

Alterity or austerity: a review on the value of health equity in times of international economic crises

Simone Schenkman (<https://orcid.org/0000-0003-1140-1056>)¹

Aylene Emilia Moraes Bousquat (<https://orcid.org/0000-0003-2701-1570>)¹

Abstract *In recent decades, the global and aggressive crises-transformed capitalist system has subjected society to fiscal austerity and strained the assurance of its right to health, as an imposition to increase health systems efficiency and effectiveness. Health equity, on the other hand, provides protection against the harmful effects of austerity on population health. The aim of this article is to analyse the effect of the global financial crisis on how health equity is considered against effectiveness in international comparisons of health systems efficiency in the scientific literature. Integrative review, based on PubMed and VHL databases searches, 2008-18, and cross-case analysis. The balance between equity and effectiveness must be sought from health financing to results, in an efficient way, as a means to strengthening health systems. The choice between alterity or austerity must be made explicitly and transparently, with resilience of societal values and the principles of universality, integrality and equity.*

Key words *Health equity, Health sector reform, Efficiency, Effectiveness, Capitalism.*

¹ Faculdade de Saúde Pública, Universidade de São Paulo. Av. Dr. Arnaldo 715, Cerqueira César. 01246-904 São Paulo SP Brasil. simoneschenkman@usp.br

Introduction

In the last decades, the capitalist system has been transformed by crises, which, non-accidentally, have taken up a central role in its maintenance. This mode of production, due to its internal contradictions, depends on these sporadic crises to despoil the accumulated excess capital and open up new possibilities for growth and investment. These reconfigurations also end up putting pressure on acquired social rights, since the expansion of capital and the flexibilization of social relations, especially those related to production and circulation, seek to consolidate new forms of class power, and has involved the loss of rights in the recent crises, when they are viewed as obstacles to their operations¹.

Thus, the human rights of different generations: – those related to freedom (individual civil and political rights), to equality (fundamental rights: social, those with emphasis on health, economic and cultural rights), and to solidarity (diffuse or collective rights) – are recurrently threatened². The situation is even more dramatic in the peripheral capitalist countries, where even second-generation rights have not been effectively guaranteed to the entire population.

The major similarities between the major financial crises (1929 and 2008) occurred at the macroeconomic level, preceded by the indiscriminate international capital movement. Decades of stagnation of workers' wages, with large profits at the top of the distribution, with the coexistence of capital and idle labor supply without social utility were the hallmarks of the years prior to the crises. Thus, these correspond to exacerbations of socioeconomic inequalities, accumulated with spatial and temporal displacements of capital, which coincided with the excessive deregulation of financial markets³.

The specificities of the 2008 Global Financial Crisis (GFC) are found in the mode of regulation chosen to replace the previous model, with lower costs and higher profits, more flexible social relations and a high rate of technological innovations, leading to structural unemployment. The financial nature of the system provides longer survival to capital, but in risky operations, which produce more aggressive and global crises in an unregulated environment, sometimes turning the optimism and freedom of some into tragedy and exclusion for many¹.

These crises also result in tensions that arise from the conceptions and recommendations of international organizations and their respective

resistance to the flexibilization of the right to health^{4,5}. In 1970, with the oil crisis and the third world debt crisis associated with a decrease in profit rates and uncontrolled inflation, the reduction in the Welfare State, through privatizations and tax reforms, financial deregulation and liberalization was proposed by the World Bank (WB) and the International Monetary Fund (IMF) as a problem-solving model^{5,6}.

In the 1990s, with the Latin American external debt crisis and the increasing financialization of capital, proposals were made by the WHO and WB for a new universalism in health, a precursor to universal health coverage. As counterpoints, it is worth mentioning the integrative and systemic approach of Primary Health Care (PHC) of the World Health Organization (WHO), in Alma Ata (1978)^{5,6}, and the committee created to discuss and appraise the social determinants of health, by the WHO, as well as proposals aimed at strengthening health systems^{7,8}.

With the GFC, starting with the banking crisis, then with the sovereign debt and low growth, the health sector started turning towards financialization and public funds are increasingly being taken over by private markets. It did not take long before 2012 was declared the year of universal coverage by the WHO and future health markets were prospected by the Rockefeller Foundation. In 2014, the Pan American Health Organization (PAHO) increased the tension as it discussed universal health and the right to health by broadening the narrow concept of coverage without guaranteeing access^{5,6,8}.

Therefore, with each crisis, fiscal austerity and the commercialization of health are sold as a solution for financial deficits, with nefarious results for the population's health^{4,5,6}. In situations of economic crisis, the collapse of health systems tends to occur when the social protection system has been previously despoiled and the health system is highly fragmented and privatized, showing the division of society regarding the choice and use of health services. Moreover, the high rates of unemployment and homelessness have important effects on the health status of the populations; some studies have associated increases with: a rise in the incidence of depression and the occurrence of suicides and homicides, as well as alcohol and drug abuse, and morbidity from infectious diseases^{4,5}. Therefore, it is exactly when the need for health services increases that public health expenditures fall dramatically, with the retraction of investments⁴, as seen in Greece^{6,9}, Spain and Italy⁶. In contrast, countries that have

prioritized economic growth, with rising public expenses, and that resisted reductions in social protection, based on the principle of solidarity and the philosophical sense of alterity, remained more stable even in times of crisis such as Iceland, Germany, France and Sweden^{4,5,6}.

Health equity once again gains prominence in crisis situations, defined as the absence of systematic differences in health determinants between social groups at different positions in the social hierarchy. Health inequities bring additional disadvantages to groups that are already historically socially disadvantaged, due to gender, ethnicity or religion, among other attributes¹⁰. Equity can be analyzed in its vertical component, of adequate unequal distribution among individuals with different needs, or the horizontal component, which refers to equal treatment to those who are the same in their health needs¹¹.

Equity has become a key element in health system performance improvement, as health sector reforms implemented in the past with a focus on efficiency or effectiveness did not attain the expected success^{5,12}. Therefore, health equity should be a primary value regarding the performance of health systems and reforms, acting as a protective factor against the unfavorable effects of capitalism crises on the health of the populations. Thus, from the perspective of alterity, the alternation between different perspectives allows individuals to aggregate different social contexts and collectively organize their social protection types.

In this scenario, the aim of the present study is to analyze the effect of GFC regarding the appraisal of health equity against effectiveness in international comparisons of the efficiency of health systems in the scientific literature after the 2008 crisis.

Method

An integrative review was performed, which was indicated to define concepts, identify gaps and review theories and methods of published studies. Having great amplitude and scope, it allows the combination of different methodologies, from theoretical to empirical studies, aiming to integrate the results, maintaining the methodological accuracy of systematic reviews. In the case of theme reconceptualization, it opens new perspectives that had not been previously explored¹³.

The research question, which guided the integrative review and the construction of this

article, is to understand how the assessments of health systems efficiency have been approached in times of crisis, having equity as their guiding principle, and how they manifest in different types of health systems.

The definitions used for efficiency and health systems were studied, by assessing how these evaluations were performed in the last ten years, their coherence and consistency, and the respective variables that represent the utilized concepts.

Search strategy

Based on the research question, a search was carried out in the PubMed and VHL databases for the terms “health systems”, “efficiency”, “equity and/or effectiveness”, excluding the following terms: “clinical”, “hospital”, “administrative”, “institutional”, “performance”, “diagnosis”, “treatment” and “technology”. A total of 838 scientific articles were identified, which were selected for title and abstract reading, and 193 articles were eligible for full-text reading. Of these, 79 were included for content analysis and theme synthesis. Figure 1 shows the article selection steps.

The inclusion criteria were: 1) full texts available in the databases; 2) texts in Portuguese, English or Spanish; 3) studies carried out or published in the last decade (2008-2018). The exclusion criteria included: 1) articles in duplicate; 2) clinical approach; and 3) institutional, administrative or organizational approach.

Data extraction

The following data were extracted from the studies: country of origin, global or local comparisons, research institutions, types of journal and publications, concepts used to define equity, efficiency and typology of health systems, methodological approaches used in the studies (sampling method, methodological stringency, selected variables, and qualitative and quantitative analyses), and especially the purpose of the research, obtained results, answers to the research questions, and recommendations or conclusions.

Health systems concepts and typologies

Böhm et al.¹⁴ conceptualize the systems based on the actors responsible for service regulation, financing and provision, that is, whether it is the government, society or the private sector that is mostly responsible for the analyzed attributes. Considering the hierarchy between the attributes

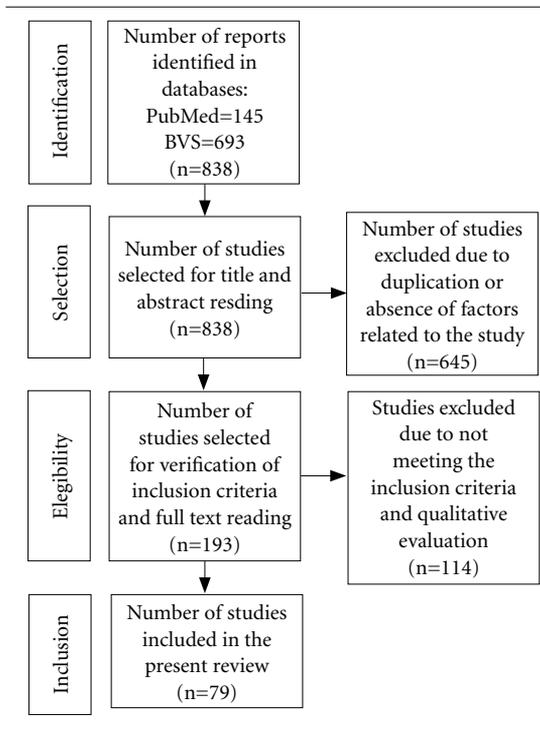


Figure 1. Flowchart of study selection and inclusion in the integrative review.

Source: the authors.

and their plausibility, five existing combinations were found: national health services and national health insurance (state regulation and financing, with public or private service provision), social security and state social health insurance (social or governmental regulation, social financing and private service provision), and the private health system.

Data interpretation and methods used

The following topics were used in the critical evaluation of the selected studies: the research question, its importance, theoretical-methodological congruence and its bases; research questions from previous studies; the adequacy of the study methodology; proper selection of participants or units of analysis for the study; answers to the research question in the article; the limitations or biases found; and the omissions and aspects about the topic that are absent, incomplete or poorly represented in the literature. These questions allowed a second and critical analysis of the articles, bringing the results closer to an

interpretative and theoretical validation. In the case of theoretical articles or studies, the evaluation was based on the following factors: public interest, logic and construction of the arguments, clear identification of the source and associated references¹⁵.

The articles were submitted to a hierarchy of evidence and levels of analysis, according to the study design and the comparisons made, classifying them according to their strength of evidence¹⁶. The levels used were the following: i) high: meta-synthesis (qualitative studies) or meta-analysis (quantitative studies); ii) medium-high: evidence from a single study; iii) medium: synthesis of studies; iv) medium-low: evidence from a single descriptive study; and v) low: expert opinions, theoretical studies or essays.

The results were ordered, coded, categorized and summarized, in a unified and integrated manner, providing the innovative synthesis of collected and analyzed primary evidence, from the perspective of thematic analysis. Patterns, themes, variations and associations were identified based on the defined categories of the extracted data, allowing the construction of analysis and synthesis matrices.

The cross-case analysis methodology proposed by Miles and Huberman¹⁷ was used, which allows comparing and contrasting the emerging patterns of the selected studies. The cases were analyzed as follows: divergent category filter, list of similarities and differences between pairs of analyzed cases, and the juxtaposition of apparently similar cases. Therefore, it was possible to advance beyond the initial impressions, especially by interposing a different view at the data. Chart 1 shows the main steps performed in the analysis and synthesis, based on the criteria of the Joanna Briggs Institute (JBI)¹⁵.

Results

Main contributions of the selected articles

The main themes addressed by the articles were: commercialization and sectoral health reforms (24.1%); association between effectiveness and equity (19%); efficiency and equity (12.7%); efficiency and effectiveness (11.4%); international comparisons of health efficiency (8.9%); universal health coverage (8.9%); societal values (6.3%); policies recommended by international organizations (3.8%); relationship between PHC and equity (2.5%), health policies in times of

Chart 1. Steps for the meta-aggregation of data in the integrative review.

Steps	Summary	Classification
Identification	How have health systems efficiency and effectiveness assessments been addressed, based on equity and how do they manifest in different health system organizations?	Concepts of efficiency, effectiveness and equity Principles of social justice Typology of health systems
Findings	Thematic content analysis Cross-case analysis	Main approaches/themes of the articles Association between selected variables
Categoryzation	Types of Efficiency Types of Effectiveness Types of Equity Types of Health Systems Conceptual models of the principles of justice Focus Values Health outcomes	Technical and allocative efficiency Cost-effectiveness and health level Horizontal and vertical equity Universal, insurance or private health system Market, professional or community focus Equal or utilitarian/neoliberal Personal or social responsibility Intermediate or final
Synthesis	Relationship between equity, efficiency and effectiveness Equity assessment of health systems	Relationship between efficiency and effectiveness, according to equity, the principles of justice, their conceptual models and the types of health systems. Equity in financing, access and health levels

Source: the authors

austerity (1.3%) and equity and intersectoriality (1.3%).

When different health systems were compared in the articles, there is generally a recommendation not to perform rankings and not directly apply indicators created in other contexts. Few studies directly compare the organization of health systems with the achieved results.

Comparisons are almost always made between the countries of the Organization for Economic Development Cooperation (OECD); in some situations, there are comparisons between middle-income countries¹⁸. Most of the time, countries with universal systems or national health insurance (United Kingdom, Nordic Countries, Iberian Peninsula, Italy, Canada, Australia and New Zealand), social health insurance (Germany and Switzerland), or state social insurance (France, Belgium, the Netherlands, Eastern European Countries, South Korea, and Japan) are compared¹⁴.

When the private health system (USA) is analyzed, there is evidence of good intermediate results concerning the investment made in high-cost technology, such as waiting lines or reduced length of stay; however, the health level outcomes are worse, when compared to universal or insurance systems. Moreover, the users' satisfaction

with the health system is lower, with several reports about the need to reorganize the system in this situation¹⁹.

In articles in which efficiency was assessed as general or allocative, equity was present as a relevant variable, under the concept of territory, in the redistribution of resources between regions, a more common view in universal systems²⁰. When technical efficiency is assessed individually, which is common in private health or insurance systems, it is usually treated more restrictedly or, at best, focused on the level of attention of the health service, without mentioning equity. They are rarely long-term evaluations. On the other hand, effectiveness usually appears as a measure of health or quality, measured by infant or under-five mortality rates, mortality from avoidable causes, total and sixty-year life expectancy, healthy life expectancy, quality of care and health care²¹. On the other hand, effectiveness in private health systems is reduced to cost-effectiveness. Health effectiveness has been rarely described as a result of policies that reduce inequalities²².

Equity has been most commonly assessed as horizontal, according to the neoliberal approach, as it would go hand in hand with efficiency. In some studies, social justice comes close to vertical equity, based on the egalitarian approach. It is

sometimes treated as income distribution; sometimes it is mistakenly taken as coverage and access to health services, or even as payment exemption by the most vulnerable groups. More rarely, it was classified as substantive, based on health needs, or deliberative, which implies social participation. It is also related to effectiveness, when the results of global indicators are compared according to income distribution or cost-effectiveness²¹. Figure 2 shows the synthesis of the associations between efficiency and effectiveness in different types of health system, according to equity and the principles of social justice, portraying solidarity and alterity in the form of social responsibility. The associations between different levels of equity in health production, from financing to health levels, can be seen in Figure 3.

The main countries that addressed the subject of commercialization and sectoral health reforms were the United Kingdom (31.6%), the USA (15.8%), Brazil (10.5%) and Sweden (10.5%). The concepts of commercialization and privatization of services are addressed, pointing out the main mechanisms used, their consequences for equity and efficiency, as well as future trends. Commercialization has been defined as a broader process than privatization, as it encompasses the use of private logic within public health systems by increasing the direct participation of the private sector as a provider of services and of private resources in financing, as well as the use of liberal principles of management, remuneration and organization of systems²³. The main trends found in the reforms were: the implementation

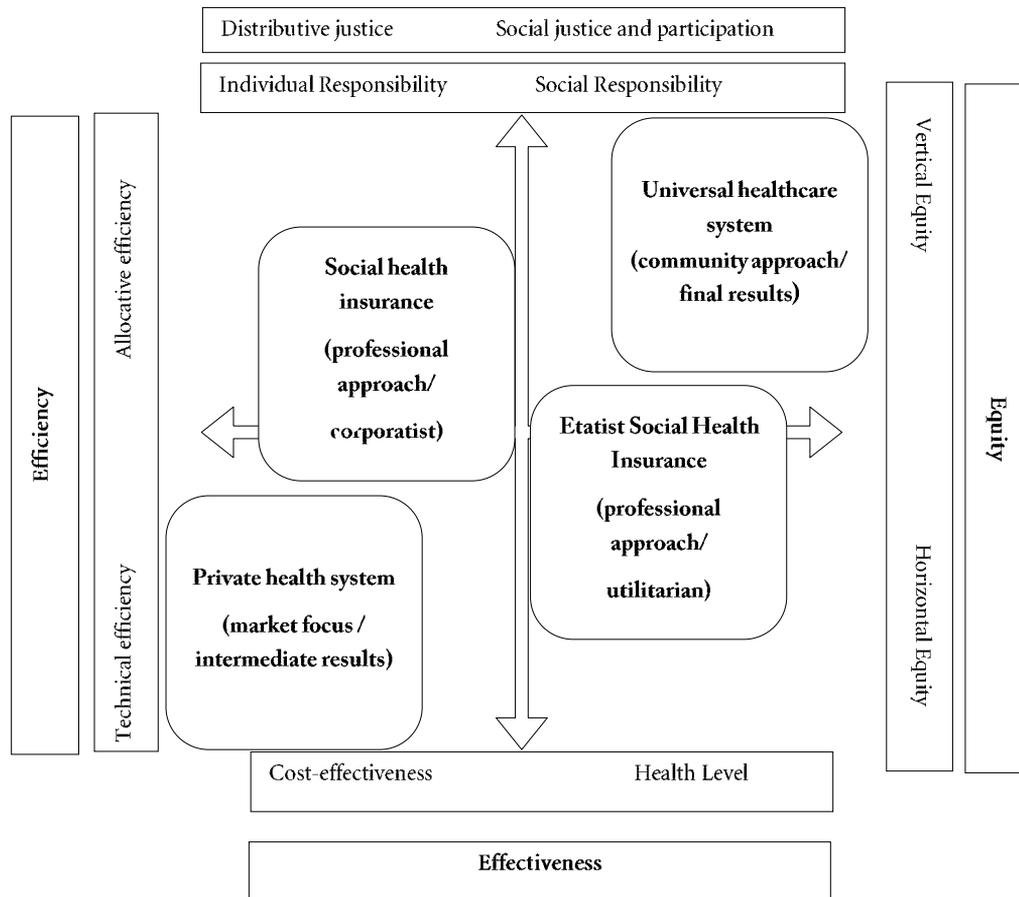


Figure 2. Association between efficiency and effectiveness according to the organization of health systems, consistent with equity and the principles of justice.

Source: the authors

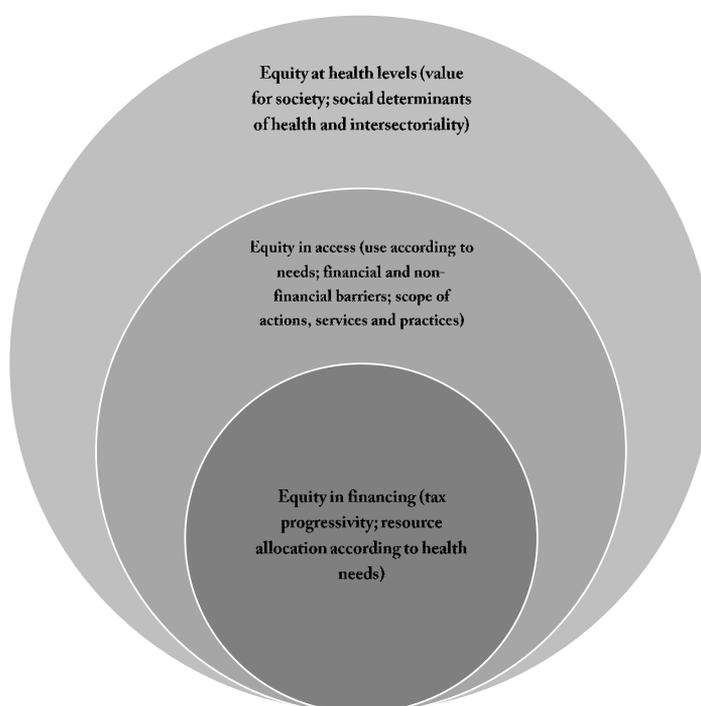


Figure 3. Association between equity in health financing, access and levels.

Source: the authors.

of universal systems, public contract models; separation between buyers and providers, choice of providers, regulated competition between providers and buyers, strengthening of the PHC, with the capacity to negotiate and purchase secondary services, restriction of hard technology coverage (protocols)²⁴. Chart 2 shows the analyses carried out in relation to the topic, prioritizing the studies with medium or high level of evidence, which was detailed in the discussion.

Regarding the values of society, most countries in the analyzed articles (60%) have universal systems, and it is up to society to define which values are crucial for the construction of their health system²⁵. This reflection should precede any other decisions on sector reforms, including its structure, operation and the desired public-private mix¹⁸.

From the perspective of modern values of increasing individualization, individual responsibility is projected as an increase in autonomy and the fulfillment of personal preferences. Rising health costs have started debates about financial differentiation in care distribution. Still,

solidarity prevails, with only a partial acceptance to bear some costs of unintentional, harmful habits, with a preference for a bonus for healthy behaviors²⁶.

As for the initial approach between efficiency and equity, among the ten articles selected in this topic, the following countries predominated: Chile and the United Kingdom/Canada (30% each), Brazil (20%), India/USA and China. (10% each). Regarding the technical approach between efficiency and effectiveness, the USA stood out with 44.4%, followed by Germany, Brazil, Spain, England and New Zealand (11.1% each). In the most recent approach between effectiveness and equity, the USA (26.7%), Belgium and the Netherlands (13.3% each) stand out; the remaining countries reached 6.7% each: Brazil, Canada, Cuba, Spain, Malaysia, New Zealand and the United Kingdom. Less than 10% of the studies showed a solid association between the three dimensions, more frequent in studies that addressed the performance of health systems^{18,21}.

Regarding the topics and countries of origin of the studies, most were from countries with

Chart 2. Analyses performed for the topic “Health Commercialization and Sector Reforms”.

Author, year, title (publication/evidence level*)	Association between efficiency, equity and effectiveness	Research question	Answer to the research question
Wenzl et al., 2017 ²⁷ . Health policy in times of austerity—A conceptual framework for evaluating effects of policy on efficiency and equity illustrated with examples from Europe since 2008 (E/II)	It demonstrates the difficulty of assessing the future effects of proposed policies regarding coverage and access to health services; short-term cost cutting does not always mean long-term efficiency.	Can the analysis of public policies be performed in relation to their future effects on social values, objectives of health systems?	There is great difficulty in determining future effects on equity, effectiveness and efficiency, but it also demonstrates that few governments perform such analyses when formulating and implementing policies in times of crisis.
Bevan et al., 2010 ³⁸ . Changing choices in health care: implications for equity, efficiency and cost (R/III)	It correlates technical and allocative efficiency, together with the achieved results, with the necessary central control of costs by the government and some competition to increase quality. To promote equity, the insurance needs to be integrated with service provision.	How to promote a balance between equity, efficiency and costs in health?	The authors suggest that some degree of competition and choice, preferably driven by GPs, increases quality, without excesses, so as not to compromise costs. At the same time, equity in access may be accompanied by inequities in health outcomes.
Vrangbaek et al., 2012 ²⁹ . Choice policies in Northern European health systems (E/II)	Unanimous association between efficiency and power of choice, followed by improved quality of health care, especially when GPs choose the services. As for equity, only the UK believed in this assumption.	Has policy-making on the choice of providers showed a convergence in northern Europe?	The convergence occurred more at the discourse level, in relation to consumer’s rights (empowerment and market competition).
Burstrom, 2009 ¹² . Market-oriented, demand-driven health care reforms and equity in health and health care utilization in Sweden (R/III)	It associates technical and allocative efficiency, according to health needs, with equity as the central objective of the Swedish health system, non-compatible with health choices, in a broad and nonregulated way.	The question is, Can whether market-driven reforms promote increased efficiency with equity?	Free choices did not improve efficiency, and reduced equity, as providers were free to offer their services unrelated to health needs.
Fotaki, 2010 ³⁰ . Patient choice and equity in the British National Health Service: towards developing an alternative framework. (T/IV)	Horizontal equity and efficiency were positively associated. In the UK, the freedom of choice is gaining space and resulting in the speech for increased equity.	Relating freedom of choice to equity.	Different paths have been shown towards the provision of multiple services and equity, since it does not address the causes of inequities and, often, this freedom is not recognized or enjoyed by individuals
Kreisz e Gericke, 2010 ³¹ . User choice in European health systems: towards a systematic framework for analysis (T/IV)	Association between efficiency and equity, in the systemic, supply and demand dimensions. It points out that freedom of choice can reduce efficiency, reducing the quality of health.	Is freedom of choice a guaranteed mechanism for increasing efficiency and promoting equity?	Most of the time, it is not. On the contrary, it can increase costs and end up reducing choices.
Kim et al., 2016 ³² . Productivity changes in OECD healthcare systems: bias-corrected Malmquist productivity approach (E/II)	The analysis is performed by the efficiency/productivity bias, focused on the effectiveness results and, at least, there are adjustments for income and globalization inequalities, representing equity.	In the studied decade (2002-12), have there been changes in the productivity of the countries? In what sense?	There was a balance between efficiency and technology, and some countries stood out in terms of innovations, such as South Korea, Japan, the USA.

it continues

Chart 2. Analyses performed for the topic "Health Commercialization and Sector Reforms".

Author, year, title (publication/evidence level*)	Association between efficiency, equity and effectiveness	Research question	Answer to the research question
Wan YC e Wan YI, 2010 ³³ . Achievement of equity and universal access in China's health service: A commentary on the historical reform perspective from the UK National Health Service (T/IV)	Indirectly, with regard to allocative efficiency and equity in financing, as well as the quality of health care.	How can the NHS experience help the Chinese health system to seek greater equity and access to health?	In part, it was possible to demonstrate the NHS's hits and misses, but the political and economic contexts are quite different.
Nwagbara e Rasiah, 2015 ³⁴ . Rethinking health care commercialization: evidence from Malaysia (E/II)	It correlates technical efficiency and technical quality of care, at the intermediate level, for public health services.	Has the commercialization of health in Malaysia been useful for increasing efficiency in public health services?	No, there was a displacement of the workforce and more complex equipment, reducing the efficiency of public hospitals.
Ferreira e Mendes, 2018 ²³ . Mercantilização nas reformas dos sistemas de saúde alemão, francês e britânico (R/IV)	The approach does not expand the association between technical efficiency and equity in access, but points out that efficiency was not achieved through privatization.	To analyze the implicit and explicit mechanisms of commercialization of supply and financing and their consequences on access and equity of the systems.	It demonstrates the negative effects of the used mechanisms, which need constant adjustment, in order not to destroy health systems as originally designed. An important point is the shift in the search for efficiency among service providers.
El-Idrissi et al., 2008 ²² . Constraints and obstacles to social health protection in the Maghreb: the cases of Algeria and Morocco (T/IV)	Relationship between social inequality (Gini index), inefficiencies in systems and inadequate health outcomes (low effectiveness).	To present the challenges of these countries in achieving satisfactory health reform outcomes.	Fragmentation of services and privatization makes universal access very difficult; the insurance format harms the unemployed and informal workers.
Scheunemann e White, 2011 ³⁵ . The Ethics and Reality of Rationing in Medicine (R/IV)	Association between horizontal equity and efficiency and the rule to save people.	Is it feasible to perform medical rationing in order to hold society responsible or legitimize the choices that have been made, considering the ethical principles?	Most of the time, it is not. The unbearable weight of decisions placed upon the collective does not allow these decisions, especially when they are identified cases. The important thing is that there is procedural justice: transparency and social participation, among others.
Halkos e Tzeremes, 2011 ³⁶ . A conditional nonparametric analysis for measuring the efficiency of regional public healthcare delivery: an application to Greek prefectures (E/II)	It did not analyze equity, only inequalities. The assessed efficiency is focused only on intermediate results.	Has the health reform brought greater efficiency?	There were problems with decentralization, both in relation to resource allocation and regional administration; economic growth has not brought efficiency; the existence of urban hospitals was a positive factor.
Esteves, 2012 ³⁷ . The quest for equity in Latin America: a comparative analysis of the health care reforms in Brazil and Colombia (E/II)	Association between technical efficiency and health outcomes. Equity can be analyzed in relation to the comparison with LA and Caribbean averages.	Have the health outcomes improved with sustainability after the health reforms in Brazil and Colombia?	No decisive and continuous improvements have been demonstrated; there was even a setback in Colombia. The explanation would be the inequities in access to care and income, underfinancing and economic crises.
Senkubuge et al., 2014 ³⁸ . Strengthening health systems by health sector reforms (R/III)	Shift in the pursuit of efficiency in the reforms to achieve equity and effectiveness regarding the vulnerable groups and health outcomes.	To evaluate the effects of reforms on system elements according to their macro functions.	Reforms must be holistic and gradual, ensuring society's participation, with the sharing of information, paying particular attention to health access for vulnerable groups.

*Type of publication: E – empirical study; T – theoretical study; R – review study. Level of Evidence: I – high; II – medium-high; III – medium; IV – medium-low; V – low.

Source: own elaboration

universal health systems, with the following proportions: commercialization of health (89.5%); international comparisons (85.7%); efficiency and equity (80%); efficiency and effectiveness (77.8%) and equity and effectiveness (46.7%). Regarding international comparisons, Germany, Canada and the USA (28.6% each) and the United Kingdom (14.2%) were the main representatives. Finally, regarding the approach to universal health coverage, countries in Africa and Asia deserve to be highlighted, with 42.9% and 28.5%, respectively, as well as Australia and Cuba (14.3% each).

The articles with the best levels of evidence focused on the association between equity and effectiveness (60%) and between efficiency and effectiveness (55.6%). Most studies are still theoretical, highlighting the topics of health commercialization (68.4%) and universal health coverage (85.7%). Regarding the association between the elements equity, efficiency and effectiveness, the studies were well balanced, with approximately 50% in each category (theoretical or empirical). Of the total number of studies, 50.6% had global comparisons and 17.7% had local comparisons.

Discussion

The liberal ideological bias has permeated the strategies of structural adjustments or sectoral reforms, since few studies previously evaluated the impact of the recommended measures²⁷. There have been extreme situations of contradiction in which, although studies carried out by the international entities themselves demonstrated that economic austerity measures did not reach the promised results, their recommendation remained in practice^{5,6}.

Thus, the recommendations of the international organizations and the donations were directed to the strengthening of health systems^{5,39}, in a horizontal way, with reduced initiatives, a proxy of the principles of universal health systems: of universality (universal health coverage), integrality of care (continuity of care and coordinating primary care) and equity (reduction of inequalities between vulnerable groups). This juxtaposition of principles and initiatives can at first glance misrepresent how equity, efficiency and effectiveness are organized in health systems.

From a utilitarian perspective, countries were recommended to maximize their levels of health, especially in times of crisis, based on efficiency gains that would be obtained through the privat-

ization of services, economies of scale, separation between buyers and providers, competition mechanisms between providers and even between insurance companies, reduction of health professionals' salaries and financial incentives on the supply and demand side¹⁹. Burström¹² and Albreht⁴⁰ warn that market-oriented strategies will increase costs, require regulation and promote inequities, as the more educated and affluent population will benefit far more than vulnerable groups in choosing and using services. Thus, it is recommended that they be compensated with resource allocation mechanisms according to the health needs or the results of epidemiological indicators, rather than simply by demands and payment capacity¹². Over the course of the privatization process, the system's universality, equity and good results may be lost, as providers are chosen based on cost reduction. Regulation should be implemented to avoid a parallel system, without equity and with adverse selection. It is important to avoid the consumerist view of health, as well as the false assertion that individual responsibility for health will be increased if one pays, directly or indirectly, for it⁴⁰.

From an egalitarian perspective, universal systems have thus remained, albeit with the increased privatization of services and the formation of quasi-markets, but the government's regulation and financing have been maintained¹². However, the principles of solidarity and citizenship started to compete with personal responsibility and the autonomy in health-related consumerist decisions²⁶. Thus, freedom and equality became irreconcilable in the construction of the right to health, reflecting the contrast between alterity and austerity.

Health sector reforms should preferably change their design, structure and organization to incrementally, deliberately and sustainably improve equity, effectiveness and efficiency. Hence, the conceptual structure proposed by Frenk⁴¹ demystifies the different levels of health policy to be analyzed: the systemic level, of which main objective is equity; the programmatic level, of which goal is effectiveness and allocative efficiency; and the organizational level, which deals with technical efficiency.

The most recurrent topic in the studies, the health sector commercialization and reforms, is justified from the perspective of assessing which measures adopted during the capitalism crises were successful ones: freedom of choice, for instance, did not lead to an increase in efficiency, nor the models of remuneration to service pro-

viders and fragmentation and privatization of health services led to an increase in the effectiveness of health levels^{12,23}. According to the hypermodern perspective⁴², the power of choice, decision-making, the individuals' autonomy in their life relationships and interactions, provided the unsustainable weight of individual responsibility and insecurity regarding the future. Modernity is characterized by increasing individualization, and an increase in the value of the market, efficiency and technique.

Thus, it is not surprising that African⁴³ and Asian countries³⁹ are being offered universal health coverage service package solutions as a means of expanding markets through the financial capital, while they are justified by international organizations as promising regarding the implementation of the right to health, according to the local political situation found and the social confrontations.

A point of great relevance is the persistence, for so many years, of the fallacy between efficiency and equity⁴⁴, removing the focus from the choice between equity and effectiveness: that being the true decision that a society must make. Thus, the association between efficiency and effectiveness improves with equity, as not only does a society's health levels increase, but also its distribution, with financial justice.

Regarding the association between equity and effectiveness, there have been efforts to create a new dimension in the context of performance analysis, or to keep it cross-sectional, very often comparing the results achieved between different strata of income, education or socioeconomic level²¹. Sometimes, composite indexes of social exclusion or globalization emerge, in their economic, political and social dimensions, in an attempt to understand the studied phenomenon. It is important to note that less than 20% of the countries studied by Tausch⁴⁵ have shown improvement in their health level with globalization, because in most cases, the latter, especially in its financial component, leads to inequities, which prevent good health outcomes.

The association initially established between efficiency and equity still persists in the literature as a true and mutually exclusive one, supporting several studies^{44,46}. There have been several studies in which equity was seen as an adjustment to an equation related to individual measures or in which allocative efficiency and horizontal equity were balanced as an important search for equilibrium between these dimensions⁴⁶. There is simply no way to attain such a balance, as efficiency only

aims to minimize resources or maximize results, whereas equity starts from the possibility of a fair distribution of health outcomes. The most relevant point, however, is to consider that efficiency and equity are complementary objectives for the attainment of basic and individual capacities, which include not only health services, but also the possibility of choices between ways of life⁴⁷.

An important development in equity assessment is its financing component⁴⁸, in addition to comparisons between risks, intermediate health outcomes and health levels⁴⁹. In this component, there is no way to hide the true intentions of a country's resultant health care system. There is a large number of strains between health projects, programs and policies, so that the predominant type of health system will hide these contradictions. However, when analyzing the % of GDP allocated to health, the proportion of public expenditure on health, the proportion allocated to PHC, the nature of revenues, the progressiveness of contributions, the existence of cross-subsidies of risk and income, one can see where the health of a country is headed⁴⁸. Other important dimensions are intersectoral public health (equity at health levels); financial and non-financial barriers to access (equity of access) and the amplitude of benefits⁵⁰.

The main limitations of the present article are related to the scope that an integrative review provides, as it allows the review of concepts and the analysis of theoretical studies, but does not provide quantitative results, as in meta-analyses. However, this method would not provide the produced syntheses and the interrelationships found between the variables. Another limitation concerns the contradictions found in the literature between the abundance of policy recommendations for sectoral reforms and the scarcity of outcome evaluations. From the viewpoint of the used language, the choice of English, Portuguese and Spanish provided a comprehensive search, but studies with different approaches in non-searched languages may have been excluded⁵¹.

Conclusion

With the financialization of capital, countries may have enjoyed an initial dynamism from the economic point of view and the illusion of generating greater wealth for the nation, while becoming part of a new global order⁴⁵. However, as disclosed by the carried out review, its effects

on equality were deleterious and the implementation of health as a right was severely impaired in many health systems, especially after the GFC. This is explained by the fact that the crisis occurs in a contradictory manner, as a solution to the problem that originated it: thus, the decrease in the profit rate, observed since 1970-80, is counterbalanced by the increase in the interest-bearing capital, i.e., the financial capital, which does not take into account the productive capital or workers' welfare measures, who have their wages decreased and their exploitation increased, accompanied by a rise in unemployment and labor market informality⁵².

Important movements have been observed regarding the financial crisis and globalization, such as the opening of foreign trade and the increase in share capital, as well as the denationalization of the state, the destatization of politics and the internationalization of the formulation and implementation of public policies. In addition to the reduction in local public spending for social and health policies, the organization setup of social protection systems is modified, defining the space intended for solidarity, according to the logic of global capital⁵².

Health equity can be jeopardized with the privatization of services or health insurers. It is crucial that countries decide how much privatization they will allow in their systems, regulate them transparently and responsibly, and rather try to increase the efficiency of the public system. It is important to maintain public financing, even in places where service provision is private, by regulating the systems, monitoring and evaluating them continuously. The decision regarding the privatization of services must be carefully considered: it should not be just a political response, much less an imported one⁴⁰. It should be surrounded by care, especially in relation to the more complex levels of care, which tend to be quietly privatized, while primary care baskets are established for the most vulnerable groups.

Therefore, the necessary balance between equity and effectiveness should be efficiently sought as a means of strengthening health systems. Moreover, the relationship between efficiency and effectiveness has shown better results in countries that value equity. Hence, new empirical studies on the search for this new balance should be undertaken⁴⁴.

With each capitalism crisis, and there are many yet to come, there is an increase in bottlenecks of resources aimed at social areas, the shocks and incentives to provide health care in bundles or baskets of products, according to the capacity to pay or through the reversal of citizenship. If we are increasingly distancing ourselves from the social determinants of health, on the other hand, some principles remain strong to the point that they have been included in certain hegemonic and ambiguous initiatives, at least as an indicative, such as the pursuit of equity in universal health coverage^{39,53}.

Achieving good results in individual and collective health requires a continuous effort to direct scarce resources to maximized results, to live longer and better. However, despite all efforts to increase efficiency and reduce social protection, fortunately it has not yet been possible to eliminate a fundamental principle of the human condition, i.e., solidarity, supported by alterity and expanded in universality, an indispensable ingredient for human interaction and the desire for a fair and cohesive society, in which the rights of all groups are recognized in a plural society.

The choice between alterity or austerity must be an explicit and transparent one, with the resilience of values that society wants: attention must be paid to the concealment of the principles of universality, integrality and equity, through mere semantic traps or initiatives that exclude the quality of life and citizenship.

Collaborations

AEM Bousquat contributed to the project concept and manuscript design, data interpretation and critical review of the manuscript. S Schenkman worked on the project concept and manuscript design, database search, publication analysis, data interpretation, writing and discussion of the manuscript. All authors approved the manuscript version to be published.

Acknowledgements

S Schenkman is a CNPq fellow from the Ph.D. course in Public Health.

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Article submitted 20/03/2019

Approved 12/07/2019

Final version submitted 09/08/2019