interface
comunicação, saúde, educação
https://www.interface.org.br
eISSN 1807-5762

Editorial

Quality-equity in health: new challenges in a social ill-fare state

Qualidade-equidade em saúde: novos desafios em um estado de mal-estar social

Equidad de calidad en salud: nuevos desafíos en un estado de malestar social

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According to the theories of social welfare[1,2], in democratic societies, the economy, the society, and the State's purpose is to improve people's lives. According to this discourse, the State would ideally be configured as an institutional device aimed at political stability, public safety, justice enforcement, and market regulation, enabling the common good, ensuring civil rights, and fostering equity. Therefore, social and economic inequalities would be undesirable subproducts of crises and unforeseen events of the productive system, to be overcome by social, economic, and human development of countries and by the mediating or interventionist measures of the welfare state with public policies that promote equity, focusing on the distribution of benefits to the most underprivileged social segments.

According to Thomas Piketty[3] in *Capital in the Twenty-First Century*, a centuries-old trend of inequalities, which unfold in capital property and income inequalities, is the structural foundation of the capitalist economic system. In his last work[4], the author refers to his new

findings on late capitalism as *Le retour des inégalités* (p. 48). Piketty[3,4] posits that, with the internationalization of capitalism, its productive base is updated with cognitive assets, and its ways of achieving profitability by financialization is revisited. There is an increase in extreme inequalities to be overcome or compensated with social and economic policies that, in many contexts, are not occurring.

Based on this reference, Julia Lynch[5] analyzes what she refers to as the "resilient inequality enigma." According to the author, institutions created to reduce inequalities in health in European post-war welfare states faced neoliberal economic policies starting in the 1980s. Instead of solving the structural inequality issue with effective "political remedies," investments were made in supposedly simple and effective optimized management processes. In these countries, the inequality problem was generally assumed as an exclusively legal issue to be solved in the normative sphere, enabling to formally maintain a historical commitment with equity without challenging the tax policy foundations that support the State. In this context, the issue of inequities in health entered the center-left-wing political agenda, which avoided discussing the contradiction between a conservative-corporativist welfare order and the neoliberal paradigm that spread all over Europe in the 1980s[5] (p. 207).

Focused on the economy in general, Piketty's suggestion can be considered, from a theoretical point of view, a new Political Economy, since it refers to economic inequalities as an epiphenomenon or a subproduct of the economic system, not a structural condition of the capitalist modes of production. In health, in turn, despite the pretention to create a theoretical criticism of the so-called "regimes of inequity," Lynch's analysis is self-referenced as a "political economy of wealth and health." When referring to economic inequalities (and their political, social, managerial, societal, and sanitary counterparts) as an undesirable secondary effect of economic and political crises, processes, and cycles prone to solutions capable of "taming the inequality machine" (according to Schrecker[6]), both Piketty and Lynch follow the functionalist perspective dominant in the epistemologies of the North. Therefore, they do not hide their intent to try to efficiently and viably solve, in public policies, deadlocks and contradictions imposed by iniquities in health on the social and economic system.

Under this Neo-Keynesian perspective, which is the basis of a moderate neoliberalism, the existence of subjects that, due to economic or political reasons, are prevented from benefiting from public policies required by the society would imply an open social debt to be overcome or settled. In Brazil, this rhetoric is present since the redemocratization and the New Republic as a technocratic reply to the finding that development models based on foreign indebtedness and income concentration as generators of investment to increase poverty and result in social inequalities. In this discourse, the idea of "social debt" is justified by the "ethical assumption that each citizen should have their basic needs minimally guaranteed; [...] similarly to the public debt, it would be a society debt to itself"[7] (p. 38). "Social debt" actually refers to society's structural inequalities that define a historical commitment that is oftentimes postponed but always expected with the guarantee of equity and justice regarding human's fundamental rights.

Nonetheless, from the operational point of view, the notion of social debt can be justified, but only for specific cases such as health-disease-care phenomena. In health, this social or sanitary debt [8] (p. 67) can refer both to the unequal distribution of risks, in the

epidemiological sense, and to the unequal access to healthcare systems with effective and available programs and technologies, and healthcare practices with the highest human quality possible, which should be guaranteed as a right to all members of a society.

However, only in the idealized perspective of a mythical welfare state responsible for the welfare of all its citizens can we talk about social debt. Actually, health's social debt cannot be renegotiated, since deadlines that cost human lives cannot be extended and would not be subject to audit, moratorium, or complaint simply because it would imply a structural issue that constitutes a political and moral commitment with the radical transformation of society. Social debt would indeed be social inequalities that become iniquities, in the sense of a peculiar form among inequities (defined as avoidable in the redistributive logic) revealed as negative effects of a socio-historic dynamics based on exploration, exclusion, and oppression. Several authors[9-12] posit that capitalism is the result of a global historical process that constitutes, in the contemporary world, a broad and complex phenomenon—not only a mode of production but also a mode of life[12]. Through structural and super-structural relations, this mode of production interacts with (conditions, determines, overdetermines, etc.) health in different scales of reality by a series of processes, conditions, determinants, and vectors[13].

Overdetermination of the deep and underlying structural effects of capitalism on, and of, health on the mode of production and modes of life is observed at multiple scales, comprising new theoretical, scientific, and political challenges in the health field. The globalized world's macro economy currently controlled by the conservative neoliberalism profoundly affects health governance through different policies and actions such as austerity programs, international trade, investments in health, pharmaceutical and equipment industry, food safety, and ultra-processed food consumption. According to Sell & Williams[13], it is necessary to develop an account of capitalism as "structurally pathogenic with negative impacts on human health," understanding this global and broad mode of production as a generator (and resulting) of social and economic inequities and health iniquities like no other productive system in human history.

As an analytical strategy to better understand this issue taking into account the specificity of its application in health, I suggest breaking down the concept of equity in its elementary forms aiming at critically overcoming conventional theoretical perspectives[14].

In this sense, strictly for reasoning purposes, let us consider that both in the social, democratic, and efficient welfare state, idealized as a redistributive device[1,2], and in the socialist projects of a democratic, egalitarian, fair, and supportive society[15,16], full health equity would be translated into four possibilities:

1. Equity in the health situation: when the risks of becoming ill are homogeneous among all populational groups.

2. Equity in health conditions: when all citizens are covered by effective programs of health promotion and protection.

3. Equity in healthcare access: when, in a context of social equity, healthcare and health recovery systems and services are equally guaranteed to all.

4. Equity in care practices: when technological effectiveness, humanization, and quality care are equally available to all citizens.

In the first mode of health equity, it is necessary to take into account that, when considering health risks and homogeneous probability of becoming ill and dying, equality is a concrete possibility only with regard to socioenvironmental risk factors. This is due to the fact that, in the epidemiological sense, actual health risks result not only of external environmental factors but also of individual vulnerability and susceptibility, as well as interactions between the individual and the environment. Therefore, individuals of all species, but even more humans—primates endowed with language, producers of culture, dependent on social bonds, i.e., political animals—suffer from inevitable processes of health differentiation (as a vital functionality). Under a strictly epidemiological perspective, the global indicator of this inequity in the health situation is a higher or lower inequality in the average life span (measured in years with quality of life) among the different geopolitical, economic, and social combinations, which can be complemented by other morbidity, mortality, and health service use indicators[17].

The second and third modes of health equity indicated above share a similar dynamics, since they are subject to public health policies. In both meanings, iniquity would result from the State's omission to promote quality of life to its citizens by ensuring fundamental rights, such as housing, safety, healthy environment, political freedom, education, and health. Considering health, a redistributive or compensatory measure by the State would be granted with actions and policies to expand access (to its full extent, becoming universal and equanimous) to available and appropriate resources to improve the population's health conditions.

These three manifestations of the social inequality and inequity issue in health have been the object of deep conceptual and empirical production in different realities and concrete situations[18]. The determinants and effects of qualitative inequalities in the access to diagnostic, assistive, preventive, and rehabilitative technologies related to different levels of efficiency and efficacy, and especially human quality care, are less known.

This takes us to the fourth component of health equity, which I propose to be considered a concept: "quality-equity." In fields of social policies, such as in education, both topics are considered separate dimensions, dynamics, or processes that, throughout the public/private division, are taken as elements in contradiction[19,20]. In health, there is a pattern of an even greater isolation, where quality assurance is typically considered one of the main factors of effectiveness under an instrumental perspective of health services planning and evaluation[21], while the issue of equity is considered one of the social determinants of health[14,18].

The issue of quality with equity under a perspective of convergence and comprehensiveness is found in the blurred interface between quantitative and qualitative aspects of healthcare production, and between supply and use of health services in the acts of care and in therapeutic itineraries, within health systems. For greater objectivity, I suggest analyzing it under the negative perspective, as quality inequity—a deviation of the attribution of quality in healthcare.

Under this perspective, the emergence of inequalities in quality-equity—internalized in healthcare practices—reveals another order of inequities, which appear in four aspects:

1. Breach of comprehensive healthcare, which is partially not followed by the operation, still incipient in the point of view of technology, of reference and counter-reference systems that socially select patients for different levels of care.

2. Unequal availability of diagnostic, preventive, and therapeutic technologies, especially state-of-the-art equipment, procedures, and high-cost and highly effective medicine (in some cases, this aspect can be aggravated by the phenomenon of judicialization of the right to health).

3. Positive or negative differentiation when using efficient and decisive technologies in equivalent care contexts and levels, excluding, discriminating, and segregating patients of different social segments or cultural origins.

4. Differential quality in healthcare acts: Positive or negative differentiation in the treatment of users through a selective bias, such as invisibility, segregation, discrimination, differentiation by class, sex, race, generation, or origin.

How can we ensure “quality-equity” in health as a fundamental right to all? Generally speaking, it is necessary to prioritize ethical and political elements of care, since it would not be morally and politically fair to exclude anyone from accessing a quality healthcare. Strictly speaking, it is necessary to transform the “quality-equity” concept into a universal standard of health practice based on a specific notion of social justice in all levels, from the macro-economic to the micro social one, as a political achievement of the right to health beyond redistributive strategies of social welfare.

In this specific sense, there are some practices to be taken into account. Even with the typical legal and normative guarantees of constitutional democracies, the reality of health situations and systems enables to question the way this right can be applied. Firstly, it is necessary to verify in which dimension and on which object of care the desired quality-equity will be applied: Health as a vital state? As a set of care practices? As a value and measure? Secondly, it is necessary to assess in which level of care (All levels of complexity?) and quality (The best possible? What does this mean? Optimization? Feasibility?) equity is established. Thirdly, and maybe the most essential of these practical issues, it is necessary to confirm how quality-equity will be applied. (Which care models? With which acts of care?)

For illustration purposes, let’s briefly see the particular case of Brazil. Despite the implementation, which started thirty years ago, of a unified care system—the Brazilian National Health System (SUS)[22]—, Brazil still has deep health iniquities mainly focused on the differential quality of resources socially aimed at health promotion [23]. Recent advances in the Brazilian sanitary context are increasingly providing previously excluded subjects of socially disadvantaged classes and groups—generally living in remote areas— with access to SUS, mostly in primary healthcare through the Family Health Strategy[24,25]. Nevertheless, people who need the most and are more vulnerable keep facing difficulties in using health promotion, protection, and rehabilitation programs, mostly in the secondary and tertiary care levels, which are broadly available to social sectors that already benefit from better life conditions and private health plans[23].

In the Brazilian context, SUS has been underfunded, and suffer from management and quality problems, which become even worse with the recent social, political, and

economic crisis[26]. In the country's public healthcare sector, the organizational aspects of health programs and institutions, and selective underfunding conform with material and institutional obstacles that result in differentiation, inequalities, and segregation, based on income disparity and social insertion, in the access to available care resources, as well as the gap in information due to differences of gender, generation, education, and income.

Therefore, despite being accepted into the system, individuals of vulnerable social segments who typically need more quality care suffer other inequalities internalized in acts of care, which are a result of the system's structure and operation, and of care practices with low effectiveness and lower level of humanization. These individuals are in a situation of deep iniquity, in the condition of users of lower category, in a public health system that is supposedly universal. A reasonable conjecture is that this quality-equity breach, this new "internalized inequity" of qualitative, daily, intrafunctional, and camouflaged nature, is being practiced in different levels and dimensions with subtle and culturally sensitive forms of intersubjective, inhumane, segregating, and discriminatory relationship. What is scary in this conjecture is that, in our country, the development of competencies to produce and operate these inequities is rooted and reproduced in the formal education system[27] and in the ideological process incorporated in the training of technical staff and health professionals[28].

In Brazil, in order to peacefully overcome the end of the military dictatorship (1964-1985) in a context of social and economic crisis, we intended to create a "social welfare state" in a patrimonialist, oppressive, and predator capitalism, in a society that was still based on colonialism, slavery, and racism, without transforming it. Therefore, in the current context of the global advance of ultra-neoliberalism, we are left with a partial democracy, or a low-intensity democracy (according to Boaventura de Sousa-Santos[16]), considering the social, political, and economic exclusion of most of the population. Despite being a consequence of the restoration of a poorly-agreed republican order, the country fails to comply with the basic functions of a modern democratic State established since its conception in the early 19th century as a device capable of redistributing power and wealth, attenuating the economic inequality effects and political imbalances to their minimum to ensure social peace. Therefore, the country confirms its status as a social ill-fare state, or "predator state", as defined by James Galbraith[29]. Underfunded and inefficient to conduct public policies capable to offset current disadvantages and fix historical social debts, the public sectors are a real plant of transformation of economic inequalities into social and political inequities, mostly in the safety, education, and health areas.

In different contexts, even in the social welfare states with greater political stability, there is robust evidence that the allocation of governmental public resources can, direct or indirectly, benefit the wealthiest segments of society[30,31]. Considering this theoretical and empirical reference, I suggest the hypothesis that, particularly in countries of peripherical economy and low-intensity democracies, such as Brazil, the State works as a promoter and implementer of inequalities, acting as the main social agent of transformation of inequities into iniquities[32]. Specifically in health, the corollary of this hypothesis is that a broad and complex process of mutation of the nature of social and economic inequalities ends up producing new forms of health inequities.

In short, in this globalized hyper-capitalism context, we are in a global political situation ruled by an unjust combination of fundamentalism and obscurantism, with economic adjustments guided by neoliberalism, which produce social inequalities with strong negative impacts on health. In this current situation, it is relevant to say that, in social ill-fare states like Brazil, the increase of extreme inequalities result in varied forms of basic inequality, generating new modes of social inequities and, consequently, new forms of iniquity in all spaces of differentiation, including health. In this context, inequalities, inequities, and iniquities paradoxically grow with the increase of the resolutive capacity of health technologies available and the expansion of the formal health system coverage. In order to at least avoid these negative effects, an intense and urgent political fight is required to take back the State, reaffirming its characteristic of a democratic device committed to social progress, expanding and renewing alliances with all social forces and political movements that have contributed to consolidate and expand public health policies over the last forty years, resulting in an improvement of the health situation in Brazil.

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Translator: Caroline Alberoni

Submitted on 04/02/20.
Approved on 04/06/20.