

# Health sector reform and social determinants of health: building up theoretical and methodological interconnections to approach complex global challenges

*A reforma do setor saúde e os determinantes sociais da saúde: construindo interconexões teóricas e metodológicas para abordagem de desafios globais complexos*

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**ABSTRACT:** Health Sector Reform and Social Determinants of Health are central issues for the current international policy debate, considering the turbulent scenario and the threat of economic recession in a global scale. Although these themes have been discussed for a long time, three major issues still calls the attention of the scientific community and health policymakers. The first one is the matter of how to approach scientifically the intricate connections between them in order to understand the consequences of policies for healthcare services, once this debate will become much more tensioned in the coming years. The second one is the lack of explanatory frameworks to investigate the policies of reform strategies, simultaneously observed in a variety of countries within distinct health services, which aim to achieve multiple and contradictory goals *vis-à-vis* the so-called social determinants of health. The third one is the challenge that governments face in developing and sustaining equitable health services, bearing in mind the intense political dispute behind the health sector reform processes. This article discusses an all-embracing theoretical and methodological scheme to address these questions. The aim is to connect macro- and middle-range theories to examine Social Determinants and Health Sector Reform interdependent issues, with view to developing new knowledge and attaining scientific understanding upon the role of universal and equitable healthcare systems, in order to avoid deepening economic crises.

**Keywords:** Social determinants of health. Health policy analyses. Political economy. Health sector reform. Regulation theory. Advocacy coalition framework. Universal healthcare services.

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**RESUMO:** A Reforma do Setor Saúde e os Determinantes Sociais em Saúde são questões centrais para o atual debate político internacional, considerando o cenário turbulento e a ameaça de recessão econômica em escala global. Embora esses temas venham sendo discutidos há longo tempo, três grandes questões ainda chamam a atenção da comunidade científica e dos formuladores de política. A primeira é como abordar cientificamente suas intrincadas relações e as consequências políticas para os sistemas de saúde, levando-se em consideração que esse debate irá se tornar cada vez mais tenso nos próximos anos. A segunda questão diz respeito à carência de esquemas teóricos explicativos que permitam investigar o ambiente político das estratégias de reformas, observadas numa variedade de países com sistemas de saúde distintos, almejando alcançar múltiplos e contraditórios objetivos vis-à-vis os determinantes sociais em saúde. A última questão aqui tratada é o desafio que os governos terão pela frente para desenvolver e sustentar sistemas equânimes de saúde, em face da intensa disputa política por trás das experiências de reformas setoriais. Esse artigo apresenta um amplo esquema teórico-analítico e metodológico para abordagem dessas questões. Seu objetivo é demonstrar a utilização de teorias de macro e médio alcance para análise das questões interdependentes entre os determinantes sociais e as reformas do setor saúde, contribuindo, assim, para o desenvolvimento de novos conhecimentos e entendimento científico do papel dos sistemas universais e equânimes de saúde, para evitar o aprofundamento das crises econômicas.

**Palavras-chave:** Determinantes sociais de saúde. Análise de política de saúde. Economia política. Reforma do setor saúde. Teoria da regulação. Modelo de coalizões de defesa. Sistemas universais de saúde.

## **HEALTH SECTOR REFORM AND SOCIAL DETERMINANTS OF HEALTH: UNCOVERING STRUCTURAL AND HISTORICAL INTERCONNECTIONS**

Health Sector Reform (HSR) is a complex global phenomenon, involving several layers and dimensions of simultaneous change, embedded by a structural process of reform which goes well beyond sector boundaries. Since the early 1990's, authors such as Collins, Hunter, and Green<sup>1</sup> have pointed out the phenomenon of an orthodox approach to the health sector shaping a "new reform agenda", guided by the market throughout the world. Curiously, this overall strategy was diametrically opposed to the previous period of reform, which lasted from the end of the World War II until the end of the so-called Golden Years. That historical period was marked by political agreements and social pacts, intrinsically connected to the idea of Social Determinants of Health (SDH), resulting in the establishment of public healthcare as a worker's or citizen's right, inserted on the social protection agenda of most industrialized countries. These political agreements spawned the implementation of a variety of models of National Health Services, offering varying degrees of access to comprehensive care,

centrally planned by governmental health authorities. That period of reform was also marked by a public policy convergence, which seems to have broken down since the last structural crisis.

Although the causes of the economic crises are still subject to analysis, the consequences, especially for healthcare policies, are now very well documented. A radical project to reform national health services was proposed by the governments of advanced economies as a way to overcome the stagflation and the fiscal crisis, by following the neoclassical economic orthodoxy. The initiative to introduce a major reform in the health sector was primarily taken by right-wing administrations in the context of the political debate regarding the high costs and poor performance of public healthcare services. The well known market-driven reform aimed, among other constraints, to reduce the burden of fiscal deficit that had come to affect all countries since the beginning of that crisis in the 1980's.

At that stage, the macroeconomic imperative seemed to impose the adoption of dominant strategies, such as one size fits all, as a way of reforming national healthcare services on a global scale, including especially low- and middle-income countries in Latin America, Africa and Asia along the same reformist lines. The framework for implementing reforms in healthcare services in those countries has been strongly influenced by International Financial Institutions. The solution proposed for public sector problems was built up on the framework of the Economic Adjustment Programme, supported by an extensive line of scientific publication, highlighting the bureaucratic inefficiency found in state-owned organizations, working under hierarchical top-down control without economic incentives.

International agencies prescribed the application of market mechanisms to solve healthcare problems, aiming to improve micro-efficiency, in a similar vein to the way these were implemented in other policy areas for almost two decades. Such institutions have become important players in the health sector, supporting the general idea of rolling back the state, reducing the extension of healthcare rights and, the contracting-out of health-service for private provision, as a way of achieving a higher level of productive efficiency among healthcare organizations<sup>2,3</sup>. Not surprisingly, national health services around the world have been affected by or subjected to contradictory changes ever since. Several of these changes are directly related to the role of the universal access and have profound repercussions on the way in which nations uphold the right to healthcare.

However, far from answering the challenges found in tackling the serious problems of health sector, the situation has instead been worsened by the market trade-offs and structural limitations. The results and overall achievement in terms of the health status of populations has been very disappointing and has provoked growing international dissatisfaction with the market-driven project in several countries<sup>4,7</sup>. After recurrent financial disruptions, also global in scale, such radical market-driven health sector reform project seems to be reviewed. HSR guided by efficiency has come under scrutiny.

Analysing the policy debate at the international level, there are clear differences between the soft approaches from the United Nations (UN), such as World Health Organizations (WHO), in regard to the process of health sector reform comparing with Breton Woods financial institutions, like the World Bank (WB) and International Monetary Fund (IMF). For several years, these differences are demonstrated by the official discourse based on fairness and social justice, linked to the idea of Social Determinants of Health, to support the extension of healthcare rights, taking for instance, the Declarations of Alma Ata in 1978, Ottawa in 1986, and Rio de Janeiro in 2011. In contrast, the financial international organizations have been oriented by hard approaches to restrict such rights to basic packages for the poor imposed by the process of economic support. The market-driven discourse found in WB/IMF publications for HSR are usually based on consumer's choice, freedom and individual preferences to achieve micro-efficiency in healthcare policy.

This dispute has been played out at the international level by these institutions for a long time. However, the discourse of health sector reformists wanting better outcomes has been gradually redirected during the last decade from micro-efficiency to effectiveness associated with quality, accountability and equity. Different stages in this process can be seen from a longitudinal perspective. Analysing official documents published by these international agencies, anyone can see a contradictory debate behind the Health Sector Reform proposals more recently.

The normative frameworks are changing the implementation of reforming processes in countries receiving orientation from international agencies. At the present time, a good deal of the current health sector reform has been oriented by the controversial agenda of the second generation reforming package, putting the state back in, and the New Public Governance (NPG) guidelines. This agenda is now heavily emphasized by governments, regardless of their ideological background. Healthcare services around the world are huge laboratories for changes that have continued at a relentless pace in recent years. In developing countries, many of these changes have a direct impact on the structure and governance of national healthcare services and the way it is delivered by a mix of economic agents with ambivalent results<sup>8,9</sup>.

HSR and SDH have become very political academic fields which are developing scientific expertise in the analysis of the state intervention. Authors studying both themes in Mexico and Brazil see the role of expert communities that uses a considerable array of cognitive skills and scientific influence to implement such policy processes<sup>10</sup>. In this context, Buss and Pellegrini Filho emphasizes the importance of the Social Determinants Commission which has been institutionalized in Brazil since 2006<sup>11</sup>, and Navarro ironically points out the European experience for being less critical in regard to political perspectives of SDH<sup>12</sup>. The role of experts dealing with this highly contradictory policy area has long been analysed in an effort to understand the influence of science and these players beyond the academic sphere. More recently, in the USA, social forces are

coming together to spur a strong political debate as to whether to implement universal access to healthcare or not.

The distance is narrowing between universities and social movements committed to major healthcare reforms towards universal healthcare as the duty of the state. This demonstrates that, in the current global scenario, there are many reasons to be worried about the consequences of the ongoing severe economic crisis in the developed world upon health sector reform processes. The challenges ahead for health policymakers are enormous, considering recent financial shocks and the threat of global economic recession.

The main overarching question which still mobilizes public opinion is the achievement of a health policy rationale that provides and sustains good healthcare for all. Thus simultaneous layers of change have been debated within the restructuring processes in virtually every part of the world. It does not matter whether the health services are predominately run or financed by the state, through public organizations, or whether they are mixed healthcare organizations with statutory health insurance. Even those systems guided primarily by liberal principles, with healthcare structured by the market and dominated by for-profit organizations, are now seriously challenged<sup>13</sup>. The ambiguous and contradictory long-term reform regarding the duty of nation-states, market and third sector organizations to deliver healthcare requires analytical efforts to understand scientifically the current process and its consequences for the future. In the 21st Century, universal, equitable, sustainable and good-quality healthcare is a central policy issue for the agenda of governments and policymakers in a troubled world.

## **FOLLOWING AN APPROACH BASED ON THE COMPLEX THEORY TO STUDY SCIENTIFICALLY SDH/HSR INTERCONNECTIONS**

This paper combines theories in a relatively fresh way for this area of knowledge, following an approach based on the perspective of complexity. Whilst distinctive theoretical models have been used to study these issues together, most of them are either descriptive or lay great weight — albeit without proper theoretical foundation — on diffuse contextual factors related to social-economic, political, organizational and technological features, which could generate a great diversity both of health policy interventions and of ways of introducing them. Several studies still make reference to the important role played by the idea of social determinants of health influencing the level of state intervention in healthcare. Nonetheless, research on this subject requires even more epistemological and methodological efforts to understand the dense and interdependent relations played out in the real world. There is no dispute that there are macro level forces driving major changes and vital internal questions co-evolving within healthcare services in regard to reform processes. So, the main question is: how do they operate to produce the ambiguous results and contradictory outcomes observed in the real world up to now?

The scientific world does not exist in isolation from crises and changes. Since the paradigm shift reached academic circles, a substantial impact has been seen on health policy studies and the idea of social determinants. This is especially true in the case of the fragmented post-positivist sciences, which lack a basis theory capable of supporting the investigation of complex global changes observed in the health sector<sup>14</sup>. Each academic discipline tends to offer an approach based on isolated explanations which is clearly insufficient. In order to understand much more complex phenomenon, with multiple levels and dimensions, further theoretical work needs to be done. Moreover, finding scientific support for the study of any particular country's historical trajectory within these structural processes is a considerable challenge itself, given the degree of interdependence of relations and complex variables interacting on the ground.

Reductionist research models applied to these objects are poorly adapted for the identification of relations between key variables. And they cannot provide the complex synthesis of multiple determinations and contingencies necessary for comprehensive understanding amongst capitalist social relations, the reproductive role of healthcare rights and, the reform processes *vis-a-vis* the well-known market limitations. Even policy studies based on comprehensive methods — which usually try to address these themes in a broader way — are blighted by their own theoretical and methodological limitations. This raises concerns as to how to disentangle interrelated factors using such approaches.

A complexity-based theoretical support needs to deal with cause-effect issues. However, a consistent theoretical foundation also needs to avoid epistemological and methodological pitfalls in two crucial respects. The first involves an attempt to move away from the linear deterministic logic and the idea of equilibrium of closed systems, observed in natural sciences, influencing the research processes. Investigation of complexity perspective needs to avoid treating cause-effect mechanisms in a linear, rationalistic and reductionist fashion<sup>15,16</sup>. Secondly, it is necessary to connect properly macro- and middle-range theories, approaching the object of research as a whole, for consistent micro-level analyses. This means examining more than one plane of analysis simultaneously, using abstract concepts to deal with the complex empirical reality. Research projects aiming to investigate several dimensions of HSR/SDH require increased interconnection between scientific knowledge to study concrete cases. From such a perspective, combinations of theories founded on a number of disciplines are needed to guide the empirical inquiry.

On the other hand, the combination of disciplines/theories that aim to put together large cognitive frameworks brings about the risk of loss of consistency when distinct levels are simultaneously analysed. The problem is not only restricted to meanings and concepts. There are important concerns regarding theory compatibility that need to be addressed. The theoretical scheme needs to seek internal coherence, on which basis, epistemological issues must ensure conceptual correspondence and clear connections between the various levels analysed in order to develop rigorous scientific investigations. Methodologically speaking, research procedures need to take

into consideration the principle of commensurability, approaching the same object from different levels of analysis. This kind of analytic framework requires coherent theoretical connections to be scientifically consistent and reliable when approaching the interface of HSR and SDH.

The theoretical scheme for the study of HSR/SDH interrelations, proposed by this article, is based on political economy abstract-simple concepts, as a theoretical starting point, moving on to the concrete-complex processes of institutional changes which could be used for studying particular or comparative cases of reform. It draws on the Regulation School's macro-level ideas, which is connected by strong theoretical linkage, common paths and conceptual parallels to the Advocacy Coalition Framework. The next section presents the way in which this analytical scheme proposed is logically and hierarchically assembled to approach such inter-relations according to the degree of theoretical abstraction.

## **THE REGULATION SCHOOL BACKGROUND: ADDRESSING THE DYNAMICS OF THE HISTORICAL AND STRUCTURAL CONTEXT**

The Regulation School (RS) provides theoretical and empirical support for an understanding of the overall market economy process of development, structural crises and reforms. The main contribution of this line of investigation to healthcare policies is the application of a useful set of concepts for the study of the contradictions and crises/reforms affecting all complex policy systems and the consequences for specific sectors like health. These interrelated broad concepts encompass three basic regulationist ideas below the level of the mode of production: the Mode of Regulation, the Regime of Accumulation and the Mode of Development<sup>17</sup>. The dynamic interactions found among these main concepts represents, theoretically, how economy works, as it attempts to overcome structural problems and the incompleteness of market relationships. For the Regulation School, market contradictions are the internal causes of cyclical economic crises and their consequences.

The Mode of Regulation, which is made up of economic/non-economic procedures, frames institutional packages providing support for the economy, as an historical and unbalanced social relation. A process of regulation is always needed to treat the endogenous instability arising from the market<sup>18</sup>. According to this line of thought, if the markets were left alone, the tendency of the economy to produce crises would be aggravated by its core contradictions, making the entire system unsustainable. The mode of regulation thus adjusts this permanent disequilibrium within dynamic processes of change, with the involvement of the state apparatus and its institutional role as an important mediator of strategic relations between the various interests of complex social groups. Regime of Accumulation refers to a particular historical period when institutional packages

provide support for the overall structure and dynamics of society as a way of overcoming redistributive challenges. The Mode of Development meant to be a period of time when a regime of accumulation and a specific type of mode of regulation stabilize themselves, enabling periods of continuous economic growth and social development<sup>19</sup>. These periods help understanding the historical and structured context in which the entire policy system is embedded.

Two more fundamental ideas put forward by the Regulation School that are very useful for understanding health sector reform processes are the concepts of minor crises and major crises, as both can trigger distinctive types of policy adjustments. A minor crisis involves instability within the mode of regulation. By contrast, a major crisis somehow affects the regime of accumulation. A major crisis is a situation when an extensive process of breakdown of economic regulation occurs, implying a rupture of the accumulation regime. In this situation, fractions of capital are destroyed or disappear and, new forms of institutional relations also emerge, when a process called structural reform usually begins<sup>20</sup>.

For the Regulation School, two archetypes clearly epitomize historical periods, these being understood as new regimes of accumulation emerging from structural reforms. These are Fordism and post-Fordism, which characterize the overall process of structural and strategic transformation found in the contemporary world<sup>21</sup>. In this context, new forms of state intervention with distinctive characteristics emerged, including new ways to deliver healthcare, as part of the strategy of institutional support and mass consumption agreement, in an attempt to overcome the limitations of the market economy. This process marks the historical periods of nation-state intervention and the role of public healthcare. The state is constantly searching for ways of managing the core contradictions, dilemmas and ambiguities thrown up by the market. Several models of public healthcare services are included in this redistributive strategy supported by multiple levels of recurrent determinations.

Although no one can speak of total homogeneity in terms of structural crises and reforms, given the variety of national experiences and distinct trajectories of many countries, certain patterns of development and crisis-responses can be observed on a global scale. This means that the mode of development can be characterized and these patterns can be described in the long run, when a relatively stable situation is temporally achieved.

The Fordist regime of accumulation was thus managed by the nation-state. Under that regime, a similar configuration emerged around the world, and a health policy convergence was observed, until the institutionalised commitments began to fail around the 1980's. A long term structural rearrangement slowly emerges until a new mode of regulation finally replaces the old institutionalised commitments. The post-Fordist regime of accumulation has marginalized the executive role of the state with a persistent restructuring process that favours private enterprise and worldwide competition, in a way that goes well beyond the ability of the nation-state alone to manage important



aspects of the economy, as anyone can see right now. The idea of workfare replaces the widespread welfare agenda, which is now focused on the incentive to work, and social policies are subordinated to macro-economic restrictions. This is the one of the most important demonstrations of the explanatory power of the Regulation Theory with regard to the economic crises and structural changes that occur when the mode of regulation and its institutional packages can no longer stabilize the regime of accumulation.

In these historical periods, healthcare policy was introduced onto the social protection agenda, along with other social policies, that aimed to tackle the reproductive needs of the economy. Distinct models of comprehensive healthcare have been considered as worker's or citizens' right. This political process is responsible for the establishment of institutional procedures, under which access to different healthcare packages formed part of mass consumption agreements assigned by nationality. This is the most common form of health services organization based on various degrees of risk sharing which has been implemented around the world, since the mid 20th Century. Health services are considered to be part of the institutional package that aims to support the unbalanced social relations and the strategic-structured interests of complex social groups in distinct societies. For the past two decades or so, the healthcare services have been undergoing a complex process of global change at several extents and dimensions. The health sector reform is surrounded by a process of structural reform affecting the state and the public sector within the transitional period from Fordism to post-Fordism.

This theoretical political economy background sheds light on the overall context, especially with regard to the contradictory role of the state/market/third sector and their relations in health sector. The states try to mitigate the market's redistributive limitations, dealing with contradictions between social needs and the economic interests of highly diverse groups operating within and beyond the health sector. Hence they are submitted to historical cycles of crises/reforms and adjustments, with a strong impact on the extension of healthcare rights in any given society and the way it is financed, organized and delivered over time. In this context, the path each country takes is historically dependent of and contingently influenced by macro driving forces within which national health services are shaped in such a way as to support contradictory structural interests.

## **REACHING DOWN TO THE POLICY LEVEL USING THE ADVOCACY COALITION FRAMEWORK**

In order to study deeper interrelationships amongst HSR and SDH at the policy level, it is necessary to find a consistent complementary approach. Considering that the process of health sector reform, although is embedded by macro level change, is not an epiphenomenon solely determinate by macro social relations. The Advocacy Coalition Framework (ACF) has been proved to be very well suited for research when substantial political conflicts and highly technical features are present, as in the questions posited here.

Its structure encompasses the main categories and variables of most health policy analyses models. However, the ACF goes even further, establishing interdependent relationships between the aforementioned issues and policy change outcomes

This framework has relevant contributions to make to health policy studies at this level of analysis. The first concerns the unit of analysis. In ACF based-research, the unit of analysis is the entire policy subsystem. The policy subsystem is a policy domain in which groups and individual actors called Advocacy Coalitions are actively concerned to influence policy issues and the implementation process, on a long-term regular basis<sup>22</sup>, usually more than ten years.

Another fundamental contribution concerns the implicit theories underpinning the behaviour of a coalition, which is cognitively organized as a belief system. Such belief systems involve the reification of ideas, principles and values, hierarchically structured in terms of their importance and their liability to change. These are key features in developing the main assumptions and hypotheses underlined by the framework. The belief systems are organised according to degree of abstraction and scope into deep core, policy core and secondary aspects. The deep core is considered ontological and the secondary aspects are mainly related to operational policy procedures. The structure of ACF shows how the strong policy core is the main source of linkage between advocacy coalition members, guiding their strategic movements<sup>23</sup>.

The policy subsystem concept incorporates the multilevel structure of governance, including international organizations and the third sector, such as the World Health Organization, World Bank, and Non-Governmental Organizations working globally on healthcare policy. In so doing, it is much more appropriate to approach the reality of the policy dispute, in the contemporary world, considering social determinants and reform processes. The shared belief systems guiding causal assumptions and perceptions about policy problems held by such groups is the driving force behind the advocacy coalition's external conflicts and internal cohesion working as a mental map for intervention.

Two exogenous variables called relatively stable parameters and external events encompass the ACF's theoretical construct and exert a powerful influence on the policy subsystem<sup>24</sup>. These form the overall structure and time-bound context of HSR. In these circumstances, advocacy coalitions seek to influence healthcare policy according to their belief system using various strategies, resources and their political sense of opportunity.

For the purposes of research, the ACF also provides a clear definition of the concept of policy change. There are two different paths for policy change arising from alterations in the belief system. Policies can change under cognitive or non-cognitive influences, which are logically divided into two types: minor changes and major changes. Therefore, policy change in a specific subsystem is understood as the consequence of two main processes that vary in scope and depth. Major changes are associated with deep alterations in the policy core. Furthermore, minor changes are limited to secondary aspects, which are dependent on some extension of the learning-process. On the one hand, minor

changes are processes that are adjustable in the light of evidence, experience, and new knowledge. These are very frequent but not powerful enough to produce major policy reform. On the other hand, major change depends on external or internal shocks which can produce alterations in the policy core. However, the processes of major change also require the coalition to make an effort to translate these into new policy procedures, seizing the opportunity when the necessary pre-conditions arise. Shocks, like economic crises are therefore necessary, but not sufficient conditions for major change. Non-cognitive alterations can deeply affect the policy core and provide the real pre-conditions for major reform in reality<sup>25</sup>.

Following this logic, the cognitive process can alter factors which are much more fluid with less strong convergence within coalitions. For the ACF, the search for policy solutions by technical professionals is based on trial-and-error processes<sup>26</sup>. Professional forums thus play an important role in changing the secondary aspects mainly, such as the ways of funding, coordinating and delivering healthcare.

ACF provides theoretical foundations which enhance the validity and reliability of the political implications of Social Determinants and Health Sector Reform. The idea of a policy subsystem is vital for understanding the politics of healthcare reform, as a global phenomenon, at the institutional level. In this context, particular country's trajectories and experiences meant to be nested subsystems in which international and internal players form advocacy coalitions vying for the policy core which potentially generate confusing institutional outcomes also considered as path dependence processes.

## **PUTTING EVERYTHING TOGETHER INTO RIGOROUS RESEARCH PROCEDURES TO INVESTIGATE HSR AND SDH INTERDEPENDENT ISSUES**

The final sections of this paper address vital scientific issues by using the Regulation School background innovatively and recursively complemented by the Advocacy Coalition Framework for these studies. It is also important to show the advantages of the proposed all-embracing approach which is different from superposition of theoretical models without proper scientific connections.

The first important question is the compatibility of the overall body of theories in ontological and epistemological terms. Although Regulation School research is based on political economy-derived theories, it has also drawn on American Institutionalism. This acknowledges the first epistemological linkage between RS and ACF, which are both rooted in Complex Systems Theory. They also share common methodological principles, especially with regard to the need of testing hypotheses to ensure scientific rigor. On the one side, the RS avoids any ad hoc hypotheses and, at the same time, it rejects the idea of linear economic determinism that guides dogmatic circles of research. Both criticize the main assumptions of neoclassical economically-driven theories found

in several disciplines supporting reductionist and functionalist research methods. Two points clearly illustrate this: 1) the importance given to the structural context, and 2) the general line of argument used by both, which is based on contradictions and conflicts in the social relations analysed.

The second important issue to be highlighted is the correspondence of concepts and dynamic of variables related to the distinct level of analysis again used by both. The main regulation school concepts and categories correspond to the external variables of the ACF. The dynamics of change also follows the same logic. This can be seen in the underlying ideas posited to explain two different types of policy change. As Regulation Theory points out, major crisis, such as the exhaustion of the regime of accumulation, is the source of multiple possibilities for change affecting the entire policy system. This guides the behaviour of numerous segments like political parties, bureaucrats, journalists, pressure groups and academics advocating policy change. In other words, a major crisis has the potential to change the policy core of the advocacy coalitions operating within the Health Sector Reform policy subsystems. Another important theoretical connection comprises the strategic relations played by important actors. For the regulation school, complex groups are modulated by new rules of the game, when a new mode of regulation is coming about as a way of overcoming major crises. The mode of regulation, at the macro level, partially and temporarily, meets the material and non-material needs of social groups, in a way that goes far beyond the idea of simple conflicts between political parties or professional rivalries regarding healthcare policy.

In regulation school, each experience and any concrete trajectory of macro changes is positioned and historically mediated by institutions and their changing role, including that of comprehensive public healthcare services. Meanwhile for the ACF, changes in variables exogenous to the subsystem (shocks) may generate opportunities both for those who favour and those who oppose the coalition's proposals. In the same way, political events can contingently change the course of any policy, which depends on the opposing coalition's strategic actions. At the subsystem level, advocacy coalitions are struggling for benefits, trying to implement policies guided by their belief systems, seizing all possible opportunities.

The final connection to be explored concerns the trial-and-error process observed on a long term basis. The learning-process matches the role of engaged intellectuals with professional knowledge which based on technical expertise and scientific methods are permanently debated, as a way of dealing with policy problems and coming up with solutions. Although, the enlightenment function of knowledge can alter the way policies are developed, usually the coalition presents considerable resistance to factors that might invalidate their beliefs. The SDH Commissions are good examples of policy debate forums based on scientific evidence to support disputable public healthcare programmes.

## **FINAL REMARKS, POTENTIAL EMPIRICAL STUDIES AND THE POLITICAL MOBILIZATION NEEDED**

Considering this degree of epistemological compatibility and consistent connections between the ACF and the concepts developed by the Regulation School, this all-embracing theoretical scheme provides some answers to the questions raised by this article in regard to understanding the interrelationships of social determinants and the processes of health sector reform. For research based on the complex theory, the macro driving forces and interrelated dynamics of crises/ change pointed out by the Regulation School are recursively complemented by the Advocacy Coalition Framework. This combination expands the explanatory scientific power of investigation of HSR/SDR, as a complex global phenomenon, opening up a knowledge frontier to be explored in comparative or isolated case studies research. HSR is understood here as a policy subsystem in which members of advocacy coalitions play a key role struggling to bring policy proposals to fruition. Theoretical gaps are then fulfilled in two folds. On one side, Regulation School needs a complementary approach to develop micro-level research. And on the other side, the ACF external variables are sinergically clarified by the regulation theory background.

This combination explains how the overall scenario of structural crises/ reform contextualizes particular processes of health sector reform and how strategic relations are played out historically by advocacy coalitions, within nested subsystems in the case of specific experiences, observed in very distinct countries during the transitional times from one mode of regulation to another.

Advocacy coalitions are, at the same time, political bodies in motion and policy thought in action. Therefore SDH is a key aspect for strategic plan, thinking in terms of collective behaviour, facing the health reform policy debate. This can be uncovered by scientific investigations, in distinctive cases of HSR in many countries, guided by the scheme proposed.

Therefore, these dense interdependent relations can be studied and clarified. Structural patterns and regularities can also be spotted, which means that a certain degree of historical periodization and territorial features can be investigated, in which particular cases of health sector reform are embedded. This broad analytical scheme enables understanding of two types of policy change -major change and minor change- occurring in the reforming processes.

Health sector reform experiences are value-laden and knowledge-driven initiatives. Close examination to identify belief systems, related to HSR advocacy coalitions, provides the starting point for research and the development of new knowledge regarding this object of inquiry. The concept of health and its social determination is a good way to distinguish the policy core advocated by such groups; given that healthcare is one of the most controversial areas of state intervention. This conceptual distinction is a fundamental point of cleavage for policy research purposes. It is a key issue for

understanding the formation of health policy-makers' beliefs systems and the processes of their political engagement, while taking into consideration their opposing values, contrasting points of view and sometimes contradictory and ambiguous procedural convergence. This is especially true in particular cases. For example, the Brazilian case of Health Sector Reform and the Unified Health System (SUS) contradictory process of Social Security Model of Healthcare, which is unfinished after more than two decades of intense political struggling.

For this reason, operational policy proposals in the current HSR experiences may converge and could be advocated by opposing coalitions with different strategic objectives. For example, the decentralization of health services to local health authorities; the increasing role of primary healthcare focusing on the neediest people based on health promotion/prevention and; the participation of market and non-governmental organizations which is associated with incentives for a stronger regulatory role for governmental health authorities. These secondary aspects of such reforms have been strategically implemented in all parts of the world.

On the other hand, the idea of equity and social justice in healthcare policy is a good example of ontological concepts. It is part of the deep core, which depends on subjective interpretation, based on societal values, ideological principles and interests held by advocacy coalitions guiding the formation of the policy core. Investigation of the policy core of health sector reform coalitions may therefore lead to clarification HSR confused outcomes.

Research evidence shows how the idea of social determinants of health is part of the opposing belief system regarding to the policy core in permanent dispute at this subsystem. The concept of health upheld by coalitions working within the HSR subsystem is vital to understanding their strategic movements. Health can be viewed in a broad sense as a citizen's right, which justifies struggling for universal access to an equitable healthcare service. Or, on the other hand, it can be deemed to be a private good, available only to those who can afford it, like any other commodity bought and sold on the market, with some basic support provided for the poorer sectors of society. This clearly separates distinct health sector reform policy core and strategic actions taken by organized advocacy coalitions committed to these policy proposals. This approach explains the contradictory and ambiguous process of change brought about by opposing advocacy coalitions in the domain of health sector reform in the long run.

In view of the enormous challenges ahead that the entire world is facing, which involves simultaneously, climate change, new globally-spread infectious diseases, a fast-growing ageing population affected by chronic health conditions, well informed political mobilization need to be done in order to expand universal healthcare access for all. Now, more than ever, facing the threat of a major economic shock with unpredictable consequences, Social Determinants of Health need to be taken into consideration to avoid worsening the overall situation. This article aims to spark a scientific alert on this fundamental policy debate for the nearly future.

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