry of information that characterizes it. The existence of such failures associated to the existence of important externalities, beyond the high social relevance of the services and products of the sector, justifies the intervention of the State, in the direction of regulating it, in order to increase its efficiency, minimizing the imperfections and guaranteeing greater equity in the access of the society and greater offered product quality and services.

- ✍ The regulation of the health market, as it is today, can be done in two forms: on the operators (insurance companies, Medicine of group, self management etc) and on the renders. The ANS seems to be focused in the regulation of the behavior of the operators. The renders have not suffered a more incisive action from the State, except for the actuation of the ANVISA - National Agency of Sanitary Vigilance. Of the economic point of view, these companies have had little control.

- ✍ The PLANSERV already exert some control on the renders, but such action has had as focus only the financial survival, that depends to a large extent on the level of prices, in which the renders has kept themselves.

- ✍ It is possible to the PLANSERV to assume the regulating function and to reformulate itself in this direction. The assumption of the regulating function in a systemized and

institutionalized way demands a decision that is not technique, but politic. However, even if kept inside of the scope of a public operator, it can exert its regulating role bringing the renders to a standard more socially responsible behavior and more economically efficient with gains reflected in the whole health market, including the segment of the private operators.

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